

**ADAP ADVISORY COMMITTEE MEETING
HENRICO DOCTORS HOSPITAL
MAY 20, 2008**

Members Present: Bob Higginson PA-C, Nancy Wade RPh, Craig Parrish RPh, Donald Walker, Linda Eastham NP, Robert Brennan MD, Margaret Tipple MD, Karen Council OSS, Daniel Nixon DO, and David Wheeler MD.

VDH STAFF: Diana Jordan RN MS; Steve Bailey LCSW, Faye Bates RN, Stephanie Lewis, HIV Specialist and Rosalyn Campbell, Administrative Support

Guests: Mike Herbert and Ella Perkins

Other: Anne Rhodes

Diana Jordan, Director of Health Care Services called the meeting to order at 10:15 a.m. Welcome and introductions were made. Minutes from December 17, 2008 meeting were reviewed by members and approved.

Diana provided an update on VDH activities. The total Ryan White award received for this grant year was \$28.8. The ADAP earmark was level funded and the ADAP supplemental received was \$4.1 million. The total ADAP award amounted to \$20.8 million. Diana also stated that VDH is working with the HRSA Project Officer on budget strategies using some ADAP funds for care services. There is more funding in the ADAP stream and the services funding side has not kept pace with ADAP funding. ADAP money will be used for additional services allowable under ADAP. A penalty situation may occur if the money is not spent down to 2% by the end of the grant year. Every region who is operating consortia-based services will receive an increase, which will help with services.

Diana informed the committee of the appointment of the new Virginia Department of Health State Commissioner, Dr. Karen Remley. An update was given on the outcome of General Assembly. The legislation on the simplification of HIV testing consent and testing was passed. The process will be simplified and will allow health care providers to test in compliance with CDC guidelines. The law will go into effect July 1, 2008. VDH will be disseminating information in the future.

As mentioned at a previous ADAP Advisory Committee meeting, VDH has started testing under the CDC HIV testing grant. HIV testing is being conducted at community health centers on the Eastern Shore as part of routine medical care. Whitman Walker Clinic in Northern Virginia is implementing a social networking model as part of that initiative. Testing through the emergency rooms and corrections are not at the implementation stage at this time.

Steve Bailey provided an update on the State Pharmaceutical Assistance Program (SPAP) and other programmatic updates. Patient Services Incorporated (PSI) is the contractor for the SPAP. They recently completed a consumer satisfaction survey that will be distributed to providers and consumers along with a written status update with everyone involved in SPAP in the community. The responses ranged in the 90% satisfaction ranges, and PSI will be looking at program issues that could be improved. PSI has showed more cost savings than initially anticipated. They have been very responsive to the client population and the agency. PSI has been able to enroll an additional 50 clients in cost-sharing and possibly enrolling more. In addition to ADAP medications, clients are able to access all of their medications under Medicare Part D. VDH has been in communication with HRSA in hopes of using some of the state funds to support premium assistance and the administrative cost of ADAP outside the SPAP allocation of \$285,000. The full \$285,000 will be used for cost sharing assistance. This will reduce the wait list for cost sharing assistance. Over 100 people are enrolled in SPAP currently and new applications are being received.

Steve attended a congressional briefing on May 16, 2008 in Washington, DC. Virginia was invited to discuss the role of ADAP in health care nationally to educate members of congress and the members of the health committee about the role of ADAP and the need for increased funds to ensure that we are meeting the growth that is occurring in the ADAP programs. Another issue presented was that federal dollars cannot be used toward true-out-of-pocket (TrOOP) costs under Medicare Part D, which causes the client to stay stagnant in Medicare D and never progress to lower costs. That was behind the initiation of the SPAP. Congress asked about Virginia's experiences with being one of the first states to have a SPAP. If federal dollars could be used toward TrOOP, that would solve problems in many states. There were 15 Congressmen represented, most of the national AIDS Advocacy Groups, AIDS Action, NAPWA, AIDS Institute, and NASTAD were in attendance. A physician from Philadelphia attended, Dr. Kwakwa, who practices out of the Philadelphia Department of Health and talked about the role of positive outcomes of providing medications to people with HIV.

Several questions were raised about the demographics of the SPAP clients. Since there are over 100 people enrolled, PSI will do a demographic breakdown of clients. The results will be forwarded to committee members when available. A question was asked how are clients are identified. Clients are identified through local health department ADAP Coordinators who have clients with Medicare Part D on their roles. These clients are to be referred to PSI. Case managers also make referrals as well. A new SPAP brochure will be distributed soon.

Steve gave an update on the status of the ADAP Centralized Eligibility and Enrollment Program. As ADAP eligibility has become more complex, it has become a burden for local health departments. Funds have been set aside to pay for a centralized process. The Request for Proposals (RFP) was released on May 7, 2008 and the deadline for proposal submission is June 30, 2008. It is a very specific RFP, especially around data security issues. HRSA requires that ADAP eligibility be done every 6 months. The RFP is posted on the VDH website and on the eVA site. Input on centralized eligibility was

sought from consumers, ADAP Coordinators and providers. The focus groups results will be posted on the Division's website simultaneously at the time of the pre-proposal meeting. The pre-proposal conference is scheduled on May 21, 2008 at 10:00 a.m. and is open to the public.

With the additional funding, VDH was able to carve out funds to increase adherence support at the local level. The VCU HIV/AIDS Center will provide assistance in developing and implementing adherence programming that can be replicated throughout the state to help local health departments assist consumers to adhere with their treatment regimen.

Diana gave a programmatic update on projects that are linking clients to ADAP and other services. There are currently three Minority AIDS Initiative funding projects in high prevalence areas in the state that use intensive outreach strategies and strength-based case management to ensure clients are linked into ADAP and follow through with eligibility. VDH is looking to expand this initiative so that every region in the state will have linkage activities.

On April 4, 2008, the first annual Virginia Ryan White All Grantees Meeting was held in Richmond. This event was held in collaboration with the Virginia HIV/AIDS Resource and Consultation Center and the local performance site for AIDS Education Training Center. There were about 130 participants who gave positive feedback. VDH looks forward to seeing a large annual Grantee event in the future.

The Leadership in Advocacy and Planning (LEAP) Training Program will be held on June 4 through June 6, 2008. This is a free training and an opportunity for consumers to become involved in Ryan White planning processes. All grantees have requirements for consumer involvement. This is a great opportunity to have targeted training and giving the skills necessary to enhance the ability to advocate. There will be L.E.A.P. training in Norfolk late June 2008.

Diana informed the committee of the unit name change. Health Care Services is now HIV Care Services.

HRSA is sponsoring a new quality improvement initiative called the Patient Safety and Clinical Pharmacy Collaborative. If a network or system of care involves any HRSA funded entity that system of care would qualify to participate in the collaborative. The main focus is improving the effective use and safety of pharmaceuticals.

Faye Bates and Linda Eastham lead a discussion on the mission statement and goals of the ADAP Advisory Committee. This was a continuation of the discussion that was initiated at the December 17, 2008 meeting. There was a review of information obtained from the previous meeting. The questions posed were "What is the vision of the Virginia ADAP Advisory Committee? What are the priorities of the ADAP Program in Virginia?" The question for the present meeting for discussion was "Should the committee focus on HIV-specific treatment?" However, Linda Eastham had a question

now that the HIV testing law has changed is it anticipated that more people will be found who are HIV infected? There will be more people who will be in need of services, is there any idea on how ADAP funding can be used for other resources? What are the resources that ADAP money could be used?

Diana responded if ADAP money is limited just for the use of pharmaceuticals, it would be a struggle to spend it effectively. If there is a sudden influx of clients needing services, ADAP could handle the increase. One of the challenges is how to better use the money now and to plan for the future. Based upon the present testing initiative right now, rates are slow, and it is difficult to gauge the impact of the testing initiative.

A question was asked about allowable services under ADAP. Diana responded that the allowable services under ADAP included certain HIV specific labs, outreach and linkage into care, adherence support, health insurance continuation, premiums and copays.

There was a discussion about HRSA requirements for ADAP, what is allowable, the addition of medications to the formulary, and the requirement of adding new classes of medication. Nutritional supplements purchases are not covered under ADAP, but allowable under Ryan White Part B funds. Other requirements for ADAP, that a client is HIV infected, ADAP is the payer of last resort, and medications that are HIV related. Only approved FDA medications and cover every class of antiretrovirals. There was a lengthy discussion on HIV-relatedness. The top priority is always directly related to HIV treatment in antiretroviral therapy and opportunistic infections. A suggestion was made to establish "tiers" of covered treatments and a pathway to allow the committee to follow the funding in case of a funding shortfall.

Draft vision statement as per Advisory Committee discussion is: "To oversee the responsible provision and distribution of medications needed for people living with HIV (PLWHAs) to maintain a good quality of life while living with an often long term chronic illness. Optimize adherence and monitor outcomes, evaluation and quality improvement." Diana suggested that further dialog can be done by conference call or email. Proposed goals are that no HIV positive Virginian will live without medications and no waiting list for ADAP. Mission statement and goals will be a continued discussion at future advisory committee meetings.

Stephanie Lewis, HIV Specialist gave an update on the Virginia Medical Monitoring Project. The project consists of matched interviews and medical record abstraction. Information is collected on behaviors, clinical outcomes, type, and quality of care received and identify met and unmet needs for HIV care and prevention services. There were 24 facilities sampled in 2007. Of those, 22 facilities agreed to participate. 18 provider sites were contacted to participate. Presently, data collection and client interviews are being conducted. Interviews are to be completed by May 31, 2008 and medical record abstractions are to be completed by July 31, 2008. It is anticipated that data will be available by the end of the year or early 2009.

Faye Bates presented some formulary issues before the committee regarding the double dosing of Hepatitis B vaccines. The information submitted were footnotes from the Recommended Adult Immunizations Schedule October 2007 through September 2008, which addressed the medical indications for Hepatitis B vaccine for special formulation for hemodialysis and immunocompromised clients. The question to the committee was “Should Hepatitis B double dosing be a standard or clinician choice?” After a brief discussion, it was decided that Hepatitis B double dosing is an option and not a standard. Correspondence will be sent to inform the local health departments that double dosing of Hepatitis B is acceptable if they receive a request, and that it is reimbursable under ADAP.

There was a medication addition to the formulary for discussion. The guest speaker at the December 17, 2008 meeting, Dr. Klinger, had made some recommendations on an addition of valproic acid (Depakote) to the formulary. She recommended adding Depakote to the formulary as an alternative treatment for bipolar disorder. Lithium is presently on the formulary. The other issue for discussion was the recommendation of removing chlorpromazine (Thorazine) from the formulary.

After much discussion, it was decided to add valproic acid to the formulary. During the course of the discussion, a request was made for Seroquel to be considered for formulary addition. Information on Seroquel will be researched on the potential for abuse and cost. The issue of removing chlorpromazine from the formulary was discussed. There has not been any request for this medication since it was added to the formulary. It was suggested by Diana that the Richmond Behavioral Health Authority and other major mental health facilities will need to be contacted to access utilization of this medication and recommendations. Craig Parrish also mentioned that there are a couple of drugs on the formulary that have not been used for 4 years. A review of medication with low or zero utilization will be an agenda item at the next ADAP Advisory Committee meeting. No medications will be removed from the formulary at this time.

Anne Rhodes, Survey and Evaluation Research Laboratory, Virginia Commonwealth University, presented the ADAP data report. She will e-mail the presentation to committee members. Newly enrolled ADAP clients appear to be younger, with the average age of clients new to ADAP in the last 3 years being 40.6 years compared to 45.4 for those on ADAP longer than 3 years. The largest increase in enrollment is the 13 to 34 age group with 28% of new clients in this category, compared with 10.8% of continuing clients. The average length of time clients are on ADAP has increased to 50.5 months in 2007-2008.

There was a question about CD4 and viral load collection. Anne Rhodes stated that CD4 and viral loads available are primarily from time of intake, but updated laboratory results are not consistently provided. The centralized eligibility system will be collecting that information at 6-month intervals, making trend analysis possible. The SPAP will be collecting CD4 and viral loads at 6-month intervals as well. Diana mentioned that all viral loads and CD4s are now reportable. The surveillance unit is receiving reports, but do not have the electronic interface ready to make use of the data at this time. Craig

Parrish mentioned that there is a new pharmacy computer system, with new software. At present, CD4 viral and viral loads are being entered into the pharmacy computer system. He will try to run a report with the information that is being collected.

Faye Bates gave a follow-up on the Seamless Transition Program. When looking at clients that are linked to ADAP at some point after referral, the revised report showed a success rate of 64% in 2006. Of the inmates not linked to ADAP, 10% were female. It was suggested that a card or other materials be given to inmates at release to help with linking to services. The toll-free VDH HIV/STD/Viral Hepatitis Hotline number will be included in the materials.

The meeting was adjourned at 2:00 p.m.