Virginia Community HIV Planning Group
Four Points at Sheraton Hotel
Meeting Summary

Members Present: Tim Agar, Nataly Anifrani, Sylvester Askins, Roy Berkowitz, Reed Bohn, Gennaro Brooks, Shawn Buckner, Emeka Chinagorom, Victor Claros, Jerome Cuffee (Community Co-Chair), Daisy Diaz, Pierre Diaz, Colin Dwyer, Earl Hamlet, Russell Jones, Marquis Mapp, Elaine Martin (Health Department Co-Chair), Eric Mayes, Diane Oehl, Darius Pryor, Zachard Roberson, Robert Rodney, Anthony Seymore, Dorothy Shellman, Lee Stone, Stanley Taylor, Nechelle Terrell, Joyce Turner, Stacie Vecchietti, Chris Widner, Robyn Wilson

Members Absent: Keri Abrams, Justin Finley (represented), Cristina Kincaid

Others Present: Sahithi Boggavarapu, Heather Bronson, Kathleen Carter, Felencia McGee, Renate Nnoko, Amanda Saia, Bruce Taylor, and Carrie Walker of the Virginia Department of Health, Division of Disease Prevention; Jennifer Flannagan and Latisia Grant of Virginia Commonwealth University AIDS Education & Training Center; Michelle Reed (represented Justin Finley); Rashaad Banks of Inova Juniper Program; Mike Mallon of the Virginia Department of Health, Office of Health Equity

Total: 44 participants

Greetings and Introductions - Co-Chairs

Old and New CHPG Business - Care and Prevention Planners
No new or old business reported.

Approved 2017 Meeting Dates:
Friday, February 3
Thursday, April 6
Friday, June 9
Thursday, August 17
Friday, October 20
Thursday, December 7

Approval of October Minutes - Co-Chairs
Motion made to approve the minutes with a caveat to add a summary of the workgroup sessions.

Prevention Update – Elaine Martin

- 1506 and 1509 – Elaine reported several productive meetings with contractors and HD staff, increased collaboration between health departments and CBOs, tension has been removed from the process that existed in the past and now looking at what's best for the clients we serve. Eric reported that Norfolk opened its PrEP clinic and is seeing five patients; also four at Inova. Yesterday VDH staff met with UVA staff, now have six months' worth of PrEP data. Will be meeting January 12 to analyze it. Five clinics are up and running, another two agreements in the works in Southwestern and Eastern. State funding is available to support clinic time and meds.
- Health Commissioner – Naloxone update re: opioid crisis - legislative proposal will go forward again this year at the GA session.

Care Update - Renate Nnoko

ADAP Re-certification:

- Clients need to return 2017 premium information to VDH by December 22 to ensure a premium payment is made for those with January 1 effective dates. Enrollment sites should be sending complete ACA checklist, including address, phone number and client signature.
- Beginning January 1, 2017, VDH will discontinue ADAP services to clients whose eligibility information (proof of income, address, and insurance status) is outdated. Clients with eligibilities completed before January 1, 2016 will be dis-enrolled from the program.
- Any client who is dis-enrolled may resume ADAP services by completing a new application and providing proof of income less than 400% of the federal poverty level, a Virginia address, and health insurance information.
- This action is required to ensure compliance with federal policy. HRSA oversees ADAP programs and requires a complete eligibility assessment (including proof of income, address and insurance status) for each client every year.
- HRSA also requires ADAPs to recertify client eligibility every six (6) months. Clients may use a simple one-page form to self-attest there have been no eligibility changes. If the client reports any changes to income, address, or health insurance status, he/she must submit documentation of the changes to Virginia ADAP.
- The purpose of annual and six-month re-certifications is to ensure all ADAP clients meet current legislatively-mandated eligibility criteria, and that VDH has the most up-to-date client information.
- HRSA prohibits state ADAPs from allowing grace periods or presumptive eligibility. If Virginia ADAP provides services to clients lacking documentation of eligibility, HRSA may implement serious financial and disciplinary penalties. Therefore, VDH must take action to ensure compliance with federal requirements.
- Virginia ADAP will mail applications to clients three months prior to the eligibility expiration date.
- Around the time Virginia ADAP staff send out re-certifications, they also send a list to each provider requesting an updated medical certification form with updated labs within six months. However, a client can be re-certified pending the receipt of the medical certification form.
- Each re-certification letter sent to clients includes a due date by which the materials need to be returned to VDH. After three documented attempts to re-certify over 60 days, unresponsive clients are dis-enrolled from the program.
- After the due date has passed, Virginia ADAP provides a list to the health department, provider, and/or case manager stating which clients have not yet re-certified.
- In order to ensure compliance with this process, VDH will put an end or hold date on client accounts, if insured, through Ramsell. If clients are not re-certified as eligible at that time, a denial will be triggered by claims at point of service. In order for the end ate to be updated and for clients to be able to access medications again, clients need to send updated eligibility/re-certification information to Virginia ADAP. Local health departments and medication access sites will be notified by fax of ineligible clients in January 2017.

Discussion followed about challenges to the process and Elaine reiterated that VDH is not causing the challenges to the process; these are federal (HRSA) guidelines but VDH is working hard to assist the process. Care & Prevention had a collaborative contractors' meeting on Wednesday and one topic was how to find the 2,500 clients that haven't re-enrolled and get them re-enrolled. If people miss the deadline, it doesn't mean that they won't get coverage in 2017. There is talk about raising the federal poverty level from 400% to 500%. Jerome gave Part A update: the Norfolk Planning Council has

completed its biannual needs assessment which includes a survey of in-care and out-of-care clients. The data will be complete by mid-January, so he will report the findings at February meeting.

Election of Co-Chair and Membership Committee – Care and Prevention Planners
Bruce distributed a ballot with nominations for the community co-chair and membership committee. Nominees for community co-chair were Jerome Cuffee and Robert Rodney, and both spoke about why they would like to serve. The membership committee meets once a year to review applications, and Bill Briggs' leaving has left a vacancy. The nominees were Robin Wilson, Victor Claros, and Tim Agar. The committee voted and Jerome was re-elected as community co-chair, and Robin was elected to the membership committee.

HIV Testing Technologies and Strategies - **Heather Bronson, Felencia McGee,**
4th Generation Testing, Rapid Testing, Home Test Kits, Pharmacy Testing,
Increasing Testing among Men – Heather indicated that in most settings, women receive more tests than men and research shows that overall, women seek health care more than men. But HIV cases are overwhelmingly male, so getting more men tested has been identified as part of the Integrated Plan. New settings to explore: urgent care centers, sports medicine center, gyms, gambling facilities, etc.

Expanded access to HIV Testing through Retail Pharmacies - Walgreens contract in 2014 in 13 stores statewide, with an additional 19 stores added in 2015. The sites were determined by high minority populations, high poverty, and those having private testing rooms. Twenty-five positives have been identified. Pharmacists conduct preliminary testing only; DDP staff are available 24/7 for positive clients, local CBOs or DIS conduct confirmatory testing. Pharmacy testing will be continued under PS12-1201. DDP and Walgreens are communicating with other states interested in replicating the program.

No Wrong Door 2.0: Home HIV Testing for MSM in Virginia - Home HIV Testing Pilot – one goal is to increase access to testing for stigmatized or isolated Virginians. Heather distributed home tests kits for members to open and see what's inside. Limitations are that all data are self-reported, eligibility criteria can encourage reporting false info, and very few users complete post-test survey. Next steps: broader-based advertising (phone apps), stakeholder feedback about survey, further dissemination of results from pilot. Eastern and Southwest regions have requested the most test kits.

4th Generation HIV Testing Pilot – Felencia explained that it is able to detect acute HIV infection faster. Multi-Spot withdrawn from the market in July and will be replaced by Geenius. Some labs in Virginia have already started to use Geenius; others will start using it in 2017.

A demonstration of testing technologies followed the presentation.

Rural Health in Virginia - An Overview - Office of Health Equity – Mike Mallon
Mr. Mallon posed the question: What exactly is "rural" in Virginia? Different agencies use different definitions, and there is no definitive one. He showed a slide of rural census tracts showing aging populations in rural areas in Virginia specifically and in the US generally. Uninsured rates are higher in rural areas for adults and children, and the lowest areas of economic opportunity are located there as well. The Office of Health Equity provides incentive programs to health professionals to help entice physicians to work in rural areas. Project ECHO (Extension for Community Healthcare Outcomes model) builds capacity to treat complex health conditions in rural and underserved areas that lack ready access to clinical specialists. Project ECHO links primary care clinicians with specialists through a real-time learning model using inexpensive video-conferencing technology. This allows physicians, nurse

practitioners, and others to jointly manage complex illnesses and promotes use of best practices of care. Mr. Mallon's contact info is michael.mallon@vdh.virginia.gov or 804-864-7432.

Discussion followed: Eric talked about a rotating PrEP clinic that would rotate between three HDs in rural areas of Virginia. Bruce talked about challenges writing the Jurisdictional Plan considering transportation and medical services. One idea was recruiting Uber drivers to transport clients, which was identified as an example of thinking outside of the box.

An Overview of HIV in Rural Virginia - Amanda Saia, HIV Surveillance Epidemiologist
"HIV Disease in Rural Virginia" – Amanda began by defining rural and urban areas. Using 2010 Census Bureau data, of the 134 counties in Virginia, 44 were considered rural. New HIV diagnoses in rural Virginia vary each year, go up and down; 2015 had the highest number with 89 cases. From 2006-2015, on average, 7% of new diagnoses in Virginia were from rural counties. Breaking down new cases by region in 2015, the highest was 35% in Southwest, followed by 22% in Northwest. Elaine: Bottom line - services need to be directed at the special needs of rural areas. Disparities exist in rural counties and we are working to address them by telemedicine (pilot at Lenowisco HD); exploring needle exchange, and expanding services. Amanda's contact info is amanda.saia@vdh.virginia.gov or 864-7862.

Nataly asked, "What determines where the funding goes?" Elaine explained that funding goes to areas of highest incidence. But she used Indiana as an example of how lack of funding in an area of low incidence resulted in a crisis. Therefore, "Do we wait until southwest Virginia has an outbreak of HIV or do we provide funding there now? How do you both prevent and also put the money where the greatest need is?"

CDC's Designation of Vulnerable Counties for HIV Outbreak with Emphasis on Virginia Counties - Sahithi Boggavarapu, VDH-DDP Surveillance
Sahiti discussed sociodemographic indicators and drug use-related variables used to identify the most vulnerable counties in the US for HIV or HCV outbreaks. Virginia has eight vulnerable counties: Buchanan, Dickenson, Russell, Lee, Wise, Tazewell, Patrick, and Wythe. From 2013-2014, fatalities from prescription opioid overdoses in Virginia increased by 8.3%; heroin overdoses increased by 12.2%. Forty-four percent of all drug treatment admissions in Virginia were due to IDU.

Feedback from CHPG members on Rural Health Issues
Discussion followed about possible funding sources for rural areas and the economic challenges that exist that might prevent services from reaching those most in need. Bruce: There is political and cultural pushback in rural areas due to stigma and denial – "We will arrest them but not provide services because what they are doing is wrong." Elaine: Integrated plan addresses trauma-informed care to try to address questions about why people don't seek treatment or stay in treatment, or engage in high-risk behaviors.

Meeting Wrap-Up - Jerome Cuffee, Elaine Martin
Darius asked "How does the CHPG help the populations we represent?" Elaine reminded members that they are charged with taking what we do here back to their communities. State government turns slowly and change takes time, but the CHPG has been instrumental in implementing several programs, such as the CHARLI program which took four years to get funding. Discussion then centered on the role of the CHPG and Elaine explained how the planning process has changed over the years. We are not charged with resource allocation, but VDH staff take back community input and it is incorporated into and affects public health services that are funded. Elaine reminded members to read the Integrated

Plan because it's what we've been working on for the last five years and is a roadmap of where we're going and what we're going to address.

Jerome stated he would like to see more workgroups to give the members who don't feel comfortable talking in front of a large group the chance to express their viewpoints and feel like they have been heard. He would also like to build in more time for discussions after presentations to process what was presented and how the members can take the information back to their communities. Elaine stated she will include Jerome in planning the next agenda.

Elaine addressed the suggestion to have a teleconference to set plans to incorporate the Integrated Plan into the meetings. Is that something we want to do? She will schedule a call, bring in Kimberly Scott, Director of HIV Care Services, and establish some focus points for how the CHPG will go forward.

Adjourn
The meeting adjourned at 4PM.