Community Planning Group Minutes

Holiday Inn Mercy Campus

Des Moines, IA

September 7 - 8, 2016

HIV & HEPATITIS COMMUNITY PLANNING GROUP MEMBERS **in attendance*					
x	Julie Baker	x	Betty Krones	x	Anthony Sivanthaphanith
x	Sue Boley	x	Roger Lacoy	x	Carter Smith
x	Colleen Bornmueller	x	Jacob Linduski	x	Rachel Stolz
x	Megan Campbell	x	Darla Peterson	x	Roma Taylor
x	Tim Campbell	x	Sara Peterson	x	Pamela Terrill
x	Scott Clair	x	Marty Reichert	x	Mark Turnage
x	Linnea Fletcher	x	Sonia Reyes-Snyder	x	Kathy Weiss
x	Greg Gross	x	Theresa Schall	X	Patricia Young
x	Holly Hanson (proxy) Meredith Heckmann	X	Shane Sharer		
x	LeeVon Harris	X	Jordan Selha		
x	Tami Haught	x	Michelle Sexton		
x	Tim Kelly	x	Cody Shafer		
Health Department Staff: Randy Mayer, Nicole Kolm-Valdivia, George Walton		*Guest(s): Chris Bidiman, Jillian Casey, Kevin Brinegar, Jenny Richards, Michael Voigt, Douglas LaBrecque, Natasha Ritchison, Jessica Baker, Chris Taylor, Donald Hillebrand*			

Wednesday, September 7

CALL TO ORDER

Colleen Bornmueller called the meeting to order at 3:00 p.m. A moment of silence was held in memory of Jerry Harms, IDPH HIV Surveillance Coordinator, who recently passed away.

ROLL CALL

Colleen Bornmueller facilitated roll call. Pat Young gave updates about absent members.

TEST AGENDA

Colleen asked if there were any additions to be made to the test agenda. No additions were made.

Ground Rules & Agenda Review

Pat reviewed the group agreements, the agenda, and goals of the meeting:

Goal 1: Review the 2017-2021 Comprehensive HIV Plan
Goal 2: Vote on Concurrence
Goal 3: Participate in small group discussions on prevention, testing and linkage, and care and treatment of hepatitis
Goal 4: Discuss the drafting of the 2017-2021 Iowa Hepatitis Action Plan

Approval of June 16, 2016 Minutes

Colleen facilitated the approval of the June 16, 2016, minutes. No objections were raised. Roger Lacoy motioned to approve the minutes. Sue Boley seconded the motion. Motion carried.

Review of June 16, 2016 Check-outs

Colleen facilitated the review of the June 16, 2016, meeting checkouts.

- Overall positive comments centered on all the work accomplished in preparation for the development of Iowa's 2017-2021 Comprehensive HIV plan.
- Members stated that they found the background and information shared about drug overdose and the provision of Naloxone very helpful.
- They found the presentation on the Hepatitis C epidemiological profile very helpful.
- Members also enjoyed the trauma-informed care information.

NEW BUSINESS

1. **CPG Guest Attendance**
   Randy Mayer, HIV, STD, and Hepatitis Bureau Chief, reminded members that CPG minutes get posted on the website, which includes names of guests. A former guest expressed concern about their name being posted on the website. Randy stated that CPG members, when inviting guests, should discuss with them that minutes will be posted online, which includes their names if the guest signed in. He said that while we'd like to have a record of guests that attended the meeting, they wouldn't necessarily have to be included in the minutes that get posted online. For this situation, he removed the guest's name from the minutes and then re-posted the document online. However, Randy said that he needs CPG approval to amend the minutes in this manner. Roger Lacoy motioned to approve the modification to the past minutes. Marty Reichert seconded the motion. Motion carried. After further discussion, it was decided to update the "welcome guest" flyer. The MOBE committee will work on this.

2. **2017-2021 HIV Comprehensive Plan**

Jordan discussed the HIV Comprehensive Plan that is divided into three sections. The first section is the HIV epidemiological profile. The second section includes the goals, objectives, strategies, and activities. The third section includes the monitoring plan. Jordan reviewed the plan and discussed the goals, objectives, and strategies. Jordan asked if there were any questions, comments, or concerns. Members generally felt the plan was representative of the work of the last year.

3. **Concurrence**

Pat Young discussed the process of concurrence. Voting for concurrence means that the CPG concurs with the goals and objectives set forth in the *Integrated HIV Prevention and Care Plan*; that the plan includes a description of the process and response to the guidance set forth by CDC and HRSA; and that programmatic activities and resources are allocated to the most disproportionately affected populations and geographic areas that bear the greatest burden of HIV disease. Pat and Colleen, as the CPG co-chairs have to write a letter on behalf of the CPG to CDC and HRSA stating whether the CPG concurs with the plan. The options for concurrence include concur, concur with reservations, or non-concurrence. Betty Krones motioned to vote on concurrence. Julie Baker seconded the motion. A vote for concurrence was held. The CPG members unanimously voted to concur with Iowa's plan.

4. **Review of HIV Prevention Annual Performance Report**

Pat discussed the HIV prevention program and provided data for 2015 and the first half of 2016. She reviewed with the CPG how the prevention program is putting the comprehensive plan to work. During the first half of 2016, there were 2,646 HIV tests administered. Over 30% of those tests were administered to men who have sex with men. There were 14 clients newly identified as living with HIV.

5. **Ryan White Part B Supplemental Funds**

Pat gave an update on the $6.9 million Ryan White Part B Supplemental Funds received from HRSA. Some of the key initiatives that will be addressed include data to care, trauma-informed care, retention and case finding, data quality, regional outreach and education, community-based case management, behavioral health consultants, housing and stability, expansion of testing, transportation, and mobile outreach, among others.

A member asked about the client to case manager ratio, and whether more case managers will be hired. Meredith Heckmann, proxy for Holly Hanson, stated that most agencies are at that ratio, and now IDPH will look at the tiers of needs of clients to determine on an agency-by-agency basis whether that ratio needs to be modified. A question was asked about the AIDS Drug Assistance Program (ADAP). Randy Mayer stated that IDPH was in the process of amending Administrative Rules to increase the eligibility requirement for

the medication assistance program (i.e., no insurance) to 400% Federal Poverty Level, to be the same as for the insurance assistance program. He also said that hepatitis medications (for HIV and HCV co-infected clients) were added to the ADAP formulary. Randy stated that some states are at 500% FPL, rather than 400% FPL, but we are not considering that move at this time. Meredith said that Iowa also expanded insurance purchasing through ADAP.

6. Policy Initiatives

Randy discussed initiatives that IDPH or others could pursue during the next legislative session.

- Iowa Code currently requires medical providers to offer risk-based HIV testing rather than routine, opt-out testing. This would be an area to consider to change, although we are doing what we can to expand routine testing at FQHCs. There is also the issue of requiring minors to give written consent that they understand their parent/guardian will be notified if they are positive.
- Another policy issue includes working more collaboratively with Medicaid to improve health outcomes for PLWH who are Medicaid recipients. There is a new project supported by HRSA and CDC to improve data sharing between state Medicaid programs and health departments. It's called an HIV Affinity Group, and Iowa has enrolled in the program. Each of the managed care organizations (MCOs) in Iowa has agreed to work with Medicaid and IDPH to develop data-sharing agreements so that we can look at the care continua for each MCO. Some of the projects will include expanding routine HIV testing, implementing reengagement in care, improving viral suppression at each MCO, and improving access to oral health care for Medicaid recipients.
- Randy also discussed the department's efforts to remove or relax earmarks and restrictions on state funding. For example, the bureau receives separate funds for ADAP, STD prevention, and hepatitis prevention. If these funds were combined, the bureau would have more flexibility to use the funds to implement the state HIV and hepatitis plans. This year, the department will likely ask the legislature to combine these funds but keep them focused on HIV, STD, and hepatitis prevention and care more broadly.
- Randy said that IDPH has been working on administrative rules that need to go to the Board of Pharmacy (BOP) on the Naloxone bill. The soonest they could take effect is the November BOP meeting. Once it's passed, there would be a state standing order that would allow all pharmacists to sell naloxone to persons who need it, without a prescription. He also said that the Quad Cities Harm Reduction Coalition would like to go back to the legislature and get the Good Samaritan part of the bill passed. The Good Samaritan law provides some immunity to persons who call emergency services when someone in their presence overdoses on heroin

or opioids. For example, the person who made the call wouldn't be charged with possession of drugs or drug paraphernalia.

A question was asked about how a person proves they *need* naloxone at a pharmacy. Randy said pharmacists will have a form that needs to be completed. The client must respond that they are family, a friend, or someone in a position to assist someone who might overdose. A question was asked if it's up to the pharmacist to opt-in to the standing order. Randy said that yes, pharmacists can opt-in. It's not required that they provide naloxone. The medical director of the health department will be listed as the prescriber. Randy said that EMS and police departments also have access to naloxone.

Panel Discussion

Pat introduced Dr. Michael Voigt, Dr. Donald Hillebrand, and Dr. Douglas LaBrecque, who served as the panelists for the evening session. Chris Taylor, from the National Alliance of State and Territorial AIDS Directors, facilitated the panel.

As an opening Dr. Hillebrand discussed the need for primary care providers to screen for hepatitis, especially with more effective treatment regimens. Dr. LaBrecque discussed the changes to the field of hepatitis. Dr. Voigt discussed the problem with access to care, including the cost of drugs and getting insurance to cover the treatment. He also discussed the problem with getting substance abuse treatment to those who need it.

Chris asked about challenges with prescribing hepatitis C treatment. Dr. Voigt stated that insurance prior authorization and getting treatment covered by insurance are challenges. Dr. LaBrecque stated that it is also challenging when insurance companies reject claims related to HCV treatment. Most clinics don't have the staff to continue to battle with the companies to get treatment covered. He asked CPG to imagine if other diseases were treated this way. Dr. Hillebrand stated that persons with HCV are at risk for other diseases when they are treated so late for HCV, which is often based on insurance company guidelines (not treatment guidelines). A question was asked about withholding treatment from groups of people. Drs. LaBrecque and Hillebrand stated that the insurance companies triage people who need to be treated first, and injection drug users aren't on their lists. Taxpayers need to insist on transparency from Medicaid, including the number of people treated and cured of HCV.

Chris asked about successes with treating people with an active substance use disorder. Dr. Voigt said newer studies show treating people who inject drugs helps improve their health and prevents transmission to others. A member commented that the public often does not have sympathy for HCV because it's associated with injection drug use. Dr. Hillebrand stated that the fastest growing population of HCV is youth under age 30, specifically in

rural areas. A member asked about re-infection of HCV after being cured. Dr. LaBrecque stated that people who are cured do not become immune, and there is always a risk of re-infection.

Chris asked about the role of primary care providers in identifying and treating HCV. Dr. Voigt said easier access to treatment may make providers more likely to test. He said he still sees many HCV patients because primary care providers do not want the hassle of dealing with insurance.

Dr. LaBrecque discussed the recommendation of testing all baby boomers for HCV. Dr. Hillebrand said that the majority of HCV patients are asymptomatic. He reinforced routine testing of all baby boomers. He urged IDPH to release statements recommending testing. He said it should be a quality measure for providers and insurance companies. Less than 10% of HCV in the United States has been successfully treated. He said screening needs to be part of any other medical service.

Chris stated that pharmaceutical companies and insurance companies blame each other for costs for HCV treatment. Federal CMS sent out letters to state Medicaid offices stating that they shouldn't be placing restrictions on treatment. However, CMS likely won't follow up on the letter with states that have restrictions in place. He said that he believes insurance companies and Medicaid offices should try harder to negotiate on drug prices. Dr. LaBrecque said that the lack of transparency on drug pricing is problematic because no one knows what anyone else is paying.

Chris stated that some state ADAPs have put HCV drugs on their formulary, but that there hasn't been a significant uptake. Chris queried the panelists for potential reasons. Dr. Hillebrand said telemedicine may help get more people treated, especially in rural areas. Dr. LaBrecque said Iowa Medicaid is one of the most restrictive in the country for HCV treatment, including a requirement that the provider be a hepatologist. He said that primary care providers could easily treat HCV. It's simple to treat and usually successful. Dr. Voigt said it's difficult for Medicaid programs to deal with treatment costs and so prioritizing makes fiscal sense. Dr. Hillebrand said that it's critical to figure out how to make treatment accessible to more patients in a cost-effective way.

Chris stated that the next day's CPG meeting will include discussion about strategies for prevention, linkage to care, and treatment of HCV. He asked the providers what they think is critical for Iowa to try to address. Dr. Voigt said case finding is critical, as well as reducing transmission. One method is through education. He also encouraged advocacy from consumers. Dr. LaBrecque encouraged IDPH to promote public education, including in high schools. One study showed that youth were unaware of HCV and HBV. Dr.

Hillebrand said education is a priority. People need to be encouraged to get tested. One idea is that electronic medical records could automate screening reminders for baby boomers to get tested. He also encouraged transparency among the insurance companies.

Thursday, September 8

New Business (continued)

7. **Looking Back-Looking Forward**

Chris Taylor introduced the day and asked for impressions and thoughts about the previous day's meetings.

- A question was asked about the re-infection rate for people who have been cured. Dr. Voigt said re-infection would often be with a different genotype. He said that with interferon, the re-infection rate was quite low. He said the value is that treating everyone means that fewer people overall will become infected. Chris said there has not been enough research on re-infection, but clinical trials are continuing to monitor for reinfection. Some data indicate reinfection in less than five percent.
- A member commented that she enjoyed the panel and thought it was eye-opening.
- Another member commented that she liked the conversation about the cost of medications and the negotiations and the lack of transparency that is driving those costs up.
- A member commented on appreciating the parallel from HIV to the HCV epidemic and the potential development of the cascade. Dr. LaBrecque said he is thrilled to see the HIV community coming in strongly on hepatitis. There is no need to re-invent the wheel. We just need to work together. Jillian Casey from NASTAD commented that we can build on the education so that every time we talk about HIV, we also talk about hepatitis.
- A member commented that flexible funding which IDPH is seeking from re-allocation of state ADAP money would be helpful to address hepatitis.
- Another member commented that he enjoyed that the providers addressed the importance of treating hepatitis C sooner rather than later.

Chris discussed the history of hepatitis being integrated into the CPG. He said the CPG should feel great about what they are doing to address stigma, social determinants of health, HIV, and HCV in Iowa.

Shane Scharer, adult viral hepatitis coordinator, discussed the goals and objectives under the previous Viral Hepatitis Strategic Plan. He provided an update on the completion of objectives. He discussed his work in surveillance of HCV. A comment was made that being able to offer rapid testing and confirmatory RNA testing is important. Chris stated that

policy and advocacy are important aspects of the next strategic plan. A question was asked about hepatitis C in pregnant women. There are new reports showing there are children who are undiagnosed who were born to women living with HCV. More research needs to be done on prevention interventions for this population. We don't have research on treating prophylactically newborns like we do on HIV.

Nicole Kolm-Valdivia, HIV prevention program evaluation coordinator, presented a summary of the HCV epidemiological profile. (PowerPoint)

8. **Focus on Prevention- Small Group Discussions and Group Report backs**

Themes identified for Prevention of HCV included:

- Education: awareness, schools, providers, populations;
- Integration: existing programs with reach to populations leveraging existing media campaigns;
- Stigma: social determinants of health, disclosure, drug use;
- Population-specific outreach: people who inject drugs, incarcerated, non-English speaking, communities of color, people under 30, baby boomers;
- Substance use treatment access: inpatient, outpatient, 12 step programs, medication-assisted therapy;
- Syringe services programs: exchange, safer injection practices, equipment, paraphernalia law.

CPG members were asked to rank the importance of these themes in order to prioritize them for planning purposes.

The ranking was as follows:

- Syringe services programs;
- Education;
- Substance use treatment;
- Integration;
- Population-specific outreach;
- Stigma.

9. **Focus on Testing and Linkage to Care- small group discussions and group report backs**

Themes identified for Testing and Linkage for HCV included:

- Awareness/education: testing recommendations, testing algorithms, integration;
- Provider willingness: misconceptions, stigma, reimbursement issues, treatment access challenges, bias;
- Stigma: people who inject drugs, baby boomers, those who are undocumented;
- Linkage challenges: lack of specialists or other providers, distance, transportation, providers who are not culturally competent;

- Testing infrastructure and integration: disease intervention specialists, case managers, community health centers, electronic medical records, intake tools;
- Population-specific strategies: people who inject drugs, baby boomers, those who are incarcerated.

CPG members were asked to rank the importance of these themes in order to prioritize them for planning purposes. The ranking was as follows:

- Provider willingness;
- Population-specific strategies;
- Testing integration;
- Linkage challenges;
- Awareness and education;
- Stigma.

A question was asked about HCV testing in the Department of Corrections. Kathy Weiss said all inmates gets tested for HCV. If they test positive, they may or not be treated. There are specific guidelines for treatment. They only re-test during incarceration if there is blood-to-blood contact. A member commented that many county jails do not test for HCV because of the cost of treatment.

A question was asked about undocumented immigrants and fear of treatment. Sonia Reyes-Snyder stated that language barriers are an issue. Also, undocumented immigrants are afraid of releasing their names.

Chris said that the integration piece is important. If someone is getting tested for HIV, providers should assess whether the client should be tested for HCV. A member commented that her agency screens all HIV-positive patients annually. It's easier now that patients have insurance. It was more challenging in the past.

10. Focus on Care and Treatment- Small Group Discussions and Group Report-Backs

Themes identified for Care and Treatment for HCV included:

- Access: cost, restrictions, provider bias, geography of providers, specialty vs primary care, patient assistance programs, ADAP and HDAP (hepatitis drug assistance program);
- Provider willingness and availability: training, bias, geography, telehealth, warm line, insurance coverage;
- Education and awareness: client readiness, provider knowledge;
- Administrative burden: prior authorization, support services, harm reduction, case management.

CPG members were asked to rank the importance of these themes in order to prioritize them for planning purposes. The ranking was as follows:

- Access;
- Administrative burden;
- Provider willingness and availability;
- Education and awareness.

Currently, ADAP has Harvoni, Sovaldi, and Viekira Pak on the formulary. Meredith has been talking to the advisory board about adding two new drugs. She said IDPH had previously been paying for people on the medication assistance program and the insurance assistance program. When funding ran out, we discontinued purchasing the medications for those on the medication assistance program. This has now been re-implemented.

A member commented about telemedicine and said that expanding that is a priority. Chris suggested that some states are prioritizing co-infected individuals to get them cured and to prevent further infection. It's the "treatment as prevention" concept of hepatitis C.

11. Putting it all Together

Chris asked members to comment on anything that wasn't mentioned that IDPH should keep on the radar. A question was asked about whether Naloxone is on the ADAP formulary. Meredith said it has been requested to be on the formulary and has to be approved by the advisory committee.

The issue of surveillance and continued efforts is a priority for the health department. A member commented that hepatitis A & B should also be included in future efforts. Other priority issues include perinatal hepatitis B & C, incarcerated populations, mental health and substance abuse treatment.

Pat said that next steps include putting all the information gathered today together. She said this will include involving the Immunization Program at IDPH. There is not a set date, but IDPH wants to move forward and work on getting the plan developed. Jordan Selha will be helping with that. The strategic plan helps guide the work in the bureau.

Chris said that this process has been useful for him in his national work on viral hepatitis. He said he's proud of how the CPG has embraced hepatitis, STDs, and the social justice issues. He thanked CPG for welcoming him to facilitate the group. He said DHHS will be releasing the federal updated action plan in fall 2016.

OTHER BUSINESS

Pat Young discussed the 2017 CPG meeting dates. Educational Hill Day will be Tuesday, February 21, 2017.

Pat said she welcomed feedback on whether members liked meeting for a day and a half.

CHECKOUT COMPLETION

Colleen reminded everyone to complete their checkout forms.

CALL TO THE PUBLIC

Colleen asked the public if they had any comments or questions. Chris, from Idaho, thanked CPG for allowing them to observe. He said it was evident that it was a tight-knit group and the group was well-organized. He said they are taking back a lot to mimic what's happening in Iowa.

ANNOUNCEMENTS

No announcements.

Next Meeting – January 12, 2017

ADJOURN

Colleen facilitated the motion to adjourn the meeting. Roger motioned to adjourn. Carter seconded the motion.

Respectfully submitted,
Nicole Kolm-Valdivia