HIV Health Improvement Affinity Group

In-Person Meeting

December 6-7, 2016

The Dupont Circle Hotel
1500 New Hampshire Ave NW
Washington, DC

Electronic Meeting Notebook

This meeting is supported by the Centers for Medicare & Medicaid Services, the Health Resources and Services Administration, and the Centers for Disease Control and Prevention, in collaboration with the HHS Office of HIV/AIDS and Infectious Disease Policy, and in partnership with the National Academy for State Health Policy (NASHP).
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5. Jennifer Kates
6. Amy Killelea
7. SreyRam Kuy
8. Kevin Larsen
9. Paul Loberti
10. Brad Wheeler
The HIV Health Improvement Affinity Group supports states’ efforts to improve health outcomes, including rates of viral load suppression, for Medicaid and CHIP beneficiaries living with HIV. States should arrive to the convening with completed drafts of their project plan, and should also be prepared to use this meeting time to further develop requests for technical assistance. Meeting goals include:

- Facilitate exchange of ideas and experiences across and within the state teams to address common barriers and reach shared goals;
- Provide participants with technical assistance and resources from federal, national, and state experts; and
- Support state team efforts to refine project plans and aim statements that will serve as the foundation for their work throughout the Affinity Group technical assistance period.
<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>9:15am-10:00am</td>
<td><strong>Meeting Check-In and Registration</strong>&lt;br&gt;Breakfast will be available beginning at 9:15am</td>
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| 10:00am-10:30am | **Opening Plenary**<br>Welcome to the HIV Health Improvement Affinity Group In-Person Meeting. Dr. Laura Cheever, Associate Administrator for HIV/AIDS Bureau, Health Resources and Services Administration, will provide opening remarks.  
**Moderator:** Trish Riley, National Academy for State Health Policy (NASHP)  
**Speaker:** Dr. Laura Cheever, Health Resources and Services Administration (HRSA) |
| 10:30am-10:45am | **Overview of Meeting Agenda and Goals**<br>NASHP will provide an overview of this meeting’s goals and agenda.  
**Speakers:** Trish Riley, NASHP  
Katie Dunn, NASHP |
| 10:45am-12:15pm | **Group Session 1: Performance Improvement**<br>Dr. Kevin Larsen will build on November’s webinar on performance improvement, while providing time for an interactive discussion.  
**Moderator:** Josh Hardy, Centers for Medicare & Medicaid Services (CMS)  
**Speaker:** Dr. Kevin Larsen, CMS |
| 12:15pm-12:30pm | **Break** |
| 12:30pm-2:00pm | **Lunch Plenary: Data - A Foundation for Action**<br>Speakers from the National Association for State and Territorial AIDS Directors, as well as state Medicaid and public health programs, will describe opportunities for better leveraging extant data resources to improve the effectiveness, efficiency, and overall value of HIV prevention, care, and support services and activities. They will also share previous and current experiences developing the relationships, infrastructure, and strategies to move data to action and tangible outcomes, and they will identify potential lessons from these experiences that may be helpful to their Affinity Group peers. Staff from the Centers for Disease Control and Prevention and the Office of the National Coordinator for Health Information Technology will then offer “reactions” to the information presented, with an emphasis on how collaboration across state agencies and service providers can complement and augment current “stand alone” efforts by Medicaid and public health. Finally, following the panel presentations and reactions, the moderator will facilitate a 30-minute question and answer period. This session will inform state efforts to embed activities that can drive data to action within their project plans.  
**Moderator:** Lieutenant Commander Cathleen Davies, HRSA  
**Speakers:** Amy Killelea, National Alliance of State and Territorial AIDS Directors (NASTAD)  
Dr. SreyRam Kuy, Louisiana Department of Health  
Colin Flynn, Maryland Department of Health and Mental Hygiene  
**Reactors:** Patricia Sweeney, Centers for Disease Control and Prevention (CDC)  
Tom Novak, Office of the National Coordinator for Health Information Technology, HHS |
<p>| 2:00pm-2:05pm | <strong>Cell Phone Break</strong> |</p>
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<td>2:05pm-2:50pm</td>
<td><strong>Individual State Team Breakouts</strong>&lt;br&gt;States will meet and continue the process of project planning. States will refine specific, targeted objectives and drivers within their project work plan and will discuss next steps to move towards these potential goals (e.g., identifying measures, requesting technical assistance, leveraging existing state infrastructure). NASHP staff, federal agency staff, and subject matter experts will be available during this time to help facilitate these conversations as requested by state teams.</td>
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<td>State Team Room Assignments:</td>
<td><strong>Foxhall Room A</strong>&lt;br&gt;California, Georgia, Iowa, Maryland, North Carolina, and Wisconsin <strong>Foxhall Room B-C</strong>&lt;br&gt;Illinois, Louisiana, Massachusetts, New York, Rhode Island, and Washington <strong>Dupont Ballroom</strong>&lt;br&gt;Alaska, Connecticut, Michigan, Mississippi, Nevada, New Hampshire, and Virginia</td>
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<td>2:50pm-3:00pm</td>
<td><strong>Break</strong></td>
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| 3:00pm-4:15pm   | **Learning Communities Breakout Session: Best Practices and Real or Perceived Barriers**<br>States will join their learning community peers to learn from subject matter experts as well as engage in discussion with their peer states about best practices and perceived or realized barriers as they pertain to their HIV Affinity Group projects. **Learning Community Room Assignments:**<br>Data linkage and outcomes evaluation<br>States included: California, Georgia, Iowa, Maryland, North Carolina, and Wisconsin **Data analysis and use for delivery system improvement<br>States included: Illinois, Louisiana, Massachusetts, New York, Rhode Island, and Washington Provider Engagement and Quality Improvement<br>States included: Alaska, Connecticut, Michigan, Mississippi, Nevada, New Hampshire, and Virginia **Provider Engagement and Quality Improvement<br>States included: Alaska, Connecticut, Michigan, Mississippi, Nevada, New Hampshire, and Virginia**
| Presenter/Facilitator: Edwin Corbin-Gutierrez, NASTAD | Location: Foxhall Room A<br>Presenter/Facilitator: Katie Dunn, NASHP<br>Location: Foxhall Room B-C<br>Presenter/Facilitator: Dr. Kevin Larsen, CMS<br>Location: Dupont Ballroom |
| 4:15pm-4:45pm   | **HIV Health Improvement Affinity Group Evaluation Overview**<br>This session will provide an overview of the evaluation strategy for the HIV Health Improvement Affinity Group. **Speaker:** Janet Heitgerd, CDC |
| 4:45pm-5:15pm   | **Day 1 Closing**<br>Dr. Jonathan Mermin, Director of the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention will provide closing remarks. **Moderator:** Abigail Viall, CDC **Speakers:** Dr. Jonathan Mermin, CDC Katie Dunn, NASHP |
| 5:15pm-6:15pm   | **Opening Reception**<br>Location: Foxhall A, B, C |
### Wednesday, December 7, 2016

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<tr>
<td>9:00am-9:15am</td>
<td><strong>Opening Plenary: Goal-setting for Day 2</strong></td>
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<td><em>Breakfast will be available beginning at 8:30am</em></td>
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<td>Dr. Amy Lansky, Director of the White House Office of National AIDS Policy, will provide opening remarks to kick off day two of the HIV Health Improvement Affinity Group.</td>
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<td><strong>Moderator:</strong> Heather Hauck, HRSA</td>
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<td><strong>Speaker:</strong> Dr. Amy Lansky, White House Office of National AIDS Policy</td>
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<td>9:15am-10:45am</td>
<td><strong>Group Session 2: Cross-Agency Partnerships to Improve Systems of Care for PLWHA</strong></td>
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<td>Rita Flegel of the Office of HIV/AIDS Housing at the U.S. Department of Housing and Urban Development will highlight the importance of cross-agency partnership in achieving optimum care for people living with HIV/AIDS (PLWHA). She will share perspectives from working in a rural HIV/AIDS clinic in the state of Alabama, highlighting partnerships with critical stakeholders for data sharing and the development of technical assistance. In addition, current collaborations with HRSA, the Department of Justice, and the Department of Labor will be shared to illustrate how the leveraging of Housing Opportunities for Persons with AIDS funds, the provision of technical assistance, and dissemination of best practices are utilized to achieve viral load suppression by discussing various HIV Care Continuum Initiatives. Finally, following the presentations, state officials from Medicaid/CHIP and Public Health Departments will share their experiences in developing partnerships across agencies and in the community to achieve integrated services for PLWHA.</td>
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<td><strong>Moderator:</strong> Michelle Browne, CMS</td>
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|               | **Speakers:** Rita Flegel, Office of HIV/AIDS Housing, U.S. Department of Housing and Urban Development  
Paul Loberti, Rhode Island Executive Office of Health and Human Services  
Juliana Grant, California Department of Public Health  
Brad Wheeler, North Carolina Department of Health and Human Services  |

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<td>11:00am-11:45pm</td>
<td><strong>Plenary: Initiating Policy and System Changes</strong></td>
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<td>Jennifer Kates from the Kaiser Family Foundation will explore strategies to generate system change. She will examine areas ripe for transformation, such as coverage and formulary design, network composition, and provider linkages as well as levers to promote transformation.</td>
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<td><strong>Moderator:</strong> Abigail Viall, CDC</td>
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<td><strong>Speaker:</strong> Jennifer Kates, Kaiser Family Foundation</td>
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<td><strong>Working Lunch: Individual State Team Breakouts</strong></td>
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<td>States will meet and continue the process of project planning. NASHP staff, federal agency staff, and subject matter experts will be available during this time to help facilitate these conversations.</td>
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**Foxhall Room A**  
California  
Georgia  
Iowa  
Maryland  
North Carolina  
Wisconsin  

**Foxhall Room B-C**  
Illinois  
Louisiana  
Massachusetts  
New York  
Rhode Island  
Washington  

**Dupont Ballroom**  
Alaska  
Connecticut  
Michigan  
Mississippi  
Nevada  
New Hampshire  
Virginia
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| 12:45pm-1:15pm | Learning Communities Breakout Session: Reflections on Takeaways and Lessons Learned  
States will break out into their learning communities to discuss information presented throughout the meeting and to reflect on takeaways and lessons learned that can be applied to their project goals and/or broader work. Learning communities will synthesize their 2-4 biggest takeaways and/or lessons learned and share them during the Day 2 Closing session.  
**Learning Community Room Assignments:**  
**Data linkage and outcomes evaluation**  
States included: California, Georgia, Iowa, Maryland, North Carolina, and Wisconsin  
**Facilitator:** Abigail Viall, CDC  
**Location:** Foxhall Room A  
**Data analysis and use for delivery system improvement**  
States included: Illinois, Louisiana, Massachusetts, New York, Rhode Island, and Washington  
**Facilitator:** Josh Hardy, CMS  
**Location:** Foxhall Room B-C  
**Provider engagement and quality improvement**  
States included: Alaska, Connecticut, Michigan, Mississippi, Nevada, New Hampshire, and Virginia  
**Facilitator:** Cathleen Davies, HRSA  
**Location:** Dupont Ballroom  
| 1:15pm-2:00pm | Day 2 Closing  
One representative from each learning community will share their community’s 2-4 biggest takeaways or lessons learned from the previous session. Following the report out, Dr. Andrey Ostrovsky, Chief Medical Officer for the Center for Medicaid and CHIP Services within the Centers for Medicare & Medicaid Services, will share final closing remarks.  
**Moderator:** Katie Dunn, NASHP  
**Speaker:** Dr. Andrey Ostrovsky, CMS |
HIV Health Improvement Affinity Group

In-Person Meeting Participant List
December 6-7, 2016

The Dupon Circle Hotel
1500 New Hampshire Ave NV
Washington, DC

<table>
<thead>
<tr>
<th>Alaska</th>
<th>California</th>
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<tbody>
<tr>
<td>Margaret Brodie</td>
<td>Juliana Grant</td>
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<tr>
<td>Division Director, Division of Health Care Services</td>
<td>Chief, Surveillance, Research, and Evaluation Branch</td>
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<th>Name</th>
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<tbody>
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### Georgia

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<th>Name</th>
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<tr>
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### Illinois

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<th>Name</th>
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<tbody>
<tr>
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### Iowa

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<tbody>
<tr>
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<tr>
<th>State</th>
<th>Name</th>
<th>Title/Program</th>
<th>Email</th>
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<tbody>
<tr>
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<td>Dr. James Stewart</td>
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<tr>
<td>New York</td>
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<td></td>
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### North Carolina

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<tr>
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<tr>
<td>Brad Wheeler</td>
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<tr>
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### Rhode Island

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<tr>
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<td>Caroline Campbell</td>
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</tr>
<tr>
<td>Rhonda Newsome</td>
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</tr>
<tr>
<td>Henry Murdaugh</td>
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<td>Virginia Department of Health</td>
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### Washington

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<td>Program Manager, HIV Client Services</td>
<td>Washington State Department of Health</td>
<td><a href="mailto:richard.aleshire@doh.wa.gov">richard.aleshire@doh.wa.gov</a></td>
</tr>
<tr>
<td>Karen Robinson</td>
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**Health Resources and Services Administration (HRSA)**

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Laura Cheever, MD, ScM, is the associate administrator and chief medical officer for the HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA). Dr. Cheever previously served as the deputy associate administrator and chief medical officer of the HIV/AIDS Bureau, responsible for leading the Ryan White HIV/AIDS Program and HRSA's programming for the President's Emergency Plan for AIDS Relief. She has also provided national leadership for HIV/AIDS care and treatment, including the development of federal guidelines for HIV care. Dr. Cheever joined HRSA in 1999 as the chief of the HIV Education Branch where she was responsible for providing HIV/AIDS clinical education and training for the nation's health care providers. Before joining HRSA, Dr. Cheever was an assistant professor of medicine at Johns Hopkins University. She is committed to serving the HIV population and volunteers at the Moore Clinic for HIV Care at the Johns Hopkins University Hospital. Dr. Cheever received her medical degree from Brown University and is board certified in infectious diseases.

Rita Flegel is the Director of HUD’s Office of HIV/AIDS Housing. Prior to joining the Office of HIV/AIDS Housing in 2015, Rita worked for more than 20 years in the nonprofit sector developing and operating housing and supportive programs for special needs populations including PLWHA and people experiencing chronic homelessness.

Colin Flynn trained in biology and public health at the Johns Hopkins University and has worked in HIV epidemiology since 1992. He has been with the Maryland Department of Health and Mental Hygiene since 1997, where currently he is the Chief of the Center for HIV Surveillance, Epidemiology and Evaluation in the Infectious Disease Epidemiology and Outbreak Response Bureau of the Prevention and Health Promotion Administration. In that role he directs a staff of 40 that are engaged in HIV and AIDS surveillance activities, health services evaluation, and epidemiological research and dissemination projects for the State of Maryland.
Juliana Grant, MD, MPH first joined the California Department of Public Health (CDPH), Office of AIDS (OA) in August 2013 as a Direct Assignee from Centers for Disease Control and Prevention (CDC) serving as Surveillance Section Chief in the Surveillance Research and Evaluation (SRE) Branch and then moving to the SRE Branch Chief position in April 2014. Prior to joining CDPH OA, Dr. Grant worked at the CDC Division of TB Elimination, where she led the national TB genotyping surveillance program. Prior to her time with TB, she worked in Alaska on environmental health issues with the Agency for Toxic Substances and Disease Registry. Dr. Grant completed CDC’s Epidemic Intelligence Service (EIS) training program with the Utah Department of Health in 2007. She did her residency in Preventive Medicine and Public Health with UC San Diego and received her MPH from San Diego State University. Dr. Grant completed medical school and an internship in internal medicine at the University of Colorado Health Sciences Center.

Janet L. Heitgerd, PhD is the Associate Chief for Science (ACS) in the Program Evaluation Branch, Division of HIV/AIDS Prevention (NCHHSTP). As ACS, she provides scientific leadership and expertise to ensure that branch monitoring and evaluation activities and products are of high quality, use good science, and reflect HIV prevention program priorities. Janet received her PhD in Sociology from the University of Oklahoma.

Jen Kates, PhD is Vice President and Director of Global Health & HIV Policy at the Kaiser Family Foundation, where she oversees the Foundation’s policy analysis and research focused on the U.S. government’s role in global health and on the global and domestic HIV epidemics. Widely regarded as an expert in the field, she regularly publishes and presents on global health and HIV policy issues and is particularly known for her work analyzing donor government investments in global health; assessing and mapping the U.S. government’s global health architecture, programs, and funding; and tracking and analyzing major U.S. HIV programs and financing, and key trends in the HIV epidemic, an area she has been working in for twenty-five years. Prior to joining the Foundation in 1998, Dr. Kates was a Senior Associate with The Lewin Group, a health care consulting firm, where she focused on HIV policy, strategic planning/health systems analysis, and health care for vulnerable populations. Among other prior positions, she directed the Office of Lesbian, Gay, and Bisexual Concerns at Princeton University. Dr. Kates serves on numerous federal and private sector advisory committees on global health and HIV issues. Currently, she is a member of the CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHACHSPT), is an Alternate Board Member of the Global Fund to Fight AIDS, Tuberculosis and Malaria, and serves on PEPFAR’s Scientific Advisory Board. She recently served on the Institute of Medicine’s (IOM) Congressionally-mandated evaluation of PEPFAR, and on two IOM study committees commissioned by the White House to inform the implementation of the National HIV/AIDS Strategy. Dr. Kates received her Ph.D. in Health Policy from George Washington University, where she is also a lecturer. She is also a lecturer at the Johns Hopkins School of Advanced International Studies. She holds a Bachelor’s degree from Dartmouth College, a Master’s degree in Public Affairs from Princeton University’s Woodrow Wilson School of Public and International Affairs and a Master’s degree in Political Science from the University of Massachusetts.

Amy Killelea, JD is the director of the Health Systems Integration team. She leads NASTAD's health reform, public and private insurance, and health care financing efforts, including providing resources and technical assistance for state HIV and hepatitis programs and developing recommendations to inform state and federal policy. Prior to joining NASTAD, Amy worked as a senior fellow in Harvard Law School’s Center for Health Law and Policy Innovation conducting legal and regulatory analysis of federal health care reform, Medicaid, and private insurance. Amy received her B.A. from Smith College and J.D. from Georgetown University Law Center.

SreyRam Kuy, MD, MHS, is Chief Medical Officer for Medicaid in the Louisiana Department of Health. As CMO for Louisiana Medicaid, Dr. Kuy leads the drive for improving healthcare quality, promoting cost effectiveness and increasing health information technology adoption in a $7.5 billion health system serving 1.6 million patients. She most recently served as Director of the Center for Innovations in Quality, Outcomes and Patient Safety and was the first full time female General Surgeon at Overton Brooks VA Medical Center, where she worked to successfully reduce patient mortality and adverse safety events. She teaches as an Assistant Professor of Surgery at Louisiana State University. Dr. Kuy was also a
Robert Wood Johnson Clinical Scholar at Yale, completing a fellowship in health policy, public health and outcomes research, and worked as a Kaiser Family Foundation Health Policy Scholar in the US Senate in Washington DC. Dr. Kuy has served on several national committees on healthcare policy, quality and safety, including the Clinton Foundation’s Obesity Prevention Task Force, the AcademyHealth State Health Research and Policy Interest Group Advisory Committee, the Louisiana Commission on HIV, AIDS and Hep C, and the American College of Surgeons Diversity Committee. Dr. Kuy has a passion for promoting access to quality healthcare. Her vision for Louisiana Medicaid is to work towards quality healthcare in Louisiana through transparency, accountability and HIT integration. Dr. Kuy leads the Louisiana Medicaid Quality Committee, the Louisiana Medicaid Performance Improvement Projects, and the Medicaid Quality Section. She has been integrally involved in drafting state wide performance metrics, pay for performance incentivized metrics, and development of novel “Medicaid Expansion Early Wins metrics” which enable the state of Louisiana to assess how Medicaid expansion directly impacts lives.

Amy Lansky, PhD, MPH is Director of the Office of National AIDS Policy. In this role, she is the President’s lead advisor on domestic HIV/AIDS and is responsible for overseeing implementation of the National HIV/AIDS Strategy and guiding the Administration’s HIV/AIDS policies across Federal agencies. Previously, Dr. Lansky was a Senior Policy Advisor to the Office of National Drug Control Policy and Office of National AIDS Policy where she ensured coordination on issues of substance abuse and HIV infection, and co-authored the National HIV/AIDS Strategy: Updated to 2020. Prior to joining the White House, Dr. Lansky served as the Deputy Director for Surveillance, Epidemiology, and Laboratory Science in CDC’s Division of HIV/AIDS Prevention where she provided scientific direction and oversight for HIV surveillance activities, epidemiologic studies and clinical trials, and laboratory research. Dr. Lansky holds Doctoral and Masters degrees in Public Health from the University of North Carolina at Chapel Hill, and a Bachelor’s degree in political science from Swarthmore College.

Kevin L. Larsen, MD, FACP is a senior Medical Officer at the Centers for Medicare and Medicaid Services. He leads the CMS lean transformation and advises on health information technology (IT) policy and care transformation. He previously served for 4 years as the Medical Director of Meaningful Use at the Office of the National Coordinator for Health IT. Where he lead ONCs work on quality policy, measurement and improvement, including clinical decision support and registries. Prior to working for the federal government he was Chief Medical Informatics Officer and Associate Medical Director at Hennepin County Medical Center in Minneapolis, Minnesota. He is also an Associate Professor of Medicine at the University of Minnesota. His research includes health care financing for people living in poverty, computer systems to support clinical decision making, and health literacy. In Minneapolis he was also the Medical Director for the Center for Urban Health, a hospital, community collaboration to eliminate health disparities.

Paul Loberti is employed by the Rhode Island Executive Office of Health & Human Services. He serves as an Administrator for Medical Services with the Rhode Island Medicaid Division, and is the Director of HIV Care and Treatment for the Executive Office. He is also the Principle Investigator of the Ryan White Part B grant, and oversees the HIV Provision of Care & Special Populations Unit within the Medicaid Division. In his former role at the Rhode Island Department of Health, he served as the Chief Administrator of the Office of HIV/AIDS and Viral Hepatitis for over fifteen years. He also directed efforts related of the Office of Communicable Diseases at the Department of Health. He has been working in the area of public health and health administration for over 30 years. Over the last 30 years, Paul has been active in community development and health transformation projects, such as, founding the state’s Syringe Exchange Program, co-leading state efforts for a recently attained Designated State Health Program from CMS, and most recently receiving a recent HRSA award for an innovative medication adherence and tele-health project. Paul was also the lead delegate related to a grant exploring HIV prevention and care policy in China that was awarded from the US Department of State in collaboration with the US Committee on China Relations. He has published numerous articles and abstracts pertaining to HIV, health education, prevention, prison health, public health, and wellness. He has lectured extensively, both nationally and internationally, on the topics of policy, social justice, bio-ethics, communications, community development, media and marketing, and many other topics associated with healthcare and public health. He has been, and continues to be, a keynote speaker at national and
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Jonathan Mermin, MD, MPH (RADM, USPHS), is the Director of the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP). From 2009-2013, Dr. Mermin served as Director of the Division of HIV/AIDS Prevention, NCHHSTP. Under his leadership, the Division spearheaded a new approach to HIV prevention, called High Impact Prevention, that aligned funding with epidemiology and ensured program and research activities had the greatest effect on reducing incidence and improving health equity. Dr. Mermin also served as Director of CDC-Kenya and HHS Public Health Attaché for the U.S. Embassy from 2006-2009, where he oversaw CDC's largest country office, implementing programs and research involving a broad range of infectious diseases, including HIV, malaria, tuberculosis, and emerging infections. From 1999-2006, he was Director of CDC-Uganda where he oversaw CDC's HIV prevention and care programs, including implementation of the first antiretroviral treatment program funded by CDC outside of the United States, and the development of a basic care package that was incorporated into PEPFAR and World Health Organization guidelines. Dr. Mermin began his career at CDC in 1995 as an EIS officer with the Foodborne and Diarrheal Diseases Branch. He completed an internal medicine residency at San Francisco General Hospital and a preventive medicine residency at CDC and the California Department of Health Services. He is a graduate of Harvard College and Stanford University School of Medicine, and received his MPH from Emory University. He has co-authored more than 150 scientific articles. He currently serves as an Adjunct Professor at Emory University School of Public Health.

Thomas Novak is the Medicaid Interoperability lead in the Office of Policy at the Office of the National Coordinator for Health IT where he supports the advancement of Medicaid interoperability in the drafting and review of Federal regulations. He is detailed part time to the Centers for Medicare and Medicaid Services – Medicaid Data and Systems Group – where he provides direct support to state Medicaid agencies and state governments on Health Information Exchange funding and strategy.

Andrey Ostrovsky, MD is a social entrepreneur and practicing physician. He serves as the Chief Medical Officer for the Center for Medicaid and CHIP Services (CMCS). Prior to working for Medicaid, he co-founded and sold his software company, Care at Hand, an award-winning predictive analytics platform that used insights of non-medical staff to prevent aging people from being hospitalized. Under his leadership, Care at Hand published several peer-reviewed studies, enabled home and community based service providers to sustain their care transition programs, and saved Medicare and Medicaid millions of dollars by preventing hospitalizations. Dr. Ostrovsky has served on several boards and committees dedicated to interoperability standards, quality improvement and measurement, and innovation including the National Quality Forum, Office of the National Coordinator, and the Commonwealth Fund. Prior to Care at Hand, he led teams at the World Health Organization, United States Senate, and San Francisco Health Department toward health system strengthening through technology. Andrey holds a Medical Doctorate and undergraduate degrees in Chemistry and Psychology Magna cum Laude from Boston University and is a member of Phi Beta Kappa. Andrey completed his pediatrics residency training in the Boston Combined Residency Program at Boston Medical Center and Boston Children's Hospital where he was a clinical instructor at Harvard Medical School. He is currently teaching faculty and attending physician at Children's National Medical Center.

Patricia Sweeney, MPH is a Senior Epidemiologist in the HIV Incidence and Case Surveillance Branch, Division of HIV/AIDS Prevention (DHAP) at CDC who has worked on HIV surveillance and reporting issues for over twenty five years. She serves as an expert resource on questions of surveillance data security, confidentiality, sharing and use policies working within CDC and with federal, state, local, national, and international public health organizations and partners. Currently, she is assisting in the development of technical assistance tools and resources for health departments related to implementation of DHAP’s Data to Care Strategy which aims to use HIV surveillance data to support the care continuum.

Brad Wheeler is a HIV Care Epidemiologist for the State of North Carolina. His work in informatics and epidemiology guides efforts to document and analyze HIV care quality improvement activities within the
Communicable Disease Branch of the Epidemiology Section at the North Carolina Division of Public Health. He led system testing of the recently-developed North Carolina Engagement in Care Database for HIV Outreach (NC ECHO) and serves as its system administrator. Brad trained in Epidemiology and Public Health Informatics at the University of North Carolina at Chapel Hill, received a Master’s degree in Public Health Management and Analysis from East Carolina University, and a Bachelor of Musical Arts from Penn State.
Health Resources and Services Administration and HIV/AIDS Bureau Update

Presented to the CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment

Laura Cheever, MD ScM
Associate Administrator, HIV/AIDS Bureau
Vision
Optimal HIV/AIDS care and treatment for all.

Mission
Provide leadership and resources to assure access to and retention in high quality, integrated care, and treatment services for vulnerable people living with HIV/AIDS and their families.
Moving Forward Framework
Challenges in Getting to an AIDS Free Generation

PUBLIC HEALTH as a KEY DRIVER OF SUCCESS

- Health Disparities
- Stigma and Discrimination
- Social Determinants of Health
- Public Health Infrastructure
HIV/AIDS Bureau Priorities

- **National HIV/AIDS Strategy (NHAS) 2020/President’s Emergency Plan For AIDS Relief (PEPFAR) 3.0** - Maximize HRSA HAB expertise and resources to operationalize NHAS 2020 and PEPFAR 3.0

- **Leadership** - Enhance and lead national and international HIV care and treatment through evidence-informed innovations, policy development, health workforce development, and program implementation

- **Partnerships** - Enhance and develop strategic domestic and international partnerships internally and externally

- **Integration** - Integrate HIV prevention, care, and treatment in an evolving healthcare environment

- **Data Utilization** - Use data from program reporting systems, surveillance, modeling, and other programs, as well as results from evaluation and special projects efforts to target, prioritize, and improve policies, programs, and service delivery

- **Operations** - Strengthen HAB administrative and programmatic processes through Bureau-wide knowledge management, innovation, and collaboration
2015 Ryan White HIV/AIDS Program Services Report (RSR)

Preview of 2015 Data
2015 Ryan White Services Report (RSR) Overview

• 533,036 clients received services from RWHAP-funded providers (97% were PLWH)

• RWHAP served approximately half of estimated persons diagnosed with HIV in the United States

• Nearly three-quarters (73%) of RWHAP clients are from racial/ethnic minority populations

• Approximately two-thirds (65%) of RWHAP clients are living at or below the poverty line
Ryan White HIV/AIDS Program Clients by Age Group, 2015—United States and 3 Territories

### 2011
N=554,631

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;13</td>
<td>2.0%</td>
</tr>
<tr>
<td>13–24</td>
<td>6.4%</td>
</tr>
<tr>
<td>25–34</td>
<td>15.3%</td>
</tr>
<tr>
<td>35–44</td>
<td>24.3%</td>
</tr>
<tr>
<td>45–54</td>
<td>34.0%</td>
</tr>
<tr>
<td>55–64</td>
<td>15.0%</td>
</tr>
<tr>
<td>≥65</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

### 2015
N=532,949

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;13</td>
<td>1.1%</td>
</tr>
<tr>
<td>13–24</td>
<td>5.1%</td>
</tr>
<tr>
<td>25–34</td>
<td>16.6%</td>
</tr>
<tr>
<td>35–44</td>
<td>20.0%</td>
</tr>
<tr>
<td>45–54</td>
<td>20.2%</td>
</tr>
<tr>
<td>55–64</td>
<td>31.6%</td>
</tr>
<tr>
<td>≥65</td>
<td>5.3%</td>
</tr>
</tbody>
</table>
Ryan White HIV/AIDS Program Clients, by Gender, 2015—United States and 3 Territories

- Male: 71.3%
- Female: 27.6%
- Transgender: 1.1%

N=531,816
Viral Suppression among RWHAP Clients, 2011–2015—United States and 3 Territories

Viral suppression: ≥1 OAMC visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL.

Viral Suppression among Key Populations Served by the Ryan White HIV/AIDS Program, 2015—United States and 3 Territories

Viral suppression: 1 OAMC visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL.

Clients Served by the Ryan White HIV/AIDS Program (non-ADAP) by Health Care Coverage, 2015—United States and 3 Territories

<table>
<thead>
<tr>
<th>Health care coverage type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>32.8%</td>
</tr>
<tr>
<td>Medicare</td>
<td>10.4%</td>
</tr>
<tr>
<td>Multiple coverages</td>
<td>10.4%</td>
</tr>
<tr>
<td>Private employer</td>
<td>8.4%</td>
</tr>
<tr>
<td>Medicare and Medicaid</td>
<td>7.7%</td>
</tr>
<tr>
<td>Private individual</td>
<td>7.2%</td>
</tr>
<tr>
<td>Other plan</td>
<td>2.2%</td>
</tr>
<tr>
<td>Veterans Administration</td>
<td>0.3%</td>
</tr>
<tr>
<td>Indian Health Service</td>
<td>0.0%</td>
</tr>
<tr>
<td>No coverage</td>
<td>20.7%</td>
</tr>
</tbody>
</table>

N=517,368
Viral Suppression among Clients Served by the Ryan White HIV/AIDS Program (non-ADAP) by Health Care Coverage, 2015

Viral suppression: 1 OAMC visit during the calendar year and 1 viral load reported, with the last viral load result <200 copies/mL.

Overview

- Two recent papers illustrate Ryan White HIV/AIDS Program impact using Medical Monitoring Project (MMP) data
  - Service delivery and patient outcomes in Ryan White HIV/AIDS program-funded and non-funded healthcare facilities (Weiser et al., *JAMA Internal Medicine*, 2015)
  - Ryan White HIV/AIDS program assistance and HIV treatment outcomes (Bradley et al., *Clinical Infectious Diseases*, 2015)

- CDC and HRSA collaboration
Weiser (paper #1): Main Findings

- Service delivery and patient outcomes in Ryan White HIV/AIDS program-funded and non-funded healthcare facilities (Weiser et al., JAMA Internal Medicine, 2015)

- 2009 and 2011 MMP data show:
  - 34% of facilities received Ryan White HIV/AIDS Program (RWHAP) funding
  - 73% of patients received care at RWHAP-funded facilities
Viral suppression* among low-income§ patients

<table>
<thead>
<tr>
<th></th>
<th>% (95% CI)</th>
<th>Adjusted prevalence ratio (95% CI)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>RWHAP</td>
<td>73 (70 – 75)</td>
<td>1.09 (1.02 – 1.16)</td>
<td>0.01</td>
</tr>
<tr>
<td>Non-RWHAP</td>
<td>67 (62 – 71)</td>
<td>Reference</td>
<td></td>
</tr>
</tbody>
</table>

*Most recent viral load undetectable or <200 copies /mL
§ Living at or below the federal poverty level
Low income patients were more likely to achieve viral suppression if they received care at a RWHAP-funded facility.
Bradley (paper #2): Main Findings

- Ryan White HIV/AIDS Program Assistance and HIV Treatment Outcomes (Bradley et al., *Clinical Infectious Diseases*, 2015)

- 2009 – 2012 MMP data show:
  - 41% of patients received RWHAP assistance
  - 25% received RWHAP assistance as a supplement to another healthcare payer type
  - 15% relied solely on RWHAP assistance for HIV care
Adjusted* prevalence of viral suppression by healthcare payer type and RWHAP assistance

*Results from logistic regression model adjusted for age, race, place of birth, poverty, education, homelessness, and HIV disease stage
Uninsured and underinsured HIV-infected patients receiving RWHAP assistance were more likely to be prescribed ART and to be virally suppressed than those with other healthcare payer types.
Viral Suppression among RWHAP Clients by State, 2010 to 2015—United States and 3 Territories

Viral suppression: ≥1 OAMC visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL.

Top Ten Increases in Viral Suppression in Ryan White HIV/AIDS Program, by State, 2010 to 2015—United States and 3 Territories

<table>
<thead>
<tr>
<th>State</th>
<th>% virally suppressed 2010</th>
<th>% virally suppressed 2015</th>
<th>% point increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana</td>
<td>58.2</td>
<td>86.8</td>
<td>28.6</td>
</tr>
<tr>
<td>Louisiana</td>
<td>52.9</td>
<td>76.2</td>
<td>23.3</td>
</tr>
<tr>
<td>Mississippi</td>
<td>55.5</td>
<td>78.7</td>
<td>23.2</td>
</tr>
<tr>
<td>Ohio</td>
<td>61.1</td>
<td>84.2</td>
<td>23.0</td>
</tr>
<tr>
<td>New Jersey</td>
<td>61.6</td>
<td>82.2</td>
<td>20.6</td>
</tr>
<tr>
<td>Maryland</td>
<td>63.7</td>
<td>83.7</td>
<td>19.9</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>67.9</td>
<td>87.0</td>
<td>19.2</td>
</tr>
<tr>
<td>Missouri</td>
<td>66.1</td>
<td>85.0</td>
<td>18.9</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>66.8</td>
<td>85.7</td>
<td>18.9</td>
</tr>
<tr>
<td>Wyoming</td>
<td>62.8</td>
<td>81.5</td>
<td>18.7</td>
</tr>
</tbody>
</table>

**Viral suppression:** 1 OAMC visit during the calendar year and 1 viral load reported, with the last viral load result <200 copies/mL.

**Source:** HRSA, HIV/AIDS Bureau, Annual Client-Level Data Report, Ryan White Services Report, 2014 & 2015
Thank you

Laura Cheever, MD ScM
lcheever@hrsa.gov
Presentation for HIV Health Improvement Affinity Group

December 7, 2016
Rita Flegel, Director, Office of HIV/AIDS Housing
Health Services Center Service Area

- 14 Northeast Alabama Counties
- HSC’s service area is larger than the District of Columbia, Connecticut, and Rhode Island combined
HSC Housing for PLWHA

- Shelter (8 beds)
- Rental Assistance Vouchers (approximately 30 vouchers)
- Permanent Housing Placement (first month rent)
- Permanent Housing Units (6 units)
- Specialty short-term housing (1 unit)
- Short-Term Rent, Mortgage & Utility Assistance
- Supportive Services
Facility-Based Housing
Outcomes and Lessons Learned

• In 2007, the year HSC started providing housing assistance, approximately 16% of HSC clients (60 of 378) were reported in CareWare as “unstably housed.”

• In 2011, approximately 8% of HSC clients (41 of 470) were reported in CareWare as “unstably housed.”

• In 2012 HSC served 173 people in households living with HIV with direct housing assistance (i.e. a bed).

• There is not enough funding to meet the need, with waiting lists for most programs.
HIV is a public health risk and a highly communicable disease. Housing is a proven, effective tool in preventing the spread of HIV by improving health outcomes and quality of life for PLWHA.

50% of PLWHA will have some form of a housing crisis in their lifetime.
Housing’s Impact on HIV Health Outcomes

Housing Instability
- Delayed diagnosis
- Increased risk of acquiring & transmitting
- Delayed entry into care
- Lack of regular care visits
- Delayed use of ART
- Less likely to be virally suppressed

Housing Stability
- Reduced risky behaviors
- Increased rates of care visits
- More likely to return to care
- More likely to receive ART
- More likely to achieve viral suppression
- Reduced use of ER and public resources
Office of HIV/AIDS Housing Vision

To elevate housing as a structural intervention in ending the AIDS Epidemic in the United States.
The Housing Opportunities for Persons With AIDS (HOPWA) Program was created to address the housing needs of low-income individuals living with HIV/AIDS and their families.

Established by the AIDS Housing Opportunity Act of 1992 (42 U.S.C. 12901)

To provide state and local governments with resources and incentives for devising long-term strategies to develop a range of housing assistance and supportive services for low-income persons living with HIV/AIDS and their families to overcome key barriers to stable housing - affordability and discrimination.
HOPWA Funding

HOPWA Appropriations for Fiscal Years 2011-2016
HOPWA Structure

HOPWA

Formula 139 Jurisdictions

Competitive 92 grantees

Formula

90%

State and Local Governments

Competitive

10%

State and Local Governments & Non-Profits
HOPWA Client Eligibility

Client Eligibility Requirements

- HIV/AIDS Diagnosis
- Documented Housing Need
- Gross incomes at or below 80% of the Area Median Income (i.e. Low Income)

Jurisdictions may impose more stringent requirements

- Based on local housing availability and community need
- Planning decisions
- HUD approval
HOPWA Eligible Activities

- Both Facility-Based and Scattered site
- Permanent Supportive Housing
- Emergency Housing
- Transitional/Short-term Housing
- Supportive Services
Who HOPWA Serves

- Approximately **55,000** are provided with housing assistance under the HOPWA program annually.

- **9 out of 10** HOPWA housing beneficiaries are extremely low or very low income.

- Among new clients served last year, approximately **4,400** (18%) were homeless and HIV-positive.

- Over **60%** of the HOPWA-eligible individuals served under the program are male and **more than half** are between the ages of 31 and 50.

- **51%** identify as Black or African American, **35%** identify as White, and **17%** identify as having Hispanic/Latino ethnicity.
Access to Care and Support

-Had a Housing Plan: 94%
-Had Contact with Case Manager: 94%
-Had Contact with Primary Care: 89%
-Accessed Medical Insurance: 90%
-Accessed Income: 83%
-Obtained a Job: 5%
National HIV/AIDS Strategy

Released in 2010 and updated in 2015 with 4 major goals:

1. Reduce new infections;
2. Increase access to care and improve health outcomes for people living with HIV;
3. Reduce HIV-related health disparities and health inequities; and
4. Achieve a more coordinated national response to the HIV epidemic.
Why is Collaboration Important?

- Need is greater than available resources
- Coordination across funding streams:
  - Leads to more efficient use of funds and prevents duplication of services
  - Results in Improved quality of services and streamlined service delivery
  - Draws upon expertise of various providers (with varying purposes and histories)
  - Allows for a comprehensive approach to HIV/AIDS care and services.
HUD’s NHAS Action Items: Cross-Agency Collaboration

• Work with DOJ to identify models of improved service integration among HIV housing providers and sexual assault, domestic violence, dating violence, and stalking service providers.

• Work with HRSA/HAB to identify models for the integration of housing and HIV care data systems

• Continue to disseminate information and encourage usage of the joint HUD/DOL Getting to Work Curriculum
VAWA/HOPWA Project Demonstration

• 2012 - White House established an interagency working group to explore the intersection of HIV/AIDS, violence against women and girls, and gender-related health disparities – HUD named as member agency

• Resulted in DOJ/HUD collaboration on the “VAWA/HOPWA Project Demonstration”

• Incorporated into the NHAS as HUD/DOJ Action Item
VAWA/HOPWA Project Demonstration

• Awards announced July 2016 - more than $9 million to support 8 local programs across the country.

• Grantees will provide housing assistance and supportive services to low-income PLWHA who are homeless, or in need of transitional housing or other housing assistance, as a result of sexual assault, domestic violence, dating violence, or stalking.

• Innovative 3-year projects that will work to improve cross-agency planning, resource utilization, and service integration between the two service systems.
8 VAWA/HOPWA Grantees:

<table>
<thead>
<tr>
<th>State</th>
<th>Grantee</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>Volunteers of America of Los Angeles</td>
</tr>
<tr>
<td>California</td>
<td>City of San Jose</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>DC Department of Health</td>
</tr>
<tr>
<td>Louisiana</td>
<td>UNITY of Greater New Orleans</td>
</tr>
<tr>
<td>Missouri</td>
<td>City of Kansas City</td>
</tr>
<tr>
<td>New York</td>
<td>Gay Men’s Health Crisis</td>
</tr>
<tr>
<td>New York</td>
<td>Unity House of Troy</td>
</tr>
<tr>
<td>Oregon</td>
<td>City of Portland</td>
</tr>
</tbody>
</table>
Addressing HIV Care and Housing Coordination through Data Integration to Improve Health Outcomes along the HIV Care Continuum Initiative:

- Partnership between HRSA’s HIV/AIDS Bureau and HUD’s Office of HIV/AIDS Housing
- Funded under HHS Secretary’s Minority AIDS Initiative Funding (SMAIF)
- Focus on integrating RWHAP and HOPWA data to improve the coordination of services for PLWHA who are unstably housed, or at risk for or experiencing homelessness.
5 Performance Sites selected for 2.5 year initiative:
• City of Hartford (CT) Health & Human Services Department
• Gregory House Programs (HI)
• Kansas City (MO) Health Department
• Palm Beach County (FL) Department of Community Services
• Cascade AIDS Project (OR)

RAND Corporation is providing support and capacity building assistance to the five selected sites and conducting the multisite evaluation.
Models of data system integration adopted by the performance sites include:

- Development of external data bridges and interfaces to interconnect CAREWare with HMIS
- Customization of CAREWare or HMIS to incorporate the corresponding data elements from either the housing or HIV care system

Data systems integration efforts are currently underway at each of the 5 sites.
Data integration will lead to more coordinated patient care, supportive services, and housing services for PLWHA. Examples include:

- Dedicating staff or re-organizing staff efforts to coordinate housing and health care services for clients (e.g., care coordinators, coordinated case management, or enhanced peer navigation services);
- Increasing the efficiency of the referral process between Ryan White and HOPWA service providers;
- Streamlining intake and assessment forms to accurately identify unmet needs of clients seeking housing and HIV care services;
- Using integrated data to inform staff efforts to quickly identify and conduct targeted outreach with clients needing additional services or support; and
- Working across the Ryan White and HOPWA programs to find clients that are no longer engaged in care.
HUD/DOL Employment Curriculum

Getting to Work: A Training Curriculum for HIV/AIDS Service Providers and Housing Providers

• Jointly developed by HUD/DOL, in collaboration with the National Working Positive Coalition, with input from DOE, DOJ, and SAMHSA

• Recognizes that employment is a key component of serving the whole person and that employment leads to improved health outcomes for PLWHA

• Assists AIDS service providers in understanding HIV/AIDS in the context of employment and the different approaches to helping clients who are ready to work identify and achieve their related goals
HIV Housing Care Continuum Initiative

• HIV Care Continuum Initiative and Federal Working Group established by the White House in 2013 (incorporated into NHAS 2015)

• HUD assigned responsibility for a number of action steps including 5.4: HUD and HHS will provide technical assistance and trainings to better coordinate and align the provision of housing services with medical care for PLWHA.

• Based on the 5.4 action step:
  o “HOPWA White Paper” developed and published by the Office of HIV/AIDS Housing – jointly promoted with HRSA/HAB
  o HUD-National AIDS Housing Coalition-Collaborative Solutions, Inc. collaboration on HIV Housing Care Continuum Initiative to increase HOPWA grantees’ ability to measure and track client health outcomes along the HIV Care Continuum
Why Build an HIV Housing Care Continuum?

- Illustrate overall engagement in care and treatment for PLWHA receiving HIV housing assistance.
- Benchmark against national and community-level HIV Care Continuums.
- Identify successes and gaps in care and treatment experienced by PLWHA receiving HIV housing assistance.
- Improve health outcomes by implementing system and/or service enhancements to programs.
- Inform policy-makers on program development.
- Align with national initiatives
  - White House HIV Care Continuum Initiative (2013)
In 2015, the Office of HIV/AIDS Housing, the National AIDS Housing Coalition, and Collaborative Solutions, Inc., hosted a series of HIV Housing Care Continuum regional meetings

- Brought together teams of grantees and project sponsors, Ryan White providers, and health department surveillance staff to create community strategies for developing and implementing HIV Housing Care Continuums.
- Meetings took place in Chicago, IL, Washington, DC, Atlanta, GA, and Portland, OR.

HIV Housing Care Continuum webinar series and workbook were developed to share the information and resources presented at the regional meetings to a broader audience of HOPWA grantees and providers.

- The resources were designed to help HOPWA grantees develop strategies in their own communities to:
  - Improve ability to measure client health outcomes;
  - Create the strategic partnerships necessary to build a local HIV Housing Care Continuum; and
  - Utilize local data to benefit clients by demonstrating the link between housing and health and engaging in cross-system advocacy efforts.
Resources

HOPWA webpage (program info and resources, grantee performance profiles, grantee contact information, HOPWA Desk Officers, Ask-A-Question):
https://www.hudexchange.info/programs/hopwa/

Getting to Work Curriculum:
https://www.hudexchange.info/trainings/dol-hud-getting-to-work-curriculum-for-hiv-aids-providers/

HIV Housing Care Continuum Initiative Resources:
RECENT HIV DATA TO CARE (D2C) EXPERIENCES MARYLAND

HIV HEALTH IMPROVEMENT AFFINITY GROUP
DECEMBER 6, 2016

Colin Flynn, Chief
HIV Surveillance, Epidemiology and Evaluation

Maryland Department of Health and Mental Hygiene
Prevention and Health Promotion Administration
MISSION AND VISION

MISSION

- The mission of the Prevention and Health Promotion Administration is to protect, promote and improve the health and well-being of all Marylanders and their families through provision of public health leadership and through community-based public health efforts in partnership with local health departments, providers, community based organizations, and public and private sector agencies, giving special attention to at-risk and vulnerable populations.

VISION

- The Prevention and Health Promotion Administration envisions a future in which all Marylanders and their families enjoy optimal health and well-being.
Data to Care Activities

- Since 2012 Maryland has expanded its D2C activities
- Using HIV surveillance data to identify persons requiring linkage-to-care and re-engagement in care services
- Increased sharing of HIV surveillance data to state and local partners
- Expanded the size of STI/HIV Field Services program at the state and local levels
- Increased support to the HIV Surveillance program to improve data quality, timeliness, and availability
- Expanded data sharing with neighboring jurisdictions
Category C

- CDC HIV Prevention Cooperative Agreement 12-1201
  Category C Demonstration Project
- March 2012-December 2015
- Enhanced linkage to and retention in care
- Programmatic use of CD4, viral load, and other surveillance data
- Highly cooperative/integrative activity for Maryland’s HIV Prevention, HIV Surveillance, and STI/HIV Field Services programs
- Focused on four high morbidity counties, but developed sustainable infrastructure for statewide implementation
Category C Activities

- HIV surveillance process improvements
- Increased regional data sharing
- Use of HIV surveillance data to initiate and inform STI/HIV partner services and linkage-to-care
- Improvements to state and local health department linkage-to-care processes and documentation
- Data-to-care re-engagement outreach
- Modification and implementation of PRISM (statewide data system for STI surveillance and STI/HIV partner services investigations)
Category C Results

- 470% increase in initiation of partner services and linkage-to-care for newly diagnosed HIV cases
- 295% increase in newly diagnosed HIV cases being interviewed for partner services
- Identified 2,585 persons living with HIV that appeared to be out of care (CD4/VL 13-24 mo. ago, but not 0-13 mo.) – provided re-engagement services

![Pie chart showing distribution of outcomes: 32% Reengaged, 25% Were in Care, 10% Unable to Locate, 10% Refused Services, 27% Reentered Care, 5% Out of State, 2% Deceased.](chart.png)
Category C Lessons

- HIV surveillance doesn’t know everything about all care
- Large amounts of cross-border care seeking
- Large amounts of migration within state and out-of-state
- Identification and coordination activities need to happen at the state-level with extensive inter-state communication
- Linkage activities at the local level need increased access to state-level data
- A lot of data work is needed in order to provide effectively targeted interventions of a reasonable size with a chance of success
Partnerships for Care (P4C)

- CDC/HRSA Joint Demonstration Project (CDC 14-1410)
- July 2014-September 2017
- Partnership of state health department, FQHC clinics (4), and local health departments (3)
- Expand routine HIV screening in clinics
- Expand capacity for HIV clinical services
- Enhance relationship of clinics and local health departments for linkage-to-care, re-engagement in care activities
- Establish sharing of clinical, surveillance, and partner services data between clinics and the state and local health departments
Partnerships for Care (P4C)

- Use case conferencing to monitor and improve status of clinic patients on the HIV care continuum
- Use surveillance data to identify PLWHAs in clinic service areas that are out of care and have local health departments provide linkage-to-care and re-engagement in care services
- Developing sustainable methods for continuation and expansion to other clinics with large HIV caseloads
P4C Lessons (so far)

- Clinics do not test all their patients and are unaware of that many of their patients are HIV infected
- Many active clinic patients get their HIV care at other clinics
- Increased focus on partnership has resulted in increased and more timely linkage activities
- Case conferencing is improving the HIV continuum of care measures (preliminary data)
Impact (Project PrIDE)

- CDC HIV Prevention Cooperative Agreement 15-1506/1509 with Baltimore City Health Department for the Baltimore MSA (Maryland DHMH subcontractor)
- October 2015-September 2018
- Reduce HIV infection and increase engagement in care among MSM and transgender persons
- Increasing availability and use of PrEP
- Using surveillance data to identify PLWHA that are out of care and providing linkage/re-engagement services
  - Initial focus on MSM with high VL in Baltimore City
Statewide Activities

- Using combinations of state funds, HIV Prevention funds, and Ryan White funds to identify and provide linkage-to-care and re-engagement in care services, statewide, to all:
  - Previous diagnoses, never linked to care
  - New diagnoses, immediately after diagnosis
  - New diagnoses, not linked to care within 12 months
  - Living cases, with a history of care, but no recent care (18 months)

- Statewide surveillance data provided to Field Services programs at the state and Baltimore City for initiation to field staff at the local levels
Issues

- Not all care is reported
  - Care without testing
  - Out of state care
  - Providers not reporting
    - Federal facilities (VHA, DOD, NIH)

- Not all cases are on regular care schedules
  - 2 visits a year, at least 6 months apart – is this an appropriate measure?

- Migration (current address)

- Unable to locate
  - Incorrect information
  - Uncooperative cases
Expansion Activities

- Health Information Exchange (HIE) – CRISP in MD, DE, DC (some), WV (soon)
  - Using ENS (encounter notification services) on cases not in HIV care – what other care are they receiving and where?
  - Encouraging providers to use HIE to locate their out-of-care patients (why should public health do all the work?)
  - Establish a provider notification system? Push notices that a clinic’s patient requires HIV services

- Incorporating ADAP prescription data into surveillance data (previously used only for case identification)

- Developing a Care Markers Database
  - Connecting HIV surveillance data with RW CAREWare data, Medicaid data, and other care data
More Activities

- Expanding regional data sharing
  - Routine lab data transfers
    - States notify each other that cases exist and resolve the earliest diagnosis and residence
    - They need to start exchanging ongoing care data
  - Black Box project (Georgetown Univ, DC, MD, VA)
    - NIH Pilot – established secure data matching/transfer mechanism
      - 1 in 6 MD HIV cases were also in DC’s database, but only half were known to be in both
    - CDC RIDR – GU and 9 states to expand pilot for de-duplication activities
    - Multi-state expansion – GU, DC, MD, NY, VA, Oak Ridge National Laboratory to expand functionality for routine matching and data exchange (towards real-time surveillance)
Medicaid D2C Activities

- Medicaid Affinity Project
  - Establish routine matching between HIV surveillance and Medicaid
  - Analyze case utilization data
  - Incorporate care utilization data (more than just lab testing) into care markers database
  - Incorporate prescription data into surveillance and care markers databases
  - Establish QA process for out-of-care notification
  - Measure the HIV continuum of care for Medicaid populations
  - Measure HIV screening rates
Prevention and Health Promotion Administration

http://phpa.dhmh.maryland.gov
HIV Health Improvement Affinity Group Evaluation Overview

Janet Heitgerd, PhD
Eka Shapatava, MPH

HIV Health Improvement Affinity Group In-Person Meeting
December 6-7, 2016
Discussion Questions

- Is there value in moving forward with an evaluation of the process and outcomes of the HIV Health Improvement Affinity Group? Why or Why not?

- How might we structure the evaluation to minimize burden and maximize benefit to the affinity group and to your program?
Evaluation Purpose

- Identify the value/usefulness of the Affinity Group
  - Support new forms of collaboration (federal partners, state programs)
  - Create awareness
  - Contribute to system-wide changes on a broader level
- Improve the effectiveness of the Affinity Group
  - Mid-course modifications and enhancements
- Inform decisions about the future of the Affinity Group beyond the 12 month project period
Affinity Group Participation: Assessing Value*

- Immediate value (activities and interactions)
  - *What happened and what was your experience?*

- Potential value (knowledge capital)
  - *Has it enhanced or created new relationships and connections?*
  - *Has it increased access to resources?*

- Applied value (changes in practice)
  - *What difference has it made to practice?*

- Realized value (performance improvement)
  - *What difference has it made in achieving what matters to you or other stakeholders?*

CDC’s Program Evaluation Framework

- Systematic way to improve and account for public health actions through the collection of information on activities, characteristics, and outcomes

- Practical, nonprescriptive tool, designed to summarize and organize essential elements of program evaluation
Proposed Evaluation Components

- Success Story/Lessons Learned Template*
- Document Review
  - Action Plans
  - TA requests
- Federal partner/NASHP input
- Phone calls, emails for follow-up and clarification

Discussion Questions

- Is there value in moving forward with an evaluation of the process and outcomes of the HIV Health Improvement Affinity Group? Why or Why not?

- How might we structure the evaluation to minimize burden and maximize benefit to the affinity group and to your program?
  - Is the current approach feasible and something you would be willing to take part in?
  - Other ideas?
Thank you!

For more information, contact CDC
1-800-CDC-INFO (232-4636)

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.
HIV Health Improvement Affinity Group: Policy and System Change

December 7, 2016
Jen Kates, Vice President & Director, Global Health & HIV Policy
jkates@kff.org
http://kff.org/hivaids
Understanding Medicaid’s Role for People with HIV

- Medicaid has played critical role in HIV care since the HIV epidemic began (the “Medicaidization of AIDS”)
- Single largest source of insurance coverage for people with HIV, and second largest source of federal financing
- Covers range of services needed by people with HIV, and those at risk
- The number of Medicaid beneficiaries with HIV and spending have grown over time

### Characteristics of Medicaid Beneficiaries with HIV vs. Overall Medicaid Population, 2011

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Overall Beneficiaries</th>
<th>Beneficiaries with HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified based on disability</td>
<td>15%</td>
<td>68%</td>
</tr>
<tr>
<td>Male</td>
<td>41%</td>
<td>58%</td>
</tr>
<tr>
<td>Black</td>
<td>22%</td>
<td>52%</td>
</tr>
<tr>
<td>Aged 45-64</td>
<td>12%</td>
<td>52%</td>
</tr>
<tr>
<td>Dually eligible</td>
<td>15%</td>
<td>31%</td>
</tr>
</tbody>
</table>

Note: Includes only the traditional state plan enrollees in fee-for-service Medicaid.
Federal Funding for HIV/AIDS Care in the U.S., by Program, FY 2016

In Billions

- Medicaid (federal only): $5.9 billion (30%)
- Medicare: $10.0 billion (51%)
- Ryan White: $2.3 billion (12%)
- Other: $1.6 billion (8%)

Total = $19.7 Billion

Note: Total program amounts may not add to $19.74 billion due to rounding; Percentages may not add to 100% due to rounding. Source: KFF analysis of data from FY2016 Congressional Budget Justifications, White House Office of Management and Budget personal communication.
Insurance Coverage of Nonelderly Adults with HIV in Care (pre-ACA)

- Medicaid: 42%
- Private: 29%
- Medicare: 6%
- Uninsured: 17%
- Other Public: 5%

N = 406,970

Notes: May not total 100% due to rounding. Medicaid includes those with Medicare coverage. Other public includes those with Tricare/CHAMPUS, VA, other city/county coverage.
Source: CDC/KFF analysis of 2009 MMP.
Number of Medicaid Beneficiaries with HIV, 2007-2011

Medicaid Spending on HIV, 2007-2011 (in billions)

Medicaid Variation by State

- Number of enrollees with HIV ranges from 100 in 4 states to more than 25,000 in 3 states (including close to 60,000 in 1 state)
- Spending ranges from under $1 million to $2 billion
- 32 states have expanded Medicaid
- 4 states (of 20) have Medicaid Health Home models that include HIV
- 13 states have home and community based waivers, 1915(c) waivers, designed specifically for or include people with HIV

Medicaid Spending Per Enrollee with HIV, 2011

Why Medicaid Spending Varies Across States

Available Revenue/Financing: per capita income, total taxable resources, tax collections, FMAP

Demand for Public Services: poverty, unemployment, need for health services (coverage, age, disability, chronic conditions)

Health Care Markets: employer premiums, Medicare spending per enrollee, primary care shortage areas, supply of providers and health facilities

Medicaid Policy Choices: eligibility levels, benefits, payment and delivery system choices, long-term care delivery systems

Budget and Policy Process: political affiliation of Governor and legislature, legislative sessions, state budget process

Opportunities & Policy Levers
Data Sharing is Great!
Recent Informational Bulletin from HHS, CMCS, HRSA, and CDC

Joint HHS, CMCS, HRSA, and CDC Informational Bulletin

Opportunities to Improve HIV Prevention and Care Delivery to Medicaid and CHIP Beneficiaries

December 1, 2016
Key Opportunities: HIV Testing

- Traditional Medicaid programs required to cover “medically necessary” HIV testing, may elect to cover routine testing (incentivized under ACA)

- Medicaid expansion programs must cover routine HIV screening (per USPSTF recommendations) w/o cost-sharing

- States have option to cover HIV testing conducted by unlicensed providers (e.g., disease Intervention Specialists, community health workers) who meet state qualifications

Sources: Kaiser Family Foundation, Fact Sheet: Medicaid and HIV, 2016; Joint HHS, CMCS, HRSA, and CDC Informational Bulletin: Opportunities to Improve HIV Prevention and Care Delivery to Medicaid and CHIP Beneficiaries, December 1, 2016.
Key Opportunities: Formulary Design

- All FDA approved ARVs covered (states required to cover all outpatient drugs of manufacturers with rebate agreements)
  - Applies to traditional Medicaid
  - Most expansion programs have aligned benefits
- Medicaid programs can set limits, utilization management tools including prior authorization, set number of scripts/month, which can present barriers to access
- Should follow DHHS Treatment Guidelines for HIV
- Options:
  - Support adherence access efforts
  - Add recommended single-tablet regimens to PDLs
  - Consider removing step therapy requirements

Source: NIH, CDC, FDA; Joint HHS, CMCS, HRSA, and CDC Informational Bulletin: Opportunities to Improve HIV Prevention and Care Delivery to Medicaid and CHIP Beneficiaries, December 1, 2016.
Key Opportunities: PrEP Coverage

- FDA approved PrEP in 2012
- CDC guidelines in 2014
- All Medicaid programs should cover PrEP
- As with Rx overall, can set limits, utilization management tools including prior authorization, which can present barriers to access

Source: NIH, CDC, FDA; Joint HHS, CMCS, HRSA, and CDC Informational Bulletin: Opportunities to Improve HIV Prevention and Care Delivery to Medicaid and CHIP Beneficiaries, December 1, 2016.
Key Opportunities: Network Adequacy

- Recent rule first update in more than a decade
- Medicaid managed care network adequacy standards
- Time and distance standards required, including for primary care providers, pharmacy
- Network adequacy to be certified annually
- Coordinate with Ryan White and other HIV provide networks

Source: CMS, Medicaid and CHIP Managed Care Final Rule (CMS-2390-F), 2016.
Key Opportunities: Other Delivery Model Options

- **Medicaid Health Homes (ACA provision)**
  - State option to provide services to enrollees with chronic conditions (and receive enhanced FMAP of 90% for 1st two years).
  - Several chronic conditions can be targeted, including HIV

- **Home & Community Based Waivers, Section 1915(c)**
  - Designed to meet needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting

- **Targeted Case Management**
  - State option to provide case management services (assist in gaining access to medical, social, educational, etc) to specific classes of individuals, or to individuals who reside in specified areas of the State (or both)

Source: NIH, CDC, FDA; Joint HHS, CMCS, HRSA, and CDC Informational Bulletin: Opportunities to Improve HIV Prevention and Care Delivery to Medicaid and CHIP Beneficiaries, December 1, 2016.
HIV Health Improvement Affinity Group: Policy and System Change
Public Health Innovation: Emerging Opportunities for Leveraging Health Systems Data

Amy Killelea, JD (NASTAD)
HIV Affinity Group Meeting
December 6, 2016
A Changing Healthcare Landscape Driving Public Health Program Change

Uninsured in the U.S.

GALLUP-HEALTHWAYS WELL-BEING INDEX
A Changing Healthcare Landscape Driving Public Health Program Change

Public Health is Changing
PrEP and Treatment as Prevention necessitate new partnerships with clinical systems and payers

Medicaid is Changing
Medicaid is shifting attention to population health, covering more services that have typically been outside the realm of insurance
Health Systems Data for Public Health Action

Emerging opportunities for health departments to leverage health systems and payer databases to better track service utilization:
- Medicaid claims
- All Payer Claims Databases
- Health Information Exchanges

NASTAD published a foundational resource on these emerging opportunities
Data Trifecta

Medicaid Claims
- HIV surveillance cross match with Medicaid claims data to determine those out of care
- Query Medicaid claims to determine service utilization
- Pursue HIV quality improvement projects

All Payer Claims Database
- HIV surveillance cross match with APCD data to determine those out of care
- Query APCDs to determine service utilization
- Query APCDs for aggregate data on PrEP uptake

Health Information Exchanges
- Query Electronic Health Record (EHR) hub for aggregate PrEP prescribing by provider and neighborhood
- Query EHR data to track ED utilization of PEP
- Query regional HIE to monitor HIV, STD, and VH care and prevention utilization
Data Uses: Aggregate vs. Personally Identifiable Information

<table>
<thead>
<tr>
<th>Epidemiology</th>
<th>Aggregate Data</th>
<th>Personally Identifiable Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E.g.,</td>
<td>E.g.,</td>
</tr>
<tr>
<td></td>
<td>• Statistical purposes</td>
<td>• Partner services/contact tracing</td>
</tr>
<tr>
<td></td>
<td>• Surveillance/CDC reporting</td>
<td>• Linkage/retention in care</td>
</tr>
<tr>
<td></td>
<td>• Research</td>
<td></td>
</tr>
</tbody>
</table>

Legal Protections for Personally Identifiable Information
- Enumerated allowable disclosures and use
- Data sharing agreements and protocols
- Data suppression rules
- Monetary penalties for confidentiality breaches
- Individual consent
- Inter-agency data sharing generally allowable; secondary disclosure to providers is more challenging
Foundation for Success

- State commitment to data modernization and infrastructure capacity
  - Functional All Payer Claims Databases and Health Information Exchanges and Medicaid commitment to data sharing

- Health department ability to leverage existing relationships and data sharing agreements
  - Long-standing ADAP data-sharing relationship with Medicaid for eligibility matches

- Health department staff capacity to take on a new and technically challenging area

- Health department commitment to working across HIV Care and Prevention and across infectious disease programs on health systems data efforts
HIV Health Improvement Affinity Group

The Louisiana Story:
Success in HIV Viral Suppression through Collaboration

SreyRam Kuy, MD, MHS, FACS
Chief Medical Officer, Medicaid
Louisiana Department of Health

DeAnn Gruber, PhD
Debbie A Wendell, PhD,
Louisiana Office of Public Health
Allow Me to Introduce Myself

SreyRam Kuy, MD, MHS
• Chief Medical Officer
  Louisiana Medicaid

• Surgeon:
  • Associate Professor of Surgery – Louisiana State University
  • Former Assistant Chief, General Surgery, Overton Brooks VA

• A Physician, a Patient and proud to be part of the beautiful State of Louisiana
Intended Project Focus: HIV Viral Load Suppression

Intended-Project Outcomes: Develop collaboration between Medicaid and OPH

Anticipated Critical Milestones and Activities: Through collaboration between Medicaid and OPH, 79% of those in care were virally suppressed statewide

Collaboration Strategy: Data sharing between Medicaid and OPH, individual-level data provided back to each Healthy Louisiana plan for their clients, use of incentives

Key Stakeholders: Medicaid, OPH, MCO, providers and patients
HIV Continuum of Care
Louisiana, 2015

- 100% of persons living with HIV are in care.
- 72% of those in care are retained in HIV care.
- 55% of those retained in care are virally suppressed (<200).

79% of those in care were virally suppressed.
Historically, a few OPH Programs had negotiated their own data sharing agreements with Medicaid, but many programs had no access to Medicaid data.

Change in leadership at Medicaid three years ago facilitated process to establish an agency-wide data sharing agreement.

Support from Medicaid and the OPH Assistant Secretary.

Process took approximately 6 months.

OPH & Medicaid Data Sharing Agreement
Signed data sharing agreement in Feb 2014

All users complete an annual “Data Sharing User Agreement”
Healthy Louisiana MCO
Viral Load Measure

- Based on HRSA HAB Performance Measure

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>HIV Viral Load Suppression</th>
<th>National Quality Forum #: 2082</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>Number of patients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year</td>
<td></td>
</tr>
<tr>
<td>Denominator:</td>
<td>Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year</td>
<td></td>
</tr>
<tr>
<td>Patient Exclusions:</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>
| Data:               | 1. Does the patient, regardless of age, have a diagnosis of HIV? (Y/N)  
                      a. If yes, did the patient have at least one medical visit during the measurement year |
Incentive-based Performance Measures

- Healthy Louisiana (Medicaid) Managed Care Organizations have incentive-based performance measures
- Viral load measure included in new RFP in 2014
- Plans will not be penalized $250,000 if Viral Load measure is achieved

<table>
<thead>
<tr>
<th>Identifier</th>
<th>Measure</th>
<th>Measure Description</th>
<th>Target Population</th>
<th>Condition</th>
<th>Target for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF #2082 (HIV) $$</td>
<td>HIV Viral Load Suppression</td>
<td>Percentage of patients, regardless of age, with a diagnosis of HIV with an HIV viral load less than 200</td>
<td>Chronic Disease</td>
<td>HIV</td>
<td>54.34</td>
</tr>
</tbody>
</table>
How were we able to add a Viral Load incentive-based measure?

- Having a quality champion at Medicaid
- Monthly meetings to discuss joint projects
- Support from both Medicaid and OPH Leadership
- Started out as a PIP (Performance Improvement Plan)
  - Evolved into an incentive-based measure
Louisiana HIV Surveillance Data

- **Complete**
  - Beginning in 1993, HIV names-based reporting required
  - Since 1999, all CD4/VL values have been reportable
  - All public/private labs are reporting (except VA)

- **Timely**
  - 90% of labs are reported electronically
  - Large laboratories report daily
Medicaid Viral Load Measure

OPH & Medicaid Match

- Conducted an initial match between Medicaid and OPH HIV Surveillance data in July 2014
  - Medicaid provided all recipients with an HIV-related diagnosis code
- Medicaid determined the Viral Load suppression target of 54.34%
- Conducted a second match in January 2015
  - Medicaid provided all recipients who were enrolled as of December 2014
    - Included the plan name and a field “Did recipient have an HIV-related claim in 2014?”
Results of Medicaid and HIV Data Match
Jan 2015 – Dec 2015

All People Enrolled in Medicaid
N=1,507,594

Persons with no HIV Claim
n=1,501,799

Matched in OPH Database
n=5,433 (94%)

No Match in OPH Database
n=353

Persons with HIV Claim
n=5,786

Duplicates
n=9

Persons without Viral Suppression
n=1,397 (26%)

No Viral Load
n=326 (6%)

Persons with Viral Suppression
n=3,710 (68%)

Matched in OPH Database
n=2,785

Duplicates
n=9

Persons with no HIV Claim
n=1,501,799

Matched in OPH Database
n=5,433 (94%)

No Match in OPH Database
n=353
Results of Medicaid and HIV Data Match
Jan 2015 – Dec 2015

All People Enrolled in Medicaid
N=1,507,594

Persons with no HIV Claim
n=1,501,799

Matched in OPH Database
n=5,433 (94%)

No Match in OPH Database
n=353

Persons with HIV Claim
n=5,786

Matched in OPH Database
n=5,433 (94%)

Duplicates
n=9

Persons without Viral Suppression
n=433 (16%)

No Viral Load
n=1,013 (37%)

Persons with Viral Suppression
n=1,339 (48%)
Healthy Louisiana Viral Load Measure
Current Matching Process

- Now conducting quarterly matches between Medicaid claims and OPH HIV Surveillance data
- Individual-level data are provided back to each Healthy Louisiana plan for their clients only
- These variables are provided by OPH:
  1. Was the client virally suppressed (i.e., VL <200 copies/mL) at the most recent test in the last 12 month period?
  2. Was the client confirmed to be HIV positive in the OPH HIV Surveillance database?
Collaboration key to Louisiana’s Success: Viral Suppression by Medicaid Plan, 2015

<table>
<thead>
<tr>
<th>Medicaid Plan</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>70%</td>
</tr>
<tr>
<td>B</td>
<td>65%</td>
</tr>
<tr>
<td>C</td>
<td>69%</td>
</tr>
<tr>
<td>D</td>
<td>71%</td>
</tr>
<tr>
<td>E</td>
<td>67%</td>
</tr>
<tr>
<td>F</td>
<td>67%</td>
</tr>
</tbody>
</table>
Future Directions

- Medicaid Quality Committee meetings with Office of Public Health
- Working together to increase viral load suppression target for the next contract in 2018 with the Managed Care Plans
- Brainstorming ways together to use data to change policy
- The Key is Collaboration!
Contact the Louisiana Team!

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Debbie Wendell, PhD, Louisiana Office of Public Health  
Debbie.Wendell@la.gov
Quality Improvement for HIV
FOCUSING THE NATIONAL HIV/AIDS STRATEGY
THE HIV CARE CONTINUUM INITIATIVE

Only 1 IN 4
HIV POSITIVE PEOPLE ARE SUCCESSFULLY MAKING IT THROUGH THE HIV CARE CONTINUUM & GETTING THE FULL BENEFITS OF TREATMENT

HRSA Continuum of Care

Not in Care  |  Fully engaged
---|---
Unaware of HIV status | Aware of HIV status | May be receiving other medical care but not HIV care | Entered HIV medical care but dropped out | In and out of HIV care or infrequent user | Fully engaged in HIV medical care

Adapted from: Mugavero et al. Clin Infect Dis 2011;52(S2)
Viral Suppression Among NHAS 2020 Key Populations Served by the Ryan White HIV/AIDS Program (non-ADAP), 2014—United States and 3 Territories

**Viral suppression:** ≥1 outpatient ambulatory medical care visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL.
National HIV/AIDS Strategy: 2020 Goals

- Increase linkage to care within 1 month of diagnosis to at least 85%
- Increase HIV serostatus awareness to at least 90%
- Increase retention among persons diagnosed to at least 90%
- Increase proportion of persons diagnosed with viral suppression to at least 80%

Keys to Success

• Build Partnerships
  – Trust is the key
  – No one organization or sector can make the change we need
• Build incrementally
  – Don’t wait until you have “all the data” to start change experiments
• Measure continuously
  – Don’t wait 3 years, build data systems “just in time”
• Include people living with HIV on your teams
  – User centered design
Kevin Larsen, MD, FACP
Senior Medical Officer, CMS

kevin.larsen1@cms.hhs.gov
RI Lessons Learned: Relocating Ryan White

Paul G. Loberti, MPH
Administrator for Medical Services
Rhode Island Medicaid Division, Principle Investigator Ryan White Part B
Director HIV Provision of Care & Special Populations

7 December 2016
Rhode Island is Small
How Small You Ask????

Rhode Island is the smallest state in size in the United States. It covers an area of 1,214 square miles. Its distances North to South are 48 miles and East to West 37 miles.

How’s Texas feeling now?
PROVIDENCE – Rhode Island’s health care uninsured rate fell to 4.5 percent in 2015 from 6.4 percent in 2014, according to the National Health Interview Survey released this week by the Centers for Disease Control and Prevention.

Rhode Island’s uninsured population totals fewer than 50,000 people.

Pre-ACA uninsured rate: 14.34%
RI Medicaid Diary: MCO Inclusion of HIV TCM In Plan Benefit/Other

**2013 Pre PPACA**
- Began process of isolating HIV TCM on the FFS side for impact and sustainability: Limits abound!!!
- Began to propose specific methods for inclusion of HIV TCM into future Medicaid Expansion agreements (plans)
- Began discussion of inclusion of core HIV measures into MCO agreements

**2014**
- Successfully met with insurers (MCOS) to pitch notion of HIV TCM for PLWHAs into the expansion agreements
- Process included discussion of how RW Part contracts would be shared as a template for what I wanted
- Metrics discussion about performance measures, HIV Continuum of Care, QI, deliverables
- Successful inclusion of HIV TCM into the plans

**2015**
- Development of HIV high risk negative concept into expansion
- Successful inclusion of HIV viral load as performance measure in MCO agreement
- Further discussion regarding more performance measures pertaining to the HIV Continuum
- Data to care discussion using Medicaid metrics across HIV metrics
HIV Targeted Case Management Services for PLWHAs Outlined

To be eligible for RI Medicaid HIV Targeted Case Management services, enrollees must be Medicaid eligible and a member of one of the following groups:

- HIV infected persons;
- HIV antibody positive infants up to age 3 years if seroconversion has not been firmly established; or
**MCO HIV TCM: High Risk, Negatives**

- **Individuals deemed to be “high risk” until tested and HIV status is confirmed.** High risk individuals are those individuals who are members of the following populations:
  - Men who have sex with men (MSM),
  - Active substance users and/or those individuals with documented mental illness,
  - Persons who have Hepatitis B or C,
  - Persons with a documented history of sexually transmitted diseases,
  - People recently released from prison and/or the training school,
  - Sex workers,
  - Transgender individuals,
  - Bisexual men and woman,
  - Sexually active adolescents engaging in unprotected sex, or
  - Persons who engage in unprotected sex with HIV+ or high risk individuals.

- High risk individuals must be evaluated upon entry via a specific HIV negative, high risk assessment. Acuity indexing shall be designated for both negatives and positives in case management.
RI Lessons Learned

- RI Medicaid systems have helped develop RI Ryan White fiscal efficiencies
- RI Ryan White has assisted RI Medicaid in many aspects of quality management and improvement
RI Medicaid and RI Ryan White Symbiosis

1. **MEDICAID** assisted Ryan White providers in understanding the new business models of MCOs, how to reduce risk management when in this business field and how to properly bill for services.

Medicaid markets in expansion states have increased “business opportunities” for AIDS service organizations: AIDS organizations that have done their homework regarding PPACA and re-styled their business plans to compete and sustain programming are better prepared for this posture.

The RI endeavor focused upon strengthening the business acumen of smaller non-profits (ACOs) while reducing risk management for them, and emphasizing to MCOs the specialized bent of services ACOs provide.

2. **RYAN WHITE**: Provided many fine examples to RI Medicaid of quality management, case management and program success stories.

The RI Ryan White program shared many quality improvement measures across the HIV Continuum of Care for Medicaid, and MCOs were intrigued as to how RI Ryan White providers had consistently exceeded national HIV Continuum endpoints.
Thank you!

Questions
North Carolina’s Engagement in Care Database for HIV Outreach (NC ECHO)

A Collaborative Effort

Brad Wheeler, MPH
HIV Care Epidemiologist
North Carolina
Siloed Care and Surveillance Databases

Probabilistic Linkage

Person-Level HIV Care Summaries for HIV Care Continuum & Out-of-Care Lists for Care Re-engagement Efforts
De-siloing Multiple Data Systems

• HIV/STD Surveillance Unit (eHARS)
  – HIV/AIDS Case Registry

• Surveillance Systems Unit (NC EDSS)
  – General Purpose Surveillance System

• AIDS Care Unit / Ryan White Programs
  – CAREWare, NC Part B Subrecipients
  – ADAP, statewide

• Medicaid Claims:
  – HIV Disease and Care Indicators
NC ECHO Contributes to Situational Awareness of HIV Care
Public Health Interventions

• State Bridge Counselors utilize NC ECHO Out-of-Care Lists for follow up
  – Prioritized by Risk Group
  – Time Out-of-Care

• SBC’s also work on care linkage referrals and provider “Out-of-Care” referrals

• ADAP has an outreach specialist
Anticipated Products

• Within the Communicable Disease Branch, identification of QA issues/ unexpected patterns
  – HIV care arker (Viral Load, CD4, ARV) completeness
  – Compare the relative validity of fields/ Data Quality

• Medicaid: Detection of potentially Out-of-Care Managed Care clients

• Building more comprehensive longitudinal care marker maps for NC PLWHA
How We Arrived Here

- Data Use Agreement with DMA for NC ECHO similar to annual request to fulfill HRSA grants
- CDC/HICSB “Not-in-Care” was original template for Out-of-Care line lists
- SPNS-funded development resources focused on process fragilities and scalability
Thank You!

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