Arkansas Department of Health
HIV Elimination Taskforce Meeting Minutes
Thursday, August 29, 2019

Meeting Minutes

Welcome and Introduction

Welcome was extended by Dr. Nate Smith (Arkansas Secretary of Health) and Dr. Michelle Smith (Office of Minority Health & Health Disparities Director) as was the purpose of the HIV Elimination Taskforce.

Presentations

❖ Jon Allen (ADH Infectious Disease Branch Physician Assistant) presented information to the Task Force regarding the background of Ending the HIV Epidemic and the four pillars outlined in the initiative (Diagnose, Treat, Prevent and Respond).

Questions

❖ Is distribution in Arkansas of individuals living with HIV evenly distributed or is it concentrated? What do we know that could help with this strategy?
  o Answer: While at UAMS, Jon saw patients from all over the state. Many travel from rural areas and that complicated care for them to get to their appointments. There are more cases in Central and NW Arkansas but patients are distributed all over the state. We need ways to bring care to them and ways they can get their labs and follow up care without traveling to an ID Specialist.

❖ Where do we have people living with HIV?
  o Answer: Most live in Central and NW Arkansas.

❖ Where do we have people living with HIV that lack access to services?
  o Answer: In the bare spots of the state where we do not have providers.

❖ Dr. Charles Bedell (ADH Infectious Disease Associate Branch Chief) and Tiffany Vance (ADH Infectious Disease Branch Chief) presented information and details regarding the Notice of Funding Opportunities (NOFO) released from CDC. The CDC NOFO has been submitted and funding is expected by September 30, 2019. This included the following deliverables:
  1. Medical Provider Engagement
  2. Consumer Engagement
  3. Update Epidemiological Profile
  4. Situation of Analysis
  5. Ending the HIV Epidemic Plan: Arkansas

Questions

❖ What is the funding announcement and what is it supposed to fund?
  o Answer: The Notice of Funding Announcement (NOFA) will be used to accomplish the five deliverables (above). They applied on July 12, 2019 and expect the award at the end of September.
Presentations (Continued)

- What is the contingency plan if you are not awarded?
  - **Answer:** We are confident we will be awarded with this one. We have had communications with CDC earlier this week. Also because we are one of the 7 states chosen we are guaranteed funding ($750,000) based on a good grant proposal.

- How comprehensive will the Situation Analysis be? Will it only look at HIV and treatment or will it look at the whole person and wrap around services?
  - **Answer:** We want to look at the whole person, the gaps we currently have in the state and any barriers. We want to present a full picture to CDC about our state and our need and where we are being able to reach consumers for medical care, treatment and retain them in care and the support services that will ensure we will be able to do those things.

- Has the tool/survey been created?
  - **Answer:** No, that is next.

Observations

- Dr. Nate Smith: We all know how HIV is transmitted. It is closely tied to social determinants (non-medical factors) of health, typically populations that have been neglected, have significant strengths that have not been utilized but also have significant challenges. It is more than a medical problem and there is an issue of health equity and that is why we are seeking this engagement to identify those challenges and address them as we are implementing some of these biometric tools to prevent the spread of HIV. This will help us identify gaps and to set priorities.

Questions

- What population of people will be included in the Situational Analysis? Are we including sex workers, those who are transgender? Are we including those people in our thought process?
  - **Answer:** We want to work with our community based organizations, federal qualified health centers. By partnering with the ADH Prevention community based organizations (since they have direct contact with those individuals) we will use their participation on the surveys and the focus groups. Yes, we want the involvement of everyone, especially those high risk populations.

- Historically when funds go through ADH you have organizations that may have the access but not the capacity needed. What will be different this time as far as policies are concerned to engage those organizations to do this work in a different manner?
  - **Answer:** As a part of this effort we can talk even more about that. We will have an Agency Consumer Meeting Group that will discuss these efforts to see how we can work with the agencies to complete everything we have to.
Observations

- Dr. Charles Bedell: We may not have all of the answers at the moment but that is the purpose of the task force and to come up with an informed plan to end the epidemic in the state.
- Dr. Nate Smith: Some community groups may have access to those at risk and knows how to work with those with HIV but not have the administrative capacity to manage a grant and jump through the hoops like a state agency can. That is a real problem and it is more of a problem in the rural areas. This is part of what has to be addressed to end the epidemic. Innovative approaches is part of what we are looking at.
- Unknown: It is not the ability to manage the grant, it is the application piece to the grant.

Presentations (Continued)

- Dr. Charles Bedell and Tiffany Vance also presented information and details regarding a second Notice of Funding Opportunities (NOFO) released from the Health Resources and Services Administration (HRSA). The HRSA NOFO is due October 15, 2019. The purpose is HIV prevention. This included the following deliverables:
  1. Increase and Expand Testing
  2. Achieve 90% Viral Load Suppression for HIV Positive Persons
  3. Ensure HIV Negative Persons Remain Negative

Discussion (Question presented by Dr. Michelle Smith)

Knowing what you know, what are some of the barriers that you think we will face in implementing this and what is your willingness and capacity within your agency to help us get there?

- **Answer:** Deidra Levi (Director of HOPWA) - Barriers: Talking to stakeholders is not the problem. It is reaching those outside of the HIV community that needs to buy in such as the Razorbacks, pastors and clergy across the state. Someone else talking about this besides us. Urban sanctuary – gap in healthcare in the Black LGBT community. We have always been willing to do what is needed but we lack the capacity to have the funds to do what is needed.

- **Answer:** Cornelius Mabin (HIV Prevention Co-Chair) stated that the HPG organizations has been working for years to invite stakeholders (legislators, clergy, etc.) and they have had empty chairs. There has been a mechanism in place that has reached out to the community for decades. HPG meets bi-monthly and everyone in this group is invited to attend.

- **Answer:** Arkansas Dept. of Correction Representative: Barriers In regards to inmates: One of the gaps for this population is they are going from state agency to state agency but they almost all run out of the drugs and lose contact for a follow-up. Those that come back (into ADC custody) who have been off treatment are harder to treat.
Continuity is needed. There is lots of time to plan for discharge but the left hand is not working with the right.

- **Question:** Are these individuals available for Arkansas Works when they are released? Flexibility in the Medicaid enrollment is needed to get them on the program when they are released.
  - Answer: Correct.
  - Answer: We could transiently enroll them in the Ryan White Program to cover their medications until other forms of payment come through

- **Question:** Accomplishing our goals is related to socioeconomic determinants. Even if we get all of the insurance issues lined up we are still losing people from the time they leave prison until their first appointment up to 4 weeks later. Is there an organizational process on the outside to receive these people and support them socially?
  - Answer: That is a million dollar question. There are close to 18,000 prisoners and over 5,000 in the county jails and none of those are tested (for HIV/AIDS). When we incarcerate these people we don’t have the resources. We have all these data points and there is no integration (between state agencies).

**Observations**

- Dr. Gary Wheeler: In Cuba (5 or 6 years ago), HIV was treated in sanitariums by locking up HIV patients there to keep them away from the general population. As therapy became available they treated all of these people, dealt with any with drug addiction. When they were discharged they went to a team in their community who was responsible to keep them on track. He was not aware of anything like that here. In the 80s there were teams of people who helped with those with HIV.

- **Question:** How can we fill that gap to connect, not just those in prison, but all people when they receive their diagnosis to fulfill their goals? The Ryan White Program is there but there are some community elements that are missing.
  - Answer: We already have community health workers. The challenge in our state is we do not get reimbursed for those services. Medical providers take a risk hiring people and not being reimbursed for the services. We know what works. The real issue is can we overcome a lack of will we seem to have to do it. We have to convince policy makers to hone in on this issue. We know how to solve it and let’s get it done.

- Unknown: Another barrier is traditional thinking in terms of how to deliver services. The medical service model is 9-5. Our expectation is patients will come to see the service provider instead of the provider going to the patients. The expectation is that a provider must have some credentialing beyond a Bachelor’s degree. If we can break out of the traditional mold of how we deliver services and define health. This is a disease that is so stigmatized that if we put a kiosk in Walmart who would be willing to walk up if it said HIV testing on the side. Dealing with the stigma is a big part of ending the epidemic. If we don’t deal with it we will be here in 10 years.
Question: Do we know the number of inmates in ADC custody with HIV?
   o Answer: Yes

Rep. Fred Love: (Going back to those in ADC custody) We have a source of funding through HOPWA. If we don’t stabilize a person’s housing they will not stay in care. We could start a pilot project with HOPWA (Housing Opportunities for People With AIDS) funds to target this population and provide support. We could test if keeping them in housing would stabilize and keep them in care. This is not policy, it is if we are going to do it or not. We have the resources. We can target the inmate population with this.

Dr. Nate Smith: Housing AND Transportation are barriers (to care).

Tiffany Vance: Our Ryan White Program has worked with ADC. She likes the idea of working with HOPWA and connect that with the Corrections to care effort.

Rep with ADC: Steps were given of what happens when an inmate is released and is HIV positive. (ADH (Gisele Hudson) is contacted, Dr. Moore (ARCare) is contacted along with other providers on the outside). Those on parole must have a parole plan in place which includes housing. If it does not then they will not be released. The inmate fills out a form that is released to these entities.

Unknown: This could also apply to LGBT youth with the same concerns. People who are incarcerated are an easy target.

Dr. Nate Smith: The population that drives the Epidemiology numbers are those that are recently infected.

Unknown: Let’s change the message. Let’s make Arkansas the first to do something different.

Discussion (Question presented by Dr. Michelle Smith)

What is your agency’s ability for system expansion (telemedicine usage, monitoring, etc.) and legal parameters for exchanging data and information between agencies?
   o Answer: The exchange of information does not seem to be a problem

Observations

- More stakeholders are needed in this discussion (like legislators) that are not in this room and not directly impacted
  o Answer: We will do that

- You most likely would not be able to share the information (provided by ADC to providers) to faith based and community groups to help people stay in care.
  o Answer: That is why we work with ADH (Gisele Hudson) and the Ryan White Program to get them the help they need and I know that is what they do to provide help. Once they leave ADC custody, the ADC rep has nothing else to do with them.

- Dr. Smith: All of this would be great to discuss as sub-groups. (A sign up list for these subgroups was passed around later in the meeting).

- Unknown: How can we increase capacity for testing? Home testing and self-testing but people with probably not want to pay $45 for the test. This is a critical area we are not doing an adequate job.
Dr. Dan Moore (ARCare). ERs should be doing HIV testing but they aren’t. He is meeting next week with rural ER staff to see how we can increase HIV testing.
  - **Question**: Why are the ERs not testing for HIV?
    - **Answer**: They don’t want to follow up
  - **Question**: Would it help if a community health center agreed to provide follow-up to ERs?
    - **Answer**: Yes, that would definitely help
    - **Answer**: We can use Ryan White to link that care and then get them a local doctor to provide care and recruit providers to provide HIV care.

Dr. Nate Smith: A project we tried was putting Telemedicine in the Local Health Units but it didn’t work. That is not where people want to receive their HIV care. We need to find out how they want to receive their care.

UAMS Technology Rep: Telemedicine can reach people using smartphones/apps using a platform that is web based and is encrypted. There is also technology (connected to their pull bottle) that will let the system know if they are compliant of taking their medicine. A Health Navigator is being used through UAMS for cancer and other diseases.

Dean Mark Williams: A subgroup is needed consisting of pastors and bishops to activate congregations and address stigma.

Dr. Bedell: We are missing the Oral Health care providers (at the table).

Unknown: We need people impacted at the table (sex workers, LGBT homeless, transgender, 18-25 year old black males who have sex with males.)

Dr. Alisha Cragbill (Healthcare Pharmacy): The UAMS College of Pharmacy trains students (in their first year) to do testing blood sugar, cholesterol, etc.). We could include HIV testing. Dr. Jeremy Thompson is the contact for this.

Cornelius Mabin: All of this has been talked about for years. What are we going to do about it?

Dr. Nate Smith: Amen. We need to have these same conversations with different people.

Dr. Michelle Smith: Please email her names of those you may want to add to the table.

**Next Meeting Date and Time**

September 19th - 2pm-3pm – HIV Elimination Taskforce
Arkansas Department of Health

2nd HIV Elimination Taskforce Meeting Minutes
Thursday, September 19, 2019

Meeting Minutes

Welcome and Introduction

Welcome was extended by Dr. Nate Smith (Arkansas Secretary of Health) and Dr. Michelle Smith (Office of Minority Health & Health Disparities Director) as was the need for informed input on how to identify gaps in the four Pillars of HIV Elimination (Diagnose, Treat, Protect, Respond) and a reminder of the purpose of the HIV Elimination Taskforce in order to provide innovative ideas to create optimal conditions to eliminate HIV.

Presentations

- Latunja Sockwell (UAMS Family and Preventative Medicine Community Research Group Program Manager) gave her personal story as someone living with HIV and her current pursuits in HIV Elimination in her position at UAMS through active projects such as AR Passion Project, Gilead Drug Court Project and PrEP. LaTunja was diagnosed in 1997 while living in Prescott, AR. She identified the barriers she faced receiving HIV related care such as living in a rural community and the lack of treatment at her primary care doctor’s office, doctors’ lack of knowledge of HIV, the lack of someone to talk to (except her family) about her diagnosis and the far distance to her HIV provider’s office in Texarkana from Prescott. At one point a doctor refused to perform an elective surgery on her because of her diagnosis and his fear “for his staff’s safety”.
  - Things Latunja would change
    - Who’s “At Risk” – Who says anyone is at the “Highest Risk”?
    - Mass Testing
    - Primary Care – The fact PCPs will not treat HIV so a person must see an Infectious Disease Specialist for care. For those like herself who make too much income to qualify for the Ryan White Program, they must pay a Specialist Copay which is usually much more than that of a visit to a PCP.
    - Tracking Clients – Track those with HIV that are not on the Ryan White Program or are seen at ARCare.
    - Education in the Communities – Get HIV education into the schools
    - Medical Profession Education – Provide this especially in the rural areas
  - Elimination and What It Means to Her
    - Linkage to Care
    - New Positive Diagnosis down to none
    - Medical Trials – To see if shots could be used to treat HIV, not just pills
    - Budgets – Eliminate restrictions against good ideas because of the cost
    - Community Events – In a couple of weeks a PS2 gaming tournament has been set up in Prescott and all the participants will be tested
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Thursday, September 19, 2019

- Elimination and What It Means to Her (Continued)
  - New Grants
    - Project Heal – 2.5 million grant from SAMHSA to help African Americans in Pulaski County involved in the criminal justice system that uses the Healthy Love curriculum that shows people how to use condoms. Testing is included along with health screens and other wrap around services.
    - SOF (Save Our Futures) – Going into colleges and including internet based counseling
  - Need to Focus on HIV Decriminalization

Questions/Comments
- Dr. Naveen Patil (ADH) stated that they current not doing a trial but they are applying for a grant regarding injectable treatments and will work with Ms. Sockwell regarding this.

Sub-Committee Breakout Sessions
- Participants of the Task Force split into four groups to discuss the Pillars of HIV Elimination (Diagnose, Treat, Protect and Respond). The questions to be discussed in regards to each pillar were
  - What barrier gaps exist?
  - What innovative ideas do you have that could reduce those barriers?
- Those who chose Diagnose presented the answers to these two questions. All other pillars were discussed and will be presented at future Task Force meetings
  - Diagnose - Barrier Gaps
    - Reason to get diagnosed/tested
    - No insurance coverage
    - No access to care
    - Trust issues
    - Availability of testing and treatment
    - Reporting
    - Stigma
    - Lack of capacity
    - How we look at those who are “High Risk”
    - What are we doing for those who test negative? If they walk out with a negative result but nothing else, then that is a barrier
    - Lack of wrap around services
    - Doctors are not comfortable talking to their patients about their sexual health
    - We have created categories that have become stigma. We have separated health from sexual health
    - Risk identification and appropriate response
    - Language
    - Religion
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- Diagnose – Innovative Ideas
  - Look at those who are “High Risk” and change our way of thinking
  - Make the local health units “Sexual Health Units” or “Be Well Clinics”
  - Give more test kits to community groups
  - Give HIV tests when someone gets married or applies for a new ID
  - Focus on a person holistically
  - Test everywhere
  - Conduct media events and present PSAs
  - Concerts – Provide incentive for testing like $10 off the ticket
  - Provide public awareness that it is not a death sentence
  - Air a series of commercials telling someone’s story (like the violence or cancer ones)
  - Learn from the Cancer Community
  - Create a campaign to keep it in people’s minds
  - Step out of the Central Arkansas Region
  - HIV patients can’t hide who they are
  - Get support groups in every county
  - Educate ALL providers with CDC risk factor information
  - Change conversations among physicians. Cancer is now normalized with screenings at age 40. Start the same with HIV testing at age 18
  - Include HIV testing as part of a wellness screening
  - Bring 3rd party payors (insurance companies) to answer what testing and treatment they will pay for
  - Electronic Medical Health Records should include HIV
  - Bring Legislators in to reduce or eliminate some barriers
  - Convince Arkansans to change their minds and hearts regarding HIV
  - Create and air HIV education podcasts

Next Meeting Date and Time

HIV Elimination Taskforce - October 24th, 2019- 2:00pm-3:30pm
Location: Freeway Medical Building Boardroom – Rm 906 - 5800 West 10th St., LR, AR 72204

Visit by Dr. David Reznick, Director, Oral Health Center’s Infectious Disease Program, Grady Health
November 14, 2019
8:00am - Grand Rounds
Location: ADH Auditorium – Basement Level of ADH main building (4815 W. Markham, LR, AR 72205)
10:00am – Roundtable
Location: ADH Boardroom – 5th Floor of ADH main building (4815 W. Markham, LR, AR 72205)
Arkansas Department of Health  
3rd HIV Elimination Taskforce Meeting Minutes  
Thursday, October 24, 2019  

Meeting Minutes  

Welcome and Introduction  

Welcome was extended by Dr. Nate Smith (Arkansas Secretary of Health) and Dr. Michelle Smith (Office of Minority Health & Health Disparities Director). Today’s focus will be Pharmacies’ role in eliminating HIV.

Presentations  

Kim Schalchin (Ryan White client) gave her personal story as someone living with HIV. Kim was diagnosed at the age of 35 in February 2015. She is a recovering drug addict and used to shoot up meth with out any concerns about contracting something. She went to the Lonoke Health Unit to renew her birth control. While there the nurse asked a series of questions and when she mentioned her drug use the nurse suggested she take an HIV test. At first, she thought it was a false positive. The LHU employee was not nice or compassionate. The counseling services she received through the LHU was cold and uncaring. It was a bad experience all together. The worst part was knowing her name is now in a database. Even after her diagnosis she still shot up since she now had a “death sentence” but that has all changed and she realized we all have a death sentence. She now sees Dr. Joseph Beck for her HIV care and he has made her life with HIV easier. She wished her experience had been better at the health department and with her previous case manager at ARcare. When she was diagnosed, her viral load was 12,000 and her CD4 was 570. Dr. Beck did not start her on meds right away because she was still shooting up. Once she did start the meds within two months her viral load was less than 20. She now tries to stay educated about HIV and being an advocate and help others. She is NOT HIV.

- Barriers she has faced
  - Meds upset her stomach so she missed a lot of work and she almost lost her job. She did not want to tell her employer why she was sick.
  - Ignorance about HIV
  - She did not face transportation or housing issues but she has friends who have
  - Health Department’s staff that were not compassionate or caring.
  - ARcare case managers (in the past) who seemed more about a paycheck than being caring and supportive of their clients.

- Elimination and What It Means to Her
  - Freedom
    - Free to live without worrying about meds, from having to tell someone she is dating she lives with HIV, from stigma, from it affecting her family and friends, from not wanting to face the public.

- Questions/Comments
  - Kim was asked how she moved from a sense of hopelessness to wanting to get her life back. She could have stayed an active addict but she wants to make a difference and help others.
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- Courtney Hampton (HIV Prevention & Viral Hepatitis C Program Manager) presented a recap of Pillar I: Diagnose - Barrier Gaps and Innovative Ideas to eliminate HIV.
- Dr. Michelle Smith presented a video that showed pharmacies offering rapid HIV tests
- Courtney Hampton spoke about Voluntary Counseling and Testing (VCT) Training which is available to anyone who would like to participate. It is a two day class that teaches you how to perform HIV tests and how to become a counselor held every three months. Contact Courtney at 501-661-2749 or Courtney.Hampton@arkansas.gov if you are interested in attending.

Courtney also demonstrated how to perform a Antibody Rapid HIV test which produces results within 1 minute. It has a shelf life of 24 months. Oral Quick takes at least 3 months after exposure to provide accurate results. This test takes 21 days. Once someone tests positive they are referred to a local health unit or their primary doctor. A Disease Intervention Specialist (DIS) with ADH will be assigned to them to track down their partners to have them tested.

- At the recent HIV/HEP C State Fair Testing Event – 682 people were tested two-weeks diagnosing 55 Hep C positives and 15 HIV positives.
- The use of home HIV tests were discussed.
  - At a pharmacy, a home test costs about $45.00.
  - Pro – Patients don’t have to go to the LHU or their doctor to be tested
  - Pro – If we could make them free/low cost then that would remove stigma.
  - Con – Lack of reporting. Who is getting the results of the test? Reporting is not mandated by law in Arkansas
  - A suggestion was made to remove VCT training.
  - Arkansas is way behind the curve regarding home tests. It will be important to build relationships with community groups and to be creative. Self-testing has worked in other parts of the world, now by using an app where the patient takes a picture of the positive result and they send it in. There is no excuse for the tests to be $45.00. The health department gets them for $9.50. In India they are using self-test vending machines.
  - Kim (Schalchin) was asked if she would have taken a self-test and she said no because she did not think she had to worry about HIV. A barrier would be lack of educations. It depends on the situation if someone would take a test on their own.
  - Ideas regarding self-testing
    - Pair the tests with syringe exchange.
    - Link testing to benefits such as SNAP like vaccines were linked (very successfully) to WIC. Rebuttal to this - It would be bad public policy. Testing should not be tied to benefits to less fortunate. We would not ask the rich to be testing when submitting their tax returns.
    - Do a stigma analysis and provide education everywhere, not to those we deem as “high risk”.
    - Provide incentives like they gave $15 gift cards during the State Fair Testing Event.
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- Show an informational video at the DMV. With the new federal regulations regarding new driver’s licenses will result in more traffic.
- Largest barrier seen is that people don’t think they need to be tested.
- The group was reminded that there are ideas in place. We just need to implement them.

Pharmacies’ role in ending the HIV epidemic was discussed
- Largest Barrier - money. Pharmacies do not receive compensation for providing HIV tests and counseling. Some have reached out to pharmacies and they are not interested.
- Small local pharmacies struggle to stay afloat. If they can be paid it would help. Also, the availability of HIV meds is a barrier for small pharmacies.
- Walgreens was represented. They want to help communities but they also have to make sound business decisions.
- Another barrier is the lack of consistent care across all locations. They have patient health rooms who allow community groups to use for testing but there is not enough staff utilizing these rooms.
- Walgreens was praised for their help on HIV/AIDS Testing Day.
- If pharmacies could establish an agreement with physicians and provide services including PreP, pharmacists would fill and monitor labs. This would be lucrative for pharmacies and bring in more business for the other things they sell.
- Why can’t the UAMS Pharmacy School train students to test and counsel for HIV like they do for diabetes and hypertension and then take that knowledge to local pharmacies. Start the training their freshman year.
- Offer continuing education credits to pharmacists for their cooperation.
- Geographically target a pharmacy (like in Chicot County) instead of targeting all of AR.

Other things mentioned
- People in nursing homes are at risk for HIV
- Anyone having unprotected sex, regardless if they are “high risk” or not are at risk.
- A request was made to have Cornelius Mabin (Arkansas HIV Prevention Group Co-Chair) speak at a future meeting to discuss the great things his organization has been doing.

Next Meeting Date and Time

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