Minutes

Florida Viral Hepatitis Council (VHC) Meeting, May 30-31, 2013

Thursday, May 30, 2013

Members:	**Guests:**
Barbara Rush, Community Co-Chair	Rick Mendola- OraSure
Phil Styne, MD	Henry Sims- GSK
Susanne Crowe	Jimmy Minton- GSK
Pat Simmons	Michelle Scavnicky- The AIDS Institute
Philip E. Reichert, DOH Co-Chair	Gordon Licatia- HepatitisMain
William Chen, PhD	Shawn Rich- Gilead Sciences
Enid Santiago-Cruz	Jessi Embleton- Hepatitis HQ
Donna Dowling, RN	April Crowley- Hepatitis HQ
Mike Jolly, ARNP	

Welcome and Introductions- Barbara Rush/Phil Reichert
"People Search" icebreaker

Old and new Council Business- April Crowley
August 2009 Minutes
Motion to approve the minutes from the last meeting (August 27-28, 2009).
None opposed
Previous minutes approved

Membership Vacancies
April stated that in order to fulfill the by-laws, we need members in the following categories:

a. Community Members: we need three more
b. Other Governmental: we need one more
c. Associations and community-based-organizations: we need one more.

Nominations
Peggy St. Croix nominated Karen Muller in the last VHC meeting. April has called Karen and left her voicemails to see if she is still interested in being a member. Karen is from Bay Pines Veteran's Administration Hospital, which is representation the VHC has been looking for.

Barbara recommended trying to contact her at lunchtime and come back with an update before voting on her.

Donna Dowling commented that she knows someone from Gadsden County that may be interested in becoming a member.

Phil stated he would like to have representation from different parts of the state as well as different disciplines.

By-Laws
April brought up some minor changes.

First Change: Article I, Council Authority, Section I, number 2 states, "The Florida Department of Health (DOH), Florida Hepatitis Program (HPP), operates under Florida Statute, Sections 381.003 and 381.00325." Florida Statute, Section 381.00325 was eliminated by legislature in 2012 and section 381.003 is not hepatitis specific even though it does refer to STDs and vaccine preventable diseases.

The members unanimously voted on changing "operates under Florida Statute, Sections 381.003 and 381.00325" to read "operates within the Bureau of Communicable Disease in the Division of Disease Control and Health Protection."

Second Change: Article III, Membership, Section I, number 3 states, "In the event that a Council member is absent from two consecutive meetings, that member shall be determined to have resigned from the Council, effective at the end of the second consecutively missed meeting. The Council may make exceptions in the event of extraordinary circumstances." April stated Cindy McLaughlin has only attended one meeting in July 2007. She has contributed a lot and she does call to inform of her absence. Alice Adams was nominated and approved at the last meeting in 2009. We have not had a meeting since then, it has been four years, and she may not want to be a member anymore. The question is, since travel has been so limited and the Viral Hepatitis Council (VHC) has not met in four years, do they remain on board as members?

Mike Jolly stated, "beggars can't be choosers" and votes to leave Cindy McLaughlin on and try to contact Alice to see if she is still interested.

Dr. Styne agreed with Mike in keeping Cindy on would be appropriate.

Barbara Rush mentioned getting back into a regular structured meeting would hopefully get more people involved and then a decision could be made about removing some members.

Mike moved to keep Cindy on the council
Dr. Styne seconded
None Opposed
Motion was approved

Third Change:. Article VI, Meetings of the Council, Section I, Meetings states, "There shall be at least two meetings per year." Phil recommends qualifying "two meetings a year" since that is not going to happen every year due to travel restrictions and budget.

Mike motioned to reword it to "two meetings per year based on funding and approval."
Phil seconded
None opposed
Approved

Phil said to keep in mind that there is space for more people to become members of the council, specifically, more consumers (people with current or past infections with hepatitis C).

Phil would like to look at the goals of the council if there is time before everyone leaves. He would also like to get a volunteer or two to come to Tallahassee to update both the goals and the objectives in the comprehensive plan.

Funding, Budgets and Program Update- Phil Reichert

Phil: As some of you know, our program in Florida is still lucky compared to other states. Most states do not have general revenue or state money funding their hepatitis program and most states do not provide vaccine or testing. They usually only give talks and provide education to health care workers and maybe do a little outreach. We are fortunate to have fifteen county health departments that we fund. The Hepatitis Prevention Program (HPP) has decreased in size and scope during the past four years with regard to state General Revenue funding. Most recently, there was a new position granted to the hepatitis program with funding from CDC. Cindy Kruty is filling in that position as the Vaccine Grant Coordinator.

Hepatitis works closely with the State Lab for test results. They have done a lot of panel tests since 2000 when the program was first developed. Phil presented a chart which listed the amount of hepatitis C tests completed by the State Lab over the years.

-2007: 22,812
-2008: 28,188
-2009: 33,004
-2010: 25,756
-2011: 21,018
-2012: 22,826

44.7% Increase in Testing from 2007-2009
31% Decrease in Testing from 2009-2012

This information was based on LabWare Data

Phil presented a slide which showed the positivity rate (raw data from LabWare) for hepatitis testing in the state lab from January-December of 2012.

-Hepatitis A Antibody: 30.1% + (A Antibody means immunity due to previous infection or vaccination)
-Hepatitis B Surface Antibody: 46% + (B Surface Antibody usually denotes vaccine protection)
-Hepatitis B Surface Antigen: 0.8% + (B Surface Antigen usually means acute or chronic infection)
-Hepatitis C Antibody: 9% + (over 99% of Hep C Antibody positives are chronic)

1992 was the first year in Florida that infants were required to have the hepatitis B vaccine. To vaccinate children born before 1992, in 1997, there was a requirement to have the series completed before going into the seventh grade. For the most part, everyone under the age of thirty to thirty-two years has been vaccinated. The question now: Is the vaccine still effective thirty+ years later? CDC is studying this to decide whether to recommend a booster dose, or not.

Hepatitis recently acquired 2,000 rapid HCV test kits. They were all distributed to ten (Broward, Collier, Duval, Leon, Charlotte, Monroe, Okeechobee, Orange, Pinellas and Sarasota) county health departments (CHDs) with the exception of a 150 tests kept at headquarters. The CHDs are required to have a Clinical Lab Improvement Amendments (CLIA) waiver to conduct the rapid HCV test. This is a pilot project and they were provided to the Hepatitis Prevention Program at no cost.

Florida reports about 22,000 cases of chronic hepatitis C and 33 cases of acute hepatitis C in the state of Florida each year. About half the states do not report chronic hepatitis C cases. There is an estimated 309,000 cases of hepatitis C in Florida, around 4 million in the US, or, 3.2 to 5 million, depending on the source. There is a prevalence of one percent to around two percent of the general population. Twenty-five to fifty percent are unaware of the infection in Florida and up to seventy-five percent in the US.

CDC released new testing guidelines based on the Baby Boomer Cohort. CDC is now recommending testing anyone born between 1945 and 1965. Seventy-five percent of chronic hepatitis C cases in the US are in this age bracket.

The number of acute hepatitis B cases have gone down significantly in the past ten years. In 2012 there were 257 acute hepatitis B cases reported in Florida, this number is down from 563 in 2003.

Hepatitis A vaccine has prevented several outbreaks in the last decade.

The Hepatitis Prevention Program provides adult hepatitis B vaccine to county health departments. In the past, we provided adult hepatitis A vaccine and A/B combination vaccine. Total A, B and A/B Vaccines given based on HMS Data and CHD activity only from 2005-2012:

-2005: 33,601
-2006: 31,221 down 2,380 doses from the previous year
-2007: 37,026 up 5,805 doses from the previous year
-2008: 41,431 up 4,405 doses from the previous year
-2009: 35,429 down 6,002 doses from the previous year
-2010: 28,921 down 6,508 doses from the previous year
-2011: 23,405 down 5,516 doses from the previous year
-2012: 18,884 down 4,521 doses from the previous year

These numbers of vaccines given are declining due to limited resources, realigned priorities and competing public health initiatives. The Hepatitis Prevention Program had CDC 317 vaccine initiative for four years (2007-2010), which provided extra funding to purchase the vaccine. Right now, the HPP is operating on a $40,000 budget line item specific to vaccine purchase. The 317 Vaccine Initiative was great because the HPP was able to encourage the county health departments to vaccinate as many eligible individuals at risk as they needed to. The HPP applied for a grant last year to get more 317 vaccines from the CDC. Depending on sequestration constraints, it will provide about 15,670 doses of vaccine over a two-year period. The good news is, general revenue vaccine can be spread over the remaining 61 counties, since the vaccine grant will provide vaccine to six county health departments involved in this pilot vaccine project. Through this grant, the HPP was able to hire the new OPS person.

The Viral Hepatitis Council has not been able to meet face-to-face since 2009. The HPP also hosts hepatitis coordinator meetings (these are usually yearly), and we got approval for a meeting in December 2012. When that one got approved it opened the door to have this Viral Hepatitis Council meeting. The hope is to have another Viral Hepatitis Coordinator meeting before the end of the year, or early in 2014.

Something happened this year that has not happened in the past eight or nine years. Normally there is a "Hepatitis Day at the Capitol" every year where the hepatitis program had a display and provided information on the third floor rotunda. There used to be a press conference and a press release. For the first time in about ten years, this event was not approved. The hope is this is temporary, since this is an opportunity to provide hepatitis and other public health information to legislators and their staffs.

About a year ago, Florida State Legislature introduced a bill based on language that was introduced into Congress. The HPP provided the information for bill writers. The bill got a lot further than anticipated based on previous years but was not approved. What it would have done is provide up to about a million and half more dollars toward viral hepatitis prevention in Florida, and to fund the county health departments and provide the ability to conduct more tests. The ultimate goal is to get more people tested. Unfortunately, it was not introduced into the 2013 legislature.

The new CDC hepatitis prevention campaign is "Know More Hepatitis" with emphasis on the "no" in "kNOw." This was put together to go along with the CDC recommendations on the baby boomer cohort. Posters are available free of charge at www.cdc.gov/KonwMoreHepatitis

Questions/Comments:
None at this time

The AIDS Institute/Planning Groups Update- Michelle Scavnicky

Michelle is the Director of Education at The AIDS Institute (TAI). In June of 2012, TAI and AIDS Alliance for Children, Youth and Families merged in what was a naturally fitting partnership. The AIDS Institute, founded as Florida AIDS Action, began in the mid 1980s. In 1992, this advocacy network became incorporated as a 501(c) 3 nonprofit organization. Over the years, TAI has expanded its vision to become a leading national nonprofit organization with offices in Tampa, Florida and Washington, DC.

TAI remains focused on HIV/AIDS while incorporating work on related healthcare issues, including viral hepatitis. The mission of TAI is to promote action for social change through public policy research, advocacy and education. In 2012, former state of Virginia hepatitis coordinator, Brian Anderson, was hired to assist with increasing hepatitis education, training and capacity building programs.

TAI's policy staff has workd closely with the HIV/AIDS community on the Ryan White (RW) Program. It has been quite challenging due to many unknowns and the new Affordable Care Act (ACA).

TAI is working on submitting a competitive proposal for CDC's Viral Hepatitis Networking, Capacity Building and Training grant to assist organizations, increase the

number of individuals who receive testing for chronic viral hepatitis and who are unaware of their infection.

TAI has worked with the Florida Department of Health, HIV/AIDS program to assist with the coordination of the statewide planning contracts for the past twelve years. However, in 2012, with the changes and reorganization of the Department of Health, including institution of a competitive bid process, TAI was awarded the statewide contract for coordination of the planning efforts and work of the Florida Comprehensive Planning Network, which includes the Patient Care Planning Group (PCPG) and the Prevention Planning Group (PPG). Both meetings were held in November 2012 in Tampa.

In 2013, PCPG and PPG meetings were convened in April and agenda items included HIV/AIDS, Hepatitis and Prevention Program updates. People should visit www.theaidsinstitute.org/florida-policy/patient-care for a copy of the presentations at the meeting. PPG was also held in April and presentations included the HIV/"AIDS Prevention Program update, Hepatitis Prevention Program update, a transgender presentation and a local presentation addressing HIV among young African American men who have sex with men. Feel free to visit the following link for a copy of the presentations from the meeting. http://www.theaidsinstitute.org/florida-policy/prevention .

The combined *leadership* meeting of PCPG and PPG also met in April, where co-chairs from both groups were there as well as key HIV/AIDS and Hepatitis Prevention Program staff including Phil. The purpose of the meeting was to exchange ideas on ways to begin the integration of patient care and HIV prevention planning efforts. The agenda consisted of an overview of each of the required statewide plans (Patient Care and HIV Prevention Plan), discussion of early identification of individuals with HIV/AIDS (EIIHA), and improvements within coordination and information dissemination to and from each of the groups. An agreed upon outcome was to host quarterly combined co-chairs conference calls, in addition to the standing co-chairs calls that are currently being conducted by each group's leadership.

TAI developed the *Red Ribbon Report* which was distributed five days after the last Florida Comprehensive Planning Network (FCPN) meeting. Presentations are uploaded to a centralized webpage on TAI's website and a hyperlink is provided to the presentations from the meeting.

Upcoming calls/webinars:
-PPG hosted a webinar to solicit input on proposed restructure of Florida's PPG including the composition of the group to align with CDC's revised HIV planning guidance.
-PCPG workgroup to continue refining the template for reporting on activities relevant to the next planning cycle.

Feel free to email Michelle at MScavnicky@theaidsinstitute.org to be included on any of their email distributions including the *Red Ribbon Report*.

Questions/Comments:

Phil stated- Regarding Ryan White (RW) and the AIDS Drug Assistance Program (ADAP), in the past, if someone was co-infected with viral hepatitis they were able to be

treated using ADAP funds. It was never used to its full capacity. ADAP had a waiting list of 4400 for the first time in its history about two-to-three years ago. Florida applied for and was granted $6.5 million from the federal government and some general revenue from the state to eliminate the waiting list. If you were 400 percent above poverty level, you were eligible to access RW and ADAP services. This has now changed to 300 percent.

Dr. Styne- This is really important now because the number-one cause of death for HIV co-infected folks is liver failure.

Phil- The Department of Health has never had the capacity to get people treated for hepatitis B and C but there are a few resources in the state to help people. When ADAP and RW had to make changes, they scaled back and took hepatitis treatment drugs off the formulary. Phil spoke with Joe May, the Patient Care Section Manager, and they are working on getting those drugs back on the formulary.

Dr. Styne- Anyone that is treating hepatitis B or C patients can get medication for free, for patients who are eligible.

Phil- A gap to that is finding them a medical home while they are on the medication. In all the monthly conference calls and the meetings within the past three years, it seems as if the Division of Viral Hepatitis at CDC is counting on the Affordable Care Act as a way to treat people with hepatitis C and find medical homes.

Dr. Styne- Phil, what do you mean by a "medical home?"

Phil- A medical home is where someone can stay and be seen by a physician on a regular basis and have their medications administered and monitored properly.

Dr. Styne- I don't think it will be a problem getting patients a medical home in my area.

Phil- In some parts of Florida, it is not a problem.

Dr. Styne- Find resources to get care.

Michelle- CDC is really getting the word out to test baby boomers. Once they are tested and if they test positive, where do you send them for care? Yeah, they have drugs but where do they get the care? Who's going to pay for it? That's the bottom line.

Michelle will let everyone know what's going on and be in touch about trainings and if funding is granted.

Recent & Upcoming Hepatitis Awareness Events, Educational Materials & Training- April Crowley

April- First let me start of with letting you know Bob Keane, who was on the VHC for two years 2006-2008, passed away. He used to work at the Pinellas CHD as a nurse. He retired in 2007 due to health issues. Before he became a nurse, he worked up north as a police officer in undercover vice. He often said, being a former cop helped him be a better nurse. He understood the streets and substance abuse. He was sixty-seven when he died and had three sons and three grandchildren.

Michael Amidei also passed away within the last year. He was involved in the VHC since it was initiated in 2004. He was also involved in the HIV community planning and in the patient care-planning group through the RW consortia. Additionally, Michael was a huge advocate for services to the homeless communities in the Tampa Bay area. Like Bob, he is surely missed.

As far as education goes, April is finding smaller is better. There are not many CDC brochures anymore. CDC is offering fact sheets now. The HPP developed a new hepatitis B palm card to distribute. The next adventure is to do one for hepatitis C. Hepatitis ABC charts (one side English, the other side Spanish) are still available.

Questions/Comments:

Phil- The good thing about the palm cards, it has a place on the back to track your vaccine series. It will serve as a reminder to finish the series. Right now hepatitis B vaccine is being pushed the hardest. Hepatitis has to live within their means, which means taking advantage of the 317 vaccine grant from CDC.

Barriers, Gaps in Services & Needs Assessments/Goals- Phil Reichert

Phil- Let's discuss and update gaps in services and barriers as part of the plan. I want to concentrate more on hepatitis B and C. A is out there but it is not a serious problem right now. Where are our gaps?

GAPS

-**Primary Care Education, Screening** (Mike Jolly)

Dr. Styne stated- Primary Care comes from **discord between CDC and US Prevention Task Force.** Primary care doctors are not sure what they are supposed to do. We need to be sure that we have a single voice when we educate the primary care physician (PCP).

-**Consistent guidance**

-**Linking uninsured patients with care** by a PCP, linking all with care services, education program for the people about medication compliance. (Barbara Rush)

Dr. Styne stated- Most patients that sign up to get hepatitis C therapy are ready to go until they start getting sick from interferon. I think that is a one-on-one patient thing (Quality 1-on-1, health care worker, HCW to client).

-**Quality 1-on-1 health care worker to client education**

Phil asked- As a private physician, if a twenty year old walks in for services, and they claim to have had several sexual partners in the last six months, and they have a telltale sign of an STD or risk factors for HIV/hepatitis, do you go through a whole protocol for testing them and if so, can we add hepatitis to it?

Dr. Styne answered- Getting that history may be the biggest barrier. If you get to a level where the HCW has figured out the patient's history and they are smart enough to test for HIV, they are smart enough to get hepatitis markers.

Phil then asked- Is that a gap or a barrier? You only have so much time to spend with a patient. Is time a barrier or a gap?

Dr. Styne responded- **Time is a barrier**, no question.

Mike said- Ideally, everyone in the US would get HIV, hepatitis B and hepatitis C testing and we could deal with the problem within a couple of years instead of ten or fifteen years.

-From a public health standpoint, a gap is inadequate funding (i.e.: testing, education, vaccination). What about other gaps? Other resources maybe? (Phil Reichert)

-**Inadequate access to the higher risk populations** (Donna Dowling)
-**Limited resources** (i.e.: if all 1945-65 cohort got tested for hepatitis C (Dr. Styne)
-**Funding** (Gordon Licata)
-Medication side and the **ability to use needed drugs** (Gordon Licata)
-**Treatment management** (Gordon Licata)
-**Side effect/risk of drug toxicity** (Dr. Styne)
-**People who have skills to counsel patients when they test positive** (April Crowley)
-**Collaboration among programs** (Enid Santiago-Cruz)
-**Adequate primary, secondary and tertiary education** (Dr. Chen)
-**Not enough providers, not enough facilities** (Dr. Chen)
-**Jail inmates in and out so quickly there is no proper follow-up** (Donna Dowling)
-**Significant inconsistency in screening and treatment** in a defined high risk population (i.e.: jails and prisons, military, state and federal facilities) (Dr. Styne)
-**Raising awareness of populations at risk** (Mike Jolly)
-**Education about fatty liver** (Jimmy Minton)
-**Consistent surveillance of hepatitis**, especially chronic B and C (Phil Reichert)

Dr. Chen asked if hepatitis is a reportable disease. Phil responded to him by saying, "In the state of Florida, acute hepatitis A and chronic and acute hepatitis B and C are reportable diseases. They should be reported to a local health department. Electronic lab reporting (ELR) is on board for Quest and LabCorp. If result does not go to the lab, the doctor is supposed to report it."

-**Consistent reporting** (Dr. Chen)
-**Best use of limited resources for testing** (Susanne Crowe)
-**CEU and CME opportunities** (Dr. Chen)
-**Social media use** (Phil Reichert)
-**Gaps in analysis** (Phil Reichert)
-**Evaluation** (Phil Reichert)

BARRIERS
-**Time for getting full history on patient** (Dr. Styne)
-**Lack of funding** (Dr. Styne)
-**No access to care** (Dr. Styne)
-**Many Infected populations are not likely to have access to an intervention** (Dr. Styne)

Phil- That barrier also extends to people you do see but who are not likely to adhere to the treatment regiment. To use HIV as an example, the shotgun approach, vaccinating anyone and everyone no matter what. Did that do any good? It is hard to say. It has always been hard to tell that anything you do to prevent someone from being infected is working. We know people that are most likely to be infected with AIDS are men who have sex with men (MSM) or injecting drug users (IDU).

-**Stigma** (Phil Reichert)
-**Politics** (Mike Jolly)
-**Lack of education** (i.e.: people at risk, HCWs, partners, etc) (Donna Dowling)
-**Education level of education materials**
-**Cultural competency/different cultures** (Phil Reichert)

Phil- Florida is one of the most diverse states in the country. Years ago an HIV/AIDS video was created. It was about fifty minutes long and if you watched it, you were supposed to know everything there is to know about HIV/AIDS. They made one in English, Spanish and in Haitian Creole. In the state of Florida, it is not just Spanish speaking. There is Cuban Spanish, Columbian Spanish, Caribbean Spanish, Mexican Spanish, Puerto Rican Spanish, etc. You have to try to be middle-of-the-road as much as you can. The workbooks to go along with the videos were written in a way that was culturally correct for all of the audiences. Until about thirty years ago there was no written language in Haiti, only spoken. The barrier would be cultural competency.

-**Differences in rules between prisons and local** jails (For example: Inmates can have comic books in jails but not in prisons) (Donna Dowling)

Mike Jolly asked Donna if that decision depended on the sheriff of that county. Donna responded and said, "Yes it does."

-**Religion** (Mike Jolly)
-**Lack of OR too many policies and procedures** (Donna Dowling)
-**Multi-tasking** (a single person at a facility may be responsible for STD, TB, HIV, hepatitis, etc.) (Jimmy Minton)
-**Lack of time** (Jimmy Minton)
-**Quality assurance** (Jimmy Minton)

Phil- HIV/AIDS has a medical director, Dr. Jeffery Beal. Phil has had several conversations with him about this barrier. Dr. Beal would like to double-dose everyone for hepatitis B who are infected with HIV, but the HPP cannot afford to do that.

Barbara- Does HIV (ADAP) have the money to do that?

Phil- They used to years ago but they took that off the formulary when the waiting list developed with ADAP. It will eventurally come back, but it is not back as of yet.

-**ADAP formulary** (Pat Simmons)
-**Vaccine availability** (Enid Santiago-Cruz)
-**Distribution of vaccine** (Enid Santiago-Cruz)
-**Availability of Testing** (Enid Santiago-Cruz)
-**Lack of interest from general public and decision makers** (Dr. Chen)
-**Not enough HCWs** (the more we test, the more services are needed) (Dr. Chen)

-**Reaching homeless populations** (Phil Reichert)
-**Patients unaware of their specific medical history** (Phil Reichert)
-**Proper interpretation of viral hepatitis serologies** (Dr. Styne)
-**Promotion/advertising of educational opportunities** (Jessi Embleton)
-**No uniformity of services among CHDs** (Dr. Styne)

Phil- Moving on to Pat Simmons and the Prevention Section Update. Going to take a break from this and come back later.

HIV/AIDS Prevention Section Update- Pat Simmons

Pat Simmons is on the VHC representing HIV Prevention. She has worked at the state office for eight years. When she started, she realized many people that worked within the program knew a little about HIV and a little about AIDS but did not know the difference between the two. Hepatitis was known even less. Her "job" is to go into the field and do rapid test trainings. When she does, she always mentions hepatitis.

The fiscal year 2012-2013 brought changes to Rule 64D and the technical assistance guidelines for HIV testing. The most important change was testing sites that provide medical services are only required to provide clients with the opportunity for pre-test counseling.

During the past three years, Florida has documented about 400,000 HIV tests each year. The number for 2012 is 407,453, which is down about 25,000 from 2011.

The HIV Testing Counselor manual has been completely renovated and should be ready to go out to the early intervention consultants by the end of May. Once cleared by CHD staff, the online training will be open to all via the Internet. This will reduce the training time from three and a half days to one day.

Prevention and Patient Care collaborated to provide guidance to test sites regarding immediate linkage to care for clients who screen HIV reactive on a rapid test.

In April of 2012, the Bureau of Laboratories updated the HIV testing algorithm. The changes allow for a faster turnaround, more reliable results and confirmation of acute or very early infections before antibody seroconversion is complete.

New grant applications were completed for Minority AIDS in Miami-Dade, RW Part B and High Impact Prevention (HIP).

The Jail Linkage Program implemented a new peer education program at the Central Florida Reception Center in Orlando, and the TOPWA jail linkage program guidelines have been amended.

HIP was launched in 2012 with an award of six million dollars for thirty-four projects in Florida.

The HIV educational material database was updated and should be more user-friendly. The database can be found at www.preventhivflorida.org

The section's Facebook and Twitter feeds continue to gather friends and followers. Facebook has 830 friends and there are 1,050 people following on twitter. There is only one person in the office that monitors this activity.

The Florida HIV/AIDS Hotline has expanded to offer online chatting with a certified HIV/AIDS counselor through the Big Bend 211 agency's hotline website.

The counseling and testing data system is being upgraded to a web-based application. The new system, called Counseling, Testing Linkage (CTL) will make it possible to send electronic HIV test results to CHDs for their medical records, and to other sites depending on their capacity to accept them. It is hoped that the new system, which may also allow electronic site registrations, will be up and running in the fall of 2013.

NEEDS ASSESSMENT (continued from previous topics regarding gaps, barriers and needs)

Phil- If we had plenty of funding and could afford to do anything, what would we do with the money?

-**Fifteen funded county health departments with a minimum funding for at least one FTE position** (Phil Reichert)
-**Add additional funded county health departments** (Phil Reichert)
-**Buy more vaccine** (Dr. Styne)
-**Educate providers and patients** (Mike Jolly)
-**Screening those at highest risk, and targeting at-risk populations** (Mike Jolly)
-**Treatment** (Mike Jolly)
-**Enhanced Surveillance** (Dr.Chen/Phil Reichert)
-**Media campaign** (Dr. Chen)
-**Incentives** (Dr. Chen)
-**Regional hepatitis coordinators** (Phil Reichert)
-**Improved coordination among programs** (Dr. Chen)
-**Statewide educational conference** (Enid Santiago-Cruz)
-**Develop a statewide website** (Dr. Chen)
-**Better funding for everything** (Phil Reichert)
-**Affordable Care Act** (Dr. Chen)

Minutes, continued

Florida Viral Hepatitis Council (FVHC) Meeting

Friday, May 31, 2013

Karen Muller Update- April Crowley

April called and left Karen a voicemail. She will follow-up with Karen to see if she is still interested in being a member of the VHC. A vote will be made via email if she is interested.

News items, CDC consult, rapid testing, testing guidelines- Phil Reichert

Phil sends out daily Google Alerts. One recent alert was about the warehousing of HIV co-infected patients waiting because they do not want to be treated with Interferon.

The US House voted to appeal the ACA, thirty-seven times. Phil does not know how this is going to play out. It looks like a lot of people are counting on it to find medical homes or doctors for services for people with viral hepatitis. You can go to the US Dept. of Health and Human Services website to look at the Viral Hepatitis Action Plan (Google HHS Hepatitis Action Plan). The plan goes over the basics of what it is trying to accomplish. When they wrote it, they asked for input from the CDC's Division of Viral Hepatitis Prevention, whom in turn asked all the states that have a viral hepatitis program. They used some of the information they collected to complete the plan. This plan is the reason the hepatitis surveillance grant was awarded last year in Florida (and in several other states).

CDC guidance for hepatitis C virus (HCV) testing and MMWR is worth looking at. It is about screening to determine current HCV in people.

"Return on Investment" is a big phrase in public health right now. Does Prevention pay? Phil has been in prevention for most of his career (STD, HIV, hepatitis), and around 1988 CDC sent out so much money for HIV prevention but there was no knowledge base on how to spend it. CDC basically said, "think of good ways to spend it, and spend it that way." This is how the shotgun effect developed, "let's just reach everyone with a general message about prevention." The people that have been the hardest to convince that funding prevention programs does, in fact, pay is Congress, which in turn has made it hard to get funding. If we give out one million condoms in Florida, we know we are preventing a certain amount of cases. Yes, we can give a condom to someone, teach them how to use, store and dispose of it properly, but you can't be there with them when they actually use it to make sure everything is done properly.

Phil was involved in a CDC consultation at the beginning of February of this year. The idea was to get a group of experts together to discuss updating guidance for HCV testing. This consultation included several viral hepatitis prevention coordinators from several states.

As mentioned yesterday, funding at CDC for the Division of Viral Hepatitis went from 19.5 million to 29.5 million, which is how the surveillance grant got funded.

People who were vaccinated for hepatitis B about twenty years ago are recorded in FloridaSHOTS. They are getting tested now and are not showing any surface antibodies. Jimmy Minton said there are no studies at this time looking at providing booster doses of hepatitis B vaccine to people who were previously vaccinated. Andi Thomas was finding people that should have been immune, but were not. Even though she could not prove they were vaccinated, they should have been.

The Viral Hepatitis Testing Act of 2012 was a bill introduced into the state legislature during the 2012 session. It was written to increase hepatitis C testing in high risk individuals, and was based on the 1945-1965 baby-boomer cohort guidance released by CDC. Congress has introduced what started out as a hepatitis B act a few years ago, and has transformed into a hepatitis B and C testing act. They continue to introduce it each year, but it never goes beyond committee discussions. If it was introduced and funded the way the sponsors want it funded, the Division of Viral Hepatitis would be considerably better funded at CDC. The 2012 state bill only advanced through several subcommittees and committees in the house and senate.

Barriers, Gaps & Needs Assessments (continued from previous day)

Barbara Rush said education is probably something we can start working on now. Education really needs to get to the providers. There would not be a funding issues, but it would be a step in the right direction.

Needs Assessment (no money—no additional cost to the program)

-**Education for HCWs and providers** (Barbara Rush)
-**Webinars** (Donna Dowling)
-**Give CME and CEU through hepatitis, for free**. Health Departments and Corrections would be perfect venues to educate providers. (Mike Jolly)

Phil said the Hepatitis Foundation International spoke at the last educational conference back in 2007 and they were able to work with the University of South Florida to do CMEs and CEUs to provide the health education.

Mike said that was done through *Simply Speaking Hepatitis* which is a program from Rush University in Chicago. There are 200 speakers in the country. All they require is someone to ask for the program. They will come in and set up a dinner program, provide one CME or CEU. This can be anyplace as long as they get someone to request it and to act as the host. The only cost they require is expenses/stipend.

-**Resource playbook** (Dr. Styne)
-**Website for educational opportunities** (Dr. Chen)
-**Resources for providers** (Dr. Styne)
-**Celebrity face of hepatitis** (Pat Simmons)
-**Consistency of services among CHDs** (Mike Jolly)
-**Surveillance data local and statewide** (Dr. Chen)

Goals (within Department of Health)

1. **Surveillance and reporting** (Mike Jolly)
2. **Prevention/Intervention** (keep the goal we already have)
3. Find what the mission is and the make that the mission
   -**Increase treatment opportunities** (Dr. Styne)
4. **Analysis and evaluation**
5. **Raise awareness** (may be an objective for number two).
6. **Distribute materials** (education)

Add-

-**Identify and target high risk populations for prevention and intervention** (Dr. Chen)
-**Collaboration** (Pat Simmons)
-**Prioritize/focus resources** (Donna Dowling)
-**Strategies based on new technology advances** (Dr. Chen and Donna Dowling)

Phil asked if there was anyone in this group willing to come to Tallahassee to go through goals, come up with objectives to match, and action steps to match the objectives.

Dr. Styne, Barbara Rush and Donna Dowling volunteered.

Update and discussion on future position papers- Council Members

Phil said come up with any ideas of position papers that can be written. In the past "pie in the sky" has been done, i.e. syringe exchange.

A needle exchange bill was presented in the Florida legislature this year. It went further then expected, however, it was not passed. Data is there to show a benefit of providing clean needles for IDUs.

Please email April if you come up with any thoughts about any topic you want to write a position paper about.

Unfinished Business (Comprehensive Plan)- Council Members

No further unfinished business

Community Conerns/Discussions- Guests

Phil reminded everyone to nominate anyone that may be a good candidate for serving as a viral hepatitis council member. April will contact Charles Dennis to see if he would be interested in rejoining the VHC.

Dr. Styne said the council needs the voice of a patient, that is one of the biggest failings of the group.

Phil stated that he spoke with Gordon Licatia about becoming a member but he is unaware if Gordon is a hepatitis patient. Plus, Andi thomas is still a member.

Next meetings- Council Members

Phil said typically the group meetings have only been held in Tampa or Orlando. The best meeting had fourteen of the sixteen members in attendance. Does the group want to move to Orlando next time? When is a good month in the beginning of 2014, February? March? Should we wait until the Affordable Care Act kicks in so we can discuss that? We will send a couple of different dates to everyone to see what is best for most of the people.

Location? Tampa? Orlando?

Raise your hand if you vote for Orlando (no hands)
Raise your hand if you vote for Tampa (three hands)
Raise your hand if you do not care one way or the other (eight hands)

The meeting was adjourned at 11:30 AM.