

**Minutes – Florida Viral Hepatitis Council Meeting
July 27-28, 2006
Embassy Suites
Tampa, FL**

Members in attendance:

Debbie Barnes
Gina Bispham
Jennifer Bourgeois
William Chen
Susanne Crowe
Bob Griffin
Frank Johansen
Bob Keane
Barbara Rush
Phillip Styne
Andi Thomas

Guests in attendance:

Jodi Baldy – DOH
Nosipho Beaufort – DOH
April Crowley – DOH
Meghan Daily – DOH
David Sammons – Glaxo Smith-Kline
Jennifer McLeod
Karen Muller – Roche
Phil Reichert - DOH
Michelle Scavnicky – The AIDS Institute
Cheryl Urbas – DOH
Sterling Whisenhunt – Glaxo Smith-Kline

Council Business (Susanne)

- Council reviewed minutes from February 2006 meeting – minutes approved with change on page 3.

Meeting Overview and Strategic Plan Update (Phil)

- Update on hepatitis program – working on increased funding (LBR), met with Dr. Nelson,
 - o 1.9 million is tobacco money. All tobacco money will cease in 11 years and some could be cut to funnel money to the tobacco program.
 - o Part of the LBR is for pre-treatment, the rest is for vaccine, testing and prevention programs.
 - o Attended National Immunization Conference
 - o Is the money statewide?
 - Yes
 - o Can the council submit a request?

- People can submit them independently or the council can submit a letter/position statement supporting the additional funding.
 - Need to talk about what we want to have position papers about, do an outline and then write them based on today's recommendations.
 - Are there legislators who are favorably inclined to approach for a sign on or "dear colleague" letter?
 - Yes. Will give names later. The turnover of governor and legislators will change things.
 - Dr. in Charlotte CHD has been vocal – will open clinic Sept 1.
 - Has a cost analysis been done for what is being proposed? If we were going to expand testing into community, the next step is an expanded diagnostic evaluation. Should assess the cost so we know the dollar value for what we are asking for.
 - Has been done – couple of years ago. Costs assigned may not be accurate anymore.
 - Many, many LBRs – government and nongovernmental. For DOH, has to clear many hurdles and approvals. LBRs are prioritized based on perceived need. Persistence is valued.
 - Looking at integration of hepatitis services – Phil, April, and Cheryl have attended trainings.
 - National Viral hepatitis roundtable plan is out (available on www.nvhr.org). Last set of edits will be done at Sept 11 meeting. Includes goals for surveillance, treatment, and vaccination.
 - CDC has a hepatitis elimination plan
 - Surveillance:
 - In DOH – Bureau of Epi
 - Looking at unreported cases – reporting is good for acute cases, but not chronic.
 - Didn't ask for chronic reporting until 1999 and many didn't start until 2000.
 - Surveillance is traditionally least funded
 - Chronic HBV is difficult to report in Merlin – very extended entry.
 - Epi is in the process of changing the rules
 - Phil will be attending USCA in September (in FL)
 - Looking to see what is being done that can be adapted to FL.
 - The strategic plan needs to be updated.
 - ADAP funding to treat up to 100 patients who are coinfecting with HIV and HCV.
 - Need to look at some of the deadlines
 - Need to reevaluate some of the goals.
 - FVHC is part of FCPN (which includes PPG and PCPG).
 - How do you want to update the plan?
 - Barb Rush – not happy with how the plan was written – doesn't feel that it is user friendly. Likes the idea of workgroups, but need to sit down and decide how we want the plan to work. Not useful for giving a profile of hepatitis in the state of Florida.

- Andi agrees – needs to have good baseline data and specific measurable goals. Goals are mapped out badly in the current version.
- Bob Keane – agrees. Need to change publication format and look at content.
- Repetitive in places.
- Is there a shift in CDC regarding how things are looked at? For example, the emphasis on integration. Strategic plan should be written to speak to those changes – look at the life cycle rather than disease specific.
- Was rushed to press to get to the legislature. Need to fill in gaps.
- Look at updating through 2009 (Jan 07 – Dec of 09) – PPG and PCPG are trying to get on the same schedule.
- Let's identify things that need to stay or go:
 - Need an overview of the status of hepatitis in FL
 - Need to look at redundant objectives.
 - Plan will be for Jan 07-Dec 09
 - Will talk about the mission.
 - Need to pare down goals for what is achievable
 - Some are measurable and some can never be measurable
 - Needs an action plan and who is responsible for accomplishing goals
 - Think about the audience:
 - PPG – CDC funders
 - PCPG – HRSA Ryan White funders
 - Also plans are intended to be integrated into local plans
 - Individual programs will have to adjust their guidelines accordingly
 - Need to build in benchmarks and a body (review committee) to assess progress
 - The role of the FVHC.
 - Require yearly reports from the programs regarding what they have done towards the goal and objectives of the program.
 - No baseline quality of care from one county to another. Need to work on equalizing the counties
 - Counties (Polk and Alachua – Leon on ballot) have passed half cent sales tax for indigent health care.
 - Problems in Alachua because underused.
 - Need clear definitions of the terms
 - Need to update program overview. Does it need to be in the plan?
 - Need to change some sections to insert for future updating
 - Should be in a binder or solely online. Update frequently and note date of updates.
 - Should we refer to website or delete altogether?
 - Delete

- Reading level is too high – use plan as an education component
 - Should be appropriate for funder.
 - Usually keep documents at a 5th grade level.
- Plan shouldn't be an educational document.
 - If giving to legislator, will need some information
- Simplify
- Shorten executive summary to one page or list.
- Do we need to have the DOH profile (after the exec summary and in the appendix)? Focusing on the DOH program limits the work and goals of the VHD and a community/govt collaboration.
 - No.
- *April will be the lead on the strategic plan update* – Susanne will help
 - Conference calls will be held to discuss suggestions and recommend.
 - *Other members: Bob Keane, Meghan Daily, Andi Thomas, Barb Rush (alt)*
 - Need to have as many people approve the changes so the plan isn't being written by a small exclusive group. Can the council work through what should be changed?
 - Form small group, send to council via email and have a comment period
 - This shouldn't take 6 months to get done.
 - **ACTION:** Suggest that people take time to review the document tonight and have a comment session tomorrow (30 minutes)
 - What are we looking for?
 - What belongs, what doesn't and general ideas for changes (length, reading level, etc). Not word by word.
 - Get a general consensus on the goals.
 - Don't worry about the appendices.
 - Need a copy of the NVHR plan.

Committee report: Integrated risk assessment form (STD/HIV/HEP/TB) with handout (Andi and Bob)

- Workgroup took 4 forms (Hep-C Alert, Pinellas RA, DOH Hep RA, and HIV 1629 form) to compare and combine.
- Realized that counselors are unlikely to adopt this form in real life because there are too many preexisting forms.
- Committee decided to use more as a counseling intake form for the client to fill out prior to the visit. Information includes all of the elements that are present on the state hep and HIV forms.
- Forms and breakdown are included in the hand out.
- Implemented the intake form at Hep-C alert. Clients (new and existing) accepted the form just fine. Very few issues with literacy, although there were some language issues. If the client couldn't fill the form out, the counselor filled it with the client.

- Puts the focus on the client for disclosure instead of having the counselor have to spend the session coaxing answers from the client.
- Challenges – shifting from forms based counseling (asking questions to elicit answers to questions) – counselors had nothing to talk about. Had to do a training to teach the counselor how to use the form and do risk reduction counseling. Took a month for the change to click with everyone. Used intake form and session notes to transfer information to state required forms.
- Did a survey to assess the reception of the forms.
 - 83% felt that completing the form helped them have a better counseling session.
 - Once counselors understood how to use the form, they liked it.
 - 5-10% of forms were not filled out properly – counselor would fall back on prior form of counseling
 - Next step: to see how the form would work in other settings and to send out to the funded counties to see how they feel about it and if they want to use it. Every county is different and there may be some problems with the integration of the forms. Need buy in from the counties.
 - Implementation will work best where services are already integrated.
 - Is the data meaningful for the state or just on the local CBO/CHD level? Can it be compared to existing data?
 - Help if you can demonstrate that the integrated form identifies additional risk factors.
 - When DOH HEP receives risk Assess, it is inputted into a database. The lab results are sent from the lab and linked together with risk assessments.
 - Changed perception of wait times because the clients are engaged in care from the moment they receive the form.
 - Suggestion: ask if they have ever had yellow jaundice/ yellow eyes. A little picky but a good alternative way to ask if the person may have had hepatitis.
 - Levels the issues with good and bad pre test counselors
 - Seeking to bypass the pre test counseling with client entered risk assessment.
 - Suggestion: ask if they are a health care worker or worked with needle sticks.
 - Andi will send an email out with the form copy and will request suggestions and comments.
 - CFDFL – be careful with removing human component. If the same person does the pre and post – higher return rate. If you send them to the computer first, it is harder to engage them. If they go to the computer after seeing a person, then the engagement rate is the same.
 - Suggestion: instead of asking if pregnant, ask for the date of their last menstrual cycle.
 - Clinic flow – fill out intake form, watch slideset(s), see counselor, return to reception area and are asked to complete a survey. Had 93% completion

- rate on survey during first 30 days. After initial press, still had an 83% completion rate.
- Barbara will pilot.
 - (Bob) Hard sell to public health because have individually run nursing programs who are resistant. Good for counseling intake and not sure if it can be sold to nurses or STD. A little long for a quick scan for a decision. Can sit down to talk with people.
 - Intended for places that do more than single faceted testing.
 - (Phil) Hepatitis coordinators want to see it and have the same problems of Bob and that have come up before. 1628 is not going to go away in the near future. It is a requirement. CDC is going to relax its recommendations on counseling and testing in an effort to make HIV testing a routine part of care and testing. Many private and public doctors never wanted to do pre/post test counseling because it takes up valuable time. It has gone away in private sector but remains in public sector to gather data. In the future, it will be more like an intake form. There are many rules in the F.A.C. that would have to be changed if the 1628 form was eliminated.
 - Easier to implement in the smaller CHDs than the larger CHDs because they have one nurse doing most of the testing in general. Division director wants an integrated form for everything. But there are CDC requirements on how things are reported.
 - STD and HIV are integrated due to overlap of risk factors.
 - Form can be useful in some places.
 - Funded counties need to look at the form and see what their use would be for it.
 - Hep-C Alert will continue to use and adapt as suggestions come in. Section 4 is vague. Would like to have an adaptable local use section. Have started collecting data.
 - Phil has discussed adapting the 1628 to add separate sections on the back that apply to Hep, STD, and TB. Will keep on one form and hopefully scannable on both sides.
 - Dr. Eggert wants to standardize across the bureaus in the division. If we can come up with a workable solution, will provide support.
 - A recommendation from the Bureau or Phil to some counties to pilot test.
 - Bob Griffin will take it back and suggest it.
 - **ACTION:** Andi will email the form to April with notes about how it was implemented. April will send out for two week comment period.
 - Can it be implemented in a small county and compare the old way to the new way?
 - Need data to show that it is an improvement so that people will be receptive to the change. In large counties, there is an issue about entering the data.
 - Would be a good project for an EIS officer to research and publish.
 - Does the general nature of the questions make it harder to compare them?
 - Yes, but can add comments.

Committee Report: Statewide resource guide for consumers (April)

- Updated and has been emailed to the VHC
- Question about whether or not to put it on the web and the web format.
 - o **ACTION:** will get with April about the format.
 - o Format the PDF for bookmarks to jump to county

Discussion: Referring hepatitis positive inmates to local CHD when released from DOC

- Upon release, the aftercare coordinator acts as a liaison. They fill out a form and are directed to a county health department for an appointment.
 - o Person is DOH? DOC? employee and work as a liaison between the agency and the inmate as a temporary case manager. They help complete a form for HIV viral load, hepatitis C status, as well as other infectious diseases. HCV is just yes/no option – no immunization status or info on HBV or HAV. **ACTION:** talk to Priscilla Wood and find out who directs this person and about getting the form and adjusting it. Dr. Johanson will email April.
 - Can this be expanded in the future to cover chronic HBV and HCV cases. Currently follow those who are HIV+.
 - Do treat some, but not all
 - Is the criteria for treating HCV a duration of symptoms?
 - Must have 18 months left on their sentence for treatment so they aren't released mid treatment.
 - Are supposed to immunize HCV patients, but is not being done. Also repeating lab work, etc.
 - In county jails, the linkage person does the referrals. Also funded through the SAMHSA grant.
 - o What is the protocol?
 - Anyone who says they are HCV+ are enrolled in a treatment program and are also offered vaccination. HIV+ are tested for HAV/HBV/HCV. Do not usually test for liver function. Treating more HCV+ each year.
 - Have a lot of criteria for treatment aside from duration of sentence.
 - o During intake or exit, are there any screening programs?
 - Receive education when they enter the system. Testing is encouraged and offered, but is not mandated. HIV testing is mandated before discharge by state law, but not hep. Hep is offered and is done when someone who is treating sees symptoms, but is not mandated.
 - If diagnosed with HCV and the genotyping indicates they are infected and are a good candidate are they treated?
 - Yes, if they want to be treated.
 - How many people are treated?
 - o Not sure, but there are a lot.

- If they are on treatment and go to the feds, do they continue treatment?
 - If they come in on treatment, treatment is continued.
 - Used to hear a lot of complaints from prisoners.
 - Used to be harder to get treatment than it is now.

Discussion: Working with substance abuse centers on hepatitis issues

- Main problem with substance abuse and hepatitis is that if they do anything (vaccination) and they have HCV, they will get sicker. Did a survey 60% of those with HCV think that they have HAV and HBV and that is how they got HCV.
 - Looking at where these assumptions and information is coming from. The result is that HCV+ think they can't do anything except take their treatment – don't get vaccinated, don't do vitamin regimens, etc. There is not enough medical follow up to explain what they can and cannot do.
 - VHC needs to come up with an education component for HCV+. People who have high educational levels share these beliefs as well – needs to be addressed.
 - Bob Keane does educational sessions in methadone clinics and the county jails to take questions about the disease and dispel the myths.
 - Tracked a lot of the poor education of the clients back to the HIV workers
 - small CBOs, CHDs, and some of the faith based organizations.
 - When asked, they are very resistant.
 - Talking EI about 501 class and working on integration. EI is open to having hepatitis information in 501 curriculum so good information can be given.
 - If Medicaid funded, all SA clients have to get HIV counseling so they can get their methadone – which gives access to continue spreading bad information.
 - Not just in substance abuse centers – bad information everywhere. Drs are not giving good information.
 - Bob K. started in 1999, but still have people who say their doctor told them not to worry about HCV contact. Has started doing an hour of hepatitis in 501 and that is working better.
 - Barb did in Orange and being allowed would depend on the individual conducting the training.
 - Andi – hepatitis is not as simple as HIV/AIDS and you can't teach about it in a meaningful way in an hour, a half day or a day.
 - Counselors won't take that much time for something they are not being funded for. Need to teach something though. Need to make it mandatory that there is a one hour hepatitis component.
 - 501 updates don't have a hepatitis update.
 - Possible position statement: advise the state agencies that do to the nature of the diseases that any training for HIV/AIDS EIC has to include hepatitis education. Can't mandate hours, but can mandate content.
 - HAV, HBV, HCV

- Hepatitis program of NY is doing integration trainings. Working on doing this in Florida. Need to outline the position statement and make a recommendation.
 - Two day training with good information about hepatitis.
 - Hepatitis educational conference would be an opportunity to train CTL, health care workers, doctors and nurses
 - What does DOE teach in public schools about hepatitis?
 - Probably very little. CDC Division of Adolescent School Health to coordinate a school health program about AIDS. Handful of county school boards who get grants for materials. Provides training for biology and life sciences teachers during the summer. Presented in 7th grade and 10th grade in certain places and not every year.
 - There is someone in Pinellas who does programs on hepatitis in the schools.
 - DOE health education board has representation from the agencies, but not every county. 25-30 people on the council.
 - Andi – attended integration program with April and has an obligation to train people in the program. Has to start with those who have done those program. Have to go train captive audience people (nurses, nursing homes, doctors, nurses, counselors, etc) because they are on the front lines. Can we do something with EI that is another training and give them something that indicates they have achieved something (501 level 2).
 - HIV prevention has a CD ROM to replace HIV/AIDS 104 manual. Gives enough information to teach somebody else about HIV/AIDS. CD-ROM has PowerPoint, live action video, teacher manual and place to print out certificate of attendance. Have never been able to certify people in a good way because you can't police it. Can do a 4 hour class or a CD-ROM to do it. Don't have enough people to teach classes all the time. Doing CD-ROM sends a consistent message regardless of who does the class.
 - Can do a certificate and a pre/post test. Just can't formally certify.
 - Don't need to certify, just acknowledge the extra effort. But need to do something to increase the knowledge.
 - With the people working in the field, you need someone who is actually there to answer questions and explain terms. A CD is not sufficient.
 - But there are not enough resources or people to teach classes.
 - But what about an educational initiative – pharmaceutical companies would support.
 - Different levels of training – harm reduction, substance abuse. The 104 CD-ROM is there because 1988 Omnibus AIDS Act. If you are a licensed person (doctor, nurse, cosmetologist, barber, etc.), you have to have AIDS training. The CD-Rom makes it easier to administer all of the training. Separate level of training for Dr, nurses, and health care workers to teach them to be comfortable asking the questions for the risk

- assessment. AETC (U so Carolina has CDC contract) – could have a contracted agency to do the trainings and have experts in to conduct the trainings.
 - For a position statement – what do we want to suggest? Broad spectrum training?
 - Should consider mandatory training on how to ask a couple of additional questions as part of the repertoire.
- Remember that there is a lack of education among the people who are doing HIV/AIDS education. two day training is fine. Would like to see some of the money that the CHD used for education shifted into education for HCV+. Some of the people who are teaching HIV education wouldn't take much away from a longer training. Should target the good people and the educated HIV/STD workers.
 - Good idea and also educate them in Training of Trainers (TOT) so that they can spread the knowledge locally. AETC does annual trainings and gives CMEs to doctors and nurses – looking into doing a breakout session on hepatitis. Similar audience to a separate conference.
- Dr. Styne: If we are trying to deal with basic misconceptions, then keep the hepatitis section to very simple basic stuff and give them a simple cheat sheet (like the one DOH already puts out), and a blurb about the markers. Have internists who get confused. It is possible to teach someone who knows the basics about HIV the basics about HEP with backup documentation. An hour or two should be sufficient.
- Position statement should say that 501 update should include basic hepatitis knowledge. Hep info should be done in the 500 instead of the 501. The trainers for their update should be required to do Hepatitis training. They don't need to be specialist, but need to provide good information.
 - 1 hour class – Basic
 - 2-4 hours – STD DIS, CTL people, DOH counselors
 - 4-8 – training of trainers
- Hep 101 is a good course. It is sufficient for people to absorb on their first exposure. Lose STD people when we get into the serology parts.
 - Hep 101 is available to anyone – nurses can get CEUs.
 - Want to refer more people to Hep 101.
 - Can have more people on the call through getting groups together.
- Contracted programs were done to get more community members trained to provide information and would be receptive because they are from the community. Sometimes they do not understand the information that is given. But we can teach them the information and give them good resources to pass on the information. But educated are not necessarily the best to give the information.

- Lack of resources for hepatitis lead to lack of correction along the line. With increased knowledge, there will be more correct information circulating in the community.
 - Can use the format from a few years ago and put the information for this statement into the format. Then email the document to everyone for review.
 - The position statement:
 - Three levels of training
 - Look over the position statement that was included in the packet.
 - Will use similar format, but make the title more prominent.
 - The shorter, the more likely to be read
 - Treated like a recommendation coming from one the advisory groups. The recommendations go to different venues (HAPC mtg, CHD directors and administrators, national meetings, etc). Placed on the website.
 - If you ask for a response, it ultimately comes back to the hepatitis program to write the response on behalf of Tom, Dr. E, Dr. F, etc.
 - Usually are signed by the co-chairs of the group. Can be done in the form of a letter. Keep to two pages or less. Will say “From the Viral Hepatitis Council” with names of the VHC member
 - Council of state and territorial epidemiologist developed position statements on hepatitis in conjunction with the hepatitis legislation in Congress.
 - Audience is legislators, public and private health leaders.
 - Need to direct 501 position statement to Marlene and Tom.
 - How does training cycle work?
 - Different training cycles.
 - 500 – 4 hours 501 – 2-3 days. Annual update is 4 hours.
 - TOT is a week

Position statements:

- *HIV 501 and hepatitis education*
- *Supporting the LBR*
 - Would go to Tom Liberti, Dr. Eggert., Dr. Sorenson and Dr. Francois
 - Statement of need
 - Support \$4 million request
 - Need sustainability of vaccine program
 - Hepatitis program staff will draft a 1 page document and email to VHC. If no response = consent. Then will make changes and send out for final review. After that will take to HAPC and SHC meetings for premiere.
- Hep program will have a display at FADAA and USCA conferences
 - Phil trying to attend an STD managers meeting.
- Potential for position statements from the workgroups.
- *Making vaccinations available through Medicaid*
 - Florida is one of 5 states in the country that do not provide vaccination through Medicaid.

- David will forward a list of the states that do cover vaccine through Medicaid
 - Why not?
 - Because no money has been set aside for Medicaid reimbursement and physician level have not been asking for it.
 - What is available from Medicaid?
 - Changes from day to day. There is a legislator in Tallahassee would present a position statement. Do not want it from a pharmaceutical company, but will from a community planning group or group of physicians.
- Specify for adults
- Public health/patient benefit. Medical benefit.
- Costs
- Benefits
- Important for a uniform way for people in every county to have vaccine available through the CHD. Or develop the resources to tell people what they should do county by county. Currently have a patchwork system.
 - Problems develop when new staff come in over the 09 program and they don't know anything about the 09 program.
 - Need to get information about the 09 program out to CHDs.
 - CHD Directors meet twice per year
 - Can someone get on the agenda to remind them?
 - Yes, but it's not a priority right now.
- Dr. Styne – would like to see a statement supporting an educational program supporting a uniform system for vaccination for the uninsured and the underinsured through the 09 program.
 - Does it need to be a position paper? Could be a dear colleague letter to the CHDs as a reminder or mentioned at the CHD D/A meeting. For that, it may have to come from Dr. E or Dr. Sorenson.
 - Premise: inconsistency is not the best for patient care. Therefore, need to educate the CHDs on standardization of vaccine distribution.
 - STD programs do TAG (technical assistance guidelines)
 - Not easy to get into the book. Would have to convene a small group, do the wording, goes through a review process (9-12 months).
 - Are larger counties urged to participate in the 09 program? (Hillsborough)
 - They do receive an allotment and have done two MOAs. They are not a funded county.
- Funding: For high risk infected adult with insurance – can get vaccine. If you ask for 09 – can get it. Medicaid – can't get it
 - Ideally, you should be able to referred to any CHD. Some CHDs are better than others.

- Most states don't have the 09 program – but do provide vaccine through Medicaid.
 - Some CHDs send Medicaid patients to their doctors for vaccine.
 - Andi - Some private providers will cover vaccine, but some won't.
 - Dr. Styne – can't get partners to vaccinate in the office due to medical/legal issues. Give almost no injections. Refers to a travel clinic. There are a few primary care physicians who will who cater to travelers.
 - Is this an issue of specialists shifting responsibility to GP?
 - Don't think that GPs know about the vaccine recommendations
 - Providers (specialist/GP) couldn't determine who was covering what. Losing money stocking vaccine.
 - Barb ran into an issue at CDFL with Med Dir refusing to vaccinate HAV for staff.
 - Legal developed a waiver specific to the issues.
 - Against the law to waive a constitutional right "the right to sue".
 - Vaccines and the complications are a hot legal issue. Highly unlikely, but have created a lot of fear.
 - Higher risk for flu vaccine than hepatitis vaccine.
- *Position paper on vaccine for first responders:*
 - People getting vaccination on the scene – thinking that made them immune.
 - Recommendations for vaccination for first responders.
- *Position paper on counseling and testing procedure on what should be done and what is being done. Set the standard as a CTL issue. Justification for the funds.*
 - When based on signal to cutoff ratio, 15-25% self resolve.
 - Need to add PCR back to algorithm
 - No, a matter of education on behalf of the doctor. Need to tell the patients that they have been exposed, not that they are infected. And refer for confirmatory testing.
 - Division between screening and medical care.
 - See contradictory test results (qualitative and quantitative) regularly (Dr. Styne)
 - Need to include PCR and a RIBA
 - Statement should say that the standard is antibody and PCR testing and anything less has to be justified.
 - **ACTION:** Andi will draft a few paragraphs with Bob and Dr. Styne as references.
 - Unsure that this is a nationwide position – medical community is not sure about doing it, or if everyone needs to do it.

- Andi lost the battle at NVHR. Folks are not lab literate and felt that it was too complex. Tabled the issue.

July 28:

Position statements:

- Vaccinations through Medicaid. – Dr. Frank Johanson will take the lead on writing a few paragraphs.

New business from yesterday:

- Vacancies on the council:
 - In the bylaws re: missed meetings and resignation (Article III, Section I, Part 3).
 - Martha DeCastro – has not been in contact with the FVHC. Does not respond to emails or phone calls. Do we want to give her a reprieve?
 - Will email and can do a certified letter. Don't know the circumstances. Voice mail messages and emails have been sent.
 - Now need a community co-chair.
 - Nominations needed for Dr. Nelson's position and Community Co-Chair
 - Dr. Nelson's position (ask April for the list)
 - Dr. Trupkett
 - Allison
 - Community Co-Chair

Hepatitis A and B vaccine in Nontraditional Settings (Barb – ppt)

- Provided Twin-Rix in the out patient methadone program.
 - High risk community (IDUs) captured in methadone program
 - Clients testing HCV+ during screening
- Targeted all clients enrolled in the program
 - Challenges – what if they leave the program before completing the vaccine series?
 - Posted flyers in the lobby and planted “gatekeepers” in the lobby to talk up the vaccine.
 - Provide vaccine at dosing times.
- Biggest obstacles:
 - HCV clients think they can't get the vaccine
 - HCV think they get sicker
 - Think they can't take meds
- Response:
 - Education – starting with receptionist
 - Flag vaccine doses in dosing machine
- Early morning vaccine dosing has been very popular
- Vaccinate even when people are out of the program (various reasons)
- Where do you get the vaccine?
 - SAMHSA funds

- What testing do you do on that population?
 - If high risk, don't test. Just immunize. If they want to be tested, still vaccinate first. Have leftover vaccine that may be used in residential program. Don't want to lose people waiting on test results. Executive mgmt doesn't want to give vaccine to people who have been dropped from the program.
 - Problem: family members want to be vaccinated too.
 - Research shows high rates of hepatitis in substance abuse centers.
 - They are being risk assessed before vaccination. Used to send to HIV for test and referral. Clients were never following up on the referral for vaccine. Vaccine in house
 - Bob Keane – test first, then start on vaccine. If vaccine isn't needed, then DC it. Found that 5am didn't work at all. Wanted to get in get dosed and got o work. Start at 8 through 11.
 - How many have pre-existing immunity?
 - 45 – 50% are susceptible in Miami. Miami has more A immune due to immigration from endemic areas.
 - Bob Griffin – run about 35% immune in testing – but in a specific area.
- Most HCV + are in the 34-45 age bracket. Seeing 40% positivity rate.
- Does vaccination give a false security?
 - Education component.
 - Resistance to needles from drug users and fire fighters.
 - Would do first dose on nontraditional settings and refer back to CHD to do testing.
- What were the findings of the vaccine committee:
 - Did not meet.
 - What is the status of developing MOAs to do nontraditional vaccination?
 - What are the staffing needs for such a program?
 - If you want to use an LPN, they have to be under the supervision of an MD. Vagueness about what constitutes “supervision.” An RN does not have to be under the supervision.
 - Also in the law that injecting someone else is 2nd degree assault if they are not appropriately licensed.
 - Medical director can train people to do certain things outside of the scope – but doesn't state proximity.
 - CFDFL MD won't let people do anything without observing them doing the injection first.
 - Requiring an MD severely limits what can be done with vaccine
 - Not unless you have one who is willing to take responsibility and work at it.
 - Liability issue – is CHD liable for CBO problem with vaccine.

- Pinellas CHD legal will not allow transfer of vaccine to CBO for nontraditional use.
- Hep program have been told LPN to RN, but must be under the supervision of an MD.
- Can get an opinion from the state Board of Nursing. But a nurse has to ask.
- Will ask Legal in Tallahassee. (Phil)
- Medical assistants are trained to go injections, etc. but are not licensed in FL – only receive a certificate.
- Who is doing an accelerated schedule (0,1,4 months)?
 - Seems most appropriate for nontraditional settings.
 - Don't know of anyone who is doing it.
 - SAMHSA says no as part of the pilot program. Non-incentive program. There should be access to vaccine for spouses and significant others – spoke to Dr. Huffman.
 - Want to try in an outpatient setting.
- What is the difference in cost between B and A/B vaccine? About \$11
- Is there money from 09 that can go to CBOs?
 - Piloting 4 projects right now. MOA with each on how they will track. The biggest problem is vaccine accountability. Make sure it is stored properly and inventories.
 - CFDFL signed a MOA with the CHD. Having a problem with staffing right now.
 - No one has a problem with a CHD nurse going to a nontraditional setting.
 - What is the barrier?
 - Integrity of the vaccine
 - Transfer of the vaccine from the CHD
 - Storage standard
 - Problem with jail linkage – couldn't be out of DOH custody. Had to have a DOH presence in the jails.
 - Can the vaccine come from central pharmacy?
 - Very difficult to add another site unless already listed as a vaccine for children site.
 - CFDFL did MOA and ad staff as DOH volunteers. Kept logs.
- Having vaccine go through CHD adds a layer of complication.
 - If the pharmacy was willing to establish a site, would be different but they are not.
 - Is there a painless process? How can it be adapted to include CBO participation in testing and vaccination?
- Possible position statement/guidance/policy
 - Set out requirements for nontraditional sites.
- **ACTION: Phil will talk to legal in TLH**
- **Barb is already head of that committee.**
 - **CONFERENCE Call: Thursdays after 2 – middle September**

- **4:00 – send out two dates that are good for Phil/Cheryl (Sept 14).**
- TLH HIV distributes rapid testing materials – not CHDs
 - Pilot program with pharms with TLH in CHD role. Do RFP and send vaccine from pharms to CBOs (via TLH).
- Miami-Dade TB/Refugee – buy directly, doesn't go through pharmacy.
- Phil will check with other states for best practices

Involving the community in decisions through town hall/consultations/ etc.

- Have done with Black leaders, Latino leaders, women, youth, etc.
- FVHC is an advisory group.
 - Biggest problem is that we can test and vaccinate, but many people are diagnosed as HCV+ and don't know what to do next. How do we get services to the uninsured and the underinsured? There are a few places that do case management, but not enough for all of the people that are out there.
 - Is it in our best interests to do a consultation and get experts together (liver doctors, gastro, hepatologists) in different parts of the state to put the questions out there.
 - What is the target audience?
 - Can we get council members to act as hosts?
 - Can this be done via teleconference into public forums?
 - Can be done.
 - Meetings and committees are fine (government answers) but needs to be approached by approaching the testing companies
 - Chance Center works with Qwest – but has to have statements from doctors for support. Can treat a patient for \$3000 – but they act as case management. Schering-Plough and Roche are generous with medication.
 - Meetings could be good to rally physicians to do pro bono treatment of HCV and HBV patients – but still limited by labs. Need to get them together with Qwest and LabCorp executives. If the physicians see that labs can get done, they will do it. Labs need to see the commitment from physicians. Include the hospitals for the liver biopsies.
 - Bringing physicians to the table is a wonderful idea, but there aren't enough doctors to serve the need. Community health centers are a constant and they need to be at the table. CHDs have not budgeted for HCV care.
 - Easier for doctors to travel to see indigent patients than bring them to the office. Easier to handle social problems of that group in that setting than in

- the private office setting. Don't want *those people* around your clients.
- Hold meetings on a district rather than county basis to access rural areas.
 - Roche has assisted by funding physician positions.
 - Not everyone who has HCV needs to be treated. Once you weed out to the people who are need eligible – only a small number. Hinges on having an appropriate medical evaluation.
 - Dr. Styne – most people do get treated in his population. People are weeded out for a variety of reasons that can be controlled.
 - Is it possible to get to the point where noninvasive tests can be done to weed out who needs to be treated? Not now.
 - Shorter treatment schedules
 - Everything being tested is interferon based
 - Perhaps within 2-3 years, but not much help for today. It is an additional drug for the current cocktail.
 - Shorter duration looks at rapid viral response and if you can shorten the treatment for 2 & 3s, then 1s. 2&3 yes. 1 no.
 - HCV vaccine would only be preventative and would have no bearing on people who are currently infected.
 - Needs assessments are essential to understand the population that needs treatment and what resources are present and needed.
 - Roche and Schering track the number of prescriptions that are written.
 - But limited by the number of people that haven't been tested or aren't seeking treatment.
 - State lab enters into Merlin. CHDs are entering acute, not chronic.
 - Merlin is POS
 - Dr. Nelson is going everywhere to lobby for money to treat people with HCV.
 - Says he has no problem rallying physicians to do a few hours per month to provide services and can get drugs from the pharmacies. The problem is getting the money to do the required testing (liver biopsy, etc).
 - Want FVHC members to identify physicians, drug reps, and lab reps for their areas to invite to the consortiums.

- How close are we to having private labs reporting to Merlin?
 - STD has people working on it through the integration program.

Debbie – working on getting primary care physicians to screen for hepatitis

- Dinner in November
- Seeing a lot of Bosnia and Croatian immigrants with HBV.
- The Hope Center in Port Charlotte is set up – can't see patients until November, but can be vaccinated and screened
- Fundraiser/Awards Ceremony in September featuring April Crowley as keynote speaker

Nominations for community co-chair:

- 10 of 18 active members are present
- Barbara Rush
 - Unanimous vote

Strategic plan update:

- Dr. Styne – very redundant. Goals, then outline, then specific. Nothing in the strategic plan to measure outcomes. No timeline. All the baselines are TBD. Is there work being done on the baselines or are they unobtainable.
- Possibly rephrase to increase/decrease.
- Can look at recommendations from CDC and Healthy People 2010
- Work on improving reporting into Merlin – set achievable goals.
- For a 3 year plan, may need to limit goals to 3-6. Prioritize goals and objectives.
- Take the 1st appendix out of the plan. 2nd appendix should be abridged.
- The structure of the overarching goals – came out of a statewide meeting. It doesn't work now. Not useful for encouraging integration. Change the goals from disease centered to Infrastructure/Prevention, Care and Treatment. Models HIV programs.
- The mission statement needs to be expanded and made broader. Program has its own goals and objectives, then another set of goals and objectives. The two need to align.
- Goals need to be written as a strategy and realign the objectives accordingly. Cut out the redundancy in the action items.
- Need to shorten the strategic plan summary. (Section 1 page 8)
- Make references to websites and update the dates to limit what has to be put into the document.
- 32 objectives under 6 goals – more like strategies than objective and need to be streamlined.
- Everything that is included should be done – but need to streamline and project out over the next 3 years.

Next meeting probably in January. Will try not to interfere with MLK.

- Ok with Thursday/Friday meeting? Yes
- Ok with day and a half meeting? Yes
- Would prefer to use this hotel again?

- Is Tampa ok?
 - o Yes
- Need to set aside time to do committee level work on Wednesday night – have people come in early.