

**UNITED STATES OF AMERICA  
BEFORE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Request for Information (RFI): Improving Efficiency, Effectiveness,  
Coordination, and Accountability of HIV and Viral Hepatitis Prevention,  
Care, and Treatment Programs**

**COMMENTS OF WHITMAN-WALKER HEALTH ON THE NATIONAL VIRAL  
HEPATITIS ACTION PLAN**

*Submitted via Electronic Communication to [HepHIVStrategies@hhs.gov](mailto:HepHIVStrategies@hhs.gov)*

In response to the Request for Information issued on February 8, 2019, 84 Fed. Reg. 2883, Whitman-Walker Health (Whitman-Walker or WWH) submits the following comments on the updates to the National HIV/AIDS Strategy and National Viral Hepatitis Action Plan (NVHAP).

We support updating the National Viral Hepatitis Action plan to create a more detailed roadmap to guide our ongoing journey to combat the spread of viral hepatitis. Our comments embrace major scientific developments of the past five years, namely in the realm of treatment as prevention for viral infections. Our comments emphasize the importance of routine testing and continuous engagement in care for all individuals living with or at risk for HCV.

**INTEREST AND EXPERIENCE OF WHITMAN-WALKER HEALTH**

Whitman-Walker Health is a Federally Qualified Health Center serving greater Washington, DC's diverse urban community, including individuals who face barriers to accessing care, and with a special expertise in HIV care and serving lesbian, gay, bisexual, transgender and questioning/queer (LGBTQ) populations. We empower all persons to live healthy, love openly, and achieve equality and inclusion. WWH services include primary medical care, HIV and LGBTQ specialty care, oral health, mental health care, substance use disorder treatment services, psychosocial support, medical nutrition therapy, early intervention

services, public benefits and insurance navigation, nurse-focused case management, HIV and STI screening, legal services, youth programs, and two onsite pharmacies – one in Northwest DC and one in Southeast DC. WWH has achieved Level 3 Patient Centered Medical Home accreditation from the National Committee for Quality Assurance. Our team provides high quality, affirming health care to more than 20,000 individuals annually and is the medical home to more than 10,000 patients. The center has five sites and a team of more than 280 highly educated and practically experienced staff. Our diverse patient populations include African Americans; Latinx individuals; gay and bisexual men and lesbian and bisexual women; individuals with substance use disorders; and low-income and homeless individuals. Transgender and gender non-binary individuals comprise a substantial and growing part of our patient and client base: approximately 6% of all those receiving health services; 13% of medical patients; 20% of persons receiving mental health services; 8% of those receiving substance abuse treatment services; and 20% of our legal clients.

Whitman-Walker has been a nationally recognized leader in HIV treatment and prevention for almost four decades. In calendar year 2018, we provided health care to 3,505 people living with HIV. We serve more than 25% of the District of Columbia's reported HIV-positive population, many of them low-income or members of otherwise underserved communities. Eighty three percent of our patients living with HIV are virally suppressed – a success rate much higher than the national and DC averages for people living with HIV, and comparable to the success rate for Ryan White-funded programs.

Whitman-Walker's Medical, Behavioral Health and Community Health Departments have been at the forefront of HIV education and prevention since the earliest days of the epidemic. In 2018, we provided HIV tests to 7,787 individuals, and our walk-in Sexual Health

and Wellness clinics, which offer STI and HIV testing, served 1,719 individuals. In 2017, our STI testing program diagnosed approximately 9% of the new HCV cases, 27% of the new cases of primary and secondary syphilis; more than 18% of the new cases of gonorrhea; and more than 9% of the new cases of chlamydia in the District of Columbia. Whitman-Walker also has more than 1,000 patients on PrEP, and has instituted a low-barrier “PrEP clinic” to make it easier for individuals who would benefit to start and remain adherent to the therapy.

Increasing numbers of our patients are being diagnosed with HCV; many of them are duly diagnosed with HIV and HCV, and Whitman-Walker medical providers have become experts in HCV care. In 2018, they cared for 341 patients living with HCV.

WWH has been conducting clinical research since 1987, when the first HIV treatments were being tested. Our studies investigate new ways to prevent or treat diseases in our community, particularly infectious diseases. Whitman-Walker has engaged in a wide range of research studies including; improved methods to screen for anal cancer; HIV and heart health; PrEP for HIV prevention; and HIV and cognitive impairment. Our research priorities also include new treatments for opioid addiction, the health and wellness priorities of LGBTQ youth, and improving HIV prevention and treatment for sex workers. WWH’s current research studies include clinical trials that test the long term effects of HCV treatments, how well new medications work, and the safety and efficacy of treatments for HIV and HBV co-infected adults; as well as behavioral studies that look at such topics as disease prevention and medical adherence.

Whitman-Walker has seen great success in testing and linking people with HIV, HCV, and (often co-occurring) substance use disorders to treatment and to prevention services, for one primary reason: we provide care with the core principle of dignity at the forefront. This principle

of dignity respects the uniqueness of every individual and motivates us to provide care in ways that celebrate uniqueness, rather than shame people for their gender identity, sexuality, race, ethnicity, age or other characteristics. Any efforts to improve the health and wellness of communities that are clouded by efforts to disenfranchise those same communities will not be successful. The leadership within the HIV and HCV communities knows this all too well and we urge this Administration, and all agencies of the federal government, to do more to protect the rights and dignity of people living with, or at risk for HIV, HCV and HBV.

#### **COMMENTS ON THE NATIONAL VIRAL HEPATITIS ACTION PLAN**

At the outset, Whitman-Walker reiterates here two fundamental concerns discussed at length in our Comments on the National HIV/AIDS Strategy, pertaining to engagement with sexual, gender, racial and ethnic minorities, and to the federal laws and programs that provide access to health care for millions of Americans. Policies and actions of the Administration that curtail legal protections for LGBTQ people and for individuals and families seeking to immigrate to or enter the U.S., and that have the effect of further alienating and stigmatizing people of color, foreign-born people and LGBTQ people, will make it more difficult to engage those communities in HCV testing and medical care. Policies and actions that restrict Medicaid, Medicare, and the health insurance reforms accomplished through the Affordable Care Act, threaten the access to affordable health care that is critical for the fight against viral hepatitis.

Whitman-Walker also offers the following specific comments in response to questions posed by the Request for Information.

**Question (1b)** of the Request for Information asks:

What components of the NVHAP do you think should be maintained? What changes should be made to the NVHAP? This may include changes to the structure, goals, and indicators, key areas of focus and/or populations, and annual reporting processes by

federal agencies. This may also include areas of the current strategy that should be scaled back or areas of the current strategy that should be expanded or scaled up.

Whitman-Walker supports mainstreaming viral hepatitis prevention efforts into primary care by promulgating standards that encourage routine testing. In alignment with the current NVHAP's emphasis on an integrated approach to reducing viral hepatitis, the CDC should recommend routine HCV and HBV testing in primary care settings. Routinization normalizes viral hepatitis in communities and helps to reduce the stigma associated with HCV and HBV infection.

We recommend more education in middle school, high school and college about modes of HCV and HBV transmission, and about substance use disorders. Recommendation, consistent with **Strategy 1.1** of the current NVHAP, will normalize education around sexually transmitted infections and reduce disparities in access to HCV and HBV testing and treatment by reaching populations at significant risk of exposure. We recommend that the updated NVHAP recognize the structural role that comprehensive sexual education for school-age children plays in reducing transmission of infectious diseases. The federal government can have a powerful role in facilitating and promulgating a medical consensus around sex and sexuality education. We recommend that the federal government promulgate standards for sex and sexuality education that are realistic and non-judgmental, and that provide specific, accurate information about HCV and HBV transmission risks and how to avoid them. We recommend that education on healthy relationships and healthy bodies begin in middle school classrooms. At the onset of puberty if not before, students should be provided with accurate information about sexual health and infectious diseases that helps empower them to make fully informed, healthy decisions.

The current NVHAP recognizes that the majority of new HCV infections arise from people who inject drugs, and that recent or active injection drug use is not a contraindication of

HCV therapy. We request that the updated plan specifically employ the lessons learned from harm reduction strategies in the HIV and opioid epidemics to address the syndemic of these three maladies and substance users.

We recommend that the national plan continue to recognize that people living with HCV and HIV coinfection are a priority population. We recommend additional funding through the Ryan White Program to treat HCV as a component of the care and treatment for people living with HIV. Prescribing cure therapy to co-infected patients will help ensure successful treatment of both infections – viral suppression of HIV and HBV and cure of HCV – and successful viral suppression or cure will not only benefit those patients but will also reduce new HCV and HBV as well as new HIV transmissions. We recommend additional funds be allocated to expand resources for charity care and insurance coverage to treat HCV and HBV in order to achieve treatment and prevention goals in states that did not expand Medicaid.

We recommend expanding access to HCV testing for homeless populations by funding mobile testing and treatment sites. In alignment with the current NHVAP recognition of homeless persons as a priority population, we also recommend creating and promulgating standards for same-day initiation of HCV treatment.

We encourage more aggressive strategies to prevent viral transmission through injection drug use – not only making clean needle exchange widely available but also consider other strategies in places most heavily affected by the opioid epidemic. In alignment with **Strategy 1.6** of the current NVHAP, we recommend research on the effectiveness and benefits of safe injection sites where testing and linkage to treatment are available.<sup>1</sup>

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<sup>1</sup> See, e.g., AIDS United, *Statement on Supervised Injection Facilities*, last updated June 29, 2016, [https://www.aidsunited.org/data/files/Site\\_18/Policy/Statement%20on%20Supervised%20Injection%20Facilities%20July%207%202016.pdf](https://www.aidsunited.org/data/files/Site_18/Policy/Statement%20on%20Supervised%20Injection%20Facilities%20July%207%202016.pdf).

The current NVHAP acknowledges the challenge of provider knowledge around HCV and opioid use disorder treatments. We recommend adopting harm-reduction approaches in provider education. Specifically, we recommend removing requirements that someone be completely abstinent of non-prescription drugs in order to access Medication Assisted Treatment (MAT) for opioid use disorder. Stringent restrictions are often not medically indicated and present unnecessary and sometimes insurmountable obstacles to obtaining treatment.

**Question (2b)** seeks

[s]pecific recommendations you think will improve the efficiency, effectiveness, accountability, and impact of the national response to viral hepatitis.

We recommend that the federal government encourage the development of generic cure therapies for HCV, in recognition of the potential for HCV infection levels to increase to crisis levels. The current NVHAP recognizes that currently existing cure therapies treatment are out of reach of the uninsured and under-insured, and that even many public and private insurance plans will not cover such therapies, or impose substantial restrictions on coverage, because of their high cost. The high cost and lack of adequate insurance coverage have resulted in a widespread reluctance to treat that disproportionately disadvantages impoverished communities.

We recommend expanding access to HCV and HBV care through telemedicine programs that allow physicians to practice medicine across state lines. Current NVHAP **Goal 2** identifies telemedicine as an opportunity to reduce mortality and morbidity from viral hepatitis. Allowing telemedicine practices would increase access to HCV and HBV treatment, particularly in rural areas. Currently, these services have been limited because of difficulties around state licensure and payment. The updated NVHAP should encourage regulatory and legislative action to require public and private insurance plans to reimburse for telemedicine encounters.

We recommend that the updated NVHAP include more indicators that address the HCV epidemic in correctional facilities. Correctional facilities house a disproportionate number of people living with HCV infections. The current NVHAP considers correctional facilities “a key opportunity to diagnose people living with viral hepatitis” (page 34). We note that medical care offered within coercive contexts is historically less efficacious than medical care sought voluntarily. We recommend that viral hepatitis testing and treatment programs in correctional contexts be subjected to stringent oversight to protect the human rights of incarcerated persons.

The federal government should support efforts combatting LGBTQ discrimination in health care – particularly for gay and bisexual men and transgender people. The current NVHAP recognizes the negative impact of stigma related to viral hepatitis infection. We suggest that the stigma faced by people living with or at risk for viral hepatitis is exacerbated by intersecting discrimination based on age, race, and sexual orientation in housing, employment, and many other areas of life. Experiences of stigma and discrimination in healthcare compound feelings of alienation and mistrust, making it more difficult to reach the priority populations of LGBT people in HCV testing and treatment efforts.

We recommend increased focus on providing culturally competent care to disproportionately impacted communities. **Strategy 2.5** of the current NVHAP calls for culturally competent and linguistically appropriate care. We recommend that the updated Plan continue to apply learnings and research on culturally appropriate care to the distribution of viral hepatitis in priority populations. We suggest research on tailored prevention and treatment efforts from organizations that have demonstrated abilities to work effectively in hard to reach communities of men-who-have-sex-with-men and transgender people. In alignment with the current **Goal 3 and Strategies 3.1 and 3.2**, we recommend leveraging community health

workers who can go out into the community to test, engage people in treatment, and support patient treatment adherence. We recommend that the federal government create a mechanism by which health centers can be reimbursed for patient engagement activities performed by community health workers.

We recommend the updated plan expand access to resources to address the social determinates of health in people living with or a risk for acquiring HCV. **Goal 3** of the current NVHAP acknowledges that access to adequate housing, employment, education, clean water, nutritious food, and culturally competent medical care is central to effectively reducing health disparities for priority populations.

**Question (3b)** asks:

What specific actions should the federal government and others take to improve the coordination of funding and delivery of viral hepatitis services?

We recommend expanding the mandate of the current NVHAP to conduct research on the use of electronic health records to facilitate the coordination of care and services across local jurisdictions. We support going beyond **Goal 4**'s strategies of exploring uses for electronic health records, to active encouragement of their use in the ongoing response to the HBV and HCV epidemics.

## CONCLUSION

Whitman-Walker appreciates this opportunity to contribute to this critical effort. Please feel free to contact us if we can be of assistance in any other way.

Respectfully submitted,



Daniel Bruner, JD, MPP, Senior Director of Policy  
[dbruner@whitman-walker.org](mailto:dbruner@whitman-walker.org)  
(202) 939-7628



Benjamin Brooks, JD, MPH, Assistant Director of Policy  
[bbrooks@whitman-walker.org](mailto:bbrooks@whitman-walker.org)  
(202) 797-3557

Naseema Shafi, JD, Chief Executive Officer  
Sarah Henn, MD, MPH, Chief Health Officer  
Juan Carlos Loubriel, Director of Community Health and Wellness  
Raymond Martins, MD, Senior Director of Clinical Education and Training

WHITMAN-WALKER HEALTH  
1342 Florida Avenue, NW  
Washington, DC 20009

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