

# **Presidential Advisory Council on HIV/AIDS (PACHA)**

## **Thirty-eighth Meeting**

**The White House**

**Eisenhower Executive Office Building**

**Washington, DC**

**February 2, 2010**

### **Council Members Present**

Helene D. Gayle, M.D., M.P.H., Chair, Presidential Advisory Council on HIV/AIDS  
Antonio Cornelius Baker  
Praveen Basaviah, B.A.  
Dawn Averitt Bridge  
Douglas Brooks, M.S.W.  
Humberto Cruz, M.S.  
Ernest Darkoh, M.D., M.P.H., M.B.A.  
Kevin R. Frost  
Patricia Garcia, M.D., M.P.H.  
Robert Greenwald, J.D.  
Kathie Hiers  
David R. Holtgrave, Ph.D.  
Michael Horberg, M.D., M.A.S., FACP, AAHIVS  
Ejay L. Jack, M.S.W.  
Jack Jackson, Jr., J.D.  
Naina Khanna  
Jim Kim, M.D., Ph.D.  
Douglas Michels, M.B.A.  
Mario J. Perez  
Rosie Perez  
Malika Saada Saar, M.A., J.D.  
Sandra Torres-Rivera  
Phill Wilson, B.F.A.

### **Council Members Absent**

Calvin O. Butts III, D. Min.  
Anita McBride

**Ex Officio Government Members**

Centers for Disease Control and Prevention (CDC)

Kevin Fenton, M.D., Ph.D., FFPH

Director

National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Disease (STD),  
and Tuberculosis (TB)

Prevention

Centers for Medicare & Medicaid Services (CMS)

Barbara Edwards, M.P.P.

Director

Disabled and Elderly Health Programs Group

Center for Medicaid and State Operations

Health Resources and Services Administration (HRSA)

Deborah Parham Hopson, Ph.D., R.N., FAAN

Associate Administrator

HIV/AIDS Bureau

National Institutes of Health (NIH)

Jack Whitescarver, Ph.D.

NIH Associate Director for AIDS Research

Director

Office of AIDS Research

Office of the U.S. Global AIDS Coordinator (OGAC)

Ann Gavaghan, M.P.H.

Special Assistant for Policy

Substance Abuse and Mental Health Services Administration (SAMHSA)

Beverly Watts Davis, M.A.

Senior Advisor to the Administrator

Center for Substance Abuse Prevention

U.S. Department of Housing and Urban Development (HUD)

David Vos

Director

Office of HIV/AIDS Housing

**Staff Present**

Christopher Bates, M.P.A., Director, Office of AIDS Policy, and Executive Director,  
Presidential Advisory

Council on HIV/AIDS (PACHA), U.S. Department of Health and Human Services  
(DHHS)

Melvin Joppy, Committee Manager

## **Presenters**

Jeffrey Crowley, M.P.H, Director, White House Office of National AIDS Policy and Senior Advisor,

Disability Policy

Barbara Edwards, M.P.P., Director, Disabled and Elderly Health Programs Group, Center for Medicaid

and State Operations, CMS

Kevin Fenton, M.D., Ph.D., FFPH, Director, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB

Prevention, CDC

Deborah Parham Hopson, Ph.D., R.N., FAAN, Associate Administrator, HIV/AIDS Bureau, HRSA

Howard Koh, M.D., M.P.H., Assistant Secretary, DHHS

Claudia Richards, M.S.W., LICSW, Chief, Community Grants and Program Development Branch, Center

for Substance Abuse Prevention, SAMHSA

Kathleen Sebelius, M.P.A., Secretary, DHHS

David Vos, Director, Office of HIV/AIDS Housing, HUD

Jack Whitescarver, Ph.D., NIH Associate Director for AIDS Research and Director, Office of AIDS Research

## **MORNING SESSION**

### **Welcome**

Presidential Advisory Council on HIV/AIDS (PACHA) Executive Director Christopher Bates introduced himself and extended a warm and special welcome to all, especially to members new to the Council. Mr. Bates said PACHA members are in for a lot of work over the next 2 years because they have joined the Council at a particularly exciting time. Mr. Bates then introduced the morning's first speaker, Jeffrey Crowley, Director of the White House Office of National AIDS Policy and Senior Advisor, Disability Policy.

### **Mr. Crowley's Remarks**

Mr. Crowley said it was his great privilege to welcome everyone to The White House for the important occasion of the first PACHA meeting of President Obama's Administration. Mr. Crowley said he is happy to have PACHA Chair Helene D. Gayle here as well as other new Council members and top leaders of the Administration—Kathleen Sebelius, Secretary of DHHS, and Howard Koh, Assistant Secretary of DHHS. Mr. Crowley then addressed the White House's perspective on the economy and the HIV/AIDS epidemic.

Noting that the President had just released his proposed FY 2011 budget, Mr. Crowley acknowledged that it was a tight budget, adding that the President has faced unprecedented challenges and taken unprecedented steps to get the American economy back on track. Mr. Crowley said the President is committed to creating jobs in the near future and to more economic stability moving forward.

As one can see from the proposed budget, HIV/AIDS remains an ongoing priority of this Administration, Mr. Crowley said. He noted that during his Presidential campaign, President Obama made a commitment to developing a National HIV/AIDS Strategy. Over the past year, the Administration has been in an information-gathering phase of the Strategy, which included nearly 20 community meetings held across the country to listen to what the American people had to say and to their best ideas for moving forward on this front.

Work is now under way on a report of common themes garnered from these meetings, Mr. Crowley said. In addition, a Federal Interagency Working Group has been formed to assist with the Strategy, many of whose members are here today.

Mr. Crowley noted that DHHS has a large role in all of this, with Dr. Koh playing a central role. He promised that as work continues, by the Interagency Working Group and others, there would be further opportunities to engage the public in general and PACHA in particular.

Mr. Crowley commented that some in the community feel he has already written the National HIV/AIDS Strategy, but this is not the case. A process is under way, and it has been encouraging. Current plans are for the Interagency Working Group to convene in late February and to update the public on the process.

### **PACHA's Role in the National HIV/AIDS Strategy**

Mr. Crowley said that PACHA as a full Council and/or its new Subcommittees (of which there will be four), all aligned with the President's priorities of reducing HIV incidence, increasing access to HIV/AIDS care and treatment and improving quality of care, decreasing HIV/AIDS-related health disparities, and international HIV/AIDS programs and activities, will be involved. Specifically, as the Interagency Working Group looks at recommendations and brings its own expertise to bear on a new Strategy, prioritization will be needed. The Administration will check on priorities with PACHA, most likely through its Subcommittees first, to see "whether we are getting it right." Later, there will be continued check-ins with the Interagency Working Group, with PACHA, and with the public. There also will be a request for formal public comment prior to finalization of the Strategy.

Mr. Crowley promised that while the Administration will take the time needed to get a new National AIDS Strategy right, there also is an urgent need to complete it. Therefore, he hopes that a draft will be available for sharing toward the end of May.

### **Conclusion**

Concluding, Mr. Crowley said important work on developing the Strategy will take place over the next few months and that the Administration believes PACHA members have much expertise to tap. He promised that he would be looking to PACHA for its leadership in the future, to assist not only in developing the Strategy but also in implementing it.

## **Comments by Howard Koh, Assistant Secretary of DHHS**

Dr. Koh thanked Mr. Crowley for his dedication and leadership. "We are proud of you," he said.

Dr. Koh said he is honored to be here today to recognize PACHA members as leaders for health in this country and the world and to thank PACHA Chair Dr. Gayle and all the leadership represented on the Council for their many contributions to public health to date.

## **An Historic Moment**

Today marks an historic moment in the Administration's mobilization of HIV/AIDS leadership across DHHS, a mobilization that began with the Secretary's request that Dr. Koh oversee 13 relevant DHHS Offices, including Mr. Bates' Office of HIV/AIDS Policy and this Council. Since that time, Dr. Koh has convened principals from CDC, CMS, OGAC, HRSA, and SAMHSA to foster collaboration and coordination on HIV, work with the White House, and support Global AIDS Ambassador Eric Goosby.

## **Reflections on the Journey Taken Together**

Dr. Koh reflected on the journey we have all taken so far in the epidemic. He noted that as a medical doctor, he has cared for hundreds of HIV patients and has served as a State Health Commissioner, professor, and researcher. So many times in his life, the odds against ending the epidemic were massive and seemed overwhelming. However, at those times, leaders like those represented on the Council stepped forward and led with passion and compassion.

Dr. Koh recalled when he was at Boston City Hospital in 1981 as the epidemic "exploded" and how little hope there was against overwhelming infection, stigma, and discrimination, yet many in this room stepped in undaunted and offered new hope. Dr. Koh recalled when he was the Massachusetts State Health Commissioner trying to create the perfect HIV policy in an imperfect environment but then met some of the PACHA members sitting before him today and how they were always encouraging, for which he was and remains grateful. Then, as a professor at Harvard, he witnessed the devastating inequities in the epidemic and the inequities that arise from it, domestically and globally, yet again many heroes, including members of PACHA, led the effort for health for all.

Dr. Koh then reflected on his DHHS appointment and his participation in community discussions across the country, along with Mr. Crowley, Mr. Bates, and other members of DHHS, hearing from more than 5,000 people in the front lines of the epidemic who want to embrace a new opportunity in a new day, from which he takes inspiration.

## **HIV Is a Leadership Challenge**

HIV is a leadership challenge, Dr. Koh said. Like all public health crises, HIV is heartbreaking, plays out in the public eye, involves many stakeholders, and

requires treatment and elimination of stigma, which remains. Yet there is new hope to embrace science, policy, and practice to create lasting change. With PACHA's commitment, Dr. Koh pledged that we would rebuild our community in the midst of suffering and great challenge by working interdependently and interconnectedly to keep our promises, "as you don't have to be infected to be affected by this virus."

## **AIDS.gov**

Dr. Koh invited PACHA members to visit <http://www.AIDS.gov> to learn about its sponsor, the Federal HIV/AIDS Web Council, and its cutting-edge media and social media efforts to raise awareness, including sponsorship of AIDS Awareness Days such as National Black AIDS Awareness Day on February 7.

## **Conclusion**

Concluding, Dr. Koh expressed hope that we will all look back at today as truly honoring health in its broadest dimensions—a state of complete physical, emotional, and mental well-being and not just an absence of infirmity. He said it is an honor for him to work with everyone in this meeting, colleagues at the State and local levels, and DHHS Secretary Kathleen Sebelius, who will conduct the PACHA members swearing-in ceremony in a few minutes.

Dr. Koh noted that he has been working with Secretary Sebelius daily and therefore knows how she has stepped forward in many crises and led DHHS with great determination and passion. Dr. Koh thanked the Secretary for her deep commitment to the issues we are dealing with—care and treatment as well as, especially, prevention.

## **Comments by Kathleen Sebelius, Secretary of DHHS**

Secretary Sebelius opened her comments by stating her delight at being here today with Dr. Koh who, by virtue of his range of experience and personal interest, is the right leader for DHHS in the fight against HIV/AIDS. Secretary Sebelius extended thanks, too, to Mr. Bates for the roles he has played in this fight. Now, she said, it is also time for PACHA members to "roll up their sleeves" once again for the work ahead.

Secretary Sebelius said Dr. Koh has the opportunity to coordinate many of the agency's key initiatives and that it is important for the HIV/AIDS effort to be "under his thumb." She said that Mr. Crowley is doing terrific work as a relentless, tenacious policy director constantly focused on increasing care for people with HIV/AIDS while also recognizing that this care "has to be part of every health conversation we have."

## **Dr. Gayle's Appointment as PACHA Chair**

Secretary Sebelius recalled that one of the first standing ovations she received as DHHS Secretary had nothing to do with what she had done but, rather, with her announcement that Dr. Gayle would be PACHA's new Chair. That was the first time

the Secretary had met Dr. Gayle, but she has concluded that if she invokes Dr. Gayle's name on a regular basis, "people will like me better."

Secretary Sebelius went on to note not only Dr. Gayle's revered status but also her fellow PACHA members, who, the Secretary said, represent a "dazzling array of advocates and experts who take HIV/AIDS very seriously, represent a balance of geography and gender, and, all told, are the right leaders to have in place at this critical moment."

### **Why a National HIV/AIDS Strategy Is So Important**

Secretary Sebelius noted that she has been visiting DHHS' many agencies and getting a sense of their priorities. In her visit to NIH, she had an up-close-and-personal experience about why a National HIV/AIDS Strategy and implementation is so important. A young man in the NIH Clinical Unit presented himself. He was 26, HIV-positive, and had been nearly dead before he found his way to NIH thanks to his grandmother, who had a connection. Prior to that time, he had been in and out of doctors' offices and hospitals losing fluid by the gallon but not once recommended for an HIV/AIDS test. In short, this young man had not been properly cared for until he got into the NIH program, where they literally saved his life.

### **Commitment No Longer To Stand in Place on Domestic AIDS Policy**

The Secretary said this experience serves as a reminder that we are in the District of Columbia, which has some of the best medical care in the Nation, yet this young man was days away from death because he was not connected to the right treatment. This experience also serves as a reminder of the words of the late Sen. Edward Kennedy (D-Mass.), who often said "To stand in place is to fall behind." Yet, the Secretary noted, that is what has happened for a while in domestic AIDS policy. Therefore, part of the President's commitment, his budget commitment, and her commitment is "not to stand in place any longer." Thanks to Mr. Crowley's leadership, the Secretary said, the Administration has proposed \$3 billion for AIDS treatment and support of investments in other key areas.

### **Complacency and Stigma**

Americans have become complacent about HIV/AIDS and are "not nearly as worried as they should be," Secretary Sebelius commented, explaining that the percentage of those who fear infection has dropped off. Therefore, DHHS is launching a CDC initiative to reach out to the whole country but also with a focus to those traditionally underserved. This initiative is particularly important, the Secretary said, because, despite best efforts, a high level of HIV/AIDS stigma still exists in some communities, which results in fear of being tested for fear of discrimination and even fear of picking up educational flyers on treatment for fear of others' assumptions.

The Secretary went on to note that last year, the Federal Government finally eliminated the HIV/AIDS travel ban, which was a big blow against discrimination. In addition, in 2012 we will welcome the International AIDS Conference back to the United States.

### **Much Work Remains/NIH-D.C. Partnership**

Despite some victories, much work remains. HIV/AIDS is increasingly concentrated in certain communities, Secretary Sebelius noted. Although 10 percent of the U.S. population is black, nearly one out of every two new infections is among this population, with new infections on the rise in other groups as well. Given that some of the highest rates of infection are right here in the District of Columbia, where 3 percent of adults and adolescents are infected, it is particularly important to note that a new partnership has been struck between NIH and the D.C. Health Department.

Through this new partnership, NIH scientists will help the local health department reach out with screening and new tools and information as well as help D.C. track care that has been provided here and set up clinics for the underinsured. NIH will be helping D.C. test new models of awareness in the community calling for voluntary testing and immediate antiretroviral (ARV) treatment for those who test positive. What we learn here, the Secretary added, will be helpful across the country for scale-up.

### **PEPFAR, a Domestic Match, and PACHA's Role**

Secretary Sebelius said that while the President's Emergency Plan for AIDS Relief (PEPFAR) is one of the truly global health successes of the last Administration, "we have to match that here at home." That is why this Administration is bringing new resources, new energy, and a new plan to the domestic scene. Here, PACHA has a key role to play as a platform for sharing the Administration's plans and activities with the broader public but also as a conduit for carrying the public's messages back to the Administration. Given the wide range of background and expertise among PACHA members, the Secretary said she would count on all to keep her up to date on concerns, priorities, and insights.

### **Conclusion**

Concluding, the Secretary called this a pivotal moment for doubling down on our efforts. President Obama has chosen this course, so she looks forward to working with all to reach his goals.

### **Swearing In of New PACHA Members by the Secretary**

Secretary Sebelius swore in all new PACHA members, and an official all-member photograph was taken on the stage of the South Court Auditorium in The White House Eisenhower Executive Office Building.

## **Formal Introduction of PACHA Chair**

Mr. Bates introduced PACHA's Chair, Helene D. Gayle, to make some comments, adding that Dr. Gayle "is my shero."

## **Comments by PACHA Chair Helene D. Gayle**

Dr. Gayle thanked everyone who has worked so tirelessly to get us here.

Looking around the room, Dr. Gayle noted that she is seeing the face of PACHA and those who will be engaged in the work of the Council. To her, this feels like a homecoming, as many here have played a role in her own history.

Dr. Gayle said she thought a long time about the wisdom of accepting this position. She was involved in HIV/AIDS for a long time, including 20 years with CDC and then directing the HIV, TB, and Reproductive Health Program at the Bill & Melinda Gates Foundation. Now, as President and Chief Executive Officer (CEO) of CARE USA, she is doing humanitarian development work, and she could have left well enough alone, but this position "really spoke to me. It means a lot to me to be part of this effort."

Dr. Gayle continued by saying that she decided to become a member and Chair of PACHA when she realized she missed her former career in HIV/AIDS efforts. While neither domestic work nor global work on this disease is more important than the other, she wants to redouble her efforts and work with PACHA members to address the unacceptable level of infection here, in the richest Nation in the world, as well as continue our obligations around the world.

## **PACHA's Inspiring Spirit**

Dr. Gayle said the spirit of PACHA is incredibly inspiring. Here is a group of volunteers, many of whom are engaged in the fight against HIV/AIDS professionally and full time, who will help guide the U.S. Government's (USG's) overall efforts. "All of you are busy people, but you are giving your time to be part of an effort that will enrich all of us and make us a better Nation."

Dr. Gayle recognized a number of the PACHA members sitting before her whom she already knows, including David R. Holtgrave, with whom she worked at CDC; Ernest Darkoh, whom she met when he was providing leadership to Botswana's National Antiretroviral Treatment Program; and Phill Wilson, whom Dr. Gayle called "a mentor to many of us in a lot of ways."

Dr. Gayle also thanked actor, choreographer, and director Rosie Perez for becoming a PACHA member and lending her celebrity status to this effort.

## **PACHA's Role**

Dr. Gayle said the role PACHA will play in the coming months and years to help guide USG efforts will be incredible. PACHA will not be doing all the work but, rather, will act as an "honest broker and represent different communities and

expertise." Having worked in the Federal Government, Dr. Gayle said she knows the importance of the inside and outside coming together in a way that responds to the American public and keeps that accountability. PACHA is the outside voice that will help the inside voice in the partnership in a check-and-balance way that is so much part of our democracy.

Dr. Gayle urged all involved to stay motivated in order to live up to the challenges Dr. Koh and Secretary Sebelius have tossed out, noting that there will be further discussion soon with Mr. Bates and Mr. Crowley about the different roles PACHA can play. Her observation so far, she added, is that everyone's efforts are coming together in a way that is "bigger and better than any one of us."

### **Haitian Example**

Thinking about Haiti, the work CARE USA is doing there, and how important it is that the communities themselves come to the table to be part of the response, Dr. Gayle reflected that PACHA too represents communities and an important voice for response. Therefore, it is important that PACHA engage in this process in a way that makes us recognize we have real ownership, and when the National HIV/AIDS Strategy is done, that PACHA's role will be as an important ambassador for communication and implementation, as a Strategy is only as good as its communication and implementation. It will be important throughout "for none of us to sit back and be critical about what those on the inside are doing or not," Dr. Gayle added, for this is something we all have to own to make a real change in HIV in this Nation.

### **Conclusion**

Concluding, Dr. Gayle said she is honored to be here and to play a leadership role, yet "all of us are leaders" in an effort that "we will look back on as something incredibly important that made a difference in the lives of the people of this Nation and around the world."

### **Public Comment Period**

Mr. Bates welcomed anyone from the public or from PACHA who might want to make a statement to do so at this time after introducing themselves. He noted that he had received at least one written statement as well.

**"Wanda," Light Link**, introduced herself and gave the following statement:

"I am from Baltimore, Maryland. I was diagnosed with HIV 22 years ago. HIV-positive individuals are living longer, and Americans over the age of 50 represent one of the fastest growing segments of the country's HIV population.

"Importantly, not only is HIV of concern but also health-related comorbidities. I have concerns about continuum of care for those living with HIV and also those suffering from health-related comorbidities.

"I advocate enhanced Government accountability to ensure appropriate response to the needs of people over the age of 50 who are living with HIV/AIDS."

**Bishop John Selder, United Church of Christ, United Church of Christ HIV & AIDS Network (UCAN)** (<http://www.ucaninc.org>), introduced himself and gave the following statement:

"Founded in 1987, UCAN's mission is to build a network of people, congregations, and organizations within and beyond the United Church of Christ to respond to the U.S. and global AIDS pandemic through care giving, prevention interventions, and advocacy efforts.

"At this first meeting of PACHA in this new Administration, we would like to acknowledge this as a 'kairos' moment—that is, a moment filled with opportunity, possibility, and promise. This is a moment that must be grasped in order to mobilize our country's moral and political will and human, organizational, and financial resources to respond in strategic ways to the HIV/AIDS epidemic that continues to devastate so many communities and take so many lives. If we fail to act, this moment will surely pass.

"As we all know, every 9 ½ minutes, another person in the United States will become infected with HIV. Before the general meeting of this Council is over, more than 15 Americans will become infected with HIV. This presents a challenge to all of us to work even more creatively and collaboratively. As a faith-based network, we are committed to bringing critical presence where it is needed most and working smarter and harder with others to realize a vision of health and wholeness for all. Having said that, the U.S. HIV epidemic demands leadership and commitment from the highest levels of Government, although history has shown us that Government cannot, nor should it, respond to this epidemic alone. Partnerships with community-based, faith-based, and other organizations are even more critical if we are to reduce HIV incidence and respond to the needs of our neighbors, colleagues, relatives, church members, and friends who are living with HIV/AIDS.

"The mission is as urgent today as it ever has been. UCAN's challenge to PACHA, a body of dedicated individuals, is that you work strategically in this current political environment to advance policies and programs that prevent new cases of HIV infection, provide universal access to treatment, and offer compassionate care to people who are living with and affected by HIV/AIDS. And, lastly, that you intentionally solicit ongoing input from populations most at risk for HIV and those organizations that service them to shape your thinking and strategies and to make the most of this opportune moment."

**Regan Hoffman, Editor-in-Chief of *POZ* magazine** (<http://www.poz.com>), introduced herself and gave the following statement:

"I have been living with HIV for 15 years. On behalf of all those who contact *POZ* magazine every day, I am excited about PACHA, as many of those who contact my magazine have many real concerns."

**Carl Schmid, Deputy Executive Director, The AIDS Institute**, introduced himself and gave the following statement:

“There is an issue of critical importance that needs to be addressed now, and that is emergency funding for the AIDS Drug Assistance Program (ADAP). The severe economic downturn has jeopardized State contributions to many ADAPs, while job losses have resulted in individuals’ losing their health insurance, which places greater strains on the Ryan White Program, including ADAP.

“Enrollment in ADAPs has also increased due to intensive efforts to identify people through HIV testing programs. People are living longer, and there are still 56,000 new infections every year. The National Alliance of State and Territorial AIDS Directors (NASTAD) estimates that the average monthly growth for ADAPs in 2009 was 1,271 new clients, or an 80 percent increase from the prior year.

“While passage of meaningful health reform remains our ultimate goal, and it can relieve some of the stress on the Ryan White Program, expanded coverage under even the best scenario would not occur until 2013. We need a response now to address the immediate crisis in several States that have waiting lists or are facing other shortfalls and a response for the next few years.

“While the President proposed and the Congress approved a \$20 million increase this past year or just a 2.5 percent increase to ADAP for FY 2010, this was far from what was needed to keep up with the increased number of ADAP clients and falling State contributions. Any increase proposed for FY 2011 will not flow to the States until April of 2011, which is more than a year from now. In order to meet current needs, The AIDS Institute is requesting an additional \$126 million in FY 2010 emergency funds for the ADAP Supplemental.

“We ask you to act at this meeting and join us in support of this request. Time is of the essence. We urge you to ask President Obama to request from the Congress emergency support for the ADAP Supplemental this year to ensure that the funds will flow to the States that need it. A few years ago when we were facing long ADAP waiting lists, PACHA responded and urged President Bush to address the situation, which he did with \$20 million in emergency funding. Today our economy and State budgets are in a much worse situation, so we trust that you will respond expeditiously.”

**Ronald Johnson, Deputy Director, AIDS Action Council**

(<http://www.aidsaction.org>), introduced himself and gave the following statement:

“On behalf of the members, Board, and staff of AIDS Action Council, I congratulate the members of this new and, we trust, reinvigorated PACHA. You begin your work as we approach, in 4 months, the beginning of the 30th year of the HIV/AIDS epidemic here in the United States. This fact, among many, underscores the importance of your work.

“As you contribute to the development and implementation of the National

HIV/AIDS Strategy, I want to highlight an issue that is often overlooked but was mentioned by the first public comments speaker today, and that is HIV/AIDS among people 50 years of age and older. I also highlight the issue because repetition often helps to make the point. HIV and AIDS among people over 50 years and older includes those, like myself, who were infected/diagnosed at a younger age and are aging with HIV, those newly diagnosed after the age of 50, and people over 50 who become newly infected. There are treatment and care challenges, there are prevention challenges, and there are important areas of research that need support. I want to highlight especially the need for prevention messages and programs that target people 50 years and older. AIDS Action urges that you include HIV/AIDS in people over 50 years of age in your considerations to ensure the Strategy addresses this population that is too often overlooked or forgotten completely."

**Thelma King Thiel, Chairman and CEO of the Hepatitis Foundation**

**International** (<http://www.HepatitisFoundation.org>), introduced herself and gave the following statement:

"Hepatitis Foundation International works on the front lines to promote liver health and is becoming more involved with the HIV community. We have to motivate people to change risk behaviors, to be tested, and to know why they need to do these things.

"It is appropriate for the Foundation to be involved in the HIV community because both HIV/AIDS and hepatitis are silent diseases. I look forward to working with PACHA and Mr. Crowley in the future."

**Ariana Childs Graham, Senior International Policy Association, Sexuality Information and Education Council of the United States (SIECUS),**

introduced herself and gave the following statement:

"On behalf of SIECUS, please allow me to thank you for your service on the Presidential Advisory Council on HIV/AIDS and for allowing the opportunity for public comment here today.

"We are pleased that the Obama Administration has taken several steps to promote and fund programs to improve sexual and reproductive health for young people. Evidence has clearly returned to the helm of the Federal Government. We welcomed the elimination of dedicated funding for abstinence-only-until-marriage programs and funding reprogrammed for more comprehensive approaches to sex education. In these times of tight budgets, we are grateful to the President that his FY 2011 budget increased funding for the new teen pregnancy prevention initiative. However, by focusing the funding on teen pregnancy prevention and not including the equally important health issues of STIs and HIV, we think the Administration has missed an opportunity to provide comprehensive sex education that promotes healthy behaviors and relationships for all young people, including LGBT (lesbian, gay, bisexual, and transgender) youth. Other negative health outcomes stem from the same behavior of unprotected or underprotected sex, and those are the behaviors we need to change. As funding for this new prevention program for teens

continues and as the prevention portion of the National HIV/AIDS Strategy comes to fruition, we hope PACHA will urge that comprehensive sex education be a foundation for prevention efforts moving forward.

“With regard to the U.S. response to the global HIV/AIDS epidemic, we are greatly encouraged by the conceptual framework for the PEPFAR prevention portfolio as mapped out in the PEPFAR strategy documents, including the commitment to ‘scaling up high-impact, evidence-based, combination prevention approaches’ and to addressing ‘structural factors, such as existing economic, social, legal, and cultural conditions [which] contribute to increased risk for HIV infection.’

“In order to operationalize these commitments, it is imperative that clear, comprehensive, and consistent guidance is available. Communications from the Office of the Global AIDS Coordinator (OGAC) to the field come in various forms. However, issuing new policy guidance would serve in alleviating confusion on the ground, providing the lens to interpret the mandates outlined in the legislation and strategy documents, while still mindful of country-specific response championed by OGAC. OGAC is already developing a guidance document regarding injection drug users (IDUs), and we hope that additional guidance is forthcoming.

“SIECUS is excited and ready to work with this new PACHA to ensure that all young people, here in the United States and abroad, are getting the information they need to make healthy and responsible decisions over the course of their lives. Thank you.”

**James Sykes, Director of Global Programs, Policy, and Advocacy, The AIDS Institute**, introduced himself and gave the following statement:

“Today, we would like to share with you our comments on President Obama’s Global Health Initiative, the 5-year strategy mandated by the Tom Lantos and Henry Hyde United States Global Leadership against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 or PEPFAR II, as it is commonly called. Since its inception in 2003, the PEPFAR program has achieved unprecedented success—more than 3 million people are now on ARV treatment, compared to approximately 50,000 people when the program started in 1993, and millions of new infections have been prevented. Millions of orphans and vulnerable children are receiving care and support as part of this program. To quote Ambassador [Eric] Goosby, ‘the millions of lives that have been touched are a testament to the effectiveness of this collective effort—and to the generosity of the American people.’ Despite the success of PEPFAR, it is striking the need that still exists in countries around the world.

“According to the Food and Agriculture Organization (FAO) of the United Nations, 1.02 billion people across the world are hungry. Every day, almost 16,000 children die from hunger-related causes—one child every 5 seconds. According to UNICEF, an estimated 9.2 million children under the age of 5 will die this year—nearly 26,000 per day, or 18 every minute. Two million people will still die from AIDS, malaria will claim approximately 900,000, and TB will claim another 1.5 million

lives. The vast majority of these deaths will be due to neonatal disorders, pneumonia, and diarrhea. In his first State of the Union Address last week, President Obama referenced the Global Health Initiative by stating that ‘We are helping developing countries to feed themselves and continuing the fight against HIV/AIDS. And we are launching a new initiative that will give us the capacity to respond faster and more effectively to bio-terrorism or an infectious disease—a plan that will counter threats at home and strengthen public health abroad.’

“The AIDS Institute applauds the Administration’s commitment to global health. While we fully support the strategy to expand the program’s impact within infected and affected populations around the world, we are concerned that without significant increases in funding, the program will not keep pace with the needs of as many people as possible. The AIDS Institute calls on the President and Congress to fund the Global Health Initiative fully. Given the realities of the economic situation in which this Nation finds itself, we know hard choices will have to be made. It is our hope that we will choose ‘to help save lives, build economies, and strengthen human security through addressing the world’s major health crises’.”

**Carole Treston, Executive Director, AIDS Alliance for Children, Youth, and Families**, introduced herself and gave the following statement:

“The AIDS Alliance for Children, Youth, and Families represents the Ryan White CARE Act (RWCA) Part D population. The AIDS Alliance would like to congratulate PACHA for the diversity of its new members in terms of gender, race, special populations, and youth. PACHA’s membership is also geographically diverse and includes representation from Puerto Rico, an inclusive and welcoming fact.

“The AIDS Alliance will support PACHA’s efforts and also act as a conduit for information between PACHA and its populations, both ways.

“As PACHA goes about its work, we would like you to consider the need for comprehensive care for persons living with HIV, as in the United States, it is estimated that 30-60 percent or more of those who have been diagnosed are not currently in care. If this estimate is true, there is something wrong with our care systems. While expanded testing is necessary, the AIDS Alliance is concerned that it will add to the estimate of those diagnosed but not in care. Therefore, we would like PACHA to think about a strategy for getting those who are diagnosed into care and retained in care.

“Ryan White CARE Act Part D grant recipients have a long history of providing comprehensive care. While the AIDS Alliance understands budget constraints and economic realities, there is still a need to ensure that appropriate services are in place for getting those diagnosed with HIV into and retained in care. ”

**Bambi Gaddist, Executive Director, South Carolina AIDS Council**, introduced herself and gave the following statement as a black woman member of the HIV/AIDS Network and as a woman who lives in the South:

"The HIV/AIDS Network congratulates the newly sworn-in members of PACHA. The Network wants to note that, according to the most recent CDC statistics, a leading cause of death among black women in the United States ages 25-34 is HIV/AIDS, yet African American women remain invisible.

"As the director of a nonprofit organization and as a woman who lives in the South, I am perplexed by the growth of HIV infection among women and children, particularly in rural areas. So I appeal to you to make a special effort to reach out to disenfranchised populations that, to date, have not really had a voice.

"I look forward to working with you to ensure that all African American women and those who live in the South are not left behind."

**Suzanne Miller, Health Policy Manager, National Coalition of STD Directors,** introduced herself and gave the following statement:

"The National Coalition of STD Directors represents STD program directors in health departments across the Nation. As this Council looks toward the development of a National HIV/AIDS Strategy with the primary goals of reducing HIV incidence, increasing access to care and optimizing health incomes, and reducing HIV-related health disparities, a core element of this Strategy must be STD prevention, testing, and treatment.

"As we are all well aware, there is a strong link between HIV and other STDs. Persons with an STD have a twofold to fivefold increased risk of acquiring HIV if exposed to the virus through sexual contact, and HIV-infected persons who are coinfecting with another STD are more likely to transmit HIV through sexual contact than other HIV-infected persons.

"The current trends in syphilis are particularly troubling and have serious implications for HIV infection. Throughout the 1990s, rates of syphilis steadily decreased, reaching an all-time low in 2000. Since then, however, the syphilis rate has increased by 76 percent in men who have sex with men (MSM), who bear the brunt of new infections. In 2008, MSM accounted for 63 percent of all syphilis cases, while in 2000, MSM accounted for only 4 percent of these cases.

"The racial disparities that exist for gonorrhea are the greatest for any reportable STD. Young African American women experience the highest rates of this disease, and African American men aged 15-19 experience the greatest disparities—they are 39 times more likely than white men in this age group to have gonorrhea. Another area of increasing concern for gonorrhea is antimicrobial resistance, and MSM in particular are disproportionately impacted. In 2007, 14.6 percent of all gonorrhea cases demonstrated drug resistance, while 36 percent of gonorrhea cases among MSM demonstrated resistance.

"Rates of STDs continue to rise to record levels year after year, while Federal funding for CDC's Division of STD Prevention has steadily declined since FY 2003. In addition, drastic State and local budget cuts have further hampered the ability of health departments to respond to the increasing demand for STD services. The

need for Federal resources and leadership on STD issues is greater now than ever. We are grateful for the proposed increase in the President's FY 2011 budget and will work with appropriators in Congress to ensure the greatest possible funding increase for the Division of STD Prevention."

**Nancy Bernstine, Executive Director of the National AIDS Housing Coalition**, introduced herself and gave the following statement:

"Another matter of urgency is the imminent implementation of the 24-month lifetime cap on housing under the Ryan White CARE Act for people living with HIV/AIDS. Eviction notices are going out, and homelessness is a real danger for those approaching the cap at a time when other housing is not available.

"I hope that PACHA and all those who are proponents of structural intervention will turn their immediate attention to this critical issue."

**Eli Camhi, Executive Director of the NewYork-Presbyterian System Select Health** (<http://www.nyp.org/selecthealth>), introduced himself and gave the following statement:

"Good morning, and congratulations to all PACHA members and the Administration for making a great start in addressing the epidemic.

"I want to bring to the Council's attention a subtlety that needs to be highlighted regarding treatment. Although we have been very successful in treatment through use of ARV therapies, many people living with HIV (PLWH) who have been in treatment are now at risk for heart disease, cancer, diabetes, and other illnesses. I had one patient say he does not want his tombstone to read that he died with an undetectable viral load. My point is that ARV medications are the beginning of care, not the end of care, and we should address the full range of health care needs of those living with HIV/AIDS."

**Jennifer D. Collier with the Ryan White Medical Providers Coalition** introduced herself and gave the following statement:

"The Ryan White Medical Providers Coalition represents Ryan White CARE Act Part C medical programs and providers in 44 States providing quality care to people living with HIV/AIDS, which will be promoting the concept of the medical home as we all go forward. This concept is at risk in these times. People living with HIV/AIDS are getting into care, but when it comes to whole-person care, those providing it are shutting down.

"The Coalition is grateful to the Administration for requesting Part C appropriations in its recently released proposed budget, because these are stark economic times for States and localities. The Coalition is hoping to showcase the concept of the medical home to the Nation as part of the larger health care reform movement. At present, however, the gains made in medical home care by Coalition members are at risk, and we need to work together to make sure those gains are not lost and that our successes stay real."

**Laura Hanen, Director of Government Relations, National Alliance of State and Territorial AIDS Directors (NASTAD)**, introduced herself and gave the following statement:

“NASTAD represents HIV/AIDS directors in the States and Territories who have programmatic responsibility for HIV and viral hepatitis prevention and care programs and who coordinate programs across the continuum of HIV prevention and care, including administration of the ADAPs funded through Title II of the Ryan White CARE Act.

“PACHA will be playing an important role in the development of the National HIV/AIDS Strategy. As such, I would like to bring to your attention a crisis in access to treatment for people living with HIV/AIDS. This is a crisis in State ADAPs. The Nation’s economic downturn has increased the number of individuals living with HIV/AIDS in need of safety net services provided through the Ryan White program. Individuals losing jobs and losing insurance have created increased demand for ADAP. In FY 2009, ADAPs saw an average monthly growth of 1,271 clients. This is an increase of 80 percent from FY 2008 when ADAPs experienced an average monthly growth of 706 clients. This client growth is unprecedented in the program over the past several years.

“Ironically, as we continue to invest more in finding the 21 percent of people who do not know their status, there are 10 States that cannot provide them with treatment services.

“As of January 22, there were 361 individuals on waiting lists in 10 States, including Arkansas, Idaho, Iowa, Kentucky, Montana, Nebraska, South Dakota, Tennessee, Utah, and Wyoming. [In addition], North Carolina has closed enrollment to its program and anticipates having 1,000 clients on its waiting list by July. Thirteen States have had to institute or anticipate instituting cost-containment measures such as reducing their eligibility level, cutting drugs from their formulary, instituting annual expenditure caps per client, or capping enrollment. A few States have even had to drop existing clients from their rolls due to lack of sufficient resources. More and more States are reporting that they will be unable to serve new individuals seeking ADAP services throughout FY 2010.

“ADAPs received an increase of \$20 million through the FY 2010 congressional appropriations process; however, this amount falls far short of what is necessary for ADAPs to clear current waiting lists and curtail implementation of additional cost-containment measures. This program historically has grown by \$101 million every year. The reason that the crisis is not worse is that State legislatures have stepped up to the plate to fund shortfalls in their ADAPs. Unfortunately, in the current economic downturn, States have had to reduce their commitments to these programs. In State FY 2009, 26 State HIV/AIDS programs lost more than \$170 million in State general revenue funds. A recent survey conducted by NASTAD found that 48 percent of ADAPs experienced funding decreases in State FY 2009, and additional cuts are expected in FY 2010.

"Another reason the crisis is not worse is that our pharmaceutical partners have ensured that ADAPs are paying the lowest prices in the country. Unfortunately, that is not enough. Through negotiations with the industry, ADAPs have saved \$827 million since 2003.

"We believe that ADAPs are in dire need of emergency FY 2010 funding to continue to serve eligible clients in need of their services. NASTAD approximates that ADAPs need an additional \$126 million in FY 2010 Federal funding for a total of \$961 million to meet current program needs. We believe additional funding should be directed to the ADAP Supplemental, which currently is allotted to States with ADAP restrictions. This additional funding will allow States to continue their programs as is through the next fiscal year, not to expand their programs in any way.

"While we appreciate that we are running record deficits and Federal belt-tightening is warranted, the National HIV/AIDS Strategy will not be successfully built on a crumbling foundation. I thank you for your attention to this matter. I hope that PACHA will encourage President Obama to take action and address the needs of ADAPs nationwide in the current fiscal year."

**Kimberly Crump, Policy Officer, The HIV Medicine Association (HIVMA) of the Infectious Diseases Society of America (IDSA)**, introduced herself and gave the following statement:

"The HIVMA of the IDSA would like to congratulate the new appointees to PACHA and offer our support as a resource in your important work.

"The HIVMA of the IDSA represents more than 3,600 frontline medical providers and researchers from across the country dedicated to the field of HIV medicine. We advocate for science-based health policies that optimize health outcomes for those affected by the disease and help reduce the incidence of new cases. We also strongly advocate for adequate resources to support the national programs and research infrastructure that allow the United States to remain at the forefront of innovative prevention and treatment strategies.

"In addition, a key project is the Center for Global Health Policy, which provides a mechanism for physicians and scientists working in global HIV and TB to join the policy discussion about the effective use of U.S. funding for addressing the global HIV/AIDS and TB epidemics.

"We applaud the President's commitment to the development of a National HIV/AIDS Strategy that, we hope, will signal a strengthened national commitment to the battle against HIV/AIDS. HIV clinicians and researchers will play a critical role in the implementation of the Strategy, and their input in developing and refining it will therefore be essential to ensuring its success.

"We have submitted our complete recommendations to the Office of National AIDS Policy for priority areas of action to achieve the Strategy's three core goals. In brief, those priorities include:

- A prominent focus on earlier diagnosis and treatment through routine HIV testing and linkage to quality HIV care and treatment throughout the health care system
- Aggressive action to address the looming shortage of HIV clinicians, including recruiting and supporting minority physicians (The Strategy should also highlight the imperative of addressing provider reimbursement issues that threaten availability of HIV care under Medicaid and Medicare.)
- Promotion and expansion of evidence-based prevention measures, such as syringe exchange
- Increased access to comprehensive, coordinated care through medical homes for patients with HIV through improved coordination of Federal program resources, reduced administrative burden, and adequate resources to support the delivery of care
- A robust research agenda that includes creative ways to support crosscutting research that closely examines issues that are critical to meeting all three of the President's goals, such as the role of stigma in initiating and staying in care, barriers for patients to access and staying engaged in care, and the long-term impact of HIV disease and its treatment on the aging process.

"Thank you for your consideration, and we look forward to working with PACHA, the Office of National AIDS Policy, and the Interagency Working Group on development and implementation of the National HIV/AIDS Strategy."

**David Bryden, Senior Program Policy Officer, Infectious Diseases Center for Global Health Policy and Advocacy**, introduced himself and gave the following statement:

"For the second consecutive year (FY 2011), the Administration's budget has proposed a single-digit increase—2.6 percent or \$141 million—for PEPFAR. Unfortunately, that is not enough to preserve vital momentum in HIV treatment scale-up, nor is it enough to fund important new HIV prevention innovations in the developing world.

"While HIV treatment has expanded dramatically in recent years, only 40 percent of HIV-infected patients who need medications to stay alive have access to the drugs. HIV/AIDS is the number one killer of women of reproductive age, and only one-third of pregnant women currently have access to ARV drugs that prevent transmission of the virus to their babies, fueling an ongoing HIV epidemic among children in the developing world.

"PEPFAR has been a forceful engine driving down AIDS mortality, heading off new infections, and extending life-saving drugs to millions. Unfortunately, the current budget proposal could imperil the fragile gains made over the past decade in treating HIV. It could also force a 'Sophie's choice' between prevention and treatment."

**Praveen Basaviah, PACHA member and former Bill Clinton Fellow in India,** introduced himself and gave the following statement:

“In December, a meeting on youth and HIV was held that revealed a wide range of barriers youth face. Represented and/or discussed were youth homelessness, queer youth, racial and ethnic minority youth, and orphan youth—all issues that need to be addressed.

“We need to think about the door through which HIV/AIDS is entering our communities. What I see in my community, queer youth of color, is an epidemic of these youth thinking they are not worth anything. We wake up every day to messages that we are not worth anything, in our schools and the way sex ed is taught, through ‘don’t ask, don’t tell’ policies, and through the marriage laws that exist in this country.

“One way to help queer youth is through prevention and care but also evidence-based methods that look at the way family support does or does not work for our youth. There is much evidence that youth who come from accepting families are likely to have lower STD, drug abuse, and HIV/AIDS rates.

“I have been involved in queer youth activism here and in India. In the global society, there are many commonalities among queer populations. In the United States, those who come from immigrant populations include those with families who affect how we make our decisions, including unsafe sex.

“I would love for PACHA to support initiatives out there that deal with supporting families who support their queer youth. The question is how to support these programs so that people like me who come from rejecting families can survive and thrive. We are contributing members, and we are fabulous.”

**Naina Khanna, PACHA member and Director of Policy and Community Organizing, Women Organized to Respond to Life-Threatening Disease (WORLD), and Manager and Director of the U.S. Positive Women’s Network (PWN),** introduced herself and gave the following statement:

“I want to say as an HIV-positive woman and as Manager and Director of the U.S. Positive Women’s Network working for responsive policies in the United States that community participation in the National HIV/AIDS Strategy goes beyond PACHA. The PWN will be conducting briefing calls and looks forward, also, to working with media partners so that those with HIV and those who are vulnerable are brought to the table.”

**Phill Wilson, PACHA member and Executive Director, The Black AIDS Institute,** gave the following statement:

“Congratulations to all my colleagues. I would be remiss if I did not say that the first thing we hope will lead us through is comprehensive health care reform enactment, even if it takes a bit longer. I am a 30-year-old man living with HIV, but I was lucky. I had access to care and a loving family. Another year without access

to care for others is too long. I see at least 50 others in addition to me without my good fortune. We cannot allow another year to pass by for others like me but without my good fortune, because they are dying every day.”

## **End of Public Comments**

Mr. Bates thanked everyone for their comments.

## **PACHA Member Introductions**

Mr. Bates asked PACHA members to stand and introduce themselves.

PACHA members introduced themselves as follows:

- Phill Wilson, CEO, The Black AIDS Institute
- Malika Saada Saar, Founder and Executive Director, The Rebecca Project for Human Rights
- Dawn Averitt Bridge, Founder and President of the Board, The Well Project
- David R. Holtgrave, Professor and Chair, Department of Health, Behavior, and Society, Johns Hopkins Bloomberg School of Public Health
- Kathie Hiers, CEO, AIDS Alabama
- Rosie Perez, Founder, Urban Art Institute
- A. Cornelius Baker, National Policy Advisor, National Black Gay Men’s Advocacy Coalition
- Naina Khanna, Director of Policy and Community Organizing, Women Organized to Respond to Life-threatening Disease (WORLD), and Manager and Director of the U.S. Positive Women’s Network (PWN)
- Robert Greenwald, Executive Director, Treatment Access Expansion Project, Harvard Law School
- Mario J. Perez, Director of the County of Los Angeles Department of Public Health, Office of AIDS Programs and Policy (OAPP)
- Douglas Michels, President and CEO, OraSure Technologies, Inc.
- Douglas Brooks, Vice President for Health Services, Justice Resource Institute (JRI)
- Jim Kim, President, Dartmouth College
- Kevin Frost, CEO, The Foundation for AIDS Research (amfAR)
- Ernest Darkoh, Chairman, BroadReach Healthcare, LLC

- Sandra Torres-Rivera, Executive Director, Bill's Kitchen
- Humberto Cruz, Director, AIDS Institute, New York State Department of Health
- Patricia Garcia, Founder and Director, Women's HIV Program and the Perinatal HIV Program, Northwestern Memorial Hospital
- Jack Jackson, Jr., Principal, The Agassiz Group, LLC
- Ejay L. Jack, Graduate Assistant, Multicultural Affairs, University of Nebraska at Omaha
- Praveen Basaviah, HIV/AIDS Advocate
- Michael Horberg, Director, HIV/AIDS, Kaiser Permanente
- Helene D. Gayle, President and CEO, CARE USA

The PACHA members applauded each other.

### **Adjournment of Public Portion of This Meeting**

Mr. Bates said PACHA looks forward to all public partners' returning to Council meetings in the future. He then adjourned the public portion of this meeting.

### **New Member Lunch and Administrative Orientation**

Closed to the public.

## **AFTERNOON SESSION**

### **PACHA Agency Orientation Facilitated by Mr. Bates**

Mr. Bates introduced six of PACHA's seven Ex Officio Members from the USG to give presentations on their Agencies and Departments: Kevin Fenton, Jack Whitescarver, Deborah Parham Hopson, Barbara Edwards, David Vos, and Ann Gavaghan. Mr. Bates thanked Claudia Richards for filling in today for Ex Officio Member Beverly Watts Davis.

### **Presentation on Introduction to CDC, NCHHSTP, and HIV Prevention Priorities, by Kevin Fenton, M.D., Ph.D., FFPH, Director, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), CDC**

Dr. Fenton congratulated PACHA members on their appointments and on the Council's reconvention. He noted that he has had the pleasure of working with many of the members and that he looks forward to his new role as an Ex Officio Member of the Council.

## **Presentation Focus**

This is a very exciting time for CDC, given the arrival 7 months ago of its new Director, Thomas R. Frieden, Dr. Fenton said. Therefore, in his slide presentation today, Dr. Fenton said he would focus first on organizational improvements brought to the Agency by Dr. Frieden; second on introducing the National Center he directs; and third on CDC's key HIV prevention priorities and major ongoing initiatives.

Dr. Fenton noted that he will stay at the 30,000-foot level today, so if members do not hear about special projects or opportunities, they can rest assured that he will go into more depth at future Council meetings.

## **Dr. Frieden's Priorities/CDC Organizational Improvement**

Dr. Fenton characterized Dr. Frieden's vision as fresh and clear, with a laser-like focus on health impact and returns on investments. As CDC Director, Dr. Frieden's priorities are:

- To strengthen the role of and support for epidemiology and surveillance
- To strengthen assistance to States and localities
- To renew CDC's commitment to global health and health policy, with particular passion toward the role of policy in structural changes for chronic and infectious diseases
- To explore how to get more return on health investments and greater yields in terms of health impact.

Dr. Fenton said that over the past few months, the Director's focus has been on "winnable battles"—ways to rally the Agency to reduce impacts and mortalities from smoking, obesity, lack of food safety, HIV, and motor vehicle accidents.

To support the Director's priorities and focus on winnable battles, CDC has undergone some restructuring, as noted on Slide 4. A major change has been dissolution of CDC's Coordinating Centers. Under the previous Administration, there were a number of these Centers organized into thematic areas. Under the reorganization, newly created Offices perform some of the Centers' functions in a smaller and leaner way. Features of these new Offices include some consolidation of functions to allow CDC to better engage in some of the winnable battles and to serve as an intermediate level between the CDC Director and National Center Directors such as Dr. Fenton. One example is the new Office of Global Health, which Dr. Fenton said would help focus CDC's work and priorities in global health.

## **About NCHHSTP**

NCHHSTP is one of 11 National Centers at CDC. It was the largest Center until this year, when the Global AIDS Program was moved from the NCHHSTP to the new Center for Global Health. NCHHSTP facts include the following:

- NCHHSTP was established in FY 1995 to bring together CDC's HIV, STD, and TB prevention activities.
- Global AIDS activities commenced in 1999, and in 2010 these activities were realigned and assigned to the Center for Global Health.
- The Division of Viral Hepatitis was added to NCHHSTP in 2006.
- NCHHSTP supports both domestic and global activities with more than \$1 billion in annual funding and more than 2,000 full-time and non-full-time staff here and abroad.

### **Syndemics (Overlapping Epidemics)**

Dr. Fenton noted that NCHHSTP is the only National Center with the names of its conditions in its title, because it deals with similar or overlapping at-risk populations; the social determinants driving HIV, hepatitis, and STD infection are consistent; and these diseases as well as TB share very similar prevention and control strategies (Slide 6). Dr. Fenton emphasized that from his perspective, as we reflect on these as overlapping epidemics, a syndemic approach is needed, both here and abroad.

### **NCHHSTP Strategic Plan: 2010-2015**

Dr. Fenton showed a map of NCHHSTP's Strategic Plan (Slide 7) that depicts what the Center is doing and how it is responding to major changes. He noted that this plan should be formally released and ready to launch by this Friday (February 5).

At the top of the map is the Center's vision—a future free of HIV, viral hepatitis, STD, and TB—followed by the Center's mission—to prevent, control, and eliminate disease, disability, and death from HIV, viral hepatitis, STD, and TB in the United States and, through partnerships, globally. Below that are six crosscutting goals: prevention through health care; program collaboration and service integration; health equity; global health protection and systems strengthening; partnerships; and workforce development and capacity building.

Dr. Fenton detailed the six crosscutting goals. Prevention through health care addresses how the Center works with the health care system, particularly at a time of system transformation and reform. Program collaboration and service integration entails achieving better interconnectedness between disease programs and better coordination at the client level, which will move us toward more holistic client services. The goal of health equity addresses reducing health disparities. Here Dr. Fenton noted that some of the most glaring health disparities are connected with the Center's diseases, so the Center is adopting a social determinants of health approach to look at barriers and opportunities for prevention. Not only is the Center adopting this approach, but it is also looking for opportunities to work with colleagues across the Federal Government on this approach. Dr. Fenton said he looks forward to sharing more about this with PACHA in the future.

In terms of the goals of global health protection and systems strengthening and partnership, Dr. Fenton said the Center is still responsible for a large component of global health activities and will be focusing on work with partners, including new, nontraditional partners. Last, in terms of the goal of workforce development and capacity building, Dr. Fenton said the Center is looking at deficiencies in this area and working with partners inside and outside CDC to strengthen workforces.

Dr. Fenton noted that under the six crosscutting goals are key strategies, which he will not address today.

## **NCHHSTP: A Look Ahead to 2010**

Dr. Fenton noted that in 2010:

- NCHHSTP's Strategic Plan will be released as well as its Annual Report.
- A new national Sexual Health Initiative will be launched, picking up on former Surgeon General David Satcher's report released 10 years ago, which discusses how to frame new conversations about sexual health.
- An MSM Sexual Health Initiative will be launched later this year.
- Thanks to congressional funding, the Center will be supporting jurisdictions across the country to implement Program Collaboration and Service Integration (PCSI) leadership, networking, and collaboration.
- A major Workforce Initiative will be launched across Federal agencies, looking at the connectivity between diseases and the workforce.
- A Social Determinants of Health White Paper will look at major social determinants.
- There will be a focus on community prevention and other opportunities for health system reform as well as strategic refocusing moving forward.

## **HIV Prevention Priorities**

Dr. Fenton showed three key slides regarding HIV prevention priorities.

Slide 10 provides CDC estimates of persons with HIV and awareness of HIV status in the United States as published in 2008 as follows:

- Number HIV infected: 1,106,400
- Number unaware of their HIV infection: 232,700 (21 percent)
- Estimated new infections annually: 56,300

Slide 11 provides CDC estimates of HIV prevalence from the National Health and Nutrition Examination Survey (NHANES), 1999-2002, which indicate the highest prevalence in ages 18-39 among black males (2 percent) followed by black females

(about 1 percent), and the highest prevalence in ages 40-49 again among black males (4.5 percent), followed by black females (about 2.75 percent).

Slide 12 provides CDC estimates of the percentage of new HIV infections by sex and transmission category from 2006 data from 50 States and the District of Columbia. These data indicate inequities in new infections as well as in prevalence. Dr. Fenton noted that among males, MSM had the highest estimated percentage of new infections, and that among females, the highest risk, at 80 percent, was estimated to be among women who engage in heterosexual intercourse.

Dr. Fenton noted that he provided these figures “because they will determine our prevention priorities and guide the work we’re doing in specific intervention.”

### **Division of HIV/AIDS Prevention (DHAP) Priorities**

Specific priorities for this Division are the five articulated in CDC’s proposed budget 2 years ago, as follows:

- Increase the proportion of Americans who know their HIV status
- Increase the reach of effective HIV prevention programs
- Develop new behavioral, biomedical, and structural tools for HIV prevention
- Improve policy effectiveness
- Strengthen systems to monitor HIV and to evaluate and improve HIV prevention programs.

Dr. Fenton noted that these priorities are crosscutting and guide all HIV activities across CDC.

### **Major DHAP Initiatives and PACHA**

In outlining major DHAP initiatives as follows, Dr. Fenton stressed that he looks forward to seeking PACHA’s advice on how to strengthen these initiatives moving forward.

#### **1. National HIV Testing**

**Purpose:** The purpose of CDC’s HIV testing initiative launched in 2007 is to support adoption of 2006 recommendations for HIV testing in clinical settings; increase HIV testing opportunities for populations disproportionately affected by HIV (primarily African Americans); and test more than 1 million persons annually.

**Progress:** More than 1.4 million persons had been tested by the end of August 2009, and more than 16,600 HIV diagnoses were confirmed, including more than 10,000 new diagnoses.

2. National HIV-Testing-Funded Jurisdictions: Investment has been targeted to promote testing among African Americans and, more recently, MSM, so the jurisdictions funded reflect these populations, Dr. Fenton noted.
3. Enhancing MSM HIV Prevention: Beginning in 2009, CDC has expanded and enhanced MSM HIV prevention activities as follows:
  - By funding six sites to develop and test new behavior interventions for MSM
  - By assembling experts to discuss the most recent data, theories, and prevention perspectives on serosorting among MSM
  - By cofunding an MSM sexual health research agenda-setting workshop with NIH
  - By undertaking cross-DHAP strategic planning for HIV prevention among MSM
  - By establishing a cross-CDC workgroup on MSM sexual health.
4. Act Against AIDS, launched in April 2009, is the first campaign of its type mounted in the past decade. It features:
  - A 5-year national communication and mobilization campaign in English and Spanish
  - Goals to reduce HIV incidence by refocusing attention on domestic HIV and AIDS and combating complacency; promoting awareness, targeted behavior change, and HIV testing; and strengthening and establishing networks and other partnerships to extend the reach and credibility of HIV prevention messages.
5. Identifying and Disseminating Evidence-based HIV Prevention Interventions
  - This initiative includes the Diffusion of Evidence-Based Interventions (DEBI) program, which is designed to bring science-based community, group, and individual-level HIV prevention interventions to community-based service providers and State and local health departments.
  - The initiative's goal is to enhance capacity to implement effective interventions at the State and local levels to reduce the spread of HIV and STDs and promote healthy behaviors.

- This initiative also involves publication of 69 evidence-based interventions (EBIs) in CDC's 2009 Compendium, including Best and Promising EBIs and fair representation of EBIs for People Who Use Drugs.

## **Summary: DHAP in 2010**

In summary, in 2010, DHAP will launch or will have launched:

- A new National HIV Prevention Strategy
- Transparent and effective communication of data, policy, and planning
- Improved strategies for implementing, assisting, and monitoring programs
- Infusing science and evidence-based approaches in all aspects of the Division's activities
- Prevention in health care.

## **Presentation on the National Institutes of Health Office of AIDS Research, by Jack Whitescarver, Ph.D., NIH Associate Director for AIDS Research, and Director, Office of AIDS Research**

Dr. Whitescarver noted that PACHA members have a copy of his extensive slide presentation, so he will abbreviate his presentation, which is primarily devoted to a broad overview of the National Institutes of Health (NIH), the largest supporter of biomedical research in the world.

## **NIH Institutes and Centers and Research Components**

NIH is composed of 27 Institutes and Centers dedicated to organs or diseases such as cancer (Slide 2). Interestingly, all 27 have a portfolio in HIV/AIDS research. Appropriated dollars are divided amongst extramural and intramural research (Slide 3). More than 325,000 researchers are involved in the extramural program at any given time, and about 6,000 scientists are involved in intramural work at any given time in laboratories on NIH campuses.

The intramural program is immediately in a position to begin research, and this is what happened in early investigations of AIDS.

## **NIH Peer Review Process**

Slide 4 depicts how NIH grants are awarded.

## **NIH AIDS Research Program**

Slide 5 details the NIH AIDS Research Program. Dr. Whitescarver noted that, in the early days, thought was given to establishing a separate AIDS research institute, but a decision was made not to do this because other Institutes and Centers already had AIDS research portfolios and to take those away would be too disruptive to the

research program in process. Dr. Whitescarver said the decision was wise, as AIDS is not a single disease but, rather, a constellation of diseases, malignancies, coinfections, comorbidities, and conditions. Institutes and Centers continued their AIDS research programs, and that has helped everyone, Dr. Whitescarver said, because basic research about HIV pathogenesis and how it accelerates cardiovascular disease, for example, also assists understanding of cardiovascular disease in non-AIDS individuals.

In 1993, legislation was passed to create the Office of AIDS Research (OAR) as a coordinated, unified NIH research front against the AIDS pandemic.

## **OAR**

OAR functions as an “Institute without Walls” which annually composes a trans-NIH strategic plan for AIDS research. The annual trans-NIH AIDS research budget is then linked to that strategic plan (Slides 6 and 7). Dr. Whitescarver explained that OAR does not make grants but, rather, manages multi-Institute research, fosters research through designated funds and targeted workshops, and identifies areas that require focused attention, such as the Prevention Science Initiative. In supporting workshops, think tanks, and pilot funding for small initiatives identified over the course of a given year, OAR gives a “jump start” to new activities so they can roll into the normal budget process.

## **Annual Trans-NIH Plan for HIV-Related Research and OAR Budget Development Process**

Dr. Whitescarver noted that this trans-NIH plan is reviewed by the OAR Advisory Council (OARAC), the Office of Management and Budget (OMB), and Congress and that its language is driven by outside experts, although the process begins with NIH program staff and tends to build on the plan from the year before (Slides 8 and 9). Overarching priorities of the trans-NIH strategic plan (Slide 10) are:

- Reduce HIV incidence
- Improve disease outcomes
- Reduce HIV-related disparities
- Expand basic discovery research
- Translate research from bench to bedside to community.

The annual trans-NIH plan is then used by the Institutes to generate budget requests to OAR for research they want to do where identified in the plan (Slide 11). OAR prioritizes these requests according to the plan and OAR priorities, makes selections, and along with the NIH Director, allocates budget levels to each Institute and Center. In short, “we don’t fund AIDS research by percentage increase or any kind of formulation,” Dr. Whitescarver said, adding, “some Institutes get higher

increases than others because the research they want to do in that year has a higher priority.”

In the past few years, the main research priority has been prevention, Dr. Whitescarver noted.

### **Overarching Priorities of the Trans-NIH Strategic Plan**

Slides 12-17 detail NIH efforts to reduce HIV incidence through prevention science, vaccines, microbicides, behavioral and social sciences, and treatment as prevention. Slides 18-20 detail NIH findings in terms of improving disease outcomes through research on therapeutics and AIDS and aging. Slides 21 and 22 detail NIH activities regarding reduction of HIV-related disparities. Slides 23 and 24 detail NIH's commitment to expand basic discovery research, and Slides 25-28 detail NIH's commitment to translating research from bench to bedside to community, including through support for development of state-of-the science Federal treatment and prevention guidelines published in hard copy and through *AIDSinfo* (<http://www.aidsinfo.nih.gov>).

Dr. Whitescarver highlighted Dr. Fenton's mention of DEBI and how it translates AIDS research for community and care providers. He also noted a recent meeting with the International AIDS Society in Cape Town, South Africa, on what NIH can do to fund translational research and “get it out in useful form.” Dr. Whitescarver reflected that while there is no “real definition” of this, he came away from the meeting with a series of recommendations, and OAR subsequently chose some simple definitions to get started. Slide 26—“What is implementation science in health and HIV/AIDS?”—provides the following definitions in answer to the question:

- Comparisons between two or more established interventions
- Comparison of different approaches to delivering a health intervention
- Strategies to encourage uptake of available services
- Improved processes to guide implementation and program management
- Adaptation of interventions to new populations and settings
- Cost-effectiveness modeling
- Improved methodologies to implement interventions at scale.

Dr. Whitescarver also highlighted “one obvious translation,” which is therapeutics. Herein lies the domain of the Federal Treatment and Prevention HIV Guidelines, which determine the most recent and best formulations for treatment, and not just for adults (Slides 27 and 28).

Today these Guidelines are accessed and used by care providers around the world, primarily through the *AIDSinfo* Web site, which is managed by the National

Library of Medicine with support from OAR. Last year, the site received more than 2.4 million visits and more than 9 million page views, in addition to visits to and page views from *infoSIDA*, a Spanish-language companion site.

## **Facilitating Domestic and International Collaborations**

Slide 29 shows how OAR is facilitating domestic and international collaborations.

## **Additional Information**

OAR's Web site URL is <http://www.oar.nih.gov/>.

## **Availability**

Dr. Whitescarver said he is available to the Council to provide bench or clinical science on any subject in the future when questions come up or there is a need for further information.

## **Conclusion: Where We Stand on Vaccines and Microbicides**

Dr. Whitescarver then concluded by briefly summarizing where we stand on HIV/AIDS vaccines and microbicides.

Vaccines: Dr. Whitescarver said he is happy to report that we have, for the first time, a candidate vaccine that showed some efficacy, but much work remains and more funds are needed, including for going back to basic research.

Microbicides: Dr. Whitescarver said microbicides are "a very important mode of prevention the science of which has been neglected." However, now, much science is being conducted in this area, "not as fast as we had hoped, but, nonetheless, there is one candidate that will work against HIV transmission." Now, we "just have to improve on that and learn from continued research efforts."

## **Presentation on Providing the Health Care Safety Net for People Living with HIV/AIDS, by Deborah Parham Hopson, Ph.D., R.N., FAAN, Associate Administrator, HIV/AIDS Bureau, HRSA, DHHS**

Dr. Parham Hopson noted that she is wearing the uniform of the U.S. Public Health Service because Surgeon General Regina Benjamin is one of her bosses.

## **What HRSA Has To Do with HIV/AIDS Care and Treatment**

Beginning her slide presentation, Dr. Parham Hopson noted that:

- HRSA is the primary Federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable.
- HRSA comprises six Bureaus and 13 Offices.

- HRSA provides leadership and financial support to health care providers in every State and U.S. territory.
- HRSA leadership includes Administrator Mary Wakefield, Ph.D., R.N.; Deputy Administrator Marcia Brand, Ph.D.; Senior Advisor Tina Cheatham; and Chief Public Health Officer Kyu Rhee, M.D.

## **HIV/AIDS Bureau**

As lead official of HRSA's HIV/AIDS Bureau (HAB), Dr. Parham Hopson's major responsibility is the Ryan White HIV/AIDS program, which is a large program named for an HIV-positive teenager who became an AIDS advocate and for which the Ryan White CARE Act (RWCA) was named after Ryan died.

HAB:

- Is one of six Bureaus within HRSA, formed in 1997 to consolidate oversight for all CARE Act programs
- Administers the current version of the Ryan White CARE Act, the Ryan White HIV/AIDS Treatment Extension Act of 2009, which benefits low-income, uninsured, and vulnerable persons living with HIV/AIDS
- Administers several PEPFAR programs.

## **Intent of the Ryan White HIV/AIDS Program**

The intent of the Ryan White HIV/AIDS program is:

- To increase access to care for people living with HIV disease (PLWH)
- To be the only disease-specific discretionary grant program for care and treatment of PLWH
- To act as the payer of last resort, a safety net for uninsured and low-income individuals living with HIV/AIDS
- To provide funding for primary health care, including medications, support services, technical assistance (TA), provider training, and demonstration projects.

Dr. Parham Hopson highlighted that the Ryan White HIV/AIDS program is the payer of last resort. Through this program, HRSA's HAB fills in gaps not filled by CMS programs, paying for care for those with no other way of getting care.

## **Ryan White HIV/AIDS Program**

Dr. Parham Hopson noted that this program has many parts, including Part G, which was added last year with the new reauthorization. Program parts, participants, and specific programs are:

- Part A: Cities
- Part B: States and Territories (ADAP)
- Parts C and D: Health Care Agencies (Early Intervention Services and Capacity Development and Women, Infants, Children, and Youth)
- Part F: Other Programs Dealing with Dental, Education/Training, Planning, Capacity Development and Demonstrations, and the Minority AIDS Initiative (MAI)
- Part G

## **Explication**

Dr. Parham Hopson explained that the administrative parts of the Ryan White HIV/AIDS program are Parts A through F and that “a lot of your tax dollars go to support these programs.” Slide 7 depicts the percentages of the FY 2009 Ryan White HIV/AIDS program appropriation of \$2.24 billion devoted to each part.

Dr. Parham Hopson said the FY 2010 appropriation is \$2.9 billion, and while she has not calculated the proposed FY 2011 percentages per program, the total amount proposed is the same “or has gone up.”

Dr. Parham Hopson noted that the largest percentage of Ryan White program dollars go to ADAP. ADAP dollars flow to the States, the District of Columbia, and U.S. Territories for the most part mainly to pay for medications (Slide 11). More than 160,000 individuals receive medications through ADAP each year. Some of the smaller ADAP States, such as Utah and Montana, have low incidence levels and therefore receive fewer ADAP dollars. At present, 11 States have waiting lists of more than 100. FY 2009 money was spent through the end of March 2009. FY 2010 money will go out later, and it is hoped that it can be used to clear waiting lists.

HAB retains fund case managers in the waiting list States, and these case managers work with those on the list to make sure they can access medications, often through the pharmaceutical companies, Dr. Parham said. In short, “we work with those on waiting lists to make sure they get their medications while waiting.”

## **Comments/Questions**

- A PACHA member commented that not only States with low incidence are affected but also limited revenue States on both the East and West Coasts, California being one.
- Dr. Parham Hopson responded that most States are fiscally challenged right now, but some are putting together funds for ADAP in any way they can.
- In response to a question about the total number on the waiting lists (428 in 11 States was mentioned), Dr. Parham Hopson said North Carolina is the

newest State with a waiting list and that waiting lists are prevalent primarily in low-incidence States.

- In response to a question about whether any of the States have money left over, Dr. Parham Hopson said that if States do not spend all the money they have been allocated, HRSA can recapture that and give it out elsewhere. However, States have become very sophisticated in spending their allocations.

## **Ryan White HIV/AIDS Program: Parts C and D**

Slide 12 details Part C of the Ryan White HIV/AIDS program. Slide 13 details Part D.

## **Core Medical Services for Parts A, B, and C and Support Services**

Slide 14 details core medical services for Parts A, B, and C. Dr. Parham Hopson noted that 75 percent of funds for these Parts must be spent on these services. Examples of support services funded by many grantees (Slide 15) include:

- Outreach
- Medical transportation
- Emergency housing assistance
- Health insurance continuation
- Legal services
- Child care
- Respite services
- Psychosocial support services.

## **Ryan White HIV/AIDS Program—Part F/Special Projects of National Significance (SPNS)**

Slide 16 shows how Part F provides funds for the following:

- Innovative models of care and support in the development of effective delivery systems for HIV care
- Dissemination of successful models for replication and integration of Ryan White-funded grantees
- Development of a standard client-level data system (beginning in 2007).

## **Current SPNS Initiatives**

Current SPNS initiatives (Slide 17) include:

- Developing innovative models of care to provide oral health care to HIV-positive, underserved populations (through 2011)
- Enhancement and evaluation of existing health information electronic network systems for PLWH in underserved communities (through 2011)
- Enhancement of access to HIV primary care in jail settings (through 2011)
- Capacity building to develop standard electronic information data systems (2009)
- Enhancement of access to and retention in quality HIV primary care for women of color (through 2013)
- Enhancement of access to and retention in quality HIV primary care for young MSM of color.

Dr. Parham Hopson said that finding and getting those into care is a “real challenge.” Here, HRSA has had “some successes and some failures.”

## **Ryan White HIV/AIDS Program—Part F/Training**

Slide 18 details Ryan White HIV/AIDS program Part F and training, as follows:

- The AIDS Education and Training Center (AETC) program supports a network of 111 regional centers (and more than 130 local, associated sites) that conduct targeted, multidisciplinary education and training programs for health care providers treating PLWH.
- The AETCs providing training in all States, U.S. Territories, and the District of Columbia, Puerto Rico, and the Virgin Islands.
- Part F also funds four national centers: the National Clinicians Consultation Center, the National Resource Center, the National Evaluation Center, and the National Minority AIDS Center

## **Ryan White HIV/AIDS Program—Part F/Dental**

- The Dental Reimbursement Program expands access to oral health care for PLWH while training additional dental and dental hygiene providers.
- Reimbursements are provided to dental schools, schools of dental hygiene, and postdoctoral dental education programs.
- The Community-Based Dental Partnership Program provides oral health services to PLWH via cooperative projects with community-based providers of oral health services.

- Currently, Part F funds 57 Dental Reimbursement Programs in 20 States and the District of Columbia and 12 Community-Based Dental Partnership Programs in 11 States.

## **How Ryan White Program Dollars Are Allocated**

Slide 20 provides 2006 data on how Ryan White program dollars are allocated. The slide shows that ADAP has the highest allocation, at 41 percent of the total.

## **Ryan White Program Accomplishments**

- Most Ryan White program funding goes to care, treatment, and support services provided to about half of the PLWH in the United States. Of the estimated 1 million to 1.2 million people living with HIV and AIDS in the United States, the Ryan White program has served more than 529,000 of those who are uninsured or underinsured.
- HRSA/HAB has built networks and systems of care with and between public and private providers for a comprehensive response to the epidemic.
- HRSA/HAB has extended its knowledge base and expertise to improve the quality of HIV/AIDS care and treatment across the health care system.

## **Meetings in 2010**

Dr. Parham Hopson noted that 2010 marks the 20th anniversary of the Ryan White CARE Act, a fact that will be celebrated at the next HAB all-grantee training and TA meeting to be held August 23-26 at the Marriott Wardman Park Hotel in Washington, D.C. These meetings are held biannually.

HAB also holds a clinical conference annually for HIV medical care providers working in Ryan White programs. Every other year, this conference is combined with the all-grantee meeting.

## **Conclusion**

Concluding, Dr. Parham Hopson noted that the rest of her slides, 23-28, deal primarily with the HRSA/HAB Global HIV/AIDS Program. Slides 27 and 28 in particular detail HRSA/HAB's International HIV/AIDS Portfolio.

## **Presentation on Substance Abuse and Mental Health Services Administration (SAMHSA) Minority AIDS Initiative (MAI), by Claudia Richards, M.S.W., LICSW, Chief, Community Grants and Program Development Branch, Center for Substance Abuse Prevention, SAMHSA**

Ms. Richards began her slide presentation by noting she is filling in for PACHA Ex Officio Member Beverly Watts Davis, who is Senior Advisor to the SAMHSA Administrator.

## **SAMHSA's Agency Background**

- SAMHSA was established in 1992 and reauthorized in 2000.
- SAMHSA administers a combination of competitive, formula, and block grant programs and data collection activities.
- Programs are carried out through the Centers for Substance Abuse Prevention (CSAP), for Substance Abuse Treatment (CSAT), and for Mental Health Services (CMHS).

## **SAMHSA's Vision**

The Agency's vision, which "we take into the field," Ms. Richards noted, is: "A life in the community for everyone based upon the principle that people of all ages with or at risk for substance abuse disorders and mental illness should have the opportunity for a fulfilling life that includes a job, home, and meaningful relationships with family and friends."

## **SAMHSA Goals and Objectives**

SAMHSA's goals include:

- Increasing access by racial and ethnic minority communities to HIV prevention, care, and treatment services
- Implementing strategies and activities specifically targeted to the highest risk and hardest-to-serve populations
- Establishing collaborations, partnerships, or opportunities for such for programs and/or activities to be integrated.

SAMHSA's objectives include:

- Increasing testing of affected minority populations
- Capacity building
- Sustainability.

Ms. Richards noted that the focus of her presentation today would be on the second objective, and that SAMHSA has been focusing on increasing HIV/AIDS capacity for the past 5 years. In this regard, the third objective is now required of all grantees as well as use of evidence-based approaches.

## **New Administrator**

SAMHSA's new Administrator, Pamela S. Hyde, has been in place since December 2009 (see Slide 5 for background and priorities).

## **SAMHSA and Congressional Funding for MAI**

- The purpose of the CSAT Targeted Capacity Expansion and HIV Services (TCE/HIV) grant program is to enhance and expand substance abuse (SA) treatment and/or outreach and pretreatment services in conjunction with HIV/AIDS services. These grants require that, at a minimum, 80 percent of all clients be tested for HIV/AIDS.
- The purpose of the CSAP TCE/HIV grant program is to assist communities in expanding existing HIV/AIDS and SA prevention services.
- The purpose of the Department of Mental Health HIV/AIDS Minority Mental Health Services (DMHS HIV/AIDS) grant program is to increase capacity to provide culturally competent mental health treatment services to individuals living with HIV/AIDS.

## **SAMHSA MAI Funding**

Slide 8 shows the MAI funding received by SAMHSA's three Centers in FY 2008 and FY 2009. In FY 2009, CSAP and CSAT received slight increases, but for years before that, the budget was all "pretty consistent and flat," Ms. Richards said.

## **Focus on CSAP MAI**

Ms. Richards turned to her Center's MAI, the purpose, objectives, and funding for which are as follows:

- Increase access to the nexus of SA and HIV prevention services by highest risk and hardest-to-serve racial and ethnic minority populations and communities, with the objectives of:
  - Increasing access of racial and ethnic minority communities to HIV prevention, care, and treatment services;
  - Implementing strategies and activities specifically targeted to the highest risk and hardest-to-serve minority populations; and
  - Establishing collaborations, partnerships, and opportunities for such for programs and activities to be integrated.
- Funding: \$5.09 million.

## **CSAP's MAI Portfolio**

Slide 10 details CSAP's MAI portfolio of grantee awards, activities, and award amounts, including for grants that will end in fiscal years 2010, 2013, and 2014. Ms. Richards noted that Cohort 6 on the slide is minority and minority reentry populations, and Cohorts 7 and 8 are minorities at risk reentry populations, including MSM, adolescents, and other gender- and age-specific populations.

Slide 11, a grant distribution map, shows how CSAP's grants target communities in greatest need.

### **CSAT Targeted Capacity Expansion Rapid HIV Testing Initiative**

Ms. Richards turned to a recent supplementally funded initiative within CSAT to expand rapid testing.

The purpose, objectives, outcomes, and funding for the Targeted Capacity Expansion Rapid HIV Testing Initiative are:

- Purpose—to augment existing SA treatment providers with rapid HIV testing services to increase access for testing to racial and ethnic populations
- Objectives—to develop rapid HIV testing (RHT) protocols to include the production, dissemination, and tracking of rapid testing forms conducted by 49 grantees
- Outcomes—preliminary RHT results from Cohort III TCE-HIV grantees include administration of 1,312 tests at program entry/intake and an HIV-positive rate for new testers entering treatment of 2.8 percent.
- Funding: \$350,000.

### **CMHS Mental Health HIV/AIDS Services Collaborative (MHHSC) Program**

The purpose, objectives, outcomes, and funding for the MHHSC program are:

- Purpose—expand effective, culturally competent care in minority communities for persons with HIV/AIDS and with a mental health need
- Objectives—Target unmet mental health treatment needs of individuals living with HIV/AIDS who are African American, Hispanic/Latino, and/or from other racial ethnic minority communities, and strengthen the capacity of community-based entities to provide culturally appropriate/competent mental health treatment services targeted to African American, Hispanic/Latino, and/or other racial ethnic minority communities.
- Funding: \$4.4 million annually for 5 years ending September 2011.

### **Mental Health HIV/AIDS Services Collaborative (MHHSC) Program Demographics and Outcomes**

Ms. Richards noted that the MHHSC program current target population is 60 percent African American, 20 percent white, 8 percent multiracial, 1 percent Asian, 1 percent Native American, and 10 percent other.

MHHSC outcomes include:

- More than 5,000 individuals with HIV and mental health problems were served in Cohort I (FY 2001-FY 2006).
- More than 3,000 individuals with HIV/AIDS and mental health problems were or are being served in Cohort II (FY 2006-FY 2010).
- Nearly 100 percent of consumers served by this program reported positive perceptions of care. There also was evidence of strong improvements in social connectedness and client perception of their functioning.

### **SAMHSA: Secretariat Emergency Funds**

Ms. Richards provided a “snapshot” of expenditures of these funds, beginning with the CSAP Minority Education Institution (MEI), which was a small, \$1.1 million program and is now funded at the \$5 million level.

### **CSAP MEI**

Slide 17 details the universities and colleges that participated in the MEI program from 2005 to 2009. Slide 18 details outcomes in terms of the total number of HIV tests administered on participating campuses since the program began, which peaked at 7,348 in 2009. Ms. Richards commented that other positive outcomes were seen in terms of building capacity on participating campuses and that students had expressed a great need and demand for testing.

### **Tribal Colleges/Universities Initiative**

Ms. Richards noted that the MEI program was recently expanded through the leadership of Ms. Watts Davis. The expanded initiative currently involves seven Tribal colleges and universities (see Slide 21 for the list) and use of a student peer educator approach to build capacity to provide SA, HIV, and hepatitis prevention among Native American students.

Goals, key activities, and awards total to date for this initiative are:

- Goals—increase the number of individuals who know their HIV/AIDS status through testing, and increase the number of individuals who are referred for care and treatment.
- Key Activities—engage student peer educators; conduct broader outreach to Tribal communities; and conduct National Native HIV/AIDS Awareness Day, World AIDS Day, and National HIV Testing Day events.
- Awards total to date: \$90,000.

### **American Indian/Alaska Native (AI/AN) HIV/AIDS Initiative**

Ms. Richards noted that under this 2010 initiative, affiliated Tribes are expected to work together to expand the breadth of their services. The initiative’s purpose and goals are the same as the Tribal colleges/universities initiative, but key activities

are slightly different and include conducting HIV testing and referral as well as outreach to Tribal communities and conducting National AIDS Awareness Day events.

Slide 23 shows the 10 member Tribes currently engaged in this initiative.

### **American Indians/Alaska Natives (AI/AN) Rapid Testing Initiative (CSAT)**

Ms. Richards noted that for the purposes of this initiative, HRSA worked closely with the Indian Health Service (IHS) to expand outreach, education, stigma reduction, and prevention and treatment for American Indians and Alaska Natives at risk for SA and HIV/AIDS.

Initiative outcomes include provision of 50,000 rapid HIV test kits and control kits to Tribes, Tribal Organizations, and urban Indian Health Clinics along with training and TA.

### **Enhancing Substance Abuse Treatment Services To Address Hepatitis Infection in Injection Drug Users (IDUs) (CSAT)**

Ms. Richards noted that this 4-year ongoing program to prevent hepatitis infection among IDUs and reduce risk for HIV transmission basically provides a cost-effectiveness methodology to identify patients in need of hepatitis A, B, or both vaccines and screens for hepatitis C (HCV). The program has provided 7,920 vaccinations for use primarily in methadone clinics across the Nation. At present, the program is funded at \$1 million.

### **One SAMHSA Institute**

The purpose, objectives, outcomes, and funding of this event were:

- Purpose—unite, connect, and expand the capacity of MAI grantees to collaborate for increased access and use of HIV/AIDS, SA prevention and treatment, and mental health services for minority populations.
- Objectives—increase access of racial and ethnic minority communities to HIV prevention and care and treatment services, and establish collaborations, partnerships, or opportunities for such for programs or activities to be integrated and leveraged.
- Outcomes—facilitation of improved networking opportunities among SAMHSA-funded grantees with each other and with the broader HIV/AIDS field, and 100 percent attendance by all 571 SAMHSA HIV/AIDS grantees.
- Funding: \$350,000.

## **Faith and Community Support Initiative**

The purpose, objectives, outcomes to date, and funding for this initiative are:

- Purpose—strengthen the capacity of faith-based and grassroots organizations to deliver high-quality HIV health care and supportive services.
- Objectives—increase the number of individuals who receive SA and HIV education through faith organizations by 25 percent, and recruit and engage churches with the capacity to conduct widespread HIV awareness and outreach.
- Outcomes—from November 2008 to September 2009, reached more than 200,000 people through media and community outreach activities; delivered more than 400 clergy- and faith-based capacity building training events, reaching 6,783 participants from 1,183 churches; and made more than 125,000 HIV testing referrals as well as conducted 96,801 counseling engagements, reaching nearly 787,000 participants.
- Funding: \$2 million.

## **MSM Outline Curriculum**

The purpose, objective, and funding of this second-year pilot program are:

- Purpose—develop an online curriculum on SA disorders treatment for minority MSM at risk for HIV.
- Objective—increase awareness and knowledge that will enable addiction treatment providers to more effectively meet the needs of culturally specific subpopulations.
- Funding: \$500,000.

## **Presentation on CMS Initiatives Related to HIV/AIDS, by Barbara Edwards, M.P.P., Director, Disabled and Elderly Health Programs Group, Center for Medicaid and State Operations, CMS**

Ms. Edwards noted that she has been with CMS for a month and that she is responsible for the program in Medicaid for those in need of long-term care, which constitutes a broad range of chronic and disabled conditions. She provided a fact sheet.

## **Background**

Background highlights include:

- Medicare and Medicaid (Federal portion only) account for \$9.8 billion or approximately 50 percent of projected FY 2010 Federal expenditures for domestic programs and research related to HIV/AIDS. Federal Medicaid

expenditures comprise about half of that \$9.8 billion. Related State Medicaid expenditures amounted to \$2.7 billion in 2009.

- CMS is by far the largest single Federal payer. NIH and the Ryan White program administered by HRSA are second and third, with expenditures of \$2.6 billion and \$2.3 billion respectively.
- Medicaid is the single largest source of care for individuals with HIV/AIDS receiving treatment in the United States. An estimated 4 in 10 HIV/AIDS patients receive services through Medicaid.
- Individuals with HIV/AIDS are often eligible for Medicaid because they have low income and/or because they are considered permanently disabled.
- Medical treatment advances have moved HIV/AIDS from an epidemic status to a disease management approach.

## **Medicare HIV Testing**

Medicare HIV testing highlights include:

- Under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), CMS announced last December that Medicare enrollees will be covered for tests that screen for HIV. This coverage is an important step for protecting beneficiaries from the potentially life-threatening complications of HIV/AIDS.
- Medicare will cover tests to detect HIV for beneficiaries who are at increased risk for the infection and for those who voluntarily request the test.

## **Medicaid Coverage of HIV Testing**

Medicaid coverage of HIV testing highlights include:

- A State Health Official Letter released in late June of last year emphasized that Medicaid-eligible adults are covered for medically necessary HIV testing through the mandatory laboratory benefit (under the Social Security Act). The Letter also mentions the States' option of covering routine HIV testing of Medicaid-eligible adults as a preventive screening benefit (under the Social Security Act).
- The Early Periodic Screening Diagnostic and Treatment (EPSDT) benefit enables Medicaid-eligible children under age 21 to be tested for HIV, including routine testing as part of a well-child exam as well as for medically necessary HIV testing.
- States with a CHIP Medicaid extension cover HIV testing in the same way as described above.

## **HIV/AIDS Initiatives Under Medicaid State Plans**

HIV/AIDS initiatives under Medicaid State plans highlights include:

- Medicaid-eligible individuals with HIV/AIDS can receive the full array of Medicaid services, including prescription drugs.
- Medicaid provides long-term services and support for those with long-term-care needs. States have been developing community-based programs as an alternative to institutional settings such as hospitals and nursing homes.
- Thirteen States have established community-based programs, including for individuals with HIV/AIDS, which can include a range of services, and New York State provides Adult Day Health Center (ADHC) services under the Clinic benefit targeted to individuals with HIV/AIDS.

## **Section 1115 Demonstrations**

Section 1115 demonstrations highlights include:

- Hawaii, Maine, and the District of Columbia (D.C.) have been authorized by CMS to conduct demonstration projects targeted to serving individuals with HIV/AIDS.
- The D.C. demonstration project was approved in 2001 and implemented in 2005. Current approval expires June 30, 2010. The project provides full Medicaid benefits to uninsured D.C. residents who are HIV-positive and whose incomes are at or below 100 percent of the Federal poverty guidelines. The project's goal is to provide more effective, early treatment of HIV disease and thereby reduce expensive hospitalizations and improve quality of life. About 325 individuals are enrolled in the demonstration at an annual cost of about \$1.5 million.
- The Maine demonstration project was approved in 2000 and implemented in 2002. Current approval expires June 30, 2010. The project applies rigorous care protocols to totally disabled Medicaid recipients under 100 percent Federal poverty level (FPL) with the goal of delaying the onset of full-blown AIDS and using those savings to expand coverage to uninsured, low-income individuals living with HIV. Expanded coverage provides a comprehensive benefits package, including all ARV therapies to individuals not otherwise eligible for Medicaid but who are HIV-positive and at or below 250 percent of FPL. The demonstration's primary goal is to arrest progression of HIV/AIDS by providing early and optimal care coupled with high quality and cost efficiency. About 600 individuals are enrolled in the demonstration at an annual cost of about \$9 million.

## **Another Medicaid Option**

The 40 States that subscribe to the premium buy-in option can allow Medicaid recipients with disability who can return to work to do so without danger of losing

Medicaid services and support. Ms. Edwards called this “an important step forward in offering substantial coverages for those who would otherwise be disqualified.”

## **Demonstration To Maintain Independence and Employment (DMIE)**

Ms. Edwards briefly mentioned CMS’ conduct of a DMIE in D.C. designed to test the hypothesis that providing health care and other services early in the progression of a disease may delay loss of a person’s ability to be self-sufficient and delay the onset of cash assistance. Services provided during the demonstration included full Medicaid benefits to those who were not officially disabled but who had a potentially disabling condition. Most of the beneficiaries had prescriptions for ARV medications.

A final report summarizing study results as well as demonstrations conducted in five States (on non-HIV populations) is expected in March 2010.

## **Conclusion**

Concluding her presentation, Ms. Edwards noted that through her Office, CMS provides TA to States interested in engaging in demonstrations such as those mentioned in her presentation and in changing some aspects of their long-term programs under Medicaid. One of her staff’s goals is trying to develop more tools for States to mount better programs and services to serve people long term in their homes and their communities.

Ms. Edwards added that she welcomes this opportunity to join forces to work with Federal colleagues and with PACHA.

## **Presentation on Promoting Stable Housing Outcomes and Access to Care, by David Vos, Director, Office of HIV/AIDS Housing, HUD**

Mr. Vos began his slide presentation by expressing the hope that the idea of helping others will inform all of our work moving forward.

The story of the programs administered by his Office is that stable housing makes a difference in lives and health outcomes. In addition, analyses by his Office (commonly referred to as HOPWA) and by CDC and Johns Hopkins can show that stable housing is cost-effective.

## **HUD’s Mission**

Mr. Vos noted HUD’s formal mission (Slide 2), which states commitment to creating affordable housing opportunities for many Americans in need, including, specifically, “people living with AIDS.” HUD’s mission, too, is to promote economic and community development “as well as enforce...the Nation’s fair housing laws.” In short, HUD’s goal is decent, safe, affordable housing. For those living with AIDS, “all of HUD needs to be part of the solution,” Mr. Vos said.

In the past year, HUD Secretary Shaun Donovan has talked about a greater focus on results and how to address special needs. Specifically, as part of HUD's Strategic Planning for 2010-2015, there is new focus in policy and programmatic priorities on special needs and new focus on goals and performance objectives. Public comments will be solicited on HUD's 2010 specific plans in this and other regards (Slide 3).

### **FY 2010 HOPWA Funding**

HOPWA received a \$335 million appropriation in FY 2010, an increase of 8.1 percent. Of that, some \$298 million will be devoted to formula grants and \$33 million to model program renewals on a competitive basis. In addition, \$3.4 million will be devoted to TA as part of the HUD Transformation Initiative, which Mr. Vos explained would take a holistic, whole-community supportive approach (Slide 4).

### **FY 2011 Proposed Budget**

Mr. Vos noted from a handout that the President's just-released budget for FY 2011 proposes using housing as a platform for improving quality of life by asking Congress to provide:

- An additional \$2.1 billion to assist 2.3 million families in public and assisted housing with 78,000 additional housing vouchers
- An additional \$350 million for Transformation Rental Assistance to vulnerable households.

The President's request also contains an additional \$200 million for a commitment to prevent and end homelessness that involves long-term savings through special needs partnerships with other Federal agencies and up to 10,000 new units of permanent housing.

In addition, the President's request calls for a \$150 million investment in sustainable communities with inclusive, local capacity.

### **FY 2010 HOPWA Grants**

Formula allocations for 133 areas are based on AIDS surveillance data by Metropolitan Statistical Area (MSA) and AIDS incidence data for 29 MSAs with higher-than-average incidence. Slide 5 notes the number of grants and the range of award amounts, and Slide 6 notes formula grantees in 123 localities in 40 States, Puerto Rico, 81 cities, and Wake County. [PACHA: PLEASE CONFIRM WAKE COUNTY HERE; WE HAVE NOT BEEN ABLE TO DO SO.] Mr. Vos noted it is likely that 10 cities will make arrangements to have their States administer HOPWA funds in their MSAs. Grantee administering agencies include:

- 71 housing and community development, economic development, and planning agencies
- 33 health departments

- 10 social services/human welfare agencies
- 6 management agencies
- 3 housing authorities.

### **Partnership in Service Delivery**

Mr. Vos noted that there are 958 formula project sponsors ranging from nonprofit organizations, including faith-based organizations, to housing authorities, health departments, local governments, and so on (Slide 7). He noted his Office's goal of reaching more housing authorities who feel "they have no responsibility for people living with AIDS." He also noted that more than 40 percent of sponsors receive less than \$100,000.

### **Use of HOPWA Resources**

Mr. Vos noted that eligibility for HOPWA resources by low-income PLWH/A households is "very flexible" (80 percent of area median incomes). Other aspects of how HOPWA resources are used include:

- Assistance with housing support (rental assistance, community residences) and supportive services (case management)
- Targeting of assistance to persons with lowest incomes (83 percent of beneficiaries have extremely low incomes and 12 percent very low incomes)
- A diversity of beneficiaries (54 percent black/African American; 40 percent white; 6 percent other or multiracial; and 11 percent Hispanic ethnicity).

### **Assessment of Housing Status and HOPWA Results**

Mr. Vos noted that everyone who comes into the HOPWA system is assessed in terms of their housing and service needs (Slide 10).

HOPWA performance reports through FY 2009 (Slides 11 and 12) indicate that:

- 23,862 households are being assisted with permanent housing.
- 34,505 households are in short-term and transitional housing.
- 39,932 households are in leveraged housing (through State, local, or private sources).
- Among those in permanent housing, 94 percent of the households achieved housing stability.
- Among those in short-term and transitional housing, 92 percent of the households have stable outcomes or reduced risks of homelessness, but high percentages of those in certain programs expect to experience ongoing housing needs.

## **HOPWA Expenditures by Type of Activity/Costs by Type of Housing**

Mr. Vos noted Slides 13 and 14 on these two topics, emphasizing that 60 percent of HOPWA expenditures go to housing assistance through rent subsidies, and 52 percent of housing type provided is tenant-based rental assistance.

## **Access to Care Results**

Mr. Vos noted that according to FY 2008-2009 data (Slide 15):

- 87 percent of HOPWA beneficiaries have a housing plan for maintaining or establishing stable, ongoing housing.
- 88 percent have contact with case managers/benefits counselors consistent with the schedule in the client's service plan.
- 80 percent have contact with a primary health care provider consistent with the schedule in the client's individual service plan.
- 78 percent have accessed and can maintain medical insurance or medical assistance.
- 68 percent have successfully accessed or maintained qualification for sources of income.

## **Coordination with Related HUD Programs**

Mr. Vos noted that in addition to new resources proposed in the President's FY 2011 budget, the President's stimulus package included \$5.5 billion in Homelessness Prevention and Rapid Re-Housing and Neighborhood Stabilization programs that "can be or should be tapped for HOPWA clients." (Slide 16)

## **Conclusion**

Concluding, Mr. Vos noted Transformation Initiative ideas being put into place across HUD that include:

- Addressing practitioner assistance and capacity building through holistic approaches in communities, analysis of needs and targeting of responses, measuring performance and accountability in results, and core competencies
- Compliance policies, requirements, contracts, and management and fiscal controls
- Partnerships, such as the HOPWA SOAR curriculum to expedite Social Security Income (SSI)/SS Disability Income (SSDI) outreach, access, and recovery in 11 areas.

## **Presentation Delayed**

Due to impending weather-related complications, PACHA Ex Officio Member Ann Gavaghan's slide presentation on the President's Emergency Plan for AIDS Relief was held over until the next PACHA meeting. Ms. Gavaghan, M.P.H., is Special Assistant for Policy to Global AIDS Ambassador Eric Goosby in the Office of the U.S. Global AIDS Coordinator (OGAC).

Ms. Gavaghan provided the following URLs for members wishing to access information on PEPFAR before the next meeting: <http://www.PEPFAR.gov>, <http://www.facebook.com/PEPFAR>, and <http://twitter.com/USPEPFAR>.

## **Closing Remarks by Mr. Bates**

Mr. Bates gave PACHA members their Subcommittee assignments.

## **Meetings Calendar**

Mr. Bates noted that due to the weather, discussion would not be held today on the calendar for future PACHA meetings. Instead, his Office will send to members in the next few days a questionnaire that will help his staff pare down the options for future meetings commensurate with members' schedules. This initial questionnaire will deal only with the full face-to-face PACHA meeting schedule. After that, a schedule will be pulled together in a similar fashion for Subcommittee meetings.

## **Questions/Comments**

Responding to members' questions, Mr. Bates noted that:

- Copies of any presentations given today that were not in the meeting binder will be sent to members via FedEx within a day.
- The initial meeting calendar will be for full Council meetings for the remainder of this year, and every effort will be made to accommodate members.
- Switches in members' Subcommittee assignments might be made in some situations.
- Members who wish to be on more than one Subcommittee should contact Mr. Bates.
- Presenters' contact information was usually provided at the end of each presentation, but members who need more information should contact Mr. Bates.
- In terms of response to public comments made today, some of which contained requests for PACHA's assistance, Mr. Bates' Office is aware of many of these requests, and the minutes of this meeting will assist PACHA's response. All the public comments will be captured in those minutes, which

will be provided to PACHA members as well as mounted on PACHA's Web site.

- In terms of future communications, Mr. Bates' Office will construct phone and e-mail address contact information for all members, and all members will have access to that contact information.

### **Closing Remarks by Mr. Crowley**

Mr. Crowley thanked the PACHA leadership, Mr. Bates, and PACHA Committee Manager Melvin Joppy as well as his staff for organizing the meeting. He thanked all PACHA members in advance for their service, adding that he looks forward to an ongoing relationship with them. He noted that since her appointment last August, Dr. Gayle already has been serving as a key counselor to his Office.

Mr. Crowley closed by noting that we all have a significant opportunity to collectively address national and global HIV/AIDS issues and, collectively, to move forward in a significant way.

### **Adjournment**

Before adjourning the meeting, Mr. Bates urged PACHA members to think as "broadly as possible." He encouraged members not to return to believing that they have to think narrowly, because it will be "big, creative, new, and visionary thinking that will move our epidemic and, hopefully, bring us some relief."

Mr. Bates then adjourned the meeting.