

**THE HEALTH RESOURCES AND SERVICES
ADMINISTRATION**

and

CENTERS FOR DISEASE CONTROL AND PREVENTION

convene the

**CDC/HRSA ADVISORY COMMITTEE ON HIV AND STD
PREVENTION AND TREATMENT**

***Bethesda, MD
November 20 – 21, 2003***

Record of the Proceedings

TABLE OF CONTENTS

November 21, 2003

List of Members and Participants.....	2
Introductions and Welcome	4
Update – HRSA’s HIV Care and Support Programs	4
Update - CDC’s HIV and STD Prevention Programs	4
IOM Reports	6
HRSA’s CARE Act Programs: CARE Act Reauthorization Update	7
Discussion of Recommendations by CARE Act Reauthorization Workgroup.....	8

November 21, 2003

Advancing HIV Prevention: New Strategies for a Changing Epidemic	21
Trends in STD Surveillance and Syphilis Elimination	24
Old Business: HIV/STD Integration Workgroup	26
Agenda Items/Dates for Next Meeting	26
Public Comment	26
Wrap-up and Adjournment.....	26

CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment

Members in Attendance

Terje Anderson, M.S.W.
A. Cornelius Baker
Renee Cobos, M.D.
Carlos Del Rio, M.D.
David Farabee, Ph.D.
Robert Fullilove, Ed. D.
Donna Futterman, M.D.
Deliana Garcia
Gale Grant, M.A., C.P.P.
Thomas Liberti
Ron MacInnis, M.P.H
Dorothy Mann
Sandra McDonald
Jean Flatley McGuire, Ph.D.
Freda Bush McKissic, M.D.
Jesse Milan, Jr., J.D.
Judy Goforth Parker, Ph.D. R.N.
M. Keith Rawlings, M.D.
Alejandro Torrez
Mildred Williamson, Ph.D., M.S.W.

HRSA Representatives

Amy Barkin
Barbara Braden
Bea Millie Brown
Tanesha Burley
Yolanda Cavalier
Loise Eldred
Shelley Gordon
Joan Holloway
Michelle Jackson
Damon Smith
Helen Rovito

Members Not in Attendance

Patricia Fleming
Loretta Sweet Jermott, Ph.D.
Arnold Perkins
Beny J. Primm, M.D.
Stephen Tabet, M.D., M.P.H.
Michael Tapper, M.D.
Antonia Villaruel, Ph.D.

Designated Federal Officials

Ronald Valdiserri, M.D., M.P.H.
Executive Secretary

Elizabeth Duke, Ph.D.
Executive Secretary

CDC Representatives

Chris Cagle
Ann Cronin
Paulette Ford-Knights
Sean David Griffiths
Tim Hack
Lisa Lee

Federal Liaisons

Paul Gaist, NIH
Randy Graydon, CMS
Daniel Simpson, IHS

Presenters

John Douglas, M.D. (CDC)
Harold Jaffe, M.D. (CDC)
Ida Onorato, M.D. (CDC)
Deborah Parham, Ph.D., M.S.P.H., R.N. (HRSA)
Raul Romaguera, M.D. (CDC)
Steven Young, M.S.P.H. (HRSA)

Audience Participants

Christopher Bates, HHS
Gene Copello, Title I, Florida
Donna Crews, AIDS Action
Mark Del Monte, AIDS Alliance for Children, Youth & Families
James Driscoll, AHF
Mat Dunn, Mayatech Corporation
Gary Garcia, BETAH Associates
Beatriz Gil, AIDS Alliance for Children, Youth & Families
Laura Hanen, NASTAD
David Harvey, AIDS Alliance for Children, Youth & Families
Ann Lefert, NASTAD
Brent Minor, Alexandria Commission on HIV/AIDS
Myla Moss, American Dental Education Association
Aaron Park, HHS
Esmeralda Pereira, HHS
Jessica Pollak, Maryland AIDS Administration
Gary Ross, Title II CANN
Carl Schmid, AIDS Institute
Greg Smiley, American Academy of HIV Medicine
Michael Stevens, AIDS Alliance for Children, Youth & Families
Jessica Tytel, AIDS Action
Andrea Weddle, HIV Medicine Association

Introductions and Welcome

The CDC/HRSA Advisory Committee on HIV and STD Prevention held their bi-annual meeting in Bethesda, MD on November 20-21, 2003. CHAC Co-Chairs Jesse Milan, Jr., J.D. and Robert Fullilove, Ed.D. welcomed committee members and public observers to the meeting. Ron Valdiserri, M.D., M.P.H., Deputy Director of the National Center for HIV, STD, & TB Prevention (NCHSTP), spoke of the merger of two previously separate advisory committees of CDC and HRSA as an expression of the agencies' commitment to better linking HIV/AIDS care and prevention services.

Dr. Valdiserri announced that the meeting would be the last for three members who had previously served on the CDC advisory committee, and thanked them for their service to the Federal government and their commitment to people living with HIV/AIDS. They are:

- Mr. Arnold Perkins
- Dr. Renee Cobos
- Dr. Carlos Del Rio

Dr. Valdiserri announced that the following three members had had their terms extended until November 2004:

- Dr. Robert Fullilove
- Ms. Dorothy Mann
- Mr. Cornelius Baker

Elizabeth Duke, Ph.D., HRSA Administrator thanked the committee for their efforts to secure public input on the development of recommendations for the reauthorization of the CARE Act. "I appreciate the committee's leadership in that endeavor," she said and noted the departure of several additional members of the former HRSA AIDS Advisory Committee, whom she thanked for their efforts, their expertise and their dedication to serving people living with HIV. They are:

- Dr. Keith Rawlings
- Mr. Terje Anderson
- Dr. Donna Futterman
- Dr. Judy Goforth Parker
- Ms. Sandra McDonald
- Mr. Jesse Milan, Jr.
- Dr. Steven Tabet
- Dr. Mildred Williamson
- Ms. Deliana Garcia

Update – HRSA's HIV Care and Support Programs

Deborah Parham, Ph.D., Administrator of HRSA's HIV/AIDS Bureau (HAB) welcomed committee members to the meeting and announced that Steven Young, formerly of the Office of Science and Epidemiology, would be assuming the position of Director of Training and Technical Assistance. He would replace Angela Powell, who would be relocating to Denver for a position with the Office of Performance Review.

Dr. Duke then addressed the group, saying it was great to have representatives from surveillance, prevention, care, and treatment serving on the committee. She provided a brief update on HRSA's HIV/AIDS programs.

HRSA is spending \$2 billion per year on HIV, making it the largest program within the agency. Half of clients served earn less than \$25,000 per year, a sum almost equal to a year's supply of AIDS drugs. Of all clients, 47% are African American, 2% are Hispanic and 1/3 are women.

HRSA efforts to work more collaboratively with CDC are ongoing and include responding to CDC's new initiative to conduct prevention efforts with HIV-positive individuals. She announced a joint HRSA-CDC meeting in Atlanta the following Monday to discuss strategies for incorporating prevention into primary care settings. Additionally, the two agencies are working jointly to address international needs through the Global AIDS Program, for which HRSA will commit \$1.5 million over five years.

She then relayed some 2002 data on the Community Health Center (CHC) program:

- 91% of health centers provide HIV testing and counseling;
- Of the more than 320,000 people served through CHCs, 63,000 are treated for HIV;
- Many CHCs are dual grantees receiving funding from both the CARE Act and the Bureau of Primary Health Care (BPHC); and
- Of 843 health centers, 166 receive a total of \$168 million in CARE Act funds.

BPHC and HAB are working closely to increase the provision and quality of HIV services through the CHCs. The Administration's goal is to expand the number of CHCs by 1200 in the next five years. This would double the number of people served to 16,000,000 and ultimately 22,000,000.

Update - CDC's HIV and STD Prevention Programs

Harold Jaffe, M.D., NCHSTP Director, gave a brief update from CDC. He announced the creation of an office of health disparities within NCHSTP, which would focus on HIV, STD and TB issues among the incarcerated, women and minorities. Hazel Dean would be the director of the program.

Janet Cleveland has become Acting Deputy Director of the Division of HIV/AIDS Prevention's (DHAP's) Intervention Research and Support Division.

In early October, President Bush named Randall Tobias as the global AIDS coordinator. Tobias was formerly the Chief Executive Officer of Eli Lilly pharmaceuticals and will be responsible for coordinating all of the government's international AIDS programs. Dr. Jaffe expressed his belief that Mr. Tobias would be instrumental in assuring the most efficient use of Federal resources for international efforts.

Dr. Jaffe stated that the 2004 budget would likely offer no increases for HIV prevention and domestic AIDS programs. The President had requested a \$10 million increase for mother and child initiatives in the international realm. Congress has agreed to \$2.4 billion for the President's international efforts.

The General Accounting Office (GAO) is continuing its review of AIDS programs in resource poor countries. The agency is also examining interagency collaboration on mother-child programs. Results of these efforts should be ready in time for the 2005 appropriations cycle.

In response to committee member questions about their replacements, Dr. Duke said that HRSA was collecting nominations and would keep members informed of their progress. Dr. Valdiserri reiterated the practice of having committee members continue to serve until their replacements had been appointed, and stated his understanding that this practice would apply to those members of the committee whose terms were expiring.

Members also asked about the issuance of the CBO grant announcement. Dr. Jaffe said it was undergoing clearance and would be released soon.

Dr. Del Rio expressed concern about resource levels at CDC given the agency's goals of reducing new infections by 50%. Dr. Jaffe stated there would be no additional resources available to implement the AHP and Dr. Valdiserri said that CDC would be providing budget updates the following day.

Ms. McDonald asked about HRSA's plan to provide services to those identified under the new initiative. Dr. Duke said that HRSA was developing a new guidance for grantees, but stressed that HRSA would be unable to handle the influx of clients alone. The agency would be part of a larger system response to the anticipated rise in demand for services.

Institute of Medicine (IOM) Reports

Steven Young, M.S.P.H., Director of the Division of Training and Technical Assistance presented on the two IOM studies commissioned by HRSA. The first was to address inefficiencies in the public financing of HIV programs. The charge to the IOM was to design a system that was accessible, equitable, cost-effective, high quality, comprehensive and easy for clients to negotiate. The second was to determine: 1) whether the HIV reporting system provided data that was reliable enough to be used in CARE Act allocations; 2) what data was available to assess severity of need; and 3) what data exists to measure quality of CARE Act services.

The first study, due to be completed in February 2004, will take into account the costs of current care barriers, cost saving derived from administrative efficiencies, and appropriate roles for public and private payers. Issues to be considered include a profile of people living with HIV, public funding of HIV care, variations in Medicaid and CARE Act programs, and disparities in access to care.

Mr. Young reported on IOM's recommendations from the second study, which had been completed.

IOM Recommendations on the use of HIV data for CARE Act formulas included:

- 1) Use estimated living cases for next four years while improving HIV data reporting;
- 2) Allocate more funding to HIV to improve the quality and consistency of data reporting;
- 3) CDC should obtain estimates of HIV prevalence and evaluate methods using an independent body;

- 4) Congress should re-evaluate formulas to determine if they target resources appropriately; and
- 5) The Secretary should use an independent body to assess inter-regional variations given alternate data inputs and allocation formulas.

IOM recommendations on assessing severity of need included:

- 1) Title I supplements should be based on quantitative need as defined by applicants/grantees;
- 2) Heavy consideration should be given to quantitative data that reflect variations in cost of care and fiscal ability across eligible metropolitan areas (EMAs);
- 3) HAB should explore the use of social area indicator models to estimate need; and
- 4) The Secretary should evaluate the cost and usefulness of re-designing and implementing CDC and HRSA studies to assess need.

IOM recommendations on data to assess quality and access included:

- 1) HRSA should work with grantees and constituents to develop standard criteria;
- 2) The Secretary should provide funding to CDC and HRSA to develop system for monitoring quality at patient, provider and population levels; and
- 3) The Secretary should convene a working group to consider strategies and models for public-private collaboration.

Mr. Young said that HAB would be meeting internally, with CDC, and with the Department to consider the IOM's recommendations. The finding would also be considered in activities related to reauthorization.

Dr. McGuire referenced the IOM's recommendations in terms of the administrative burden placed on programs. She said without adequate resources and funding, they would be hard to achieve. There was also discussion regarding the need to assess Medicaid's impact within states given the trend of flat funding within the CARE Act, and Dr. Duke's statements that HRSA programs alone could not accommodate the potential influx of new clients.

Mr. Young said that much of the discussion within the IOM committee had been related to the availability of resources in different areas. He added that the richness of data, or lack thereof, in state Medicaid programs was a big part of the study.

HRSA's CARE Act Programs: CARE Act Reauthorization Update

Dr. Parham provided an update on HAB's reauthorization activities. In January 2003, staff met with several grantees and outside partners to discuss ADAP issues. The agency will be doing a related policy study.

Internally, the agency has begun to identify and divide issues into administrative and legislative categories. They have also met with AIDS policy and national healthcare organizations.

HAB held a consumer consultation in conjunction with the U.S. Conference on AIDS (USCA), providing eligible consumers with scholarships for attendance. The full-day meeting yielded good recommendations. HAB also provided staff support to the CHAC's reauthorization subcommittee as it held public meetings throughout the fall, and is working on a white paper for the Secretary that outlines major reauthorization issues.

Discussion of Recommendations by CARE Act Reauthorization Workgroup

Mr. Milan, co-chair of the Reauthorization Workgroup, began a discussion of the workgroup's draft report and recommendations for CARE Act reauthorization. This discussion filled the balance of the day's agenda. Mr. Milan and co-chair Terje Anderson said that in offering the recommendations early in the reauthorization process, it was the workgroup's hope that they would guide discussion at the national level of the major and relevant issues.

Mr. Milan briefly reviewed the process for developing the recommendations. They included:

- Impaneling a 12-member workgroup and four-member drafting committee
- Developing questions on CARE Act effectiveness, access, planning and funding to guide public input and publishing them in the *Federal Register*, and
- Impaneling a drafting workgroup to take the input and draft the recommendations;
- Holding public meetings in Washington, D.C., Los Angeles, and Miami, that were attended by more than 430 persons; and
- Hearing oral testimony from 105 individuals and reviewing written testimony submitted by more than 80 individuals and organizations.

On behalf of the Reauthorization Workgroup, Mr. Milan made a motion for the full CHAC to consider the draft report and recommendations. Ms. Garcia seconded the motion. The group decided that they would discuss each recommendation, make amendments, vote on each amendment, and then vote on adoption of a revised report package, which would include both recommendations and rationale.

The group began to discuss the draft recommendations. Mr. Anderson said in developing the recommendations, the working group focused on not writing legislation but putting forth ideas that were, in part, responsive to the public comments workgroup had heard.

1) CARE Act Reauthorization

Draft Recommendation

- The Ryan White CARE Act should be reauthorized.
- The reauthorization period should be extended to ten years, rather than the current five years.

Discussion

The group discussed the benefits of a 10-year reauthorization. It would lend stability to programs providing HIV services and would enable the use of greater resources toward the provision of HIV services, rather than preparation for reauthorization. Mr. Anderson added that as the epidemic shifted, Congress could pass legislative changes in response.

There was additional discussion about the ten-year reauthorization period. A motion was made to keep the time period at five years. The motion failed on a vote.

A second motion was made to recommend a minimum six-year authorization period. There were no second to the motion. Another motion recommended a 7-year authorization period. The motion was seconded but failed on a vote.

Dr. McGuire then made a motion to strike the second bullet completely. The motion was seconded, and passed on a vote of 13 to 7.

Final recommendation

- The Ryan White CARE Act should be reauthorized.

2) CARE Act Structure

Draft recommendation

- Retain the current title structure in a reauthorized CARE Act.

Discussion

Dr. McGuire stated that she was not necessarily in favor of retaining the current Title structure, due to duplication, expanding patient populations and other issues.

A motion was made to pass the recommendation. The motion was seconded and the recommendation was passed by a vote of 19 to 1.

3) Adequate funding of the CARE Act

Draft recommendation

- The CARE Act should be funded commensurate with the care, treatment and service needs of those living with HIV and AIDS. Each year, either the Congressional Budget Office (CBO) or Health and Human Services (HHS) should provide Congress with the actual cost of meeting identified HIV and AIDS care needs.
- HRSA should be given increased financial and human resources to fulfill its administrative and oversight responsibilities under the CARE Act.

Discussion

Ms. Mann suggested changing the word “funded” in the first sentence of the recommendation to “authorization levels,” citing that the CARE Act is not an appropriations bill. The group also discussed the need to unlink the two sentences in bullet 1.

A motion was made and seconded to accept the recommendations as revised. The motion passed by a vote of 17 to 3.

Final Recommendation

- The CARE Act should have authorization levels and be funded commensurate with the care, treatment and service needs of those living with HIV and AIDS.
- Each year, either the Congressional Budget Office (CBO) or Health and Human Services (HHS) should provide Congress with a comprehensive analysis of identified HIV and AIDS needs and with the actual total resources required to meet those needs.

4) Funding/Resources for CARE Act Administration

Draft Recommendation

HRSA's HIV/AIDS Bureau and other parts of HRSA working on CARE Act activities should be given increased financial and human resources to fulfill their administrative and oversight responsibilities under the CARE Act.

Discussion

Upon a suggestion by Dr. Futterman, the group elected to create a new fourth recommendation.

A motion was made to pass the new recommendation. It was seconded and the vote to adopt it was unanimous.

Final Recommendation

HRSA's HIV/AIDS Bureau and other parts of HRSA working on CARE Act activities should be given increased financial and human resources to fulfill their administrative and oversight responsibilities under the CARE Act.

5) Increasing Length of Grant Periods

Draft recommendation

- Any grant period in a CARE Act title, whether formula, supplemental or discretionary, that is currently a one-year cycle should be increased to two years.

Discussion

Ms. Mann suggested a revision to the rationale that clarified while a grant period is two years, a budget period is one year. The group agreed to make the change.

A motion was made to accept the recommendation. The motion was seconded. The motion passed by a unanimous vote.

Final recommendation

- Any grant period in a CARE Act title, whether formula, supplemental or discretionary, that is currently a one-year cycle should be increased to two years.

6) Administrative Caps/Program Evaluation

Draft recommendation:

- The amount allowed for administrative expenses for those directly providing CARE Act services should be increased to 20%.

Discussion

Noting that Title IV programs do not have an administrative cap, Ms. Mann requested a change to the language clarifying that the 20% increase be applied only to those programs that currently have a 10% cap.

The change was made and Ms. Mann made a motion to adopt the new recommendation. Dr. Futterman seconded the motion. The motion passed 19 to 1.

Final recommendation

- For those directly providing CARE Act services under a 10% administrative cap, the administrative cap level should be increased to 20%.

7) Statewide Coordinated Statement of Need (SCSN)

Draft recommendation:

- Consistently strong language within each title should require all grantees participate in the development of the statewide coordinated statement of need.
- A legislative mandate should require that relevant federal agencies providing direct services in a state (e.g., the Veterans and Social Security Administrations) and state agencies receiving federal funds (e.g., state agencies receiving funds from CMS and SAMHSA) participate in the development of the coordinated statement of need.

Discussion

Dr. McGuire suggested that the way the recommendation was written would not compel any greater use or value to the process of doing an SCSN. She suggested strengthening the recommendation by identifying who would manage the process.

There was much discussion about whether the recommendation should be made at all, as the SCSN was an un-funded mandate. Mr. Anderson argued that the committee should encourage greater collaboration, not less, even though the SCSN was an imperfect process. Mr. Perkins responded that the recommendation as it read, meant nothing.

In the end, the recommendation was revised by Dr. McGuire and Mr. Liberti. A motion was made and seconded to adopt the revised recommendation. The vote to adopt the recommendation was unanimous.

Final recommendation

- The Statewide Coordinated Statement of Need (SCSN) process should be administratively strengthened so as to better assure equitable service access, integration and coordination. Consistently strong language within each title should require that all grantees participate in the development of the SCSN.
- A legislative mandate should require that relevant federal agencies providing direct services in a state (e.g., the Veterans and Social Security Administrations) and state agencies receiving federal funds (e.g., state agencies receiving funds from CMS and SAMHSA) participate in the development of the SCSN.

8) Increased Service Delivery Coordination Between Titles

Draft recommendation

- A reauthorized CARE Act should require that service delivery be coordinated among the different titles of the Act.
- As a condition of funding, CARE Act grantees and sub-grantees must document efforts and outcomes for the coordination of service delivery.
- Integration of service delivery must be a requirement of Title I and II planning activities and documented in their comprehensive plans.

Discussion

There was no discussion of the recommendation. A motion was made to adopt the recommendation. The motion was seconded and the vote to adopt was unanimous.

Final Recommendation

- A reauthorized CARE Act should require that service delivery be coordinated among the different titles of the Act.
- As a condition of funding, CARE Act grantees and sub-grantees must document efforts and outcomes for the coordination of service delivery.
- Integration of service delivery must be a requirement of Title I and II planning activities and documented in their comprehensive plans.

9) Establishment of Consumer Grievance Procedures

Draft Recommendation

- All grantees and sub-grantees in all Titles providing direct services to consumers should be required to have a grievance process through which consumers can address service concerns. Grantees and sub-grantees providing direct services should be required to present a written notice of the grievance policy to all of the consumers receiving their services. HRSA should provide to all grantees recommended guidelines for the implementation of consumer grievance procedures.

Discussion

The group agreed to separate the recommendation into separate bullets but retain the language. A motion was made to adopt the recommendation. The motion was seconded and the vote to adopt was unanimous.

Final Recommendation

- All grantees and sub-grantees in all Titles providing direct services to consumers should be required to have a grievance process through which consumers can address service concerns.
- Grantees and sub-grantees providing direct services should be required to present a written notice of the grievance policy to all of the consumers receiving their services.
- HRSA should provide to all grantees recommended guidelines for the implementation of consumer grievance procedures.

10) Title I Planning Councils

Draft Recommendation

- Maintain the requirement that 33% of planning council members be people living with HIV and AIDS and consumers of Title I services, but modify the “non-aligned” requirement, so that if a consumer is designated “non-aligned” at the time of joining the planning council, that designation is maintained until expiration of the consumer’s term.
- Allow honoraria for consumers of CARE Act services to support participation in planning council activities.

Discussion

There was no discussion of the recommendation. A motion was made to pass the recommendation. The motion was seconded. The motion passed by unanimous vote.

Final Recommendation

- Maintain the requirement that 33% of planning council members be people living with HIV and AIDS and consumers of Title I services, but modify the “non-aligned” requirement, so that if a consumer is designated “non-aligned” at the time of joining the planning council, that designation is maintained until expiration of the consumer’s term.
- Allow honoraria for consumers of CARE Act services to support participation in planning council activities.

11) Title II—Participatory Planning

Draft Recommendation

- Title II of the CARE Act should include a legislative mandate for a public advisory planning process that includes people living with HIV and AIDS and a range of representatives from affected communities and service providers.
- States receiving Title II funds must be required to demonstrate that such a participatory process exists and that participants are consulted in decisions about needs assessment and priority setting for Title II funds.
- Consortia funded through Title II must be required to demonstrate that their membership includes representation reflecting the epidemiology of HIV and AIDS in their geographic area and includes people living with HIV and AIDS as well as providers of services to impacted populations. Consortia should be required to conduct open nomination processes and to conduct open business meetings.

Discussion

The only discussion of the recommendation was a point of clarification about how the process differed from the SCSN. A motion was made and seconded to adopt the recommendation as is. The motion passed unanimously.

Final Recommendation

- Title II of the CARE Act should include a legislative mandate for a public advisory planning process that includes people living with HIV and AIDS and a range of representatives from affected communities and service providers.
- States receiving Title II funds must be required to demonstrate that such a participatory process exists and that participants are consulted in decisions about needs assessment and priority setting for Title II funds.
- Consortia funded through Title II must be required to demonstrate that their membership includes representation reflecting the epidemiology of HIV and AIDS in their geographic area and includes people living with HIV and AIDS as well as providers of services to impacted populations. Consortia should be required to conduct open nomination processes and to conduct open business meetings.

12) Grievance Process for Title I and Title II Grantees

Draft Recommendation

- A reauthorized CARE Act should create a process by which consumers and sub-grantees/subcontractors can file a grievance against a Title I or Title II grantee for serious or ongoing mismanagement of the grant or failure to meet CARE Act requirements.
- HRSA should be given the authority to investigate such grievances, and, if sustained, employ interventions including HRSA/Secretary of HHS taking over the grant.
- HRSA should be given the resources necessary to carry out this process.

Discussion

Dr. Futterman suggested that the recommendation did not give HRSA the authority to move forward if it identified a problem with a grant. Dr. McGuire said that re-working the language could help give HRSA the authority it needed to manage the grants. Both worked on a revision.

A motion was made to pass the revised recommendation. The motion was seconded and the vote was unanimous.

Discussion

Ms. Mann made a motion to delete the third bullet. The motion was seconded. The motion carried by a vote of 17 to 2.

Final Recommendation

- A reauthorized CARE Act should assure the authority of HRSA to investigate and assess deficiencies of Title I and II grantees and sub-grantees fund management and service delivery. If such deficiencies are upheld, HRSA can employ interventions including HRSA/HHS Secretary taking over the grant.
- HRSA should establish processes by which consumers, sub-grantees and the public can request investigations.

13) Price of Pharmaceuticals

Draft Recommendation

- A reauthorized CARE Act should ensure that all Title II AIDS Drug Assistance Programs receive the lowest price for pharmaceuticals available to the federal government.

Discussion

Mr. Liberti explained that the recommendation suggested there were other pricing structures in the Federal system and that ADAP should be able to get the drugs at those prices. Mr. Rawlings suggested that all CARE Act Titles should have access to the best drug prices, not just ADAP.

The recommendation was revised to reflect the input. A motion was made to pass the revised recommendation. The motion was seconded. The motion passed unanimously.

Final Recommendation

- A reauthorized CARE Act should ensure that all drug assistance programs, including the Title II AIDS Drug Assistance Programs, receive the lowest price for pharmaceuticals available to the Federal government, unless otherwise negotiated at a lower rate.

14) Title III – Consumer Participation

Draft Recommendation

- As a condition of funding, Title III grantees must be required to demonstrate that they have a mechanism for meaningful consumer input into grantees' Title III programs (e.g. a consumer advisory board)

Discussion

There was no discussion of the recommendation. A motion was made to pass the recommendation. The motion was seconded. The vote on the motion was unanimous.

Final Recommendation

- As a condition of funding, Title III grantees must be required to demonstrate that they have a mechanism for meaningful consumer input into grantees' Title III programs (e.g. a consumer advisory board)

15) Title II Supplemental ADAP Grants

Draft Recommendation

- The amount set aside to fund ADAP supplemental grants in Title II should be increased from the current 3% to 10%.
- The requirements for state supplemental drug grants should be modified to allow HRSA the discretion to provide supplemental grants to areas of greatest unmet need while maximizing adequate state participation in supporting ADAP.

Discussion

Ms. Mann asked if the reauthorization workgroup had thought about mechanisms to incentivize states to invest in drugs? Mr. Anderson responded that the intent was to give HRSA the authority to respond to the areas of greatest need, whether due to lack of state funding, increased disease burden, or other factors.

Dr. Rawlings expressed concern about making the recommendation without adequate data to get a real sense of what the need is. How did the workgroup derive the 10% figure? Mr. Anderson responded that the 10% did not represent a solution, but an attempt to alleviate some of the problem. Mr. Liberti added "we did feel like 10% would in fact get us in the ball park of what ADAPs would need to eliminate waiting lists."

Mr. Anderson suggested that the group could request additional data from HRSA and CDC in order to better consider the recommendation.

Dr. Futterman made a motion to table the recommendation until the committee had further data to consider it more fully. Ms. Mann seconded the motion. The motion passed unanimously and the recommendation was tabled.

16) Supplemental Grants to Emerging Communities

Draft Recommendation

- Emerging communities found eligible to receive a grant award, having a cumulative total of between 500 and 1,999 cases of AIDS for the most recent period of 5 calendar years for which

such data are available, should remain eligible for funding even if AIDS case numbers fall below 500.

Discussion

Mr. Anderson moved to table the recommendation because it made reference to AIDS cases. Ms. McGuire seconded the motion. The vote was unanimous and the recommendation was tabled.

17) Public Health Service Guidelines as Priority for CARE Act Services

Draft Recommendation

- All grantees under all titles of the CARE Act must be required, as a condition of award, to document the specific steps they are taking to ensure that people living with HIV and AIDS in their area of service are receiving care that meets or exceeds all of the Public Health Service (PHS) guidelines for HIV-related treatment, care and prevention.

Discussion

Dr. Valdiserri clarified that there would be certain funding streams to support prevention efforts with HIV-positive individuals under the new initiative. He said that guidelines developed by CDC, HRSA and the Infection Disease Society of America were intended to be followed by all providers of HIV services.

Dr. Futterman suggested that the guideline stipulate that individuals are “offered” care, to cover instances in which consumers may not want care that follows the guidelines. She and Mr. Baker worked to revise the recommendation.

A motion was made to pass the revised recommendation. The motion was seconded and passed by unanimous vote.

Final Recommendation

- All grantees under all titles of the CARE Act must be required, as a condition of award, to document the specific steps they are taking to ensure that people living with HIV and AIDS in their area of service are offered services that meet or exceed all Public Health Service (PHS) guidelines and joint CDC/HRSA recommendations for HIV-related treatment, care and prevention.

18) Priority to Core Services and Linkages to Health Care

Draft Recommendation

- The CARE Act must instruct grantees to give the highest priority, as appropriate to the needs in the locality, to the provision of health care services and medications.
- The CARE Act must continue to provide a variety of supportive services that are necessary to connect and maintain people in health care.

Discussion

Dr. David Farabee asked how budgeting would affect highest priorities in a service area. Mr. Anderson clarified that the priorities identified could be met through other funding sources, in which case CARE Act funding could be used to support the next set of service priorities.

Ms. Mann said that the recommendation was about priority setting, but did not address resource allocation. She suggested that language be added to the rationale explaining that resources must be available to fund priorities, if not specifically CARE Act funds.

Dr. Futterman suggested adding a new bullet to the recommendation that would address CDC's new initiative. After some limited discussion, the group agreed and Dr. Futterman developed a new bullet.

There was a motion made and seconded to adopt the first bullet, which had been revised by Dr. Futterman. The vote to pass the motion was unanimous.

A motion was then made to adopt the second bullet. The motion was seconded and the vote was unanimous.

Final Recommendation

- CARE Act grantees and planning bodies should develop strategies and implement programs to voluntarily connect into health care those not currently accessing it (while respecting client choice and autonomy around care decisions) through expanded outreach and voluntary counseling and testing services.
- The CARE Act must instruct grantees and planning bodies to give the highest priority, as appropriate to the needs of the locality, to the provision of health care services and medications.

19) Integration of Care and HIV Prevention Services

Draft Recommendation

- The CARE Act should promote integration of care and prevention services by encouraging the development of coordinated planning and service systems between HRSA and CDC-funded programs.

Discussion

Dr. Futterman suggested adding the following language to the recommendation: "Grantees should recognize responsibility to integrate prevention into the care of HIV-positive people."

A motion was made to adopt the revised recommendation. The motion was seconded. The motion passed by a vote of 17 to 1.

Final Recommendation

- The CARE Act should promote integration of care and prevention services by encouraging the development of coordinated planning and service systems between HRSA and CDC-funded programs. Grantees should recognize their responsibility to integrate prevention into the care of HIV-positive people.

20) Dental/Oral Health Care

Draft Recommendation

- Support for dental school clinics should continue. In addition, funds should be made available, on a competitive basis, to support community-based clinics providing dental care for people with HIV, especially in communities without a participating dental school clinic or with high unmet oral health care needs.

Discussion

There was limited discussion of the recommendation. Ms. Mann expressed concern about setting up more categorical grant programs. After some discussion, members decided to keep the recommendation as written.

A motion to adopt the recommendation was made and seconded. The motion was passed by unanimous vote.

Final Recommendation

- Support for dental school clinics should continue. In addition, funds should be made available, on a competitive basis, to support community-based clinics providing dental care for people with HIV, especially in communities without a participating dental school clinic or with high unmet oral health care needs.

21) Addressing Stigma, Cultural Competence and Discrimination

Draft Recommendation

- CARE Act resources should be allowed to be used to address ongoing stigma and discrimination against people living with HIV and AIDS, as these issues continue to represent significant obstacles to care, treatment and services. In addition, HRSA should consider prioritizing Special Projects of National Significance (SPNS) projects or creating specific set-asides for programs that focus on addressing and reducing stigma and discrimination..

Discussion

There was some discussion about the need for the recommendation. Dr. Futterman wondered if addressing stigma within the CARE Act would go far in alleviating the stigma people with HIV face outside the healthcare system. Dr. Parham added that she wasn't sure legislation was needed to address stigma, as the agency has already been working on projects related to the issue.

A motion was made to delete the recommendation, but was not seconded.

Mr. Baker suggested adding language around cultural competency and then made a motion to have the revised recommendation adopted. His motion was seconded and passed by a vote of 17 to 1.

Final Recommendation

- CARE Act resources should be allowed to be used to address ongoing stigma and discrimination against people living with HIV and AIDS, and cultural competence, as these issues continue to represent significant obstacles to care, treatment and services. In addition, HRSA should consider prioritizing Special Projects of National Significance (SPNS) projects or

creating specific set-asides for programs that focus on addressing and reducing stigma and discrimination and improving cultural competency.

22) AIDS Education and Training Centers

Draft Recommendation

- The AIDS Education and Training Centers (AETCs) should continue to focus on providing training on HIV care for health care providers, but their mandate should be expanded to include the training of additional disciplines involved in the care, treatment and support of people living with HIV and AIDS.
- Priority should be given to training providers in areas of severe unmet need, training providers who are willing to go to areas of severe unmet need, and to building cultural competence among health care providers.
- The mandate of the AETCs should include improving service delivery systems by training clinicians on how to incorporate primary and secondary HIV prevention messages into clinical encounters.

Discussion

There was some discussion on the level of emphasis given to the AETCs. Many in the group were concerned that too much emphasis was being placed on the AETCs over other CARE Act programs. Dr. McGuire suggested moving some of the language to the rationale section of the recommendations report.

There was a motion to adopt the first bullet. The motion was seconded and passed by unanimous vote.

Dr. McGuire moved to delete the second bullet. The motion was seconded and passed by a unanimous vote.

Similarly, Mr. Anderson made a motion to delete the third bullet from the recommendation. The motion was seconded and passed by a unanimous vote.

Final Recommendation

- The AIDS Education and Training Centers (AETCs) should continue to focus on providing training on HIV care for health care providers, but their mandate should be expanded to include the training of additional disciplines involved in the care, treatment and support of people living with HIV and AIDS.

23) Vocational/Employment Training

Draft Recommendation

- CARE Act resources should be allowed to be used for vocational and employment training for people living with HIV and AIDS.

Discussion

There was some discussion of the need for the recommendation. Ultimately, a majority determined that given the critical health and support service needs of people living with HIV in the context of current budgetary considerations, the recommendation should be deleted

A motion was made to delete the recommendation. The motion was seconded and passed by a vote of 12 to 6.

Final Recommendation

- CARE Act resources should be allowed to be used for vocational and employment training for people living with HIV and AIDS.

24) Enactment of the Early Treatment for HIV Act

Draft Recommendation

- If the Early Treatment for HIV Act (ETHA) has not been signed into law at the time of CARE Act reauthorization, it should be enacted into law as part of CARE Act reauthorization.

Discussion

Mr. Liberti expressed concern about ETHA being “tacked onto” the CARE Act, but administered by CMS. Mr. Anderson said that while placed under consideration by a different Congressional committee, it would not be prevented from happening.

Mr. Baker asked about complications related to the use of HIV data for allocations within the CARE Act.

Mr. Anderson responded that in his opinion, inclusion of ETHA in the recommendations package provided a means for highlighting gaps in Medicaid and how they impact on CARE Act programs.

This completed the committee's discussion and amendments to the workgroup's report.

Adoption of Final Report and Recommendations

As Workgroup co-chair, Mr. Milan made a final motion to adopt the entire package of recommendations, rationale, and the draft report as amended and revised by the full CHAC. The motion was seconded by Mr. Anderson and passed unanimously by the committee with a vote of 18-0.

Additional Business Related to CARE Act Reauthorization

The final vote of the day was to have the reauthorization workgroup continue its efforts. The motion was made by Ms. Mann and seconded by Ms. Garcia. The vote to continue the workgroup was unanimous. Following the vote, the CHAC also expressed their consensus to empower the workgroup co-chairs and the CHAC co-chairs to work with the HRSA and CDC staff to produce and disseminate the final report and recommendations. Lastly, the committee expressed hearty thanks to the workgroup, the drafting team, the consultants, and especially to the workgroup co-chairs for their efforts on the Reauthorization report, recommendations and public hearing process.

DAY 2

Advancing HIV Prevention (AHP): New Strategies for a Changing Epidemic

Ida Onorato, M.D. and Raul Romaguera, D.M.D., M.P.H. provided an update on the CDC's AHP, the goals of which are to reduce barriers to early diagnosis of HIV and increase access to and use of quality care, treatment and prevention services by HIV-positive individuals and their partners.

The four priority strategies of the AHP are to:

- Make voluntary HIV testing a routine part of medical care;
- Implement new models of diagnosing HIV outside medical settings;
- Work with HIV-positive individuals and their partners to reduce new infections; and
- Further decrease perinatal transmissions.

Dr. Onorato described AHP in the context of CDC's overall prevention strategy. The AHP comprises 18% of the total domestic HIV appropriation. As part of AHP, CDC has been conducting trainings on the use of the rapid HIV test, and is scheduling trainings for 2004. Trainees learn to perform OraQuick tests, how to counsel clients in a rapid-test environment, and how to ensure safety with biohazardous materials. CDC is collaborating with the AETCs to adapt their curriculum for the training of health care providers.

CDC has developed a procedural guidance on conducting rapid tests in non-clinical settings. The agency also maintains an information Web site at www.cdc.gov/hiv/partners/ahp.htm that is generating between 7,000 and 9,000 hits per month. The agency has a post-marketing surveillance plan to determine the impact of its efforts.

Seven AHP demonstration projects have been funded to develop models for implementing AHP strategies. Three are in health departments, three in community-based organizations, and one is in a medical setting. Information on these projects can be found on the AHP Web site.

The demonstration projects have funded:

- Four health departments to conduct rapid HIV testing in jails;
- Six health departments to conduct partner counseling and referral services using rapid HIV testing;
- Four health departments to routinely recommend HIV testing as part of regular medical care;
- Nine community-based organizations (CBOs) to work with people living with HIV to reach persons in their social networks at high risk for HIV infection in communities of color;
- Seven CBOs to conduct rapid HIV tests in non-clinical settings;
- Nine CBOs for prevention case management and
- Health care providers in six areas to integrate prevention into care settings.

CDC is putting performance indicators in place to measure the success of AHP in health departments and CBOs. The agency is also in the process of developing 2004 program announcements for health departments and CBOs, as well as an announcement for capacity building projects.

Dr. Onorato reviewed some of CDC's scientific materials on the AHP, including the initial MMWR announcement in April 2003, and interim technical guidance for health departments and CBOs for selected interventions and a procedural guidance for interventions for CBOs that will receive direct CDC funding. CDC has also put together a number of fact sheets, a brochure, a slide set, and a social marketing campaign on AHP strategies.

Finally, the agency has a speaker's bureau to coordinate requests for presentations on the AHP. CDC has been training speakers on how to present information using a standard slide set and answer questions. The bureau received 10 requests for presentations in its first month of operation.

Dr. Romaguera discussed specific collaborative projects that CDC has developed with HRSA and outlined future collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare and Medicaid (CMS) and other HHS Agencies.

Last May, CDC and HRSA officials met to discuss how to collaborate in the implementation of AHP. The group agreed to strengthen communication, to share and review language in program announcements, guidance documents and other AHP-related documents, and to collaborate in the implementation of training and other projects related to prevention with positives. For example, HRSA's application guidance for RWCA Titles I, II, III and IV for FY 2004 suggested that applicants describe how they would incorporate the "Recommendations for incorporating HIV prevention into medical care of persons living with HIV" into their programs, and to reassess program priorities based on the anticipated impact of AHP.

CDC and HRSA are also collaborating in consultations with consumers and providers to assess the impact of AHP in various communities and to address issues such as: (1) how to strengthen the delivery of prevention services in clinical settings, (2) how to address stigma, and (3) how to coordinate case management services. Last month, CDC, HRSA and CMS held a preliminary meeting to discuss how to coordinate case management services across agencies and decided to invite SAMHSA and the Housing and Urban Developing Agency to the group. In the future we are planning to invite state representatives and consumers to participate in these discussions.

In addition to the HIV/AIDS Bureau, CDC is also working with the Bureaus of Primary Health Care and Maternal and Child Health at HRSA. Last September, CDC signed an Intra-Agency Agreement with HRSA's Bureau of Primary Health Care to assess, in collaboration with the National Association of Community Health Centers, current policies and practices related to HIV screening in primary care settings and incorporating HIV prevention services for persons living with HIV. CDC is also working with staff from the Maternal and Child Health (MCH) Bureau to update educational materials for pregnant women and MCH providers. CDC was also invited to present an update on HIV Screening in Pregnant Women in one of the MCH DataSpeak sessions. DataSpeak are interactive Internet and telephone conferences on topics involving women, children and families. The update has been scheduled for April, 2004.

CDC has had preliminary discussions with SAMHSA to collaborate in the implementation of the HIV rapid testing program in substance abuse treatment centers, and to evaluate HIV testing offered with methadone treatment. Collaboration may include sharing training materials and evaluation tools.

CDC has also participated in conference calls with CMS staff and is currently discussing how we can work together to expand coverage for HIV prevention services.

Finally, Dr. Romaguera shared with the group other projects that CDC has developed with outside partners, CDC is working with: (1) the American Hospital Association to assess current policies and practices related to HIV prevention services and HIV testing in hospital settings; (2) purchasers of care to develop a business case that will support reimbursement for HIV prevention services, (3) health plans and managed care plans to study the cost-effectiveness of early diagnosis of HIV.

Ms. Mann relayed the difficulty she has had in integrating rapid testing into clinics in Philadelphia due to state rules regarding laboratory licensing. Dr. Onorato said that many states have the same problem due to laboratorians' concerns about quality of rapid HIV testing in the field. She said that CDC is working with APHL to try and enlist the support of state lab directors for rapid testing.

Mr. Baker asked about the level of utilization of the rapid test in various settings. Dr. Onorato said CDC had purchased \$2 million worth of tests from Orasure and expects to do the same in 2004. In addition, the agency anticipates the approval in 2004 of an oral fluid rapid test, which will address some issues around CLIA.

Mr. Baker then asked what had been dropped from the prevention portfolio to accommodate the 18% of the budget being used to fund AHP activities. Dr. Onorato explained that with a flat budget CDC needed to directly fund less health education and risk reduction (HERR) activities but that health department funding was being used to indirectly fund CBOs for HERR. She added that some of the AHP money had come from projects that would have ended anyway and some of the money was new in 2003. \$12 million would still be used to fund HERR activities. It was anticipated that \$30 million total would be distributed to CBOs for HERR and interventions for very high-risk seronegatives, as well as counseling and testing for the uninfected.

Mr. Baker then asked about a plan to accommodate the potential influx of new clients. This sparked a substantial discussion about what the Department was doing to both determine the level of need and identify the resources to address the need. Representatives from HRSA and CMS assured committee members that they were concerned and working with each other on those issues. Doug Morgan, M.P.H., Director of the Division of Services Systems, echoed earlier sentiments by Dr. Duke regarding the need for HRSA to work within a larger care system to address the needs.

Chris Bates, M.P.H., Acting Director of the Office of HIV/AIDS Policy expressed the Department's concern regarding the situation, and said that the problem required the community to conduct education efforts with policy makers and the Department to assess the need and use those numbers to make the case for increased funding for HIV/AIDS programs.

Joan Holloway, HAB's Director of Community Relations, said that HRSA is working on a plan to maximize all of HRSA's resources in meeting the needs, while acknowledging that the agency could not do it alone. She added that there were ongoing efforts by the agency to have that acknowledged by additional stakeholders.

Dr. Onorato stated that CDC was working on estimates of both the numbers of infected persons newly identified by the initiative and the numbers of persons requiring care and treatment. She

said an estimate of the former would be ready in a few weeks, whereas getting an estimate of the need for care and treatment would take longer.

Ms. Mann suggested that the CHAC co-chairs write a letter on behalf of the committee to the Secretary requesting information on Department activities to assess the potential number of new clients resulting from AHP efforts and the capacity of HHS programs to meet the need. The committee endorsed this request by consensus.

Mr. Liberti discussed the roll out of seven rapid test demonstration projects in Florida. He said in Jacksonville, for example, 5000 rapid tests have been conducted in a jail. There have been issues with false positives. The state used a checklist approach to prepare health departments and CBOs and ensuring that counselors were trained, understood OSHA guidelines, etc. In 2003, the program will test over 300,000 people.

Dr. McGuire said that while the test is rapid, it is not simple. She asked about the possibility of peer assistance from States like Florida. Ms. Mann echoed the request, asking if CDC could arrange for technical assistance for Pennsylvania to address the previously mentioned licensing obstacles.

Dr. Onorato said that CDC is investigating the number of false positives reported from post marketing surveillance sites. Preliminary data show that the Oraquick rapid test is more sensitive than the standard EIA and that after follow up, persons who had a positive rapid test and a negative standard EIA have turned out to be seroconverters. This underscores the quality assurance guidelines that recommend performing a Western blot when the Oraquick rapid test is positive even if the standard EIA is negative. She added that as new products come out, they will be added to CDC's training program.

Trends in STD Surveillance and Syphilis Elimination

John Douglas, Jr., M.D., Director of STD Prevention reported on the progress of CDC's syphilis elimination program.

Between 1997 and 2002, CDC has witnessed an overall 20% decline in syphilis cases. This includes significant reductions in the number of cases among women and people of color. However, during that same period, there were a number syphilis outbreaks among men who have sex with men (MSM), in cities such as Chicago, San Francisco, Los Angeles and Miami.

CDC's exploration into factors surrounding these outbreaks revealed some interesting data. Numbers of gay men reported meeting partners over the Internet. For example, in San Francisco, as many as 60% reported meeting partners in this manner in 2003. In Los Angeles and elsewhere in the state the numbers were closer to 35%.

CDC also discovered that many MSM reported some anonymous sex partners or individuals they were unable to locate. In Fort Lauderdale, for example, 88% of partners were anonymous, and in Houston, 33% of the men studied provided no names for their sex partners.

While the numbers represent some significant challenges ahead, syphilis elimination efforts have met with positive results, such as:

- New and improved partnerships for syphilis elimination;
- Reductions in infectious syphilis for women;
- Reductions in the rate of congenital syphilis for African Americans; and
- Reductions in the rate of infectious syphilis for African Americans.

Challenges include maintaining the momentum in initially targeted heterosexual and minority communities, while devising strategies to address new outbreaks among MSM. Since initial syphilis elimination efforts did not target gay men, there will likely be a need for new strategies to address their unique situations, including the development of messages for those who identify as gay and those who do not, and the fact that higher rates of HIV among this population may result in new or altered syphilis strains.

CDC has developed a strategy for conducting syphilis elimination with MSM. It involves education efforts within public health entities, with providers and within the community.

Mr. Anderson asked if CDC had data about sero-discordance or concordance among gay men. Dr. Douglas responded that Supplemental HIV/AIDS Surveillance (SHAS) data reveals that approximately 50%-60% are having unprotected sex, and about 15% report having unprotected sex with individuals with unknown HIV status.

Mr. Baker wondered how much of the epidemic among MSM was related to the use of crystal methamphetamine. Did CDC have data on that? Dr. Douglas said there was a small study in New York, and indicated that he would follow up with the Substance Abuse and Mental Health Services Administration (SAMHSA) on the issue.

Mr. Baker also asked about underreporting, citing the number of cases reported for Washington, DC. Dr. Douglas stated that provider education has been a first strategy in all cities through a number of methods, but that it was hard to know to what degree provider readiness was having an impact on the epidemic. Dr. Valdiserri said that CDC's guidelines stipulate routine screening for HIV.

Dr. McGuire asked about legal issues surrounding Internet-based interventions. Dr. Douglas said that CDC had held a meeting in the summer that addressed legal issues, among other things, and that the agency is working on a related guidance. Dr. Valdiserri said that CDC has been in negotiation with an Internet service provider for pro-bono banner ads on Internet sites where people go to meet each other.

Dr. Bush McKissic asked what was being done to integrate syphilis, HIV and STD prevention. Dr. Douglas responded that community mobilization for safer sex norms is not centralized at CDC. Messages about safe sex have not been an explicit part of syphilis prevention, although they have been a large part of STD prevention. In that context, CDC makes it clear that abstinence is the first part of the hierarchy, followed by monogamy (i.e. a single partner) and condom use.

Mr. Liberti emphasized the importance of examining the connection between crystal methamphetamine and the spread of syphilis, citing experience from Miami and Fort Lauderdale. He added that Hepatitis A and B should also be addressed with respect to financing. He said in Florida Medicaid will not pay for the Hepatitis vaccine, despite the fact that it is reasonably priced and easy to administer.

Mr. Liberti also asked about funding for partner counseling and referral services (PCRS). Dr. Douglas said that PCRS is an enormous issue in STD control, yet it isn't happening to the degree it should in testing sites. Dr. Valdiserri said that grantees are required to conduct PCRS as a condition of their receipt of HIV prevention funding, but that presently there is no good national data on these services.

Old Business: HIV/STD Integration Workgroup

The committee adopted the minutes from its May meeting without changes.

Mr. Milan suggested that the committee wait until new members were assigned to discuss continuing the workgroup on HIV/STD integration. Members agreed.

There was some concerns expressed by committee members regarding trends in funding emanating from White House policies. Mr. Anderson urged CDC to advocate for its autonomy to support and conduct scientific research on HIV issues that it deems useful and appropriate.

Agenda Items/Dates for Next Meeting

The group decided to work by e-mail to select dates for its next meeting in Spring 2004.

Two agenda items were identified for the next meeting:

- 1) A report from CDC on its efforts to work with SAMHSA to address the use of crystal methamphetamine by MSM in the context of syphilis and HIV transmission; and
- 2) Reports from CDC and HRSA on their HIV budgets.

Public Comment

There was no public comment.

Wrap-up and Adjournment

Ms. Holloway thanked committee members for all their hard work and said she hoped to continue to work with them in the future.

There was some discussion among committee members regarding the way their term expirations had been announced. Ms. Mann suggested that there should have been clearer communication with committee members about the fact that they would be transitioning off the committee, and asked both CDC and HRSA staff to relay her comments to the Secretary. Mr. Baker expressed his belief that there is no public "transparency" for the Department's nomination and appointment processes. Dr. Valdiserri responded that committee members who had previously served on the CDC advisory committee were notified the day after he received notice from the Secretary's office regarding their term expirations. He emphasized that he personally phoned and wrote each member who was transitioning off the committee. He further stressed that membership decisions are made by the Secretary's office, not HRSA or CDC staff.

Mr. Anderson expressed concern over the number of people leaving the committee. He worried about the “drain of experience and institutional knowledge.”

Ms. McDonald said she had enjoyed being a part of the committee, and added that Mr. Milan and Mr. Anderson had gone beyond the call of duty to lead the committee in the development of an exceptional document detailing CARE Act reauthorization recommendations. She was concerned that Dr. Duke had not fully understood the extent of their work in that particular area.

Mr. Milan concluded the meeting by thanking the committee and saying he thought it was one of the most thoughtful and cohesive meetings the committee had ever had. He then called for a motion to adjourn the meeting. The motion was made and seconded and the meeting was adjourned at 1:17 p.m.