

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
and
HEALTH RESOURCES AND SERVICES ADMINISTRATION**

convene the

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

*May 11-12, 2005
Atlanta, Georgia*

RECORD OF THE PROCEEDINGS

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ATTACHMENT 1

List of Participants

CHAC Members

Dr. Jean McGuire, Co-Chair
Mr. Jesse Milan, Jr., Co-Chair
Ms. Renee Austin
Dr. Dorothy Brewster-Lee
Ms. Theresa Devlin
Mr. Dale Anthony Edmonston
Dr. David Farabee
Dr. Fernando Garcia
Dr. Dennis Leoutsakas
Mr. Thomas Liberti
Dr. John Martin
Dr. Judy Goforth Parker
Dr. Donna Sweet
Dr. Lydia Temoshok
Dr. Priscilla Young
Dr. Carmen Zorrilla

Outgoing CHAC Members

Mr. Cornelius Baker
Dr. Robert Fullilove
Ms. Gale Grant
Ms. Dorothy Mann

Ex Officio Representatives

Dr. Pradip Akolkar (FDA)
Mr. William Grace (NIH)
Dr. Fabian Eluma (SAMHSA)
Ms. Claudia Richards (SAMHSA)

Designated Federal Officials

Dr. Deborah Parham Hopson (HRSA)
Dr. Ronald Valdiserri (CDC)

CDC and HRSA Representatives

Dr. Janet Collins,
NCHSTP Acting Director
Dr. Elizabeth Duke
HRSA Administrator
[via conference call]
Dr. John Anderton
Ms. Sara Bingham
Ms. Chris Cagle
Ms. Janet Cleveland
Dr. Hazel Dean
Ms. Susan DeLisle
Dr. John Douglas, Jr.
Ms. Theresa Durden
Ms. Paulette Ford-Knights
Ms. Shelley Gordon
Mr. Timothy Hack
Mr. Timothy Harrison
Dr. Robert Janssen
Mr. Eva Margolies
Dr. Matthew McKenna
Mr. Reginald Mebane
Mr. Kevin O'Connor
Dr. Bradley Perkins
Ms. Ursula Phoenix
Ms. Laretta Pinckney
Ms. Amy Pulver
Dr. George Roberts
Dr. Raul Romaguera
Mr. Kenneth Rose
Ms. Margie Scott-Cseh
Dr. Robert Spengler
Ms. Melissa Thomas
Dr. Robin Wagner
Dr. Howell Wechsler

Members of the Public

Mr. Gene Copello (The AIDS Institute)

Ms. Patryce Curtis

(The MayaTech Corp.)

Dr. Feremusu Kamara

(DeKalb County Board of Health)

Ms. Donna Gallagher (New England
AIDS Education and Training Center)

Mr. Patrick Kelly (National AIDS
Education and Services for
Minorities)

Mr. Nathan Linsk (Midwest AIDS
Education and Training Center)

Ms. Marsha Martin (AIDS Action)

Ms. Laura Pittard (DeKalb County
Board of Health)

Mr. Leo Rennie (National Alliance of
State and Territorial AIDS Directors)

Dr. Ira Schwartz (Southeast AIDS
Education and Training Center)

K. Washington

(Community Education Group)

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Draft Minutes of the Meeting

The Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC), and Health Resources and Services Administration (HRSA) convened a meeting of the CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment (CHAC). The proceedings were held on May 11-12, 2005 at the Omni Hotel-CNN Center in Atlanta, Georgia.

Opening Session

Dr. Jean McGuire and Mr. Jesse Milan, Jr., the CHAC Co-Chairs, called the meeting to order at 8:45 a.m. on May 11, 2005. They welcomed the attendees to the proceedings and opened the floor for introductions. The list of participants is appended to the minutes as Attachment 1.

Dr. Ronald Valdiserri, the CDC Designated Federal Official (DFO), made several announcements. CHAC meetings are open to the public and all comments made during the proceedings are a matter of public record. *Ex officio* members represent federal agencies and participate in all discussions during the meeting, but do not have voting privileges. Members should be mindful of potential conflicts of interest identified by the CDC or HRSA Committee Management Office and recuse themselves from voting or participating in these discussions.

Dr. Valdiserri presented plaques and letters signed by the CDC Director to acknowledge the outstanding tenures of CHAC members whose terms have expired: Mr. Cornelius Baker, Dr. Robert Fullilove, Ms. Gale Grant, Ms. Dorothy Mann, and Dr. Antonia

Villaruel *in absentia*. The participants applauded the valuable contributions the outgoing CHAC members have made to CDC, HRSA, the HIV/AIDS and STD fields, and communities throughout the country. Dr. Valdiserri recognized and welcomed the new CHAC members: Ms. Theresa Devlin, Mr. Dale Anthony Edmonston, Dr. Lydia Temoshok, Dr. Priscilla Young, and Dr. Nathan Thielman *in absentia*.

Dr. Deborah Parham Hopson, the HRSA DFO, also welcomed the participants to the meeting. She was pleased to note that the consolidation of the two advisory bodies in 2003 has strengthened coordination between CDC and HRSA and improved policies generated by the two agencies.

Report by the CDC National Center for HIV, STD and TB Prevention (NCHSTP) Acting Director

Dr. Janet Collins covered the following areas in her report. The deadline to submit applications for the NCHSTP Director's position was extended to July 1, 2005. CDC will interview applicants for the position of the Global AIDS Program (GAP) Director in May 2005 and plans to officially appoint a candidate over the next two months. NCHSTP will allocate its FY'05 budget of \$960.7 million to the following programs: \$662.3 million to HIV, \$159.6 to STD and \$138.8 million to TB. The FY'05 GAP budget is \$123.8 million from CDC and an additional \$350 million from the Department of State for the President's Emergency Plan for AIDS Relief (PEPFAR) initiative. The President's FY'06 budget for NCHSTP includes \$956.3 million for HIV, STD and TB prevention programs and \$123.8 million for GAP. Congress established a new budget structure for CDC in FY'05 with a specific line item for business services.

CDC will submit a report to the House Appropriations Committee by June 1, 2005 on its efforts to measure the success of HIV and STD prevention programs. CDC reviewed and summarized 4,776 comments that were submitted in response to the content review guidelines, drafted revisions based on public comments, and forwarded the updated guidelines to HHS for review and approval. CDC hopes to finalize the document for publication in 2005. CDC recently convened a meeting with representatives from all 25 GAP country programs and four regional offices. The meeting was successful and resulted in the countries networking, sharing information and discussing critical issues related to GAP and PEPFAR activities.

Secretary Michael Leavitt recently issued "500 Day" and "5,000 Day" Plans that outline the future leadership, vision, priorities and direction of HHS. The plans explicitly state that HHS will reduce HIV/AIDS throughout the world, implement PEPFAR goals

according to the established schedule, and reauthorize the Ryan White Comprehensive AIDS Resources Emergency Act (RWCA). CDC will host the National HIV Prevention Conference on June 12-15 2005 in Atlanta. Participants will represent diverse audiences, including the research community, academia, non-governmental organizations, state-of-the-art practitioners and governmental agencies.

Dr. Valdiserri clarified that NCHSTP's policy is to apply Congressional recissions equally across the HIV, STD and TB divisions. Recissions are not for a one-year period, but are instead perpetual unless or until revoked by Congress.

Update by the CDC Division of HIV/AIDS Prevention (DHAP)

Dr. Robert Janssen, the DHAP Director, provided a status report on recent activities. DHAP will present updated and new data during the National HIV Prevention Conference in June 2005, including a recent estimate of the number of persons living with HIV; a new HIV prevalence estimate of persons who do not know their status; and results from the follow-up study to the Young Men's Survey. Behavioral surveillance data on 16,000 men who have sex with men (MSM) will be released by the fall of 2005. HIV incidence estimates based on 2005 data will be published in 2006. All areas in the United States are now implementing HIV surveillance.

DHAP conducted a national evaluation to determine the degree to which records are duplicated across states. The systematic review of ~200,000 records of all HIV and AIDS cases reported through December 2001 showed the following results. CDC removed ~40,000 from its national database because 80,000 records were duplicates. States met CDC's standards for overall duplication rates of AIDS and aggregate AIDS cases, but did not meet the standard for the overall duplication rate of HIV cases.

DHAP will revise its HIV/AIDS guidelines for grantees in 2005 in several areas, including screening in medical care settings; counseling, testing and referral for both patients and partners; partner notification; prevention case management; and interim guidance for interventions. Many of the HIV/AIDS guidelines will be integrated with STD. DHAP is serving on an internal workgroup to address the relationship among crystal methamphetamine use, HIV and MSM as well as to review behavioral surveillance data. DHAP will disseminate outcomes from this effort to increase awareness and will also explore the possibility of funding novel interventions that local health departments are implementing. DHAP will partner with the Substance Abuse and Mental Health Services Administration (SAMHSA) in this activity.

DHAP will participate in an International AIDS Society meeting in May 2005 to address issues related to the tenofovir prophylaxis trials. U.S. safety trials were launched among MSM in Atlanta and San Francisco. Phase II and III trials will be initiated in Thailand among injection drug users (IDUs) in May 2005 and in Botswana among heterosexuals over the next month.

Update by the CDC Division of STD Prevention (DSTDP)

Dr. John Douglas, Jr., the DSTDP Director, provided a status report on recent activities. DSTDP hosted a consultation in May 2005 to revise and update the 2002 STD treatment guidelines. The revised guidelines will be available in 2006 and will address a number of emerging issues, such as lymphogranuloma venereum (LGV) in MSM, quinolone-resistant gonorrhea in MSM and among heterosexuals in specific geographic areas, emergency contraception and HIV prophylaxis following sexual assault, antiviral therapy for the prevention of herpes simplex virus (HSV), and syphilis laboratory technology advances. Several controversial areas were identified by DSTDP and will be addressed in the guidelines, including expedited partner therapies (EPT), HSV serology testing in asymptomatic MSM or HIV-positive persons, anal Pap smears in HIV-infected persons, the role of metronidazole in the treatment of pelvic inflammatory disease, and titer-based recommendations in the determination of latent syphilis.

DSTDP is addressing the role of EPT in the treatment guidelines in part because insufficient resources at the program level prohibit public health staff from tracing contacts of STD patients and encouraging partners to present for testing and treatment for STDs. EPT is widely used, but public health laws are ambiguous about this practice in many states and several public health boards do not specifically recommend this approach. Results of a randomized clinical trial published in 2005 showed that EPT played a role in significantly reducing gonorrhea and chlamydia reinfection rates among both males and females. DSTDP sent a "Dear Colleague" letter to emphasize the usefulness of EPT in facilitating partner management, especially when treating male partners of women with chlamydial infection or gonorrhea.

Congressional legislation passed in 2000 mandated CDC to conduct surveillance, research and public and provider education on human papillomavirus (HPV) and submit two reports to Congress on its progress in adhering to the requirements. The two reports were submitted; analysis of sentinel surveillance data special research studies will be completed in 2006; results of a behavioral study on the impact of HPV diagnosis on women will be published in 2006; surveys of knowledge, attitudes and practices

about genital HPV infection among the public and health care providers were completed in 2005; and HPV educational materials were developed for the public and healthcare providers and will be distributed in 2005. DSTDP is also closely collaborating with other CDC divisions on issues surrounding HPV vaccines that are in clinical trials and scheduled for review for licensure by the FDA within the next several months.

DSTDP is a member of a CDC workgroup that is focusing on STDs and crystal methamphetamine use. DSTDP established a national project to identify and monitor LGV cases. LGV is a strain of chlamydia that is particularly virulent, rare and difficult to diagnose. To date, CDC has confirmed 12 LGV cases.

CHAC made several comments on CDC's HIV/AIDS and STD budgets and activities. The members were pleased that CDC's new budget structure now prohibits tapping of divisional dollars for administrative costs at the agency level. However, CHAC expressed significant concern that annual Congressional rescissions and flat funding of HIV and STD programs will adversely impact activities over time. Several members noted that constituents throughout the country have raised similar concerns. Most notably, tremendous budget cuts in state, local and community-based programs are causing delays in service delivery to clients and additional burdens in HIV and STD surveillance and reporting. CHAC's suggestions to strengthen CDC's HIV/AIDS and STD budgets and activities are outlined below.

- Increase efforts to leverage more funding for DHAP and DSTDP. Emphasize that the lack of prevention and primary care funding is a tremendous disservice to HIV care and treatment in the United States.
- Include an estimate of the number of persons living with HIV who are not currently in care in the DHAP presentation that will be given during the National HIV Prevention Conference.
- Tailor future HPV educational materials and training efforts to reflect ethnic and cultural differences among providers. For example, Hispanic obstetricians/gynecologists in Puerto Rico are extremely reluctant to discuss HPV with their patients.
- Design STD educational materials for the public to assist in changing traditional perceptions about preventive methods. For example, the evidence shows that women >65 years of age no longer need Pap smears. Dual gonorrhea/chlamydia tests are administered to women who actually only need the chlamydia test. Reductions in screening these populations would be extremely cost-effective.

- Include specific guidance in the STD toolkit to clinic- and community-based providers about effective strategies to discuss partners with their patients in an effort to reduce reinfection of STDs.
- Provide CHAC with CDC's Congressional report on the success of its HIV and STD prevention programs that will be submitted to the House Appropriations Committee.
- Provide CHAC with detailed budget information on CDC programs for FY'04-FY'06. Describe funding and program changes that will be needed and clarify the process to execute reductions.
- Revisit CHAC's pending request to meet with the HHS Secretary.
- Provide CHAC with the most recent data on perinatal prevention of HIV after DHAP completes this study.
- Devote time during the next CHAC meeting to a presentation and follow-up discussion on adolescent sexual health with particular emphasis on HPV vaccines that would be administered to youth <19 years of age.
- Appoint an STD expert to fill one of CHAC's current vacancies.
- Adopt a general statement to demonstrate CHAC's continued support of DSTDP's efforts to facilitate EPT whenever appropriate.

HIV/AIDS and STD Disparities Among African Americans (AAs)

Ms. Janet Cleveland of DHAP presented data to highlight HIV/AIDS disparities among AAs. A decrease was seen in the number of AIDS cases and deaths around 1993 when the AIDS surveillance definition was expanded, highly effective anti-retroviral therapy was introduced and prevention activities were increased. However, an increase was seen in the number of persons living with HIV/AIDS by race/ethnicity from 2000-2003 based on data reported to CDC by 33 areas that collect confidential names of cases. AAs bear the greatest burden of the HIV/AIDS epidemic and accounted for 49% of 43,171 estimated AIDS cases that were diagnosed in the United States in 2003. MSM, IDU and heterosexual contact are the three leading causes of HIV infection among AA males, while heterosexual contact and IDU are the two leading causes for AA females.

HIV/AIDS is among the top three causes of death for AAs among men 25-54 years of age and women 35-44 years of age. Of 90 infants reported with HIV/AIDS in 2003, 62 were AA. Of 902,223 AIDS cases reported to CDC through 2003, AAs accounted for 39% of the total, 59% of women, 58% of heterosexuals and 59% of children <13 years of age. Of new AIDS cases reported in 2003, 47% were among AA adults and adolescents. AAs accounted for 37% of the 524,060 persons who died from AIDS through 2003. Of the reported AIDS cases among adults and adolescents in 2003,

13,735 of the 33,250 cases were AA males and 7,329 of the 11,561 cases were AA females. Based on data reported by all 50 states and the District of Columbia in 2003, AAs accounted for 13% of the population and 48% of all AIDS cases.

Since the 1988, CDC has provided funding, technical assistance and capacity-building initiatives for community-based organizations (CBOs) to conduct HIV prevention in communities of color. CDC developed and launched the Advancing HIV Prevention (AHP) initiative in 2003 to reduce barriers to early diagnosis of HIV infection; decrease HIV transmission; and increase access and use of quality medical care, treatment and prevention services for persons living with HIV. This effort is undertaken in collaboration with other federal partners. CDC designed AHP with four priority strategies. HIV testing will be incorporated as a routine component of medical care. New models will be implemented to diagnose HIV infections outside of medical settings. New infections will be prevented by collaborating with HIV-positive persons and their partners. New cases of perinatal HIV transmission will be further decreased.

CDC targets HIV prevention program interventions to persons at highest risk by providing counseling, testing, referral, partner notification, health education and risk reduction strategies. These projects are implemented by community planning groups, state and local health departments, CBOs, businesses and private partners. CDC delivers evidence-based, successful and innovative capacity-building tools by diffusing effective behavioral interventions, providing training and technical assistance, and replicating programs with demonstrated track records of effectiveness and efficacy.

CDC ensures that state, local and community programs and services supported by federal dollars are culturally relevant and responsive to local needs. However, CDC acknowledges the limited amount of HIV/AIDS research that has been conducted in the AA community. As a result, funding is allocated to minority research organizations to conduct studies on HIV/AIDS disparities among AAs and other communities of color. These grantees include the Minority HIV/AIDS Research Initiative, Research Fellowship on HIV Prevention in Communities of Color, and Association of Schools of Public Health Institute for HIV Prevention Leadership.

CDC will increase diagnoses in both current and new venues by conducting screening in medical settings. CDC will continue its efforts to prevent HIV by providing support to maintain the health of HIV-negative persons; relying on behavioral prevention approaches; contributing to community planning and voluntary testing activities; and funding CBOs, particularly those that serve minority populations.

Ms. Susan DeLisle of DSTDP presented data to highlight STD disparities among AAs. CDC developed its National Plan to Eliminate Syphilis from the United States because of large racial disparities. In 1997, the black:white rate ratio for syphilis was 44:1. Through the Syphilis Elimination Effort (SEE), the 2003 black:white rate ratio was 5:1. Other SEE successes include new, improved and sustained partnerships with local communities, improved public health infrastructure, a 75% reduction in infectious syphilis among AA women, a 60% reduction in the rate of congenital syphilis among AAs, and an overall decline in the rate of infectious syphilis among AAs. CDC is in the process of evaluating SEE to date and will convene a consultation on August 1-2, 2005, to identify necessary changes, additional efforts to confront the changing dynamics of the syphilis epidemic and future direction of the SEE. A broad and diverse range of stakeholders is being invited to participate in the consultation.

DSTDP is focusing on racial disparities in gonorrhea. Of 335,000 gonorrhea cases reported in the U.S. in 2003, 71% were among AAs. Disparities are even greater among AA females 15-19 and 20-24 years of age. Gonorrhea has the widest black:white disparity (20:1 in 2003) of all CDC notifiable conditions.

Less progress has been made in reducing racial disparities in gonorrhea than in syphilis for a number of reasons. Strategies and activities that were effective in reducing syphilis disparities cannot be directly applied to gonorrhea due to several factors. The majority of gonorrhea cases are reported from private rather than public clinics. The combined gonorrhea/chlamydia test in family planning clinics places more emphasis and resources on chlamydia than gonorrhea. Selective screening criteria for gonorrhea that focus on new or multiple partners and other individual risk factors have not been useful. Partner services for gonorrhea are inconsistently provided. Effective strategies have not yet been identified or developed to address the close association between gonorrhea risk and disease burden.

CDC recognizes that some of the lessons learned from SEE will need to be adapted and applied to gonorrhea control. Racism, poverty and other social issues must be acknowledged and addressed. Partnerships, such as those that were developed from SEE activities, must be maintained and expanded to increase access to prevention and care services beyond syphilis. Affected communities must serve as collaborators in creating, delivering and evaluating interventions.

CHAC was extremely pleased with the outstanding progress CDC has made in the syphilis elimination effort, particularly the tremendous decline in the ratio between AAs and whites. Several members made remarks for CDC to consider in further

development and refinement of its activities to address HIV/AIDS and STD disparities among AAs.

- Review and formally evaluate best practices and evidence-based models of behavioral interventions that are being implemented at the community level to determine whether these tools are actually effective in the field.
- Explore whether successes in the HIV/AIDS movement in the early 1980s that resulted from social and political efforts by white MSM can now be applied to close the gap in disparities among AA MSM.
- Include other disproportionately affected groups in future efforts to address HIV/AIDS and STD disparities. For example, Alaska Native women are developing new HIV infections faster than any other racial/ethnic population, but the state health department does not consider this group to be a priority. CDC's existing HIV and STD activities are not designed to address cultural and other unique needs of Alaska Native men, women and youth.
- Take caution in replicating syphilis elimination activities for gonorrhea because syphilis efforts stem from a historical, political and racial context in the United States.
- Evaluate the "south" as a potential risk factor for HIV/AIDS and STD disparities among AAs. Collect demographic data from this area of the country and provide a forum to begin discussing regional differences.
- Highlight and widely publicize successes in HIV/AIDS and STD disparities among AAs because the continued negative focus on this issue causes stigma in the affected community.
- Ensure that CHAC is represented at the August 2005 meeting on the syphilis elimination effort.
- Invite the National Institutes of Health to the next CHAC meeting to present its portfolio of funding and activities related to the development of behavioral interventions.
- Inform CHAC about significant HIV resources that can be co-aligned with other STDs. Provide this information for CHAC to appropriately advise CDC on integrating messages and maximizing intervention opportunities and funding. For example, programs, communities and other grantees are burdened by attempting to absorb multiple messages from HIV and other STDs.
- Provide CHAC with information from CDC's counseling and testing data system on the actual number of persons of color across the country who receive these services.

Dr. Parham Hopson mentioned that HRSA allocates RWCA dollars to provide services to poor and underserved persons living with HIV/AIDS. Of this population, 70% are persons of color. HRSA has a solid track record of providing services to racial/ethnic minority groups represented in the epidemic. HRSA also targets Minority AIDS Initiative funds to build capacity for minority communities to serve persons of color living with HIV.

Report by the HRSA Administrator

Dr. Elizabeth Duke joined the meeting by conference call and covered the following areas in her report. One, the President made a commitment to the RWCA reauthorization and described several principles that will be used to guide this effort. Federal resources will be focused on life extending care, such as anti-retroviral drugs, physician visits and laboratory tests. Flexibility will be increased to better target RWCA resources to areas of greatest need. Efforts will be made to ensure that RWCA produces results and is held accountable to taxpayers. Performance will be measured and progress will be made toward achieving RWCA's stated goals.

HRSA will continue to closely collaborate with HHS and Congress in the ongoing effort to reauthorize RWCA. HRSA's FY'06 budget was submitted to Congress and includes the President's request of \$2.1 billion for RWCA activities. The request reflects the largest amount of funding in RWCA's history. The budget will support the AIDS Drug Assistance Program (ADAP) and a comprehensive approach to address healthcare needs of persons living with HIV/AIDS. HRSA's entire budget only reflects increases for ADAP in RWCA and CHCs. All other programs received flat funding, cuts or no dollars at all.

Two, the President prioritized an expansion of HRSA's CHCs with an overarching aim to add 1,200 new CHCs and serve 6.1 million more persons by the end of 2006. HRSA's achievement of this goal will result in a total of 4,400 CHCs and service to 16.1 million persons. HRSA has established 958 new CHCs and is now operating in 3,700 sites. The President's FY'06 budget request includes an increase of \$303 million for CHCs. A portion of these funds will be allocated to some of the poorest counties in the country to compete in the healthcare expansion program.

New grantees in these jurisdictions will develop priority programs to meet healthcare needs. HRSA will establish CHCs in areas that do not have a rural health clinic or CHC. HRSA acknowledges the increasingly important role of CHCs in the care of HIV/AIDS patients. In 2003, CHCs administered HIV/AIDS tests to 342,000 persons; provided

medical care to 68,000 HIV-positive persons; and received \$76 million in Title III early intervention grant funds. These figures reflect dramatic increases in CHC services and funding since 2001.

Three, HRSA is continuing its involvement in implementation of the Medicare Modernization Act (MMA). One of the key features of MMA is the coverage of prescription drugs to seniors. The revision reflects the first time in the history of the Medicare program that beneficiaries will receive assistance in purchasing prescription drugs. HRSA is closely collaborating with the Centers for Medicare and Medicaid Services (CMS) in implementing MMA and the new HHS Secretary has prioritized this effort.

Dr. Duke acknowledged CHAC's extremely important role in providing valuable advice to CDC and HRSA on strengthening complimentary activities between the agencies. Most notably, CHAC made outstanding recommendations during the RWCA reauthorization public meetings. HRSA found the comments to be extremely beneficial and forwarded the recommendations to both the former and current HHS Secretaries. Dr. Duke thanked CHAC for its outstanding contributions in this regard and confirmed that she would convey CHAC's pending request to meet with the HHS Secretary.

CHAC was extremely appreciative that Dr. Duke was able to join the meeting by conference call. The members made several comments in response to the HRSA Administrator's report.

- Distribute data to CHAC on the amount of funding and number of patients who are seen in CHCs, but do not receive co-existent Title III dollars. Provide this information for CHAC to explore strategies to build CHC capacity in offering appropriate and quality HIV care.
- Provide CHAC with information on the profile of persons who receive care in CHCs.
- Ensure that providers are thoroughly trained in both the chronic care model and highly sophisticated techniques of HIV care during the CHC expansion.
- Provide an opportunity for CHAC to provide guidance to HRSA on the requirement for CHCs to administer STD care and treatment.

CHAC concluded the discussion by forming a writing group to develop recommendations to HRSA on expanding CHC initiatives, while ensuring quality care for persons living with HIV. Drs. Garcia, Sweet and Zorrilla volunteered to serve on the writing group, draft the recommendations and present the guidance to the full

membership for review and input. **Mr. Timothy Harrison**, of the HHS Office of National AIDS Policy, confirmed that he would also convey CHAC's interest in meeting with the HHS Secretary.

CDC's 2001-2005 HIV Prevention Strategic Plan

Dr. Collins reported that CDC widely solicited public comments while developing the strategic plan in January 2001. Extensive input was provided by a diverse group of stakeholders, including CHAC, governmental agencies, academic institutions, HIV/AIDS advocates and community groups. The strategic plan is a focused and practical document that has been of great benefit to NCHSTP. The overarching national goal is to reduce new HIV infections by 50% from 40,000 to 20,000 per year by 2005 with a particular emphasis on eliminating racial/ethnic disparities.

CDC's best estimate at this time is 40,000 new HIV infections occur each year in the United States. Although the national goal will not be reached by December 2005 at the end of the strategic plan, CDC still believes the target ultimately achievable so long as sufficient funding is allocated. Aggressive prevention activities resulted in several successes. Mother-to-child transmission of HIV has drastically declined in the United States. Sexual risk behavior and pregnancy trends show more delays in sexual initiation among high school students, increased condom use among sexually active youth, a significant decline in pregnancy rates among adolescents, and a dramatic 50% reduction in pregnancy rates among AA females 15-17 years of age. HIV testing rates increased among pregnant women, high-risk groups and populations served by CDC CBOs and HRSA CHCs. HIV incidence has remained stable despite the increase in HIV prevalence.

CDC has made several major changes since developing the strategic plan in 2001. Data systems to monitor, evaluate and plan program outcomes were greatly improved. Policy and program initiatives were refined. Stronger efforts were made to ensure that effective interventions were implemented in the field. Training to CBOs and capacity-building assistance organizations was increased and enhanced. Accountability was strengthened at both CDC and grantee levels. AHP strategies were implemented to increase the focus on early diagnosis and prevention among HIV-positive persons. AHP rapid testing demonstration projects were launched in various settings.

CDC has identified several challenges in achieving the national goal to reduce new HIV infections by 50%, such as the shift to view HIV as a chronic illness, higher prevalence rates, and less fear of developing HIV due to highly effective anti-retroviral therapy. HIV

constantly intersects with other issues, including the use of crystal methamphetamine and other drugs, mental health problems, violence and the Internet. Collaborative efforts will need to be undertaken with outside experts and short-term demonstration projects will need to be launched to address persistent racial and ethnic disparities in AIDS.

CDC will take several major actions to advance the strategic plan. Regional meetings have been proposed to solicit input from CHAC, other outside experts and partners on updating the strategic plan goals and strategies to reflect the most current knowledge. Demonstration projects will be refined to capture and disseminate best practices on the AA epidemic, crystal methamphetamine interventions, testing and treatment of acute infections and other models. Results from demonstration projects will be implemented to guide approaches state and local health departments and directly-funded CBOs use to perform outreach, counseling, testing and partner notification.

Routine testing will be expanded, the emphasis on social networks will be enhanced, and partner counseling, testing and referral services will be increased. Areas where system and policy changes can be made that afford long-term impact will be identified and maintained over time. For example, opt-out voluntary testing could be routinely performed in emergency centers and STD clinics. Resource allocation decisions will be examined. Improved linkages between prevention and care will be supported with growing recognition that these strategies form a continuum rather than a dichotomy in HIV prevention. Collaborative efforts with HRSA will continue to be undertaken on demonstration projects, quality of care issues and other activities.

Dr. Collins concluded the presentation by requesting CHAC's guidance in addressing a sense of "entitlement" among some agencies or organizations after funding is allocated. Due to budget constraints, resources must be redirected to locations, populations and strategies that will have the largest impact.

NCHSTP leadership provided additional comments about CDC's HIV Prevention Strategic Plan. **Dr. Valdiserri** cautioned that some sectors may view prevention as a failure because the national goal will not be reached. He urged the members to consider groups beyond CDC and HRSA that can be engaged to assist in advancing the strategic plan goal to reduce new HIV infections. CDC and all other public agencies that receive taxpayer dollars must be open to input, new ideas and innovative approaches from all sources. **Dr. Janssen** confirmed that the strategic plan has been extremely beneficial and valuable to DHAP. Most notably, the document assists DHAP in allocating funds each year.

CHAC supported CDC's plan to update the 2001-2005 HIV Prevention Strategic Plan and extensively engage CHAC in this effort. Comments by the members for CDC to consider while revising the document are outlined below.

- Strengthen morale at community and grassroots levels by emphasizing to outreach workers that their HIV prevention activities and other efforts in the field did not fail. Translate "successes" to the community with descriptive outcomes rather than data or numbers. Highlight this type of information in the updated strategic plan.
- Collaborate with the American Hospital Association, Joint Commission on the Accreditation of Healthcare Organizations and other organizations that can make regulatory changes for medical institutions to offer routine and rapid HIV testing as a standard of care.
- Provide CHAC with evaluation data on impacts related to rapid testing. For example, staff may be unable to address and follow-up with persons who had adverse mental health outcomes after being informed of a positive HIV test result.
- Revise the strategic plan as an effective marketing tool for providers and health departments by highlighting the goals.
- Acknowledge that strict laws established in the 1980s on confidentiality, informed consent and pre-test counseling now serve as tremendous barriers to routine HIV testing in the private sector.
- Recognize that the strategic plan goal to link persons to care cannot be achieved until and unless care systems are open and available to deliver services.
- Shift the focus from "referrals" to "linkages" in the updated strategic plan to emphasize the need for persons to receive appropriate services throughout the continuum of obtaining a positive test result to receiving care.
- Acknowledge that crystal methamphetamine use and the Internet served as major contributors to not reaching the national goal. Re-analyze the strategic plan data without these factors to determine whether new HIV infections are actually lower than 40,000. Inform the public about these issues, racial/ ethnic disparities, significant budget decreases at federal and state levels, and any other factors that played a role in not achieving the national goal.
- Recognize that geographical and community targeting served as key contributors to successes in syphilis. Determine whether these activities can be replicated in HIV/AIDS.

- Make efforts to increase the likelihood of reaching the national goal in the updated strategic plan. For example, establish stronger performance standards for health departments and CBOs that receive HIV prevention and testing funds. Urge grantees to aggressively implement activities in the field rather than rely on persons to present to facilities. Decrease funding for grantees that do not meet performance standards. Incorporate specific indicators or requirements in requests for proposals, such as collaborations with grassroots organizations. Allocate funds to grantees in phases based on performance in meeting program announcement criteria.
- Provide grantees at the local level with flexibility to implement innovative and cutting-edge strategies to reduce new HIV infections in the respective target populations.
- Ensure that targets in the updated strategic plan are realistic and feasible based on current knowledge, existing data gaps and uncertainties. For example, surveillance goals cannot be met without a robust tracking and monitoring system. “Unexpected” consequences will play the same role in outcomes as any other factor.
- Explore opportunities to collect long-term behavioral data on HIV-positive persons beyond two or three years post-diagnosis.
- Identify methods for CDC to more rapidly gather, analyze and disseminate data on demonstration projects and other activities.
- Convene meetings in small communities and rural areas in addition to regional events that will be held to solicit input on updating the strategic plan.
- Update CHAC on strategic plan accomplishments during a 2006 or 2007 meeting after CDC improves and refines its HIV/AIDS data systems. Include a discussion of CDC’s focus on and achievements in HIV racial/ethnic disparities during implementation of the 2001-2005 strategic plan.

CHAC concluded the discussion by agreeing to implement the following process to provide CDC with formal guidance on the performance and future of the 2001-2005 HIV Prevention Strategic Plan. **A CHAC workgroup will be established to advise CDC on updating the strategic plan and using the document as a resource to direct HIV prevention and care activities. The workgroup will ensure that the revised strategic plan addresses the HIV budget, racial/ethnic disparities and other concerns raised by CHAC.** The workgroup will be represented by existing and former CHAC members with historical and institutional knowledge of the strategic plan, new CHAC members and external experts as needed. CHAC agreed to craft language to

formalize this process. The motion would be presented on the following day for the entire membership to review and officially adopt.

Dr. Collins fully supported CHAC's proposal to form a strategic plan workgroup and welcomed guidance from the new group on updating the document.

CDC's Performance-Based Management Process

Dr. Bradley Perkins, of the Office of Strategy and Innovation, outlined CDC's new performance-based management framework, process and system. CDC will produce several deliverables under the Futures Initiative, including a new organizational structure; strategic imperatives; people, preparedness, places and global goals; goals management pilot projects for adolescents, adults and preparedness; efforts to align the FY'05 budget to goals; and implementation of goals management "trailblazer" activities for obesity, adolescent health, influenza and preparedness measures.

The strategic imperatives will focus on health impact, customers, public health research, leadership, global health impact and accountability. The new organizational structure will eliminate traditional silos by combining individual centers into coordinating centers. The reorganization will allow CDC to more efficiently use and allocate federal resources. The framework of the health protection goals abandons the traditional categorical disease paradigm to holistically address needs related to persons, preparedness and places. The goals management process will drive CDC's priority decisions for expending funds, allocating personnel and evolving the workforce. CDC's resource allocation will be consistent with evidence-based action plans, accountability and responsibility to accelerate health impact and make investments in research.

CDC is piloting a portfolio management initiative in eight states to provide better service and support to state health programs. Under this project, senior management officials from CDC are placed in large states or regions to perform three key functions. State and local public health systems will be supported. Assistance will be provided on management issues related to procurement, funding, political or other challenges at the state level in conducting CDC activities. Efforts will be made to ensure that funding, partnerships and other state initiatives implemented with CDC dollars are appropriate.

CDC established the trailblazer goals management process by defining specific criteria and developing a five-tier system of assessment, modeling, prioritization, strategy and management. CDC implemented this system to launch trailblazer projects for influenza, preparedness, obesity and adolescents. Lessons learned from conducting and

allocating funding to these pilots will be applied to the broader goals management process. CDC identified systems dynamics modeling techniques to address complex systems problems and redirect the course of change. CDC will strengthen its commitment to make the budget and investments completely transparent. A system will be launched for all CDC staff to access budget information and locate internal partners that have resources and similar interests. The new tool will also allow CDC leaders to more effectively manage portfolios of critical activities.

CDC will take several actions to advance the performance-based management process. Objectives and activities that support the achievement of goals will be prioritized through extensive internal and external collaborations. The goals management process will be refined to accomplish goals and share information throughout the agency. The budget and performance integration system will be shifted to a planning- and knowledge-based tool. Long-term strategies will be developed both internally and externally to support, foster and share innovative public health initiatives. Dr. Perkins confirmed that CHAC, all other CDC advisory bodies and a diverse group of stakeholders will be extensively engaged in the process for external vetting of the goals management process.

CHAC was extremely pleased that the performance-based management process will eliminate CDC's traditional silos. CHAC also commended CDC for significantly expanding its historically narrow definition of "customers." However, some members were concerned about the new system minimizing or diminishing reproductive health, STD, HIV and other individual programs that need internal and external advocacy efforts to sustain funding.

CDC's New Research Agenda

Dr. Robert Spengler is the Director of the Office of Public Health Research in CDC's Office of the Chief Science Officer. He presented an overview of activities that are underway to develop the new CDC-wide research agenda for both intramural and extramural projects. The research agenda will cover the period of 2006-2015, but will be periodically updated during this time. CDC established several roles for the research agenda. Research will be supported to achieve health protection goals for people, places, preparedness and global health. Critical evidence will be provided to improve existing or new programs and interventions. Broad research themes and focus areas will be identified to provide guidance throughout CDC. Assistance will be provided in planning, communicating and marketing CDC research. Progress toward achieving the research agenda goals will be monitored on an ongoing basis.

The research agenda will integrate CDC's goals, programs and research to accomplish goals, achieve health impact, and improve services, programs and response. This paradigm includes health protection goals for health promotion and community preparedness; public health services, response, research and other programmatic activities; and innovations for new priorities, threats and emergencies. CDC has taken several actions to develop the research agenda. Plans were formulated and approved by management, workgroups were formed, and input was gathered from internal and external partners. An initial list of research themes and discussion topics was developed. Public participation meetings were convened throughout the country to obtain feedback from a diverse group of stakeholders and other customers.

The workgroups were established with CDC leadership, staff and external partners to develop goals and focus areas for the research agenda. The workgroups mirror CDC's new organizational structure of coordinating centers and offices. Research agenda priorities were defined based on criteria of public health need and importance; relevance to reducing health disparities; potential for broad impact; and contribution to CDC's mission and health protection goals. Research agenda themes and categories were established, including promotion of health and well-being in every life stage; enhancement of community preparedness and response; ability to promote and sustain healthy places; partnerships for a healthy world; and support of innovation and infrastructure research. CDC is now synthesizing and prioritizing items to include in the research agenda and will soon release a draft for public comment. These comments will be used to revise and finalize the document.

CDC identified ~129 themes to incorporate into the research agenda. Examples of research themes that are of interest and relevance to CHAC are outlined as follows. The "global HIV/AIDS, TB and STDs" theme will focus on prevention, treatment, diagnostic testing, surveillance and service delivery. The "optimal adolescent development" theme will focus on the establishment of healthy behaviors that promote lifelong health and reduce disease risk. The "promotion of safe motherhood and infant health risk" theme will focus on the prevention of mother-to-child transmission of HIV and other diseases. The "implementation of effective health promotion strategies" theme will focus on the establishment of and ability to sustain healthy behaviors across life stages to prevent risky behaviors.

CDC created a web site at www.cdc.gov/od.ophr for the public to obtain additional information on the research agenda, but is continuing its direct outreach efforts. A broad overview of the research agenda is now being presented to CHAC and all other CDC advisory committees. The public comment version and revised draft will be circulated to advisory committee chairs and DFOs for distribution to the respective

memberships. This approach will give advisory committees two opportunities to provide input before CDC finalizes the research agenda.

CHAC's suggestions for CDC to consider in further developing, revising and finalizing the research agenda are outlined below.

- Incorporate language into future requests for applications for grantees to develop experimental evaluation designs for intervention research. Use this methodology to improve the quality of studies and increase the effectiveness of interventions for intent-to-treat groups.
- Include community-based participatory research initiatives in the research agenda.
- Clarify CHAC's role in CDC's goals management process and development of the research agenda.

Update on the CDC Coordinating Center for Infectious Diseases (CCID)

Mr. Reginald Mebane, the CCID Chief Management Official, covered the following items in his status report. NCHSTP is housed in CCID along with the National Center for Infectious Diseases and National Immunization Program. CCID's mission is to protect health from the threat of infectious diseases to enhance the potential for full, satisfying and productive living across the life span of all persons in all communities. CCID is the largest of CDC's four new coordinating centers with a current budget of ~\$4 billion and 4,403 total staff. Of CCID's total budget, ~\$3.3 billion are allocated to external programs and grantees.

CCID will undertake several efforts to fulfill its mission. Opportunities for coordination and integration of research among CCID centers and programs will be identified and leveraged to increase CDC's health impact. Duplication and redundancy will be decreased in programs to maximize available resources, achieve public health goals and streamline logistics for interaction with partners. Leadership, management and accountability will be provided for CCID goals and programs. Resources will be leveraged to be more flexible in responding to public health threats, emerging issues and chronic health conditions.

CCID and all other coordinating centers are organized into six key functions for management, enterprise communications, strategy and innovation, science and public health practice, program integration, and workforce and career development. CCID has defined its roles and responsibilities to perform the six key functions. Areas of synergy

and collaborative opportunities will be identified within the three CCID centers and across other coordinating centers. Opportunities for coordination and integration of programs will be identified throughout CDC to improve health outcomes. Leadership, decision-making and management will be provided in developing infectious disease goals and programs throughout CDC. Efforts will be made to ensure science and programs are high quality and meet CDC's goals. Collaborative efforts will be undertaken with the CDC Office of the Director to reduce redundancy in business practices.

CCID contracted an outside consultant to conduct three major activities. CCID's science and prevention programs were reviewed to identify areas for synergy and efficiency. The roles of CCID public health advisors in state and local health departments were assessed to establish staff priorities in the field. State and local health department cooperative agreements were refined to streamline and standardize administrative procedures. Key findings from the consultant's evaluation will be discussed during the CCID management retreat with division directors and senior staff on May 27, 2005. The meeting will also provide a forum to build consensus in several areas. CCID's guiding principles will be developed and finalized. Critical roles at the primary management level will be defined. Emphasis will be placed on programs and science. The potential need to reorganize CCID's current structure will be discussed.

CCID has several efforts underway to advance its organizational structure. Positions have been announced and posted to fill current vacancies with permanent staff by September 2005. The FY'05 budget will be executed in close collaboration with the three CCID centers to ensure that the process is transparent and understandable. Operational targets, financial measures and other key performance indicators will be developed. These benchmarks will be used to evaluate on an annual basis whether CCID's efforts resulted in cost savings and more efficient programs. Mr. Mebane welcomed input from CHAC on additional issues CCID should address during the management retreat.

CHAC was uncertain whether CCID's efforts will improve the delivery of science because most of the focus and investments will be targeted to strengthening CDC's internal workforce. Communities will be extremely disappointed with and unsupportive of CCID's strong emphasis on internal organizational issues in light of significant budget cuts and racial/ethnic disparities in HIV. CHAC advised CCID to review its previous comments and recommendations on the Futures Initiative related to the Procurement and Grants Office, staffing capacity and other topics.

Dr. Valdiserri committed to obtaining the following documents from Mr. Mebane for distribution to CHAC: the McKing evaluation report on CCID programs; a table that clearly illustrates the transfer of resources due to the reorganization and annual recessions; and key outcomes from the May 2005 CCID management retreat when available.

With no further discussion or business brought before CHAC, **Dr. McGuire** recessed the meeting at 5:38 p.m. on May 11, 2005.

HRSA Update

Mr. Milan reconvened the meeting at 8:43 a.m. on May 12, 2005 and yielded the floor to the first presenter. **Dr. Parham Hopson** covered the following areas in her status report. CHAC's recommendations on the RWCA reauthorization are consistent with principles the President stated will be used to guide this effort. HHS convened a series of meetings to develop proposals, formulate recommendations and explore different components of RWCA. The White House Office of National AIDS Policy is now developing the Administration's proposal on the RWCA reauthorization. HHS, HRSA and the Office of Management and Budget (OMB) leadership are engaged in the White House discussions.

HRSA's FY'05 budget includes a \$35 million increase for ADAP. For the FY'05 RWCA budget of ~\$2 billion, HHS, HRSA and the HRSA HIV/AIDS Bureau (HAB) placed collective taps of 5.04% for evaluation, technical assistance to grantees, CHAC meetings and administrative costs. HRSA's FY'06 budget was proposed at the same level as the FY'05 budget with a \$10 million increase for ADAP. The flat funding has resulted in HRSA allocating less dollars to grantees. The Title III planning grant program will not be funded in FY'05 or FY'06. States and eligible metropolitan areas received significant cuts in Title II base funding and must identify activities to maintain or remove at the local level.

HRSA convened a consultation with CDC in April 2005 to examine state-of-the-art outreach strategies for identifying and retaining HIV-infected persons in care. Limitations to current approaches were also discussed. The agencies drafted several questions to guide the consultation. One, what are the actual or current estimates of persons living with HIV who are in and out of care? Two, why are persons living with HIV who are out of care under-represented in outreach studies? Three, what are the most and least effective interventions in reaching persons living with HIV who are out of care? Four, what new research is needed? Five, should efforts be refocused in light of

limited resources? If so, what strategies will be needed to conduct this activity? Six, what recommendations can be made for future directions?

The consultation resulted in HRSA and CDC identifying five groups that need targeted outreach strategies: HIV-positive persons who have never been tested; newly tested persons out of care; persons who were previously tested and never received care; persons who were previously in care and discontinued care; and persons who receive intermittent care and do not benefit from proper treatment. HRSA will summarize key outcomes from the consultation and distribute the document to CHAC prior to the next meeting.

HRSA and CDC will convene a joint project officer's partnership meeting in July 2005 in Washington, DC. Many HIV/AIDS grantees receive funding from both agencies, but HRSA and CDC project officers typically have no interaction. The overarching goals of the meeting will be to provide the agencies' HIV/AIDS project officers with a general overview, outline the roles and responsibilities of the respective programs, identify dually funded programs in the agencies, and initiate ongoing discussions and collaborations among the project officers. HRSA and CDC hope the meeting will strengthen the continuum of HIV/ AIDS prevention, care and treatment and reduce funding redundancies and duplication. HRSA and CDC will provide CHAC with periodic updates on the progress of the project officers' joint efforts in improving the allocation of prevention, care and treatment funds to grantees.

HRSA and CDC are conducting a tuberculosis (TB) study to evaluate the degree to which RWCA grantees and other HIV service providers in the country deliver TB screening and treatment services. Case studies will soon be implemented with six RWCA Title III grantees with high TB/HIV co-morbidity in Los Angeles, Miami and New York City. The studies will focus on strategies for Title III grantees to successfully provide TB prevention services; ecological factors, program characteristics and specific activities related to successful TB screening and treatment rates at Title III clinics; and the cost of providing TB screening and treatment at Title III clinics.

HRSA still does not collect and report client-level data despite the fact that RWCA was established in 1990. This omission played a major role in HAB receiving a low score on the OMB Program Assessment Review Tool. HRSA is unable to answer several questions with aggregate data that are currently gathered, such as the number of AA women who receive RWCA services. HRSA will convene a consultation on May 23, 2005 with a diverse group of HAB grantees to determine the feasibility of and identify challenges in advancing RWCA grantees toward collecting and reporting client-level data. HAB grantees will assist HRSA staff in assessing the willingness and capacity of

programs to undertake this effort. Client-level data reporting will significantly improve HRSA's data systems and better target services, but no changes will be made until the HRSA Administrator is briefed on whether the activity is feasible at this time.

HRSA is closely collaborating with CMS to ensure the successful implementation of MMA. On January 2, 2006, Medicare will provide pharmaceutical benefits under the Part D Program. The two groups of Medicare beneficiaries living with HIV that will be affected by MMA are persons who are also eligible for Medicaid and persons who only receive Medicare benefits. HHS, HRSA and CMS will meet on May 13, 2005 to discuss uncertain issues related to the interaction between ADAP and Medicare Part D benefits. HAB will develop a training and technical assistance plan to provide guidance and accurate information to RWCA project officers, grantees and patients.

HRSA is partnering with CDC in the AHP initiative to ensure CHCs provide HIV/AIDS counseling and testing. The increase in the CHC budget will be used to establish new access points and expand services at currently funded sites. However, the Administration has stated that a portion of the new dollars should be used to increase the number of persons who receive care at CHCs regardless of the disease. The most significant challenge in this effort will be to strengthen the HIV expertise of every clinician in the country.

As an initial step in addressing this need, HRSA, CDC and the National Association of Community Health Centers jointly administered a survey to a random stratified sample of CHCs. The survey generated a 70% response rate and the data are now being analyzed to obtain more specific information. A large number of respondents provide HIV services, but the types of services were not defined in terms of CHCs that offer support, care and treatment, counseling and testing or case management. No distinction was made between CHCs that do and do not receive RWCA funding. HRSA will present the refined data during CDC's HIV Prevention Conference in June 2005.

Mr. Milan was pleased to note that CHAC served as a leader in establishing guiding principles to formulate RWCA reauthorization recommendations and submit the guidance to the HHS Secretary. CHAC's efforts were based on evidence presented during public hearings as well as the need to shift the focus of RWCA from palliative care to chronic disease management. Organizations and advocacy groups throughout the country have since followed CHAC's model. The outgoing members were encouraged to widely distribute CHAC's recommendations. Mr. Milan reminded CHAC that the President's budget was proposed with flat funding for all RCWA titles with the exception of ADAP. As a result, he urged CHAC to also focus on the budget because full funding and the structure of RWCA are equally important.

CHAC was extremely pleased with the increased collaborative projects and interactions between HRSA and CDC. However, some members expressed tremendous concerns about the HRSA budget in terms of Congressional rescissions, flat funding, budget cuts and administrative taps. The possibility was raised of CHAC drafting and adopting an official statement to convey that “flat funding” is actually a “cut” due to inflation and routine cost of living increases. Additional comments by CHAC on the HRSA update are outlined below.

- Ensure that the CMS *ex officio* member or a designated representative participates in all future CHAC meetings, particularly in light of urgent Medicare issues.
- Explore the possibility of developing a cross-agency outreach strategy that focuses on the continuum of counseling, testing and sustaining care.
- Invite a CHAC member to attend the upcoming HAB meeting on client-level data reporting.
- Identify all social health services that support primary care, such as transportation. Evaluate the impact of the presence or absence of these services on intermittent care. Analyze other factors that play a role in HIV-positive persons discontinuing care, such as housing challenges and medication side effects.
- Consider the differential contribution of data collected at individual, behavioral, health status and care levels. Analyze the intersection of these activities with HIV Service Utilization Study and broader sampling efforts.
- Provide CHAC with detailed budget information on HRSA programs for FY'04-FY'06. Describe funding and program changes that will be needed and clarify the process to execute reductions.
- Provide CHAC with information on the amount of RWCA funding in all titles that will be allocated to outreach.
- Assist CHAC in formulating cogent recommendations to HRSA. For example, distribute information on HIV/AIDS and STD benefits CHCs provide and new dollars that will be allocated to sites.

Update on CDC's AHP Initiative

Dr. Raul Romaguera of CDC provided a status report on the component of the AHP initiative that is designed to make voluntary HIV testing a routine part of medical care. CDC published recommendations in 1993 advising hospitals and associated clinics with

an HIV prevalence of $\geq 1\%$ to offer routine counseling and voluntary testing to patients 15-54 years of age. CDC acknowledges that the guidance is typically ignored and is now updating the 2001 counseling and testing guidelines for both clinical and non-clinical settings.

CDC collected data from its supplemental HIV/AIDS surveillance system in 2000-2003 that showed most hospitals, physician offices and CHCs offer HIV tests, but very few sites offer HIV tests as a routine part of medical care. Tests are typically offered to patients with HIV symptoms or risk factors and are generally administered too late in the progression of disease. The majority of "late testers" are AAs and Hispanics. An assessment of HIV testing practices showed that the percentage of hospitals offering rapid HIV tests or HIV tests to women during labor and delivery is low. Many persons will be overlooked if testing is only administered to patients with risk factors.

CDC is engaging in several collaborative efforts with external partners to address this need. An assessment will be conducted of current HIV testing policies and practices in hospitals. An operational guide for HIV screening in hospital settings will be developed. The document will address local policies, laws and regulations specific to CHCs throughout the country; describe available funding and reimbursement mechanisms for healthcare settings to provide HIV services; and identify local resources to assist providers. Technical assistance will be provided for hospitals in high prevalence areas to establish HIV screening programs. A social marketing campaign will be launched with training sessions, technical assistance, a toolkit and guidance to hospitals and providers on rapid HIV testing and appropriate delivery of test results.

Consultations will be convened to identify and discuss major barriers to emergency departments incorporating HIV testing, such as state laws on written informed consent; conflicts between RWCA language and CDC's AHP guidance; lack of knowledge among providers about pre-test HIV counseling; difficulties in reimbursing providers for HIV testing; and inconsistent national standards and regulations developed by organizations. CDC is attempting to address these challenges by proposing revisions for HRSA to consider in the RCWA reauthorization; encouraging states to adopt language similar to Texas; and identifying state laws, statutes and regulations that serve as barriers to implementing the AHP strategies. A map will soon be posted on the CDC web site that will highlight laws in each state.

CDC and several other groups are developing guidance and conducting other activities to increase the number of healthcare institutions that provide routine HIV testing. These recommendations address routine HIV screening of asymptomatic adults and pregnant women; clinical protocols on routine rapid HIV testing of women in labor with an

unknown HIV status; repeat HIV screening during pregnancy in high prevalence areas; and HIV testing during labor and delivery.

CHAC fully supported CDC's stronger emphasis on routine testing because this effort will play a critical role in preventing new HIV infections and increasing the number of persons in treatment. Other comments by CHAC on the AHP initiative are outlined below.

- Shift the focus from physicians in private settings because public sites diagnose more HIV-positive persons in the affected population. For example, some hospitals and physician offices have less experience in delivering an HIV-positive diagnosis and weaker linkages with community services than community-based clinics. Practitioners should be given guidance on appropriately referring patients to community services.
- Evaluate the wide body of literature that shows AAs are not routinely offered the same tests as whites.
- Redesign HIV tests to mirror medical tests as much as possible by requiring medical staff to administer tests rather than non-medical counseling and testing personnel. Use this approach to minimize difficulties in providers receiving reimbursement for HIV testing.
- Conduct a rigorous evaluation of local barriers to incorporating HIV testing in healthcare settings. Extensively engage local partners in developing approaches to overcome these challenges. For example, communities need effective strategies rather than additional guidelines to assist in changing hospital practices on HIV testing of women during labor and delivery to prevent perinatal transmission. Many state health departments refuse to allow physicians to provide rapid HIV testing.
- Conduct a joint study with SAMHSA to determine the degree to which HIV rapid testing is offered to clients in substance abuse treatment programs.
- Provide CHAC with an update on the differential contribution of various HIV testing mechanisms and sites, including the Indian Health Service.

CHAC Business

Dr. Valdiserri made several announcements that were of interest to CHAC. A Deputy U.S. Global AIDS Coordinator has been appointed. Dr. Robert Janssen, the DHAP Director, is appearing before the Senate Aging Committee on this day to provide testimony on HIV/AIDS among older Americans. The written testimony will be circulated to CHAC. DHAP asked Dr. Valdiserri to share additional information with

CHAC on HIV/AIDS disparities among AAs as follows: ~2.1 million tests performed at CDC-supported HIV counseling and testing sites in 2003, 39% or 829,231 were administered to AA clients. Of all positive HIV tests, 52% were among AA clients.

Dr. McGuire and Mr. Milan led CHAC in a review of formal recommendations, follow-up requests for information, the sense of CHAC and ongoing concerns that were raised throughout the meeting. For items 1 and 2, CHAC made formal recommendations on CDC's HIV Prevention Strategic Plan and the potential establishment of a CHAC STD Workgroup. For item 3, CHAC discussed follow-up requests for information, ongoing concerns and the sense of CHAC. For item 4, CHAC placed a budget motion on the floor.

Motions were properly placed on the floor and seconded by voting members for CHAC to officially adopt each of the four items. Each item was **unanimously approved and adopted** with no abstentions. The four items are fully outlined and collectively appended to the minutes as Attachment 2.

Dr. McGuire asked the members to provide her and Mr. Milan with e-mail messages of potential topics to place on future CHAC agendas. A preliminary list of future agenda items that were suggested during the meeting will be circulated to CHAC.

Dr. McGuire entertained a motion to approve the previous meeting minutes. Mr. Baker submitted changes to the minutes into the record. Mr. Milan requested that "minimal" be deleted from the last paragraph on page 19. A motion was properly placed on the floor and seconded by voting members to adopt the minutes with changes submitted into and noted for the record. The November 18-19, 2004 CHAC Meeting Minutes were unanimously approved with no further changes or discussion.

Public Comment Period

Mr. Gene Copello, The AIDS Institute (TAI) Executive Director, made remarks on several agenda items. First, several organizations have been meeting with CMS to emphasize the need for public education on MMA and discuss other issues related to Medicaid and Medicare. These groups can serve as a valuable community resource to CHAC. Second, TAI distributed its position paper on the RWCA reauthorization to CHAC and is now asking the members to review and provide input on the document. TAI's proposed changes to the RWCA reauthorization are consistent with CHAC's recommendations. The position paper focuses on the critical need for equity,

standardization and minimum care to ensure all persons throughout the country have access to HIV/AIDS medication.

Third, CDC's national goal in the HIV Prevention Strategic Plan to reduce new HIV infections by 50% was unrealistic. CDC has received flat funding or budget cuts since the document was developed. HRSA's efforts to reauthorize RWCA will also not be feasible unless sufficient appropriations are allocated. TAI is extremely pleased with and supportive of CHAC's strong advocacy efforts to increase funding for HIV/AIDS prevention, treatment and care. The White House will soon issue the "Statement of Administrative Priorities" that will provide the Administration with an opportunity to change the President's proposed budget. CHAC may be able to influence this process by providing solid recommendations to the HHS Secretary.

Fourth, CHAC should hold the public comment period before formal motions are placed on the floor for a vote. This format will allow community organizations and other members of the public to weigh on CHAC's important recommendations. Mr. Copello encouraged CHAC to contact him at gcopello@aol.com for additional information.

Ms. Marsha Martin of AIDS Action presented the organization's official recommendations to streamline and modernize ADAP. First, the President should be encouraged to allocate \$720 million to ADAP in FY'06 to increase the total FY'06 budget to \$1.5 billion. Additional funds of \$100 million should be appropriated to ADAP each year during the five-year period of FY'07-FY'11. The initial \$720 million in FY'06 will allow medical and clinical support programs to be incorporated into ADAP for persons entering care. Data collected by the National Alliance of State and Territorial AIDS Directors show that ADAP will need \$100 million each year for a five-year period due to program growth.

Second, all state formularies should have all basic HIV/AIDS drugs approved by the Food and Drug Administration as well as drugs to treat opportunistic infections and unintended side effects. ADAP should be nationalized state-by-state with the development of an ADAP participant card (APC) that can serve as a solid tool to collect patient-level data and report progress to Congress on providing lifesaving medications to persons. The APC would include the individual's prescriptions, CD4 count and other health outcome data. Each APC would be activated within 30 days after an individual moves to another state and is re-certified in the new state system. AIDS Action's prototype of an APC was distributed to CHAC.

Third, AIDS Action proposes that RWCA Title V be created with the following goals. Access to all HIV medications will be ensured. The pursuit of care and treatment near

an individual's home or place of employment will be supported. The number of persons served in every state and territory will be increased. State participation and flexibility in Title V will be rewarded. Accountability of health outcome measures will be reinforced. Responsible program funding will be established. Title V would not be designed to tap other RWCA titles; instead, the new law would create mobility at the top of the ADAP tier, enroll additional persons into care and treat more new clients. Ms. Martin distributed AIDS Action's Title V proposal to CHAC and asked the members to engage in the organization's efforts to streamline and modernize ADAP.

ATTACHMENT 2

CHAC Business

1. HIV Prevention Strategic Plan Recommendation

- CHAC applauds the continued efforts of CDC to achieve the goals of the 2001-2005 HIV Prevention Strategic Plan. CHAC believes the strategic plan has played a significant role nationally in focusing the efforts of all communities toward important objectives in the common mission to reduce HIV transmission, especially among racial and ethnic minority populations.
- CHAC encourages CDC to extend the strategic plan framework until 2008.
- CHAC proposes to create a workgroup to review the progress and needed areas of update of the strategic plan in partnership with HRSA, other relevant stakeholders at federal, state and local levels, non-governmental organizations and community representatives.
- CHAC, in undertaking this process, further urges CDC to conduct expedited data collection and evaluation as needed to determine the current status of the HIV epidemic and the effect of the nation's prevention activities toward achieving the plan.
- CHAC advises CDC to use this process to update the objectives as warranted and identify fiscal and other barriers to achieving the plan's goals.
- CHAC looks forward to receiving periodic updates on the progress of the workgroup and the strategic plan review.

2. Recommendation for a Potential CHAC STD Workgroup

- CHAC recommends that CDC and HRSA representatives and the CHAC Co-Chairs determine the scope of work and best mechanism, including a workgroup, for CHAC to advise the CDC Division of STD Prevention on the following areas in 2005: new challenges in syphilis elimination efforts and human papillomavirus with a focus on vaccine development. The process should particularly focus on racial and ethnic disparities and begin to be implemented with concurrence of CHAC's Designated Federal Officials (DFOs).

3. Follow-Up Requests for Information and Sense of CHAC

Budget Requests

- CDC and HRSA program-level budget information for FY'04-FY'06 with a supplemental assessment of needed funding or program changes.

- Clarification on the process to execute reductions.
- Description of the status of core HIV and STD surveillance capacity and the impact on adequately tracking epidemics.
- Summary of full-time equivalents in CDC and HRSA programs.

Requests to CDC for HIV and STD Information

- CDC's Congressional report on efforts to measure the success of its HIV and STD prevention programs that will be submitted to the House Appropriations Committee.
- Update on projected costs and impacts of the Advancing HIV Prevention initiative.
- Differential contribution of various HIV testing mechanisms and sites, including the Indian Health Service.
- Evaluation data on HIV rapid testing related to staff, client impact, follow-up and other components of post-marketing surveillance.
- Clarification on CDC support and CHAC availability to participate in the town hall meeting during the June 2005 HIV Prevention Conference.
- Matrix on sexually transmitted infections, screening recommendations, projected costs, and delays between coverage and uptake.

Sense of CHAC on HIV and STD

- CDC collaborative efforts with local partners to develop model state legislation on the use of and barriers to routine and rapid HIV testing.
- CDC collaborations with the Joint Commission on the Accreditation of Healthcare Organizations to offer routine and rapid HIV testing as a standard of care where appropriate.
- CHAC support of CDC's continued efforts to facilitate expedited partner therapy as appropriate.
- Recommendation for an STD expert to fill one of CHAC's current vacancies.
- CHAC representation at the August 2005 meeting on the syphilis elimination effort and the annual STD meeting in 2006.

Requests to CDC for Reorganization Information

- Key outcomes from the May 2005 Coordinating Center for Infectious Diseases management retreat.
- Findings from the McKing evaluation report on CCID programs.
- Impacts of CDC's new trailblazer goals and research priorities on HIV and STD budgets, programs and personnel.
- Clarification on CHAC's role in the goals management process and development of the research agenda.

Requests to HRSA for Information

- Update on the profile of persons out of care.
- Update on sites of care for persons with HIV/AIDS, including the number of clients in community health centers (CHCs) with no Title III funding.
- Review of letter that will be developed by the CHAC writing group on the CHC expansion, collaborations and capacity development regarding HIV/STD prevention, screening and treatment.
- CHAC representation at the meeting on client-level data reporting.

Sense of CHAC on the Office of the HHS Secretary

- Urgent restatement of CHAC's concerns expressed during the November 2004 meeting on coverage and implementation of the Medicare Modernization Act for persons with HIV/AIDS. Participation by the Centers for Medicare and Medicaid Services *ex officio* member or a designated representative at all future CHAC meetings.
- Clarification within the next two weeks on CHAC's pending request for a meeting with the HHS Secretary given the urgency of AIDS Drug Assistance Program (ADAP) and Medicare funding challenges.

CHAC's Ongoing Concerns

- Maintain the implications of racial/ethnic disparities in HIV and STD as a central focus in all presentations of data, program reviews and innovation efforts.
- Facilitate improved rapid assessment of changing epidemic trends, potentially effective interventions and related changes in resource allocation.
- Acknowledge the contribution of different research models and methods in understanding intervention efficacy. Continue evaluations of effective interventions when applied to other populations.
- Follow up on the request by the CDC National Center for HIV, STD TB Prevention Acting Director for assistance in addressing the sense of "entitlement" among some agencies or organizations after funding is allocated. Explore strategies to facilitate ongoing funding of existing activities in a reduced resource environment.
- Consider the differential contribution of data collected at individual, behavioral, health status and care levels. Analyze the intersection of these activities with the HIV Service Utilization Study and broader sampling efforts.
- Follow up on CHAC's access to background reports during interim periods between meetings.
- Recognize that "unexpected" consequences play the same role in outcomes as any other factor.

4. CHAC Budget Motion

CHAC expresses concern that administrative restructuring and shifting of FY'05 administrative funds to support new or higher levels of administration at both CDC and HRSA will have negative impacts on HIV and STD prevention and care administration and service levels. CHAC requests that CDC and HRSA convey to CHAC in a timely manner financial impacts on the agencies' HIV and STD programs resulting from these budget shifts.

CHAC expresses concern that the CDC and HRSA HIV and STD prevention and care programs will face significant negative impacts on service levels and the administration of these programs. These outcomes are a result of increasingly scarce resources at community levels, proposed FY'06 flat funding, Congressionally authorized recissions and administrative budget "taps." CHAC requests that HHS, CDC and HRSA convey to CHAC in a timely manner financial impacts on the agencies' HIV and STD programs resulting from these budget issues for FY'05 and FY'06.

CHAC commends HHS for proposing a significant expansion in CHC facilities and services across the country. However, CHAC expresses concern that the increase in access points to health care for persons living with HIV/AIDS must also include a higher level of new funds than currently proposed for FY'06 to provide treatment to those persons. CHAC urges HHS to further increase its proposed FY'06 support for ADAP and other mechanisms for HIV treatment needed by persons newly seeking HIV care in CHCs.

Closing Session

The members will be polled by e-mail to determine availability for the next CHAC meeting. The date of the next meeting will be circulated after the members confirm their respective schedules.

With no further discussion or business brought before CHAC, **Dr. McGuire** adjourned the meeting at 12:23 p.m. on May 12, 2005.

I hereby certify that to the best of my knowledge, the foregoing Minutes of the proceedings are accurate and complete.

Date

Jean Flatly McGuire, Ph.D., Co-Chair
CDC/HRSA Advisory Committee on
HIV and STD Prevention and Treatment

Date

Jesse Milan, Jr., JD, Co-Chair
CDC/HRSA Advisory Committee on
HIV and STD Prevention and Treatment

ATTACHMENT 3

List of Acronyms

AAs	—	African Americans
ADAP	—	AIDS Drug Assistance Program
AHP	—	Advancing HIV Prevention
APC	—	ADAP Participant Card
CBOs	—	Community-Based Organizations
CCID	—	Coordinating Center for Infectious Diseases
CDC	—	Centers for Disease Control and Prevention
CHAC	—	CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment
CHCs	—	Community Health Centers
CMS	—	Centers for Medicare and Medicaid Services
DFO	—	Designated Federal Official
DHAP	—	Division of HIV/AIDS Prevention
DSTD	—	Division of STD Prevention
EPT	—	Expedited Partner Therapy
GAP	—	Global AIDS Program
HAB	—	HIV/AIDS Bureau
HHS	—	Department of Health and Human Services
HPV	—	Human Papillomavirus
HRSA	—	Health Resources and Services Administration
HSV	—	Herpes Simplex Virus
IDUs	—	Injection Drug Users
LGV	—	Lymphogranuloma Venereum
MMA	—	Medicare Modernization Act
MSM	—	Men Who Have Sex With Men
NCHSTP	—	National Center for HIV, STD and TB Prevention
OMB	—	Office of Management and Budget
PEPFAR	—	President's Emergency Plan for AIDS Relief
RWCA	—	Ryan White Comprehensive AIDS Resources Emergency Act
SAMHSA	—	Substance Abuse and Mental Health Services Administration
SEE	—	Syphilis Elimination Effort
TAI	—	The AIDS Institute
TB	—	Tuberculosis