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

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

May 7-8, 2007
Atlanta, Georgia

Record of the Proceedings

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ATTACHMENT 1

List of Participants

CHAC Members
Dr. Edward Hook III, Co-Chair
Mr. Jesse Milan, Jr., Co-Chair
Ms. Renee Austin
Dr. Dorothy Brewster-Lee
Ms. Theresa Devlin
Dr. Fernando Garcia
Rev. Debra Hickman
Mr. Thishin Jackson
Dr. Dennis Leoutsakas
Mr. Thomas Liberti
Dr. John Martin
Dr. Donna Sweet
Dr. Lydia Temoshok
Dr. Nathan Thielman
Dr. Carmen Zorrilla

CHAC *Ex-Officio* Representatives
Dr. Pradip Akolkar (FDA)
Ms. Beverly Watts Davis (SAMHSA)
Dr. William Grace (NIH)
Ms. Kenni Howard (CMS)
Dr. John Redd (IHS)

Designated Federal Officials
Dr. Laura Cheever (HRSA)
Dr. Kevin Fenton (CDC)

HHS, CDC and HRSA Representatives
Ms. Lynn Barclay
Ms. Andrea Barrett (CDC Contractor)
Dr. Stephanie Bernard
Ms. Sara Bingham
Dr. Chris Cagle
Ms. Janet Cleveland
Dr. Hazel Dean
Dr. John Douglas, Jr.
Ms. Teresa Durden
Ms. Shelley Gordon
Dr. Robert Janssen
Dr. Laura Kann
Dr. Mary McFarlane
Ms. Amy Pulver
Dr. George Roberts
Dr. Lisa Romero
Ms. Margie Scott-Cseh
Ms. Jenny Sewell
Dr. Howell Wechsler

Members of the Public
Mr. Sean Barry (Community HIV/AIDS Mobilization Project)
Dr. Robert Carroll (Northwest AIDS Education and Training Centers)
Ms. Kimberly Carbaugh (Association of Nurses in AIDS Care)
Ms. Donna Gallagher (New England AIDS Education and Training Center)
Mr. Nathan Linsk (Midwest AIDS Education and Training Center)
Dr. Jean McGuire (Commonwealth of Massachusetts, Executive Office of Health and Human Services)
Ms. Sarah Ray (HealthStat)
Mr. Carl Schmid (The AIDS Institute)
Ms. Ruth True (Community HIV/AIDS Mobilization Project)

ATTACHMENT 2

Acronyms Used In This Report

AAs — African Americans
ACIP — Advisory Committee on Immunization Practices
ADAP — AIDS Drug Assistance Program
AETCs — AIDS Education and Training Centers
AI/AN — American Indians/Alaska Natives
APIs — Asian/Pacific Islanders
BHPr — Bureau of Health Professions
BPHC — Bureau of Primary Health Care
BSC — Board of Scientific Counselors
CARE Act — Ryan White Comprehensive AIDS Resources Emergency Act
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
DSTDP — Division of STD Prevention
EIS — Early Intervention Services
EMAs — Eligible Metropolitan Areas
EPT — Expedited Partner Therapy
GAO — Government Accounting Office
GPRA — Government Performance Result Act
HAB — HIV/AIDS Bureau
HHS — Department of Health and Human Services
HPV — Human Papillomavirus
HRSA — Health Resources and Services Administration
HSV-2 — Herpes Simplex Virus 2
IHS — Indian Health Service
IOM — Institute of Medicine
MAI — Minority AIDS Initiative
MMWR — *Morbidity and Mortality Weekly Report*
MSM — Men Who Have Sex With Men
NCHHSTP — National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention
NCQA — National Committee for Quality Assurance
NCSD — National Coalition of STD Directors
NIPP — National Infertility Prevention Program
OMB — Office of Management and Budget
P&S — Primary and Secondary Syphilis
PACHA — Presidential Advisory Council on HIV/AIDS
PART — Program Assessment Rating Tool

PEMS	—	Program Evaluation and Monitoring System
PEPFAR	—	President's Emergency Plan for AIDS Relief
PID	—	Pelvic Inflammatory Disease
PCSI	—	Program Collaboration and Service Integration
PLWH	—	Persons Living With HIV
RWHATMA	—	Ryan White HIV/AIDS Treatment Modernization Act
SAMHSA	—	Substance Abuse and Mental Health Service Administration
SMAs	—	State Medicaid Agencies
SPNS	—	Special Projects of National Significance
STIs	—	Sexually Transmitted Infections
TAI	—	The AIDS Institute
TCE	—	Targeted Capacity Expansion
TCOE	—	Technology Center of Excellence
TGAs	—	Transitional Grant Areas
USPSTF	—	U.S. Preventive Services Task Force
XDR-TB	—	Extensively Drug-Resistant TB

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CDC/HRSA ADVISORY COMMITTEE ON HIV AND STD PREVENTION AND TREATMENT
May 7-8, 2007
Atlanta, Georgia

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 at the Embassy Suites Hotel in Atlanta, Georgia on May 7-8, 2007.

Opening Session

Dr. Edward Hook III and Mr. Jesse Milan, Jr., the CHAC co-Chairs, called the meeting to order at 8:35 a.m. on May 7, 2007. 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. Kevin Fenton, Director of CDC's National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP) and CHAC's Designated Federal Official (DFO) for CDC, announced that CHAC meetings are open to the public and all comments made during the proceedings are a matter of public record. 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. Fenton presented a plaque to Dr. Jean McGuire, the former co-Chair of CHAC, in recognition and appreciation of her outstanding leadership. The participants applauded Dr. McGuire's tremendous contributions to CHAC, CDC and HRSA. Dr. Fenton also acknowledged and welcomed Dr. Hook in his role as the new co-Chair of CHAC.

Dr. Fenton announced that Dr. Patsy Sulak, one of CHAC's two new members representing CDC, resigned on April 21, 2007. CDC is attempting to identify her replacement and has resubmitted names of potential candidates to HHS. Ms. Dianna Lightfoot, the other new CHAC member representing CDC, is expected to attend the November 2007 meeting.

Dr. Laura Cheever, Deputy Associate Administrator of the HRSA HIV/AIDS Bureau (HAB) and CHAC's Acting DFO for HRSA, acknowledged the valuable service of CHAC's five members representing HRSA whose terms would expire in June 2007: Mr. Milan and Drs. John Martin, Dennis Leoutsakas, Judy Goforth Parker and Donna Sweet. Dr. Cheever reminded CHAC that outgoing members continue to serve up to 180 days until officially replaced. She announced that the five outgoing members would be asked to attend the November 2007 meeting.

Update by the CHAC Co-Chairs

Mr. Milan announced that the HHS Secretary signed CHAC's new charter on November 27, 2006 with two important changes. First, CHAC is now charged with advising CDC and HRSA on activities related to the prevention and control of HIV/AIDS and other STDs. CHAC was previously charged with providing advice directly to the HHS Secretary. Second, CHAC's membership was reduced from 20 to 18 members. The new charter was included in the meeting packets for CHAC's review.

Mr. Milan reminded the members that CHAC charged the co-Chairs with sending a letter to the HHS Secretary highlighting six major recommendations made during the November 2006 meeting. In response to CHAC's request, Dr. McGuire and Mr. Milan sent a letter to the HHS Secretary dated December 19, 2006. In a letter dated March 14, 2007, Dr. Julie Gerberding, Director of CDC, responded to CHAC's letter on behalf of the HHS Secretary.

In response to CHAC's fourth recommendation, Dr. Gerberding confirmed that CDC is currently developing projections for the number of newly diagnosed HIV-infected persons who might be identified through CDC's revised HIV testing guidelines. In response to CHAC's fifth recommendation, Dr. Gerberding explained that HRSA has a cooperative agreement with the National Alliance of State and Territorial AIDS Directors to offer information and technical assistance on providing HIV/AIDS therapies and most efficiently utilizing Medicare Part D. CHAC's letter and Dr. Gerberding's response were included in the meeting packets for CHAC's review.

Mr. Milan reported that he and Dr. Hook received a telephone call from the Office of the HHS Secretary requesting a meeting with Dr. John Agwunobi, Assistant Secretary of Health at HHS. Mr. Milan and Dr. Hook were unable to attend a meeting in April 2007 and have asked for the meeting with Dr. Agwunobi to be rescheduled at a later date.

Dr. John Martin is a CHAC member and CHAC's liaison to the Presidential Advisory Council on HIV/AIDS (PACHA). He provided a brief update on PACHA's activities. PACHA's international subcommittee is focusing on reauthorization of the President's Emergency Plan for AIDS Relief (PEPFAR), while the domestic subcommittee is focusing on reauthorization of the Ryan White Comprehensive AIDS Resources Emergency Act (CARE Act). HRSA informed PACHA that the reauthorized CARE Act will sunset on September 30, 2009. The domestic subcommittee will continue to evaluate the impact of the reauthorized CARE Act in the field. Overall, PACHA's position was that Congress should take proactive actions to ensure continuation of this legislation.

Dr. Martin reported that HHS informed PACHA of its commitment to participate in ~2,000 events over the next two years. PACHA noted that www.aids.gov is a useful resource to facilitate HHS's involvement in local programs. Dr. Martin pointed out that PACHA recognized the importance of ongoing communications with CHAC. As a result, Dr. McGuire made a presentation during the previous PACHA meeting on CHAC's December 2006 letter to the HHS Secretary. Dr. McGuire's compelling presentation resulted in PACHA endorsing CHAC's formal motions, particularly the recommendation for the HHS Secretary to initiate the development of a multi-sectoral National Strategic Plan for HIV/AIDS Prevention, Treatment and Care. Dr. Martin announced that the next PACHA meeting would be held in June 2007.

Several CHAC members expressed concerns about the change in CHAC's charter to provide advice to CDC and HRSA rather than the HHS Secretary directly. A number of members described examples in which the new charter potentially could impact CHAC's guidance.

CHAC's motion to develop a National HIV Strategic Plan "addresses activities of all sectors and includes all relevant federal agencies." Under the previous charter, direct communications with the HHS Secretary gave CHAC the ability to indirectly provide guidance to the Centers for Medicare and Medicaid Services (CMS), the Substance Abuse and Mental Health Service Administration (SAMHSA), and other HHS agencies with a critical role in the development of a National HIV Strategic Plan. Under the new charter, however, CHAC will provide advice to CDC and HRSA only. A number of members also noted that the development of a National HIV Strategic Plan was one of CHAC's most important motions, but Dr. Gerberding did not address this recommendation in her "generic" response.

In a second example, the CHAC members pointed out that SAMHSA acquired a number of rapid test kits in 2006 during an expansion of rapid HIV testing. Under the previous charter, CHAC could directly communicate with the HHS Secretary to outline SAMHSA's problems with implementing the rapid test kits and request that these issues be addressed. CHAC can only communicate with CDC and HRSA under the new charter, but neither of these agencies has jurisdiction or influence over SAMHSA.

In a third example, the CHAC members explained that the new charter would prohibit direct communications with the HHS Secretary to provide guidance to CMS. As a result, CHAC would be unable to advise CMS on implementation of Medicare Part D for clients who receive HIV/AIDS services under the CARE Act. Overall, the members emphasized the need for CHAC to identify and discuss strategies to maintain its ability to facilitate interagency dialogue and continue to provide guidance to other HHS agencies under the new charter.

Dr. Fenton made several remarks in response to CHAC's concerns about the change in the charter to advise CDC and HRSA rather than the HHS Secretary directly. The new guideline was established to streamline communications between CHAC and the HHS Secretary. CHAC will now make formal motions and recommendations to CDC and HRSA, but is still free to correspond with the HHS Secretary. Under the new charter, however, CHAC's letters to the HHS Secretary would be sent to the two agencies first.

Dr. Fenton explained that the new guideline would ensure the two agencies have a proper accounting of CHAC's formal advice to the HHS Secretary. The new process would also eliminate previous concerns related to direct communications between federal advisory committees and the HHS Secretary. Advisory committees have submitted formal resolutions and recommendations directly to the HHS Secretary, but the CDC Director or HRSA Administrator had no knowledge of these key issues.

CDC Update

Dr. Fenton covered the following areas in his report. CDC's revised recommendations for HIV testing of adults, adolescents and pregnant women in healthcare settings were published in the *Morbidity and Mortality Weekly Report* (*MMWR*) in September 2006 and also were posted on the CDC web site. Since that time, CDC has been collaborating with a number of partners to implement the revised HIV testing guidelines and ensure diverse settings and domains are covered, including health departments, professional organizations, academic institutions, community-based organizations (CBOs), correctional settings, implementation guidance, monitoring and evaluation, reimbursement, laws and regulations, barriers and linkages to care, social marketing and laboratories.

CDC is providing training and technical assistance to strengthen professional partnerships with a broad range of national organizations and enhance support and implementation of the revised HIV testing guidelines. CDC is collaborating with professional partners and stakeholders to develop implementation guidance for various types of settings, including hospitals, STD clinics, substance abuse treatment centers, community health centers (CHCs), correctional health facilities, primary care settings, urgent care clinics and prenatal care clinics. The guidance is being designed as a step-wise approach to implement the

revised HIV testing guidelines. CDC expects to release the implementation guidance later in 2007.

CDC is addressing CHAC's previous concerns related to reimbursement for additional HIV tests as a result of the revised HIV testing guidelines. CDC is partnering with CMS, health insurers and state Medicaid directors to achieve several goals: (1) obtain reimbursement for HIV screening; (2) incorporate HIV testing into CMS's Early Periodic Screening, Diagnostic and Treatment Program; (3) explore options for uninsured patients; and (4) identify CPT codes to cover increased costs associated with the use of single point of care tests, such as labor costs and use of external controls.

CDC is conducting additional activities to foster implementation of the revised HV testing guidelines. Six regional workshops were convened to raise awareness of the guidelines. High priority was given to emergency departments. CDC formed public/private partnerships to facilitate implementation of the revised HIV testing guidelines at the local level. For example, the National Medical Association is collaborating with primary care providers in five cities with a high incidence of HIV/AIDS among African Americans (AAs). Gilead Sciences is providing funds to support acute care testing in eight cities.

Dr. Fenton reported that NCHHSTP held several consultations to discuss key programmatic issues, including male circumcision and recommendations for the identification and public health management of persons with chronic hepatitis B virus infection.

Dr. Fenton announced that NCHHSTP senior staff and division colleagues are continuing to conduct site visits to promote its program integration and service collaboration (PISC) initiative. NCHHSTP used site visits to four California cities in February 2007 to test preliminary concepts for some of the PISC activities. Partners at the four California sites provided NCHHSTP with tremendous feedback on the PISC initiative and confirmed that similar meetings would continue to be held at the local level.

NCHHSTP used the Albany, New York site visit in April 2007 as an opportunity to identify changes in PISC six months after the first New York site visit. NCHHSTP had discussions with HIV, STD and TB directors to support this effort. NCHHSTP was pleased that local jurisdictions and professional organizations expressed a strong interest for CDC to take national leadership in PISC. NCHHSTP recognized the need to closely collaborate with surveillance partners to harmonize and streamline data in its PISC initiative.

Dr. Fenton informed CHAC that the Coordinating Center for Infectious Diseases (CCID) Board of Scientific Counselors (BSC) held its first meeting in March 2007. The BSC is charged with providing independent and scientific oversight and advice to CCID's programs. The BSC is organized into four subgroups to match NCHHSTP's four divisions for HIV, STDs, TB and viral hepatitis. During the BSC meeting, overviews were given on

surveillance, laboratory and other activities to address antimicrobial resistance because this issue cuts across all of NCHHSTP's divisions.

The BSC's key recommendations for NCHHSTP to address drug resistance in its activities are summarized as follows. For drug resistance in international settings, surveillance of extensively drug-resistant TB (XDR-TB) and HIV drug resistance should be given the highest priority, particularly among women and children. Monitoring of herpes simplex virus 2 (HSV-2) resistance and the development of more formal laboratory networks for monitoring gonorrhea antibiotic resistance should be given medium priority.

For domestic drug resistance, surveillance of XDR-TB and HIV drug resistance among persons with new HIV infections should be given the highest priority. New surveillance systems to monitor HIV should be strongly endorsed. Surveillance of resistant HIV strains should be investigated. The feasibility of HIV resistance testing for low-prevalence mutations should be pursued. Collaborative efforts should be undertaken with states to obtain XDR-TB reporting and possible reporting of multidrug-resistant TB and also to assure complete contact investigations. Rapid molecular methods for drug resistance screening should be developed and made available. Results of all HIV and TB drug resistance testing should be readily available and easy to interpret. The final report from the March 2007 BSC meeting will be shared with CHAC.

Dr. Fenton announced that Dr. Gerberding participated in a Congressional briefing in March 2007 on XDR-TB. She also provided testimony on XDR-TB in March 2007 before the Africa and Global Health Subcommittee of the House Foreign Affairs Committee.

Dr. Fenton provided an update on NCHHSTP's budget. A joint resolution was passed for FY'07 with funding remaining relatively flat for STD, TB and viral hepatitis prevention programs. Despite the largely stable budget, NCHHSTP had two key opportunities to increase its funding in FY'07. NCHHSTP successfully competed for additional funding under CDC's emerging infectious diseases portfolio to support several important projects. In addition, CDC allocated $45 million received in the joint resolution in 2007 to NCHHSTP for HIV testing. These new dollars were not based on diverting funds from NCHHSTP's existing programs. CDC's FY'06 and FY'07 budgets were the same, but some programs were eliminated in FY'07. As a result, CDC had additional funds under the joint resolution that could be allocated to requests made in the President's budget.

NCHHSTP will use the $45 million to fund and support prevention activities in the President's FY'07 budget request. Most notably, a strong infrastructure will be established for the HIV testing initiative with four major goals: (1) initiate expanded HIV testing; (2) facilitate new investments in HIV testing in FY'08 and thereafter; (3) monitor and evaluate the impact of these new investments on identifying persons with undiagnosed HIV infections earlier in the course of disease; and (4) link HIV-positive persons identified through the HIV

testing initiative to care. NCHHSTP will develop solid metrics to demonstrate the added value, public health benefits and other positive outcomes of the new $45 million allocation.

The majority of the $45 million will be allocated to health departments for HIV testing in clinical settings, including STD and TB clinics and emergency departments. States and CDC's directly funded cities and counties that accounted for 95% of AIDS diagnoses among AAs in 2005 will be eligible to compete for these funds. CDC is currently finalizing and expects to release the competitive program announcement in the near future. Of 26 eligible jurisdictions, CDC expects to fund up to 20 sites across the country. Individual awards will be based on AIDS rates among AAs in each jurisdiction. CDC will award funds by fiscal year-end on September 30, 2007.

Dr. Fenton described key changes in NCHHSTP's senior leadership. Dr. Nickolas DeLuca is serving as the Acting Associate Director for Health Disparities after Dr. Hazel Dean was appointed as the Acting Deputy Director of NCHHSTP. Ms. Susan DeLisle is serving as the Acting Associate Director for Program Integration. Dr. Hsi Liu is serving as the Acting Associate Director for Laboratory Sciences. Dr. Salaam Semaan is serving as the Acting Associate Director for Science. Dr. Fenton has prioritized filling the acting positions by the end of July 2007 to produce a strong, permanent and stable leadership team.

Drs. Fenton and Robert Janssen, Director of the NCHHSTP Division of HIV/AIDS Prevention (DHAP), provided additional details about CDC's HIV/AIDS and STD activities in response to CHAC's specific questions and comments. In terms of reimbursement for HIV testing, the overarching purpose of the competitive program announcement for HIV testing in clinical settings is to promote investments. CDC does not have sufficient resources to support implementation of the revised HIV testing guidelines across the country. The program announcement is designed to facilitate collaborations between health departments and clinical settings to initiate HIV testing.

CDC's position is that insurers, Medicaid and other payors should also pay for HIV testing because this service is a component of medical care. New CPT codes for HIV testing that were approved and will be implemented in January 2008 will help facilities to bill for screening. CDC has encountered difficulties in its previous attempts to obtain CMS's support for routine HIV testing of persons in healthcare settings. CDC is partnering with a number of professional organizations to secure endorsement of the revised HIV testing recommendations. This approach was successful in payors reimbursing perinatal HIV screening.

Drs. Fenton and Janssen described other components of the HIV testing program announcement. The funds will be used to replenish or replace core prevention capacities at the local level in addition to identifying and diagnosing new HIV infections. Health departments will receive 80% of funds for HIV testing, linkages to care, and partner counseling and referral services. Grantees will use these awards to address the HIV crisis

among AAs and implement the HIV testing guidelines in healthcare settings. CDC has made a strong commitment to consider linkages to care for persons who are newly diagnosed with HIV through the revised HIV testing guidelines.

Local jurisdictions will be allowed to use the remaining 20% of funds for staffing needs, monitoring and evaluation activities, outreach, social networks, and other infrastructure costs. CDC will recommend, but will not require grantees to use the 80%/ 20% ratio. The program announcement will contain clear language that the two-year project will only be funded for one year if funds are not appropriated in year 2.

An integrated approach to HIV testing will be emphasized in the HIV testing program announcement. Grantees will be required to closely collaborate with local TB, STD and viral hepatitis prevention partners. The need for additional resources in CHCs and STD clinics to support partner notification activities will be highlighted in the program announcement. Emphasis will be placed on sites with a higher prevalence of HIV.

A distinction will not be made between targeted and routine HIV testing in the program announcement due to existing state laws and policies. Broad HIV testing will be promoted to minimize barriers to state and local jurisdiction statutes. CDC is partnering with HRSA to urge health departments to implement targeted testing in CHCs. CDC's phased implementation of the HIV testing guidelines will initially target facilities thought to have the highest number of HIV-infected persons who do not know their status. Other settings will be targeted over time. At the end of the project period, CDC expects to identify jurisdictions that successfully implemented routine HIV testing models and enhanced targeted testing.

Dr. Janssen announced that CDC formed a workgroup to focus on and test new algorithms for rapid confirmatory HIV tests, the polymerase chain reaction technique, and the Western Blot test. CDC expects to release guidance in 2008 on using HIV tests and interpreting results. In addition to gathering input from the workgroup, CDC also will consult with the Association of Public Health Laboratories on rapid confirmatory HIV tests. However, CDC's position is that current data are not sufficient to make recommendations at this time.

Dr. Janssen explained that CDC is continuing its efforts to streamline the collection of HIV data through the Program Evaluation and Monitoring System (PEMS). CDC is collaborating with health departments, CBOs and other partners to identify data variables to collect and determine the best use of PEMS. CDC will continue to collaborate with health departments and clinical settings to reach agreement on minimum data elements to collect through PEMS.

Dr. Janssen noted that the U.S. Preventive Services Task Force (USPSTF) is re-reviewing data CDC used to develop the HIV testing guidelines. For example, CDC analyzed cost-effectiveness data to formulate its guidance, but USPSTF typically does not use this data

source. CDC does not expect USPSTF to change its HIV testing recommendations, but the two sets of guidelines should not present a barrier to payers reimbursing for HIV testing.

CHAC was extremely pleased that CDC realigned funds in FY'07 to allocate $45 million to HIV testing. The members thanked CDC for responding to its request to provide projections on the number of newly diagnosed HIV-infected persons the HIV testing initiative is expected to identify. Following the previous meeting, CDC distributed a memorandum to CHAC explaining that the new $45 million allocation is expected to support 2 million HIV tests to identify 22,000 new HIV infections in FY'07 and potentially 31,000 new HIV infections in FY'08. The members pointed out that the estimates would allow CHAC to demonstrate the impact of CDC's revised HIV testing guidelines on public health. CHAC was also pleased that the HIV testing program announcement could lead to a multitude of AAs being tested earlier in their HIV diagnoses.

Several CHAC members made suggestions for CDC to consider in its ongoing efforts on the HIV testing initiative.

- CDC should ensure that new CPT codes for point of care testing are broad and not limited to HIV. HIV-specific CPT codes have traditionally served as a barrier to screening for other STDs.
- CDC should give higher priority to rapid confirmatory HIV tests because many clients will not return to obtain results.
- CDC should identify strategies at this time to address one-time funding if dollars are not appropriated in year 2 of the HIV testing program announcement. Continued funding will be particularly important to support a mental health infrastructure for persons who are newly diagnosed with HIV through the revised HIV testing guidelines.

HRSA Update

Dr. Cheever covered the following areas in her report. HRSA's budget decreased by $166 million from $6.6 billion in FY'06 to $6.4 billion in FY'07. HAB's budget for CARE Act programs increased by $83 million from $2.06 billion in FY'06 to $2.1 billion in FY'07. Of the overall increase of $76 million, $75 million is in the Part B base.

In the FY'08 President's budget, HRSA's budget is projected to be $5.8 billion or a $596 million decrease from FY'07. The HAB budget for CARE Act programs is projected to be $2.14 billion or a $14 million increase from FY'07. The projected $20 million overall increase in the FY'08 President's budget includes a $25 million increase in the AIDS Drug Assistance Program (ADAP), a $5 million decrease in the Part B base, a $6 million increase in Part C programs, and a $6 million decrease in the AIDS Education and Training Center (AETC) Program.

Dr. Cheever described a number of HAB's HIV initiatives for FY'07. HAB is closely collaborating with CDC on implementation of the revised HIV testing guidelines to ensure that linkages to care are provided to newly diagnosed persons. CDC and HAB held a meeting in January 2007 to extensively discuss the impact of the HIV testing guidelines on CARE Act grantees. HAB is continuing efforts on its client-level data initiative for CARE Act grantees to report data. HAB is currently conducting an assessment of all grantees to determine existing capacity, unmet needs and potential problems in generating client-level data. HAB also is performing a rigorous analysis of all ADAP grantees.

The Institute of Medicine (IOM) previously advised HRSA to develop a core set of quality measures for use across all CARE Act programs. In response to the recommendation, HAB developed and posted draft quality measures on its web site and is now soliciting input throughout May 2007. HAB will incorporate some of the quality measures into client-level data and will advise grantees to use these indicators. However, the quality measures will not be mandated or required. HRSA's Office of Performance Review also will use some of the quality measures to measure the performance of Parts C and D grantees (formerly Titles III and IV).

Dr. Cheever provided an update on HAB's personnel changes and administrative activities. Dr. Lois Eldred, the Global Director, resigned from this position. Dr. Barbara Aranda-Naranjo was appointed as the Director of the Global AIDS Program. The Office of Management and Budget (OMB) conducted the second Program Assessment Rating Tool (PART) review of HAB programs. HAB performed a number of studies to respond to OMB's comments and improve its score from the 2002 PART review. HAB will receive its score from the 2007 PART review in August 2007.

Dr. Cheever highlighted three of HAB's ongoing studies. Mathematica Policy Research was contracted to conduct a financing study. This research will include an assessment and the development of technical assistance strategies to address challenges posed by healthcare financing provisions of the Deficit Reduction Act and other state Medicaid reforms. HAB is closely collaborating with CDC to conduct a retention in care study. This research will attempt to identify successful and effective models to retain patients in care.

HAB is conducting a case management study because medical case management is listed as a core service in the reauthorized CARE Act. This research will determine core competencies rather than actual degrees of case managers. The study also will identify case management activities that are most important in linking clients to medical care. Findings from the case management study will be compiled and distributed to grantees as best practices and technical assistance. HRSA expects to develop and release a final report from the case management study over the next year.

Dr. Cheever announced that the CARE Act was most recently reauthorized in 2006 as the "Ryan White HIV/AIDS Treatment Modernization Act" (RWHATMA). RWHATMA was signed into law on December 19, 2006 for a three-year authorization period that will sunset in 2009. RWHATMA retains the structural aspects of the previous CARE Act, but "Titles I-IV" are now "Parts A-D." Part E contains general provisions. Part F includes AETCs, the Dental Program, the Minority AIDS Initiative (MAI), and Special Projects of National Significance (SPNS).

RWHATMA codifies MAI programs and maintains the purpose of the previous CARE Act. Primary care and support services for persons living with HIV (PLWH) disease will continue to be the primary focus. Life-extending HIV/AIDS drug therapies will continue to be provided. Support will continue to be provided to persons who lack health insurance and financial resources for their care. The importance of training, technical assistance and demonstration projects will continue to be emphasized.

Dr. Cheever's overview of major changes between the CARE Act and RWHATMA is summarized below.

<u>Part A: Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs)</u>

- EMA eligibility is based on >2,000 cumulative AIDS cases during the most recent five years. The population size was significantly reduced from ≥500,000 to ≥50,000. The number of EMAs decreased from 51 to 22.
- TGA eligibility is based on 1,000-1,999 cumulative AIDS cases during the most recent five years. The 34 TGAs include five new TGAs and 29 small EMAs and Tier 1 Emerging Communities from the former Title II.
- EMAs and TGAs must maintain initial AIDS cases and a minimum number of living AIDS cases.
- EMA funding is based on the most recent calendar year of living HIV/AIDS data.
- HIV/AIDS data must be used from name-based and code-based jurisdictions for grant awards.
- The formula versus supplemental ratio is 2/3 of state funding and 1/3 of supplemental grants.
- The hold harmless provision for the amount received applies to EMAs only: 95% in FY'06, 100% in FY'07 and 100% in FY'08. The hold harmless provision is funded by supplemental grants and unobligated balances beginning in FY'08.
- MAI activities are funded by a competitive grant application process with supplemental funds.
- Grantees must spend 75% of funding on core medical services. The remaining 25% of service funds can be spent on support and other types of services after deducting 10% for administrative costs and 5% or $3 million for quality. Grantees can apply for waivers.

- Planning councils are required for current and former EMAs, but are optional for five new TGAs: Baton Rouge, Charlotte, Indianapolis, Memphis and Nashville.
- Carryover dollars are allowed for formula grants, but are not permitted for supplemental grants. Grants can be reduced by unobligated balances in the next fiscal year.
- Formula awards were distributed on March 1, 2007 and supplemental awards are expected to be distributed in late May 2007. MAI awards are expected to be distributed by August 1, 2007. Technical assistance will continue to be provided to EMAs and TGAs.

Part B: States, Territories and ADAP Grantees

- The formula award is based on living HIV/AIDS cases and on the most recent calendar year of living HIV/AIDS data.
- HIV data must be used from name-based and code-based jurisdictions for grant awards.
- Grantees must spend 75% of funding on core medical services. The remaining 25% of service funds can be spent on support and other types of services after deducting 10% for administrative costs and 5% or $3 million for quality. Grantees can apply for waivers.
- Medical care and all other services delivered by consortia are defined as "support services."
- The distribution factor is 75% of all cases, 20% of cases outside of EMAs, and 5% of cases in states without an EMA or TGA.
- "Emerging communities" are defined as non-EMAs and non-TGAs with 500-999 cumulative AIDS cases during the most recent five years. Emerging communities must maintain minimum living AIDS cases.
- New competitive supplemental grants will be awarded to states based on demonstrated need.
- The hold harmless provision for the amount received is as follows: 95% in FY'06, 100% in FY'07 and 100% in FY'08.
- Carryover dollars are allowed for formula grants, but are not permitted for supplemental grants. Grants can be reduced by unobligated balances in the next fiscal year.
- MAI activities are funded by a competitive grant application process.
- The number of ADAP grantees was increased from 54 to 59 to include all Pacific jurisdictions.
- The HHS Secretary is required to establish a list of drug classes under which ADAP grantees must provide therapeutics. Technical assistance is being provided to help grantees in complying with this new requirement.
- The ADAP formula award is based on the most recent calendar year of living HIV/AIDS cases.
- Supplemental grants for ADAP were increased from a 3% to a 5% set-aside.

- Base formula and ADAP formula awards were distributed on April 1, 2007. ADAP supplemental awards are expected to be distributed on June 1, 2007 and MAI awards are expected to be distributed by August 1, 2007. State supplemental grants will not be awarded in FY'07. Technical assistance will continue to be provided to states and territories.

Part C: Early Intervention Services (EIS)

- Grantees must spend 75% of funds on core medical services and 50% of funds on EIS. Grantees are allowed to allocate 10% of funds to planning, evaluation and other administrative costs, but clinical quality management is excluded.
- Preference is given to areas with high rates of STDs, TB, drug abuse, and hepatitis B or C.
- For capacity building, preference is given to entities that provide primary care services in rural areas or to underserved populations.

Part D: Women, Infants, Children and Youth

- A new 10% administrative cap is added, but indirect costs are not included under the administrative cap.
- The HHS Secretary will perform an annual review of programs no later than 180 days after the fiscal year.
- Information and education will be provided on opportunities to participate in HIV/AIDS-related clinical trials.
- The Government Accounting Office (GAO) is required to complete a report on the use of funds for administrative expenses, indirect costs and services.

Part E: General Provisions [New Section]

- The HHS Secretary must ensure that HRSA, CDC, SAMHSA and CMS coordinate planning, funding and implementation of federal HIV programs.
- The HHS Secretary is required to prepare and submit to Congress a report on coordination efforts at federal, state and local levels every two years.
- States must assure that RWHATMA-funded health support services are integrated with other such services, programs are coordinated, and care and prevention services are enhanced.
- Local governments or private nonprofit entities must assure that RWHATMA-funded services are integrated, programs are coordinated, and care and prevention services are enhanced.
- The HHS Secretary must annually select representative samples of RWHATMA program audits, prepare summaries of same, and submit these samples to Congress. Each audit received from state Part B entities must be posted on the HRSA web site in its entirety. Beginning in FY'09, the HHS Secretary may reduce Parts A and B grant amounts if grantees fail to prepare audits.

- During an emergency period and in an emergency area, the HHS Secretary may waive RWHATMA requirements to improve the health and safety of RWHATMA care recipients and the general public. However, no more than 5% of funds available under Part A supplemental funds and Part B state supplemental funds may be expended for these public health emergencies. The funds shall be returned to the "original pots" for the HHS Secretary to redistribute if Part A supplemental funds and Part B state supplemental funds are not spent for public health emergencies during the fiscal year of the emergency.
- GAO is required to prepare and submit a report to Congress every two years on expenditures of RWHATMA funds and the role of these funds in increasing access to prevention and care, program integration and barriers to care.
- A severity of need index must be developed and submitted to Congress by September 30, 2008.

Part F: SPNS, AETCs, Dental Reimbursement Program, and Community-Based Dental Partnership Program

- SPNS programs are required to quickly respond to emerging needs of persons receiving assistance and support the development of standard client-level data systems. A competitive program announcement will be released in FY'07 to support this effort.
- AETC Program language was expanded to include training of health professionals who provide treatment to minority individuals, "Native Americans," and "hepatitis B or hepatitis C co-infected individuals."
- No changes were made to either the Dental Reimbursement Program or the Community-Based Dental Partnership Program.

HRSA has started to implement RWHATMA and intends to phase-in the provisions throughout FY'07. HRSA will send letters to grantees to highlight changes in RWHATMA and will continue to provide technical assistance.

Dr. Cheever explained that ~70%-80% of Medicare beneficiaries living with HIV will not be affected by the Medicare Part D "donut hole" due to their automatic qualification for the full low-income subsidy under Medicaid. At this time, CMS cannot estimate the proportion of 20,000-30,000 non-Medicaid recipients who would qualify for either a full or partial subsidy. Due to the high cost of antiretroviral medication, HRSA closely collaborated with ADAP grantees prior to implementation of Medicare Part D.

Dr. Cheever provided additional details about HRSA's activities in response to CHAC's specific questions and comments. HRSA has a contract with the National Committee for Quality Assurance (NCQA) to develop national HIV quality performance measures. NCQA will convene an expert panel with diverse organizations to analyze indicators developed by HRSA, other federal agencies and professional associations. HRSA will make every effort

to ensure that its performance measures are aligned and consistent with approved national indicators.

In terms of interagency coordination of the HIV testing initiative, Dr. Cheever confirmed that CHCs have been included in the CDC and HRSA discussions. CHCs have responded to CDC's HIV testing guidelines by revising HIV/AIDS program notices and guidance documents to grantees to specifically address routine testing. CHCs anticipate that CPT codes and other mechanisms will play a significant role in addressing concerns about the cost of HIV testing.

CHAC commended HRSA on interpreting an extremely complex law and making Herculean efforts to distribute information and awards to grantees as quickly as possible. On the one hand, several CHAC members noted a number of positive changes in RWHATMA, such as the new focus on core competencies rather than degrees of case managers and increases in RWHATMA dollars to rural and traditionally under-funded states.

On the other hand, some CHAC members expressed concerns that RWHATMA did not resolve previous problems or anticipate and address new issues.

- Part F grantees will still be unable to meet the oral health needs of their clients because no changes were made to the RWHATMA dental program.
- The increase in Medicare Part D co-payments will require some patients to be shifted to other insurance companies.
- Some grantees are required to maintain multiple data collection systems due to the distinction between "medical" and "non-medical" services. HRSA should develop one data collection system that physicians, nurses, dentists and social services providers can use.
- High-burden states might have less funds to provide care to patients because CDC's new HIV testing initiative is projected to identify 22,000 new infections in FY'07 and potentially 31,000 new infections in FY'08.
- HRSA's efforts to estimate costs for HIV/AIDS care are at a slower pace than CDC's projections for the number of newly diagnosed HIV-infected persons who might be identified through the HIV testing initiative. This gap will adversely impact linking newly diagnosed persons to care. Moreover, HRSA's projections on the cost of HIV/AIDS care will be limited to drugs, but data also must be collected on primary care capacity and other services.
- The FY'08 President's budget projects a $6 million decrease in the AETC Program, but RWHATMA adds a new responsibility for AETCs to provide treatment to hepatitis B or C co-infected persons. This reduction will devastate the AETC Program because AETCs are the only facilities that provide training, products and other services to non-specialized HIV providers in communities throughout the country.

- Explicit language was added to RWHATMA for health professionals to provide treatment to Native Americans, but the law does not specifically define the role of the Indian Health Service (IHS) in this effort.
- AETCs, CBOs, capacity-building organizations and other grantees under different parts of RWHATMA will still conduct repetitive activities and deliver the same services to providers and clients, particularly those related to training and technical assistance. RWHATMA did not result in more efficient allocation and use of funding.

Mr. Milan informed CHAC that its concerns related to RWHATMA would be revisited on the following day during the development of formal motions and resolutions. Several CHAC members proposed additional issues to include in this agenda item. The possibility of reconvening the Reauthorization Workgroup should be discussed to determine CHAC's specific role and next steps in the reauthorization of RWHATMA in 2009.

The workgroup also could be charged with identifying strategies to communicate with the HHS Secretary in light of the change in the charter for CHAC to advise CDC and HRSA only. Direct communications with the HHS Secretary would be extremely important for CHAC to formally state its position on the new Part E provisions, particularly interagency coordination in planning, funding and implementing RWHATMA and the series of budget and performance reports the HHS Secretary is required to submit to Congress.

The federal agencies made several remarks for CHAC to consider in developing formal motions and resolutions on the following day. Dr. Cheever clarified that projecting costs for HIV/AIDS care is extremely difficult because Medicaid, Medicare and other sources pay for HIV/AIDS care of RWHATMA patients, but HRSA is the payer of last resort. However, she confirmed that HRSA would accelerate this effort to maintain pace with the implementation of CDC's HIV testing initiative. HRSA would review two papers on the cost of HIV/AIDS care that were developed over the past two years to guide its projections.

With respect to the change in CHAC's charter, Dr. Cheever emphasized that HRSA would carefully review and then communicate all of CHAC's formal recommendations, resolutions and motions on RWHATMA to the HHS Secretary. At this point, HRSA, CDC, SAMHSA and CMS have not held discussions to respond to the new Part E provisions for interagency coordination in planning, funding and implementing RWHATMA. However, the agencies intend to discuss this issue over the next two months to determine specific roles and responsibilities. Dr. Cheever noted that HRSA would provide CHAC with regular updates on the interagency discussions to respond to the Part E provisions.

Ms. Beverly Watts Davis is CHAC's *ex-officio* representative for SAMHSA. She agreed with CHAC's comments on the critical need for interagency collaboration and coordination to implement RWHATMA and develop a National HIV Strategic Plan. Because SAMHSA's mission relates to substance abuse and mental health, federal agencies, partners,

constituents and other stakeholders typically are unaware of opportunities within SAMHSA for PISC of HIV/AIDS and other STDs.

Ms. Watts Davis described opportunities that are being missed for SAMHSA to play a role in the development of a National HIV Strategic Plan.

- SAMHSA's extramural HIV portfolio is completely disconnected from HRSA and CDC grantees, but the three funding streams should be fully integrated.
- SAMHSA will launch an HIV initiative targeted to Indian Country.
- SAMHSA is collaborating with partners to recruit new fellows in the HIV field and strengthen the workforce.
- SAMHSA awards Substance Abuse Prevention and Treatment Block Grants to 25 states with AIDS case rates >10/100,000. These states are allowed to use 2%-5% of block grant dollars for any activity, but no relationships are being built with HIV grantees in other agencies to streamline and improve HIV/AIDS service delivery.
- SAMHSA's mental health grantees are typically excluded from HIV/AIDS activities, but these groups play a critical role in providing services to newly diagnosed persons.
- SAMHSA successfully launched its hepatitis B vaccine program in 2006 and is expanding this initiative in 2007.

Ms. Watts Davis pointed out that the lack of coordination of collaboration has led to inefficient allocation and use of resources. As a result, government agencies must take leadership in promoting true collaboration among health departments, treatment centers, CHCs, and other groups at state and community levels to fully blend, integrate and leverage federal HIV/AIDS dollars. To support this effort, Ms. Watts Davis suggested that the federal agencies sponsor a retreat to specifically focus on the development of a National HIV Strategic Plan. She also urged CHAC to take leadership in advising the agencies on developing a National HIV Strategic Plan.

Dr. Fenton announced that a panel presentation would be made on the following day on the roles of four federal agencies in HIV and STD prevention. He hoped that this agenda item would result in identifying concrete action steps to advance PISC across the four agencies.

Update by the CDC Division of STD Prevention (DSTDP)

Dr. John Douglas, Jr., Director of DSTDP, covered the following areas in his report. STD prevention programs were initiated in 1938 and serve as one of the first organized public health programs in the United States. From 1938-2006, STD prevention, control or elimination programs focused on syphilis, gonorrhea, HIV, hepatitis B, infertility, chlamydia and HPV. Data collected on chlamydia, gonorrhea, syphilis, hepatitis B, HIV,

trichomoniasis, HSV-2 and human papillomavirus (HPV) estimated that the burden of STDs increased in the United States from 15.3 million cases in 1996 to 18.9 million cases in 2000. The U.S. burden of these eight STDs is projected to cost $14.7 billion each year.

STD prevention is important in achieving three major goals. A reduction in ongoing transmission of STD infections has a population impact. Prevention of the development of complications and sequelae has a personal impact on infertility, adverse pregnancy outcomes and cancers. A reduction in HIV transmission and acquisition has both population and personal health impacts.

In 2005 and 2006, two studies were published on the cost-effectiveness of STD prevention and showed the following results. From 1971-2003, federally funded STD prevention efforts averted 32 million gonorrhea cases and generated savings of $3.7 billion. From 1990-2003, reductions in the annual incidence of gonorrhea and syphilis saved $5 billion in direct medical expenses. The total direct medical cost of gonorrhea and syphilis was $3.8 billion compared to $8.9 billion if STD rates had remained at 1990 levels.

The Hidden Epidemic report was published in 1996 with a vision of establishing an effective national system of STD prevention. This system would include services and information to individuals, families and communities to prevent HIV infection and other STDs and also to ensure comprehensive and high-quality STD-related health services for all persons. The public health community has made tremendous progress since the publication of the report in 1996, but STDs are still a "hidden epidemic" in 2007.

CDC programs have received more, stable or less funding from 2001-2006. Adjusted for inflation, programs with decreases over the past five years include TB with a 14% reduction, STDs with a 15% reduction, and domestic HIV/AIDS with a 17% reduction. STDs impact a number of diverse populations. Estimates show that ~50% of young adults will have acquired at least one STD by 25 years of age. Large syphilis outbreaks, extremely high rates of HIV co-infection, increases in gonorrhea cases, chlamydia outbreaks, and increased case reports of HIV infection have been documented among men who have sex with men (MSM) in cities across the United States. Methamphetamine use and Internet partnering are among the risk behaviors associated with MSM.

Syphilis elimination programs have resulted in a dramatic reduction in the syphilis disparity. The syphilis rate ratio between AAs and whites decreased from 42:1 in 1997 to 5:1 in 2005. However, this disparity has flattened over the past three years. Gonorrhea is hyper-endemic in the AA community and is now the number one notifiable disease disparity in the United States. The gonorrhea and chlamydia rate ratios between AAs and whites are 18:1 and 8:1, respectively. Although racial disparities for these three STDs dramatically decreased from 1997-2005, the ratios are still strikingly disparate.

Dr. Douglas outlined CDC's STD prevention priorities. STD-related HIV transmission, adverse pregnancy outcomes, STD-related cancer and STD-related impaired fertility are important organizing principles of CDC's STD prevention goals. CDC conducts STD prevention activities based on *Healthy People 2010* objectives and Government Performance Result Act (GPRA) STD goals and measures. These federal indicators focus on the reduction or elimination of chlamydia, gonorrhea, syphilis, genital herpes infection, pelvic inflammatory disease (PID), infertility and congenital syphilis. CDC has translated the federal disease prevention goals and measures into a number of programmatic activities under four broad categories.

STD Prevention Category 1. The Infertility Prevention Program (IPP) was launched in October 1992 to prevent STD-related infertility in women. IPP focuses on gonorrhea and chlamydia because these two STDs have a tremendous burden of infection. Gonorrhea and chlamydia account for >50% of all preventable infertility and are the major cause of reproductive health consequences, particularly in women. Congress appropriated funds for IPP to provide chlamydia screening, prevention, treatment, counseling, outreach, control, information and education services to women and their partners. IPP also supports training of healthcare providers.

National chlamydia rates among both men and women have been steadily increasing since 1986 with rate increase since the early 1990's partly attributable to widespread screening. However, chlamydia positivity trends among women 15-24 years of age who were tested in HHS regional family planning clinics have been relatively flat from 1990-2005. Chlamydia prevalence among women 16-24 years of age entering the National Job Training Program showed a decrease from ~11.7% to 9.7% between 1998 and 2005. Progress in reaching the *Healthy People 2010* target for gonorrhea has flattened over the past eight years, while PID cases have dramatically decreased among women 15-44 years of age from 1980-2004.

CDC identified several priority activities to further prevent infertility related to gonorrhea and chlamydia. For chlamydia, public sector screening should be expanded to include school-based clinics, CHCs, correctional facilities and other populations with a potentially higher prevalence. Screening should be broadened in the private sector to comply with guidelines; strengthening partnerships with health plans and professional organizations may help with this. Re-infection should be reduced by improving partner management and re-screening females. Male screening guidance should be developed to help define the role male screening recommendations in selected programs. CDC is in the process of releasing venue-based male screening guidance for chlamydia.

For gonorrhea, effective therapy should be maintained by monitoring gonorrhea resistance and providing access to effective antibiotics. Approaches should be developed to address racial disparities in gonorrhea. Partnerships should be established with communities to examine the implications of focusing on reducing gonorrhea in AAs. Analyses should be

performed to identify possible intervention approaches, such as deficiencies in screening, partner notification, delayed presentation and barriers to using health care.

Data collected in 2006 showed that opportunities were being missed at the national level in screening young sexually active women for chlamydia. National coverage of chlamydia screening by managed care has shown a steady but slow increase among women 16-26 years of age from 2000-2006. Over this time period, compliance with chlamydia screening recommendations has been ~33% in commercial managed care organizations and nearly 50% in Medicaid managed care agencies.

Data published in 2006 showed that the highest ranking clinical preventive services with the lowest utilization rates include tobacco use screening and intervention at 35%; colorectal cancer screening of adults ≥50 years of age at 35%; pneumococcal immunization of adults ≥65 years of age at 56%; and annual chlamydia screening of sexually active women ≥25 years of age at 40%. To address these gaps, a reinvigorated screening program for young women is one of CDC's highest STD prevention priorities.

Chlamydia screening coverage has gradually improved, but remains low at 30%-55%. Educational efforts and partnerships with health systems, providers and the general public are the best opportunities to heighten awareness in the absence of large increases in public testing. A broad array of national partners will be needed to "normalize" chlamydia screening. The focus on chlamydia screening can be enhanced and leveraged to address important and related issues by other organizations, such as contraception, vaccination, Pap test screening and improved sexual health education. Best practices that can be replicated in other areas should be identified.

Expedited partner therapy (EPT) is a process in which medication or prescriptions are dispensed to index patients to give to their partners. Capacity is not available at this time for public health staff to assist in contacting, notifying and bringing sex partners of persons infected with STDs to treatment. National surveys indicate that formal partner services are conducted in only 89% of syphilis cases, 17% of gonorrhea cases and 12% of chlamydia cases. To address this gap, ~50% of physicians throughout the United States widely use EPT as an alternative approach and 24% of physicians use EPT in >50% of cases.

The effectiveness of EPT was evaluated in three randomized clinical trials that were published over the past five years. These data showed that administration of antibiotics to index patients to give to their partners reduced the reinfection rate of index patients by ~25%. CDC endorsed EPT through a "Dear Colleague" letter, EPT technical guidance, revisions to the STD treatment guidelines, and an ongoing collaboration with the Center for Law and the Public's Health to identify major legal barriers to EPT in all 50 states. At this time, EPT is unequivocably permissible in only 12 states.

Two provocative papers regards chlamydia prevention were published in 2005 and 2007. One paper concluded that in the absence of strategies to alter sexual networks, a vaccine would be needed to halt the spread of chlamydia infection. The paper also indicated that a chlamydia infection control program based on early case identification and treatment could interfere with the effects of immunity on population susceptibility to infection. The second paper suggested that the benefit of chlamydia infection screening programs to reduce population prevalence are not supported by sound evidence. The conclusions of neither paper have been accepted by the public health community although they raise important questions.

In terms of gonorrhea, an article published in the March 16, 2007 edition of the *MMWR* reported gonorrhea increases of 42% in eight Western states from 2000-2005. The article attributed some of the increases to additional and more sensitive testing, but a true increase is likely. It is speculated that Methamphetamine use and improper treatment could be possible factors. An article published in the April 13, 2007 edition of the *MMWR* reported that fluoroquinolones would no longer be recommended for treatment of gonorrhea. This guidance is an alert of a potential major crisis, as there is only one class of drugs remaining to treat gonorrhea. DSTDP has recently successfully competed for CDC funding to enhance surveillance of resistant gonorrhea and develop new treatment strategies.

The persistent disparity in gonorrhea between AAs and other racial/ethnic groups is another key challenge in STD prevention. CDC will convene a consultation with internal partners and external stakeholders in June 2007 to address disparities in bacterial STDs among AAs. Lessons learned from other efforts that have been successful in reducing disparities will be reviewed and replicated, such as syphilis elimination and childhood immunization. The consultation also will provide a forum for participants to discuss stigma and other determinants that contribute to disparities. Approaches to reduce disparities at both community and public health levels will be identified during the consultation as well.

The consultation is expected to result in several key outcomes. Strategies to frame and communicate disparities of bacterial STDs among AAs will be explored. The impact of framing specific approaches will be defined. Promising approaches for synergy with HIV and other efforts to reduce disparities will be identified. A plan for plausible next steps will be developed for both communities and public health agencies.

STD Prevention Category 2: Reported syphilis cases dramatically decreased in the United States from 1941-2005. The syphilis elimination effort was launched in 1999 and resulted in additional reductions in both males and females. However, MSM are the primary source for the recent increase in primary and secondary (P&S) syphilis. The national P&S syphilis burden in the United States among MSM increased from approximately 2% of all reported P&S syphilis cases in 1997 to an estimated 65% in 2005.

CDC updated its “National Plan to Eliminate Syphilis” in 2006 with a goal of reducing P&S syphilis cases to <1,000 per year and a target of decreasing P&S syphilis cases to <2.2/100,000 by 2010. CDC established three primary strategies to achieve these goals: invest in and enhance public health services, prioritize and target interventions, and enhance accountability and implementation. CDC acknowledges that the challenges in accomplishing these goals are maintaining momentum in original target populations and responding to the emerging epidemic in MSM.

STD Prevention Category 3: Vaccine-preventable STDs is CDC’s newest focus in STD prevention. Genital HPV is extremely common in the population with 6 million new infections each year and an estimated prevalence of 20 million persons. Of all persons 15-49 years of age, 15% are estimated to be infected at a given time. Of sexually active men and women, 50%-70% will acquire genital HPV infection during their lives. Persistent infection resulting in increased cancer risk will occur in ~10% of those infected with cancer-associated types. Genital HPV is detected in 99% of cervical cancers and the majority of anal, penile, vulvar and vaginal cancers.

A study published in 2007 on the prevalence of low- and high-risk HPV types among females 14-59 years of age showed that the prevalence of any HPV type was quite high in the 14-24 age group. The Food and Drug Administration licensed the quadrivalent HPV vaccine in June 2006 for females 9-26 years of age for prevention of cervical cancer, genital warts, and cervical, vaginal and vulvar precancerous or dysplastic lesions caused by HPV types 6/11/16/18.

In June 2006, CDC’s Advisory Committee on Immunization Practices (ACIP) approved routine vaccination for females 11-12 years of age, initiation of the vaccination series at nine years of age, and catch-up vaccination through 26 years of age. ACIP’s recommendations were published in April 2007. Efficacy data on the HPV vaccine in males are expected to be produced in 2007. A new bivalent HPV vaccine is expected to be licensed in 2007 or early 2008.

CDC identified several post-implementation issues associated with the HPV vaccine. Both the commercial cost of the vaccine of $120/dose and the government contract price of $96.76/dose are expensive and difficult to implement in some private practice settings. Controversies have surfaced over school entry mandates for the HPV vaccine. To date, >20 states have introduced legislation for school entry requirements. Texas recently issued an executive order requiring HPV vaccination to middle school students.

Several groups have issued position statements citing problems with the HPV vaccine, including a published editorial on mandatory HPV vaccination and a statement by the Association of Immunization Managers on state immunization mandates. A number of organizations have emphasized that school mandates of HPV vaccination are premature at

this point because problems related to vaccine financing and availability have not been resolved.

The impact of the HPV vaccine on monitoring also is a challenge in terms of biologic outcomes, sexual behavior and Pap smear utilization. CDC will take several actions to address this issue. Cancer registries will be analyzed to monitor cervical cancer. Studies on typing of cervical cancers will be launched at several sites. The prevalence of specific HPV types will continue to be examined through self-collected vaginal swabs from the National Health and Nutrition Examination Survey. Administrative databases, new sentinel projects, and supplemental data collection in the Vaccine Safety Datalink will be initiated to support monitoring of precursors of cervical cancer. Administrative databases and data gathered from STD clinics will be used to monitor genital warts.

The hepatitis B vaccine has been available since 1982. However, many high-risk adult populations are still unvaccinated. To address this issue, CDC developed and released new guidance recommending hepatitis B immunization of adults in certain venues, such as STD clinics, correctional facilities, drug abuse treatment and prevention centers, clinics serving MSM, and HIV testing and treatment sites. CDC endorsed venue-based hepatitis B immunization of adults in its 2006 STD treatment guidelines and “Dear Colleague” letters.

Other STD Prevention Issues: The absence of organized prevention programs for some STD is another significant challenge in STD prevention. Most notably, the burden of trichomoniasis in the United States was estimated to have increased from 5 million cases in 1996 to 7.4 million cases in 2000. National surveillance and cost impact data have been gathered on trichomoniasis. CDC also updates treatment for this STD in its STD Treatment Guidelines. However, additional activities on trichomoniasis are minimal due to limited resources.

The incidence of HSV-2 was estimated to have increased from 1 million cases in 1996 to 1.6 million cases in 2000. A study published in 2006 analyzed HSV-2 seroprevalence by race in the 1976-1980, 1988-1994, and 1999-2004 time periods. The data showed that increases in the national prevalence of HSV-2 have now been reversed from the mid-1990s, but HSV-2 still presents a considerable public health challenge.

The U.S. incidence of HSV-2 is estimated to be 1-2 million new cases each year and the prevalence is estimated to be >40 million cases. Increased rates of HSV-1 infection have been observed as well. The effectiveness of population-based prevention strategies is unknown at this time, including antiviral and suppressive therapies and type-specific serologic tests to guide lesion recognition and counseling. Of all STDs, HSV-2 might have the most significant impact on HIV transmission. Regular condom use reduces but does not prevent transmission of HSV-2. An editorial commentary was published in 2006 calling for a national genital herpes control program.

Access to health care, the public health workforce, and program collaboration and integration with other prevention efforts present both challenges and opportunities for STD prevention. At this time, 46 million uninsured Americans account for 16% of the U.S. population. The proportion of uninsured non-elderly persons increased from 16.3% in 1996 to 19.1% in 2004. The uninsured population corresponds with demographic profiles of persons at risk for STDs, including the 18-24 age group, racial/ethnic groups and low-income groups. Solid data show that uninsured persons are less likely to have access to Pap tests, chlamydia screening and prescription drugs. IOM estimated that the absence of health insurance leads to 18,000 unnecessary deaths each year and lost economic value of $65-$130 billion.

The national public health workforce is rapidly aging with current personnel representing 46.6 years of age on average. Public health retirement rates are expected to be as high as 45% over the next five years. These retirements will result in a shrinking labor pool and chronic shortages in professional areas, including public health nursing, epidemiology, laboratory science and environmental health. In the public health field, current vacancy rates are up to 20% and turnover rates are up to 14% in some states. At the federal level, the number of DSTDP field staff has dramatically decreased from 1986-2006.

Despite these challenges, CDC is currently conducting a number of activities to strengthen collaboration and integration of STD programs into core public health activities; HIV, viral hepatitis and cervical cancer prevention; and reproductive health. Guidance on partner services is being harmonized across programs. Surveillance and data systems are being streamlined to operate more efficiently and collaboratively. STD guidance and training are being incorporated into HIV testing and care. Efforts are underway to improve monitoring and evaluation capacity.

STD programs are establishing partnerships to expand HIV prevention activities, increase venue-based hepatitis B immunization, initiate and monitor cervical cancer immunization programs, and frame comprehensive sexual health messages for reproductive health. An important priority is to expand the "ABCs" of STD prevention to reflect a larger alphabet, including (A) abstinence and awareness for persons who choose to be sexually active; (B) being faithful or selective; (C) condoms or other contraception; (D) diagnosis, screening and treatment for all persons; (E) education and empowerment; and (V) vaccines.

Dr. Douglas concluded his update by requesting CHAC's assistance and guidance in answering three key questions: (1) What strategies should CDC implement in partnership with HRSA and communities to promote regular chlamydia screening and integrate this message into other activities? (2) What opportunities are available to strengthen interactions between CDC and HRSA on STD prevention, service delivery and clinical care? (3) What criteria should CDC use to prioritize STDs?

CHAC thanked Dr. Douglas for presenting an extremely comprehensive and informative update. Several members made comments and suggestions on CDC's STD prevention activities in response to Dr. Douglas' request for guidance.

- The STD community should take caution in replacing the term "STDs" with "sexually transmitted infections" (STIs) to avoid confusion. The "STI" acronym is commonly known as "strategic treatment interruption" throughout the HIV community.
- CDC should take caution in promoting and endorsing EPT due to legal and medical barriers to dispensing antibiotics without examining the patient. For example, the partner of the index patient could have allergies or side effects to the medication. Instead, CDC should encourage physicians to prescribe a "double dose" to index patients to treat re-infection or to give to their partners.
- CDC should identify strategies to address barriers to reimbursing physicians for the HPV vaccine. Insurers most likely will be reluctant to reimburse physicians for treating patients with the HPV vaccine or spending time with patients for education and counseling.
- CDC should develop and target STD prevention activities to racial/ethnic groups other than AAs that also are at risk for STDs, including Hispanics and American Indians/Alaska Natives (AIs/ANs).
- CDC should take advantage of widespread publicity and marketing on the HPV vaccine to promote and raise public awareness about the critical need for chlamydia screening, particularly since both STDs target the same demographic groups. A broader sexual health campaign should be developed to co-promote the positive benefits of both HPV vaccination and chlamydia screening. This strategy would be more effective and accepted by the public than the traditional disease paradigm and disease prevention approach.
- CDC should ensure that the STD diagnostics industry and the broader STD community are visible and represented at HIV/AIDS and other public health events. These opportunities should be used to promote chlamydia screening.
- CDC should provide CHAC with an updated STD budget. These data should clearly illustrate the alignment between federal dollars and state resources because most states do not have specific line items for STDs. The budget information could provide CHAC with strong advocacy base and also could assist CHAC in advising CDC on prioritizing STDs.
- CDC should target its STD investments, activities and communications to fill gaps in education at the college level in addition to middle and high school levels. CDC should take leadership in building a market for STD information for this age cohort and widely launching and targeting an STD campaign to college students. Social networking could be an effective approach in marketing this effort because college-age women could be educated and then play an important role in delivering interventions.

- CDC should not prioritize the development of an HSV-2 prevention and control program and a massive expansion of chlamydia screening at this time. States would be extremely challenged in undertaking these efforts because current HIV/AIDS funding to states is still not sufficient.
- CDC should clearly define its STD prevention activities to make a distinction between urban and rural or small communities due to differences in medical care and community prevention. For example, STD physicians and other providers with medical expertise most likely would not be appropriate to disseminate STD education to small and rural communities. Community workers should be trained in this effort. Moreover, user-friendly STD materials and messages should be developed specifically for small and rural communities and other lay audiences.
- CDC should partner with professional medical societies to encourage gynecologists to add chlamydia as a routine part of screening when young sexually active patients present for regular care.
- CHAC should continue to promote collaborative efforts and leveraging of resources among four training centers: AETCs, STD/HIV Prevention Training Centers, Reproductive Health Training Centers, and Addiction Technology Transfer Training Centers.
- CDC should conduct activities in collaboration with the following groups to broaden its STD prevention activities and enhance PISC:
    — Improve STD screening and care while providing continuous care to persons with HIV [CDC/HRSA].
    — Use reinforcing messages to translate appropriate topical research of STDs into comprehensive care [CDC/HRSA].
    — Determine whether testing and treatment of chlamydia and other STDs are allowable expenses under RWHATMA and ADAP [CDC/HRSA].
    — Compile and distribute a package of STD information and training materials to AETCs, CHCs and drug treatment centers [CDC/HRSA/SAMHSA].
    — Strengthen partnerships with professional associations to broadly implement STD prevention activities [CDC/Infectious Disease Society of America].

Dr. Garcia made a strong recommendation for CDC and HRSA to consider in future meetings. For all HIV and STD activities targeted to racial/ethnic groups, CDC and HRSA should present data to CHAC demonstrating the risk to all populations. He pointed out that federal HIV and STD programs typically focus on disparities between AAs and whites only.

Dr. Fenton thanked CHAC for providing CDC with helpful suggestions on its STD prevention activities, but he requested more concrete and detailed guidance. He posed specific questions to assist CHAC in this effort.

- What strategies would be effective for CDC to maximize current STD prevention investments?
- What new areas should CDC prioritize with STD prevention investments?
- What approaches should be taken to promote integration and ensure that STD interventions are maximized at every opportunity, including HIV testing and training?
- What are the specific components of an integrated in package of care, *i.e.*, HIV testing, HPV vaccination, chlamydia testing, hepatitis B vaccination and hepatitis C testing?
- What is the cost of an integrated package of care?
- Should CDC submit budget requests for an integrated package of care to advance the development of a broader sexual health agenda?

Dr. Fenton noted that CHAC might need to convene a workgroup to address these issues in more detail. He confirmed that NCHHSTP would present its PISC initiative during the next meeting to assist CHAC in advising CDC in this area. He pointed out that the PISC initiative would have implications if CDC takes action on CHAC's suggestion to develop a broader sexual health agenda in United States.

Mr. Milan proposed that during the development of formal motions and resolutions on the following day, CHAC should ask HRSA to describe its activities and opportunities for program integration across all bureaus, particularly the Bureau of Primary Health Care and other bureaus with HIV and STD activities outside of HAB. Dr. Hook agreed that representatives from all HRSA bureaus should be invited to the next CHAC meeting to present and discuss integrated activities on HIV and STD prevention and treatment.

Update on CDC's HIV Prevention Strategic Plan and Overview of New HIV Prevention Initiatives

Dr. Fenton covered the following areas in his report. CDC views the Strategic Plan as a valuable tool and uses the Strategic Plan as a living document to link HIV prevention programs, activities and budget allocations to specific goals and objectives. CDC also uses the Strategic Plan as a guide in identifying new and expanded programs and initiatives, establishing priorities, directing and targeting resources, and ensuring objectives are appropriately prioritized. The addendum to the Strategic Plan serves as a guide for CDC's HIV prevention efforts through 2010 and maintains the structure of the original overarching goal and four domestic goals.

CHAC's HIV Prevention Strategic Plan Workgroup draft report was issued in July 2006. Dr. Fenton's summary of CDC's responses to the workgroup's recommendations is outlined below.

- *Workgroup Recommendation*: The overarching goal and first three domestic goals should be revised.
  CDC Response: The structure of an overarching goal and four domestic goals was maintained. All goals were extended to 2010.

- *Workgroup Recommendation*: Goal 4 should be deleted.
  CDC Response: Goal 4 was retained with the following language: "By 2010, strengthen the capacity nationwide to monitor the epidemic, develop and implement effective HIV prevention interventions, and evaluate prevention programs." CDC's rationale for retaining goal 4 was based on the ability to measure Strategic Plan goals that rely on ongoing capacity to perform surveillance, evaluate activities and assess current efforts, such as increased testing.

- *Workgroup Recommendation*: A new goal should be added to specifically address stigma and discrimination.
  CDC Response: A new goal was not included on stigma and discrimination because these issues are reflected in the core objectives.

- *Workgroup Recommendation*: CDC rather than the workgroup should select targets for the goals.
  CDC Response: Goal targets for the overarching goal and first three domestic goals were modified to strike a balance between aspirations and realities, such as pragmatic targets, the fiscal environment, limited time remaining in FY'07, and the feasibility of and capacity to achieve goals in the absence of new investments. The new language for the four goals is as follows:
  - — Overarching goal: "Reduce the number of new HIV infections in the United States by 10% by 2010, focusing on eliminating racial and ethnic disparities in new HIV infections." The previous language was a 50% reduction from 40,000 to 20,000 new infections.
  - — Goal 1: "By 2010, decrease by at least 10% the number of persons in the United States at high risk for acquiring or transmitting HIV infection by delivering targeted, sustained and evidence-based HIV prevention interventions." The previous language was a decrease by at least 50%.
  - — Goal 2: "By 2010, through voluntary testing, increase from the current estimated 75% to 80% the proportion of HIV-infected persons in the United States who know they are infected." The previous language was an increase from the current estimated 70% to 95%.
  - — Goal 3: "By 2010, increase from the current estimated 50% to 65% the proportion of newly diagnosed HIV-infected persons in the United States who are linked to appropriate prevention, care and treatment

services." The previous language was an increase in the current estimated 50% to 80%.

- *Workgroup Recommendation*: The Strategic Plan should contain 34 new objectives.
  CDC Response: The addendum contains 38 objectives compared to 27 objectives in the original Strategic Plan. CDC accepted >17 of the 34 new objectives the workgroup recommended and ranked the objectives in priority order. The 13 modified objectives were revised with a more explicit focus on MSM and AA communities. The 12 new objectives were added to:
  — address advances in understanding about the importance of acute HIV infection, the role of incarceration in the HIV epidemic, and technical advances in rapid HIV testing;
  — underscore priorities to increase HIV screening in medical settings; and
  — reflect recent data about disparities in knowledge of an individual's HIV infection, particularly among MSM.

- *CDC Response*: CDC identified 11 performance indicators in 2002 to monitor progress toward implementing the Strategic Plan. Since that time, CDC has developed new data collection systems and included process indicators to measure the impact of prevention interventions. Outputs of these new surveillance systems are reflected in 24 performance indicators in the addendum: 14 new, 8 modified and 2 unchanged indicators. The performance indicators serve as a new and consistent battery of measures for multiple purposes, including federal reporting requirements for GPRA, PART, *Healthy People 2010* and *Healthy People 2020*.

In terms of implementation, Dr. Fenton confirmed that CDC is aware of the workgroup's recommendation to increase partnerships with the medical community and the private sector. The workgroup cited the lack of support for the Strategic Plan by various partner groups.

CDC also responded to the workgroup's recommendations on the Strategic Plan by launching a new "Heightened National Response to HIV/AIDS in the African American Community." CDC created this initiative with four major strategies to conceptualize, organize and frame activities and investments over the next three to five years.

First, the reach of prevention services and the availability of targeted services will be expanded for high-risk young MSM of color and their partners. Second, opportunities for diagnosing and treating HIV/AIDS will be increased. Separate campaigns will be piloted for AA MSM, women, youth and heterosexual men. HIV counseling and testing, STD

screening and treatment, and hepatitis B vaccination will be implemented in settings where AA MSM congregate.

Third, new and effective prevention interventions will be developed for AAs. A project will be initiated to evaluate the effectiveness of prevention strategies for reaching and testing AA MSM with previously undiagnosed HIV infection. Knowledge, attitudes and behaviors of 1,600 AA students will be assessed at Historically Black Colleges and Universities. Findings from this project will assist in developing new interventions. Fourth, broader actions will be mobilized within communities to change perceptions about HIV/AIDS. New channels will be developed to communicate the impact of HIV/AIDS on AAs.

CDC convened a meeting with key AA leaders in March 2007 to discuss and begin launching the mobilization component of the heightened national response. CDC asked the AA leaders to conduct a number of activities. Silence should be broken and awareness of HIV/AIDS should be increased among friends, family members, coworkers and others within the AA community.

Partnerships should be developed with AA leaders to change community perceptions about HIV/AIDS, challenge HIV/AIDS-related stigma, motivate persons to seek early HIV diagnosis and treatment, and encourage healthy behaviors to prevent the spread of HIV. Collaborative efforts should be undertaken with organizations, businesses and faith leaders to strengthen capacity to discuss HIV/AIDS-related issues with state and local officials. Partnerships should be developed with CBOs that serve AAs to assist these organizations in linking clients to relevant prevention programs and HIV testing services.

CDC has realigned funds to support the mobilization campaign and is making investments in the HIV testing initiative to identify undiagnosed infections among AAs. CDC recently met with the National Institutes of Health Office of AIDS Research to discuss the development of behavioral interventions. The two agencies acknowledged the need to deliver consistent messages and promote the same vision on targeted research, investments and implementation of HIV prevention activities.

Dr. Fenton reported that CDC also responded to CHAC's request to provide more data on HIV/AIDS among AA males, particularly MSM. Data show that AA men have the highest AIDS rates of all racial and gender groups in the United States. AIDS rates in AA males are eight times more than those in whites, three times more than those in Hispanics, and 12 times more than those in Asian/Pacific Islanders (APIs). Of all AA men living with HIV/AIDS, 48% were infected via MSM transmission, 20% via heterosexual contact, and 20% via injecting drug use. Data collected from 33 states with confidential reporting showed that male-to-male sexual contact accounted for HIV/AIDS cases in 42% of AAs, 36% of whites and 19% of Hispanics in 2005.

AA men living with HIV/AIDS accounted for 30% of MSM diagnosed with HIV/AIDS in 2005. Data collected from 33 states showed that 60% of AA males living with HIV/AIDS were diagnosed in the South from 2001-2005. The same data set demonstrated that young AA men 13-24 years of age were particularly at risk and accounted for 14% of all males and 20% of all MSM living with HIV/AIDS. The data also showed a dramatic upward trajectory of estimated HIV/AIDS diagnoses among AA MSM 13-24 years of age that far exceeded rates among MSM 13-24 years of age in other racial/ethnic groups. However, marked increases in estimated HIV/AIDS diagnoses are being observed among API MSM in this age group.

AAs have a disproportionate disease burden and account for 13% of AIDS case reports in all states in the United States. Data collected in 2005 showed that the estimated number of AIDS cases and rates among AA male adults and adolescents in all 50 states and the District of Columbia were higher than any other racial/ethnic group. AAs accounted for 50% of all new AIDS cases reported in 2005. AIDS rates among AA men and women far exceed those of any other racial/ethnic group in the United States, but rates among Hispanic males are extremely high as well. Only AA and white males have higher AIDS rates than Hispanic males in the United States.

In addition to AIDS, HIV among AA MSM is severe as well. A study was conducted in five U.S. cities on HIV prevalence and unrecognized HIV infection. Of 1,767 MSM in the study, 25% were HIV-positive and 48% of those infected were unaware of their status. Of AA MSM in the study, 46% were HIV-positive and 67% of those infected were unaware of their status. Among Hispanics in the study, the HIV prevalence was 17% and 46% of those infected were unaware of their status.

Factors that influence HIV/AIDS transmission among AA males include high rates of bacterial and viral STDs, incarceration, substance abuse, patterns and distribution of high-risk behaviors, poverty and socioeconomic disadvantages, racism, discrimination, stigma and homophobia. These factors should play a critical role in framing messages to partners, stakeholders and policymakers and emphasizing the importance of focusing on HIV/AIDS among AA males.

Dr. Fenton concluded his update on the Strategic Plan by asking CHAC to answer three key questions: (1) Is CHAC satisfied with the addendum to the Strategic Plan and comfortable with formally adopting the document? (2) Are domains other than HIV prevention among AAs missing from the addendum or need a stronger focus? (3) What should be CDC's next steps in advancing sexual health among MSM, particularly MSM of color? Dr. Fenton confirmed that the addendum to the Strategic Plan would be posted on the CDC web site.

CHAC commended CDC on its diligent efforts in attempting to capture the workgroup's general sentiments and specific recommendations. For example, the addendum to the Strategic Plan reflects the workgroup's interest in strengthening the focus on incarcerated

populations and substance abuse. CHAC also thanked CDC for responding to its requests to provide additional data on HIV/AIDS in the AA population and include specific goal targets in the Strategic Plan.

On the one hand, some CHAC members supported the new 10% target because this goal is much more realistic. On the other hand, several CHAC members strongly disagreed with and were extremely concerned by the goal targets CDC selected. Most notably, some members foresaw future difficulties in explaining the dramatic decrease in the overarching goal target to constituents and stakeholders. The members pointed out that CHAC would be challenged by justifying and supporting CDC's rationale for changing the previous target of a 50% reduction in the number of new HIV infections to 10%.

In response to Dr. Fenton's specific question, several members noted that CDC did not provide CHAC with a rationale to endorse the addendum. CHAC's additional concerns and comments on the addendum are outlined below.

- Data sources for the performance indicators should be referenced.
- The addendum should be revised to be more transparent about the relationship between resource allocations and specific interventions in achieving the Strategic Plan goals. This information will play a critical role in obtaining public support and endorsement of the changes in the goal targets.
- The goals should be revised to be bifurcated, such as "decrease by at least [a lower]% given current funding levels and decrease by at least [a higher]% given enhanced funding."
- CDC should present slides to CHAC with the following information: (1) objectives that were not included in the addendum and (2) areas in the addendum where stigma and discrimination were incorporated.
- The addendum should take a proactive and flexible approach to prevention by focusing on other sociodemographic and minority groups that also bear a disproportionate burden of disease. For example, the Strategic Plan reflects 2005 AIDS data rather than current HIV data. Assuming a ten-year incubation period, the 2010 Strategic Plan actually would focus on persons who were infected in 1995.
- The addendum should contain a new preamble with the following talking points to explicitly and clearly state the rationale for the change in the goal targets: "CDC expected new resources over the course of five years, but new dollars were not allocated during this time. The Iraq War, terrorism, bioterrorism and public health preparedness have been the priorities for federal dollars since 9/11. As a result, the overarching goal target was not achieved."
- The target in the overarching goal should be changed to "by at least 10%."
- The addendum should emphasize the minimum level of resources that CDC would need to implement Strategic Plan activities each year.

- The addendum should be renamed, *i.e.*, "Extension and Update of the Centers for Disease Control and Prevention HIV Prevention Strategic Plan Through 2010." This title would more accurately reflect current public health realities and competing priorities.
- CDC should explore the possibility of providing incentives to grantees that achieve the goal targets.
- Goal 1/objective 7 should be changed as follows: "Increase the number of proven effective behavioral prevention interventions for all racial/ethnic minorities with a focus on African Americans."
- CDC should dedicate a session during the December 2007 HIV Prevention Conference to specifically discuss the changes in the Strategic Plan goal targets and the new HIV incidence data. This information would minimize confusion among the broader HIV prevention community.
- CDC should provide baseline HIV incidence data for the new goal target of a 10% reduction in the number of new HIV infections.
- The addendum should place more emphasis on AA women who become infected from AA heterosexual males and AA MSM.
- CHAC should initiate its strategic planning processes earlier. For example, the Strategic Plan was extended to 2010, but CHAC should begin its planning process in 2008.
- CDC should thoroughly review the addendum to correct errors that were made during efforts to combine certain objectives. For example, goal 1/objective 1 refers to PLWH "acquiring" HIV. Moreover, program activities for HIV transmission and acquisition are different and should not be combined in the same objective.

Dr. Fenton appreciated CHAC's concerns about the changes in the goal targets. He made a number of remarks in an effort to address these issues. OMB and the general public previously criticized CDC for establishing a high target of a 50% reduction in the number of new HIV infections without a commitment of new HIV prevention resources and also for not achieving the original overarching goal. These outcomes and other factors influenced CDC's decision to change the overarching goal target from 50% to 10%. Most notably, improved methods and new surveillance systems will allow CDC to better monitor the evolution of the HIV epidemic, create more realistic and pragmatic targets, more effectively track progress in reaching the targets, and strengthen accountability. Dr. Fenton was personally happier with the 10% target because a more realistic and achievable target would minimize additional failure or criticism of CDC and CHAC.

In terms of revising the addendum to show linkages between resource allocations and specific interventions, Drs. Fenton and Janssen clarified that information for the public is purposely generic. However, CDC's internal working documents on allocating resources to implement the Strategic Plan are much more explicit. The internal working documents clearly define and provide more details on objectives, strategies, core activities, budget

initiatives, and specific roles and responsibilities of staff to achieve the Strategic Plan goals. DHAP will continue to use the Strategic Plan to identify and inform priorities and expenditures at the division level. DHAP also expects to complete a resource allocation model based on interventions in the summer of 2007.

Drs. Fenton and Janssen answered CHAC's questions about new HIV incidence data. At this time, CDC has no knowledge on the actual progress that was achieved in the previous target of a 50% reduction in the number of new HIV infections. In 2002, CDC decided not to provide new estimates of HIV incidence until the implementation of its new surveillance system. CDC is now finalizing these data and methods to support the estimates. The new methods are much more robust and will provide baseline HIV incidence based on 2005 surveillance data, estimates of current HIV incidence, and changes in HIV incidence over time.

CDC will generate new estimates on HIV incidence each year to track performance over time in reducing the number of new HIV infections. CDC hopes to release the new estimates and methods of HIV incidence in peer-reviewed publications or other formats in the second half of 2007. CDC expects to provide an update to CHAC on these data during the next meeting.

CDC also is developing strategies to deliver effective messages on the new HIV incidence data to a number of key audiences, including Congress, internal and external partners, and the media. CDC recognizes that a strong voice from CHAC and other key partners will be needed to support the dissemination of the new HIV incidence data and methods.

Drs. Fenton and Janssen made additional remarks in response to CHAC's other comments, questions and concerns.

- CDC would present additional information to CHAC on the following day: (1) objectives that were not included in the addendum; (2) areas in the addendum where stigma and discrimination were incorporated; and (3) the rationale for changing the goal targets.
- CDC would develop and disseminate talking points that would be appropriate from the perspective of a federal agency. CDC agreed with CHAC that a context should be provided to clearly explain the rationale for modifying the goal targets.
- CDC would explore the possibility of revising the goal targets to be bifurcated in the addendum. However, CDC might be prohibited from including disclaimers about federal funding contingencies of the President's budget in a public document.
- CDC would continue to explore strategies to scale-up and disseminate behavioral interventions.

- CDC is placing equal emphasis on AA men and women in the "Heightened National Response to HIV/AIDS in the African American Community."
- CHAC should inform CDC about its preference for receiving progress reports on the Strategic Plan, such as written annual reports on the performance indicators or qualitative reports during CDC's regular updates at CHAC meetings.
- CDC would make editorial changes to strengthen and finalize the addendum.

Mr. Milan concluded the discussion by describing CHAC's next steps in formally accepting and adopting the addendum to the Strategic Plan. A special session would be added to the agenda on the following day for CDC to present additional information and answer CHAC's outstanding questions. A motion would then be entertained for CHAC to formally approve the goals and objectives of the addendum. If the members were uncomfortable in accepting and adopting the addendum, a conference call would be convened by June 30, 2007 for CHAC to take a formal vote.

Public Comment Period

Ms. Lynn Barclay, President of the American Social Health Association, made four key suggestions that are particularly important to both HIV and STDs. She asked CHAC to consider these issues in its deliberations. First, front-line services should be improved because successful prevention of STDs requires a stable and well-funded public health infrastructure at state and local levels. Adequate funding for surveillance, treatment, partner referral, health education, disease intervention and other core services is critical to preventing and controlling STDs. Despite the dramatic rise in the number of persons seeking services from clinics, base STD program funding levels have been frozen nationwide for more than ten years and have weakened capacity to provide services. These factors have contributed to an increase in syphilis, gonorrhea drug resistance, and inadequate support for chlamydia prevention.

Second, genital herpes and HIV/HSV co-infection should be addressed. Improving public awareness of HIV/HSV co-infection and promoting HSV testing and treatment to decrease transmission and progression of HIV disease would have substantial public health benefits. Genital herpes is one of the most prevalent STDs in the United States, plays a critical role in the global HIV epidemic, and significantly increases the risk of acquiring HIV.

Third, provision of medically accurate and comprehensive sexual health information and messages should be assured to assist in HIV and STD prevention efforts. Both abstinence materials and information on condoms should be distributed for persons to protect themselves against HIV and STDs. Several professional health associations support a comprehensive approach with information on both abstinence and condoms. Professional organizations also are supporting a Congressional bill for HHS to administer funds for a

comprehensive, age-appropriate and medically accurate sexual education program that emphasizes both abstinence and education on condoms and STD prevention.

Fourth, racial disparities should be addressed due to the disproportionate burden of HIV and STDs in communities of color. Comprehensive strategies are urgently needed in this effort, including support to states to build collaborations between HIV and STD prevention programs and CBOs.

Mr. Carl Schmid, Director of Federal Affairs for The AIDS Institute (TAI), provided TAI's perspective on CDC's addendum to the Strategic Plan. On the one hand, TAI was pleased that CDC developed and released the addendum. TAI commended CDC for adding objectives to focus on MSM and AAs and also for addressing mental health, substance abuse and other co-morbidities. TAI agreed that AA MSM should be emphasized due to the tremendous impact of HIV in this population.

On the other hand, TAI was extremely disappointed with the rather "unambitious and limited" nature of the goals and performance indicators. New HIV infections in whites were compared to AAs and Hispanics only. Performance indicators to measure new HIV infections in the broader MSM, AA and Hispanic populations were not included in the addendum. TAI pointed out that an ambitious plan should be developed and resources should be identified and obtained to reach these goals.

TAI was challenged by assessing the addendum because baseline HIV incidence data were not provided. For example, a different level of effort and resources would be needed if the target of decreasing new HIV infections increased to 4,000-6,000 each year. TAI looked forward to reviewing CDC's baseline HIV incidence data. Overall, TAI's position was that the most significant flaw in the addendum was the lack of a call for more resources to decrease new HIV infections in the United States.

TAI hoped the U.S. government would perform an annual assessment of the updated Strategic Plan, evaluate progress made in each performance indicator, and make necessary adjustments to ensure the goal targets are reached. TAI also hoped CHAC would play a role in this effort.

Dr. Robert Carroll, Director of the Northwest AETC, strongly emphasized the devastating effect of the $6 million decrease to AETCs proposed in the FY'08 President's budget. The projected budget cut represents nearly 20% of the AETC annual budget and would severely impact the capacity of AETCs to adequately address the growing training needs of providers who serve persons living with HIV or AIDS. Continued support by AETCs in training local healthcare providers is particularly important at this time due to increases in new HIV infections in rural and minority communities throughout the United States. AETCs also provide training to promote routine HIV testing in primary care settings.

Moreover, new patients are expected to enter HIV care systems with the implementation of CDC's new HIV testing initiative. The expanded population of PLWH and the decreased workforce of dedicated HIV care providers will continue to increase the demand for AETC training across the country. These trends might result in AETCs routinely denying training requests in the future. Although AETCs appreciate and encourage continued availability of supplemental grants, needs-based programs cannot primarily depend on this funding source. Dr. Carroll offered the expertise of AETCs in continuing to support CHAC's efforts in promoting an integrated national response to HIV/AIDS.

During the development of formal resolutions and motions on the following day, Mr. Liberti proposed that CHAC entertain a motion to not support the $6 million decrease to AETCs projected in the President's FY'08 budget. He noted that some of Dr. Carroll's comments could be included in CHAC's motion.

With no further discussion or business brought before CHAC, Dr. Hook recessed the meeting at 4:55 p.m. on May 7, 2007.

Panel Presentation on the Role of Federal Agencies in HIV/STD Prevention

Dr. Hook reconvened the CHAC meeting at 8:35 a.m. on May 8, 2007 and yielded the floor to the first presenter.

HRSA. Dr. Cheever's summary of HRSA's HIV/STD prevention activities is outlined as follows. Since 2000, HRSA has engaged in a number of activities under its SPNS initiative to increase prevention efforts and address the needs of HIV-positive persons. The "Prevention with Positives Initiative" was designed to analyze prevention activities in the field. The study identified incentives and barriers to providing prevention services to HIV-positive patients. This research also analyzed whether cultures, structures and potential conflicts of interest in clinics allowed providers to deliver prevention services. The study generated important information on the attitudes of providers and revealed that HIV prevention counseling was not routine in most clinics.

HRSA closely collaborated with CDC and the National Institute of Mental Health to ensure that prevention activities for HIV-positive persons were rapidly translated into practical field applications. The new prevention initiatives were launched with solid data on the effectiveness of certain interventions. The agencies explored strategies to incorporate these initiatives into training center activities.

In September 2003, HRSA funded demonstration projects in 15 diverse clinical care settings sites under the Prevention with Positives Initiative. Many of the 15 sites implemented interventions that had a track record of success or were based on strong theoretical models. These activities included the delivery of HIV prevention messages and

interventions to patients by clinicians, peer workers and other prevention specialists. The successful demonstration projects resulted in publications of 14 peer-reviewed journal articles, 30 poster presentations and 67 oral presentations.

HRSA used SPNS dollars to award one-year funding to 15 medical provider sites to replicate and evaluate the OPTIONS Project across a variety of HIV clinical settings. The OPTIONS Project is based on an intervention in which physicians use motivational interviewing techniques to deliver critical HIV risk reduction information, motivation and behavioral skills to HIV-positive patients in clinical care. An evaluation center is currently analyzing results of the project to determine the fidelity of provider/patient interactions with the OPTIONS protocol. HRSA has no knowledge at this time about the number of grantees that will actually continue to conduct the OPTIONS Project beyond the one-year funding cycle, but >50% of grantees made a commitment to continue to implement the protocol with minor modifications. HRSA expects to receive the final evaluation results by the end of May 2007.

HRSA-funded AETCs are involved in several prevention activities, including training to providers on the Prevention with Positives Initiative and CDC's new HIV testing initiative. AETCs also participate in joint efforts with training centers funded by CDC, SAMHSA and the Office of Family Planning. Prevention with positives has been a major and constant theme at meetings with the four training centers, all HRSA grantees and clinical providers. HRSA is currently developing 12 core clinical quality measures for all programs throughout the agency. The HRSA Center for Quality has already adopted the quality measure for HIV prenatal screening.

At the bureau level, HAB developed and is currently soliciting comments from grantees on ~21 clinical measures that include counseling related to prevention for HIV-positive persons and STD screening. HAB based the indicators on federal guidelines for prevention of HIV-infected persons. The Bureau of Health Professions (BHPr) supports several grants to academic institutions in which nurse practitioner and nurse midwife programs are funded to provide didactic and clinical curricula on STDs. BHPr also funds four residency programs that support HIV/STD training and clinics.

The Bureau of Primary Health Care (BPHC) reported that 91% of grantees provide onsite HIV testing and counseling. BPHC grantees reported the following data to HRSA in 2006: (1) syphilis and other STDs were the primary diagnoses in 92,000 CHC visits by 64,000 patients; (2) symptomatic HIV was the primary diagnosis in 286,000 visits by 54,000 patients; and (3) asymptomatic HIV was the primary diagnosis in 74,000 visits by 21,000 patients.

SAMHSA. Ms. Watts Davis' summary of SAMHSA's HIV/AIDS and hepatitis initiatives is outlined as follows. SAMHSA has a Congressional appropriation to increase access to prevention and treatment services to persons living with or at risk for HIV/AIDS and hepatitis

due to substance abuse and mental health disorders. The Public Health Act of 1992 requires 2%-5% of the Substance Abuse Prevention and Treatment Block Grant to be spent on HIV/AIDS-related substance abuse programs in states with AIDS case rates >10/100,000. The 25 eligible grantees with high AIDS case rates are not required to spend the 2%-5% set-aside on specific services.

SAMHSA's large "Access to Recovery" grant expands recovery support services and also addresses HIV. The grant is ~$7.6 million per year for three years and includes counseling to patients and their families, housing, employment, legal assistance, and HIV/AIDS services to patients and their partners. The 14 states that have been awarded the grant to date are leveraging resources to provide more comprehensive services. SAMHSA is currently exploring opportunities to expand the grants to all states because the HIV/AIDS will not be limited to states with high case rates.

Three SAMHSA centers collectively allocate funding to >600 grantees throughout the country under the "Targeted Capacity Expansion" (TCE) grant program. The TCE grant in the Center for Substance Abuse Treatment enhances and expands substance abuse treatment, outreach and pretreatment services in conjunction with HIV/AIDS services. The TCE grant in this center has had stable funding of $61.3 million in FY'04 to $63.1 million in FY'07.

The TCE grant in the Center for Substance Abuse Prevention assists communities in expanding existing HIV/AIDS and substance abuse prevention services to persons who were previously incarcerated with a possible high risk for contracting or spreading HIV/AIDS. The TCE grant in this center has had decreased funding of $39.6 million in FY'04 to $39.3 million FY'07.

The TCE grant in the Center for Mental Health Services increases capacity to provide culturally competent mental health treatment services to persons and communities of color living with HIVAIDS. The initiative promotes a sustained continuum of services in community-based environments. The TCE grant in this center has had decreased funding of $10.6 million in FY'04 to $8.3 million in FY'07.

SAMHSA has used its MAI funds to develop a number of innovative programs. Over a three-year project period from FY'05 to FY'08, SAMHSA will increase funding from $1.34 million to $3 million to support and expand the "Minority Education Initiative." Under this activity, grantees provide substance abuse, HIV and hepatitis prevention services in academic institutions that serve AAs, Hispanics and Native Americans. Rapid HIV testing, pre-/post-test counseling, referrals and other supportive services are offered to students and their partners who are HIV-positive or at risk for contracting and spreading the disease. To date, 358 students completed the peer educator training component of this initiative and conducted 601 educational sessions with 9,000 students. Of 4,551 students tested, 760 were referred to other HIV/AIDS services.

Over a three-year project period from FY'05 to FY'08, SAMHSA will increase funding from $1.7 million to $3 million to support the "Faith-Based Initiative." Under this activity, grantees conduct substance abuse and HIV/AIDS education and awareness activities, distribute materials, and perform community outreach with creative marketing efforts to encourage HIV testing among persons who are at risk for contracting or spreading the virus. To date, 2,663 of 12,400 persons tested were referred to other HIV/AIDS services. Outreach and awareness activities reached 169,653 persons. SAMHSA is now sponsoring all-grantee meetings to facilitate networking and leveraging of resources for the innovative programs. SAMHSA is pleased that the innovative programs reached "low-risk" persons who would not have been ordinarily identified through traditional programs.

SAMHSA used its "HIV Rapid Testing Initiative" to distribute 371,00 rapid HIV test kits from FY'05 to FY'06. Of 45,000 rapid HIV test kits that SAMHSA purchased in FY'07, 26,465 were distributed to 31 grantees in 12 states. SAMHSA provided the rapid HIV test kits to states and other grantees free of charge to promote use of this technology. SAMHSA will launch a $3 million initiative to address and support culturally-based HIV interventions in Indian Country. SAMHSA will use its existing tribal consultation policy and also will engage tribal leaders in developing this activity from the outset.

SAMHSA's "Hepatitis A and B Vaccine Prevention Project" is designed to prevent these infections through vaccination. SAMHSA reached agreement with 38 substance abuse treatment programs and HIV primary care programs in 20 states to conduct this initiative. To date, 43,953 doses have been distributed and 14,650 persons have received the vaccine. SAMHSA will expand the project in 2007 to target injecting drug users and provide 12,000 vaccinations in ten treatment centers that specialize in opiate addiction.

Ms. Watts Davis reiterated that training, development of a National HIV Strategic Plan and workforce issues provide key opportunities for interagency leveraging of resources. SAMHSA and a national organization are partnering to fund state-based fellowship programs to create a cadre of skilled HIV/AIDS professionals. SAMHSA is exploring the possibility of partnering with HHS to deploy Commissioned Corps personnel in communities. SAMHSA is interested in replicating its successful model in which multiple agencies would contribute the same amount of funding to develop and implement a comprehensive program. This model could be tailored to provide support and meet all needs of persons with HIV/AIDS and STDs, their families and partners.

CMS. Ms. Kenni Howard's summary of CMS's HIV/STD prevention activities is outlined as follows. Medicaid is the largest federal payer of HIV/AIDS services, but states have an "option" rather than a "mandate" to pay for these services. As a result, coverage of HIV/AIDS services widely varies among state Medicaid agencies (SMAs). However, SMAs are allowed to waive certain sections of the Social Security Act and target specific populations, including persons with HIV/AIDS.

The 1115 waiver allows SMAs to incorporate a managed care methodology; exempt enrollments, lock-outs and other specific requirements; and target different Medicaid programs by expanding eligibility, adding uninsured groups, and implementing special programs to certain groups. The 1115b waiver requires SMAs to provide recipients with freedom of choice in selecting any Medicaid provider. This waiver is most frequently used to focus on heavily impacted geographic areas rather than every Medicaid recipient in the state.

Under the freedom of choice and comparability of scope requirements, Medicaid recipients must present to providers in geographic areas of the state with a high burden of disease. Of 15 states that currently have HIV/AIDS waivers for Medicaid beneficiaries, three have 1115 waivers to provide full or limited Medicaid benefits to HIV-positive persons. Most of these waivers cover pharmacy services because prescription drugs are not a federally mandated service that SMAs are required to provide.

The 1915c waiver allows SMAs to cover services in the home, community and other settings outside of long-term care and nursing facilities. SMAs must comply with a number of requirements to use this waiver. Criteria for the institutional level of care must be met. Waivers for eligibility and freedom of choice requirements are not permitted. Implementation of safeguards to protect persons outside of institutions must be assured. An evaluation must be performed on the level of care provided by a hospital, nursing home, intermediate care facility for the mentally retarded, or other institution.

Recipients must be informed of all available alternative services and allowed to make a choice on institutional, home or community-based care and services. The average per capita expenditure for the waiver cannot exceed costs spent in an institution. SMAs must be accountable for all funds expended under the waiver.

The 1915c waiver is mandated by law to provide case management, homemaker services, home health aides, personal care, adult day health care, habilitation services, respite care, day treatment, and “other” services. SMAs typically apply for 1915c waivers for coverage of elderly and disabled persons, mental retardation and developmental disabilities, and specific diseases and diagnoses.

At this time, 12 states have 1915c waivers to provide home or community-based services in lieu of institutional services. The service packages are designed by states and typically include personal, respite, skilled nursing, companion, attendant, day health and adult dental care; case management; homemakers; environmental modifications; transportation; specialized medical equipment and supplies; psychosocial counseling; nutritional supplements; home delivered meals and nutritional counseling; mental health and chore services; educational support for children; therapeutic management; personal emergency response systems; private duty nursing; and moving assistance.

Because Medicaid is the payer of last resort, case managers are a critical component in waiver programs to access services, link patients to services, and utilize all existing community resources. Overall, Medicaid waivers are designed to leverage resources and ensure that a fully array of services is available to support both the individual and community regardless of the funding source.

IHS. Dr. John Redd's summary of IHS's HIV/STD prevention activities is outlined as follows. IHS was established in 1955 to meet federal obligations to provide health care to AIs/ANs based on the government's treaties and history of the treatment of AIs/ANs. AI/AN health care is a federal obligation in perpetuity that is not based on need. In the 2000 U.S. Census, 4.1 million persons or 1.5% of the U.S. population reported their status as full or partial AIs/ANs. These persons belong to 562 federally recognized tribes with 56% of AIs/ANs living in urban areas.

The federal government meets its obligations to AIs/ANs by providing services to three types of sites. IHS sites are centralized, funded by the federal government, and primarily provides care to AIs/ANs on reservations. Tribal sites include AIs/ANs who choose to be responsible for their health care, but IHS is authorized to collaborate with these entities. Urban Indian Clinics have a separate funding stream, but IHS is permitted to partner with these sites as well. IHS is active in 35 states throughout the country and serves 1.8 million users living on or near reservations and 600,000 AIs/ANs near urban clinics. However, IHS is permitted to bill Medicare, Medicaid and the Veterans Administration for reimbursement if AIs/ANs are eligible for services by these agencies.

Dr. Redd presented data to clarify two common but inaccurate perceptions of AIs/ANs. IHS's $3 billion budget is considered to be large to address the needs of only two populations. However, data collected in 2005 showed that AIs/ANs received less medical services with federal dollars than Medicare and Medicaid recipients, veterans and prisoners.

The small population of AIs/ANs is not considered to significantly contribute to disease burden and risk behaviors in the United States. IHS's 2004 surveillance report showed that chlamydia rates among AIs/ANs were twice as high as the U.S average with some service areas reporting exceedingly high rates. Ongoing P&S syphilis outbreaks in Indian Country are difficult to interrupt and are primarily associated with MSM. Of six racial/ethnic populations, AIs/ANs accounted for the second largest group with methamphetamine use.

The number of male and female AI/AN patients with first-time visits to IHS clinics for hepatitis C dramatically increased from FY'95 to FY'04. Data from two recent investigations of prenatal hepatitis C among AIs/ANs showed a 3.1% prevalence in Phoenix, Arizona and a 6.3% prevalence in the Northern Plains region. The study confirmed that methamphetamine and intravenous drug use were the primary factors for the high rates of hepatitis C in these areas.

Despite these challenges, IHS has achieved a number of important goals and made several significant accomplishments. IHS is fundamentally integrated and serves as a model of socialized medicine in the United States. IHS is a unique agency that serves as one source for clinical care, public health services, epidemiology, pharmacy services and behavioral health care. IHS has essentially eradicated hepatitis A in its target population by partnering with other agencies to begin administering the vaccine in 1996. Of all populations in the United States at this time, AIs/ANs are least likely to develop hepatitis A.

IHS uses its MAI funding of $1.9 million to conduct a number of activities. Behavioral health training and HIV/AIDS education are offered to providers. Epidemiology and surveillance studies are assessing knowledge, attitudes and practices regarding universal HIV testing among providers and patients. A large national evaluation of prenatal HIV screening is underway. Findings from this study will serve as a GPRA measure for IHS. Training is being provided to community health representatives and public health nurses. A telemedicine project is being conducted in Phoenix. Collaborations were established with urban clinics to routinize HIV screening.

Dr. Redd clarified that CDC conducts AI/AN activities in accordance with the Tribal Consultation Policy. IHS, CDC and external tribal consultants ensure that program announcements and other activities include tribal entities. IHS and CDC contract and directly partner with tribes to implement tribal-related projects.

CHAC was extremely pleased that HHS agencies other than CDC are conducting HIV/STD prevention activities. Several members made suggestions for the agencies to consider in refining these projects.

- The agencies should place more emphasis and conduct additional research on hepatitis C because this infection is significantly impacting intravenous drug users, particularly those with HIV co-infection.
- The agencies should provide faith-based organizations with guidance on encouraging HIV-positive members of congregations to serve as leaders and peers to identify other undiagnosed cases.
- The agencies should provide CHAC with regular updates on activities that are created outside of HHS to further facilitate interagency coordination and collaboration. For example, the panel presentation on HIV/STD prevention activities reflected integration at the agency level rather than the cross-departmental level. The other agencies should support and assist CHAC's efforts in ensuring that CDC and HRSA take leadership on the development of coordinated cross-departmental strategies throughout HHS.

Based on the presentations and discussions during the meeting, Dr. Fenton proposed interim activities the agencies should jointly conduct and complete over the next two to

three years. First, a new "HHS Strategic Plan for HIV/AIDS Prevention, Treatment, Care and Research" should be developed to take advantage of existing expertise and resources of HHS agencies. Second, the HHS agencies should create a new strategic plan outlining a comprehensive infrastructure to address training and workforce development in the HIV/AIDS prevention, treatment, care and research fields.

Third, the HHS agencies should develop and launch an interagency initiative on stigma and discrimination. This activity could be based on approaches to leverage resources, innovative partnerships with other agencies and private foundations, lessons learned and successful models, and a series of stigma and discrimination campaigns over the next two to three years.

During the development of formal motions and resolutions, Dr. Fenton asked CHAC to consider discrete tasks and concrete deliverables the HHS agencies should jointly complete over the next two to three years. This approach would assist CDC, HRSA and CHAC in formulating a vision to achieve HIV and STD prevention and treatment goals. The interim activities also could lead to accomplishing larger goals over the next three to five years.

Special Session on CDC'S HIV Prevention Strategic Plan

Dr. Janssen presented information in response to the concerns and comments CHAC made on the previous day related to CDC's addendum to the Strategic Plan.

- CDC will rename the Strategic Plan to the "Centers for Disease Control and Prevention HIV Prevention Strategic Plan Expanded and Extended Through 2010."
- CDC will include new language in the plan to more broadly include "African Americans and other disproportionately affected populations."
- CDC will not revise the goal targets to be bifurcated in the plan. Federal agencies are prohibited from making disclaimers about current resources and future resource needs in a public document. However, CDC's publication of its resource allocation model in peer-reviewed journals most likely would address CHAC's concerns.
- CDC did not modify the goals, but agrees with the workgroup's position on the importance of creating separate objectives for persons living with HIV and those at risk.
- CDC's rationale for not accepting some of the objectives was based on the following factors. Some objectives were redundant, repeated in various goals, or already existed in the Strategic Plan. Some objectives were inconsistent with CDC's mission or programmatic domain. Some objectives were too specific and were written as action steps or strategies. For example, an objective that was recommended for goal 2 was to "increase the

proportion of persons at risk for HIV who have access to free condoms." The workgroup advised CDC to expand this language to create an environment of expected condom use for women. The workgroup also urged CDC to conduct these activities in partnership with communities to increase support. CDC determined that this objective is too specific for an intervention and is actually a strategy or action step.

- CDC will now include an objective that the workgroup recommended for goal 1 due to its appropriateness for HIV-infected persons: "Increase the proportion of HIV care providers who perform risk assessment and provide appropriate interventions and referrals." CDC initially believed that this objective was redundant and similar to an existing objective in goal 2.
- CDC accepted and modified a number of the workgroup's recommended objectives. For example, the workgroup proposed the following language for goal 1/objective 14: "Increase the proportion of HIV-infected pregnant women who receive antiretroviral medication to interrupt perinatal transmission of HIV." CDC modified this language as follows: "Increase the proportion of HIV-infected pregnant women who are routinely tested and access prevention interventions including antiretroviral medication, caesarean sections (when appropriate) and infant formula feedings to interrupt perinatal transmission of HIV."
- CDC did not take action on the workgroup's recommendation to create separate stigma and discrimination goals. CDC's position is that measuring the impact of these factors on HIV transmission is extremely difficult. Models have not been developed to date to determine effects and behavior changes associated with reducing stigma and discrimination. CDC's approach to addressing this recommendation will be to include stigma and discrimination in the objectives when appropriate and modify the narrative to discuss these issues.
- CDC included specific language on stigma and discrimination in some of the objectives. Goal 2/objective 9 was modified as follows: "Increase the motivation of at-risk individuals to know their infection status and decrease real and perceived barriers to HIV testing, such as stigma and discrimination." Goal 3/objective 4 was modified as follows: "Reduce disparities, stigma and discrimination in access to prevention and care services that are experienced by communities of color, women and MSM."
- DHAP senior staff used the Delphi model to modify the goal targets as follows:
  - The overarching goal was based on preliminary incidence estimates, trends in HIV diagnoses, behavioral surveillance data, the proportion of persons at risk, and the reach of interventions.
  - Goal 1 was based on trends in HIV diagnoses, behavioral surveillance data, and changes in indicators of behaviors among PLWH.

- — Goal 2 was based on 50,000 new diagnoses each year and 40,000 new infections per year. Based on current testing, the gain would only be 1% per year. This target was established before new funding of $45 million became available for CDC's HIV testing initiative.
- — Goal 3 was based on CDC and HRSA data, implementation of interventions by the Antiretroviral Treatment Access Study and other sources, more emphasis on linkages to care, and testing in healthcare settings.

Dr. Janssen concluded his update by describing CDC's future plans to implement the updated Strategic Plan. To achieve specific goals by 2020, DHAP is focusing on HIV at the division level and NCHHSTP is emphasizing integration at the center level. For example, "personalized" prevention should be available in 2020 and that an individual diagnosed with HIV with a low CD4 count should be to support this effort, CDC will identify the most important surveillance, research, program and evaluation outcomes; develop indicators to achieve goals; and extensively involve external partners.

CHAC thanked CDC for undertaking an enormous effort overnight to address CHAC's comments and concerns. The members acknowledged that Dr. Janssen's detailed response demonstrated CDC's careful and thoughtful consideration of CHAC's feedback on the previous day.

Several members provided additional input for CDC to consider in advancing CHAC's formal endorsement of the plan.

- The overarching goal should be revised as follows: "Reduce the number of new HIV infections in the United States by at least 5% per year to achieve at least a 10% reduction by 2010, particularly focusing on eliminating racial and ethnic disparities in new HIV infections."
- The "acquiring" and "transmitting" language in goal 1 should be separated or clarified because only one of the targets for "acquisition" or "transmission" risks potentially could be achieved.
- Goal 1/objective 9 should be revised to "... persons at risk for HIV infection and transmission...".
- Goal 1/objective 14 should be separated and relocated as follows. The language on "routine testing of HIV-infected pregnant women" should be moved to the goal 2 testing goals. The language on "HIV-infected pregnant women who choose to take antiretroviral medication to interrupt perinatal transmission of HIV" should be moved to the goal 3 linkage to care goals.
- Goal 1/objective 14 should be revised as follows: "Increase the proportion of HIV-infected pregnant women who are routinely tested and have access to preventive strategies (such as antiretroviral medication, infant formula and Caesarian section when indicated) to interrupt perinatal transmission of HIV."

- Goal 4/objective 1 should be revised to monitor both the prevalence and transmission of the drug-resistant virus.

Dr. Fenton confirmed that CDC would further revise the addendum to make the objectives clearer. For example, the objectives would not be changed, but would be stratified into two clearly defined categories: "persons at risk for acquiring HIV" and "persons at risk for transmitting HIV." Dr. Janssen added that CDC's indicators, new HIV incidence estimates, and medical monitoring project would more fully address CHAC's concerns related to risk behaviors among PLWH and persons at risk for HIV.

Mr. Milan clarified that CDC would be unable to address some of CHAC's suggestions. The workgroup was charged with updating the 2000 Strategic Plan goals and CHAC previously endorsed the modified goals. He explained that CHAC is now being asked to formally approve CDC's new and revised objectives and goal targets only. Mr. Milan announced that a few members would meet in a small writing group later in the meeting to draft formal motions and resolutions for CHAC's vote.

Internet and Communications Technology for STD/HIV Prevention

Dr. Mary McFarlane, of DSTDP, described CDC's activities to strengthen STD/HIV prevention using the Internet and other communications technology. CBOs and other non-governmental programs have attempted to implement several communications strategies, including partner notification via e-mail or chat rooms, chat room outreach, banner advertisements, mass marketing, clinic reminders via cell phones, health department web sites, chlamydia self-test kits ordered online, online behavioral interventions, and online test slips, results and EPT.

Because these interventions have had varying degrees of success, CDC was asked to provide leadership and guidance in this area. In response to this request, CDC and the National Coalition of STD Directors (NCSD) created Internet guidelines based on current best practices of online programmatic efforts. The guidelines focus on policy, procedures, protocols, staffing, supervision and training. The guidelines will be released in the fall of 2007 with three components: Internet partner notification, Internet outreach, and Internet health communication and promotion.

The "success" of the Internet guidelines will be determined by a number of factors:

- Who are the individuals being reached? What are the demographics of the target audience for Internet programs? Are the persons who seek sex partners online the same individuals who present to clinics for services? If not, what are the venues that Internet program users present for services?

- Are Internet program users the appropriate target audience? Are at-risk populations being reached? What diseases and groups are being targeted? Are efforts needed for the general population in addition to activities for risk populations? Would interventions for the general population be costly and dilute messages?
- What are appropriate versus inappropriate messages to deliver via the Internet, such as vaccines, screening, sexual behavior, condom use and partner choice?
- What are the most effective platforms to deliver messages, such as web sites cell phones and social network sites?
- Has program reach, efficiency, efficacy and effectiveness been increased? Are these interventions assisting in locating more cases?
- Are strategies being disseminated to providers to promote adoption of technology, such as training, awareness, emergency and outbreak alerts, standing orders, treatment guidelines, access to technology for testing and treatment, provision of online results, and the ability to view local prevalence and incidence data?

CDC created a "Technology Center of Excellence" (TCOE) to respond to these questions and achieve several goals. A community of thinkers and actors will be developed. An infrastructure will be available to explore and validate online activities. Priority technological innovations and current efforts will be located, compiled and evaluated. Best practices or "practices with promise" will be determined, packaged and distributed to the field. Dissemination plans will be developed and new efforts will be piloted.

The TCOE includes a broad range of participants, including academia, health department physicians and directors, laboratorians, web experts and web site owners, sex researchers, and behavioral intervention experts. CDC is considering additional collaborators to include in the TCOE, such as corporate research departments of cell phone companies, NCSD and other large CBOs.

CDC has established both long- and short-term goals for the TCOE. A web portal will be developed and available for all STD, HIV and healthcare providers and programs to download useful program packages, such as home and rapid test systems, EPT, clinical pathways or standing orders, partner notification systems, online intervention packages, waiting-room video interventions, STD data views, kiosk programs or waiting-room software, cell phone downloads, samples of text messages, videos, e-cards, podcasts, and a social networking presence.

Partnerships will be developed with Internet and cell phone providers. These relationships will allow CDC to have centralized access rather than contacting each partner independently. A system will be created to evaluate each partnership. Incentives or "stamps of approval" will be developed for web site owners. An assessment tool will be

developed to evaluate existing web-based STD programs. The possibility of creating performance standards for web-based interventions and HIV/STD programs is being considered. Evaluation results will be rapidly communicated to the field. Promising programs will be expanded and tested, such as inSPOT, sexINFO and iwantthekit.org. A provider portal will be developed to give providers better access to CDC's materials and technical assistance.

TCOE's evaluation component will focus on a number of factors. The size of the sexual risk part of the Internet will be determined, such as the number of sex-seeking rooms in all active chat rooms and the number of "risky" sex-seeking conversations. The health promotion component of the Internet will be identified, including existing sexual behavior sites and abstinence or other behavioral models promoted by these sites. The types of health advice given online will be assessed.

CDC will partner with the Public Health Informatics Fellowship Program to use "RiskBot" to count Internet programs. The automated "web crawler" uses natural language processing to locate web-based conversations on specific topics of interest and estimate the proportion of these conversations involving risky sexual behavior, drugs or other factors related to disease transmission. RiskBot also locates cues to geography, demographics and other factors; determines the frequency of persons changing their online identities; and tracks and evaluates the uptake of public health messages. However, RiskBot gathers data about the Internet and does not collect information about individuals.

Dr. McFarlane reiterated that new communications media arise quickly. CDC will partner with NCSD and use the TCOE to rapidly explore new venues for risk and methods to incorporate prevention. CDC also will develop methods to evaluate the effect of prevention efforts.

Mr. Thishin Jackson is a CHAC member. He presented a live demonstration to provide CHAC with first-hand knowledge of sex-seeking conversations on the Internet. Prior to the actual demonstration, however, Mr. Milan stated for the record that CHAC unanimously agreed the sexually explicit presentation was appropriate for a public meeting focusing on HIV/STD prevention and treatment.

For purposes of the demonstration, Mr. Jackson created a false profile on a web site for AA MSM with his age, race/ethnicity, city of residence, gender, height, weight, sexual preference, penis size, preferred drugs of choice, alcohol use and other factors. The web site also allows users to post both clothed and nude photographs. Members of the web site can use a number of specific factors to search for and select other members throughout the world, such as screen name, age range, geographical area, preferred racial/ethnic group, penis size and HIV status.

Mr. Jackson's search showed that in the city of Atlanta alone, 245 persons were logged in at 11:19 a.m. and 116 persons disclosed their HIV status as positive. In less than three hours, Mr. Jackson received 64 messages in response to his new profile and pictures. One of the respondents requested unprotected oral and anal sex, confirmed his drug use, provided his telephone number, and allowed access to his private pictures. Another respondent gave Mr. Jackson his telephone number after only five minutes of conversation, but this individual stated his preference for using condoms.

Mr. Jackson conveyed that the live demonstration emphasizes the critical need to use the Internet and other communications technology to advance the HIV/STD prevention field. He pointed out that mobile vans, street outreach and other traditional interventions are outdated and ineffective in the 21st century. Most notably, young MSM <18 years of age, HIV-positive MSM, MSM who state a preference for not using condoms, substance abusers, and other high-risk groups are using the Internet to seek sex partners.

Mr. Jackson also informed CHAC that the Internet is an effective tool in providing referrals and actual locations for persons to obtain testing, care and treatment of HIV and STDs. For example, CDC funded his web-based project to recruit young MSM. This initiative reached thousands of persons in the target audience in only a few months.

CHAC was extremely pleased with CDC's efforts to strengthen and advance HIV/STD prevention and outreach using the Internet and other communications technology. Several members made suggestions for CDC to consider in further enhancing these activities.

- CDC should expand its outreach, education and prevention activities to broadly include Internet sites targeted to a variety of diseases and at-risk populations. For example, the positivefriends.com web site is available for all persons living with HIV/AIDS, hepatitis, HPV and other STDs.
- CDC should continue its efforts to widely promote web-based HIV/STD outreach with an organized and systematic strategy rather than an individual approach. This process will provide access to the broader population of web site owners rather than the smaller group of individual sex site users.
- CDC should assist academic institutions, researchers and other groups in overcoming Institutional Review Board and other bureaucratic barriers to accessing sex seeking web sites.

In response to one of CHAC's suggestions, Dr. McFarlane confirmed that CDC's Internet guidelines will address bureaucratic issues related to researchers accessing sex seeking web sites. CDC distributed a "Dear Colleague" letter to strongly encourage the HIV/STD prevention field to explore this area. CDC also will disseminate materials to validate the need for researchers to access sex seeking web sites for research purposes only.

CHAC Business

Dr. Hook entertained a motion for CHAC to approve the previous minutes. Dr. Leoutsakas requested that bullet 2 on page 5 be revised with additional language to more clearly and strongly emphasize concerns he raised during the previous meeting. He asked for the previous minutes to reflect CHAC's awareness of adverse impacts on testing behaviors as a result of the change in the law to "forced" name-based HIV reporting.

Dr. Leoutsakas noted that agencies and organizations traditionally have assured the privacy of persons who presented for HIV testing. However, the change in the law might facilitate public notification and trigger psychological or social issues for persons who are diagnosed with HIV. Overall, Dr. Leoutsakas pointed out that the change in the law requiring PLWH to give their names presents a conundrum in terms of social issues associated with HIV.

A motion was properly placed on the floor and seconded by Dr. Sweet and Rev. Hickman, respectively, for CHAC to accept the previous minutes as revised. CHAC **unanimously approved** the amended November 13-14, 2006 Meeting Minutes with the changes Dr. Leoutsakas noted for the record.

Several CHAC members reiterated previous recommendations or made new suggestions to improve the meeting process. Speakers should include specific questions in their presentations for CHAC to provide concrete advice; provide materials to CHAC well in advance of meetings; and present racial/ethnic data stratified by all populations rather than AAs and whites only.

Mr. Milan presented the formal resolutions the writing group drafted earlier in the day. Instead of asking for individual motions for each recommendation, Mr. Milan entertained one motion for CHAC to approve all 16 recommendations as one package.

CHAC extensively discussed and suggested changes to the draft recommendations. A motion was properly placed on the floor and seconded by Drs. Sweet and Leoutsakas, respectively, for CHAC to approve all 16 recommendations as one package with the revisions the members noted for the record. CHAC **unanimously approved** the motion. The package of 16 motions as revised and formally approved by CHAC is outlined below.

1. CHAC recommends that Dr. Gerberding and Dr. Duke independently and jointly urge the Secretary of the Department of Health and Human Services to initiate the development of a multi-sectoral National Plan for HIV/AIDS Prevention, Treatment and Care in the United State that addresses all sectors and includes all relevant federal agencies. CHAC further recommends that Dr. Gerberding and Dr. Duke offer their support to the HHS Secretary in framing a request from the

Secretary to the President urging the President to empanel a committee to develop the National Plan for HIV/AIDS in the United States. CHAC recommends that the National HIV/AIDS Plan Committee include public and private sector stakeholder representatives from the HIV/AIDS research, prevention, treatment, care, rights and PLWHA communities. CHAC further requests that Dr. Gerberding and Dr. Duke meet with CHAC or its co-chairs to discuss the development of a National Plan and this recommendation.

2. CHAC requests that HRSA create cost projections for providing adequate prevention, treatment and care services for the additional 22,000 expected persons in 2008 and 31,000 newly diagnosed persons with HIV projected in 2009 through the President's HIV/AIDS testing initiatives. CHAC further recommends that CDC and HRSA urge the HHS Secretary and the President to include adequate funding level increases in the FY'08 and FY'09 budgets to provide prevention, treatment and care services for these individuals.

3. CHAC recommends that CDC and HRSA urge the HHS Secretary and the President to increase funding levels in the President's proposed FY'08 budget for HIV and STD prevention, treatment and care.

4. CHAC recommends that CDC and HRSA urge the HHS Secretary and the President to restore the President's proposed $6 million budget cut for the AETC program in the President's proposed FY'08 budget.

5. CHAC recommends that CDC and HRSA urge the HHS Secretary and the President to provide increased funding levels for HIV and STD prevention, treatment and care in the President's upcoming proposed budget for FY'09.

6. CHAC authorizes the reconvening of its Ryan White Reauthorization Workgroup to address the upcoming 2009 reauthorization of the Ryan White HIV/AIDS Treatment Modernization Act of 2006. The workgroup will include CHAC and non-CHAC members with knowledge about the Ryan White Modernization Act and Ryan White services.

7. CHAC requests that CDC and HRSA present to CHAC their agencies' plans for supporting the HHS Secretary in responding to the Ryan White HIV/AIDS Treatment Modernization Act's requirement that the Secretary ensure that HRSA, CDC, SAMHSA, and CMS coordinate planning, funding and implementation of federal HIV programs. CDC

further requests that CDC and HRSA present their agencies' plans to support the HHS Secretary in responding to the Secretary's required biennial report to Congress on coordination efforts for HIV/AIDS at federal, state and local levels.

8. CHAC recommends that CDC and HRSA recommend that the HHS Secretary create a coordinated HHS Plan for HIV/AIDS that incorporates all HHS agencies impacting HIV/AIDS research, prevention, treatment, care, support, reimbursement and funding strategies. CHAC further recommends that CDC and HRSA recommend that a coordinated HHS Plan for HIV/AIDS be created and used by the Secretary in responding to the Secretary's coordination and reporting requirements of the Ryan White HIV/AIDS Treatment Modernization Act. CHAC recommends that CDC and HRSA offer CHAC's support for developing a coordinated HHS Plan for HIV/AIDS.

9. CHAC authorizes the convening of an STD Workgroup to address current and emerging issues for STD prevention, treatment and care in the United States. The STD Workgroup will include CHAC and non-CHAC members with knowledge about STD issues relevant to CDC and HRSA.

10. CHAC recommends that CDC and HRSA continue developing strategies with CMS and states to assure that Medicaid and Medicare benefits are available and accessed to provide appropriate reimbursements for HIV, STD and hepatitis screening and management.

11. CHAC commends CDC for its continuing effort to improve PEMS by incorporating stakeholder feedback.

12. CHAC requests that at its fall 2007 meeting, HRSA provide presentations and information from all relevant HRSA bureaus and offices concerning collaboration and integration of HIV, STD and hepatitis prevention, treatment, care, management and education services provided or potentially available through HRSA programs.

13. CHAC agrees to keep the HHS Secretary informed of its actions and concerns relating to HIV and STD prevention, treatment and care.

14. CHAC recommends that CDC continue to develop strategies utilizing the Internet as a venue for targeting prevention for populations at risk for HIV and STD transmission and acquisition. CHAC further

recommends that CDC engage HRSA and SAMHSA in developing these strategies.

15. CHAC requests that the Director of CDC, Administrator of HRSA, HHS senior officials (including the HHS Secretary and Assistant Secretary) be invited to attend in person CHAC's fall 2007 meeting in Washington, DC to discuss CHAC's May 2007 motions and emerging issues in HIV and STD prevention, treatment and care.

16. CHAC accepts and endorses the recommendations of the HIV Prevention Strategic Plan Workgroup for Updating and Extending the Strategic Plan from 2007 through 2010 with the following modifications:

    a. Revise the Plan's overarching goal to: "Reduce the number of new HIV infections in the United States by a minimum of 5% per year, or at least by 10% through 2010, focusing particularly on eliminating racial and ethnic disparities in new HIV infections."

    b. Incorporate past, current and expected resource strategies and constraints into the Plan narrative to further explain the achievement of past and new goals.

    c. Incorporate the chronology of requests and approvals of the workgroup's efforts by CHAC into the Plan narrative.

    d. Revise the Addendum title to reflect the update and extension of the Plan through 2010.

    e. Incorporate stigma and discrimination issues into the Plan narrative.

    f. Revise indicators to also include incidence measures for MSM, Latinos and African Americans.

    g. Revise goal 1 to stratify objectives by both acquisition and transmission of HIV.

    h. Revise goal 1/objective 14 regarding pregnant women to include language concerning access to prevention interventions, such as antiretroviral medication, Caesarian sections (when appropriate), and infant formula feedings.

i. Revise goal 4/objective 1 to incorporate new language regarding the prevalence and risk of HIV transmission: “Improve the capacity to measure incidence of new infections; track the prevalence of disease and its complications; monitor the prevalence and transmission of drug-resistant virus; monitor behaviors, including those that increase the risk of HIV infection (for those who are uninfected) and those that increase the risk of HIV transmission and the risk of disease progression (for those who are living with HIV); and provide locally relevant data for community planning.”

j. Revise objectives where appropriate to also include other racial and ethnic groups disproportionately affected by HIV/AIDS.

Further, CHAC expresses its deep appreciation to the Strategic Plan Workgroup and CDC staff for their exceptional support in developing the Update and Extension of the Strategic Plan.

CHAC also requests that the co-Chairs transmit these motions to the agency heads of CDC and HRSA and also follow-up with the HHS Secretary and the agency heads of CDC and HRSA for complete responses to CHAC’s December 19, 2006 letter.

Mr. Jackson expressed his interest in placing a formal motion on the floor for CHAC to form a new “Internet and Communications Technology for STD/HIV Prevention Workgroup.” However, Dr. Hook tabled action on the proposed motion due to CDC’s current activities under the TCOE. Moreover, the package of recommendations CHAC formally approved included reconvening the STD Workgroup. He pointed out that the workgroup could be charged with addressing Internet and communications technology for STD/HIV prevention.

Dr. Hook led CHAC in a review of future agenda items that were raised over the course of the meeting:

- Overview by the HHS agencies on hepatitis C prevention and management strategies.
- Presentation by HRSA bureaus and offices on efforts to integrate and promote HIV/STD prevention and management strategies.
- Update by the HHS agencies on the development of a new “HHS Strategic Plan for HIV/AIDS Prevention, Treatment, Care and Research.”
- Update by the HHS agencies on efforts to address stigma and discrimination in HIV/AIDS and STD activities.
- Presentation by CDC on the new estimates for HIV incidence.

- Presentation by NCHHSTP on its PISC initiative.
- Update by CDC on TCOE activities.
- Update on international HIV activities, including a presentation by PEPFAR representatives and a discussion by CHAC on the possibility of forming a new "International HIV Workgroup."

Closing Session

The next CHAC meeting will be held on November 15-16, 2007 in Washington, DC.

With no further discussion or business brought before CHAC, Dr. Hook adjourned the meeting at 12:26 p.m. on May 8, 2007.

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

____________________	______________________________
Date	Edward W. Hook III, M.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