

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

## **40th Meeting**

**Hubert Humphrey Building**

**Washington, DC**

**September 30–October 1, 2010**

### **Council Members—Present**

Helene D. Gayle, M.D., M.P.H., PACHA Chair

Dawn Averitt Bridge

A. Cornelius Baker

Praveen Basaviah

Douglas Brooks, M.S.W.

Humberto Cruz, M.S.

Kevin Robert Frost (by telephone)

Patricia Garcia, M.D., M.P.H.

Robert Greenwald, J.D.

Kathie M. Hiers

David Holtgrave, Ph.D.

Michael Horberg, M.D., M.A.S.

Ejay L. Jack

Jack C. Jackson, Jr., J.D.

Naina Khanna

Anita McBride

Douglas A. Michels, M.B.A.

Mario Perez

Rosie Perez (by telephone)

Malika Saada Saar, M.Ed., J.D.

### **Council Members—Absent**

Rev. Dr. Calvin Otis Butts III, D.Min., M.Div.

Ernest Darkoh-Ampem, M.D., M.P.H., M.B.A.

Jim Kim, M.D., Ph.D.

Sandra Torres Rivera

Phill Wilson

## **Staff—Present**

Christopher Bates, M.P.A., Executive Director, PACHA, U.S. Department of Health and Human Services (HHS)

Melvin Joppy, Committee Manager

## **Presenters**

Chris Collins, Vice President and Director of Public Policy, Foundation for AIDS Research (amfAR)

Ann Gavaghan, Chief of Staff, Office of the U.S. Global AIDS Coordinator (OGAC), U.S. Department of State

RADM Scott Giberson, Chief Professional Officer, Pharmacy, U.S. Assistant Surgeon General, National HIV/AIDS Principal Consultant, Indian Health Service (IHS)

Kathleen McDavid Harrison, Ph.D., M.P.H., Associate Director for Health Equity, National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Disease (STD), and Tuberculosis (TB) Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC), HHS

Warren Hewitt, HIV/AIDS Coordinator, Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), HHS

Matt Kavanagh, Health Global Access Project

Richard Klein, Office of Special Health Issues, Food and Drug Administration (FDA)

Stacey Little, Ph.D., M.P.H., M.S.W., Associate Director and Domestic Team Leader, AED Center on AIDS and Community Health

Peggy Quigg, Acting Deputy Director, Center for Substance Abuse Prevention (CSAP), SAMHSA, HHS

Randall H. Russell, LCSW, PIP, President, Healthcare Responses, Inc.

Craig Studer, Division of HIV/AIDS Prevention, NCHHSTP, CDC, HHS (by phone)

Ronald Valdiserri, M.D., Deputy Assistant Secretary for Health, HHS

David Vos, Director, Office of HIV/AIDS Housing, Office of Community Planning and Development, Department of Housing and Urban Development (HUD)

Wendy Wertheimer, Office of AIDS Research (OAR), National Institutes of Health (NIH), HHS

## **DAY 1**

### **Welcome**

PACHA Chair Helene D. Gayle welcomed the members and participants. She said the meeting would focus on reviewing the work of the subcommittees and deliberating on the Council's next steps related to implementation of the National HIV/AIDS Strategy (NHAS). Dr. Gayle added that she and others are "euphoric" that the United States finally has a comprehensive strategy in place. She congratulated Jack Jackson, Jr., for his win in the Democratic primary for the Arizona State Senate. (Mr. Jackson is unopposed in the general election.) In introducing Ronald Valdiserri, HHS Deputy Assistant Secretary for Health, Dr. Gayle said Dr. Valdiserri is among the most talented and committed people working in this area.

### **Remarks by Ronald Valdiserri, M.D., Deputy Assistant Secretary for Health, HHS**

Dr. Valdiserri said his Office is responsible for pulling together a plan to operationalize the NHAS, which must be cleared and approved by the Secretary and presented to the White House by the end of the year. An interagency working group, made up of representatives of all the Offices and Agencies in HHS, has already met twice to provide input into the operational plan. A Presidential memorandum determined the deadline and directed lead agencies to identify the steps they will take, as well as responsible individuals and reporting requirements, but does not offer details.

### **HHS Outreach, Engagement, and Coordination**

Efforts are underway to raise awareness about the NHAS and to gather stakeholder input. HHS Secretary Kathleen Sebelius gave an impassioned presentation on the NHAS at the U.S. Conference on AIDS, where the Assistant Secretary for Health (ASH), Howard Koh, and White House representative Jeffrey Crowley led a panel discussion. Department representatives participated in two teleconferences of the Coalition for a National AIDS Strategy, and the online blog at AIDS.gov has featured 15

posts about the NHAS. Comments have been submitted from numerous community groups and professional organizations.

In addition to producing the operational plan, HHS has been asked to develop a process to improve coordination of HIV/AIDS activities among HHS and the other lead agencies: the Departments of Labor (DOL), Justice (DOJ), Veterans Affairs (VA), and HUD and the Social Security Administration. Sec. Sebelius specifically requested inviting a representative from the Department of Education (ED). Dr. Koh has already convened the first meeting of the Federal leads group; the next will take place in December or January.

The NHAS directs the Secretary to engage the Offices of Faith-Based Initiatives and Community Partnerships, located in every Federal Department and the White House, to develop a plan for reducing stigma. Representatives of those Offices will meet in late October. In addition, HHS will hold a community check-in session in mid-October, inviting about 40 government and nongovernment representatives of various communities to give input on the operational plan. Mr. Jackson is the designated representative from PACHA.

### **Proposed Outline of the NHAS Operational Plan**

Dr. Valdiserri explained that the format of the plan remains in flux, but the content can be divided into four parts:

Part 1 will describe in detail the HIV/AIDS budget across HHS. This information is not accessible and has never been compiled into a single report. (State and local health departments have noted that it would be helpful to know which programs are funded by Federal dollars.) Reporting may vary between those agencies that provide services and those that don't, but most will provide data on intramural versus extramural funding, geographic distribution, types of activities, racial/ethnic groups served, populations served, gender distribution, etc.

Part 2 will summarize key efforts underway by each operative Division or Office to achieve the goals of the NHAS. Dr. Valdiserri has asked each entity to describe those efforts according to population served (e.g., men who have sex with men [MSM]) or NHAS goal targeted (e.g., reducing stigma), among other categories.

Part 3 will compile agency responses to open-ended questions about how each agency is addressing crosscutting issues, such as improving

program evaluation activities, standardizing data collection, or streamlining funding application processes.

Part 4 will describe operational steps that embody the goals of the NHAS. As an example of the kind of comprehensive efforts needed to address HIV/AIDS, Dr. Valdiserri described CDC's grants to 12 cities to plan comprehensive, integrated prevention activities.

### **Challenges**

Dr. Valdiserri emphasized that, given the time constraints, the operational plan will not provide an inventory of HIV/AIDS services and programs but rather highlight key steps planned to achieve the NHAS goals. He said his Office is engaged in a "delicate dance" in which it acts as a central point for coordination without dictating the work of all the HHS Agencies.

### **Discussion**

Humberto Cruz stressed the importance of coordinating State-level resources and services with local services when Federal proposals target funding for local programs, as in the CDC awards described. In addition, States should evaluate the NHAS and work with localities to identify similarities, differences, and potential areas for collaboration. Dr. Valdiserri agreed with the need for coordination among multiple entities. He said his Office is trying to retrofit the implementation of the NHAS into CDC's award and asking Agencies such as SAMHSA, NIH, and the Health Resources and Services Administration (HRSA) to become involved in that grant program. The experience that CDC gains from the planning grants will likely be incorporated into the State health department cooperative agreements, which are being revised. Thus, if CDC integrates programs at the local level, as many have suggested, it can make such integration part of its funding agreement with States.

Kathie Hiers asked whether any funding opportunities are available for rural areas; Dr. Valdiserri reiterated that, if successful, lessons learned would be integrated into State cooperative agreements. Robert Greenwald suggested that the Centers for Medicare & Medicaid Services (CMS)—the largest provider of health care for people living with HIV/AIDS (PLWHA)—be integrated into the CDC awards. Dr. Valdiserri assured the Council that CMS is involved and added that at the last interagency working group meeting, CMS provided very detailed information about its budget for HIV/AIDS support.

Anita McBride asked for clarification about the reporting lines among the representatives of the interagency working group. Dr. Valdiserri said the group has representation from multiple levels of each of the Agencies;

however, one representative from each is responsible for combining and presenting all the data from his or her Agency requested for the operational plan.

Dr. Valdiserri noted that HHS is not responsible for the operational plans of other Federal Departments. Douglas Brooks questioned how HHS could ensure the NHAS is implemented without authority for implementation across the Federal Government. Dr. Valdiserri said the effort at present is driven by enthusiasm and professionalism, but he conceded there are no incentives to comply yet. A. Cornelius Baker asked that PACHA receive periodic updates from other Departments on their operational plans. He also asked whether PACHA would have a liaison(s) with other Departments to keep abreast of issues in the NHAS that depend on other Departments, such as ED and DOJ. Housing is a core need, said Mr. Baker, but the integration of HUD is unclear. Dr. Valdiserri said a PACHA member could be included in the Federal leads group meetings. He also said that once all the operational plans are complete, HHS can evaluate how the Federal Government can encourage more engagement at the State and local levels.

***Followup Item***

PACHA Executive Director Christopher Bates will work with Dr. Valdiserri to ensure that a PACHA member is added as a liaison to the Federal leads group.

In response to a question by David Holtgrave, Dr. Valdiserri said that his Office is still resolving how to assess whether agency activities are sufficient to meet the goals. Dr. Gayle supported the importance of measuring the impact of the implementation effort and the need for better mechanisms to do so. Dr. Valdiserri noted that the operational plan covers only Year 1 and is unlikely to be perfect. Discussion is underway with CDC and others on methodologies that the 12 CDC-grantee cities can use to estimate denominators and assess impact. Mr. Cruz said that measurements of success for NHAS implementation will vary across the board, because States are starting from different baselines. For States such as New York, which has already invested heavily in reducing HIV/AIDS with some success (e.g., reducing perinatal HIV transmission), the achievements made toward the NHAS goals will look smaller than those of States with a lot of work yet to do.

Patricia Garcia suggested providing the details of the operational plan to the public online, for example, with links to allow the reader to drill down deeper. Dr. Valdiserri agreed the approach would be better but did not think the Office of the Assistant Secretary for Health could do so. However, Agencies may provide more detailed plans that would not be included in the

document cleared by the Secretary and provided to the White House. Dr. Gayle favored a shorter document that knits together information from the Agencies to form a comprehensive approach.

Ms. Hiers suggested that Dr. Valdiserri consider the diversity of the participants invited to the community check-in. She asked whether the operational plan would be public, and Dr. Valdiserri said he is in favor of it but the White House would determine how much of the plan would be available.

Dawn Averitt Bridge said the document described by Dr. Valdiserri did not shed light on how the goals of the NHAS would be achieved over the long term. No mention was made of the roles of non-Federal players or the unique, game-changing action that Federal programs will take to further momentum and motivation. Dr. Valdiserri responded that the operational plan is, by necessity, focused on the short term; once it is complete, it can form the basis for discussion of, for example, public-private partnerships.

Malika Saada Saar underscored the importance of the needs of women and mothers. She hoped the representatives providing input into the operational plan would include leadership that ensures that mothers and women are recognized.

## **Subcommittee on HIV Incidence**

### **Update by David Holtgrave, Ph.D., and Mario Perez**

To answer questions about what new resources are needed, one must understand how current resources are being used, said Dr. Holtgrave. Even relatively easy questions, such as how much money a given Agency has for HIV/AIDS and how it uses that money, are not easy to answer. Identifying resources is further complicated when resources are redirected, as is the case with CDC, which moved a significant amount of funding out of the pool limited to HIV/AIDS and into the Division of Adolescent and School Health (DASH). Therefore, said Dr. Holtgrave, several Agencies were invited to describe their HIV/AIDS resources, which will form the basis of the Subcommittee's recommendations.

Mr. Perez emphasized the importance of prevention in meeting the first NHAS goal to reduce new HIV infections. The NHAS calls for intensifying and expanding prevention efforts and holding partners accountable. It also indicates the need to redirect and possibly increase investment. To make recommendations to this end, said Mr. Perez, the Subcommittee must understand the range and scope of the current HIV/AIDS portfolio. He added

that PACHA must not focus solely on Federal efforts but also give attention to State and local resources. All levels of government are accountable.

The balance between prevention and treatment resources is out of whack, said Mr. Perez. The current approach is unsustainable, and it is exemplified by the waiting list for treatment in most States. Representatives from CDC have stated that simply maintaining the status quo could cost from \$120 billion to \$250 billion, said Mr. Perez. In addition, social justice remains a concern, as the poorest, most vulnerable, and most stigmatized bear the burden of treatment disproportionately, he concluded.

## **HIV General Budget Overview**

### **Christopher Bates, Executive Director, PACHA**

Mr. Bates said that of the \$19 billion for domestic HIV/AIDS services (including prevention), most (\$9 billion) goes to CMS, primarily for treatment. He noted that CMS is working to better flesh out its data. DOJ has \$21 million that goes, for example, to prison systems, but also to the Office of Civil Rights, which investigates and prosecutes discrimination cases. (Mr. Bates said DOJ wants to reach out to the general population to better identify discriminatory practices.)

VA has \$801 million and 24,000 patients receiving HIV care. The SSA has \$2.2 billion for domestic HIV/AIDS programs, much of which goes to people disabled by HIV/AIDS; the SSA believes many more PLWHA are eligible. DOL is identified as a Federal lead in the NHAS; it addresses issues such as HIV/AIDS in the workplace, especially requirements of the Americans with Disabilities Act.

The FDA has \$109 million, primarily for monitoring and testing drugs, but also for other pertinent efforts. HRSA has \$2.2 billion, including Ryan White Comprehensive AIDS Resources Emergency (CARE) Act (Ryan White) dollars, and is considered the payer of last resort. In some States, not all of those enrolled in Ryan White programs will move to Medicare or Medicaid. In addition, HRSA funds local efforts such as community-based programs, dental services, and special projects of national significance that contribute to guidance for providers.

Most of the money for IHS activities comes from the Minority AIDS Initiative (MAI). Mr. Bates summarized CDC's fiscal year (FY) 2010 budget. NIH allots \$3 billion for domestic research alone. Gathering SAMHSA data poses challenges because, for example, the Agency has no way to get information on how States use the 10-percent set-aside portion of their block grants in relation to HIV/AIDS. Mr. Bates suggesting inviting representatives from the



Agency for Healthcare Research and Quality to speak to PACHA about the work it does for HIV/AIDS, which is not well known.

The Office of the HHS Secretary oversees the MAI fund, which provides limited but important funding totaling \$53 million to increase minority populations' access to prevention and care. Across all HHS Agencies, Congress has directed \$417 million to increase minorities' access to HIV/AIDS prevention and care. HHS also administers the Global Fund.

### **CDC HIV Prevention Budget**

#### **Craig Studer, Division of HIV/AIDS Prevention, NCHHSTP, CDC**

Mr. Studer said CDC's FY 2011 budget request for HIV/AIDS totals \$27.2 billion, of which only 3 percent is allotted to prevention. Breaking down the Division of HIV/AIDS Prevention's extramural budget by race/ethnicity, Mr. Studer said the funds track pretty well, although the Division is slightly underfunded for whites:

<b>Race/Ethnicity</b>	<b>Budget</b>	<b>Epidemic</b>
Black/African American	50%	48%
White	23%	31%
Hispanic/Latino	22%	19%
Asian/Pacific Islander	2%	1%
American Indian/Alaskan Native	1%	1%

Mr. Studer said the Division is working to improve the correlation between budget and risk:

<b>Risk Category</b>	<b>Budget</b>	<b>Epidemic</b>
MSM	38%	46%
High-risk heterosexuals	37%	31%
Injection drug users (IDUs)	19%	17%
MSM/IDUs	3%	5%
Other	1%	1%

The largest portion of the Division's FY 2009 and 2010 budgets went to health departments for prevention efforts, and another large chunk to health departments for surveillance. The remainder went to community-based organizations (CBOs), testing, and other activities, including capacity-building. In FY 2010, about 12 percent went to improving program effectiveness. Mr. Studer noted that about \$40 million that had been

dedicated to CDC HIV efforts was redirected in FY 2010 to the DASH, primarily for State, local, Tribal, and territorial education agencies.

Mr. Studer listed the key approaches to HIV prevention and summarized some core programs. The HIV Prevention Projects for States are the flagship of prevention and account for half of the prevention-dedicated money that goes to State and local health departments for comprehensive planning programs. Mr. Studer acknowledged that the resulting plans don't always match where the high-risk groups are. CDC also funds prevention projects by CBOs as a way to extend outreach to those at high risk. CDC requires programs to link testing with care, and CBOs must use evidence-based interventions, such as the Diffusion of Effective Behavioral Interventions (DEBI) approach. The Division of HIV Prevention also funds 4-year grants for capacity-building to improve HIV prevention services for high-risk and minority racial/ethnic populations.

For 2010, the Division sought to increase the transparency of communication of data, policy, and planning, which it has done by providing more complete detail about programs and funding online. It has been improving its efforts to infuse science and evidence-based approaches into all aspects of the Division and continues to work on better integrating prevention into health care.

To maximize its budget impact, CDC is integrating surveillance and program data support to budget allocation and targeting of prevention efforts, monitor program performance, increase transparency and accountability, and improve the impact of HIV prevention efforts. It has implemented a new program evaluation monitoring system that links performance and impact measures. It is also assessing costs of interventions and cost-effectiveness.

## **FDA Budget**

### **Richard Klein, Office of Special Health Issues, FDA**

Mr. Klein explained that FDA's budget is organized by product line. The FDA "product" is scientific and regulatory oversight, so about 80 percent of the budget goes to personnel and facilities. Overall, FDA spent almost \$97 billion on HIV/AIDS-related product lines in FY 2009 and an estimated \$109 billion in FY 2010.

Mr. Klein provided a broad overview of the work FDA does in relation to HIV/AIDS in each of its product lines, summarizing, for example, FDA's role in development, testing, packaging, and postmarket surveillance of therapeutic human drugs and biologics, diagnostic tests, blood products,

vaccines, and medical devices. He described two examples of FDA's toxicological research on antiretroviral drugs.

The FDA Office of the Commissioner manages patient representative and consultant programs, supports community outreach, and ensures communication specifically about HIV/AIDS through a Web site, e-mail list, and telephone list. Its field activities include inspecting clinical trial sites, manufacturing facilities, and blood banks as well as auditing institutional review boards. Mr. Klein concluded that while FDA does not provide services, it supports the infrastructure for those who do.

## **NIH Prevention Research Budget**

### **Wendy Wertheimer, Senior Advisor, OAR, NIH**

Ms. Wertheimer said that instead of establishing an NIH institute for AIDS research that potentially could pull resources away from valuable research underway at the National Institute of Allergy and Infectious Diseases (NIAID) and the National Institute on Drug Abuse (NIDA), for example, Congress established OAR to coordinate NIH-funded AIDS research. The bulk of NIH's budget funds extramural research, and it can be difficult to separate domestic from international research in some cases, said Ms. Wertheimer. Many NIH awards extend over multiple years, so NIH relies on the turnover from expired grants plus new money to fund new research programs. OAR annually develops a trans-NIH strategic plan and budget for HIV/AIDS research and a Presidential By-Pass Budget for AIDS Research based on scientific opportunities.

The FY 2011 annual strategic plan for HIV/AIDS research was developed with internal and external input (including community representatives) and aligns with the NHAS goals. NIH devotes 10 percent of its budget to HIV/AIDS research. In FY 2009 and 2010, the amount of AIDS spending totaled about \$3 billion; for 2011, nearly \$3.2 billion was requested. Each NIH institute and Center builds its annual budget around the strategic plan, and OAR works with all of them to identify overlaps or areas for potential coordination. About 41 percent of the AIDS research budget can be characterized as prevention, said Ms. Wertheimer.

Ms. Wertheimer described some promising areas of prevention research, such as microbicides, behavioral and social science, vaccines, and "treatment as prevention" approaches. Ultimately, Ms. Wertheimer said, there will be a toolbox of multiple prevention strategies that providers can use. Details about the NIH budget are available online. NIH also offers the Research Portfolio Online Reporting Tool (RePORT), an online, searchable database, and AIDSInfo.gov, a resource for information.

## **SAMHSA Budget**

### **Peggy Quigg, Acting Deputy Director, CSAP, SAMHSA**

Ms. Quigg explained that CSAP's HIV funding comes from the pool of money authorized by Congress for Programs of Regional and National Significance. SAMHSA focuses on reducing risky behaviors that occur in relation to substance use and abuse—which are also linked with mental health issues. Some of SAMHSA's funding combines best practices in HIV prevention by using CDC's DEBI programs along with SAMHSA substance abuse programs. Funding has been consistent over the past 2 fiscal years at about \$41 million and supports about 80 grants per year. Funding is targeted primarily to areas with the highest rates of HIV/AIDS according to CDC. Also, CSAP receives money through the HHS MAI Secretariat Emergency Fund; that funding increased from \$6 million in 2009 to \$7.7 million in 2010.

CSAP's MAI programs seek to increase access to substance abuse and HIV prevention services by focusing on early detection and diagnosis of risky behavior and referral for treatment. The MAI programs are divided into various categories (or cohorts) according to program and population characteristics. The requests for applications are modified yearly to incorporate lessons learned from grantee information, so programs adapt to meet needs as they evolve.

SAMHSA's Ready-to-Respond initiative (\$10.8 million) is one of two new cohorts. It provides up to \$300,000 per year for up to 5 years to programs that build on previous MAI grantee accomplishments by expanding knowledge and experience in developing blended substance abuse and HIV prevention practices for at-risk minority populations. For example, programs may apply the interventions that worked with young MSM to minority women. The goal is to apply knowledge more quickly.

SAMHSA's capacity-building initiative (\$8 million) provides awards of up to \$300,000 per year for up to 5 years to colleges, universities, and community-level public and private nonprofit entities to prevent and reduce the onset of substance abuse and transmission of HIV/AIDS among at-risk racial/ethnic minority young adults. Capacity-building grants will allow these programs to implement a massive communication strategy encouraging more people to get tested for HIV, not just those at high risk, and communicating the connection between substance use and the high risk of HIV transmission.

A new award for FY 2011 will support training and technical assistance to develop new strategies and communicate lessons learned. Ms. Quigg added that money from last year's Secretariat Emergency Fund helped CSAP reach

Tribal populations and colleges with large minority populations, including Hispanics. It is hoped that such targeted efforts will improve the knowledge and evidence base on interventions for minority populations that can be translated into culturally appropriate practices.

**Warren Hewitt, HIV/AIDS Coordinator, CSAT, SAMHSA**

Mr. Hewitt said that CSAT received more than \$66 million for HIV programs under the Programs of Regional and National Significance fund and \$1.5 million from the MAI Secretariat Emergency Fund. Proposed funding for 2010 is slightly lower: less than \$66 million and \$900,000, respectively. The Secretariat Emergency Fund supports activities such as hepatitis B and C vaccination for IDUs and HIV testing.

CSAT's Targeted Capacity Expansion Program for HIV is an effort to locate treatment in areas of high risk and to meet the needs of people who are hard to reach, such as homeless people. Through FY 2010, the Targeted Capacity Expansion Program for HIV portfolio supported 142 grants with a total of \$64.4 million, serving more than 35,000 clients. Programs address not only HIV and substance abuse but also mental health issues and comorbidities. A number of gender-specific programs focus on HIV in women, incorporating unique issues women face with substance abuse. In FY 2010, CSAT implemented a rapid HIV-testing pilot program, which tested nearly 3,000 people. It identified 12 new cases and 194 clients who had been previously diagnosed as HIV-positive.

Mr. Hewitt said SAMHSA treatment programs have contributed to lower crime rates, higher employment rates, more stable housing, and better social connectedness. They have also demonstrated decreases in reported risky behavior, such as injection drug use and unprotected sex. The programs respond to changing populations and address substance users who are also at risk for HIV.

SAMHSA provides over \$53 million in block grants to States annually using a population-based formula. HIV was added later to the formula to coincide with the need for investment. Creating a mechanism that improves accountability for the block grants is a priority for SAMHSA but remains challenging.

**IHS Budget**

**RADM Scott Giberson**

RADM Giberson summarized the epidemiology of HIV/AIDS among American Indians, noting that IHS developed its own HIV/AIDS program goals before the NHAS was released to reduce transmission, improve education, increase

access to routine services, and reduce stigma. The entire IHS budget for HIV/AIDS services comes from the MAI fund, and despite flat funding for the initiative as a whole, IHS received \$3.4 million in FY 2009 and \$4.3 million in FY 2010.

Tribes and service units use money from their own operating budgets and negotiated contracts to provide HIV services, so it is difficult to track spending at the Tribal level. After money is distributed to the Tribes, the IHS National HIV Program has about \$30,000 per year to support two staff positions. In 2009, according to statute, the IHS invested 73 percent of its total HIV/AIDS budget in testing, with tremendous outcomes. Other FY 2009 IHS HIV/AIDS initiatives included provider surveys, evaluation of innovative models, use of health information technology for quality reporting, and substance abuse programs.

For 2010, IHS focused more on prevention, building on the solid network from the testing effort; expanded universal testing; conducted site-specific projects, and explored effective behavioral interventions; among other projects. IHS has substantially increased prenatal testing. Because of its limited resources, IHS collaborates with various agencies, such as CDC and SAMHSA, and relies on local champions.

Future IHS HIV/AIDS prevention efforts will focus on implementing effective behavioral interventions, expanding HIV policy, and further expanding universal testing. The Agency also seeks to improve linkages to care, expand collaboration, improve program monitoring and evaluation, and increase its network of HIV services. IHS operates under a number of mandates, including the recently passed Indian Healthcare Improvement Act, which requires outcomes reporting.

## **Discussion**

Dr. Holtgrave opened the discussion by noting that the United States is about \$400 million short of meeting its current service commitments, and that CDC needs \$700 million more to support prevention. In addition, he pointed out that the \$40 million redirected to the DASH will take the form of block grants and probably will not be used strictly for HIV, which could represent a real loss in services. In such a situation, asked Dr. Holtgrave, how do we expand prevention efforts?

Mr. Perez noted that other Federal partners will provide reports at future meetings, including CMS. He said the Subcommittee is focusing on three perspectives: budget transparency, budget priorities related to the NHAS, and mechanisms for creating a system that routinely takes into account HIV prevention priorities.

Michael Horberg said that CDC's list of key approaches to prevention did not include true preventive efforts aimed at uninfected people—that is, most Americans. He was concerned about the shift of focus to prevention of transmission by HIV-positive people, because it leaves out a major segment of the population. He praised CDC's DEBI projects on counseling and prevention and asked whether CDC had standard metrics to define what constitutes an effective link to services. Mr. Studer responded that CDC is focusing on prevention among HIV-positive people in an effort to "get the biggest bang for our buck." CDC is also targeting HIV-negative people at high risk for HIV. Regarding linkages and referrals, CDC conducted a study to determine how to routinize and ensure linkages to care, how to define linkages, and how to track them. The capacity-building grants are also aimed at improving linkages. CDC is developing mechanisms to track individual followup on referrals and receipt of care, which would improve reporting about linkages.

Naina Khanna said much of the NHAS seeks to realign resources. She pointed out that CDC's data were stratified by race/ethnicity and risk but not gender. Ms. Khanna said the category of "homosexuals at high risk" has been of limited use at the community level, and CBOs have been unable to reach them. She added that some entities have identified best practices for aligning resources. Ms. Khanna asked how CDC and others would present gender-based data, especially about budgeting, in the operational plan and how the operational plan will address sharing best practices, particularly for organizations with limited capacity (i.e., outside the 12 cities identified by CDC). She added that, while community planning guidance is likely to change, local-level providers and resources continue to be important. Mr. Studer agreed that local input remains important for community planning, and revised guidance will take that into account. He said CDC would provide budget data by gender for the operational plan, although he was not sure how it would be presented in the plan ultimately. Mr. Studer said best practices vary between rural and urban areas, which poses a challenge, but CDC is looking at models and identifying what factors are different in rural areas.

Dr. Valdiserri added that the HHS operational plan will include gender-specific data, although some Agencies will find it more complex than others to provide that data. The operational plan will also include information from the Agencies about key activities and services provided that will reveal more details about gender-specific efforts, such as services that target perinatal prevention.

Ms. Hiers said the Subcommittee on HIV-Related Disparities is seeking budget information from various perspectives and noted that CDC does not break down the data by region. She requested that the data be presented by urban and rural geographic areas, and Mr. Studer agreed to do so.

***Followup Item***

CDC will provide budget data by geographic area (urban versus rural) to the Subcommittee on HIV-Related Disparities.

Ejay Jack asked that Agencies provide information on transgendered people whenever possible, as they are disproportionately affected by HIV. Even recognizing the lack of data on transgendered people in the operational plan will highlight the need for better research, he said. Dr. Valdiserri said data on transgendered people were requested, although he was unsure that data would be granular enough to distinguish male-to-female and female-to-male transgendered people. Mr. Perez asked Dr. Valdiserri to encourage Agencies to begin collecting such data if they are not doing so already.

***Followup Item***

Dr. Valdiserri will seek to include data about transgendered people in the HHS operational plan where such data are available and indicate the absence of such data where they are not available.

Dr. Gayle said the budget figures are indicative of the consistent limited funding for prevention.

Mr. Baker hoped the data would be used to help people think differently. He said CDC put out new data on HIV prevention among MSM and there has been some shift in investments, but little has changed. "What accounts for the stagnation?" he asked. Mr. Baker said the CDC budget figures demonstrate underinvestment in relation to the epidemic by population. Other Agencies, such as the Office of Population Affairs, have put lots of effort into testing, he noted, but it's not clear that testing alone is sufficient. He wondered what other environmental or programmatic aspects should be changed, especially to address populations affected by multiple factors.

Mr. Baker said data show a strong correlation between HIV infection in gay men and a history of childhood sexual abuse, but no Agency has invested in addressing this "upstream" issue. Particularly in the South, he continued, gay men live with ongoing discrimination and little legal protection, but there is no investment in addressing environmental conditions that would make HIV prevention efforts work for them. In northeastern cities, young and minority gay men are often removed from their homes when their sexual orientation is known, but there is little intervention to provide stable housing



that would move them off the street and out of the business of trading sex for food and shelter. He suggested consideration of data in context to better understand how behavior drives incidence.

The NHAS sets goals for 2015, Mr. Baker continued. While an evidence-based approach is needed, there are huge knowledge gaps, and it is unclear how NIH or others can get answers from research rapidly enough to implement them and demonstrate changes. Mr. Baker argued that although international research may benefit the United States broadly, little international research will translate directly to benefit black gay men in America. He asked how research could be fast-tracked to provide immediate solutions to reduce incidence among the hardest hit populations. Dr. Valdiserri noted that the Secretary recently received a letter from a group of advocacy and research organizations with very specific recommendations about NIH research in the service of the NHAS.

***Followup Item***

Dr. Valdiserri will provide a copy of the September 2010 letter to the Secretary from stakeholders that provides recommendations for NIH research to further NHAS goals.

Dr. Valdiserri continued that OAR recently convened a group of experts to provide input on the research agenda for NIH's social and behavioral science portfolio around HIV/AIDS. That group made recommendations specific to the NHAS and certain subpopulations; it identified the need for more implementation research.

Dr. Valdiserri said some international research does have direct relevance, such as current tests of rectal prevention devices. He said MSM and people of color are populations of particular focus for OAR right now. In terms of gender, Dr. Valdiserri said that NIH can identify research that focuses specifically on women, although in other studies, it is more difficult to break data down by gender. He added that in the beginning, AIDS research was almost exclusively focused on gay men; starting in 2011, NIH will track research on MSM and MSM of color more carefully. Mr. Baker lauded NIH's good intentions but questioned whether research is being conducted in the right institutions to recruit and retain participants. He said the research community is still seeking to build trust in research and continuing to invest in the same strategies could have huge negative consequences. Ms. Wertheimer said NIH has given lots of attention to training minority investigators and building capacity among minority institutions.

Rosie Perez pointed out the lack of emphasis on young people who are HIV-negative, which is an important area of concern. Ms. Wertheimer said the OAR Advisory Council is focusing on HIV/AIDS in adolescents.

Mr. Brooks asked that NIH discuss its research on stigma in more depth.

***Followup Item***

Mr. Bates will coordinate a presentation by NIH about research on stigma to the Subcommittee on HIV-Related Disparities.

Mr. Perez noted that reporting needs to go beyond a recounting of the investment by population to evidence of how well programs achieved their goals in terms of health outcomes. Those with a poor return on investment should be critically reviewed. Further, Mr. Perez said that one-third of the HIV/AIDS epidemic is concentrated around eight urban areas, so resources should target the hardest hit areas. Mr. Bates noted that many agencies do not have authority to penalize programs or grantees when outcomes targets are not met.

**Next Steps**

Mr. Bates said PACHA still needs to hear from State and local representatives about service delivery and to gain their cooperation in improving accountability, outcomes, and measurement. Mr. Jackson added that Tribal governments should also be invited to give presentations.

## **Subcommittee on Access to Care**

**Michael Horberg, M.D., M.A.S., and Robert Greenwald, J.D.**

Dr. Horberg summarized the steps taken by the Subcommittee:

- Review of implementation of the Affordable Care Act (ACA) and the NHAS (ongoing)
- Development of targeted questions for Agency heads about interpretation of the NHAS implementation plan (in process)
- Creation of a resolution on HIV testing (presented to PACHA)
- Consensus on development of a white paper to address the role of Ryan White programs following full implementation of ACA

The Subcommittee is also addressing the need to expand the workforce to accommodate increased HIV testing and ACA implementation. Dr. Horberg noted that assessing quality outcomes requires quality metrics at all levels, and the Subcommittee plans to evaluate harmonization of data to improve quality assessment. Mr. Greenwald has analyzed the potential effect of ACA

and the NHAS on PLWHA and presented his findings to numerous entities, including government representatives, and so the Subcommittee asked him to give his presentation to PACHA.

## **Securing Health Care for People Living with HIV and AIDS: A Roadmap on Implementing Health Care Reform and the NHAS**

### **Robert Greenwald , J.D.**

Mr. Greenwald noted that the NHAS relies on the success of ACA, and the effectiveness of ACA depends on the effectiveness of Federal regulations and Federal and State implementation efforts. Many key reforms for PLWHA do not take effect until 2014.

Summarizing key reforms of ACA, Mr. Greenwald said that those with incomes below 133 percent of the Federal poverty level would automatically be enrolled in Medicaid, which marks the first time that eligibility would be determined by income alone. Most people in Ryan White programs will transition to Medicaid programs in 2014. Newly eligible beneficiaries will receive a nationally established benchmark benefits package that covers a wide range of services according to ACA requirements—but until the Secretary defines that benefit package, its real-world utility to beneficiaries, especially those with HIV/AIDS, will not be known.

Beginning in 2011, AIDS Drug Assistance Programs (ADAPs) will count toward the deductible for the Medicare Part D drug coverage benefit, which could help many people, especially those in States that don't provide assistance with premiums and copayments for Medicare Part D beneficiaries. Some States claim they lack guidance from HRSA on implementing the new rule, although other States already have; it is unclear whether States have sufficient funds to implement it.

New health plans will be required to cover the full cost of preventive services that have either an "A-" or "B"-level recommendation from the U.S. Preventive Services Task Force (USPSTF). However, the USPSTF does not support routine HIV testing, which undermines the NHAS goal of increasing HIV testing and links to earlier care.

Mr. Greenwald explained that ACA requires new investments in prevention and wellness, but all of the proposed funding is vulnerable, as demonstrated by congressional attempts to strip out new funding for HIV—some successful, some not. The law also includes \$11 billion for building and expanding community health centers over 5 years, which offers great potential to increase access to testing and rapid linkages to care. Expanding community health centers and Medicaid eligibility and establishing State

health insurance exchanges will improve access to care and treatment for PLWHA. However, HRSA could do more to facilitate integration of new and existing programs, Mr. Greenwald said.

Integration of Ryan White programs into broader reform efforts represents an opportunity to close gaps in care for PLWHA. One step toward integration is the establishment of temporary high-risk insurance pools, which would provide access to private insurance for people denied coverage based on a preexisting condition. The high-risk pools are a primary bridge to coverage in 2014, when the ACA requirements kick in. States can set up their own high-risk pools or, as many States have already, request that HHS coordinate a high-risk pool for them. States already have authority to declare that, for those medical conditions for which coverage is automatically denied, the diagnosis alone is sufficient for eligibility in the high-risk pool (i.e., presumptive eligibility). Mr. Greenwald said HHS could declare HIV a presumptively eligible disability. He emphasized that currently 100 percent of PLWHA who apply for private insurance coverage are denied.

***Followup Item***

Mr. Greenwald will provide a complete list of the 24 States that have opted to allow HHS to run their temporary high-risk insurance pools and, of those States that are running their own pools, what proportion have designated HIV infection as a presumptively eligible disability.

Ryan White program providers could also be integrated into the Medicaid Health Homes program, which begins in January 2011 and provides additional Federal funding to States that enhance services for people with chronic conditions. At present, HIV is not on the list of qualifying chronic conditions, but HHS has authority to add it.

Mr. Greenwald said that ADAP costs are likely to continue until 2014, and Ryan White programs are facing substantial unmet needs. Emergency funds are needed to address these gaps. Moreover, CMS could facilitate better State coverage by, for example, extending Section 1115 waivers that allow States to expand Medicaid coverage to people with HIV who are not disabled, effective immediately and continuing through 2014. Mr. Greenwald pointed out that PACHA passed a resolution at its June 2010 meeting that, among other things, endorsed passage of the Early Treatment for HIV Act.

Finally, Mr. Greenwald noted that neither ACA nor the NHAS addresses the facts that only new beneficiaries will have access to the benchmark benefits package, provider reimbursement rates do not reflect true costs of care, barriers remain for immigrant populations, and current private insurance subsidies are insufficient for people with chronic illness.

## **Draft Resolution on USPSTF Recommendation for HIV Testing**

### **Michael Horberg, M.D.**

Dr. Horberg described the rationale for the draft resolution proposed by the Subcommittee on Access to Care asking that the USPSTF reconsider its current stance on routine HIV testing. He made the case for routine testing over targeted screening of those considered to be at high risk. About half of patients who are at high risk for HIV are never identified, said Dr. Horberg.

Earlier testing and initiating treatment at higher CD4 levels lead to better outcomes, Dr. Horberg noted, with few adverse effects and decreased risk of transmission to others. Also, earlier testing and treatment are cost-effective; that is, the more advanced the disease and the later treatment is initiated, the higher the cost of care. Studies indicate people are more receptive to routine HIV testing now than in the past. Many assume they have already been tested and see minimal harm in testing if performed correctly. The Institute of Medicine favors routine testing, Dr. Horberg added.

Dr. Horberg described how the USPSTF functions. He said the group reviewed routine HIV testing in 2005 and revisited the issue in 2007 using 2005 data, giving a "C"-level recommendation. In contrast, CDC supports routine testing for all Americans ages 13–64 years old. While most leading professional medical societies support CDC's guidelines, public and private health systems generally base reimbursement on USPSTF "A-" and "B"-level recommendations.

The resolution requests that USPSTF reconsider routine HIV testing on the basis of new evidence and practices. For example, providers now often begin treatment at higher CD4 levels (<350, <500, or, in some cases, all HIV-infected people, regardless of CD4 level); in 2005, the risk/benefit evaluation was based on treatment beginning at CD4 levels less than 200. There is increasing evidence that viral control greatly lowers the risk of horizontal transmission, especially among discordant couples. Data show that, as community viral load decreases, incidence decreases, independent of any other intervention. Further, evidence shows that patients who are aware of their HIV status change their behavior to prevent transmission.

Dr. Horberg summarized the key points of the resolution, which reflects the issues described and the scope of the problem—for example, 21 percent of U.S. citizens with HIV are unaware of their status and account for 50–70 percent of new infections. He concluded:

Be it resolved that the PACHA recommends that the USPSTF immediately reconsider its recommendation regarding routine HIV

testing for persons who are not documented to be at increased risk for infection.

## **Discussion**

Mr. Cruz said there is a perception at the national level that health care reform will eliminate the ADAP waiting list. However, the lack of subsidies combined with the high out-of-pocket costs have led States to determine that they are better off paying penalties than doing what is needed. Without attention to costs, the ADAP problem will continue, he said.

Mr. Cruz said New York mandates that States offer HIV testing, which forces private insurers to pay for HIV screening. Dr. Horberg lauded that approach but said only the District of Columbia and California actually cover the cost of the HIV test. He said a State-by-State effort to require routine HIV testing would not succeed.

Mr. Greenwald added that most of those currently served by ADAP will be eligible for Medicaid on the basis of low income. Massachusetts covers not just the poorest people but those who could not afford their medications without assistance, and the State is using every penny it can to do so. A white paper on the role of Ryan White programs after full ACA implementation would highlight the remaining unmet needs.

Mr. Baker supported routine testing and the resolution in general but not the overall rationale. He and Dr. Horberg debated whether a CD4 threshold should be mentioned in the first rationale (i.e., the first “whereas” statement). Dr. Horberg agreed the wording of the rationale could be more vague, but Dr. Gayle suggested specifying a CD4 threshold of 350 or higher. Ms. Bridge suggested sticking to the most relevant points—the benefit to the individual and to public health in general. Ms. Khanna agreed that quality of life is key for HIV-positive people and suggested restructuring the first rationale.

In response to another point, Dr. Horberg emphasized that USPSTF recommendations focus on the patient-clinician interaction. Targeting HIV testing to only those patients determined to be at high risk assumes that clinicians are performing good, detailed risk assessments of patients, which is not the case.

Mr. Perez said that even if the USPSTF gives routine HIV testing an “A” or “B” recommendation, it is questionable to suggest that all parts of the country adopt routine testing. He supports strategic use of testing in communities that would benefit the most while allowing some to do only targeted testing. Dr. Valdiserri questioned whether routine testing would be

applied to all settings or only health care settings, noting that CDC is revising its recommendations for testing in community settings.

Mr. Cruz noted that among Latinos, one-third of those who test positive progress to disease within 1 year, reflecting delays in testing. The resolution should emphasize the importance of knowing one's status in order to make a decision about treatment. Dr. Gayle suggested clarifying that reducing disparities is one of the NHAS goals and addressing those disproportionately affected by disease because they are tested so late in the course.

Dr. Gayle questioned the rationale about cost-effectiveness; Dr. Horberg and Mr. Greenwald countered that data show that treatment following earlier diagnosis is more cost-effective over a lifetime than later diagnosis. Dr. Holtgrave cautioned that the studies have not compared testing strategies.

Mr. Greenwald clarified that if the USPSTF gave routine HIV testing a higher-level recommendation, that would not translate to a mandate for routine testing. Rather, Medicare, Medicaid, and most private insurers would cover the testing if patients and their clinicians chose it. Mr. Perez and Dr. Gayle both raised concerns about the cost of unnecessary testing. Mr. Cruz pointed out that CDC already recommends routine testing. New York requires routine testing at least once for an individual and more often for those at high-risk, he added; States should have that kind of flexibility. Dr. Holtgrave pointed out that the debate over routine versus targeted testing goes beyond the intent of the proposed resolution.

**Suggested changes to the draft resolution:**

- In the first sentence of the background, add the words "and care" to the end of the phrase "great strides have been made in treatment."
- Replace the specific reference to "therapy with a CD4 T-cell count greater than 500 cells/ $\mu$ L" with a more general reference to higher CD4 counts.
- Replace the phrase "screening only persons at increased risk" with "screening only persons perceived to be at increased risk."
- Replace the phrase "reconsider its recommendation" with "launch a new review."
- Replace the term "HIV-infected" with "HIV-positive."
- Add language explaining that minorities are disproportionately impacted by delayed testing and have the shortest course of disease as a result.
- Clarify the data supporting the rationale for cost-effectiveness or remove the rationale.
- Consider deleting all of the rationales and including the background narrative as the entire rationale.

- Clarify that a USPSTF recommendation of “C” or below results in financial barriers to routine testing, even when it is deemed appropriate.

### ***Followup Item***

The Subcommittee on Access to Care will incorporate the suggested changes to the draft resolution on the USPSTF recommendation for routine HIV testing. The revised draft will be circulated to PACHA members for consideration before the next PACHA meeting. If feasible, the revised draft will be presented at the next PACHA meeting for a vote.

### **Discussion Conclusion**

Dr. Gayle said PACHA would take up the question of the white paper on Ryan White programs during its deliberations on Friday, October 1.

### **Remarks by Howard Koh, M.D., M.P.H., ASH**

Dr. Koh thanked PACHA members for their service, noting that their expertise and input come at an extraordinary time, with the confluence of high-profile efforts around HIV/AIDS and health care. Having the leadership of a world-known leader such as Dr. Gayle is great, said Dr. Koh. He also thanked Dr. Valdiserri for his work. The insight provided by PACHA has been “spectacular,” Dr. Koh said. He added that continued PACHA input is critical to implementing efforts underway across the Department that are under a tight timeline. The Secretary is “heavily invested” in the goals of PACHA, as is the Deputy Secretary, said Dr. Koh.

Many of the prevention efforts under ACA fall under the ASH’s purview, Dr. Koh continued, and he said he was “delighted” that PACHA is thinking about Ryan White programs in 2014 and beyond. He said many people have asked how to build on the public health infrastructure after 2014. With so many opportunities and so many unresolved issues, Dr. Koh said, PACHA input is critical, and he looked forward to receiving it. Dr. Koh concluded by individually thanking each PACHA member for his/her service to the country.

### **Public Comments**

**Carl Schmid** said The AIDS Institute praised the NHAS as an ambitious product but, to be successful, resources and leadership are needed. The NHAS identifies gay and bisexual men as one of the populations most affected by HIV/AIDS, and more resources are needed to address them. The severity of the issue is underscored by recent findings from CDC that one-



fifth of gay men are HIV-infected, and half of those don't know they are infected. An appropriate Government response is needed to ensure that acceptable policies and prevention research are in place to reduce HIV/AIDS.

Despite the long history of HIV/AIDS, only a handful of behavioral interventions have been identified for MSM, Mr. Schmid continued. CDC has indicated that its expenditures do not match the level needed for gay men. CDC's resource allocation model found that more resources are needed to decrease HIV/AIDS. Mr. Schmid applauded the White House and CDC for their efforts and encouraged them to continue. He asked that PACHA ensure that the Federal Government is doing all it can to address HIV in the gay community. Mr. Schmid added that the implementation plan is general and needs more detailed steps describing how to decrease HIV among gay men.

**Anna Ford**, director of the Urban Coalition of HIV/AIDS Prevention Services, said her organization seeks to partner formally with PACHA and others. Scaling up HIV prevention is critical. Ms. Ford said 85 percent of the burden of disease falls on urban areas; therefore, she applauded initiatives to target areas most affected. That approach is consistent with the first NHAS goal, and the President has reminded us to focus on areas in which HIV/AIDS is most heavily concentrated, said Ms. Ford. However, previous allocation of funding has not always adhered to that concept. The Federal Government must base its efforts on data and sound principles; without those, revising funding formulas results in drastic changes. Efforts will have the most impact if they follow the epidemic, Ms. Ford noted.

To illustrate her point, Ms. Ford described funding in New York and Florida. Of the \$27 million New York receives from CDC for prevention, none goes to the New York City health department, although 90 percent of HIV/AIDS cases in the State are in the city. Florida, like all the Southern States, is "woefully underfunded" for prevention, she said. Ms. Ford urged PACHA to support more funding, end the practice of States' divesting in HIV/AIDS, and improve the strategy to meet the NHAS goals.

**Andrea Weddle**, speaking on behalf of the HIV Medicine Association and the Ryan White Medical Providers Coalition, urged PACHA to consider the issues raised by the recent Institute of Medicine workshop on HIV care systems if PACHA develops a white paper on Ryan White programs. The HIV Medicine Association and the Ryan White Medical Providers Coalition have made recommendations for strengthening the NHAS implementation plan and have identified many issues similar to those identified by Mr. Greenwald. Members are particularly concerned about the immediate future, when more HIV-positive people will be on Medicaid.

Ms. Weddle said CMS should work with HRSA to develop a new payment system for providers that supports comprehensive care that is currently supported by Ryan White programs. New York has some excellent models based on data, she noted. The implementation plan urges more providers to treat HIV, but the workforce issues are critical, and the plan does not talk a lot about the expertise needed to provide high-quality care. She asked that PACHA look not only at expanding the number of providers of HIV care but also at developing their expertise through more extensive clinical training opportunities than are available through limited continuing medical education offerings.

**Jenny Collier** of the Ryan White Medical Providers Coalition thanked PACHA.

**Jennifer Howell** said she is a public health professional who has “been involved with the HIV community for as long as I can remember on a deeply personal level.” She said women are particularly susceptible to HIV, and that is compounded by the caregiving roles women are placed in. Efforts to stem the tide of the epidemic depend on the extent we address women and girls, said Ms. Howell. The tools are in place, but the processes and the intentions are in flux. Communities and providers are waiting; they want to know whether practical, immediate, transparent, and accountable changes that will work are in place. The Department seems committed to doing things differently and seems to be so close yet so far, said Ms. Howell. The HIV community is used to seeing new recommendations, new acts, etc., and these can have an impact if they are all streamlined. Clients need to be able to speak up, said Ms. Howell; if the walls don’t come down, the disease will defeat us medically, morally, and socially.

Families and providers are ready for leadership and committed to change, Ms. Howell continued. Reno, Nevada, is not one of the urban areas that is heavily affected, but it has the right “recipe” for an increasing burden of disease, with high rates of chlamydia and unintended pregnancies, clinics for substance abuse and mental health that are overrun with patients, and other factors. The State is the third lowest in HIV/AIDS spending per capita, said Ms. Howell. She went on to describe the multiple complications a woman in Reno might encounter if she were seeking HIV treatment and unemployed, on ADAP, and taking care of children. Ms. Howell said she is among those waiting for HIV-positive women to have equitable representation in the NHAS, and she asked for PACHA’s help in making that happen.

**Roberto Archuleta** said he has been living with HIV for 19 years and is an activist and voting member of numerous advisory bodies. He shared his perspective on the importance of housing in the implementation of the NHAS. He said housing is “a lifesaver” for PLWHA and plays an important

role in an individual's support system. Housing provides not just shelter but also a huge sense of safety, a place to safely store medications, and a comfort zone where other people with HIV/AIDS can meet. Housing also provides a place to sleep and to recuperate. Most important, stable housing reduces stress, which allows for a healthier, prolonged life for PLWHA.

Mr. Archuleta said he was thankful for the NHAS but had concerns. For example, the goal in the implementation plan of increasing permanent housing for Ryan White clients from 82 to 86 percent is not acceptable. The NHAS should aim higher, he said, which will help build buy-in for the strategy among PLWHA. In addition, page 21 of the implementation plan outlines policies to promote housing; it should explicitly include those living with a diagnosis of AIDS. Mr. Archuleta asked why the housing policies were not required until the end of 2011. Finally, on page 24 of the implementation plan, Mr. Archuleta said housing should be considered part of the holistic approach to health, as it is a critical component of care.

**Tony Ray**, co-chair of the Youth Action Institute under the Campaign to End AIDS, said he is 24 years old and HIV-positive. While there is much to celebrate, there is much more to do to stop the spread of HIV, said Mr. Ray. President Obama and his Administration are committed to ameliorating the global pandemic.

Mr. Ray said he carefully considered the NHAS and offered the following comments to PACHA. The NHAS does not clearly state the need for youth-specific programs. The ADAP waiting lists are mentioned once, while management is not mentioned. School education programs are mentioned, but without a clear implementation strategy. The activities described will not be enough to reach youth, and more programs are needed. The NHAS discusses science-based education but does not provide enough information. It mentions Puerto Rico and the U.S. Virgin Islands, but more emphasis is needed on all the U.S. territories. Community marketing is great but youth should be incorporated in the evaluation and planning programs, Mr. Ray suggested.

Overall, the NHAS is weak, said Mr. Ray. It fails to address youth specifically, which is unacceptable and unnerving. It mentions the disproportionate effect of HIV/AIDS but only outlines the discrepancies. Policymakers need more input from youth, and the White House should open its doors to youth representatives, Mr. Ray concluded.

**Suzanne Miller** of the National Coalition of STD Directors read from a prepared statement, saying that for more than 20 years, CDC's DASH has worked with schools to build the infrastructure to provide education. A

significant amount—\$40 million—of DASH’s work involves funding State and local education agencies to collaborate with health departments in HIV/STD prevention programs. However, the Senate appropriations bill for 2011 would eliminate DASH funding. The National Coalition of STD Directors and others strongly urge Congress to maintain the current funding levels for DASH. Ms. Miller asked the PACHA Subcommittee on HIV Incidence to draft a letter to the relevant congressional subcommittees to support DASH funding.

Regarding CDC’s finding that one in five MSM are HIV-positive, Ms. Miller said that high rates of undiagnosed STDs compound the problem. For example, syphilis rates are 46 times higher in MSM than in heterosexuals. It is time to increase attention to STDs. Ms. Miller asked PACHA to ensure that attention to STDs is meaningfully integrated into the NHAS. She also asked that PACHA request that CDC provide recommendations for addressing HIV/STD coinfection issues in its implementation plans for the NHAS.

**Philip Hilton** of the National Black Leadership Commission on AIDS said that after three decades, billions of dollars, and thousands of lives lost, we have finally made a start in addressing HIV/AIDS. However, the disease continues to extract a heavy and disproportionate toll on Americans of color. The people deserve a strategy with actions, recommendations, and timelines that reflect the urgency of addressing the incidence and prevalence of HIV/AIDS in the African American community. Black men, women, and children have carried the burden for too long, Mr. Hilton said.

For 25 years, we have urged the Government to use epidemiologic data to identify trends, and those data show that every year African American men, women, and children have the highest rates of HIV/AIDS in the Nation, Mr. Hilton noted. The roots of the disease in black America are deep: benign neglect, poor education, high incarceration rates, disparities, stigma, discrimination, homophobia, and many other factors provide an opportunity for the disease to flourish. Efforts must be made to address the structures that feed the disease. There is much we should be doing to meet needs, said Mr. Hilton, such as effective surveillance to measure incidence and prevalence among black women and adequate funding and technical assistance to institutions that serve minorities. The Federal implementation plan must prioritize programs and funding for black Americans in this public health emergency. Mr. Hilton concluded that his organization stands with PACHA and others to ensure the Federal Government effectively implements the NHAS.

**Carole Treston**, executive director of the AIDS Alliance for Children, Youth, and Families, speaking from prepared comments, said she was here to shine

a light on a gap in the NHAS: youth are not acknowledged as a population at high risk for HIV infection. Page 2 of the NHAS notes that one-quarter of new infections occur among young people, so Ms. Treston hoped the NHAS could be changed. One reason given for the gap is that youth are considered under other categories, such as young MSM. However, clinicians acknowledge that adolescents (now defined as those up to 24 years old) are not “almost adults”; they have changing identities, special communications styles, and unique priorities and time schedules. Add on to this issues of autonomy, financial independence, insurance, and consent, and you can see that young people have more in common with other young people than with older people in similar racial/ethnic or other categories.

Ms. Treston spoke of the importance of addressing the needs of young people formally in the NHAS because the document drives decisionmaking. It reflects where agencies place their priorities, and organizations use such documents as guidance when they write proposals for Federal funding. The programs and services described in the document become models. Youth should be included in all categories, said Ms. Treston.

Youth have great suggestions, Ms. Treston continued, as demonstrated by the input provided at the White House Office of National AIDS Policy’s meeting on youth and HIV/AIDS. The words included in a document dictate what Federal Agencies are involved, what takes priority in budgets, and who is accountable, Ms. Treston added. While she was not surprised that ED was not included in the NHAS, she recognized the omission as a waste of a great opportunity. The NHAS should reflect both achievable and stretch goals. If it does not include comprehensive sex education including HIV prevention, the current prevention challenges will remain for years to come. Ms. Treston asked that PACHA formally invite ED to be an implementation partner. She also asked that the next version of the NHAS designate youth as a unique group and that implementation plans include youth-specific goals and strategies for prevention, access to care, and reducing disparities.

### **Public Comments Conclusion**

Mr. Bates said PACHA would accept written public comments until Thursday, October 7. Dr. Gayle thanked everyone for their comments, noting that some had come a long way and sat through a very long day. “We appreciate your input and your taking the time” to comment, she added. Mr. Brooks added his thanks to the public commenters for reminding PACHA that the NHAS is rooted in social justice, a concept that is essential for PACHA’s work.

### ***Followup Items***

Ms. Khanna asked that the Urban Coalition of HIV/AIDS Prevention Services provide recommended algorithms or models for preventive services for PACHA to consider.

Ms. Khanna asked for an update on the proposal to create a youth advisory council to PACHA.

Mr. Perez asked for an update from HHS on lifting of the Federal ban on funding syringe exchange programs.

### **Adjournment**

Dr. Gayle adjourned the meeting for the day at approximately 4:15 p.m.

## **DAY 2**

### **Welcome and Remarks**

Dr. Gayle welcomed PACHA members, presenters, and the public. She noted that the final hour of the day would be devoted to a closed, administrative session of PACHA, which would include discussion of future meeting dates.

### **Subcommittee on HIV-Related Disparities**

#### **Kathie Hiers and Douglas Brooks**

Ms. Hiers described the membership and work of the Subcommittee to date. One issue that arose was the need for better alignment between the NHAS and the Healthy People 2020 goals, which have not yet been finalized. The Subcommittee has asked for more data regarding community viral load in relation to the NHAS and has discussed CBO planning.

Ms. Hiers said the Subcommittee chose to focus on housing, because it is not addressed by other subcommittees. The NHAS implementation plan asks that HUD update the Housing Opportunities for Persons with AIDS (HOPWA) program to include PLWHA by 2011.

The Subcommittee's biggest challenge is defining disparities, which is necessary to define prevalence, identify baselines, and understand budgets. Funding inequities must be addressed. The topic of social determinants of health (SDH) keeps coming up, said Ms. Hiers, so several speakers were invited to give PACHA an overview of SDH. The Subcommittee is also looking at stigma and considering working with DOJ on issues related to

criminalization and incarceration. While the implementation plan uses community viral load as an outcome measure, Ms. Hiers said the Subcommittee is looking at various potential measures and hopes to lower the risk for acquisition of HIV/AIDS collectively.

Mr. Brooks said that reducing disparities can be achieved with a community-level approach to reduce risk, stigma, and discrimination. Three speakers were invited to describe their experience with community programs to address stigma from the perspectives of a Federal program funder, a consultant to Federal Agencies, and a community program director.

## **Presentations on SDH**

### **Kathleen McDavid Harrison, Ph.D., M.P.H., Associate Director for Health Equity, National Center for HIV/AIDS, CDC**

Dr. Harrison summarized data on HIV/AIDS incidence and prevalence by race/ethnicity, gender, and geographic location, noting that the disparities are systematic, unjust, and avoidable. However, disparities can be reduced by addressing SDH—a complex interaction of social structures and economic systems that affect population health outcomes. For example, as a result of hurricanes Katrina and Rita, poor people experienced increased morbidity and mortality compared with others.

Health disparities among those with HIV/AIDS, viral hepatitis, STDs, and TB are inextricably linked to social and economic factors; identifying the SDH across subpopulations can help in addressing them. Dr. Harrison noted that social structures and SDH affect an individual's vulnerability to disease by contributing to or protecting against risk.

A World Health Organization (WHO) Commission on SDH developed a conceptual framework that maps out the relationships among various factors. For example, communities are affected by HIV-related policies—such as access to testing and care or availability of syringe exchange programs, and by cultural norms—such as stigma, discrimination, the status of women, homophobia, and resilience within the gay community. To illustrate the link between community-level SDH and population health, Dr. Harrison described data indicating that relative survival rates following HIV diagnosis were worse for patients living in counties where residents were poorer, experienced more unemployment, had lower median household incomes, and were less educated than their counterparts.

At the individual level, for example, knowledge, attitudes, beliefs, and communication and negotiation skills are influential psychosocial factors that affect behavior—particularly among teens. Insurance status is an example of

a system-wide SDH; lack of health insurance is a major barrier to care, especially for minorities.

Social and structural interventions that focus on education, employment and job security, health services, housing, income, and social exclusion are needed to comprehensively address root causes of HIV vulnerability, Dr. Harrison said. She summarized a number of CDC efforts to address health equity, many of which have adopted SDH as the central focus. CDC will publish a white paper later this year on SDH that outlines the strategic vision for reducing disparities and improving health equity related to HIV/AIDS and other conditions. Beginning in 2011, all NCHHSTP funding opportunities will include language on health equity and SDH.

Dr. Harrison gave examples of CDC activities in the five major domains of action it has identified to address the social and structural barriers to HIV prevention: community mobilization, integration of HIV services, policy interventions, contingency funding, and economic and educational interventions. She explained that CDC will take a tiered approach to implementing the NHAS that addresses SDH at the individual, societal, and system levels, as appropriate for the goals. For example, to reduce incidence, CDC plans intensive individual-level interventions and community-level approaches in the hardest hit areas and populations (e.g., access to testing, condom and syringe availability, and social marketing to address community norms). At a broader level, CDC will support campaigns to improve knowledge about transmission and testing. Dr. Harrison concluded that addressing SDH is an important part of CDC's efforts to fight the HIV/AIDS epidemic.

### **Discussion**

Mrs. McBride asked whether CDC and SAMHSA have collaborated to address target populations, such as young people, or institutions, such as historically black colleges and universities, when the CDC and SAMHSA program objectives appear to overlap. Dr. Harrison said her Division works closely with SAMHSA in many areas.

Ms. Khanna said Dr. Harrison's presentation framed the SDH model well and spoke to issues of social justice. She noted that in the past week, four suicides among gay teens had received national attention. She asked how ED should be involved with NHAS implementation. Dr. Harrison said CDC is working on a white paper about sexual health that includes the DASH. As CDC develops its plan to address school-aged youth, it will reach out to ED, and DASH may already have done so, said Dr. Harrison.



### **Randall Russell, LCSW, PIP, President, Healthcare Responses**

Following an overview of SDH, Mr. Russell singled out housing as a key example. He pointed out that HOPWA has a budget of \$330 million, but at least \$1 billion is needed to satisfy the need for housing, and the NHAS recognizes the importance of housing. To address the need, we must develop better tools to maximize our resources, Mr. Russell said.

The political environment poses challenges to addressing SDH and the goals of the NHAS. For example, the National Governors Association opposes changes to Medicaid that require more State spending, is against Federal involvement in State health exchanges, and wants States to have more time to implement Federal health care reform requirements (which Mr. Russell called a stalling tactic). Twenty States are suing the Federal Government over the constitutionality of requiring States to provide health care. Only 18 States have initiated planning groups to consider health care reform, and none of those are addressing chronic communicable diseases such as HIV/AIDS. Upcoming State elections will likely affect the future of health care reform, and without community partners advocating for implementation, Mr. Russell said, it will not happen. He later noted that there are no State-level leaders charged with implementing ACA in their States.

Mr. Russell provided data about some other relevant SDH and raised some provocative questions. In looking at poverty rates compared with disbursements of Federal AIDS funding, for example, Mr. Russell asked whether SDH should be factored into funding levels and, if so, how that would affect Medicaid expansion. How will Medicaid programs absorb the 2.8 million uninsured people who will be enrolled as of January 2014? What percentage of those will be PLWHA? How many of the currently uninsured are noncitizens and thus not eligible for Medicaid? How can we achieve the NHAS goal of educating all Americans about HIV prevention when individual school systems can opt out of providing sex education, regardless of State mandates?

The NHAS also seeks to reduce stigma and discrimination, but stigma takes many forms and is difficult to measure. To address stigma, leaders at all levels must speak out, which remains a significant challenge.

Introducing the concept of SDH into efforts to address HIV/AIDS and implement the NHAS is a good step, said Mr. Russell, and it will help communities rethink their efforts. But SDH are influenced by many leaders with competing goals and priorities. Mr. Russell illustrated the complexities of addressing SDH-related HIV/AIDS with two case studies:

In Miami/Dade County, Florida, 93 percent of those newly diagnosed with HIV progress to AIDS within 1 year. Further analysis reveals that most new cases occurred within six ZIP codes, all of which are within 6 miles of a large STD clinic, among other health care providers. At that clinic, only 40 percent of those tested for STDs are also tested for HIV. Mr. Russell suggested the area would benefit from mandatory HIV testing.

In Louisiana, a survey mapped out the institutions that provide low-cost or free health care and compared them with areas of need. As a result, the State is considering expanding transportation to enable more people to get care.

Finally, Mr. Russell called on PACHA to partner with the National Governors Association and the U.S. Conference of Mayors to integrate communicable chronic disease into health care reform strategies by addressing SDH. Toolkits should be developed to help governments implement the NHAS and ACA, and advocates should push for formal leadership in each State to coordinate implementation. Finally, PACHA should ensure that SDH are part of funding models.

## **Discussion**

Mr. Cruz called for caution in using SDH as a factor in funding distribution. He said the NIH severity-of-need index took a similar approach and raised concerns at the State level. Ms. Hiers added that the approach is exceedingly complicated, and no single factor can be addressed in isolation. It is important to keep in mind the big picture, she said.

Mr. Perez said the current Federal poverty level is outdated and is a disservice to the country, because it does not reflect true poverty, and Mr. Brooks seconded the point. Mr. Perez applauded Mr. Russell for drilling down to the level of ZIP codes because it can reveal glaring disparities. Finally, he suggested reaching out to county leaders as well as Governors and mayors by partnering with the National Association of County and City Health Officials. Mr. Brooks called for more efforts to address HIV/AIDS before 2014.

Dr. Gayle said we still lack a good understanding of the attributes of poverty that go along with disparity. Overlaying social science and demographics will provide a better understanding of the issues to target with care. Dr. Gayle said we often use data about SDH to focus on efforts at the individual level without thinking about communities. To better grasp what is needed, she suggested looking, for example, at who among those in poverty do have better health outcomes and what factors influenced them. Mr. Russell agreed with the need for more research.

Mr. Bates appreciated the reminder that local decisionmakers determine school curriculums. Without a national agenda, we cannot impose an expectation on communities to change the paradigm of health education and promotion for young people. He added that States vary in geography, resources, revenue sources, and complexity of population, so it is not feasible to apply national standards or approaches that appear to work well for most States. Mr. Russell responded that having advocates from various communities represented at the table is an effective way to ensure that Federal initiatives trickle down to the local level.

Mrs. McBride noted the importance of gathering data at the local level and building up to the national level. She pointed out that the 20 States that united to sue the Federal Government are geographically distinct but rallied around the common concern about unfunded mandates. Mrs. McBride said we should not attack the political leadership in States that have real concerns about how to pay for care. Rather, we should better understand at the local, community, and regional level how each State is affected. She said many Governors have responded that implementing health care reform means cutting funding for other needs. Mr. Bates noted that in the best of times, some States do not do well at addressing SDH. He called for a national approach that ensures adequate access to care regardless of where you live or your race, color, or economic status. Mrs. McBride suggested building the case with solid data. Dr. Gayle said the discussion highlights the need for constructive dialogue and tactical thinking.

**Stacey Little, Ph.D., M.P.H., M.S.W., Associate Director and Domestic Team Leader, AED Center on AIDS and Community Health**

Dr. Little described the experience of her organization in addressing stigma, including establishing national awareness campaigns in the United States and Central America, developing an anti-stigma toolkit, and creating a workplace intervention. With funding from the Ford Foundation, AED began the National Anti-Stigma Initiative. In the first phase of the initiative (2003–2005), AED provided grants to CBOs to develop innovative and replicable interventions, many using social marketing approaches. For example, AED worked with a Cantonese community organization that used a graphic novel format to provide education about stigma. It also supported research and information dissemination.

In the second phase (2005–2008), AED expanded its focus to support organizations addressing human rights, health disparities, homophobia, transphobia, racial discrimination, and injection drug use. For example, one grantee funded retreats for PLWHA in southern States, training them to become health advocates for themselves and others. The curriculum

addressed self-stigma, which often leads PLWHA to isolate themselves. Another grantee developed a bilingual social marketing campaign for Chinese Americans promoting better communication about HIV/AIDS and featuring actress Joan Chen. Another developed social marketing campaigns targeting MSM of color, HIV-positive MSM, and transgendered women. Dr. Little gave several other examples.

Dr. Little identified many factors that contribute to stigma which, if addressed, could help achieve the goals of the NHAS to reduce incidence, increase access, and reduce disparities. For example, she called for normalizing HIV testing as a routine part of primary care, comparing it to departments of motor vehicles routinely asking if you want to become an organ donor. Cultural competency in HIV/AIDS prevention and care remains a challenge. Dr. Little emphasized the need to change perceptions so that people begin to think of HIV as a chronic disease to which we are all susceptible.

Finally, Dr. Little offered several broad recommendations for PACHA's consideration:

- Create comprehensive anti-stigma interventions/curriculums.
- Assess existing research, interventions, and tools to determine best practices that can be promoted and diffused.
- Promote diverse approaches that engage, educate, and catalyze community; go beyond social marketing campaigns and develop targeted approaches that address specific community needs and level of understanding of HIV.
- Require enhanced HIV care and treatment continuing education for all licensed medical/clinical providers annually.
- Mobilize national leadership and partnership to change community norms that help eradicate HIV-related stigma in communities. Work both from the top down and from the bottom up.
- Engage faith leaders who are already active in HIV prevention to eradicate HIV-related stigma among their communities.

## **Discussion**

Dr. Little noted that the AED Web site offers the anti-stigma toolkit and other materials. Dr. Horberg said data conflict on whether patients prefer to seek care from clinicians of their own race/ethnicity and asked Dr. Little whether she had any insight from her organization. Dr. Little responded that she did not, but anecdotally, she was aware that some black patients prefer white clinicians.

## **HOPWA: Stable Housing Outcomes**

### **David Vos, Director, Office of HIV/AIDS Housing, Office of Community Planning and Development, HUD**

Mr. Vos said that HUD's mission is to create strong, sustainable, inclusive communities and provide quality affordable homes for all. He emphasized that supporting housing is effective and data have demonstrated great results. HUD wants all of its program efforts—vouchers, public housing, fair housing, etc.—to work together. HUD's 2010–2015 strategic plan highlights the importance of affordable rental housing and housing as a mechanism to improve quality of life. Ending homelessness and reducing severe need are top priorities. For example, HUD is working with VA to find housing for homeless veterans. HUD is also guided by the Federal Strategic Plan to Prevent and End Homelessness.

Mr. Vos described challenges and pointed out that HUD research is focused on helping those most vulnerable. It is updating tracking tools to better identify how many people are homeless so that it can improve planning and funding. Current estimates suggest 4 percent of the homeless are PLWHA, although Mr. Vos believes the real figure could be as high as 10 percent.

HOPWA was the first HUD program to incorporate access to care along with housing, said Mr. Vos, and the program has solid data demonstrating the success of its efforts. Of the more than 58,000 HOPWA households, 93 percent maintain ongoing housing through a housing plan, 89 percent have a case manager/benefits counselor with a service plan, 67 percent have a primary health care provider with a service plan, 84 percent have medical insurance or assistance, and 77 percent have an income source. But HOPWA now wants to partner with others, said Mr. Vos. He asked for input from HHS on how other programs address the same challenges in access to care and what questions HOPWA should be asking to better understand the needs of its clients.

Recent research concluded that a strong central organization is key to helping people access services. HUD received \$46 billion for 2010, and Mr. Vos said he hopes to answer how HOPWA fits in with other HUD programs, such as block grants for Native American communities and fair housing efforts. It is important to start thinking about linking housing programs so we can fight discrimination and ensure that PLWHA are treated fairly, said Mr. Vos. He pointed out that the HUD Secretary has spoken out about the rights of lesbian, gay, bisexual, and transgendered (LGBT) people.

In the past year, HOPWA received \$7 billion in Federal stimulus funds to rehabilitate housing and \$1.5 billion to prevent homelessness. The 2009

Homeless Emergency Assistance and Rapid Transition to Housing Act provided HUD new authority to address administrative barriers to housing by, for example, providing emergency grants, codifying a continuum of care, bolstering rural housing stability, and targeting homeless veterans. A new \$1.68 billion grant to address homelessness seeks to address target populations, create links to services such as education, and incorporate the needs of chronically homeless families.

HOPWA's implementation plan for the NHAS identifies the following objectives:

- Set strategic targets to increase number of HIV program clients with permanent housing.
- Integrate HIV testing, care, substance abuse and mental health services, and housing.
- Co-locate HIV-related services at housing and nontraditional sites.
- Streamline data collection.
- Bundle or braid funding demonstrations.
- Coordinate with State and local health officials to improve Federal, State, and local programs.
- Implement annual reporting and target setting.
- Ensure evaluation and transparency in results.

HOPWA is revising its funding formula to incorporate more accurate, national data on people with HIV, Mr. Vos said. As HUD transforms the way it does business, there are opportunities to develop new strategic frameworks that involve other programs; address mainstream access for special-needs households; consolidate planning to better understand needs; coordinate prevention resources; improve management of rental assistance; develop or improve partnerships with HHS, VA, and other Agencies; and engage grantees in capacity building.

## **Discussion**

Mr. Greenwald noted that the Subcommittee on Access to Care is also looking at housing. Mr. Cruz pointed out that lack of communication among local and State agencies, service providers, and their clients about available housing resources is a significant barrier. Conflicting eligibility requirements add another barrier. Some administrative rules about housing are so complex that they prohibit health services provision. Housing services operate in parallel with Ryan White and other local care programs, and "the connection doesn't happen easily in these structures," said Mr. Cruz. Mr. Vos responded that these challenges were identified and he hopes to follow up to ensure there is no discrimination. Statutory requirements take extra effort to

address, but HOPWA has fewer rules than Section 8, so it's easier to modify, he noted.

Partnerships are key to addressing conflicting eligibility requirements, Mr. Vos added. He pledged that HOPWA would partner with Ryan White programs.

Praveen Basaviah asked whether formal medical education offers any guidance to health care providers on being sensitive to LGBT patients who feel they cannot disclose their sexual history or private life. Mr. Baker said most medical schools offer such courses but not as a requirement. The American Medical Students Association and the National Coalition for LGBT Health have advocated for such education, and the American Medical Association sees it as a priority issue. Along the same lines but in the context of routine HIV testing, Dr. Gayle said doctors are never the best group to address universal guidelines; she asked members to consider other important sources who could help get routine HIV testing on the national agenda.

Ms. Khanna noted that the Global Network of People Living with HIV (GNP+) has a People Living with HIV Stigma Index that has not yet been introduced in the United States. However, it helps PLWHA define barriers and can be very culturally and geographically specific. Because the index is a tool that quantifies and measures, it can be useful for thinking about capacity-building for local organizations. It also suggests mechanisms to reduce stigma in communities and employs HIV-positive people to do the qualitative work.

Mr. Baker hoped PACHA would take into account in its future recommendations that the term "stigma" is so broad and vague that it can be difficult to address. The GNP+ Stigma Index and the results from AED projects, for example, can provide insight into what community-level changes were addressed by policy. As a Federal advisory committee, PACHA can identify where stigma leads to policies that actively discriminate. There are real issues of policy and discrimination that we do not cover when we talk about stigma, said Mr. Baker. Mr. Brooks agreed, pointing out that normalization of disclosing one's HIV status is one of the deliverables identified in the NHAS implementation plan.

Dr. Holtgrave said that HOPWA has had increasing financial support, which is not only a reflection of the need but also a result of the program's collecting high-quality data showing evidence of results. Mr. Vos said resources alone will not address the larger problems, so it is important to provide information that shows communities how many households are vulnerable and what works to assist them. Data from Chicago showed that stable

housing reduces health care costs, which demonstrated that housing is cost-effective. Ms. Hiers said those in the field believe it is obvious that housing improves health care and reduces infections, but proof makes a difference. The National Housing Coalition has sponsored research summits for 5 years to spur research forward, she noted.

### **Discussion Conclusion**

Dr. Gayle said shifting strategies requires a big shift in thinking. The HIV/AIDS community often focuses on individuals and proximal issues. It is important to step back and think about upstream and connected issues that affect prevention efforts, health-care-seeking behavior, and access to health care, Dr. Gayle noted.

## **Subcommittee on Global Affairs**

### **Dawn Averitt Bridge**

Ms. Bridge described the membership and work of the Subcommittee to date. She provided the Subcommittee's draft resolution (primarily on U.S. funding for global initiatives) and said the presentations would give PACHA members some perspectives to help them digest the resolution.

### **Global Health Initiative (GHI)**

#### **Chris Collins, Vice President and Director of Public Policy, amfAR**

Mr. Collins made the case for the continuing need to scale up programs to address HIV/AIDS. Recent data from the WHO demonstrate that, thanks to global investments, treatment is increasing and, in some areas, incidence is declining. Eight countries have "universal" access to HIV prevention and treatment (defined as 80-percent coverage), and 21 more have more than 50-percent coverage. The global response saves lives and transforms communities, Mr. Collins said.

However, U.S. funding for global health has been flat for HIV since 2009, despite the recognized success of the GHI. Mr. Collins provided examples from several countries where increased investment in HIV treatment led to decreases in infant and childhood mortality, orphanhood, and TB rates. Furthermore, HIV care creates a foundation on which countries can build and expand other health care services. These documented successes, combined with recent advancements in treatment and prevention, argue for increasing investment.

Funding for HIV/AIDS prevention and treatment yields "huge" dividends, Mr. Collins said, both in human health and in diplomacy, and the U.S. investment is "tiny," he added—much lower than that of other developed



countries. Failure to follow through on the promising results of initial investments will undermine efforts to scale up programs to reach global public health goals.

Mr. Collins concluded that PACHA can play a critical role by passing the Subcommittee's resolution and sending a message to the White House that flat funding does not make sense given the track record, impact, and potential of increased HIV funding. He added that PACHA should send a strong message to the White House that bold plans of action are needed to accomplish the NHAS goals.

### **Matt Kavanagh, Health Global Access Project**

Mr. Kavanagh summarized findings from recent research that demonstrate significant return on investment:

- An African study of discordant couples found that treatment of the HIV-positive partner resulted in a 92-percent reduction in transmission.
- In British Columbia, a dramatic increase in antiretroviral treatment was associated with decreased community viral infection and fewer new cases of HIV infection.
- Applying WHO guidelines and initiating treatment at a CD4 of 350 decreased the likelihood of death by 70 percent in some populations and decreased hospitalization by 60 percent.
- Modeling the results from some African countries demonstrated not only that earlier treatment is cost-effective but also that countries can break even on their investments quickly. Earlier treatment results in a significant decrease in hospitalization, which strengthens the country's health system.

However, funding does not appear to be following the science, and despite the 2008 passage of the Lantos-Hyde act, the United States has not provided anything near the amount of funding committed and authorized by Congress. Mr. Kavanagh went on to describe several examples where initial successes have been diminished or are threatened by the lack of new funding (Kenya, Zambia, Democratic Republic of Congo). In some cases, social pressure from within the United States has resulted in targeted funding (as in Uganda), but a diplomatic opportunity was missed.

Mr. Kavanagh said President Obama is poised to announce the first-ever 3-year commitment to global HIV/AIDS funding that could result in continued flat funding or even decreased funding, despite the stated commitment. The United States plays a leading role, Mr. Kavanagh said, providing half of the

world's donor funding for HIV/AIDS. Flat funding can cause real damage, he said, and he urged PACHA to pass the Subcommittee's resolution.

### **Discussion**

Mr. Cruz emphasized the importance of including Caribbean countries in global health funding efforts because of their proximity to the United States, the large number of Caribbean immigrants here, and the frequency of travel to and from those countries. Mr. Kavanagh agreed, noting that the Global Fund is the largest HIV funder in the Caribbean. Mr. Cruz said domestic and foreign aid programs should better coordinate so they can learn from one another and work toward a common goal. Dr. Gayle said PACHA should think about the domestic-international interface. Although priorities may differ among countries, the intersection between the programs is important to domestic efforts, she said.

Mr. Kavanagh asked PACHA to consider how the United States can address HIV prevention and treatment in Haiti during reconstruction. HHS and the State Department have not been getting reimbursed by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) for their efforts in Haiti, he said.

Asked whether other donor countries plan to revise their funding, Mr. Kavanagh explained that most countries provide money through the Global Fund rather than set up their own programs. Japan and France announced small increases in their contributions, as have some others. Mr. Kavanagh said a U.S. challenge grant would be a dramatic and welcome step.

Ms. Hiers said she supported the resolution but felt compelled to point out that the United States has not yet met the standard of 80-percent coverage of HIV treatment, and ADAP has a long waiting list. "How do I answer critics" who say the United States should focus its spending domestically, she asked. Mr. Kavanagh said the question sets up a false choice, because health spending is not a zero-sum game. The United States should move toward universal access with the NHAS, for example, but the investments are interrelated. Both need to be strategic and cost-effective, and both should rely on evidence-based approaches focused on outcomes.

We cannot pretend we are not interconnected, Dr. Gayle added. If we had invested more 10 or 15 years ago, she said, we would not be paying so much today. Ignoring the global epidemic will not make it go away; we have to invest now while we have good results that we can support, said Dr. Gayle.

Mr. Brooks pointed out that General Colin Powell identified HIV/AIDS as a national security issue, encouraging President George W. Bush to establish

PEPFAR. Mrs. McBride said she witnessed the development of PEPFAR. She said policy and funding should follow the science. Moreover, PEPFAR recognized the moral imperative to address HIV/AIDS and the global leadership the United States could bring to bear on influencing other donor governments and organizations. With massive distribution of funding, it was believed that PEPFAR could do the impossible—and achieve the outcomes that we are seeing now, said Mrs. McBride.

Mrs. McBride added that PEPFAR was intended to be a model for country ownership, but not the only answer. Good country ownership is needed to ensure that money goes to the right place. In the Republic of Congo, the need to direct so much funding to governance and security led to a pull-back in funding, she explained. Mr. Kavanagh responded that his organization traces funding to nongovernmental organizations to pay for such things as supplies. While he agreed that country ownership is important, he said the concept translates into a choice between handing over financing decisions to the local government or stopping funding of direct commodities. Ideally, we will move from emergency to sustainable funding, said Mr. Kavanagh, but we are not there yet.

Mr. Baker said he agrees with the core concepts of the draft resolution but questioned the implications of it. The resolution pushes for earlier initiation of treatment on the basis of larger public health goals (i.e., an undetectable community viral load), which may conflict with health care decisionmaking at the individual level. He cautioned against comparing the U.S. epidemic with the international epidemic. “In the United States, we overuse health services,” said Mr. Baker, and we may treat very early even when it is not clear that an individual needs such treatment. He questioned whether other countries can afford to follow the U.S. model and whether it is ethical to expect them to do so.

Mr. Kavanagh responded that he is deeply concerned about the human rights implications of the lack of treatment and access to care. Individuals should remain at the center of health care, he said, but it is also important to avoid inequality on the basis of wealth. However, countries must determine what they need to do to address HIV/AIDS. “Countries don’t look at the data and say, ‘We don’t want to initiate treatment at [CD4 counts of] 350,’” Mr. Kavanagh argued; rather, they ask whether they can afford it. He advocated for setting a target of 80 percent of a country’s population having access to treatment at a CD4 of 350 because it would have huge preventive benefits and it is attainable. Ms. Bridge reminded the group that the draft resolution calls for support to provide access and does not specify that countries must use the WHO guidelines, although most already do.

## **Paula Akugizibwe**

### **AIDS & Rights Alliance of Southern Africa**

In her meetings with policymakers, Ms. Akugizibwe said she emphasizes that investments in preventing and treating HIV/AIDS are paying off in sub-Saharan Africa. Mortality is decreasing. But while there is good news, there is also some backtracking on prioritization of universal access to HIV treatment, she said. The argument is being made that investing in HIV treatment detracts from other health needs, particularly maternal and child health (MCH)—and that argument is driven aggressively by think tanks and policy leaders in the West, said Ms. Akugizibwe, despite the intuitive connection between HIV and MCH. Despite advances in antiretroviral therapy, more than 40 percent of maternal deaths are related to HIV, she said, so the argument that HIV/AIDS investment detracts from other health care must be countered aggressively.

The distinction between funding HIV prevention versus treatment poses another false dichotomy that has also been a pretext for financial backtracking in HIV treatment, Ms. Akugizibwe noted. In addition to saving lives and decreasing morbidity from TB, for example, the availability of HIV treatment has changed perceptions, because people no longer see HIV infection as a death sentence. That perception makes it easier for people to talk more openly about HIV and to encourage testing, “and you can’t quantify the value of that,” said Ms. Akugizibwe. Further, treatment has a huge preventive benefit, as demonstrated by the discordant couples study. Some policymakers are suggesting that prevention should be emphasized over treatment, but treatment is key to prevention, she stated.

Ms. Akugizibwe said these two arguments led to flat funding for PEPFAR, which translates into caps on the ability to scale up programs. PEPFAR has a sizable political impact that goes beyond dollars. It has been instrumental in influencing the global AIDS response. When compared with other initiatives, the contributions from PEPFAR and the Global Fund have been extremely successful, both politically and from a public health perspective, in motivating countries to increase their own investment in HIV/AIDS. Country ownership is not yet adequate, but progress is being made thanks to PEPFAR, said Ms. Akugizibwe.

The platforms and networks that PEPFAR created have led the citizenry of multiple countries to challenge their own Governments to become more involved and have been very useful in mobilizing social justice initiatives around HIV, Ms. Akugizibwe added. There is potential to make great strides and to achieve sustainability. Investing less in HIV means facing the costs down the line, and it is an “irrational approach,” said Ms. Akugizibwe. She recently testified to Congress, asking that the United States and others

decide now not just to do what is convenient but to make global HIV/AIDS funding a priority.

## **Discussion**

Dr. Gayle said that if Ms. Akugizibwe could not convince policymakers [to provide funding], she did not know who could. Mr. Brooks compared efforts in the United States with his own experience working in South Africa; the United States has not done well in identifying and implementing lessons learned, as for reducing stigma. He suggested adding to the draft resolution a rationale that vital lessons have been learned from international programs, including how to reduce stigma and the importance of rigorous program evaluation. He noted that PEPFAR requires programs to track and report outcomes and suggested the NHAS implement such requirements for the United States.

Mr. Basaviah said that PEPFAR helped in an effort to increase understanding about LGBT health issues in Rwanda by involving the Minister of Health as an ally. As a result, a bill to criminalize homosexuality in that country lost support. He asked whether PEPFAR has been able to facilitate such key political relationships in other countries. Ms. Akugizibwe said PEPFAR has played an important role in compelling high-level policymakers to do the right thing, especially when public opinion focuses on social justice. Recently, human rights groups have begun using public health as a platform, making the case that all people should have access to health care. Ms. Akugizibwe said HIV-related groups are well positioned and do not have to deal with as much stigma as LGBT rights groups, thanks to PEPFAR and others.

## **PEPFAR/GHI**

### **Ann Gavaghan, Chief of Staff, OGAC, U.S. Department of State**

Ms. Gavaghan explained that the GHI builds on other programs (e.g., PEPFAR, the Global Fund) and, ultimately, will connect the “stovepipes of excellence” for a more coordinated response. For example, it will weave together efforts to address MCH and malaria. The GHI focuses on developing partnerships and supporting country-led approaches and seeks to improve coordination among donors. It will identify how donors can better support countries in implementing their own plans. Ms. Gavaghan said the GHI will document how U.S. Government efforts have supported health care growth in other countries, noting, for example, where procurement chains and infrastructure have improved because of PEPFAR.

The GHI will take a women-and-girls- (or gender-) centered approach, because women are more likely to seek preventive care for themselves and

their families and treatment for their children than are men, who generally seek care only when they are sick. Targeting women benefits the whole community and their families.

While global health efforts originally took the form of emergency response, the GHI hopes to take a long-term approach, supporting sustainability and capacity-building by working with Government and civil society partners. The GHI model incorporates the following key tenets:

- Collaborate for impact.
- Do more of what works, including scaling up proven interventions.
- Build on and expand existing platforms to foster stronger systems and sustainable results, e.g., PEPFAR.
- Innovate for results.

Ms. Gavaghan explained that the GHI selected the first round of “GHI Plus” countries—that is, countries for which the United States already provides health assistance and seeks to develop strategies to better integrate global health programs. Eventually, GHI Plus will expand to address 80 countries, including 30 where PEPFAR has significant investments.

Finally, the GHI established a research agenda to learn what works within and among countries. The goal is to identify best practices that can translate to other countries.

## **Discussion**

Dr. Gayle appreciated that the GHI builds on the success of PEPFAR instead of detracting from it. Ms. Bridge asked Ms. Gavaghan to specify how the GHI can maximize efficiencies in the face of flat funding. With more joint planning and better working relationships, Ms. Gavaghan replied, the GHI can help reduce duplication of effort at the country level. The GHI seeks to examine how U.S. global health programs work and how to improve them, she added. For example, the GHI has data showing that the cost of treatment is falling in some programs. By expanding analysis in some countries, the GHI can determine what works in keeping costs down—similar to the comparative effectiveness research being conducted in the United States, Ms. Gavaghan explained.

Mrs. McBride asked whether the GHI would identify all of its efforts in the 80 countries and the gaps and overlaps in each. She also asked how the GHI could “enforce” the efficiencies it recommends. Ms. Gavaghan said the GHI program has already visited all the countries to determine who is doing what and how to coordinate those efforts. The Secretary of State leads the GHI effort with input from an operations committee made up of the U.S. Agency

for International Development, CDC, and the OGAC. A strategic council provides advice and support to the operations committee. The GHI will produce an annual report and benchmarks as well as some 5-year strategies with periodic benchmarks.

### **Discussion of the Draft Resolution of the Subcommittee on Global Affairs**

PACHA members discussed the process for reviewing, revising, and passing resolutions. Traditionally, resolutions are introduced for consideration at a full PACHA meeting, and voting is scheduled for the following PACHA meeting so that members have time to get feedback about the resolution from their own communities.

Ms. Bridge pointed out that one funding issue raised in the draft resolution of the Subcommittee on Global Affairs requires urgent attention: the call for the United States to participate fully in the Global Fund Replenishment that is to be finalized in October 2010. PACHA members unanimously agreed with the following, paraphrased from the resolution:

*PACHA recommends that the United States participate fully in the October Global Fund Replenishment by making a 3-year, \$6-billion pledge and explicitly calling on other donor governments to increase their contributions.*

#### ***Followup Item***

Dr. Gayle will communicate to Jeff Crowley of the White House that PACHA urges the United States to participate in the October Global Fund Replenishment effort.

Mr. Brooks cautioned that PACHA may diminish its influence as a an advisory body if all of its resolutions and recommendations are constantly asking for more money, because there is not an endless supply. Dr. Gayle agreed that PACHA should focus on changing policy and improving implementation whenever possible.

#### ***Followup Items***

Mr. Bates will clarify the requirements for reviewing, revising, and passing resolutions under the Federal Advisory Committee Act, particularly the process for facilitating public comment.

PACHA members will submit suggestions for the draft resolution of the Subcommittee on Global Affairs in writing to the Subcommittee for consideration and inclusion.

### **Suggestions for the draft resolution:**

- Add as a rationale, “Whereas vital lessons have been learned from international programs, including how to reduce stigma and the importance of rigorous program evaluation.”
- Add a rationale about the need for better coordination between domestic and international programs.
- Explain that domestic and international issues are not always exclusive of one another.
- Consider removing the reference to the specific CD4 cell counts identified in the WHO guidelines.
- In addition to asking that the President and the Secretary of State work with Congress, add the Secretary of HHS.
- Regarding the rationale on the estimated benefit of scaling up treatment to 80-percent coverage, consider removing the specific numbers and making a more general statement about the potential to save lives and prevent new infections.
- Regarding the rationale on the potential of new science described at the Vienna AIDS conference, add the phrase “as appropriate for the client’s medical needs.”
- Consider adding a rationale that highlights the national security component of supporting global AIDS initiatives.
- Add to the phrase beginning “encouraging their adoption of earlier treatments...” the words, “as recommended by the WHO.”
- Reconsider the phrase “Better align our domestic and global program” so that it does not suggest aligning all countries around a U.S. standard of care. At the same time, consider rewording “better alignment” to better address the question of whether the United States is advocating for better access to prevention and care in other countries than it offers domestically.

### **PACHA Administrative Affairs/Next Steps**

The full Council went off the record to discuss PACHA administrative affairs and next steps.

#### ***Followup Item***

Mr. Bates will consider a mechanism for providing all of the presentations and handouts to PACHA members digitally.

#### **Adjournment**

PACHA’s 40th Full Council meeting was adjourned at approximately 2:00 p.m.



## **PACHA Executive Session**

### **Hubert Humphrey Building**

**Washington, DC**

**October 1, 2010**

The following suggestions were made:

### **PACHA Mission and Charge**

- Evaluate the Council's charge and map it to a timeline (i.e., calendar) consistent with the implementation of the NHAS.
- Evaluate how the efforts of each subcommittee align with the overall goals of PACHA.
- Allot time on the agenda for the next PACHA meeting to discuss the work of the subcommittees, gather input from members, and create a workflow for PACHA and the subcommittees.
- Address deliverables identified in the NHAS that fall under the purview of PACHA that have not yet been addressed by any of the subcommittees. (Mr. Bates will clarify those deliverables; one is recommendations to reduce stigma.)
- Direct the Subcommittee on Access to Care to produce a white paper as soon as possible on the future of Ryan White program authorization. When data are available on the impact of ACA on Ryan White programs, a followup paper should be considered.
- In advance of the next meeting of the subcommittee chairs, subcommittees should identify key issues about implementation and monitoring related to the NHAS (e.g., how to measure success, which players are critical to implementation) and consider how to address those issues.
- Ask HHS to allow PACHA an opportunity to see the NHAS operational plan before it is published, with the recognition that the document probably would not be cleared and would be confidential and that PACHA members may have only 48 hours to provide comments.

### **Administrative Issues**

- Appoint Mr. Brooks and Mr. Baker to serve as alternate PACHA representatives to the HHS Federal leads group for the NHAS.

- Consider paring down future agendas to allow more time for discussion among members.
- Circulate resolutions of the subcommittees to PACHA members in advance of meetings.
- To ensure that communications reach all those who have a clear stake in the deliberations, Mr. Bates will be the central point of contact for all communications involving subcommittee members working on behalf of PACHA. (For example, once the Subcommittee on Access to Care completes its list of questions for key Agencies in relation to specific access goals in the NHAS, the Subcommittee will send the questions to Mr. Bates, who will direct it to the appropriate Agencies and to Dr. Valdiserri.)
- Mr. Bates will clearly label all confidential documents as such before they are circulated, and PACHA members are asked to take extra steps to ensure that confidential documents are appropriately maintained.
- Consider an alternative date for the current December 2010 meeting.
- Note that full PACHA meetings, including public participation, can take place by phone.
- At the next PACHA meeting, discuss the process for selecting PACHA representatives/liaisons to other entities.