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

CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment
May 11-12, 2010
Atlanta, Georgia

DRAFT Record of the Proceedings

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List of Participants

CHAC Members
Dr. Donna Sweet, Co-Chair
Dr. Bruce Agins
Dr. William Cunningham
Dr. Carlos del Rio
Ms. Antigone Hodgins Dempsey
Rev. Debra Hickman
Mr. Ernest Hopkins
Ms. Maria Lago
Dr. Kenneth Mayer
Ms. Lisa Tiger

CHAC *Ex-Officio* Representatives
Dr. Pradip Akolar
(Food and Drug Administration)
Dr. William Grace
(National Institutes of Health)

Designated Federal Officials
Dr. Kevin Fenton
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Dr. Deborah Parham Hopson,
HAB Director, HRSA

Federal Agency Representatives
Dr. Thomas Frieden (CDC Director)
Mr. Gustavo Aquino
Dr. Stuart Berman
Ms. Sara Bingham
Dr. Sal Butera
Dr. Chris Cagle
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Dr. Hazel Dean
Dr. John Douglas, Jr.
Ms. Teresa Durden
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Ms. Gladys Lewellen
Ms. Eva Margolies
Dr. Christine Mattson
Ms. Sheila McCarthy
Dr. Jonathan Mermin
Dr. David Purcell
Ms. Cathy Ramadei
Ms. Amy Remick
Ms. Cheri Rice
Ms. Susan Robinson
Ms. Margie Scott-Cseh
Ms. Jenny Sewell
Mr. Craig Studer
Ms. Vicki Thurber
Ms. Susan Van Aacken
Ms. André Verani
Dr. Cathleen Walsh
Dr. John Ward
Dr. Howell Wechsler
Ms. Rachel Wynn

Guest Presenters and Members of the Public
Ms. Aimee Ahmed (CDC Foundation)
Mr. Chris Aldridge (Health HIV)
Dr. Rebecca Culyba (Emory University AIDS Education Training Center)
Dr. Julia Hidalgo
(George Washington University)
Ms. Dana Kuhn (New York State Department of Health AIDS Institute)
Ms. Leah-Lane Lowe (CDC Foundation)
Mr. Kali Lindsey (Harlem United Community AIDS Center, Inc.)
Mr. William McColl (AIDS Action)
Ms. Lyndsay Patty (Office of the Inspector General, Office of Evaluation and Inspections)
Mr. Carl Schmid (The AIDS Institute)
Ms. Julie Scofield (National Alliance of State and Territorial AIDS Directors)
Mr. William Smith
(National Coalition of STD Directors)
Ms. Cathalene Teahan
(Georgia AIDS Coalition)
Mr. Frank Thompson (National Association of County and City Health Officials)

ATTACHMENT 2

Glossary of Acronyms

AA	African American
AAA	“Act Against AIDS” Campaign
AAP	American Academy of Pediatrics
ACIP	Advisory Committee on Immunization Practices
ADAP	AIDS Drug Assistance Program
AETCs	AIDS Education and Training Centers
AHRQ	Agency for Healthcare Research and Quality
APIs	Asian/Pacific Islanders
ARRA	American Recovery and Reinvestment Act
ASHA	American Social Health Association
BYOP	“Bring Your Own Partner” Strategy
CBOs	Community-Based Organizations
CDC	Centers for Disease Control and Prevention
CHAC	CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment
CHCs	Community Health Centers
CLD	Client-Level Data
CMS	Centers for Medicare and Medicaid Services
DASH	Division of Adolescent and School Health
DFO	Designated Federal Official
DHAP	Division of HIV/AIDS Prevention
DISs	Disease Intervention Specialists
DSTDP	Division of STD Prevention
DVH	Division of Viral Hepatitis
EHRs	Electronic Health Records
EPT	Expedited Partner Therapy
ETCs	Education and Training Centers
FOA	Funding Opportunity Announcement
GAP	Global AIDS Program
GWU	George Washington University
GYT	“Get Yourself Tested, Get Yourself Talking” Campaign
HAB	HIV/AIDS Bureau
HBV	Hepatitis B Virus
HCC	Hepatocellular Cancer
HCP	Healthcare Professionals
HCV	Hepatitis C Virus
HHS	Department of Health and Human Services
HIT	Health Information Technology
HPV	Human Papillomavirus
HRSA	Health Resources and Services Administration
HSV-2	Herpes Simplex Virus Type 2
IDU/IDUs	Injection Drug Use/Injection Drug Users
IOM	Institute of Medicine
KCHD	Kansas City Health Department
LHDs	Local Health Departments

MAI	Minority AIDS Initiative
MC	Male Circumcision
MMWR	*Morbidity and Mortality Weekly Report*
MSM	Men Who Have Sex With Men
NACCHO	National Association of County and City Health Officials
NASTAD	National Alliance of State and Territorial AIDS Directors
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention
NCQA	National Committee for Quality Assurance
NCSD	National Coalition of STD Directors
NHAS	National HIV/AIDS Strategy
NIH	National Institutes of Health
OIG	Office of Inspector General
ONAP	Office of National AIDS Policy
PCMH	Patient-Centered Medical Home
PCSI	Program Collaboration and Service Integration
PDPT	Patient-Delivered Partner Therapy
PLWHA	Persons Living with HIV/AIDS
PWP	Prevention With Positives
QALYs	Quality Adjusted Life-Years
RCTs	Randomized, Controlled Clinical Trials
SAMHSA	Substance Abuse and Mental Health Service Administration
SEPs	Syringe Exchange Programs
SHDs	State Health Departments
SPNS	Special Projects of National Significance
SSPs	Syringe Services Programs
TAI	The AIDS Institute
USPSTF	U.S. Preventive Services Task Force
WHO	World Health Organization
YCMSM	Young Men Who Have Sex With Men of Color
YRBS	Youth Risk Behavior Survey

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DRAFT Minutes of the Meeting

The Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC), and Health Resources and Services Administration (HRSA) convened a meeting of the CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment (CHAC). The proceedings were held at the J.W. Marriott Buckhead Hotel in Atlanta, Georgia on May 11-12, 2010.

Opening Session

Dr. Donna Sweet, co-Chair of CHAC, called the meeting to order at 8:35 a.m. on May 11, 2010. She welcomed the participants to the proceedings and announced that Dr. Edward Hook, co-chair of CHAC, would be unable to attend the meeting. Dr. Sweet opened the floor for introductions. The list of participants is appended to the minutes as Attachment 1.

Dr. Kevin Fenton is the Director of the CDC National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP) and the CHAC Designated Federal Official (DFO) for CDC. He reminded the participants that CHAC meetings are open to the public and all comments made during the proceedings are a matter of public record. He advised CHAC members to be mindful of potential conflicts of interest identified by the CDC or HRSA Committee Management Office and to recuse themselves from participating in discussions or voting on issues in which they have a real or perceived conflict of interest.

Dr. Fenton made two announcements regarding the CHAC membership. First, Ms. Regan Hofmann was recently appointed as a new CHAC member. Ms. Hofmann is the editor-in-chief of *POZ Magazine* and POZ.com. The *POZ* magazine and website serve as two of the leading U.S. and international resources for persons living with or affected by HIV/AIDS. Ms. Hofmann's biographical sketch was included in the meeting packets. The participants joined Dr. Fenton in welcoming Ms. Hofmann to her first CHAC meeting.

Second, the terms of three CHAC members (Rev. Debra Hickman, Dr. Edward Hook and Mr. Thishin Jackson) will expire on November 30, 2010. However, CDC has submitted waivers to HHS to extend the terms of Rev. Hickman and Dr. Hook for an additional two years. CDC expects HHS to approve the waivers.

Dr. Deborah Parham Hopson is the Director of the HRSA HIV/AIDS Bureau (HAB) and the CHAC DFO for HRSA. She announced that since the November 2009 CHAC meeting, national healthcare reform legislation was passed. Over the course of the meeting, she asked CHAC to consider and provide direction, advice and guidance to CDC and HRSA on the potential implications of healthcare reform on the agencies' programs.

CDC Director's Report

Dr. Thomas Frieden, Director of CDC, described CDC's new organizational structure, priorities, challenges and strategic directions to enhance the prevention of HIV and STDs. CDC's current organizational structure includes new offices and leadership for better alignment with its five key public health priorities: (1) strengthen surveillance, epidemiology and laboratory services; (2) improve capacity to support state, tribal, local and territorial public health agencies through financial, technical and personnel support; (3) increase global health impact; (4) increase policy impact; and (5) better prevent illness, disability and death.

Dr. Frieden presented a pyramid to illustrate the six factors that affect HIV prevention in order of largest to smallest impact. Socioeconomic factors include poverty, education, housing and employment. Contextual changes for individuals to make healthy default decisions include readily available condoms, clean needles or other factors that influence social norms around sexual behaviors.

Protective interventions include brief interventions for alcohol abuse, male circumcision, the availability of vaccine and other factors with long-lasting impact. Clinical interventions include treatment for viral load control and substance abuse. Counseling and education interventions include campaigns that promote knowing the HIV status of partners, reducing the number of sexual partners, and decreasing bare-backing.

Dr. Frieden emphasized that HIV prevention is a truly winnable battle. Prevention is the best investment in the public health sector at federal, state, local and international levels. However, the public health sector is losing the HIV prevention battle among men who have sex with men (MSM) because this population is 50 times more likely to become infected compared to other groups. By transmission category, CDC data showed that the estimated number of new HIV infections in the United States from 1977-2006 has steadily increased among MSM since the early 1990s.

In contrast, the number of new HIV infections has drastically declined in the same time period among injection drug users (IDUs), MSM-IDUs and heterosexuals. The steady growth of new

HIV infections among MSM has had an impact on the rapid increase in U.S. syphilis cases from 2000-2008. Over this time period, syphilis cases of all stages increased by 46%, while primary and secondary syphilis cases increased more than two times.

Dr. Frieden described a number of areas that must be strengthened to enhance the prevention of HIV and STDs. HIV testing is the first step in prevention. The 2006 Marks, *et al*. study showed that ~25% of persons who were unaware of their infection accounted for ~50% of new infections. The study further showed that ~75% of persons who were aware of their infection also accounted for ~50% of new infections. The 1999 Weinhardt study, the 2002 Weller study and the 2005 Marks study all demonstrated that knowledge of HIV status was associated with less risky sexual behavior among MSM, men, women and IDUs. Knowledge of HIV status also was found to help persons protect the health of themselves, their families and communities.

CDC is aware of the critical need to elevate its prevention with positives (PWP) activities to a higher level to further reduce the spread of HIV. PWP encourages safe sex among HIV-infected persons and is critical to stopping HIV because all new infections involve an HIV-positive individual. PWP activities help HIV-positive persons to avoid transmitting HIV to others and becoming co-infected with hepatitis B and C, syphilis, gonorrhea, herpes, and different strains of HIV-1 or HIV-2. PWP activities also allow HIV-positive persons and those at risk to be reached more easily. CDC is closely partnering with HRSA at this time to strengthen its PWP activities.

The 2006 Fisher, *et al*. study demonstrated that clinician-delivered interventions drastically reduced unsafe sexual events and other risky behaviors among HIV-positive persons. These focused interventions should be adequately funded, incorporated into existing prevention programs, and institutionalized as a core part of HIV care to achieve the overall mission of HIV prevention. The 2005 Holtgrave study showed that prevention counseling of HIV-positive persons resulted in cost-savings.

Effective behavioral interventions are delivered by healthcare professionals (HCP) in repeated sessions and are integrated into services for HIV-positive persons. These interventions are based on behavioral theory, specific to HIV transmission risk behaviors, and address coping, treatment adherence and risk behaviors.

The partner notification process is intended to notify any sex or needle-sharing partner of an HIV-positive individual. Physicians have a duty to warn partners of their potential exposure and inform these persons of the need to be tested and treated if necessary. In jurisdictions that implement the partner notification process, data show that notified partners enter care earlier. This effective intervention helps to improve outcomes, decrease transmission, and facilitate timely risk-reduction counseling among notified HIV-negative partners who are at extremely high risk.

Chlamydia screening is another effective intervention. Expedited partner treatment can reduce transmission of chlamydia among women by 40% if partner treatment rates increased from 30% to 40%. However, more efforts are needed with social marketing and electronic health records (EHRs) to increase chlamydia screening. The potential for human papillomavirus (HPV)

prevention is great, but the 2008 National Immunization Survey showed that national coverage of ≥1 doses of HPV vaccine was only 37% among females 13-17 years of age.

Dr. Frieden highlighted several key issues related to HIV/STD prevention. Alcohol abuse is strongly associated with the growing STD problem. A brief intervention of 10-15 minutes conducted in a single session has been shown to reduce problem drinking by 30%-60% for at least one year, but this technology is massively under-utilized.

Alcohol consumption was reduced following a pilot of screening and brief interventions in STD clinics. The baseline rate of problem drinking was 20%-25% in the STD clinics and >66% of problem drinkers were counseled. The intervention can be incorporated into routine clinic visits, but specialized staff should administer the session. The study showed that most patients accepted brief intervention counseling. Moreover, the intervention was found to likely reduce complications of alcohol abuse, including transmission of HIV and other STDs.

Alcohol availability and the incidence of gonorrhea also are closely correlated. Alcohol prevention policies can reduce binge drinking. CDC, HRSA and the Substance Abuse and Mental Health Service Administration (SAMHSA) are partnering with the White House Office of National Drug Policy to scale-up and incorporate brief interventions into all aspects of HIV/STD prevention, care and treatment.

Family planning and STD prevention services should be coordinated by combining services that providers accept, particularly dual use protection. However, providers need adequate resources to expand family planning coverage. Increased emphasis is needed for prevention and care in correctional facilities, including HIV/STD screening, hepatitis B virus (HBV) vaccination and chlamydia treatment. More attention also should be given to HIV care services in correctional facilities, including linkages to HIV care, partner notification and PWP activities.

HIV/STD prevention programs must place a stronger focus on online dating because this technology is linked to increased risk of sexual activity. STD control programs must maintain pace with social networking technology. The entire healthcare delivery system must be more heavily engaged to increase the impact of prevention. Data show that the vast majority of STD patients seek care from non-STD clinical settings.

Overall, health reform will provide new opportunities for prevention through wider coverage and expanded capacity. Health reform also is expected to transform both the public health and healthcare systems to bring effective care into the mainstream and make optimal use of the healthcare system for HIV/STD prevention and care.

Dr. Frieden concluded his update by thanking the CHAC members for contributing their valuable time and expertise to provide CDC with solid advice and recommendations. He confirmed that CHAC's continued commitment and dedication to HIV/STD prevention and treatment play a critical role in CDC's efforts to improve its prevention programs and strengthen its collaboration with HRSA on care and treatment issues.

In response to CHAC's specific questions and comments, Dr. Frieden provided additional details on CDC's priorities and new directions to improve HIV/STD prevention. Dr. Frieden agreed with CHAC that the complete removal of home HIV testing from clinical services potentially could increase access and testing rates, but this change would result in a number of risks and adverse outcomes. To maintain capacity in tracking the epidemic at the national level, surveillance systems will need to be updated to identify and track persons who obtain treatment based on a positive result from a home HIV test. Viral loads of all persons who receive a positive result from a home HIV test also will need to be documented and monitored over time.

Dr. Frieden was skeptical about the ability of preexposure prophylaxis to make a significant or positive impact on HIV prevention. He was more in favor of promoting and maximizing existing technologies that have demonstrated efficacy in reducing HIV transmission, such as the female condom, male circumcision and brief interventions.

Dr. Frieden fully supported CHAC's advice for CDC and HRSA to always integrate and never separate HIV testing and linkage to care. He was aware that nearly 33% of persons with positive HIV test results never present for care. Moreover, evidence has not been collected to date to demonstrate performance at the national level in retaining HIV patients in care.

To improve retention in HIV care, Dr. Frieden was in favor of HIV programs replicating best practices from TB programs. TB providers have a personal responsibility for the outcomes of their patients until each individual has completed treatment or transferred their care to another healthcare institution. Malawi utilized the TB model to develop a data system that tracks outcomes each quarter of all 250,000 patients who were placed on HIV treatment. The Malawi data system should be replicated and implemented in all U.S. states.

CHAC thanked Dr. Frieden for joining the meeting to describe CDC's new organizational structure, priorities, challenges and strategic directions to enhance the prevention of HIV and STDs. CHAC was particularly pleased with CDC's commitment to strengthen its focus on PWP activities and promote existing prevention interventions, such as the female condom and male circumcision.

CHAC also was pleased that CDC has prioritized linking HIV-positive persons to care and is partnering with HRSA to improve the retention of patients in care. The CHAC members made three key suggestions to advance this important effort. First, a survey should be administered to clinics nationally to determine and follow-up on the number of HIV-positive patients who have not presented for care in the past six months. Second, a process should be developed for correctional facilities to notify clinicians if their patients become incarcerated to ensure that HIV treatment continues throughout the period of incarceration.

Third, CDC's Program Collaboration and Service Integration (PCSI) model should be more widely promoted to enhance data sharing between state public health departments and clinics at the local level. Due to legal and ethical issues, health departments will not provide clinicians with a current address or any other information on HIV-positive persons who have discontinued care. Despite this barrier, however, actions must be taken to change the overall health delivery

culture to empower individual clinicians to locate and follow-up on their patients who have discontinued HIV care.

The CHAC members made additional suggestions for CDC to consider in further enhancing its other HIV/STD prevention priorities.

- CDC should compile the multiple interventions Dr. Frieden described in order to provide clinicians with an "integrated prevention package." The prevention package should cover the following areas at a minimum: HIV and STD testing, PWP activities, clinician-delivered interventions, the partner notification process, expedited partner treatment and HPV vaccination.
- CDC should more strongly focus on criminalization associated with persons who disclose their positive HIV status. This effort should include a campaign to educate the media on this issue.
- CDC and HRSA should obtain advice and guidance from CHAC on effective approaches to inform providers about their personal responsibility to retain HIV patients in care.
- CDC and HRSA should engage in joint efforts to widely publicize PWP in the provider community and integrate PWP messages in the care setting. For example, CDC and HRSA could collaborate with their Education and Training Centers (ETCs) to develop and distribute PWP toolkits and other resources to providers. HRSA could compile lessons learned on PWP from its Special Projects of National Significance (SPNS) and broadly disseminate this resource to providers.

Drs. Fenton and Parham Hopson made several remarks to confirm that a number of ongoing activities are consistent with CHAC's comments and suggestions. CDC and HRSA established a new cross-agency workgroup to specifically focus on PWP. CDC is updating its PWP recommendations to include more recent evidence that has evolved over the past ten years and also to reflect more effective interventions in the clinical setting. The CDC/HRSA cross-agency workgroup will rapidly disseminate the updated PWP guidelines to clinical colleagues. HRSA is closely collaborating with CDC at this time on its retention in care study. The study is designed to identify effective strategies to retain persons in care who have tested positive for HIV.

NCHHSTP Director's Report

Dr. Fenton covered the following areas in his update. At the agency level, the CDC Division of Adolescent and School Health (DASH) published a supplement in the March 2010 edition of the *Journal of Adolescent Health* that explored the relationship between positive youth development and adolescent sexual and reproductive health. DASH plans to convene an expert panel in September 2010 to review a draft of new guidelines for HIV prevention in schools. DASH will re-compete its cooperative agreement in the late fall of 2010 and begin the new funding cycle in May 2011.

DASH will release results of the 2009 Youth Risk Behavior Survey (YRBS) on June 3, 2010. YRBS is designed to track risk behaviors among young persons and allow CDC to evaluate the impact and effectiveness of prevention interventions at the population level. DASH will simultaneously launch an updated version of *Youth Online*. This interactive web-based tool allows for the exploration of YRBS data.

With the updated version of *Youth Online*, interactive tables can be created, filtered and sorted by race/ethnicity, gender, grade or location. Test differences can be compared between two data points using T-tests. Fact sheets can be created and customized. *Youth Online* is available on the CDC website at www.cdc.gov/healthyyouth/yrbs.

At the National Center level, Dr. John Douglas was the former Director of the Division of STD Prevention (DSTDP) and was recently named as the NCHHSTP Chief Medical Officer. In his new position, Dr. Douglas will serve as the principal medical advisor to the Director of NCHHSTP, represent NCHHSTP in CDC's high-level committees (*i.e.*, the Advisory Committee on Immunization Practices (ACIP)), and chair cross-Center workgroups (*i.e.*, the Blood, Organ and Other Tissue Safety Workgroup).

Dr. Douglas also will be responsible for three additional activities in his new role: (1) collaborate with the Senior Advisor on Prevention Through Healthcare to coordinate and accelerate NCHHSTP's involvement in health reform opportunities; (2) develop and implement NCHHSTP's cross-cutting and strategic priorities, including sexual and reproductive health; and (3) identify and develop new strategic partnerships with other federal agencies to accelerate implementation of NCHHSTP's prevention priorities.

Dr. Stuart Berman was recently named as the Senior Advisor to the Director of NCHHSTP. In his new position, Dr. Berman will serve as the lead for "Prevention Through Health Care: Increasing Compliance with NCHHSTP's Care-Based Recommendations." He will have responsibility for three key activities in this role:

1. take advantage of the Patient Protection and Affordable Care Act to increase the number of individuals with insurance, mandate first dollar coverage for many of NCHHSTP's recommended services, and increase primary care encounters;
2. communicate with HRSA, health departments and other partners about the implications of health reform legislation; and
3. facilitate implementation of NCHHSTP's recommendations (*i.e.*, testing, counseling and vaccination) to identify system solutions and new approaches that are now feasible.

As the lead for strengthening assessment of morbidity and service delivery by utilizing investments in health information technology (HIT), Dr. Berman will have responsibility for activities in two key areas: (1) EHRs, aggregated data and health information exchanges; and (2) opportunities offered by the Centers for Medicare and Medicaid Services (CMS) "Meaningful Use" activity.

As the lead for program improvement activities to support NCHHSTP's mission, Dr. Berman will have responsibility in two key areas: (1) collaborate with NCHHSTP divisions and external partners to identify and implement systems to gather and disseminate best practices that support NCHHSTP's prevention activities; and (2) collaborate with the CDC Office of the Director, HRSA and other partners to develop quality improvement approaches to support NCHHSTP programs.

Dr. Berman's other major role as the Senior Advisor to the Director of NCHHSTP will be to collaborate in facilitating the transition of program roles from service provision to assurance of service and quality, particularly among highly impacted populations. To support this effort, Dr. Berman will engage HCP and identify tools for monitoring and increasing compliance. Other changes in NCHHSTP leadership include the appointments of Dr. Cathleen Walsh as the Acting Director of DSTDP and Dr. Irene Hall as the Acting Associate Director for Health Equity.

Healthcare reform will provide NCHHSTP with several new opportunities. In terms of prevention through health care, health coverage will be expanded to an estimated 94% of the population and support of preventive services (*i.e.*, first dollar coverage without a co-pay) will be expanded as recommended by ACIP and the U.S. Preventive Services Task Force (USPSTF). Support of the public health infrastructure will be expanded through community-based prevention as well as screening and immunization services through Prevention and Wellness Trust Funds.

A new National Prevention Council will be established to develop a new National Prevention Strategy. Healthcare reform also will result in a number of authorized, but non-funded activities, such as workforce expansion, expanded health disparities data collection, comparative effectiveness research, development of a national quality strategy, expanded teen pregnancy prevention, and expanded community health centers and school clinics.

Governance of the Global AIDS Program (GAP) has been transitioned from NCHHSTP to the new CDC Office of Global Health. However, NCHHSTP has made a commitment to ensure that existing programmatic relationships remain unchanged. The transition will provide NCHHSTP with opportunities for new and exciting collaborations as the new Center for Global Health is established.

The dissolution of the Coordinating Centers in CDC's new organizational structure has resulted in staff being aligned back to the NCHHSTP Office of the Director and divisions. New teams that will join the NCHHSTP Office of the Director include the Informatics Team, Web Team, National Center for Health Marketing Communications Team, and Extramural Research Team. The Coordinating Center for Infectious Diseases Strategic Business Unit Teams that supported NCHHSTP have been realigned to the NCHHSTP Office of the Director. This group will form a new Administrative Services Unit with the unit chief reporting to the NCHHSTP Management Officer. The team structure within the unit has not changed due to requirements of the High Performing Organization that will expire in 2011.

NCHHSTP released its 2010-2015 Strategic Plan on February 26, 2010. The Strategic Plan articulates a vision, overarching goals and strategies to guide NCHHSTP programs over the

next five years. The six cross-cutting goals outlined in the Strategic Plan include prevention through health care, PCSI, health equity, global health protection and systems strengthening, partnerships, and workforce development and capacity building. The Strategic Plan will be a living document that will be updated as the external environment changes. The document was distributed to CHAC for review and is available online at www.cdc.gov/nchhstp/publications.

The NCHHSTP FY2010 budget includes increases in three areas: (1) $36 million for domestic HIV prevention to be allocated to the Expanded HIV Testing Initiative, PCSI, HIV surveillance, and HIV prevention projects with state and local health departments; (2) $1.5 million to expand efforts to prevent STD-related infertility; and (3) nearly $900,000 for viral hepatitis.

NCHHSTP recently released the "Addressing Syndemics through PCSI" funding opportunity announcement (FOA) with a deadline to submit applications through June 15, 2010. NCHHSTP estimates that a total of $5.4 million will be awarded under the FOA. Grantees will be required to conduct demonstration projects that support activities described in the December 2009 PCSI white paper. NCHHSTP held a PCSI webcast on May 10, 2010 to promote the content of the white paper and will convene the "Surveillance Confidentiality Consultation" on June 28, 2010.

NCHHSTP convened the "Sexual Health Consultation" on April 28-29, 2010 with ~70 external experts to discuss the public health approach for advancing sexual health in the United States. The sexual health green paper was distributed to CHAC for review and an overview of the consultation is scheduled on the agenda. NCHHSTP published its "FY2009 Annual Report" with performance indicators to assure center-wide accountability. The report was distributed to CHAC for review and is available online at www.cdc.gov/nchhstp/publications.

At the division level, the NCHHSTP Division of HIV/AIDS Prevention (DHAP) launched the *Act Against AIDS* (AAA) Campaign on April 7, 2009. The five-year multifaceted national health communication campaign was initially launched by the White House to refocus attention on and combat complacency toward domestic HIV/AIDS. DHAP released the new "I Know" phase of the AAA Campaign on March 4, 2010 to raise awareness and promote HIV testing among young African Americans (AAs) 18-24 years of age.

DHAP will launch other phases of the AAA Campaign in the future to target additional audiences, including HCP in multiple specialties, MSM of all races, and the Hispanic/Latino population. The first year of the AAA Campaign resulted in an estimated 418 million media impressions through outdoor, print and online banner advertisements; radio and television public service announcements; on-air reads; Internet video views; and media coverage.

DHAP has a number of activities underway focusing on incarcerated populations. Project START was a CDC-funded randomized controlled trial that was identified as an evidence-based intervention. The research project also was found to be efficacious in strengthening relationships, collaboration and coordination of services between prisons and community-based settings after male inmates are released back to communities.

Project START has now been packaged for national dissemination as a four-session intervention. DHAP launched the prevention intervention due to decreased emphasis on HIV/ STD screening in prisons as a result of the economic recession. A jail-based testing report was published in the *Morbidity and Mortality Weekly Report* (*MMWR*) and a chapter for publication in a book is being completed focusing on behavioral interventions for incarcerated populations.

An evaluation of multiple interventions for HIV-positive incarcerated persons is being conducted. An evaluation of two intervention adaptations for incarcerated adult women and adolescent females is underway as well. A surveillance system for medical indicators of sexual assault is being piloted in correctional facilities.

NCHHSTP received $980,000 from the Minority AIDS Initiative (MAI) to conduct demonstration projects focusing on jail-based integration of HIV/STD screening, HBV vaccination, and linkage to care and treatment. NCHHSTP will award these funds to grantees in the summer of 2010. DHAP is reviewing its HIV surveillance programs to better understand HIV reporting from correctional facilities across the country. DHAP will develop recommendations to enhance HIV surveillance based on data collected from the review.

The CDC Public Health and Homelessness Planning Group will make a presentation on "incarceration, homelessness and health" during the Public Health and Homelessness Symposium on August 25, 2010. The purpose of the symposium will be to heighten awareness of the impact of homelessness on health and highlight CDC's contributions in this area. The NCHHSTP Corrections Workgroup will lead the development of the corrections-focused presentation.

The NCHHSTP Division of STD Prevention (DSTDP) launched the "Get Yourself Tested, Get Yourself Talking" (GYT) Campaign in April 2010 to update the 2009 campaign and build on the MTV/Kaiser Family Foundation "It's Your Sex Life" platform in partnership with Planned Parenthood. The goals of the 2010 campaign are to normalize conversations around sexual health, safety and testing; raise awareness of STD prevalence and prevention methods; and normalize routine STD testing.

Planned Parenthood data show that the 2009 GYT Campaign had a tremendous impact at the local level. The number of client visits to HIV/STD clinics from April 2008 to April 2009 increased by 18% among females and 36% among males. The 2009 GYT Campaign also resulted in an increase in gonorrhea, chlamydia and HIV testing among both females and males.

DSTDP convened the National STD Conference in March 2010 and published an *MMWR* article that showed one in six Americans is infected with herpes simplex virus type 2 (HSV-2). The article also reported that seroprevalence of HSV-2 was 16.2% in 2005-2008, three times greater among AAs than whites, and twice as high among women than men. DSTDP led the joint CDC/ World Health Organization (WHO) consultation on April 6-9, 2010 in Manila on cephalosporin-resistant gonorrhea.

DSTDP expects to publish laboratory guidelines for *Chlamydia trachomatis* and *Neisseria gonorrhoeae* and initial guidelines for laboratory diagnosis of syphilis in the late summer of 2010. DSTDP also plans to publish an updated version of the 2006 STD Treatment Guidelines in the fall of 2010.

The NCHHSTP Division of Viral Hepatitis (DVH) has taken a number of actions in response to recommendations in the 2010 Institute of Medicine (IOM) report, "*Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C*." The IOM report called for improvements in four key areas: surveillance, knowledge and awareness, immunization, and viral hepatitis services. A synopsis of the IOM report was distributed to CHAC for review and the HHS/CDC response to the report is scheduled on the agenda.

DVH is conducting activities in support of "Hepatitis Awareness Month" in May and "World Hepatitis Day" on May 19, 2010. CDC will issue a media statement to publicize this event. DVH published an *MMWR* article on May 7, 2010 on hepatocellular cancer (HCC) to promote liver cancer prevention. Epidemiologic data show that HCC incidence rates increased from 2.7/100,000 in 2001 to 3.2/100,000 in 2006. HCC incidence was highest among Asians/Pacific Islanders (APIs), followed by AAs, American Indians/Alaska Natives and whites. The data also found that chronic HBV and hepatitis C virus (HCV) account for an estimated 78% of global HCC cases.

CHAC commended NCHHSTP on its impressive portfolio of new initiatives and ongoing activities to improve HIV/AIDS, STD and viral hepatitis prevention. The CHAC members made comments and suggestions in two key areas for CDC to consider in further refining these efforts.

First, NCHHSTP should develop a strategy to harmonize the ACIP/CDC recommendations and the USPSTF/Agency for Healthcare Research and Quality (AHRQ) guidelines in order to bridge three important gaps in emerging science as healthcare reform is implemented: routine HIV testing, HPV vaccination for men, particularly young MSM, and nucleic acid amplification testing for non-genitourinary sites.

CHAC noted that the dissemination of different guidelines from various agencies is extremely confusing to and difficult for clinicians to implement in the field. CHAC also advised CDC to closely collaborate with AHRQ to restructure the USPSTF process. Most notably, USPSTF does not consider expert opinion or data collected outside of randomized placebo-controlled clinical trials to formulate its guidelines.

Second, NCHHSTP should use the relocation of GAP to the new CDC Center for Global Health as an opportunity to strengthen the focus on the national HIV/AIDS epidemic. However, NCHHSTP and GAP should maintain a bi-directional flow of communication to apply lessons learned, experiences, and best or promising practices in both the domestic and global HIV/AIDS epidemics to scale-up HIV prevention, treatment and care in the United States and overseas.

Dr. Fenton made several remarks in response to CHAC's concerns regarding the harmonization of ACIP and USPSTF recommendations. He announced that leaders at the highest levels in both HHS and CDC are aware of the three gaps in science CHAC described. Most notably, HIV principals in HHS agencies meet on a quarterly basis and have discussed differences in the CDC and AHRQ recommendations related to HIV and hepatitis screening. At this time, NCHHSTP is actively involved in seeking opportunities to eliminate interagency barriers with AHRQ, influence the USPSTF process, and advance toward implementation of harmonized recommendations.

NCHHSTP also is identifying approaches to place its screening recommendations on the USPSTF agenda and giving critical thought to the level of evidence that will be required to make substantive guidance. Dr. Fenton confirmed that this topic would be placed on a future agenda in order for CDC and CHAC to explore potential strategies and data needed to harmonize the ACIP and USPSTF recommendations.

Dr. John Ward, Director of DVH, added that USPSTF/AHRQ have agreed to take responsibility for HCV screening over the next 1 to 1.5 years. DVH will use the update of CDC's HCV screening recommendations as an early opportunity to align its efforts with those of USPSTF/ AHRQ by serving as subject matter experts of potential guidelines. The USPSTF process also provides an opportunity for external stakeholders to be engaged in reviewing guidelines prior to dissemination. As a result, Dr. Ward encouraged CHAC to send a letter requesting potential issues USPSTF should address in developing HCV screening guidelines.

In response to CHAC's question regarding the status of the test and treat initiative, Dr. Fenton clarified that this strategy is not new. NCHHSTP is strengthening its existing efforts to scale-up three core public health activities: HIV testing, linkage to care, and retention in care. Moreover, NCHHSTP is the co-chair of the research component of the Test and Treat Project Committee and has had a tremendous level of input and engagement in this initiative. NCHHSTP has provided extensive feedback on existing capacity and resources in jurisdictions to deliver and evaluate the effectiveness of the test and treat strategy.

HAB Director's Report

Dr. Parham Hopson covered the following areas in her update. At the agency level, HRSA-funded health centers serve nearly 19 million patients, including 1 in 3 persons with incomes below the poverty level. Of >500,000 persons living with HIV/AIDS (PLWHA) who receive services through the Ryan White HIV/AIDS Program, ~73% are minorities. In addition to the Community Health Center Program and Ryan White HIV/AIDS Program, HRSA also administers a number of other programs that impact PLWHA.

Maternal and Child Health Programs serve 34 million women, infants, children and adolescents each year. The 340B Drug Pricing Program includes ~14,000 safety net providers who provide access to discount drug purchases. The National Health Service Corps includes >6,700

clinicians who currently work or will be working in the future in underserved areas in exchange for loan repayment or scholarships. The Health Care for the Homeless Program will provide a new opportunity for an additional interagency collaboration with the CDC Public Health and Homelessness Planning Group.

HRSA has had several changes in its leadership over the past year. Dr. Mary Wakefield was appointed as the new Administrator of HRSA in February 2009. Dr. Kyu Rhee was named as the Chief Public Health Officer with a primary role to better integrate public health and primary care in all HRSA programs.

Other changes in HRSA leadership include the appointments of Dr. Janet Heinrich (Director of the Bureau of Health Professions); Ms. Rebecca Spitzgo (Director of Clinician Recruitment and Service); Mr. Martin Kramer (Director of the Office of Communications); Ms. Leslie Atkinson (Director of the Office of Legislation); Mr. Thomas Morford (Director of the Office of Operations); Mr. Michael Nelson (Director of the Office of Federal Assistance Management); Dr. Donald Weaver (Acting Director of the Office of Special Health Affairs); Dr. Regan Crump (Director of the Office of Regional Operations); Ms. June Horner (Director of the Office of Equal Opportunity, Civil Rights, and Diversity Management); and Dr. Marcia Brand (Acting Director of the Office of Planning, Analysis and Evaluation).

The Office of Special Health Affairs houses several offices that focus on leading and cutting-edge issues across HRSA, including the Office of Health Equity (formerly the Office of Minority Health and Health Disparities), the newly named Office of Global Health Affairs, and the Office of Strategic Priorities.

After assuming her position as the new HRSA Administrator, Dr. Wakefield established three agency-wide priority areas: (1) build the healthcare workforce; (2) improve access to quality primary care and health services and establish linkages to public health; and (3) strengthen HRSA's organizational infrastructure, workforce, workplace climate and technology. However, Dr. Wakefield has reserved the right to modify these priority areas based on outcomes of the ongoing HHS strategic planning process, healthcare reform and the National HIV/AIDS Strategy.

HRSA is continuing its agency-wide focus on two important initiatives. In terms of American Recovery and Reinvestment Act (ARRA) funding, HRSA awarded $2 billion to community health centers (CHCs), $300 million to the National Health Service Corps, and $200 million to health professions. Over the past 18 months, ~24 Ryan White Part C grantees have returned their funds to HRSA due to increased difficulty and expenses in administering the grants as well as decreased support from partner organizations. The Part C grantees that returned their funding to HRSA represent providers in both large jurisdictions and small rural communities.

HRSA has made a strong commitment to maintain community-based services for patients of Part C grantees that returned their funds. Most notably, CHCs have agreed to use funds that Part C grantees returned to HRSA and assure continued care to patients by becoming a Ryan White Program or partnering with community-based Ryan White providers or other components

of the system. HRSA is currently developing a "Policy Assistance Letter" to clarify the terms of HIV testing and other expectations of CHCs. HRSA hopes that the new linkages between Ryan White providers and CHCs will ultimately increase care to PLWHA in communities.

In terms of healthcare reform, HRSA was given responsibility for implementing ~60 different components of the legislation, including the healthcare workforce, Community Health Center Program, National Health Service Corps, Maternal and Child Health Programs, and the 340B Drug Discount Program. The Ryan White HIV/AIDS Program was not specifically named in HRSA's mandate for healthcare reform, but HRSA is currently undertaking a thorough review of the 2,000-page legislation to determine its impact on PLWH. Dr. Parham Hopson will report these findings to CHAC after HRSA completes its review of the healthcare reform legislation.

In the current era of healthcare reform, HRSA is continuing to closely collaborate with CDC on HIV prevention and treatment issues. HRSA will use its interagency partnership with CDC to identify and assess the best approaches for Ryan White providers, CHCs and all other components of the health system to become integral parts of healthcare reform. Drs. Frieden and Wakefield recently met to discuss new opportunities to improve linkages between HRSA and CDC activities during healthcare reform. CDC transferred funds to HRSA for ETCs to train providers in testing patients for HIV. CDC's community-level prevention planning and HRSA's Ryan White planning through Parts A and B grantees continue to provide a seamless linkage between HIV testing and care in communities.

At the bureau level, HAB has a number of important initiatives underway: developing 13 new pediatric performance measures; implementing changes in the Ryan White statute and awarding grants; refining the client-level data collection process; launching new research activities; planning the 2010 Ryan White All-Grantee Meeting; continuing to provide technical assistance to grantees; and hiring new staff. HAB distributed the 13 new pediatric measures to Ryan White grantees for review and comment in April 2010.

HAB completed five sets of performance measures for clinical care for adults and adolescents, medical case management, oral health, the AIDS Drug Assistance Program (ADAP), and system-level measures. The completed performance measures are available on the HRSA website at http://hab.hrsa.gov/special/habmeasures.htm.

HAB implemented all changes of the Ryan White Treatment Extension Act of 2009 that President Obama signed into law on October 30, 2009. The Ryan White reauthorization called for the law to be changed in the following areas: MAI, transition grant areas, unobligated balances, ADAP rebates, hold harmless provisions, names-based reporting, and Part D services to women, children and youth.

HAB took several actions to implement new requirements in the Ryan White reauthorization that related to early identification of PLWH and linkage to care. Interim guidance for FY2010 was released. A consultation was held with Parts A and B grantees, CDC and national organizations to discuss existing data grantees could use to demonstrate their performance in identifying

PLWH earlier and linking these persons to care. Input provided during the consultation is being used to develop and disseminate final guidance for FY2011.

As of May 11, 2010, HAB awarded $652 million to Part A grantees to provide primary care and support services, including $44.8 million for MAI projects. Of $1.187 billion awarded to Part B grantees, $345 million was base funding and $841.75 million was for ADAP. However, HRSA is exploring additional opportunities and strategies to address 1,072 patients in ten states who are currently on ADAP waiting lists. Part B funding also will include $5 million to 16 states to award Emerging Community grants at the local level. Part C grantees were awarded $127.6 million in January and April 2010 for early intervention services.

HAB was pleased to report that in 2009, all Ryan White grantees and providers who delivered ambulatory and outpatient medical care, medical case management or non-medical case management submitted grantee and provider reports. HAB also was impressed that 89% (or 1,371 of 1,536) providers submitted client-level data (CLD) in 2009. HAB's next steps in this effort will be to analyze the 2009 CLD, develop a CLD collection system for ADAP, and collect and analyze calendar year 2010 CLD.

HAB is aware of concerns that 11% of providers were unable to submit CLD, but the shift from aggregate-level data to CLD was a tremendous organizational change for grantees. Moreover, HAB found the 89% response rate to be high because grantees were not awarded additional administrative dollars to collect CLD along with their existing responsibilities to submit aggregate-level data. However, HAB will provide technical assistance to the 11% of providers who did not submit CLD in 2009 to ensure that this deficiency is corrected in 2010.

HAB received new funding to launch five new research activities: (1) "Expansion of HIV Care in Minority Communities: Capacity Building in Community Health Centers;" (2) the "HIV Clinician Workforce Study;" (3) "Capacity Development for American Indian/Alaska Native Serving Healthcare Providers;" (4) "Improving HIV Outcomes Via Enhanced Provider Communication;" and (5) "Using Social Networks to Increase Access to HIV Prevention and Care." Similar to CDC, HRSA also has a large PWP initiative that has been ongoing for quite some time.

HAB will sponsor the 2010 Ryan White All Grantee Meeting and 13th Annual Clinical Conference on August 23-26, 2010 in Washington, DC with a theme of *20 Years of Leadership: A Legacy of Care*. HRSA will use these events as opportunities to applaud the outstanding service, commitment and dedication Ryan White providers have made over the past 20 years. The conference website is open for registration at www.ryanwhite2010.com. The deadline to submit abstracts is May 12, 2010. CHAC has traditionally held a session during the Ryan White All Grantee meeting for the members to interact with grantees. Dr. Parham Hopson asked CHAC to inform HAB of the CHAC members who would attend the session.

The FY2011 President's budget for the Ryan White HIV/AIDS Program requests flat funding in three areas: $679 million for Part A grantees to provide emergency relief services; ~$78 million for Part D grantees to provide services to women, children and youth; and $25 million for grantees to conduct SPNS Initiatives.

The FY2011 President's budget requests increases for the remaining parts of the Ryan White HIV/AIDS Program: (1) a $30 million increase (or 2.4%) for Part B grantees to provide HIV care with state formula grants and ADAP; (2) a $5 million increase (or 2.4%) for Part C grantees to provide early intervention services; and (3) a $4.5 million increase (or 21%) for Part F grantees to administer AIDS ETCs (AETCs) and provide dental reimbursement. If the FY2011 President's budget is approved, the total Ryan White appropriation will increase by ~$40 million (or 1.7%) from FY2010.

CHAC commended HRSA on providing grantees with new and promising tools and improving existing resources to enhance HIV/AIDS care and treatment in communities. CHAC noted that the HIVQUAL Continuous Quality Program and ongoing training and education activities have been tremendously helpful to grantees. HRSA's collaborative efforts to align and harmonize data systems across Parts A, B, C, D grantees in five states have been beneficial as well.

The CHAC members proposed several strategies to decrease the burden placed on HRSA grantees in continuing to provide high-quality HIV care and treatment services in communities.

- HRSA should collaborate with its grantees in developing an external audit system to identify and reconcile significant inaccuracies in the CLD reporting process. For example, one HRSA grantee determined that its EHR system for reporting clinical data would not communicate with the state system for reporting case management data. Although one system showed that 100 pregnant women did not receive HIV therapy, all 20 pregnant women actually received HIV therapy based on an internal audit the grantee conducted before submitting the data to HRSA. The joint effort between HRSA and its grantees should address HIV data reporting requirements and other components in existing HIV-dedicated systems that currently are not included in information systems in the broader health sector.
- HRSA should convene a consultation with its grantees to explore innovative strategies to resolve current funding and personnel constraints. The consultation might help to decrease the number of grantees that will return their Ryan White funds in the future. This approach also will be critical if HRSA continues to require grantees to undertake additional responsibilities with larger patient populations and level or decreased funding.
- HRSA should craft and distribute accurate messages to dispel fears and misconceptions regarding "testing positive for HIV" versus "being placed on the ADAP waiting list." For example, grantees could be instructed to assure their patients of linkages to HIV care based on a positive test result.
- HRSA should continue its efforts to scale-up provision of primary HIV care in CHCs, but solid experience will be needed. To advance this effort, HRSA should allocate a portion of the $2.6 million increase for AETCs in the FY2011 President's budget to three key areas: (1) more focused training from AETCs to CHCs on the provision of excellent primary HIV care; (2) development of indicators for HRSA to measure performance in CHCs providing primary HIV care of the highest quality; and (3) incentives to increase collaboration between Ryan White providers and front-line CHCs.

- HRSA should take advantage of the National Institute of Health's (NIH) alcohol research portfolio as an additional opportunity to translate research into actual clinical practice. For example, CHCs and Ryan White providers could use NIH research findings to counsel patients on the dangers of alcohol abuse in adhering to HIV treatment. HRSA should consult with Mr. William Grace, the CHAC *ex-officio* to NIH, to facilitate efforts for NIH to translate its alcohol research for use by CHCs and Ryan White providers.
- HRSA should ensure that state health departments are involved in internal discussions regarding coordination and planning of resources. HRSA also should include state health departments in the rotation of technical assistance site visits.

Dr. Sweet confirmed that the traditional "Meet CHAC" session has been included on the agenda for the 2010 Ryan White All Grantee Meeting.

Update on CDC's New National HIV/AIDS Prevention Initiatives

Dr. Jonathan Mermin is the Director of the NCHHSTP Division of HIV/AIDS Prevention (DHAP). He provided an update on CDC's new national HIV/AIDS prevention initiatives in three major areas.

First, several activities were launched to obtain input on the National HIV/AIDS Strategy (NHAS), including 14 community discussions across the country with >4,000 attendees, an online "Call to Action," e-mail messages and community-generated meetings. The Office of National AIDS Policy (ONAP) received >1,000 submissions from these activities, including recommendations on the NHAS in the following areas:

- The need for comprehensive sex education.
- The need for federal funding for needle exchange programs.
- The need for stigma reduction and a large national social marketing campaign.
- The need for additional emphasis on communities of color and MSM.
- The need to eliminate mother-to-child transmission of HIV.
- The need to train and recruit providers and researchers who reflect vulnerable communities most affected by HIV.
- The need to address co-factors of infections *(i.e.*, STDs, mental illness and substance abuse).
- The need to increase the provision of healthcare in rural areas.
- The need for additional investments in vaccine and microbicide research.
- The need to identify additional funds for ADAP.
- The need to scale-up behavioral interventions that reduce HIV risk.
- The need to ensure PLWA receive medical care consistent with federal guidelines.
- The need to ensure seamless linkages to care for person who test positive for HIV.

President Obama established three national goals for the NHAS: reduce HIV incidence, increase access to care for PLWH and optimize health outcomes, and reduce HIV-related disparities. CDC, HRSA and other federal agencies are heavily engaged in the NHAS process through an interagency workgroup, three subcommittees to specifically focus on the NHAS goals, and one subcommittee to rollout the NHAS. ONAP expects to release the NHAS within the next few months.

Second, DHAP convened an external peer review on April 13-15, 2009 to begin development of a division that its strategic planning process that would be consistent with the NHAS. The ad hoc workgroup of ~73 experts represented multiple disciplines, including surveillance, program and policy. The workgroup was divided into five panels to provide advice and guidance to DHAP in five major areas:

1. Planning, prioritizing and monitoring HIV.
2. HIV/AIDS surveillance.
3. Biomedical interventions, diagnostics, laboratory services, and health services research.
4. Behavioral, social and structural interventions research.
5. Prevention programs, capacity building, and program evaluation.

The DHAP external peer review panel presented its findings during the November 2009 Board of Scientific Counselors meeting. DHAP developed and posted its formal response to the recommendations on the CDC website in March 2010.

The external peer review panel advised DHAP to address general issues in six important areas: (1) the relevance of program activities to DHAP's mission; (2) the scope and prioritization of DHAP activities, (3) DHAP's scientific and technical quality, approach and direction; (4) the adequacy of translation and dissemination of DHAP's research finding for use in programs; (5) strengths, gaps, challenges and opportunities available to DHAP; and (6) the extent to which DHAP addresses PCSI, reduction of health disparities and maximization of global systems.

DHAP is using the findings of the external peer review panel as a platform in developing its 2010-2015 HIV Strategic Plan. There were a number of overarching themes in the recommendations provided by the external peer review panel:

- The need for CDC's national leadership of HIV prevention.
- The need for DHAP to effectively use data for planning and monitoring.
- The need for prioritization and transparency in DHAP's decision-making process.
- The need for DHAP to translate research into practice.
- The need for DHAP to integrate community-/practice-based research and community-developed interventions into its programs.
- The need for DHAP to continue building capacity and supporting programs in the field.
- The need for DHAP's stronger focus on communications, coordination and collaboration within the division, across CDC and with federal partners.
- The need for DHAP to enhance internal capacity to achieve its stated goals.

Third, DHAP initiated its strategic planning process in January 2010 with two phases. The "Strategic Direction" phase focuses on developing DHAP's vision, mission, guiding principles, goals and objectives. DHAP held a meeting on April 26-27, 2010 to obtain input on advancing this phase. The "Implementation Planning" phase focuses on identifying critical success factors, barriers, strategies and action plans. DHAP will convene two meetings on May 24-25, 2010 and June 17, 2010 to obtain input on advancing this phase.

In addition to the external peer review, DHAP also will conduct other activities to solicit outside feedback on its strategic planning process, such as the establishment of the Strategic Planning Advisory Board and interviews with CDC staff outside of DHAP, key stakeholders, partners, grantees, affected populations and sister HHS agencies.

During the "assessment" in Phase I of the strategic planning process, DHAP will gather input based on stakeholder and employee views, industry trends, partner information, and the current situation of HIV prevention in the United States. During "strategy sessions" in Phase II of the strategic planning process, DHAP will use outcomes from Phase I to devise an overarching plan. During Phase III of the strategic planning process, DHAP will advance to the rollout with a communication plan, strategic plan document and monitoring plan.

DHAP created a model to guide the development and rollout of the strategic planning process. For the Strategic Direction phase, DHAP will clearly define and articulate its vision, mission, guiding principles and goals. For the Implementation Planning phase, DHAP will identify critical success factors, determine objectives for the goals and barriers to the objectives, and develop specific strategies and action plans to improve HIV prevention.

DHAP has made significant progress in its strategic planning process to date. In February-March 2010, 49 external interviews were conducted and 276 DHAP employees completed the internal survey. DHAP will conduct reviews at the completion of each of the three phases: the Strategic Planning Advisory Board, the survey to DHAP employees, and the survey to CDC staff outside of DHAP. DHAP will post its draft Strategic Plan on the CDC website in late 2010 to solicit public input. DHAP will regularly document its performance in achieving the goals and objectives of its five-year division-level Strategic Plan.

Dr. Mermin concluded that the Strategic Plan will allow DHAP to explore opportunities to conduct business with a different approach in the current era of healthcare reform. For example, DHAP's new strategic direction will include taking advantage of new technologies in domestic HIV prevention and developing an aspirational vision to guide this effort.

NCHHSTP leadership provided additional details on CDC's new national HIV/AIDS prevention initiatives in response to CHAC's questions and comments. Some CHAC members were concerned about one finding of the DHAP external peer review panel. The panel noted that coordination, collaboration and integration between the domestic and global HIV/AIDS programs in laboratory processes and other areas needed improvement.

'In response to CHAC's comment, Dr. Fenton confirmed that Dr. Kevin DeCock, Director of the new CDC Office of Global Health, is aware of the critical need to maintain and expand partnerships, networks and linkages with the domestic HIV/AIDS program in NCHHSTP. Drs. Fenton and DeCock have made a commitment to this effort.

Some CHAC members questioned whether CDC has sufficient "legislative authority" to provide clear directives and hold grantees accountable to implementing the NHAS. In response to this question, Dr. Fenton announced that Dr. Frieden is aware of the need for CDC to strengthen its capacity to guide states and hold all grantees more accountable to conducting CDC-funded initiatives. The new Office for State, Tribal, Local and Territorial Support will have primary responsibility for this effort.

Ms. Eva Margolies, Associate Director for Policy in NCHHSTP, further clarified that CDC would not need new legislative authority related to grantee accountability to implement the NHAS. However, CDC has no knowledge at this time whether new regulatory or policy changes would be needed.

In response to CHAC's question, Dr. Mermin clarified the difference between the NHAS and DHAP's new Strategic Plan. ONAP will release the NHAS as an overarching framework with examples of strategies for implementation and metrics to assess performance. Federal agencies, state and local health departments, communities and the American public will be responsible for actual implementation of the NHAS. DHAP will release its Strategic Plan to fulfill CDC's role in implementing the NHAS. For example, the NHAS will likely call for CDC to be responsible for certain aspects of reducing HIV incidence, increasing access to quality care, optimizing health outcomes and strengthening health equity.

CHAC thanked NCHHSTP leadership for providing clarification on the release of the NHAS and implementation of the DHAP Strategic Plan. The members confirmed that communities would support CDC's new strategic direction to advance national HIV/AIDS prevention initiatives. The CHAC members also were pleased that DHAP developed and launched a thoughtful and well-designed strategic planning process to support the release of the NHAS.

The CHAC members made two suggestions for DHAP to consider before the NHAS was released. First, DHAP should implement its Strategic Plan in a coherent and cohesive approach to avoid confusion with the release of the NHAS at the community level. Second, DHAP should determine whether CDC will need regulatory, legislative or policy changes for grantees to implement the NHAS. Most notably, CDC might need greater authority and more funding for grantees to conduct NHAS activities state, local and community levels.

Panel Presentation: Impact of the Economic Recession at State and Local Levels

A panel of guest speakers gave three presentations on the impact of the economic recession on state and local prevention, care and treatment programs. The presentations are outlined below.

National Association of County and City Health Officials (NACCHO). Mr. Frank Thompson, of the Kansas City, MO Health Department (KCHD), presented NACCHO's perspective of the impact and extent of funding cuts on local health departments (LHDs). He explained that NACCHO is a national nonprofit organization representing ~3,000 LHDs across the United States. NACCHO also provides resources and technical assistance to LHDs and serves as the national connection for the local public health community.

NACCHO administered the "Job Loss and Program Cut Survey" in November 2008 to quantify and describe the impact of the economic recession on the budget, workforce and programs of LHDs. The three phases of the survey were the census design in November 2008 and stratified random samples in July 2009 and January 2010. National-level estimates were produced by weighing data to account for sampling and non-responses. The January 2010 phase of the survey had a 72% response rate with 967 participating LHDs and 721 non-participating LHDs.

Key findings of the three survey phases are summarized as follows. In January 2010, 38% of LHDs reported lower budgets in the current year compared to the previous year. However, an additional 15% of LHDs reported a lower budget in the current year when excluding ARRA dollars, H1N1 supplemental appropriations or one-time funding from other sources.

In terms of budget cuts, 23,000 LHD positions were lost from January 2008-2009, representing ~15% of the national LHD workforce. In December 2008, >50% of LHDs had budget cuts in seven states. In July 2009, >50% of LHDs had budget cuts in 20 states. In January 2010, >50% of LHDs had budget cuts in 14 states, but the number of states increased to 26 when one-time funding was excluded.

In terms of workforce cuts, 52% of LHDs lost positions in January-December 2008 due to layoffs or attrition (*i.e.*, mandatory furloughs, reduced hours or loss of paid holidays). The percentage of LHDs that lost positions decreased to ~46% in January-June 2009. The actual number of positions lost increased from 7,000 in January-December 2008 to 8,000 in January-December 2009. From January 2008-December 2009, LHDs lost a cumulative of 23,000 positions.

In terms of program cuts, 50% of LHDs cut at least one program area in 2009. For example, 25% of LHDs cut or eliminated services to pregnant women, new mothers and children. The top five program areas LHDs cut were population-based primary prevention (25%), maternal and child health (25%), clinical health services (21%), chronic disease screening and treatment (18%), and environmental health (17%). Only 12% of LHDs cut communicable disease screening and treatment programs.

In addition to the survey data, Mr. Thompson also presented direct quotes from LHD staff across the country to provide CHAC with perspectives from the field on budget, workforce and program cuts as well as cuts in HIV/STD prevention programs. He also highlighted the experience of KCHD in addressing budget, workforce and program cuts.

Missouri revised its ADAP formulary due to a reduction in state funding. This change has caused Ryan White clients to spend more of their personal income that was set aside for rent, utilities and other living expenses on medications for non-HIV-related conditions, such as diabetes, hypertension and chronic heart disease. The change also resulted in KCHD depleting its Ryan White emergency assistance dollars halfway through the program year.

The change in the Missouri ADAP formulary has had additional impacts on PLWHA served by KCHD. The national housing crisis has intensified ongoing challenges in identifying housing for PLWHA. The elimination of jobs and the subsequent termination of medical benefits provided by employers have increased requests by PLWHA for COBRA health insurance coverage.

Severe funding and staffing reductions have greatly increased the difficulty in LHDs meeting their federal in-kind or matching fund requirements. For example, projections for the upcoming fiscal year call for federal and state grants to serve as the source of >50% of KCHD's budget. The inability to compete for grants due to in-kind and matching fund requirements could have a devastating effect on KCHD. Moreover, hiring freezes have caused some LHDs to return their grant awards to federal funding agencies.

Local and state funding decreases also have increased the difficulty in LHDs maintaining adequate staff in STD and communicable disease clinics to prevent or rapidly contain outbreaks. For example, the metropolitan Kansas City area is currently experiencing a shigella outbreak with more than 15 times the usual number of annual cases. Staff reductions due to funding decreases could impede existing capacity to control the ongoing shigella outbreak and other disease clusters in the future. KCHD established a workforce goal of 50 active cases per disease investigation worker, but each worker has an average of 64 active cases at this time.

National Coalition of STD Directors (NCSD). Mr. William Smith, Executive Director of NCSD, explained that NCSD's mission is to promote sexual health through STD prevention and treatment. NCSD represents all 65 project areas that are directly funded to conduct STD prevention and control activities.

NCSD administered a national survey in September 2009 with the following objectives: (1) evaluate current STD program capacity and preparedness in the United States; (2) determine whether a stable and well-funded state and local public health infrastructure is available at this time to achieve successful prevention and control of STDs; (3) assess the impact of the current economic recession on STD programs in the United States; and (4) describe the contributions of STD programs to public health preparedness.

NCSD administered the national survey to STD program directors in health departments in all 50 states, 17 local jurisdictions and eight territories. The 85% response rate represented 64 of 75 jurisdictions that completed the survey. The survey participants included STD programs in states (75%), local jurisdictions (19%), and other project areas (6%).

NCSD acknowledges that the survey is limited due to its cross-sectional design and short time period since September 2009 to gather data. However, NCSD is exploring the possibility of

extending the survey to ask additional questions regarding the impact of healthcare reform on STD program capacity and preparedness in the United States.

Key findings of the NCSD survey are summarized as follows. In 2008-2009, 69% of STD programs experienced funding cuts. Of these programs, 50% had cuts in state and local support and 56% had cuts in federal funding. In 2008-2009, 69% of state and local governments enacted salary freezes or reductions, 50% enacted furlough or shutdown days, and 28% enacted layoffs. In state health departments (SHDs)/LHDs from 1999-2009, the STD program workforce decreased by 12% and the availability of STD program disease intervention specialists (DISs) decreased by 21%.

In 2009, 63% of STD programs had staff vacancies. STD programs faced several problems in filling these vacancies, such as hiring freezes enacted by state and local governments (63%), lack of funds to support the position (57%), hiring delays by human resource departments (47%), and difficulties finding qualified candidates (34%). Only 9% of STD programs reported no problems in filling vacancies.

From 1999-2009, the number of categorical STD clinics in SHDs/LHDs decreased by 10% and the number of STD clinicians in these clinics decreased by 21%. CDC's PCSI initiative and some state and local integration models have been successful, but the recent Golden and Kern study showed that investments in categorical STD clinics will continue to be a critical need. The study found that compared to private providers, men disproportionately utilize categorical STD clinics for STD testing and treatment. The closure of STD clinics would ultimately cause men to delay STD testing and treatment.

Severe reductions in the STD program budget and workforce caused SHDs/LHDs to decrease their service delivery in the following areas: disease intervention services (40%), STD laboratory services (37%), STD clinical care services (32%), STD screening (31%), hepatitis vaccinations (6%), HIV testing (5%), and HPV vaccinations (3%).

The NCSD survey demonstrated the importance and valuable contributions of the public health workforce to public health preparedness in general and the H1N1 response in particular. Of STD programs that participated in the survey, 84% had available trained staff in public health preparedness; 67% directly participated in H1N1 influenza outbreak activities in the spring of 2009; and 76% anticipated participating in the H1N1 influenza response during the 2009-2010 influenza season.

During the H1N1 response from April-June 2009, STD programs in SHDs/LHDs deployed program staff (49%); conducted H1N1 investigations with DISs; provided epidemiologic expertise to the H1N1 response (27%); conducted H1N1 activities with medical staff (22%); administered influenza vaccines (16%); and implemented other H1N1 response activities (13%).

The survey showed that state and local STD program capacity and infrastructure have severely eroded. Without additional support for state and local programs, the number of STD and HIV

cases will increase and local capacity for emergency response will diminish. Funding to support STD control and the public health infrastructure is urgently needed.

Current reductions in STD program capacity are competing with increased demand for public health response, particularly to address H1N1, congenital syphilis, the syphilis epidemic in the general population, and HIV/syphilis co-infection among MSM. NCSD and its partners, such as NACCHO and Trust for America's Health, are continuing to administer surveys and gather data to inform the development of strategies to address these issues.

Mr. Smith concluded his presentation by highlighting several overarching questions NCSD is considering and discussing with its partners and constituents to sustain and enhance STD program capacity and preparedness in the United States.

1. What will be the structure of local STD programs in the future after healthcare reform?
2. What strategies can STD programs implement to assure healthcare quality, access and outreach that are not guaranteed by healthcare reform?
3. What strategies can STD programs implement to coordinate public health activities with private sector and non-traditional partners?
4. What strategies can STD programs implement to assure access for uninsured and marginalized populations?
5. What is the role of categorical STD clinics in the new landscape of healthcare reform (*i.e.*, the Massachusetts experience or the European model)?
6. What essential skill sets will the public health workforce need in the future (*i.e.*, Internet and Internet partner services)?
7. What metrics will be needed to evaluate health outcomes? CDC data show that from 1973-2010, STD morbidity has increased in the United States, while federal dollars for this public health problem have decreased.
8. What actions can be taken to increase Congressional attention and grow federal appropriations for STDs? The traditional vision and focus on STDs could be renewed to stimulate dialogue in new areas, such as the public health importance of co-infections, the reemerging syphilis epidemic in the United States, the NHAS, antibiotic-resistant gonorrhea and chlamydia testing.
9. Does the Prevention and Public Health Fund hold any promise for STD/HIV prevention testing?
10. Is the public health infrastructure adequate at this time to scale-up and support PCSI, develop models for all types of jurisdictions, and ensure that HIV does not dilute multifaceted STD efforts?
11. Can CDC's sexual health framework create an opportunity for STD and other prevention programs to more effectively and strategically use limited resources?

National Alliance of State and Territorial AIDS Directors (NASTAD). Ms. Julie Scofield, Executive Director of NASTAD, explained that NASTAD recently adopted a new strategic plan with a new vision of "a world free of HIV/AIDS and viral hepatitis." NASTAD represents HIV/AIDS and viral hepatitis staff in the nation's chief health agencies in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and the Pacific Island Affiliated jurisdictions.

To fulfill its mission, NASTAD provides technical assistance and other support to HIV/AIDS and viral hepatitis programs housed in health departments; provides national leadership on HIV/ AIDS and viral hepatitis policy and programs; and provides education on and advocates for necessary federal funding for all HIV/AIDS and viral hepatitis programs.

In 2009, NASTAD administered three surveys to all state HIV and viral hepatitis programs to monitor the impact of state budget cuts in FY2009 and anticipated cuts in 2010. The 99 respondents included 37 states in the February 2009 survey, 37 states in the August 2009 survey, and 25 states in the December 2009 survey. Although all 50 states did not participate in each survey, the three surveys collectively represented a total of 45 different states. HIV/AIDS and viral hepatitis programs that are fully supported by federal dollars and do not receive state funding did not respond to the survey.

Key findings of the NASTAD survey are summarized as follows. In FY2009, 29 states (or 64% of respondents and 50% of all funded jurisdictions) reported a total loss of >$170 million in state general revenue cuts for HIV/AIDS and viral hepatitis programs. By program area, 25 states (or 55% of respondents) reported cuts to HIV prevention programs; 22 jurisdictions (or 49% of respondents) reported cuts to care and treatment programs; 17 ADAP grantees (or 37% of respondents) reported cuts from state contributions; eight states (or 17% of respondents) reported cuts to viral hepatitis programs; and six jurisdictions (or 13% of respondents) reported cuts to surveillance programs.

Based on responses from 42% of states that participated in the survey, an additional $18.5 million has been cut from HIV and viral hepatitis budgets in FY2010. However, this amount is expected to change after the state budget cycle ends in the summer of 2010. NASTAD plans to repeat the survey at that time to gather more detailed information. HIV and viral hepatitis programs are attempting to mitigate the budget cuts to their community providers as much as possible, but most of these reductions will continue to be taken at the state level where possible. Additional decreases to both prevention and care programs are expected in FY2010.

As of December 2009, 36 states reported a total of 197 open or unfilled positions in HIV/AIDS and viral hepatitis programs. Of the responding jurisdictions, 7% of the total workforce has been eliminated or is vacant due to unfilled positions. In FY2009, 13 states reported mandatory staff furloughs ranging from 1 to 36 days. In 19 states, staff was reassigned to H1N1 duties or given additional public health responsibilities in other areas.

The respondents reported hiring freezes in 20 states, freezes in salary increases or promotions, and pay cuts up to 2.5%. The survey further showed that 100% federally-funded positions are not exempt from state cuts in most jurisdictions. However, NASTAD is aware that letters from CDC and HRSA leadership or project officers to state program directors have been extremely helpful in the past in filling vacancies for federally-funded positions.

The respondents reported that state budget cuts have adversely impacted HIV and viral hepatitis prevention programs in multiple areas:

- Prevention program training.
- The number of community-based organizations (CBOs) funded to provide prevention services.
- The number of individuals receiving testing services, behavioral interventions and condoms.
- Syringe exchange programs that are fully funded by states.
- Surveillance activities.
- Partner services.
- HCV testing.
- Reduced grant awards to CBOs to provide HIV care.
- Increased barriers for clients to access care.
- Fewer training, evaluation and quality improvement activities.
- Difficulties in meeting state match and maintenance of effort requirements.
- Resurgence of ADAP waiting lists with 1,072 persons on waiting lists in ten states at the present time.
- Cost containment strategies (*i.e.*, reducing drug formularies, lowering eligibility for the federal poverty level, and requiring client cost sharing) implemented by 16 other states in addition to those with ADAP waiting lists.

In addition to the survey, state HIV and viral hepatitis programs also raised concerns about the public health workforce during NASTAD's annual meeting in May 2010. These issues included (1) the retirement of experienced and seasonal managers in HIV and viral hepatitis programs over the next three to five years; (2) extreme stress among staff due to the complete redesign of prevention and care programs and organizational changes in care and administrative staff; (3) the loss of a significant number of work hours by HIV program staff due to mandated state furloughs; and (4) the closing of state AIDS offices on specific days each month.

NASTAD has identified several factors that are increasing the pressure on care programs and ADAP. These issues include increased demand for program services due to unemployment; minimal increases in federal appropriations; state fiscal crises; expanded testing initiatives; improved client health and continued program need; and revised HIV treatment guidelines. In the current era of healthcare reform, NASTAD and its partner organizations are calling for additional federal appropriations to sustain and expand care programs and ADAP.

In response to CHAC's question, Ms. Scofield and Mr. Smith confirmed that NASTAD and NCSD have encouraged their memberships to cross-train field staff in HIV, STDs and viral hepatitis. Massachusetts and New York State have significantly reorganized their health departments to improve integration at programmatic, administrative and client service levels. NASTAD and NCSD support CDC's PCSI initiative and are reviewing other integration models developed by SHDs/LHDs. NASTAD and NCSD are exploring the possibility of convening a joint task force to pilot federal, state and local integration models in the field.

In response to CHAC's question, Ms. Scofield confirmed that NACCHO, NCSD and NASTAD are collaborating with the National Association of Community Health Centers and the HRSA Bureau of Primary Health Care to expand access to HIV/STD care in CHCs. Most notably, NACCHO and the National Association of Community Health Centers held a joint meeting and plan to release a set of consensus-based recommendations to assist CHCs in outreaching to their HIV/STD programs and expanding access to primary care.

CHAC thanked NACCHO, NCSD and NASTAD for presenting an honest perspective of the true impact of the economic recession on state and local prevention, care and treatment programs. However, CHAC was extremely disheartened, concerned and outraged by the survey data the three professional organizations presented.

The CHAC members made several comments and suggestions to publicize the current crisis within the state and local public health workforce.

- The professional organizations should distill their survey data to illustrate the impact of the economic recession on the public health infrastructure at the local level. These data would strengthen community-based advocacy, "embarrass" local politicians, and have a much greater effect on influencing local policymakers to champion increased funding for prevention, care and treatment programs. For example, any local jurisdiction that reports a case of congenital syphilis in the United States should be identified and reported to the national media as a failure of local politicians. At a higher level, the professional organizations, communities and advocates should identify a Congressional champion and hold a media event to publicize the severe erosion of state and local program capacity in prevention, care and treatment. HRSA and CDC should provide federal leadership in engaging the national media and blog editors to rapidly disseminate articles that highlight this issue.
- The professional organizations should use their survey data to develop an economic analysis and demonstrate the actual costs to the healthcare delivery system if funding to state and local prevention, care and treatment programs continues to decrease over time. The economic analysis would be compelling to Congressional appropriators.
- Schools of public health should be extensively engaged to recruit and train students and build a pipeline of new expertise as the current public health workforce begins to retire. However, incentives should be given to honor, treasure and pay for young students who devote their skills and pursue careers in the important fields of epidemiology, primary care and public health.

Dr. Fenton announced that similar to NACCHO, NCSD and NASTAD, CDC also is taking steps to prepare for the deadline of healthcare reform legislation in 2014. CDC will hold two technical consultations in the summer of 2010 in this regard. The first consultation will focus on core priorities for STD prevention with decreased resources in the current era of healthcare reform. The participants will be charged with identifying important evidence-based interventions that have the most impact for STD programs.

The second consultation will focus on STD prevention in the current era of healthcare reform with new providers, structures and systems. The participants will be charged with providing CDC with guidance on developing and implementing a new paradigm for STD prevention, treatment and care in the United States with existing core public health resources.

Based on the discussion, Dr. Fenton was aware that CHAC was energized, but extremely distressed by the NACCHO, NCSD and NASTAD presentations. In preparation of the business session on the following day, he asked CHAC to reflect on the panel presentation and decide whether to submit formal recommendations to CDC and HRSA on the impact of the economic recession on state and local prevention, care and treatment programs. He added that CHAC's formal recommendations to CDC and HRSA should be accompanied with concrete action steps.

Panel Presentation: Promotion of Sexual Health in the United States

A panel of speakers gave two presentations on CDC and HRSA efforts that are underway to promote sexual health in the United States. The presentations are outlined below.

***CDC Activities*.** Dr. John Douglas is the Chief Medical Officer in NCHHSTP. He explained that CDC has not adopted an official definition of "sexual health," but a decision was made to use the 2006 WHO definition. WHO defines "sexual health" as a state of physical, emotional, mental and social well-being related to sexuality that is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexual relationships and the possibility of having pleasurable and safe sexual experiences that are free from coercion, discrimination and violence. The sexual rights of all persons must be respected, protected and fulfilled for sexual health to be attained and maintained.

Sexual health in the United States has had several milestones over the past 13 years. The 1997 IOM report, "*The Hidden Epidemic*," concluded that STDs are hidden from public view because many Americans are reluctant to address sexual health issues in an open manner. The 2001 "*Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior*" emphasized the need to improve sexual health across the lifespan and stimulate discussions in communities and homes.

From 2001-2008, the sexual health public discourse was largely dominated by discussions of the relative merits of abstinence-only education. In his 2004 State of the Union address, President Bush proposed a solution to enhance abstinence until marriage education programs. At the present time, the United States is not at optimal sexual health.

More attention is now being given to sexual health in the United States due to recent trends. STDs, HIV and other sexual health problems, along with their associated costs, have a high population burden. Of 19 million STD infections that occur each year, ~50% are among young persons 15-24 years of age. Data show that one in four women 14-19 years of age is infected

with at least one STD. Estimates show that 1.1 million Americans are living with HIV at this time and >55,000 new infections occur each year.

Of all pregnancies in the United States, >50% are unintended. CDC data show that teen pregnancy rates in the United States began to increase in 2006 after a 15-year decline. In 2006, the U.S. teen pregnancy rate of 41.9/1,000 females was higher than any other developed country. STDs, including HIV, are estimated to cost $15.9 billion per year. A number of societal obstacles exist to achieving optimal sexual health, such as limited access to positive sexual health information, culturally appropriate information, lack of communication about sexual health and attitudes of secrecy.

Various levels of the federal government have now established sexual health priorities. At the Administration level, a strong interest has been expressed in developing initiatives to prevent unintended teen pregnancies. The 2011 President's budget request calls for an increase to improve sexual health for MSM. The NHAS is in the final stages of development and is expected to be released in the near future. National health reform legislation is expected to enhance and expand support for prevention services, insurance coverage and community prevention programs.

At the HHS level, sexual health was included as one of ten leading health indicators in *Healthy People 2010*. At the CDC level, the Director of CDC identified teen pregnancy and HIV prevention as two of six key "winnable battles" and established these issues as agency-wide priorities.

CDC identified three major advantages of a sexual health framework. First, the focus would shift from a disease-focus to a more positive health-based approach that is characterized by understanding complex factors to shape human sexual behavior. Second, the efficiency and effectiveness of prevention messaging and services would be enhanced by bundling messages and services. Third, capacity to normalize conversations regarding the contributions of sexuality and sexual behavior to overall health would be strengthened.

CDC acknowledges the importance of building the framework with a public health approach to achieve optimal sexual health. Public health principles provide a useful framework to understand sexual health issues in the United States and address the consequences and causes of sex-related health outcomes. A public health approach provides scientifically tested and proven interventions, recommendations and monitoring. A public health approach engages communities in their own health, introduces culturally sensitive health promotion programs, and brings disparate groups into partnerships.

Dr. Douglas reminded CHAC of the goals of the 2010 GYT Campaign and the outcomes of the 2009 GYT Campaign that Dr. Fenton presented earlier during his NCHHSTP Director's Report. He added that GYT encourages conversations with partners, providers and parents as well as endorses a range of STD/HIV tests recommended by USPSTF.

Dr. Douglas provided overviews of CDC's two major activities to promote sexual health in the United States. For the first initiative, CDC convened the "Sexual Health Consultation" on April 28-29, 2010. The purpose of the meeting was for participants to articulate the rationale, vision and priority actions for a public health approach to advance sexual health in the United States.

CDC staff and the external Sexual Health Steering Committee developed the sexual health green paper, "*A Public Health Approach for Advancing Sexual Health in the United States: Rationale and Options for Implementation*." The green paper is intended as a living document to stimulate discussion and potentially could serve as the basis for the publication of a formal CDC white (policy) paper in the future.

The consultation participants articulated the following vision and goal for the sexual health framework. The vision would be to use a public health approach to promote age-appropriate sexual health as well as healthy and responsible sexual behaviors for all Americans over their life course. The public health approach would be consistent with the best available science. The goal would be to improve individual and public health by promoting age-appropriate and coercion-free sexual health and healthy sexual behaviors for all persons across the lifespan.

The consultation participants proposed six potential objectives to guide CDC's public health approach to advance sexual health in the United States. Healthy, responsible and respectful sexual behaviors and attitudes will be increased. Awareness and capacity to make healthy, responsible and coercion-free choices will be increased. Healthy sexual functioning and relationships will be promoted (*i.e.*, ensuring that individuals have control over and freely decide on matters related to their own sexual relations and health).

Reproductive health will be optimized and education on this issue will be provided. Access to effective preventive, screening, treatment and support services that promote sexual health will be increased. Adverse individual and public health outcomes, including HIV/STDs, viral hepatitis, unintended pregnancies and sexual violence, will be decreased. The consultation participants emphasized the need for the framework to focus on health and wellness.

Efforts are underway to develop strategies for each of the proposed objectives. These action items include providing national leadership; promoting effective policy actions; promoting communication, awareness and education; expanding and enhancing surveillance, monitoring/ evaluation and research; strengthening strategic partnerships; and improving the public health infrastructure to provide appropriate sexual health services.

Dr. Douglas summarized his initial reflections on the consultation. The participants strongly endorsed the sexual health framework and welcomed this approach as an opportunity to normalize conversations; synergize efforts with other health approaches; reach persons with a strong indication of need or interest; and enhance the efficiency and effectiveness of health outcomes.

The consultation participants advised CDC to address a number of tensions associated with the sexual health framework. The focus should balance the vertical and the horizontal. Efforts

should be made to strike an appropriate balance between the excellence in silos (*i.e.*, STD, HIV, teen pregnancy and domestic violence prevention) and an overarching value-added framework. A clear distinction should be made between "radical inclusivity" versus "higher ground." Efforts should be made to reach and deliver messages to the "majority" without minimizing or marginalizing the "minority," such as addressing marriage and long-term partnerships.

The role of government in the sexual health framework should be clearly defined. For example, the government could catalyze and promote sexual health or support and sustain momentum of the sexual health framework without causing adverse reactions or pushback. Efforts should be made to strike an appropriate balance in targeting messages to youth versus all persons across the lifespan.

Appropriate metaphors, messages and an overall tone should be established to ensure the sexual health framework resonates with the largest segment of the population. Potential terms include a higher ground or common ground; healthy relationships; linkages between sex and sexuality to overall emotional, mental and physical wellness; and a possible paradigm shift or a comprehensive life span approach to sexual health.

An "evidence-based" public health approach should be clearly defined. An evidence basis for individual interventions directed at specific outcomes would be easiest to demonstrate, but would be more difficult for individual interventions directed at multiple outcomes. An evidence basis to demonstrate that a framework with wellness framing, bundling and normalizing improves measurable outcomes would be the most difficult. International and analogical data would be appropriate sources of evidence.

CDC's optimal role in advancing sexual health in the United States should cover multiple areas. A sufficiently crisp and compelling framework should be created for further implementation by other groups. The sexual health concept should be endorsed, institutionalized and embedded into other key documents, such as the NHAS, *Healthy People 2020* leading indicators and National Prevention Strategy. Strong sexual health partnerships should be encouraged.

Sexual health surveillance should be developed and encouraged. Research outside of CDC should be developed, implemented and encouraged through social marketing or demonstration projects with intervention packages. Sexual health education to the public, parents and providers should be developed, implemented and encouraged outside of CDC.

CDC's next steps to advance the public health approach to sexual health will be to obtain feedback on the green paper from participants of the Sexual Health Consultation, CHAC and a broader group of external stakeholders. The green paper will be finalized by the spring of 2011 and subsequently endorsed as a CDC-wide white (policy) paper. A sexual health work plan will be developed within NCHHSTP and across CDC. Collaborations will be established with partners to catalyze and support other efforts.

CDC will consider a number of issues to make further progress on the sexual health framework. Additional consultations might be needed to specifically focus on research needs, measures

and international lessons learned. A new "National Sexual Health Coalition" might need to be formally established. The IOM might need to be commissioned to develop a sexual health report.

For the second initiative, Dr. Douglas reported that CDC developed and launched the "Strategic Framework on MSM Sexual Health." The purpose of this effort is to support discussions and refine NCHHSTP's strategy to improve the health and well-being of gay men and other MSM. The vision of this effort is a future in which gay man and other MSM have a healthy life and an equal opportunity to reach the same achievements compared to others. The goal of this effort is to improve sexual health by promoting health equity and reducing HIV/STD transmission for all gay men and other MSM in the United States.

CDC drafted three objectives to guide the strategic framework on MSM sexual health. CDC will mobilize, engage and lead gay and other MSM communities and strategic partners while increasing accountability for success. CDC will increase effective prevention by expanding interventions focused on HIV/STD transmission and sexual health; increase access to culturally competent primary care in partnership with HRSA and other federal partners; and maximize prevention opportunities. CDC will monitor, evaluate and disseminate findings in a timely manner with improved data collection and analysis of HIV/STD transmission and sexual health.

In parallel to CDC's efforts, the Fenway Institute held the "Sexual Health of Gay Men and Other MSM: HIV Prevention-Plus Conference" on April 26-27, 2010. The overarching purpose of the conference was to shift the perspective from disease prevention to a broader understanding of sexual health for gay men and other MSM. Key discussion topics during the conference included the meaning of "sexual health" to gay men and other MSM; social, cultural, mental health, media and community influences on sexual health; effective and non-effective policies and interventions at this time; and new directions to improve sexual health of gay men and other MSM.

Dr. Douglas summarized his initial reflections on the Fenway conference. Sexual health is a life course issue and is particularly critical for same-sex attracted youth. However, older men have more imminent health concerns and might migrate from locations with less "MSM-friendly" environments for youth. An asset-/resilience-based focus traditionally has been neglected in MSM sexual health, but this area is important for new insights and framing.

The ability to embed sexual health within the context of relationships is a critical need. For example, civil unions, marriage and other publicly recognized relationships among MSM and other gay men are important in planning and targeting future efforts to long-term intimate relationships. Emphasis must be placed on strategies to accelerate demographic trends, particularly in minority communities.

Dr. Douglas concluded his overview by asking CHAC to consider and provide guidance to CDC on four key questions to advance and promote sexual health in the United States.

1. What are the opportunities and risks of CDC launching an initiative to advance sexual health in the United States?
2. What priority actions should CDC consider in developing and implementing a sexual health initiative?
3. What is CHAC's advice to CDC to enhance success of the sexual health initiative?
4. What should be CHAC's role in the sexual health initiative (*i.e.*, providing input on the green paper)?

***HRSA Activities*.** Dr. Julia Hidalgo is a Health Policy Research Professor at the George Washington University School of Public Health and Health Services. She presented preliminary findings of the HRSA-funded SPNS Initiative, "Sexual Health and Behaviors Among Young MSM of Color in HIV Care."

In the fall of 2004, HRSA awarded five-year grants to eight demonstration sites to conduct the Young MSM of Color (YCMSM) SPNS Initiative. Each of the eight grantee sites were awarded ~$300,000 per year to develop, implement and evaluate innovative models of care for YCMSM and also to apply intervention models to identify, engage, link and retain HIV-infected persons in care. Of the eight grantee sites, seven were able to sustain their programs after the five-year funding cycle ended.

HRSA also awarded funding to the George Washington University (GWU) YES Center to serve as the technical assistance and evaluation center for the project. The GWU YES Center was funded to oversee a comprehensive multi-site program and also to support interventions and local evaluation efforts of the eight grantee sites with capacity building, technical assistance and training. At the end of the five-year funding cycle, the grantee sites devoted the sixth year to developing and disseminating findings, best practices, lessons learned and related information of the project.

The eight grantee sites were located in large metropolitan areas in California (two sites), Illinois, Michigan, New York (two sites), North Carolina and Texas. The geographic uniqueness and organizational diversity of the grantee sites provided tremendous opportunities to develop innovative strategies in multiple settings. Of the eight grantee sites, three were combined CBO/ community-based clinic teams; one was a county-operated integrated health system; one was a county health department epidemiology program with HIV clinics in two CHCs; and one was a university medical school/Historically Black College and University.

In terms of experience, two sites received Ryan White Part D funds in the past to provide services to women, children and youth; three sites received prevention funds from CDC in the past; six sites had >3 years of experience in directly providing HIV services; six sites operated in service areas targeted by Ryan White Part D or CDC funds; and one site had experience in defining and organizing the HIV care continuum.

The study design of the YCMSM SPNS Initiative is summarized as follows. Eligibility criteria included confirmed HIV-positive persons who were born male and were not in care within three months of the baseline interview. The study participants were identified through HRSA-funded

outreach. Quantitative methods were used for the GWU YES Center to longitudinally follow the multi-site cohort of 363 persons enrolled in the YCMSM study. In-depth structured interviews from one to three hours were conducted at baseline and at three-month intervals with a mean of 3.6 follow-up interviews per respondent (or a range of 2-12 interviews per respondent). Laboratory data were longitudinally collected from the initial HIV clinical assessment.

Qualitative methods were used for the GWU YES Center to longitudinally follow the grantee sites and describe the evolution of their HIV care continuum. The grantee sites provided the GWU YES Center with annual site reports on the number of individuals who were reached through outreach, the number of services provided to the cohort, and the number of persons participating in the multi-site interviews. CDC staff visited the demonstration sites and provided the grantees with expertise on the prevention components of the care system.

The grantee sites also provided the GWU YES Center with reports on the number of continuum of care exercises the cohort completed each year. The GWU YES Center used these reports to describe the formation and evolution of the YCMSM-centered HIV care continuum in the eight HIV care networks. Moreover, the GWU YES Center tracked staff turnover in the grantee sites and used accounting methods and interviews to estimate the cost of turnover per network. Intensive technical assistance by the GWU YES Center addressed organizational and service delivery challenges.

Outreach methods the grantee sites used to identify YCMSM evolved over the course of the study. The grantee sites determined that outreach methods in order of worst to best effectiveness were venue-based outreach, HIV testing vans, youth-focused materials, chat rooms and social network sites, community drop-in centers, social and sexual networks, community-wide HIV testing initiatives, use of peer or near-peer outreach workers, and healthcare and youth-focused service system “in-reach” with networking to healthcare providers.

The grantee sites were asked to obtain detailed information from the cohort during the baseline and follow-up interviews. Baseline and clinical program data would cover demographics, social support, sexual behavior, gender identity, violence and environment, HIV testing, sexuality and racial discrimination, depression and suicide, substance use and clinical utilization. The baseline characteristics of the entire cohort of 363 persons are outlined below:

- African American (67%).
- Latino (21%).
- Mixed race/ethnicity (12%).
- Less than 18 years of age at the first interview (18%).
- No high school diploma or GED (29%).
- Currently enrolled in school (37%).
- Unemployed (54%).
- Moved at least once in the last three months (41%).
- Insufficient money for basic needs many times in the last three months (32%).
- Borrowed money many times in the last three months (21%).
- No health insurance (37%).

- Health insurance with coverage under a parent or guardian (40%).
- Fear of violence in the neighborhood (22%).
- Past experience with emotional abuse (38%).
- Past experience with physical abuse (34%).
- Emotional or psychological problems from drugs/alcohol in the last three months (13%).
- History of depression (45%).
- History of suicide attempts (23%).
- A thoughtful suicide plan at baseline (49%).
- Disclosure of HIV-positive status to at least one individual (96%).
- Engagement in transactional sex in the last three months (34%).
- On any antiretroviral therapy; including a prescription written on the day of the baseline interview (23%).
- Absolute CD4 count: ≥200 (49%), <200 (51%).
- HIV viral load: <10,000 (43%), 10,000-100,000 (41%), >100,000 (16%).
- Any routine, preventive or adolescent care in the last three months (28%).
- Hospitalized in the last three months (8%).
- Visited an emergency room or urgent care center (36%).
- Had an ambulatory care visit (38%).

Although HRSA funded the YCMSM study for the grantee sites to focus on HIV care, the GWU YES Center also collected baseline data on HIV testing. Of the entire cohort of 363 persons, ~16% were tested for HIV once in their lifetimes, 25% were tested twice, and 75% were tested more than twice with a range of 1-40 times. Of the cohort that was tested for HIV, 6% did not return for their results at least once.

Clients were more likely to have tested because of feeling sick at the most recent test (30%) rather than at the first HIV test (14%). No significant associations were observed between clinical, demographic or behavioral characteristics and the location of or reason for HIV testing. However, two key findings emerged when the data were adjusted for confounding factors (*i.e.*, age, race, condom use at last sexual experience, and number of male sex partners).

Clients were more likely to seek HIV testing at their first HIV-positive test result because of feeling sick with a CD4 count <200 rather than at their first HIV test. Clients were less likely to seek HIV testing because of feeling sick at the first HIV test if parental health insurance was available. The GWU YES Center also collected baseline data on sexual health characteristics of the cohort:

- Sexual identity of homosexual or gay (57%).
- Sexual identity of bisexual (23%).
- Attracted to persons other than males (52%).
- Teased because of sexuality few or many times (54%).
- Sexuality hurt or embarrassed family few or many times (39%).
- Mean age of first sexual encounter with a male (14.6 years).
- Male gender identity (96%).

- Very comfortable or comfortable with sexual orientation (93%).
- Reported sexual encounter with a male in the last three months (80% with a mean of 2.4%).
- Reported sexual encounter with a female in the last three months (8% with a mean of 0.08%).
- More than one sex partner in the last three months (47%).
- Transactional sex in the last three months (34%).
- Disclosed HIV-positive status to at least one sex partner (22%).
- No condom use with the last anal sexual encounter (31%).
- Meeting place of last male sexual partner: Internet (23%); friends or acquaintances (24%); clubs (14%); and other venues (*i.e.*, school, work, communities, parks, parties, community centers, sex chat phone lines or HIV clinics).

The GWU YES Center collected data on anal sex and condom use. Of the entire cohort of 363 persons, insertive anal sex rates slightly increased in the three months from baseline from 56% to ~62% in follow-up years 1 to 4. Condom use at the last time of insertive anal sex steadily rose from 74% in the three months from baseline to 84% in follow-up year 4.

Trends were not found in receptive anal sex because rates fluctuated in the three months from baseline from 77% to 73% in follow-up year 1, 84% in follow-up year 2, and 72% in follow-up year 3. Condom use at the last time of receptive anal sex steadily rose from 70% in the three months from baseline to 83% in follow-up year 4. Of the entire cohort, 96% was in care at the end of the study.

CHAC was extremely pleased and excited that CDC and HRSA are collaborating with their federal partners in applying a public health approach to promoting sexual health in the United States. The members noted that this effort is timely because compared to other countries, the United States is severely lagging in this area. The CHAC members made several suggestions to further advance the sexual health framework.

- CDC should ensure that psychological health, structural determinants and societal issues are included as key components in the sexual health framework.
- CDC should use its influence and resources to promote cultural competence in the sexual health framework among clinical providers. In this effort, CDC should broadly emphasize the need for physicians to have cultural competence training in and a better understanding of sexual health to improve care to their patients, particularly for MSM and minority populations. CDC should strongly encourage providers to use the sexual health framework as an opportunity to make a significant impact on public health epidemics, such as normalizing conversations regarding the contributions of sexuality and sexual behavior to overall health. This approach would enhance the capacity of providers in enrolling their patients in prevention or treatment services.
- DASH should take the lead across CDC in developing adolescent school curricula and sexual health education criteria for public school systems. This effort might lead to the development of metrics for health systems in public schools to assess whether teachers have received sufficient sexual health education to teach their students.

- CDC should target sexual health curricula, messages and other activities to grade school rather than high school students. Community-based interventions have shown that girls younger than high school age are sexually active, binge drink and take drugs or have been a victim of sexual or domestic violence in the home. Moreover, sexual health education by seven years of age is particularly important for girls and boys in urban communities.
- CDC and HRSA should outreach to organizers of sex parties across the country. Based on anecdotal reports, the potential for transmitting HIV or other STDs is high due to unprotected sex during these events.

With no further discussion or business brought before CHAC, Dr. Sweet recessed the meeting at 5:31 p.m. on May 11, 2010.

Update by the NCHHSTP Division of Viral Hepatitis

Dr. Sweet reconvened the CHAC meeting at 8:34 a.m. on May 12, 2010 and yielded the floor to the first presenter.

Dr. John Ward is the Director of the NCHHSTP Division of Viral Hepatitis. He presented the federal response to the 2010 IOM report, "*Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C*." CDC, other federal agencies and CBOs jointly commissioned the IOM to develop the report.

The IOM recommended the development of the national strategy to achieve three major goals: (1) determine strategies to reduce new HBV and HCV infections and related morbidity and mortality; (2) assess current prevention and control activities and identify priorities for research, policy and action; and (3) highlight opportunities for coordination across government and potential public-private collaborations.

The IOM report is based on the following background information. Primary prevention of hepatitis includes obtaining HBV vaccination, decreasing or avoiding injection drug use, high-risk sexual activities or other high-risk activities, and minimizing occupational exposures. Secondary prevention of hepatitis includes identifying persons with chronic infection, counseling persons on preventive behaviors (*i.e.*, vertical or horizontal transmission and efforts to minimize liver damage), and medically managing cases.

The incidence of HBV and HCV has declined, but new infections continue to occur. In 2007, 43,000 HBV cases and 17,000 HCV cases were reported. In 2009, 40 healthcare-related outbreaks were reported to CDC, including an HCV outbreak in an outpatient setting and an HBV outbreak in a residential care facility. Data have shown that vaccine-based interventions do not reach all at-risk populations. Adults represent 95% of new HBV infections, but perinatal HBV transmission continues to occur. HCV infection rates have plateaued since 2003 with

annual incidence of >10% among young IDUs. HCV transmission is emerging among HIV-positive MSM.

The burden of HBV and HCV disease is large with 15,000 deaths occurring each year. HBV and HCV are projected to cause >150,000 deaths in the next ten years. Previous studies have demonstrated that 65% of persons are unaware of their HBV infection and ~75% are unaware of their HCV infection.

The IOM identified the lack of resources, lack of public awareness and lack of provider awareness as three underlying issues that impede current efforts to improve viral hepatitis prevention. The consequences of these issues are tremendous. Inadequate surveillance systems do not allow the true burden of disease to be known. Many persons have no knowledge of their infection or risk for hepatitis and are unaware of interventions to prevent infection. Access to preventive services is lacking. Many healthcare providers do not screen persons for risk factors or have knowledge in managing infected individuals. Access to testing, social support and medical management services is inadequate.

Dr. Ward summarized the four major areas where the IOM recommended improvement. For "surveillance" of hepatitis, the IOM concluded that CDC should ensure all states have sufficient infrastructure to identify and appropriately investigate all suspected cases of acute and chronic HBV and HCV infection. The IOM identified a number of surveillance challenges in achieving this goal. Many cases are asymptomatic. Accurate diagnosis requires multiple laboratory tests. States lack staff and systems to follow-up on the high volume of reports. Reports lack solid data on race and risk and widely vary in terms of quality. Information technology systems are under-funded.

CDC is taking several actions at this time to respond to the IOM recommendations on surveillance of hepatitis. The IOM advised CDC to award funds to all states to evaluate the capacity of surveillance systems to track acute, chronic and new viral hepatitis infections. Due to resource constraints, however, CDC was only able to fund nine states to pilot this activity. CDC is conducting formative research to upgrade surveillance systems and use electronic medical records.

CDC is supporting pilot projects to integrate viral hepatitis, HIV and cancer surveillance activities. CDC is increasing surveillance of marginalized populations (*i.e.*, former inmates, homeless persons, IDUs and racial/ethnic minorities). However, CDC acknowledges the need to strengthen enhance its focus in this area.

For "knowledge and awareness" of hepatitis, the IOM concluded that lack of knowledge about HBV and HCV transmission contributes to the stigma of infection and serves as a barrier to testing, prevention and care. The IOM identified five major areas of deficiency in hepatitis knowledge: epidemiology of disease, clinical sequelae of chronic viral hepatitis, vaccination and screening criteria, testing methods and interpretation of results, proper follow-up management of chronic infection.

The IOM further noted that knowledge about chronic viral hepatitis is generally poor in the healthcare setting and among social service providers, members of at-risk populations and the general public. In the healthcare setting, for example, experts in the field recently provided inaccurate information to the media on HCV and liver cancer. One expert inaccurately stated that HCV is commonly spread through sexual contact. Another expert inaccurately stated that the reason hepatitis and liver cancer are much more common in Southeast Asia than in other parts of the world is unknown.

In the community setting, focus group responses showed that perceptions of risk were generally low among APIs despite the demographics for hepatitis in this group. The link between hepatitis and liver cancer was found to be virtually unknown in the API population. The traditional reluctance of characterizing APIs as a "risk group" persisted. Similar to APIs, AA focus group participants also had gaps in knowledge regarding viral hepatitis and expected their physicians to provide information on viral hepatitis testing.

CDC is conducting two major activities at this time to respond to the IOM recommendations on knowledge and awareness of hepatitis. CDC awarded <$100,000 each to two organizations to offer hepatitis educational programs to healthcare and social service providers. CDC awarded <100,000 each to two additional organizations to conduct and target innovative and effective outreach and education programs on hepatitis to at-risk populations.

For "immunization," the IOM recognized that effective HBV vaccination increases the possibility of eliminating new infections. HBV vaccination has been found to be a cost-saving or highly cost-effective intervention. ACIP currently recommends HBV vaccination for all newborns and adults at high risk for infection. Continued missed opportunities for HBV vaccination has resulted in low immunization coverage of at-risk adults. No vaccine has been developed for HCV at this time.

CDC agreed with the IOM recommendations on immunization of hepatitis, but resource constraints have limited a full response. The IOM estimated $80 million per year as a sufficient level of resources for HBV vaccination of at-risk adults, but CDC was only able to allocate $16 million to this effort in FY2009 due to provisional funding. The IOM emphasized the need to improve perinatal HBV prevention, but only 50% of these cases receive case management at this time. The IOM recommended the extension of hepatitis prevention services to household contacts, but CDC has been unable to develop and implement programs in this area to date due to resource constraints.

For "viral hepatitis services," the IOM concluded that despite being a preventable and treatable disease, viral hepatitis causes substantial morbidity and mortality. No coordinated federal strategy has been developed to date for hepatitis prevention and control. Federal agencies apply unparallel approaches and implement uneven funding streams for hepatitis. Of all foreign-born persons in the United Stares, nearly 50% originate from HBV-endemic countries. Hepatitis infection rates in illicit drug users are high, particularly among IDUs. Incarcerated populations have higher rates of hepatitis infections as well.

The IOM articulated the potential benefits of HBV and HCV screening and treatment. A "National HCV Screening and Care Program" could prevent 87,000 cases of end-stage liver disease, result in 840,000 undiscounted life-years gained, cost $43,000 per quality adjusted life-years (QALYs), and offer new therapies to increase effectiveness and benefits. A "National HBV Screening and Care Program" could prevent ~140,000 cases of end-stage liver disease, result in 3.3 million undiscounted life-years gained, and cost an estimate of $8,000-$67,000 per QALY gained.

The IOM targeted recommendations on viral hepatitis services to a number of important populations, including the general population to raise knowledge and awareness, foreign-born persons (*i.e.*, Asian Americans and recent immigrants from Africa), pregnant women to prevent mother-to-child transmission, incarcerated persons, illicit drug users, and settings serving high-risk populations.

The IOM identified five core components of comprehensive viral hepatitis services: community outreach and awareness, vaccination and harm reduction, identification of infected persons, social and peer support, and medical management. The IOM advised CDC and HRSA to provide resources and guidance to integrate viral hepatitis services into settings that serve high-risk populations. The IOM further recommended that CMS make HBV and HCV risk factor screening a required core component of preventive care in Medicare and Medicaid services.

In response to the IOM recommendation targeted to CDC and HRSA, the two agencies are piloting an HCV disparities project to stimulate discussion among front-line CHCs and state primary care associations and also to address health disparities in the identification, care and treatment of HCV among African Americans in Federally Qualified Health Centers. Training was provided for this effort with workshops in 2008 and 2009 and the development of a training module for CHC approaches to HCV.

Funding of ~$105,000 was awarded to three states to pilot HCV testing initiatives. The eight South Carolina CHCs are offering HCV therapy and hepatitis A/B vaccine. Preliminary data from the South Carolina sites show that 45 (or 32%) HIV patients were positive for HCV infection. The Maryland and New Jersey sites are in the planning stages of the HCV disparities project.

Dr. Ward described four major activities that are underway to further implement the IOM recommendations on hepatitis. First, CDC is focusing its strategic planning process on four priority areas: identify persons with viral hepatitis early and refer these individuals to care; improve monitoring of viral hepatitis; commit the nation to the elimination of HBV transmission; and develop, test and translate into action new HCV prevention tools. CDC's strategic planning process will depend on resources and will be implemented in a phased approach.

Second, CDC, the CDC Foundation and six founding corporations established a public-private partnership in January 2010 to establish the Viral Hepatitis Coalition. This effort will build capacity to conduct CDC's priority projects, such as an observational study of persons in care

for viral hepatitis, evaluation of new strategies for HCV screening, and viral hepatitis education for minority communities.

Third, Assistant Secretary for Health, Dr. Howard Koh, convened an HHS Viral Hepatitis Workgroup in January 2010 to respond to the IOM call for national coordination. CDC, HRSA, NIH and HHS's other major operating divisions will develop an HHS Viral Hepatitis Strategic Plan with the following objectives: increase knowledge and awareness, improve surveillance, prevent bloodborne transmission, eliminate HBV transmission, and expand access to screening and care. The workgroup will form subcommittees to develop specific components of the strategic plan. HHS expects to release the strategic plan by September 2010.

Fourth, the Trust for America's Health is developing a policy brief to serve as a blueprint to implement two of the IOM recommendations: prepare the nation for an era of more effective therapy for viral hepatitis and eliminate mother-to-child transmission of HBV. Congressional briefings and meetings with a diverse group of stakeholders have been held on the policy brief. The Trust for America's Health expects to release the policy brief by August 2010.

Dr. Ward concluded that the IOM report serves as a national call to action to increase awareness of the burden of disease from viral hepatitis. The IOM report also presents new recommendations for hepatitis prevention and care, offers opportunities to build capacity, and raises expectation for a federal response.

In response to CHAC's question, Dr. Fenton confirmed that CDC would approach its federal partners and external experts to investigate whether raising the volume of HBV vaccine through increased testing would encourage manufacturers to negotiate or lower the price. At the next meeting, Dr. Fenton would inform CHAC of potential opportunities to reduce the price of HBV vaccine.

A motion was properly placed on the floor and seconded by Mr. Hopkins and Rev. Hickman, respectively, for CHAC to formally recommend that CDC explore the feasibility of developing guidelines for routine HBV screening and enhanced HCV screening.

CHAC extensively discussed several issues before voting on the motion, such as continued transmission (*i.e.*, 60,000 new HBV and HCV infections that occur each year), targeted versus routine testing, and the practical implications of HBV and HCV screening in CHCs. **CHAC voted to table the motion** until the business session to allow Dr. del Rio to craft the language in writing.

In addition to its extensive discussion on the motion, CHAC also made two suggestions on the National Strategy for HBV and HCV Prevention and Control. First, HRSA should administer a survey to determine whether CHCs are conducting routine hepatitis testing. HRSA should compile and distribute best practices and lessons learned in routine hepatitis testing in CHCs.

Second, CDC should make stronger efforts to meet its obligation as a public health agency in informing the provider community and the general public about the risk for hepatitis. For

example, CDC should partner with the media to launch a national campaign to raise awareness of hepatitis and place "hepatitis checklists" in men's and women's health magazines.

Panel Presentation: New Developments in Domestic HIV Prevention Programs

A panel of DHAP leadership presented two updates on new developments in domestic HIV prevention programs. The presentations are outlined below.

***Syringe Services Programs*.** Dr. Mermin presented the update on behalf of Dr. Amy Lansky, Deputy Director of the Surveillance, Epidemiology and Laboratory Science Branch in DHAP, who was unable to attend the meeting. He reported that the relative importance of risk factors for HCV infection, particularly IDU and sexual contact, greatly increased over the last 20 years.

Of HIV/AIDS cases diagnosed in 2007 among male adults and adolescents in 34 states with confidential name-based HIV infection surveillance, 71% were attributed to male-to-male sexual contact, 10% were attributed to IDU, ~14% were attributed to high-risk heterosexual contact, and 4% were attributed to combined male-to-male sexual contact/IDU. Of HIV/AIDS cases diagnosed in 2007 among female adults and adolescents, 83% were attributed to high-risk heterosexual contact and 16% were attributed to IDU.

The 2008 Hall study showed an 80% reduction in new HIV infections among IDUs from 1997-2006. This tremendous decrease was attributed, in part, to needle exchange programs and community outreach activities. The April 2009 *MMWR* article reported data from CDC's National HIV Behavioral Surveillance System on drug risk behaviors among IDUs over the past 12 months from the period of May 2005 to February 2006. The data showed that the prevalence of shared syringes was 33%, while the prevalence of shared equipment was 58%.

CDC acknowledges that the terminology and multiple names for syringe exchange services are confusing, such as syringe exchange programs (SEPs), needle exchange programs, needle and syringe programs, syringe access programs, and syringe services programs. CDC traditionally used the term "SEPs" to clearly define the purpose of these programs as exchanging sterile needles and syringes for used needles and syringes. The goal of SEPs is to reduce the spread of HIV, HBV, HCV and other bloodborne infections by providing IDUs with new and sterile syringes for each injection.

The operation of SEPs varies with an average of six exchanges per site. Fixed SEP sites include storefronts, clinics, health centers, shooting galleries and private homes, while mobile SEP sites include health vans, cars and outreach workers on foot. In addition to exchanging syringes, SEPs also provide other services, such as the provision of condoms, alcohol pads and bleach, onsite HIV counseling and testing, STD screening, HBV and HCV testing, hepatitis A/B vaccination, TB screening, risk reduction counseling services, referrals to drug treatment facilities, and onsite medical care.

Congressional language and federal funding for SEPs have changed over time. In 1988-1997, federal funds could be allocated only on the condition that SEPs were shown to be effective. In 1998, Congress placed an absolute prohibition on SEPs and did not permit federal funds to be used for these programs. However, the second part of this Congressional language called for conditional use of funds. In 1999-2009, Congress re-instituted the absolute prohibition of federal funds for SEPs.

In December 2009, the President signed the Consolidated Appropriations Act of 2010 that modified the prohibition on the use of federal funds for SEPs. The revised provision lifted the ban on the use of federal funds for SEPs for many HHS programs. However, authorizations for some HHS programs, such as the Ryan White HIV/AIDS Program, still contain partial or complete bans on the use of federal funds for SEPs. The modified provision prohibits the use of funds for SEPs in any location that local public health or law enforcement agencies determine to be inappropriate

A 2007 *MMWR* article reported that the number of U.S. SEP operations increased from ~60 in 1994 to ~180 in 2006. Several published studies from 1997-2009 reported data on intervention costs per HIV infection averted. Most notably, the 2006 Schackman study concluded that the lifetime cost of HIV medical care was $356,000. The proposed benefits of SEPs include reductions in HIV transmission and injection risk behaviors, removal of contaminated syringes from circulation, increased capacity to reach hard-to-reach IDUs, and the establishment of linkages between clients and health and social services.

A number of studies were conducted to determine whether syringe exchange is an effective prevention strategy. This research includes a meta-analysis by the CDC Prevention Research Synthesis Team of U.S. government or commissioned reports and peer-reviewed systematic review articles in the United States as well as the March 2010 Palmateer, *et al.* study which reviewed international studies.

The CDC meta-analysis found “good” evidence in the ability of SEPs to reduce injection risk behavior; “weak” to “modest” evidence in the ability of SEPs to reduce HIV incidence or prevalence; and “limited” to “inconclusive” evidence in the ability of SEPs to reduce HCV incidence or prevalence. Similarly, the Palmateer study found “substantial” evidence in the ability of SEPs to reduce injection risk behavior; “tentative” evidence in the ability of SEPs to reduce HIV incidence or prevalence; and “insufficient” evidence in the ability of SEPs to reduce HCV incidence or prevalence.

Several activities are underway at the federal level to expand SEPs as more comprehensive syringe services programs (SSPs). Guiding principles are being adhered to that CDC developed in conjunction with HHS and SAMHSA. CDC is targeting comprehensive HIV prevention services to IDUs that include SEPs and additional activities. CDC is designing programs to offer multiple prevention services.

HHS is developing technical guidance to assist grantees in properly using HIV prevention funds for SSPs. The HHS guidance also will be used to help federal agencies in identifying SSP best

practices. CDC plans to develop program guidance in the future to provide detailed information on SSP implementation and monitoring/evaluation. CDC also will convene a consultation with experts to obtain input, continue to educate staff, update SEP evaluation data, and develop an SSP-related research agenda.

***Male Circumcision Recommendations*.** Dr. Christine Mattson is an epidemiologist in the Behavioral and Clinical Surveillance Branch in DHAP and a CDC Male Circumcision Workgroup member. She presented recent data on the role of male circumcision (MC) in preventing HIV infection in the United States and the workgroup's progress to date in developing CDC's MC guidelines.

The potential for MC to reduce the risk for HIV and protect men against HIV infection is biologically plausible. The inner surface of the foreskin of the penis is relatively susceptible to HIV infection. Compared to other parts of the penis, the inner surface has less keratin and is thinner. Moreover, laboratory studies have demonstrated that the inner surface has a higher proportion of Langerhans cells that are more susceptible to HIV infection. The sac between the foreskin and glans of the penis creates a moist environment where viruses can survive. The foreskin may have greater susceptibility to traumatic epithelial disruptions or tears during intercourse and could provide a portal of entry for HIV and other pathogens.

Due to the biologic plausibility of MC reducing the risk for HIV along with an association between MC and HIV acquisition identified in >40 observational studies, three randomized, controlled clinical trials (RCTs) of the procedure were conducted in South Africa, Kenya and Uganda with 11,304 men. In each study, men were randomly assigned to either immediate circumcision or were waitlisted to delayed circumcision at the conclusion of the study. However, all three trials were stopped early when interim analyses showed highly statistically significant reductions in HIV risk among circumcised men.

The efficacy-intent to treat analysis (or the percent reduction in HIV incidence) ranged from 51%-60% across in the three sites. The efficacy-per protocol analysis accounted for men who crossed over to the other treatment arm and ranged from 55%-76% across the three sites. The study demonstrated 60% efficacy in HIV prevention from a relatively safe and one-time surgical procedure. This finding was a landmark accomplishment in the history of HIV prevention research. The 2008 Bailey study showed that the efficacy of MC was sustained at the Kenya site at the 42-month follow-up with a 64% reduction in HIV incidence.

In addition to HIV infection, MC also has been found to be protective against other STDs and adverse health outcomes. Significant decreases in HPV and HSV-2 were observed among circumcised men in two of two RCTs. Non-ulcerative STDs in men were reported by two of three RCTs. The prevalence of trichomonas in men was lower in one of two RCT and was significantly lower among female partners in a third RCT.

The RCTs did not demonstrate any significant benefits from MC on chlamydia, syphilis or gonorrhea infection. Observational data also have shown lower rates of urinary tract infections in circumcised infants and lower rates of penile cancer and chanchroid among circumcised

males. The female partners of circumcised men have been found to be at lower risk for cervical cancer.

After the publication of the RCTs in Africa, UNAIDS and WHO released MC recommendations in March 2007. The agencies concluded that MC should be recognized as an efficacious intervention for HIV prevention and also should be considered as an additional approach to be used in comprehensive HIV prevention strategies for men in areas where HIV prevalence is high and circumcision is not commonly practiced. The recommendations were accompanied by a number of other considerations, including the partial efficacy of MC, ethical concerns, and the need for careful communication and sensitivity to the cultural context.

Key differences between the epidemiologic context in the United States and the RCTs in sub-Saharan Africa must be considered in the UNAIDS/WHO recommendations. The prevalence of HIV infection in the RCT countries ranges from 5%-18%, while the prevalence in the United States is 0.45%. The HIV epidemic is generalized in the RCT countries with most transmission occurring through heterosexual sex, while male-to-male sex accounts for 50% of overall cases in the United States. The prevalence of MC in the RCT countries ranges from 10%-25%, while the prevalence ranges from 70%-80% in the United States.

CDC used data from the 2008 Hall, *et al.* study to estimate that 73% of 56,300 new HIV infections in 2006 were among men and 27% were among women. Male-to-male sexual contact accounted for 72% of new infections among men, while heterosexual contact accounted for only 13% of new infections. The study showed that the potential impact of MC in the United States is only concentrated in 13% of male cases overall.

The distribution of transmission routes varies across different racial/ethnic groups. Data were collected on 54,230 males and females to estimate the percentage of new HIV infections by race/ethnicity, sex and transmission category in the United States in 2006. Among males, the data showed that heterosexual sex accounted for 20% (or 3,290) of infections among AAs, 13% (or 970), among Hispanics, and 6% (or 990) among whites.

RCTs on MC have been devoted to men in populations with predominantly heterosexual HIV transmission. No prospective RCTs have been conducted to date among MSM. Observational studies in MSM populations have shown mixed results. The 2008 Millett meta-analysis of 15 published and unpublished studies showed no benefit overall and found that the odds of becoming HIV infected if circumcised were close to one.

The 2009 Gust, *et al.* study showed no benefit of MC among MSM who practiced unprotected insertive anal intercourse with an HIV-positive partner. The potential for circumcision benefiting the MSM partner engaging in insertive sex is biologically plausible, but this effect has not been convincingly demonstrated. The high HIV risk to the MSM partner engaging in receptive sex and the versatility of many MSM in practicing both insertive and receptive anal intercourse most likely would dilute any potential benefit.

Most adult men in the United States are circumcised. The 2007 Xu study used National Health and Nutrition Examination Survey data of 6,174 men interviewed from 1999-2004. The study reported an overall prevalence of MC of 79%. However, the prevalence was substantially different across racial/ethnic groups with MC reported by 88% of white men, 73% of AA men, and 42% of Mexican-American men.

National Hospital Discharge Survey data showed a slight decline in the rate of infant MC performed in hospitals from 65% in 1980 to 56% in 2005. Several studies have been conducted that demonstrated an association between the lack of Medicaid payment and the decrease in the infant MC rate. Important issues must be considered with infant MC, particularly the role of the procedure in complications and adverse events.

The 2010 Weiss, *et al.* study reviewed 16 prospective studies that evaluated complications following neonatal and infant MC. Most of the studies reported no severe adverse events, but two studies reported severe adverse events in 2% of procedures. The median frequency of any complication was 1.5% with a range of 0%-16%. Bleeding was the most frequently reported complication. Child MC was associated with more complications compared to infant or neonate MC.

The 2010 Samson, *et al.* study analyzed the cost-effectiveness of newborn MC in reducing the lifetime risk for HIV among males in the United States. The study modeled the impact of newborn MC on the lifetime risk for HIV from heterosexual contact and found that MC reduced the 1.9% lifetime risk for HIV by ~16%.

By race/ethnicity, the lifetime risk for HIV was reduced by 15.7% overall, 20.9% for AA males, 12.3% for Hispanic males, and 7.9% for white males. The number of circumcisions needed to prevent one HIV infection was 298 for all males and ranged from 65 for AA males to 1,231 for white males. The study determined that newborn MC was a cost-saving HIV prevention intervention overall as well as for AA and Hispanic males. The net cost of MC per QALY saved was $87,792 for white males.

In addition to infants, the safety and cost of adult MC must be considered as well. MC is much simpler and safer in infants than in adults. Pain, bleeding and mild infections are the most common adverse events, but the rates of these complications are higher in adults. Moreover, the cost of MC increases ten-fold from ~$200-$400 in infants to ~$2,000-$4,000 in adults.

Another important issue related to adult MC after men become sexually active is behavioral risk compensation or a potential increase in risk behaviors based on the belief of complete protection from HIV infection. Although men have reported that adult MC caused changes in sexual sensation or function, the majority of men in most studies reported either improved sexual function or no change following MC. Moreover, concerns have been raised over the ethics of parental consent for neonatal MC because most benefits of this elective and preventive procedure will be gained only in adulthood.

Dr. Mattson reported the progress to date in developing CDC's MC recommendations. CDC undertook this effort based on key epidemiologic differences between the HIV epidemic in sub-Saharan Africa and the United States and the complex issues of MC. CDC's initial step in developing the MC recommendations was to convene a consultation in April 2007 with a diverse group of stakeholders, including federal partners, state and local health departments, public health practitioners, professional organizations, clinicians and other subject matter experts, academia, community representatives, and religious leaders. The purpose of the consultation was to review the current MC data, identify potential gaps in this area, and establish research priorities. After the consultation, CDC conducted a systematic review of the literature and commissioned a Public Health Ethics Committee Review.

The draft recommendations are undergoing the CDC clearance process at this time and will be distributed for a peer review mandated by the Office of Management and Budget as well additional external reviews by academic medical societies, federal partners and public health partners. The recommendations will be released for public comment, revised based on input submitted, forwarded to HHS for clearance, finalized, and published as an *MMWR Reports and Recommendations*. CDC will develop separate communication plans for various target audiences, including the general public, medical providers, CBOs and other stakeholders. CDC is continuing to administer acceptability surveys and monitor MC rates and MC-associated adverse events.

Dr. Mattson concluded that RCT data have demonstrated the capacity for MC to reduce the risk of female-to-male transmission of HIV and other STDs. However, the role of MC is limited in the United States due to the lower prevalence of HIV, lower risk of female-to-male transmission, and higher prevalence of MC. Scientific data have shown the health benefits associated with MC, but important issues must be considered, such as potential risks, costs, behavioral risk compensation, sexual pleasure and function, ethics, culture and religion.

The American Academy of Pediatrics (AAP) does not recommend MC at this time, but its guidelines are currently being reviewed. The AAP and CDC MC recommendations are expected to be released at approximately the same time.

CHAC fully supported CDC's new evidence-based interventions for HIV prevention, particularly the expansion from SEPs to more comprehensive SSPs. CHAC also commended local communities for their continued commitment to providing syringe exchange services. CHAC noted that despite the Congressional prohibition of using federal funds for SEPs from 1998-2009, innovative community activities and outreach played a major role in the 80% reduction of new HIV infections among IDUs.

The CHAC members made several comments and suggestions for CDC to consider in its ongoing efforts to expand SEPs to SSPs.

- CDC should engage pharmacists in SSPs to make syringes more widely accessible for the implementation of interventions at the local level. CDC also should partner with local law enforcement to ensure that communities have knowledge of state laws. For

example, some states and local jurisdictions enforce laws against the possession of syringes with or without an illegal substance or will prosecute providers who engage in syringe exchange.

- CDC should invite experts in New York State to the SSP consultation because these individuals have more than 15 years of experience in managing a network of SEPs.
- CDC should make a strong business case for syringe exchange by promoting the positive attributes and cost-savings of this intervention in preventing both HIV and HCV.
- CDC should take a holistic harm reduction approach to implementing SSPs, including behavioral counseling, drop-in services, behavioral health services, and interventions to reduce sexual transmission of HIV. Most notably, a study with a cohort in Baltimore showed that even among IDUs, sexual transmission of HIV was higher than needle transmission of HIV.
- CDC should make a significant investment in evaluating SSPs to determine the efficacy and impact of different components of these programs.

In response to CHAC's suggestion to include the reduction of sexual transmission of HIV as a major intervention in SSPs, Dr. Fenton announced that NCHHSTP is developing integrated recommendations at this time for HIV, STD and hepatitis prevention among drug users. NCHHSTP will publish the recommendations in the *MMWR* to encourage the field to consider these disease clusters more broadly. The recommendations will strongly emphasize prevention interventions for sexual transmission of these diseases.

Update on Expedited Partner Therapy (EPT)

Dr. Matthew Hogben is a behavioral scientist in the NCHHSTP Division of STD Prevention. He reported that the two goals of partner notification are to treat infection and disease and break the chains of transmission by reducing prevalence and treating two persons at one time. In a 2006 report, CDC defined "EPT" as the practice of treating sex partners of persons with STDs without requiring an intervening medical evaluation or professional prevention counseling.

The three core elements of EPT include oral medication for a treatable STD, a point of origin to disburse medications or prescriptions, and a mechanism to provide prescriptions or medications to sex partners of infected persons, such as public health staff, DISs, public health nurses or patients.

In the "basic" referral strategy, patients notify partners of exposure with varying levels of provider encouragement. In the "EPT" strategy, patients deliver a prescription or medication to partners along with instructions. The 2007 Trelle, *et al.* meta-analysis of five studies conducted in 1993-2005 showed that persistent or recurrent infections decreased with patient-delivered partner therapy (PDPT). The same meta-analysis of four studies conducted in 2001-2005 showed that PDPT also decreased the number of partners treated.

The 2006 CDC report provided clinical guidance on gonorrhea and chlamydial infections among heterosexual males and females along with written instructions on proper medication usage, an assessment of allergies, and situations to seek an evaluation from healthcare providers. The guidance recommended more caution with PDPT among MSM due to less data and more HIV co-morbidity in this population. The guidance recommended even greater caution with PDPT for syphilis and trichomoniasis and described this intervention as a "last resort" for these two infections.

CDC published the following recommendations in the *MMWR* in 2008 for partner services programs for HIV infection, syphilis, gonorrhea and chlamydial infections. Program managers should ensure that partners are treated according to CDC treatment guidelines as soon as possible after notification. Programs should consider field-delivered therapy for gonorrhea and chlamydial infections when partners are notified via provider referral.

Programs should consider PDPT for partners who will not be notified via provider referral for gonorrhea, chlamydial infection and other STDs in which single-dose oral therapy would be feasible. Programs should ensure that all appropriate parties are consulted to assure any EPT strategy in the jurisdiction is medically and legally sound.

The 2007 Aral, *et al.* study provided a basic framework to demonstrate the impact of EPT on prevention. The efficacy or effectiveness of the actual intervention in target groups, multiplied by the contribution of groups to population health outcomes, multiplied by an effective level of coverage would equal the prevention impact.

CDC applied research findings and STD program data to the framework to determine the capacity of EPT in achieving prevention impact. The efficacy of the intervention was defined as a high treatment rate with a 20%-100% increase and a low reinfection rate with a 20%-50% decrease. The contribution of groups to population health outcomes was defined as partners having high positivity of 20%-75%. Availability and uptake were identified as two elements that would be key to effective implementation of EPT.

The 1998 Kissinger observational cohort study gathered data from discussions between 178 females 14-39 years of age and their family planning physicians. The discussions focused on the effectiveness of PDPT in preventing recurrent *Chlamydia trachomatis*. The two arms of the study included 43 females in the PDPT group and 135 females in the partner referral group. After adjusting for age, the study showed that females in the PDPT group were less likely than those in the partner referral group to have an incidence of *Chlamydia trachomatis*.

CDC awarded a contract to Johns Hopkins University and Georgetown University to conduct an in-depth review of legal issues associated with EPT (*i.e.*, rules for prescribing and dispensing medication and the meaning of an "established provider-patient relationship"). The review covered all 50 states, several territories and other jurisdictions.

The review resulted in the development of a spreadsheet that described the facilitators and barriers to laws, regulations, policy statements, attorney general statements, judicial rulings and

administrative opinions. Hodge, *et al.* also used these data to publish the "*Expedited Partner Therapy for Sexually Transmitted Diseases: Assessing the Legal Environment*" Study in 2008.

The study noted CDC's overall recommendation for EPT nationally in limited circumstances and also outlined four specific recommendations: expressly endorsing EPT through laws; creating exceptions to existing prescription requirements; increasing professional board or association support for EPT; and supporting third-party payments for medications to partners.

At this time, EPT is permissible in 24 states, potentially allowable in 18 states, and prohibited in eight states. The spreadsheet, EPT resources from states, and other EPT-related materials are available on the CDC website at www.cdc.gov/std/ept. The website contains a disclaimer to clarify that CDC is neither dispensing legal advice nor providing a comprehensive analysis of all legal provisions with potential implications on the legality of EPT in a given jurisdiction.

CDC evaluated program data to determine EPT coverage or uptake. STD clinics in Baltimore dispensed gonorrhea and chlamydia medications with a maximum of three extra doses. Based on data as of January 2009, the uptake of EPT in the Baltimore STD clinics was 68% (or 1,046 of 1,533 patients who accepted the offer of extra doses). The modal extra doses were one among women and two among men.

No adverse events from EPT were reported by the Baltimore STD clinics based on an active assessment and passive reporting from other providers. Overall, the Baltimore study showed a 41% reduction in the rate of repeat gonorrhea and chlamydia infections (3.9% in 2007 without EPT compared to 2.3% in 2008 with EPT).

The 2008 Yu, *et al.* presentation at the STD Prevention Conference used California data to identify an appropriate denominator for EPT coverage or uptake and determine the association between treatment outcomes and management strategies by type of relationship. The data showed that among 551 partners in a "steady" relationship, EPT uptake was 89% with the "bring your own partner" (BYOP) strategy, 83% with PDPT, 60% with patient referral, and 44% with no strategy. Among 404 partners in a "non-steady" relationship, EPT uptake was 38% with BYOP, 57% with PDPT, 17% with patient referral, and 5% with no strategy.

Dr. Hogben described CDC's next steps to advance its EPT activities. The CDC Office of Policy, Planning and External Relations will convene a consultation on May 13, 2010 with program staff and legal experts to discuss additional legal barriers to implementation of EPT. The consultation will result in the development of a toolkit based on a needs assessment to provide states with clear guidance on EPT legal provisions and subsequent policies.

Best practices for implementation of EPT will be compiled and distributed to programs. CMS and other federal agencies will be engaged in CDC's EPT activities to leverage support for a new "National *Chlamydia trachomatis* Coalition. Opportunities will be explored for USPSTF to conduct a review of EPT in the context of STD prevention.

CHAC made two key suggestions for CDC to consider in its ongoing efforts to build on previous successes and address remaining challenges in EPT. First, CDC should conduct studies to demonstrate the efficacy and effectiveness of EPT among MSM due to increased concern regarding asymptomatic pharyngeal and rectal gonorrhea and chlamydia in this population.

Second, CDC should gather data from research studies or actual experiences in the field on the uptake of EPT services by partners. STD clinics should use these data to educate partners on the need to be tested for HIV and syphilis in addition to gonorrhea and chlamydia. For example, CDC could provide STD clinics with a standard script on testing and other services for other STDs that patients would give to their partners. To strengthen the evaluation of the uptake of EPT services among partners, CDC could offer incentives to partners to report follow-up testing to STD clinics in 30 days.

Update by the Future of Healthcare Reform and Possible Impacts on HIV Services Workgroup

Ms. Dana Kuhn, of the New York State Department of Health, is the coordinator of the workgroup that is co-chaired by two CHAC members: Dr. Bruce Agins and Ms. Antigone Hodgins Dempsey. Following the November 2009 meeting, the workgroup agreed to change its name from the "CHAC Workgroup on HIV Care, Treatment and Prevention in the New Millennia" to the "Future of Healthcare Reform and Possible Impacts on HIV Services Workgroup."

The workgroup was established during the May 2009 CHAC meeting to assess trends in healthcare reform and evaluate care and prevention models, particularly the patient-centered medical home (PCMH) model. The workgroup was charged with gaining a better understanding of the direction of healthcare reform and determining if its trajectory would align with and support the current HIV model of care and prevention. The workgroup also was charged with developing a formal statement that would initially reflect its priorities, but subsequently would be translated into "Principles and Recommendations."

The workgroup's initial step in fulfilling its charge was to thoroughly review the literature. Major findings of the workgroup's literature review are summarized as follows. The major driver of health reform is the PCMH model and its key components: a personal physician to provide continuous and comprehensive care; physician-directed medical practice; whole-person orientation; coordinated and integrated care; quality and safety; enhanced access; and payment reflecting the added value of the PCMH model.

At the federal level, the Patient Protection and Affordable Care Act provided an option for states to enroll Medicaid beneficiaries with chronic conditions into a medical home. The legislation also established a CMS "Center for Medicare and Medicaid Innovation" to develop, test and fund pilot projects.

At the non-governmental level, the National Committee for Quality Assurance (NCQA) created nine standards and ten "must-pass" elements. Depending on the number of points earned, NCQA will recognize a program as a PCMH in one of three tiers. The most reimbursement is given to programs at the highest recognition level, while the least reimbursement is given to programs at the lowest recognition level.

To achieve PCMH recognition, the content of programs must receive sufficient scores in nine NCQA standards: access and communication, patient tracking and registry functions, care management, patient self-management support, electronic prescribing, test tracking, referral tracking, performance reporting and improvement, and advance electronic communications. However, NCQA is currently updating its PCMH standards.

Following its initial literature search, the workgroup evaluated peer-reviewed studies on the PCMH model and administered a survey to CHAC. The survey showed that CHAC identified HIV specialty care, mental health services and prevention as the top three priorities for inclusion in PCMHs. The remaining seven issues that CHAC identified as priorities for inclusion in PCMHs in order of most to least importance were patient-centered care, comprehensive care, case management, social services (excluding specific mental health or substance abuse), substance use, treatment, and cultural sensitivity.

During this time, the workgroup also coordinated and held eight webinars with direct service providers and experts at national, federal and state levels on the following topics:

- Healthcare reform and HIV.
- The ability of PCMHs model to transform healthcare.
- Opportunities for the Ryan White HIV/AIDS Program in healthcare reform and HIV care.
- Medical homes and systems of care.
- Health centers as medical homes.
- The Massachusetts experience in healthcare reform.
- The medical home model in New York State Medicaid Programs.
- The case for PCMHs and community networks in building a sustainable medical home.
- The medical home model at the PACE Clinic.
- The integration of mental health and substance use into PCMHs.
- Open-door family medical centers and the PCMH model.

Ms. Kuhn explained that the workgroup conducted two major activities since the previous meeting. First, CHAC unanimously approved a motion during the November 2009 meeting for the workgroup to draft core principles related to HIV care and service delivery that should be recommended as part of the health reform legislative agenda. Second, the workgroup drafted recommendations for CHAC's discussion, review and official adoption during the current meeting. The workgroup's proposed core principles and recommendations are outlined below.

Proposed Core Principles:

1. The PCMH model should be supported. The PCMH model offers an integral advantage to health care, embraces patient-centered primary care, and integrates the key concepts of primary care (*i.e.*, quality, safety and HIT).

2. Ryan White HIV/AIDS Programs should be recognized as comprehensive systems of care because these programs have embraced the majority of PCMH components for many years. Ryan White Programs incorporate the basic elements and principles of the PCMH model while encompassing the components of chronic HIV care. The ability of Ryan White Programs to integrate HIV specialty care into a primary care framework represents a unique blending of measurements and comprehensive preventive care.

3. Access to HIV specialty expertise within PCMHs should be supported through either direct provision of services or referral. PCMHs that provide comprehensive services should offer access to healthcare providers with experience in antiretroviral management and treatment as well as co-morbid conditions associated with HIV.

4. HIV providers and other specialists should be recognized as PCMHs. The healthcare reform legislation does not identify specialists who offer primary care services as providers who can qualify as PCMHs. HIV clinical programs that provide comprehensive care should qualify as PCMHs.

5. The integration of behavioral health services, team-based care, case management and the role of pharmacists into PCMHs should be supported. Ryan White Programs should strengthen their focus on substance abuse and mental health services and characterize these issues as essential elements of care. PCMH regulations should recognize the important role of primary care practice teams as providers of comprehensive and coordinated care. The practice teams should be rewarded and their requirements should be explicitly outlined in NCQA scoring criteria.

6. Increased emphasis on prevention services and cultural competency should be supported. NCQA scoring criteria do not address prevention at this time. Prevention criteria should include behavioral health and harm reduction strategies. PCMHs should address cultural competency in assessment criteria, health literacy, translation and interpretation of materials to reduce stigma in infected populations.

7. The integration of HIT into Ryan White Programs should be supported in accordance with the PCMH model.

<u>Proposed Recommendations</u>:

1. CDC and HRSA should convene a formal consultation with an expert panel to explore strategies to implement the PCMH recommendations, particularly the integration of the PCMH model into Ryan White Programs. The workgroup should continue to serve as an external advisor to CDC and HRSA on implementing the PCMH model to further improve the quality of care for PLWHA.

2. CDC and HRSA should partner with organizations that play a key role in implementing the PCMH model (*i.e.*, NCQA and the Patient-Centered Primary Care Collaborative) to ensure that the needs of the HIV community are included in these discussions. The HIV community should be extensively engaged in reviewing and providing input on the draft NCQA standards before these criteria are finalized. CDC/NCHHSTP and HRSA/HAB should serve on the oversight board and subcommittees of the Patient-Centered Primary Care Collaborative to ensure that important HIV issues are included on the agenda.

3. HRSA should fund pilot projects of the PCMH model in HIV settings; evaluate these projects; and compile and disseminate best practices to guide the development of HIV medical homes in the future. Guidance language should be added to SPNS Initiatives for grantees to conduct and evaluate specific components of the PCMH model, such as behavioral health, primary care and practice integration.

4. CDC should increase its focus on STDs and prevention by developing guidance for PCMHs to address the prevention of STDs, HIV testing and HIV treatment.

5. HRSA should encourage the use of HIT and use HIT funds to provide incentives to Ryan White grantees for adoption of HIT. HRSA should align these efforts with other federal initiatives, particularly those conducted by its Office of Health Information Technology.

6. CDC and HRSA should support education to raise awareness in the HIV community about the programmatic and administrative components of the PCMH model as well as its implementation.

7. HRSA should incorporate PCMH standards into program guidance documents for Ryan White grantees. These standards should include education to providers about the PCMH model and strategies to integrate the model into the Ryan White continuum of care.

8. CDC and HRSA should communicate CHAC's PCMH principles and recommendations to ONAP for inclusion in the NHAS.

9. CDC and HRSA should continue to address shortages in the primary care workforce, particularly HIV specialists. The workforce shortage should be a key consideration in developing policies to ensure that the PCMH model reaches its full potential.

CHAC applauded the workgroup for its outstanding efforts over the past year and expressed full support of the proposed core principles and recommendations. Data from initial studies have shown that the PCMH model has improved the quality and reduced the cost of primary care. CHAC also was pleased that the core principles and recommendations addressed HIT because this issue will play a critical role in both healthcare reform and the PCMH model.

CHAC unanimously approved all nine of the workgroup's proposed recommendations for immediate implementation by CDC and HRSA. CHAC asked the workgroup to include "access to oral health services" as an additional component in the PCMH model.

Public Comment Session

Mr. Carl Schmid is the Deputy Executive Director of The AIDS Institute (TAI). He reported that NASTAD data showed a 34% decline (or a decrease from $329 million to $215 million) in state contributions to ADAP in only one year. State funding for ADAP has been cut, but enrollment is steadily increasing due to job losses and the subsequent termination of health insurance.

The enrollment of clients in ADAP was unprecedented in FY2008 with an average of 1,554 new clients per month (or >18,000 new clients per year). Moreover, enhanced testing initiatives are identifying more HIV cases, persons are living longer, and 56,000 new HIV infections continue to occur annually. ADAP budget cuts have required states to institute waiting lists, decrease the number of drugs on formularies, and reduce eligibility and capped enrollment. At this time, 1,001 persons in 11 states are on ADAP waiting lists.

At the federal level, ADAP was increased by only $20 million in FY2010 and the President's budget request calls for the same increase in FY2011. Federal funding for ADAP decreased from 69% in 2000 to 49% at the present time. However, drug company rebates now account for 31% of the ADAP budget with an increase of $171 million (or 52%) in FY2009 alone for a total of nearly $500 million.

To address the funding crisis, TAI requests an increase to the ADAP budget of $370.1 million in FY2011. Of this increase, TAI requests $126 million in FY2010 as part of emergency supplemental funding. Because healthcare reform will not result in expanded coverage until 2014, an immediate response is needed to address the current crisis. TAI also requests CHAC's support of emergency federal funding to assist PLWHA in accessing their medications.

Dr. Fenton read a statement by **Dr. Lisa Gilbert**, Vice President of Health Communications for the American Social Health Association (ASHA), that was submitted in the public record. The national freeze on base STD program funding has been in existence for over ten years. The steady erosion in base funding for core STD program activities has not allowed the nation to maintain a stable and well-funded state and local public health infrastructure to achieve successful prevention and control of STDs. In terms of treatment, the number of persons seeking services from STD clinics has increased, while the ability of states to provide these services has decreased.

After CDC awarded funding to ASHA in FY2007 to establish baseline knowledge of state STD prevention funding, ASHA collected data from directors of state STD, immunization, laboratory and hepatitis programs. Dr. Gilbert's statement highlighted key findings from the FY2007 study. The full report along with interactive comparisons are available at www.ashastd.org.

ASHA updated the FY2007 STD prevention funding study in FY2009 and again collected data on funding from state general revenues, expenditures and policies from directors of state STD, immunization, laboratory and hepatitis programs. In the FY2009 study, however, ASHA also gathered data from other sources on federal contributions, public health funding, population characteristics and surveillance rates. ASHA is continuing to collect and analyze the FY2009 data and contact state directors who have not yet responded to the survey.

Preliminary findings of the FY2009 study are highlighted as follows. The response rate among STD directors in the FY2009 study was 90% (or 46 of 51 STD directors). Of these respondents, five state STD directors needed additional analyses of their data and seven received $0 from their state general revenue budgets.

The average amount of general revenues for STD prevention decreased by 24% ($904,437 across 39 states in FY2007 to $683,621 across 41 states in FY2009. At the next CHAC meeting, ASHA offered to present the complete FY2009 report along with comparisons to the FY2007 data.

Ms. Lyndsay Patty, of the Office of the Inspector General (OIG), Office of Evaluation and Inspections, reported that OIG has been tasked with studying the implementation of CDC's 2006 HIV testing recommendations in HRSA-funded health centers. She requested CHAC's expertise in two areas to assist OIG in fulfilling its charge.

First, given the differences between the CDC and USPSTF recommendations on HIV testing and the important role of USPSTF in healthcare reform, should implementation of the USPSTF guidelines in health centers also be explored? Second, should OIG expand its charge to also study the implementation of HIV treatment guidelines? During his presentation on the previous day, Dr. Frieden emphasized the need to always integrate and never separate HIV testing and linkage to care.

Dr. Sweet confirmed that CHAC would consider, discuss and respond to the two questions Ms. Patty posed at some point after the meeting.

CHAC Business Session

Dr. Sweet entertained a motion for CHAC to approve the previous meeting minutes. A motion was properly placed on the floor and seconded by Rev. Hickman and Dr. Agins, respectively, for CHAC to adopt the previous meeting minutes. CHAC **unanimously approved** the "Draft November 2-3, 2009 Meeting Minutes" with no changes or further discussion.

Dr. Sweet announced that CHAC addressed the vast majority of its nine formal motions and actions items raised during the November 2009 meeting, but clarification is needed on one of the motions CHAC unanimously approved. CHAC advised CDC, HRSA and SAMHSA to jointly

convene a "Policy Academy" (*i.e.*, regional meetings) to provide clients with comprehensive HIV/ STD, mental health and substance abuse prevention and management services at CDC-, HRSA- and SAMHSA-funded sites. CDC and HRSA would contact Ms. Beverly Watts-Davis, the *ex-officio* member to SAMHSA, to obtain clarification on this recommendation.

Dr. Sweet led CHAC in a review of presentations, overviews or updates that were proposed as future agenda items.

Agenda Items:

1. **Recurring Agenda Item:** Update by CDC on the "Promotion of Sexual Health in the United States" Initiative.

2. **CDC:** Update on AAP's revised MC guidelines and the impact of the guidance in paying for MC in the United States. CDC will distribute AAP's revised MC guidelines to CHAC for review.

3. **CDC/HRSA:** Initial status report on implementation of the nine recommendations CHAC unanimously approved by the Future of Healthcare Reform and Possible Impacts on HIV Services Workgroup.

4. **HRSA:** Update on changes in the healthcare reform legislation and their impact on HIV patients and treatment and care programs.

5. **CDC/NIH:** Overview of the limited capacity and weak infrastructure in the United States to test for antibiotic-resistant gonorrhea (CDC). Overview of funded research studies on antibiotic-resistant gonorrhea and other bacteria and the federal research agenda in this area (NIH).

6. **CDC:** Presentation on efficacy data from a vaginal microbicide study.

7. **CDC:** Update on the NHAS, including necessary resources at federal, state, local and community levels for successful implementation.

8. **Guest Presenters:** Overview of high-risk pooled insurance plans at the state level and their impact on PLWH.

9. **CDC:** Status report on over-the-counter home HIV tests.

10. **HRSA/Office of the National Coordinator:** Updates on the integration of HIT into the PCMH model that would be relevant to HIV grantees, allocation of ARRA dollars, and CMS's Meaningful Use activity.

11. **CDC:** Update on strategies to educate the medical community on the need to routinely offer HIV testing, even to females, older persons and other patients who appear to be at

"low risk." The update should result in CHAC making recommendations to eliminate barriers to wider implementation of CDC's HIV testing guidelines.

12. **CDC:** Update on efforts to harmonize the USPSTF and ACIP recommendations in three areas: routine HIV testing, HPV vaccination for men (particularly young MSM), and nucleic acid amplification testing for non-genitourinary sites.

Dr. Sweet led CHAC in a review of the agenda items for the May 2010 meeting that would need action by CHAC, CDC or HRSA.

Action Items:

1. CDC would approach its federal partners and external experts to investigate whether raising the volume of HBV vaccine through increased testing would encourage manufacturers to negotiate or lower the price. At the next meeting, Dr. Fenton would inform CHAC of potential opportunities to reduce the price of HBV vaccine.

2. CDC and HRSA staff will convene a conference call for CHAC to discuss the NHAS after the document is released. CHAC's development of a letter to ONAP on the NHAS will be a key discussion topic during the conference call.

3. Drs. Sweet and Mayer will draft a letter to share CHAC's concerns and express its outrage regarding the impact of the economic recession on state and local prevention, care and treatment programs. The letter will note that during the May 2010 CHAC meeting, NACCHO, NCSD and NASTAD presented emerging trends and data that are of grave concern and might adversely impact public health. The letter will be addressed to CDC and HRSA leadership (Drs. Frieden and Wakefield); the National Governor's Association; and various professional societies (*i.e.*, American Medical Association, American Nurses Association, American Public Health Association, American College of Physicians). Dr. Sweet will distribute the letter for CHAC's review and comment prior to distribution.

4. CDC and HRSA will make strong efforts to submit comments on the NCQA accreditation criteria supporting the inclusion of standards related to HIV and other infectious diseases in the PCMH model. **This action item is time sensitive.**

5. CDC and HRSA will explore the possibility of identifying staff to serve on the Patient-Centered Primary Care Collaborative to ensure screening and prevention of HIV and other infectious diseases are emphasized in these discussions. **This action item is time sensitive.**

Dr. Sweet opened the floor for the members to propose motions or reach agreement on issues that would require CHAC's formal action.

***ISSUE 1*:** On the previous day, Dr. Fenton asked CHAC to review the "NCHHSTP STD Disparities Public Health Ethics Resource Realignment Consultation" document that was

distributed and consider establishing a new workgroup to provide guidance to CDC on this effort. CDC is realigning these resources to better address its focus on four major benchmarks: strategic alignment, strategic partnership expansion, accountability, and community participation and engagement.

The document outlined the purpose and objectives of the consultation; the background and justification for CDC's annual investment of ~$2 million to support the Tuskegee University National Center for Bioethics in Research and Health Care; and five questions for the new workgroup to address during the consultation.

1. What actions can CDC take to realign the funds to effectively promote the health of disadvantaged communities (e.g., STD disparities, health disparities, public health ethics or a combination of these issues)?
2. What future opportunities can accelerate the impact on health disparities (e.g., direct service programs, policy or research)?
3. What key principles (e.g., program, policy and research) should be considered in the development of a new FOA for the use of realigned resources?
4. What should be the appropriate balance between research and program?
5. What institutions or entities should be eligible for the new FOA?

CHAC approved the establishment of the new workgroup with the following membership: Drs. Sweet and Mayer, Rev. Hickman and Mr. Hopkins. Ms. Hodgins Dempsey also expressed an interest in serving on the workgroup if CDC plans to address different and comprehensive system approaches.

Dr. Fenton explained that the workgroup's primary activities would be to review background materials provided by CDC in advance of attending the one-day consultation in Atlanta and provide CDC with advice and recommendations in response to the five questions.

***ISSUE 2*:** The following motion was properly placed on the floor and seconded by Drs. Mayer and Agins, respectively. CHAC recommends that CDC study the feasibility of developing guidelines for routine HBV screening in the general population in the clinical care setting and offering HBV vaccination to seronegative at-risk persons. **CHAC unanimously approved the motion.**

***ISSUE 3*:** The following motion was properly placed on the floor and seconded by Drs. Mayer and Agins, respectively. CHAC recommends that CDC review and revise its existing HCV screening guidelines to make the recommendations easier to implement in the clinical setting. CHAC further recommends that CDC and HRSA collaborate to integrate HCV services into other appropriate programs serving at-risk populations as recommended by the IOM. **CHAC unanimously approved the motion.**

***ISSUE 4*:** Rev. Hickman and Mr. Hopkins proposed that CHAC establish a new "Prevention with Positives (PWP) Workgroup" in the era of healthcare reform. The new workgroup would link its efforts to the PCMH model and consider the extensive PWP portfolios of both CDC and HRSA.

The new workgroup also would propose strategies to improve communications between providers and consumers.

The proposal was withdrawn and replaced with future activities and agenda items. Dr. Parham Hopson committed to including PWP as a key component in the scope of work that HAB is currently developing for its new "Improving HIV Outcomes Via Enhanced Provider Communication" Study. HAB will fund the study by the end of FY2010.

CHAC will devote a significant portion of the November 2010 meeting to PWP. This agenda item will cover the following areas.

- Dr. Gary Marks (CDC) and Ms. Faye Malitz (HRSA) will present data to illustrate current knowledge on PWP and barriers to implementing PWP strategies.
- CDC will present its revised PWP recommendations if the guidelines are available at that time.
- NIH will be invited to present findings from its PWP research portfolio and discuss its test and treat strategies.
- CHAC will craft formal PWP recommendations for submission to CDC and HRSA.

***ISSUE 5*:** A motion was properly placed on the floor and seconded by Dr. Mayer and Mr. Hopkins, respectively, for CHAC to formally support the request by The AIDS Institute to increase the ADAP budget ($370.1 million in FY2011 and $126 million of those funds in FY2010 for emergency supplemental funding). **CHAC unanimously approved the motion.**

Dr. Sweet will draft letter a letter to the CDC Director, HRSA Administrator and other key parties in the federal government to officially express CHAC's support of an increase to the ADAP budget in FY2011 and emergency supplemental funding to ADAP in FY1010. CHAC's letter to CDC and HRSA leadership will emphasize continued improvement of and appropriate dollars to ADAP through emergency supplemental funding. **This recommendation is time sensitive.**

Closing Session

Dr. Sweet closed the CHAC meeting by acknowledging several groups. The CHAC members were thanked for continuing to dedicate their time and expertise in providing CDC and HRSA with solid advice and guidance to improve HIV/STD prevention and treatment for patients in communities.

Drs. Fenton and Parham Hopson were thanked for continuing to provide outstanding leadership to CHAC. The CDC and HRSA staff were thanked for continuing to provide excellent service in planning and organizing the CHAC meetings. Members of the public were thanked for continuing to attend CHAC meetings and provide the membership with important perspectives from the field.

The next CHAC meeting will be held on November 15-16, 2010 in Washington, DC. With no further discussion or business brought before CHAC, Dr. Sweet adjourned the meeting at 2:25 p.m. on May 12, 2010.

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

_____ _____

Date

Edward W. Hook III, M.D., Co-Chair
CDC/HRSA Advisory Committee on
HIV and STD Prevention and Treatment

_____ _____

Date

Donna Sweet, M.D., Co-Chair
CDC/HRSA Advisory Committee on
HIV and STD Prevention and Treatment