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004. form	re: Drug testing (1 page)	12/30/1997	b(6)

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Admin - Agency Representatives - Weber, Todd

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RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
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b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

CURRICULUM VITAE

CDR JONATHAN TODD WEBER
PHS # 59252
June 19, 1998

White House Office of National AIDS Policy (*Temporary Assignment*)
736 Jackson Pl NW
Washington, DC 20503
Phone: (202) 456-2437 Facsimile: (202) 456-2438

EDUCATION

Year	Degree	University
1987	M.D.	College of Physicians & Surgeons Columbia University New York, New York
1980-82	None	School of General Studies (Pre-medical courses), Columbia University New York, New York
1980	A.B.	Princeton University Princeton, New Jersey

POST-GRADUATE TRAINING

1987-1990	Residency in Internal Medicine, Bellevue Hospital Center and Tisch Hospital, New York University; New York, New York

MEDICAL LICENSES

State	Number	Expiration Date
New York	On request	2/28/00
Georgia	On request	12/31/99
Drug Enforcement Administration	On request	5/31/99

CERTIFICATIONS

Certificate	Board	Number	Expiration Date
Diplomate	National Board of Medical Examiners	336833	None
Diplomate	American Board of Internal Medicine	130305	2001
Fellow	American College of Physicians	52776	None

WORK EXPERIENCE

January - June 1998

Agency representative, temporary assignment to White House Office of National AIDS Policy, Washington, DC

- Major Duties
  - Liaison to Centers for Disease Control and Prevention
  - Responsible for specific issues regarding HIV prevention effectiveness, HIV surveillance, and prevention of HIV among world maritime workers

1995-current

Medical Epidemiologist, Clinic and Special Surveys Section, Prevention Services Research Branch (PSRB), Division of HIV/AIDS Prevention - Surveillance and Epidemiology (DHAP-SE), National Center for HIV, STD and TB Prevention (NCHSTP), Centers for Disease Control and Prevention (CDC), Atlanta, Georgia

- Major Duties
  - Project officer for nationwide data system of all publicly-funded HIV counseling and testing (reported from >9,000 sites)
  - Supervise project manager, data managers, public health advisor, and workstudy student
  - Provide technical assistance to 65 state, local, and territorial health departments
  - Design, initiate, and conduct epidemiologic studies; analyze data and prepare manuscripts for professional publications
- Accomplishments
  - Organized new team of data managers, public health advisors, and computer programmers to work on publicly-funded HIV counseling and testing data system.
  - Created plan for national, publicly funded, HIV counseling and testing to improve system's utility for monitoring testing trends and incidence of HIV infection among persons tested
  - Designed study for surveillance of HIV subtypes resistant to antiretroviral therapy in newly infected persons
  - Author and co-author of several manuscripts (published and in press) and presentations.

WORK EXPERIENCE (continued)

1995-current (continued)

- Impacts
  - Provided technical assistance to project areas, improved data collection, collected information for annual summary, and provided data for research
  - Appointed by Director of National Center for HIV, STD, and TB Prevention to work group to review current system and propose new, inter-branch organization for HIV CTS.
  - Provided data on the cost-effectiveness of HIV CT in hospitals, on trends in testing patterns in HIV CTS, on the prevalence of HTLV-I/II in a hospital population, on pregnant women not being offered HIV CT in hospitals, on HIV infected patients who receive hospital care without recognition of their HIV infection, on the lack of HIV infection among commercial sex workers who use condoms correctly and consistently, and on the first U.S. outbreak of diarrheal illness associated with *Cyclospora*, and the use of a new botulism immune globulin.

1993-1995

Medical Epidemiologist, Population Studies Section, HIVSB, DHAP, NCHSTP, CDC, Atlanta, Georgia

- Major Duties
  - Project officer for contracts and cooperative agreements with health departments and hospitals conducting research on the epidemiology of HIV
  - Supervise data manager
  - Design, initiate, and conduct additional epidemiologic studies and analyze data and prepare manuscripts for professional publications

WORK EXPERIENCE (continued)

1993-1995 (continued)

- Accomplishments
  - Presentations at national and international conferences
  - Prepared several manuscripts for publication
  - Assisted center director in tracking health care reform legislation and formulating comments on health care reform proposals
  - Contributed to "For a Healthy Nation: Returns on Investment in Public Health"
  - Implemented expanded protocol for Sentinel Hospital Surveillance System for HIV Infection, collecting information on risks for HIV among hospitalized patients, and prevalence of diseases included in 1993 AIDS case definition

- Impacts
  - Provided data showing that despite the efficacy of zidovudine in preventing perinatal HIV transmission, many pregnant women are not being offered HIV counseling and testing and infected pregnant women are not all taking zidovudine
  - Showed that prevalence of HIV among sentinel hospital patients is stable or declining in many age and race groups
  - Determined that cost of detecting HIV infection by providing counseling and testing in hospitals was lower than many other screening programs
  - Demonstrated very low prevalence of HIV infection among insurance applicants
  - Helped show that public health measures will provide future savings in medical care

1993-current

Attending Physician, HIV Early Care Clinic, Eleanor L. Richardson Health Center, DeKalb County Board of Health STD/HIV Program, Decatur, Georgia

- Major Duties
  - Diagnosis and treatment of patients in the early stage of HIV infection
  - Consultant to nurse clinicians

WORK EXPERIENCE (continued)

1992-1993

Medical Epidemiologist, Bacterial Studies Section, Clinical Research Branch, Division of Sexually Transmitted Diseases and HIV Prevention, National Center for Prevention Services, CDC, Atlanta, Georgia

- Major Duties
  - Evaluate standard and recently approved therapies for *Chlamydia trachomatis*
  - Development of guidelines for the diagnosis and therapy of *C. trachomatis*
- Accomplishments
  - Wrote budget initiative on the prevention of infertility in women by the early detection and treatment of sexually transmitted diseases
  - Wrote article on treatments for *C. trachomatis* genital infection (published 1995); wrote guidelines for the treatment of *C. trachomatis* genital infection
  - Chaired task force on technical developments in STD prevention, diagnosis and treatment for strategic planning
- Impacts
  - New guidelines for treatment of *C. trachomatis* published for clinicians
  - Provided results of "evidence-based" approach to the published literature in background paper published in 1995, from which published STD treatment recommendations were synthesized.

1992-1993

Attending Physician, Sexually Transmitted Diseases Clinic, Eleanor L. Richardson Health Center, DeKalb County Board of Health STD/HIV Program, Decatur, Georgia

- Major Duties
  - Diagnosis and treatment of patients with sexually transmitted diseases
  - Counseling regarding testing for HIV
  - Consultant to nurse clinicians

WORK EXPERIENCE (continued)

1990-1992

Medical Epidemiologist, Epidemic Intelligence Service (EIS) assigned to the Enteric Diseases Branch (now Foodborne and Diarrheal Diseases Branch), Division of Bacterial and Mycotic Diseases, National Center for Infectious Diseases (NCID), CDC, Atlanta, Georgia

- Major Duties
  - Investigating bacterial enteric disease outbreaks
  - Preparing manuscripts for publication
- Accomplishments
  - Investigated following outbreaks: *Cyclospora*-associated diarrhea in Chicago; hemolytic uremic syndrome in Twin Falls, Idaho; typhoid fever in Westmoreland Parish, Jamaica; type E botulism in Cairo, Egypt; and cholera in Ecuador and Honduras.
  - Published articles on investigations in medical journals
  - Designed "Voice Information System," an automated telephone response system for public inquiries
- Impacts
  - Results of typhoid epidemic investigation prompted Agency for International Development to earmark funds for water and sewage treatment in the area
  - Investigation of cholera in Ecuador revealed first multidrug resistant *V. cholerae* organism in hemisphere
  - Voice Information System instituted, allowing public to quickly obtain information on agents and vehicles of foodborne and diarrheal diseases

WORK EXPERIENCE (continued)

1982-1983

Legislative Assistant, U.S. Senate, Office of Senator Daniel Patrick Moynihan, Washington, D.C.

- Major Duties
  - Drafting health and education legislation
  - Responding to constituent inquiries
  - Following health and education legislation
- Accomplishments
  - Drafted legislation on HIV/AIDS, food stamps, and organ donation
- Impacts
  - Legislation was passed into law providing increased funding to U.S. Public Health Service to perform research on HIV/AIDS
  - Legislation was passed into law promoting organ donation

PROFESSIONAL ASSOCIATIONS

American College of Physicians
Commission Officers Association, U.S. Public Health Service
Infectious Diseases Society of Georgia

AWARDS

1995

Honor Award Certificate, NCID

1994

Honor Award (Outstanding Unit Citation), USPHS, Commissioned Corps

- for outstanding service to assist in the investigation, treatment and prevention of epidemic cholera in the western hemisphere

AWARDS (continued)

1994 (continued)

Honor Award (Unit Commendation), USPHS, Commissioned Corps

- for participating in the development of the 1993 STD Treatment Guidelines

James H. Nakano Citation, NCID, CDC

- for an outstanding paper published in 1993

Honor Award Certificate, NCID

1993

Honor Award (Commendation Medal), USPHS, Commissioned Corps

- for outstanding performance in investigations in Egypt, Honduras, and Jamaica and for developing a voice information system

Honor Award Certificate, NCID

1992

Honor Award (Achievement Medal), USPHS, Commissioned Corps

- for the investigation of epidemic cholera in Guayaquil, Ecuador

Honor Award Certificate, NCID

1991

Outstanding poster presentation (co-author), EIS conference, Epidemiology Program Office, CDC

- Diarrheal Outbreak Associated with a Cyanobacteria (Blue-Green Algae)-Like Body, Chicago

Foreign Duty Service Award, USPHS, Commissioned Corps (Jamaica)

Foreign Duty Service Award, USPHS, Commissioned Corps (Egypt)

Foreign Duty Service Award, USPHS, Commissioned Corps (Ecuador)

EDUCATIONAL ACTIVITIES - TEACHING

1994

Patient/Doctor Course (section leader for weekly seminar). Emory University School of Medicine, Department of Family and Preventive Medicine (Spring)

Implementing National HIV Sentinel Surveys (section instructor). CDC, International Course in Surveillance and Applied Epidemiology for HIV and AIDS

1992

Cholera in Ecuador (lecture). Epidemiology course, Columbia University School of Public Health

Diagnosis and treatment of botulism and discussion of a massive outbreak of botulism, Egypt, 1991 (lecture and seminar). Infectious Diseases Combined Conference (Columbia University affiliated hospitals)

1991

Epidemiology of Cholera (lectures). Course on diagnostic and laboratory methods for *Vibrio cholerae*. Panamerican Health Organization/Instituto Nacional de Higiene, Caracas, Venezuela

EDUCATIONAL ACTIVITIES - SCIENTIFIC REVIEWER FOR JOURNALS

American Journal of Epidemiology
Annals of Emergency Medicine
Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology
Journal of the American Medical Association
The Lancet
The Medical Letter
The New England Journal of Medicine
Social Science & Medicine

EDUCATION - COURSES TAKEN AT CDC

Assessing the Effectiveness of Public Health Programs
Basic Project Officer (Contracts)
Categorical Data Analysis
Effective Information Display, Statistical and Other
Genetics and Public Health : An Introductory Course
HIV Prevention Counseling/Training of Trainers
Manage and Control Multiple Priorities
Orientation to Grants Management for Program Officials
Preventing Sexual Harassment

EDUCATION - COURSES TAKEN AT CDC (continued)

Regression Modeling in Epidemiologic Research
SAS Basics for the Personal Computer
SAS Fundamentals for the Mainframe
Statistics II
Statistics III
Supervisory Survival Skills I (supervisory course)
Building Leadership Skills (supervisory course)

PRESENTATIONS AT NATIONAL MEETINGS

1998

Invasive Cervical Cancer in Human Immunodeficiency Virus-infected and Uninfected Hospital Patients, 1994-1995 (poster), 5th Conference on Retroviruses and Opportunistic Infections, February 1-5, Chicago, IL (Paper 717)

1997

Prevalence of Tuberculosis, Recurrent Bacterial Pneumonia, and Invasive Cervical Cancer among HIV-Infected Hospital Patients, 1994-1995 (poster),4th Conference on Retroviruses and Opportunistic Infections, January 22-26, Washington, DC (Session 23; Paper 188)

1996

Absence of HIV Seroconversion among Sex Workers at Legal Brothels, Nevada, 1990-1995 (oral), 124th Annual Meeting of the American Public Health Association, November 17-21, New York, N.Y.

1995

HIV-1 among Applicants for Life, Health, and Disability Insurance, 1991-1992 (poster). 2nd National Conference on Human Retroviruses and Related Infections, January 29-February 2, Washington, D.C.

Antiretroviral Chemotherapy and Undetected HIV Infection among Obstetrical Patients in U.S. Hospitals with High HIV Prevalence (oral). 35th ICAAC, September 18, 1995, San Francisco, CA

1993

Increasing HIV-1 Seroprevalence at Sentinel Hospitals (poster). First National Conference on Human Retroviruses and Related Infections, December 12-16, Washington, D.C.

PRESENTATIONS AT NATIONAL MEETINGS

1992 (continued)

Investigation of Cholera Epidemic, Ecuador, 1991 (oral). EIS Conference, April 6

Massive outbreak of botulism, Egypt, 1991 (oral). EIS Conference. April 7

Cholera in the United States, 1965-1991: the Role of Domestic Shellfish, International Travel, and Imported Foods (oral). 33rd ICAAC, October 13

Multiply-resistant Epidemic Cholera in Ecuador: Transmission by Water and Seafood (oral). 33rd ICAAC, October 13

1991

Outbreak of Typhoid in Westmoreland Parish, Jamaica (oral, late breaking report). EIS conference, April 11

Diarrheal Outbreak Associated with a Cyanobacteria (Blue-Green Algae)-Like Body - Chicago (poster, co-author). EIS conference, April 11

PRESENTATIONS AT INTERNATIONAL MEETINGS

1996

Missed opportunities for HIV testing in a South Bronx community at high risk for HIV infection, New York, New York, U.S.A. (poster). XI International Conference on AIDS, July 7-12, 1996, Vancouver, Canada

1994

Trends in recent HIV-1 infection among patients at Sentinel Hospitals in the United States, 1988-1992 (poster). Tenth International Conference on AIDS, August 7-12, Yokohama, Japan

INTRAMURAL PRESENTATIONS

1994

Trends in HIV seroprevalence and $\beta_2$microglobulin at Sentinel Hospitals. Public Health Service workshop: AIDS case projections, and HIV seroprevalence and incidence estimates, February 23-24

1992

Massive outbreak of botulism, Egypt 1991. CDC Epidemiology Grand Rounds, November 19

1991

Epidemic of cholera in Ecuador, 1991. CDC Epidemiology Grand Rounds, August 6

BIBLIOGRAPHY

CDR JONATHAN TODD WEBER
PHS # 59252

Publications - Journals

Published

1998

1. Mintz ED, **Weber JT**, Guris D, et al. An Outbreak of Brainerd Diarrhea Among Travelers to the Galapagos Islands. *J Infect Dis* 1998;177:1041-5.

2. Valdiserri RO, **Weber JT**, Frey RL, JR.. Trends in HIV Seropositivity in Publicly Funded HIV Counseling and Testing Programs: Implications for Prevention Policy *Am J Prev Med* 1998;14(1):31-42

1997

3. **Weber JT**, Frey RL, Jr., Horsley R, Gwinn ML. Publicly Funded HIV Counseling and Testing in the United States, 1992-1995. *AIDS Educ Prev*, 9, Supplement B, 79-91, 1997

4. Irwin K, Pau C-P, Lupo D, Hu D, Schable C, Olivo N, Luo C-C, Minor P, **Weber JT**, et al. Presence of human immunodeficiency virus (HIV) type 1 subtype A infection in a New York community with high HIV prevalence: a sentinel site for monitoring HIV genetic diversity in North America. *J Infect Dis* 1997;176:1629-33.

1996

5. Irwin KL, Olivo N, Schable CA, **Weber JT**, Janssen RS, Ernst J. Performance of a rapid HIV antibody assay in a hospital with high prevalence of HIV infection. *Ann Intern Med* 1996;125:471-5.

6. Irwin KL, Olivo N, Schable C, **Weber JT**, Janssen R, Ernst J. Absence of human immunodeficiency virus type 2 infection among patients in a hospital serving a New York community at high risk for infection. *Transfusion* 1996;36(8):731-3.

Publications - Journals (continued)

Published (continued)

1996 (continued)

7. Hibbs RG Jr, **Weber JT**, Corwin A, et al. Experience with the Use of Botulism Immune Globulin [$F(ab')_2$] Heptavalent, Equine During an Outbreak of Type E Botulism in Egypt. *Clin Infect Dis* 1996;23:337-40.

8. Factor SH, Irwin KL, Lal RB, Rudolph D, **Weber JT**, Olivo N, Ernst J. Prevalence of and risk factors for HTLV-I and HTLV-II infection among patients at a hospital in the South Bronx, New York [letter]. *J Acquir Immune Defic Syndr Hum Retrovirol* 1996;12(4):431-2.

1995

9. **Weber JT**, Johnson RE. New treatments for Chlamydia trachomatis genital infection. *Clin Infect Dis* 1995;20(Suppl 1):S66-71.

10. **Weber JT**, Janssen RS, George JR, Ward JW, HIV Counseling and Testing in Hospitals [letter]. *JAMA* 1995;274:129-30.

11. Huang PP, **Weber JT**, Sosin DM, et al. The First Reported Outbreak of Diarrheal Illness Associated with *Cyclospora* in the United States, *Ann Intern Med* 1995;123:409-14.

1994

12. **Weber JT**, Mintz ED, Cañizares R, et al. Epidemic cholera in Ecuador: Multidrug-resistance and transmission by water and seafood. *Epidemiol Infect* 1994;112:1-11.

13. **Weber JT**, Levine WC, Hopkins DP, Tauxe RV. Cholera in the United States, 1965-1991: Risks at home and abroad. *Arch Intern Med* 1994;154:551-6.

14. **Weber JT**. Wound botulism [letter]. *Hospital Practice* (Office Edition) 1994;29(4):16,26.

15. Levine WC, Berg AO, Johnson RE, et al. Development of STD treatment guidelines, 1993 - New methods, recommendations, and research priorities. *Sex Trans Dis* 1994;21(2 Suppl S):S96-S101.

Publications - Journals (continued)

Published (continued)

1993 (continued)

16. **Weber JT**, Goodpasture HC, Alexander H, et al. Wound Botulism in a Patient with a Tooth Abscess: Case Report and Review. *Clin Infect Dis* 1993;16:635-9.

17. **Weber JT**, Hatheway CL, Blake PA, Tauxe RV. Clarification of Dietary Risk Factors and Religion in a Botulism Outbreak [letter], *J Infect Dis* 1993;168:258.

18. **Weber JT**, Hibbs RG Jr, Darwish A, et al. A Massive Outbreak of Type E Botulism Associated with Traditional Salted Fish in Cairo, Egypt, *J Infect Dis* 1993;167:451-4.

19. Besser RE, Lett SM, **Weber JT**, et al. Is Apple Cider a Health Food? An Outbreak of *Escherichia coli* O157:H7 Infections from Fresh-pressed Apple Cider, *JAMA* 1993;269:2217-20.

1992

20. Dagher PC, Balsam L, **Weber JT**, et al., Modulation of Chloride Secretion in the Rat Colon by Intracellular Bicarbonate, *Gastroenterology* 1992;103:120-7.

Publications - Editorials

1992

21. Outbreak of type E botulism associated with an uneviscerated, salt-cured fish product -- New Jersey, 1992(editorial note), *MMWR* 1992;41(29):521-2.

1991

22. Paralytic Shellfish Poisoning -- Massachusetts and Alaska, 1990 (editorial note), *MMWR* 1991;40(10):157-61.

Publications - Book Chapters

1994

23. **Weber JT**, Hatheway CL, St. Louis ME. Botulism. In Infectious Diseases, Hoeprich PD, Jordan MC, eds. Philadelphia: J.B. Lippincott Company 1994. Chapter 143: pp. 1185-94.

Publications - Journals (continued)

In Press

Chin K, Sidhu JS, Janssen RS, **Weber JT** and the Sentinel Hospital Surveillance System for HIV Infection Principal Investigators. Prevalence of Invasive Cervical Cancer among HIV Infected and Uninfected Hospital Patients. *Obstet Gynecol*

In Preparation

Weber JT, Reich RR, Horsley R, Todd RL. Absence of HIV Seroconversion among Sex Workers at Legal Brothels, Nevada, 1990-1995

Weber JT, Green T, Janssen RS and the Sentinel Hospital Surveillance System for HIV Infection Investigators. Trends in Prevalence of HIV among Hospital Patients.

Weber JT, Karon JM, Raimondi VP, Kleinsasser WL, Janssen RS. HIV-1 among Applicants for Life, Health, and Disability Insurance, 1991-1992.

Nakashima AK, Horsley R, Frey RL, Sweeney PA, **Weber JT**, Fleming PL, Impact of HIV Reporting by Name Policies on Utilization of HIV Testing Services in Publicly Funded Counseling and Testing Programs.

CONTINUING EDUCATION/TRAINING SUMMARY: 1998

CDR JONATHAN TODD WEBER, M.D., F.A.C.P.
PHS # 59252

Date	Title/Sponsoring Organization	Outcome
4/1-4/5	79th Annual Session; American College of Physicians; San Diego, CA	pending certificate
4/4	The Framework for Migraine Prevention; CME Consultants, Inc.; San Diego, CA	2.25
4/20-4/24	48th Annual Epidemic Intelligence Service Conference; CDC; Atlanta, GA	pending certificate
6/24-6/27	2nd International Workshop on HIV Drug Resistance and Treatment Strategies; International Medical Press; Lago Maggiore, Italy	planned
6/28-7/3	12th World AIDS Conference; Geneva, Switzerland	planned
	Total	2.25

June 19, 1998

Todd

This is most of an earlier version of what I wanted to send to PACHA. It does not follow order of recommendations (I put it in an order that I thought made more sense). Some aspects may stray from the official response Helene provided last week, so you should **NOT** consider this CDC policy, but information that I have provided that you might find useful.

jtw

HIV Surveillance

Accuracy and Completeness

CDC has established performance criteria for HIV and AIDS surveillance to assure that surveillance data are of sufficient quality to target prevention and care resources and to detect emerging trends in the HIV epidemic. Based on evaluations of HIV and AIDS surveillance programs, the completeness of HIV surveillance (79-95%) and AIDS surveillance (85-95%) is high; nearly one-half of AIDS cases and three-quarters of HIV cases are reported to the national HIV/AIDS reporting system (without patient identifiers) within 3 months of diagnosis. In 1996, the duplication rate of HIV and AIDS cases reported from different states to the national surveillance data base was less than 7% and 2% respectively. The high level of completeness has been achieved for several reasons. At the beginning of AIDS surveillance, the Office of Technology Assessment found a lack of completeness of reporting and recommended that active surveillance for cases be instituted. Congress appropriated funds for this purpose. There has been strong support for the collection of these data from providers and communities. More recently, Ryan White funding has been linked to the number of AIDS cases reported by grantees, providing incentive to states for having as complete reporting as possible.

In the only evaluation of the use of unique identifiers, there was a high rate of incomplete case reporting and the follow up and collection of risk factors was hampered by this system of surveillance. There is currently no other unique identifier that would satisfactorily overcome these problems. However, the Health Insurance Portability and Accountability Act mandates the universal use of a unique coded patient identifier system for medical records. The adoption of such an identifier may change the practice of name-based record keeping by providers and surveillance methods could be adapted to this system.

Strengths

The strengths of having all states conduct HIV surveillance include having the only national system for the collection of HIV data that includes data from the public and private sector, that can provide disease rates for different population subgroups, including different racial/ethnic groups, and that includes risk information not found in medical records. The use of names includes the advantages of allowing providers to use existing name-based clinical records, allows for local public health authorities to eliminate duplicate reports on the same individual, to obtain additional epidemiologic information from health care providers, and to link with other public health data systems such as tuberculosis surveillance and vital records that are name-based.

Limitations and Weaknesses

The limitations of HIV surveillance, by any method, is that those who are tested and reported may not be representative of all persons infected with HIV, since persons who are not tested and those who test anonymously are not included, and there are variations in testing practices among different areas within a state and among states, in addition to some states not having HIV surveillance.

Confidentiality Safeguards and Potential for Abuse

Review of Confidentiality Safeguards - State level

CDC has reviewed recently state and local security policies and procedures. Since 1981, states have conducted AIDS surveillance. To date, states have maintained an exemplary record in protecting the confidentiality of HIV/AIDS data. No names have ever been publicly released or misused. Since 1981 there has been one reported breach of confidentiality of a state AIDS reporting system, and there have been no known breaches associated with the adoption of name-based HIV surveillance. CDC did an extensive investigation of this breach and found that no names had been released directly or indirectly through the newspaper that received the electronic data. Of note, the person responsible for this single breach of confidentiality was successfully prosecuted by state authorities. In response to this event, the state increased the penalty for this crime in terms of imprisonment and fines. There have been no other legal cases on the release or misuse of confidential HIV surveillance data; there have cases of inappropriate release information on HIV status in other health care settings.

In 1994, CDC and the Council of State and Territorial Epidemiologists sponsored a review of state confidentiality laws that protect HIV surveillance data. Based on this review, all states and many localities have legal safeguards of confidentiality of governmentally maintained health data, and these laws were found to provide greater protection than laws that protect the confidentiality of health information held by private health care providers in clinical records. State and local governments used a variety of legal protections of the health data collected by their agencies. Most states have specific statutory protections for the collection, use and disclosure of data related to HIV.

The receipt of federal surveillance funding is dependent on the recipient's ability to ensure the physical security and confidentiality of case reports. CDC has issued technical guidance for security procedures and includes confidentiality and security safeguards as evaluation criteria for federal funding of state HIV/AIDS surveillance activities.

Review of Confidentiality Safeguards - Federal level

At the federal level, HIV/AIDS surveillance data are protected by a limited right to informational privacy under the U.S. Constitution; federal statutes that protect the privacy of federal records, including the Privacy Act and exemptions to the Freedom of Information Act; and an Assurance of Confidentiality under Public Health Law 308(d). This Assurance provides that no CDC HIV surveillance information that could be used to identify any individual on whom a record is maintained, either directly or indirectly, will be made available to anyone for nonpublic health purposes. In particular, such information will not be disclosed to the public, parties involved in civil, criminal, or administrative litigation, or non-health agencies of the federal, state, or local government. Full names, addresses, social security numbers, and telephone number are **not** reported to the national surveillance system.

Penalties for Improper Use

Breaches of confidential HIV/AIDS surveillance data are to be investigated thoroughly, sanctions imposed when appropriate, and reports of such incidents maintained. All breaches of confidentiality are to be reported to CDC immediately.

Model Laws and Regulations

Over the past few years, CDC has been working to evaluate additional measures at the state level that could improve confidentiality even further. To assess the strength of local confidentiality laws that protect HIV surveillance data, CDC requested that the Georgetown/Johns Hopkins Program on Law and Public Health review local laws and regulations. This review found that the strictest and most comprehensive protections of health data apply to government-held information generally and to HIV-related data specifically.

To promote strong and uniform legal protections of confidentiality, CDC, in collaboration with the Council of State and Territorial Epidemiologists, the Association of State and Territorial Health Officers, and the National Conference of State Legislatures is developing model confidentiality language for state and local legislation. The proposed model legislation will be available in late 1998. Ideally, state and local confidentiality laws should include the objectives of the collection of personal identifying information, the public health officials who have access to surveillance information and the justification for this access, the procedures for expunging personal identifiable information when no longer needed for the stated purpose, the safeguards against disclosing HIV and AIDS case surveillance data through subpoena or court order, and the significant civil or criminal penalties that are in place to penalize individuals for breaches of confidentiality.

The confidentiality assurance should also follow the transmission of surveillance data, and penalties for violation of privacy and security should apply to all recipients of surveillance information.

Record Keeping and Database Maintenance

CDC requires that state and local surveillance program's security and confidentiality policies and procedures be consistent with CDC standards for HIV and AIDS surveillance programs.

The *CDC Guidelines for HIV/AIDS Surveillance* (April 1996) include detailed guidance regarding security and confidentiality policies and procedures. The security policy should specify the individual(s) responsible for the security of the surveillance system, the individual(s) who may authorize access to HIV and AIDS surveillance data, and the measures used to physically and electronically secure surveillance data. Local programs should have a description of their security polities and procedures available for external review. These guidelines have been updated and are under review, with the objectives of reducing the number of persons with access to the data, reducing the number of registries within the data system, and restricting its use.

Guidelines on Matching with Other Public Health Data

Linkages with other public health data are useful so long as security and confidentiality procedures are followed. The decisions about linkages to HIV prevention and care programs should be made at the local level by state and local health officials in consultation with HIV Prevention Community Planning Groups. HIV and AIDS surveillance data should not be used for purposes that do not have well defined public health objectives or by programs that can not assure confidentiality. If not currently available, state and local health departments should develop a formal process of program development and review to assess the need for linkages between prevention or care programs and name-based HIV and AIDS surveillance data.

Such linkages between surveillance systems should only share the minimum amount of epidemiologic information necessary to accomplish a specific public health activity. Programs should include methods to evaluate the effectiveness of this public health approach and to guard against and to identify breaches of confidentiality. Areas that elect to link name-based surveillance to other public health programs must require that recipients of this information be subject to the same penalties for unauthorized disclosure as surveillance personnel.

Impact on Test Seeking and Acceptance

Among Individuals

CDC has evaluated the impact of HIV surveillance on test-seeking behavior. In the HIV Testing Survey, conducted during 1995 and 1996 in nine states, persons at risk for HIV exposure were recruited from various venues (bars, STD clinics, and street outreach). When asked why the person had not been tested or delayed testing, the principal reason was fear of finding out that they were infected. Only 2% gave fear of reporting to the government as the main reason and only 19% of persons gave fear of reporting to the government as one reason among others for not getting tested. Reasons persons gave more often for not being tested included being afraid to find out, believing that exposure to HIV was unlikely, believing that the they were HIV negative, not wanting to think about it, believing that little could be done if they were positive, and being unsure where to go for testing. Most persons did not know whether or not the names of persons testing positive were reported to the health department; less than 18% could correctly describe the reporting system in their state.

In the AIDS Patient Survey, conducted during 1995 and 1996, persons with AIDS were asked about reasons for delaying testing and seeking care after testing positive. Of persons who delayed seeking care for more than one month after diagnosis, 0.5% responded that fear of being reported was the main reason for delay; 10% cited it as one among other reasons.

Among Communities

To assess the impact on test seeking and acceptance among communities, CDC recently analyzed trends in utilization of HIV testing services in publicly funded HIV counseling and testing programs before and after implementation of HIV reporting policies. The trends in numbers of persons tested in publicly funded HIV counseling and testing (CT) sites in the year before and the year after implementation of HIV reporting policies were examined using data from six state health departments. No significant declines in the total number of HIV tests provided by CT sites in the months immediately following implementation of HIV reporting policies occurred in any state, other than those expected from trends present before HIV reporting. Increases in testing occurred among men who have sex with men in four states and declines in testing occurred in two states after HIV reporting. Declines in testing were seen among injecting drug users in three areas. If states adopt HIV reporting policies, they can expect that the changes in utilization of publicly funded HIV testing services among most groups will be minimal.

Impact on Discrimination among Individuals and among Communities

As stated above, since 1981 there has been one reported breach of confidentiality of a state AIDS

reporting system, and there have been no known breaches associated with the adoption of name-based HIV surveillance. The discriminatory impact of being infected is distinct from the process of HIV surveillance. No names from a surveillance registry have ever been publicly released or misused. The recent, highly publicized release of names of two HIV infected persons in Missouri and New York were unrelated to HIV or AIDS surveillance activities. Because of this history, it is anticipated that the strengthened standards for security and confidentiality for HIV surveillance will make it even less likely in the future that there will be any impact on discrimination on individuals or communities.

The Strategy for Explaining HIV Surveillance System and Data

Health Departments

31 states already have HIV reporting. Since 1989, CDC has held numerous technical workshops for state health departments for states, with or without HIV reporting, on the HIV surveillance systems and the uses of HIV surveillance data. Most recently, in November 1997, CDC convened a meeting of representatives from all 50 states' and six cities' HIV and AIDS surveillance programs for a consultation on HIV reporting. CDC has contracted with the Academy for Educational Development to produce technical materials for use by state and local health departments.

Community Planning Groups

Health departments are responsible for assuring that HIV prevention community planning groups have access to current information related to HIV prevention and analyses of the information. As a part of the development of a comprehensive HIV prevention plan, project areas are expected periodically to review, revise, and refine the plans, as indicated by any new or enhanced surveillance data or other relevant information. The health department provides an epidemiologic profile of the HIV prevention community planning group's jurisdiction to assist the group in establishing program priorities based on the extent, distribution, and impact of the HIV/AIDS epidemic. The profile compiles and analyzes data from a variety of sources including, where available, reported HIV infections in areas with confidential reporting. Through a cooperative agreement with the Council of State and Territorial Epidemiologists, CDC funds to PhD-level epidemiologists to provide technical assistance to state health departments to produce these epidemiologic profiles.

Ryan White Consortia

National data are provided to the Health Resources and Services Administration. CDC has sponsored state and local staff to provide data on request to Ryan White Consortia. CDC staff

have attended the national meeting of Ryan White grantees to discuss surveillance data and the role of community planning groups.

Affected Communities

Representatives from CDC have met with many groups throughout the country representing affected communities. In addition, CDC has presented on this issue before the CDC Prevention Consultants (includes 100 Black Men of America, Inc., Advocates for Youth, AIDS Policy Center for Children, Youth and Families, AIDS Action Council, AIDS National Interfaith Network, Asian Pacific Islander Wellness Center, Harlem Directors, Human Rights Campaign Fund, National Association of People with AIDS, National Coalition of Hispanic Health and Human Services, National Minority AIDS Council, National Latino/a Lesbian And Gay Organization, National Task Force on AIDS Prevention, National Council of Negro Women, National Native American AIDS Prevention Center, National Alliance of Positive Youth, National Association of People with AIDS, National Advocacy Coalition on Youth and Sexual Orientation, and the National AIDS Fund), and the organizations that participate in the National Organizations Responding to AIDS (AIDS Action Council, AIDS Policy Center for Children, Youth and Families, American Foundation for AIDS Research, American Nurses Association, Human Rights Campaign, National Minority AIDS Council, National Association of People with AIDS, National Alliance of State and Territorial AIDS Directors, and the National Hemophilia Foundation).

Health Care Providers

State and local health departments will be responsible for informing\ local health care providers or organizations regarding HIV surveillance. Medical specialty organizations may also be utilized nationally. The American Academy of Pediatrics has already publicly supported an expanded pediatric HIV surveillance program, providing background and rationale through an article in *Pediatrics*.

How Data Will Be Collected and Used

Collecting Data: Strategy and Implementation

The current AIDS surveillance infrastructure should be used for HIV case surveillance. HIV and AIDS case surveillance efforts should be directed toward the collection of data from all private and public sources of HIV-related testing (except anonymous testing) and care services. Unless prohibited by law, laboratory-initiated surveillance methods should be used to collect information for cases that meet the laboratory reporting criteria for HIV infection and AIDS. Reports from laboratories should be used by local programs to initiate the reporting process by

health care providers and clinicians and to update records for previously reported cases. Statistics regarding anonymous tests should continue to be reported through the Counseling and Testing Data System.

Presenting Data: Strategy and Implementation

HIV and AIDS data sets are available for analysis by the public. CDC publishes a report on these data twice a year (this is available through CDC's internet site) and states publish the data periodically.

HIV and AIDS surveillance data made available for epidemiologic analysis must not include names or other identifying information. State and local data release policies should ensure that the release of data for statistical purposes does not results in the direct or indirect identification of individuals reported with HIV or AIDS.

Prevalence Estimates

HIV surveillance can be used to provide a minimum estimate of persons living with HIV (HIV prevalence), to identify emerging trends and patterns of infection, to characterize persons more recently infected than those with AIDS, and to evaluate prevention interventions. States that report both HIV and AIDS cases increase the number of persons known to be living with HIV by 140% by reporting HIV infection cases in addition to AIDS. Such minimum prevalence estimates can be made on the national and state level. The feasibility and appropriateness of making minimum prevalence estimates for smaller areas depends on the population density and whether there is sufficient number of cases to allow a reliable estimate. Demographics and risk behavior information are collected as a part of surveillance.

Incidence estimates

Studies of incidence in specific settings among specific high risk groups are being conducted (see Unlinked Seroprevalence Studies and Sentinel Surveys). In addition, several states are piloting methods for detecting incidence among persons being tested in the Counseling and Testing System. Laboratory methods are being developed that may detect recent infection, close to the time of incidence (see *New Laboratory Technology*). Estimates of the trends in national and regional incidence of HIV can be made through indirect means using data from HIV surveillance and focused studies, however these methods will not quantify incidence. In the future, if laboratory methods for detecting recent infection are perfected and put into widespread use, quantifying incidence may be possible.

Use of focused surveillance studies and other research methods

Unlinked Seroprevalence Studies and Sentinel Surveys

Unlinked seroprevalence studies are conducted by CDC among high risk populations. These include sexually transmitted disease clinics, where unlinked seroprevalence studies are conducted in 12, geographically diverse, sentinel cities, including cities in the U.S. with the highest prevalence of HIV. In most of these sites there are concurrent incidence studies conducted. Unlinked seroprevalence studies in drug treatment centers (methadone maintenance and detoxification programs) are conducted in 10, geographically diverse, sentinel cities including cities in the U.S. with the highest prevalence of HIV. Some of these sites also conduct incidence studies. Seroprevalence data are also collected from programs that conducted HIV testing such as from selected blood donor agencies, the Job Corps, which routinely offers HIV testing, and civilian applicants for military service.

Behavioral Research and Surveillance

CDC has a large portfolio of HIV behavioral research and surveillance projects. This research is public health driven and responds to epidemiologic trends as well as program needs. CDC supports research that is directly applicable to programs, uses close collaboration between biomedical and behavioral scientists, and encourages extensive community participation.

For behavioral surveillance, CDC designs and implements survey tools and analyzes data from national, state and local surveys of risk behaviors, knowledge, attitudes, skills, and health care utilization. These are done through the HIV modules of the Behavioral Risk Factor Surveillance System and the National Health Interview Survey.

Behavioral determinants research is the identification of psychosocial, cultural, or contextual determinants of risk behaviors, behavior change, disease transmission, and disease progression. This form of research is being employed in the Human Immunodeficiency Virus Epidemiology Research (HER) Study, a prospective cohort study of human immunodeficiency virus infection in US women.

Behavioral and social epidemiologic research, the description of the relationship between behavioral and social characteristics of individuals or communities at risk and disease exposure, is being conducted in the Young Men's Survey, which collects data from 15- to 22-year-old men who have sex with men and who attend public venues. The survey estimates the prevalence of risk behaviors, potential determinants of these risk behaviors, and HIV and STD prevalence. Similarly, the Young Women's Survey enrolls young African American women attending medical clinics and conducts interviews regarding their HIV/STD risk behaviors and factors

potentially associated with these risk behaviors, such as the power dynamics in their sexual relationships.

Behavioral surveillance conducted in conjunction with HIV and AIDS surveillance includes the Recent HIV Infection Project. This is conducted as an extension of current surveillance activities and is providing needed data on behaviors related to acquisition of HIV and current behaviors that may be associated with ongoing transmission that will be useful for developing prevention interventions, particularly among adolescents.

Although not a surveillance system or a study, the HIV Counseling and Testing Program collects and reports behavioral data for each episode of counseling or testing funded by CDC (approximately 2.5 million tests per year) among persons who are uninfected or infected with HIV.

Mathematical and Statistical Modeling

Statistical modeling is useful for and has been used to estimate the period between the actual time of infection and when HIV infection is detectable by laboratory testing as well as the time between infectiousness and when HIV infection is detectable by laboratory testing. This latter estimate is of particular importance to policy making on blood donations, banking, and transfusions. Statistical modeling can be used to understand the natural history of HIV disease by estimating the time from infection to various disease stages as well as the time spent in these stages (specific CD4 counts, opportunistic infections, and death). Statistical models have been used successfully to reconstruct the pattern of HIV incidence in the U.S. population. Mathematical modeling of the transmission of HIV from person-to-person is useful for testing theoretical hypotheses on the effect of interventions. Mathematical modeling is not useful, however, for predicting the future of the epidemic or estimating the current prevalence and incidence of HIV. This poor ability to predict the epidemic is revealed when different mathematical models that fit historical epidemiologic data equally well have very different projections for the short or longer term.

New Laboratory Technology

New laboratory technology is being used in a variety of studies, surveillance systems and programs. The clinical stage of disease at diagnosis has traditionally depended on the level of CD4 cells or the incidence of opportunistic infections. This has been most useful for the later stages of HIV infection. Methods are being developed that may reliably determine at the time of testing whether a person has been recently infected (within the previous three to six months). There are several new methods for determining the antiretroviral susceptibility of viral isolates and CDC is using some of these to conduct surveillance for antiretroviral resistance among

persons who have not been treated with antiretroviral chemotherapy. New testing technologies are being used or supported in concept that would allow persons to be tested without having blood drawn (oral fluid testing) or learn their infection status during the same visit (rapid tests). The epidemiology of opportunistic infections and the natural history in context of more effective treatment are both reliably studied through surveillance methods.

Policy on Availability of Anonymous Testing

CDC continues to strongly support anonymous HIV testing. The availability of anonymous services may encourage some persons at risk for HIV infection to seek HIV prevention services that they may otherwise be reluctant to access. CDC requires that states receiving prevention funds make anonymous testing available in order to make testing as accessible as possible, unless prohibited by law. Maintaining anonymous test sites is important for prevention efforts and will not seriously inhibit our ability to track the epidemic. Most people are diagnosed with HIV infection in confidential care settings. And when people test positive for HIV in an anonymous setting, they are referred for medical care. Upon entering the confidential care setting and having their HIV status re-confirmed through a confidential HIV test, their case will be reported. Evaluations are planned to assess the potential impact of anonymous testing on HIV surveillance trends. Maintaining an anonymous testing option may help ensure that more individuals learn their status, and if infected, seek early treatment and care. Of the 28 states that currently conduct name-based HIV case surveillance among adults, 18 states provide anonymous HIV testing services and 10 do not. Anonymous HIV testing is available in all other states, the Virgin Islands, and the District of Columbia.

Jonathan T. Weber
06/19/98 03:44:03 PM

Record Type: Record

To: Todd A. Summers/OPD/EOP, Daniel C. Montoya/OPD/EOP, Sarah T. Holewinski/OPD/EOP, Matthew Murguia/OPD/EOP

cc:
Subject: whereabouts

Folks

After the picnic tomorrow, I am out of here.

Contact information:

June 23-27: 2nd Int'l Workshop on HIV Drug Resistance ..., Lago Maggiore, Italy

Grand Hotel Dino
Via Garibaldi, 20
28042 Baveno (Verbania)
Lago Maggiore, Italy
Tel. +39 (323)-922201 Fax. +39 (323)-924515

June 28-July 3: 12th World AIDS Conference, Geneva, Switzerland

Hotel Continental
Place de la Gare 2
1003 **Lausanne**, Switzerland
Tel: 021 320 15 51 Fax:021 323 76 79

In the unlikely event that you want to stop by and see my poster:

Poster 13248
Pulmonary tuberculosis in HIV-infected and
uninfected patients in sentinel hospitals in the United States, 1994-1995
Monday, June 29, Track C, Position 248
I will be there: 08:00-08:50, 12:00-13:00 (maybe not), and 17:00-18:00

After July 20:

Prevention Services Research Branch
Division of HIV/AIDS Prevention - Surveillance and Epidemiology
Centers for Disease Control and Prevention
Mail Stop E-46
1600 Clifton Road NE
Atlanta, GA 30333
Phone: (404) 639-2085 (x2082 direct and voice mail, please don't distribute)
Fax: (404) 639-2029

jtw

Todd —

My new password:

nemoalius

jtw

Nascobal™

(Cyanocobalamin, USP)
Gel for Intranasal Administration
500 mcg/0.1mL

SP3166 10/97

Withdrawal/Redaction Marker
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. form	re: Other government employees [Personally Identifiable Information] [partial] (1 page)	06/18/1998	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Sandra Thurman
OA/Box Number: 40015

FOLDER TITLE:
Admin - Agency Representatives - Weber, Todd

2018-0764-F
jm1982

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

WHITE HOUSE OFFICE
OTHER GOVERNMENT EMPLOYEES

TO: OFFICE OF MANAGEMENT AND ADMINISTRATION

FROM: (Requesting official's name and department or office)
Todd Summers, AIDS Policy

THIS IS TO REQUEST THAT THE FOLLOWING INDIVIDUAL PERFORM DUTIES IN THE WHITE HOUSE OFFICE

NAME Last: Weber First: Jonathan Middle Initial: T.

BIRTHDATE: SOCIAL SECURITY NUMBER: (b)(6)

DATE AND TYPE OF APPOINTMENT IN EMPLOYING AGENCY: [001]

GRADE/STEP: SALARY:

PARENT AGENCY: CDC/HHS

DESCRIPTION OF PROJECT OR DUTIES (PLEASE BE SPECIFIC). IF THIS IS AN EXTENSION, PLEASE NOTE BELOW.
Agency rep. status terminated as of 6/21/98

TYPE:

- [ ] DETAILEE
- [ ] ASSIGNEE
- [ ] PRESIDENTIAL MANAGEMENT INTERN
- [ ] HISTORICALLY PROVIDED SERVICE
- [ ] WHITE HOUSE FELLOW
- [X] AGENCY REPRESENTATIVE
- [ ] STUDENT VOLUNTEER
- [ ] OTHER

DRUG TESTING DESIGNATION:
TDP = TESTING DESIGNATED POSITION [ ] TDP [ ] Non-TDP

BEGINNING DATE (Mo/Day/Yr):

ENDING DATE (Mo/Day/Yr): 6/21/98

POSITION TITLE (At the EOP Complex):

APPROVING OFFICIAL IN PARENT AGENCY (Name & Telephone):

TYPE OF DETAIL (If applicable):
[ ] Non-Reimbursable [ ] Reimbursable

IF REIMBURSABLE, FMD CERTIFICATION OF FUNDS AVAILABILITY:

ASSIGNMENT LOCATION
(Office or Division, Building, Room Number, & Telephone)
Office of National AIDS Policy
736 Jackson Place

WHO CONTACT PERSON (Name & Telephone): Todd Summers 6-2444

SIGNATURE OF WHO APPROVING OFFICIAL: Tod [signature]

DATE: 6/18/98

OFFICE OF MANAGEMENT AND ADMINISTRATION APPROVAL:

DATE:

WH FORM
Revised 5/94

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

April 9, 1998

Ms. Sandra Thurman
Director, Office of National AIDS Policy
The White House
736 Jackson Pl NW
Washington, DC 20503

Dear Ms. Thurman:

This letter is to acknowledge that CDR Jonathan T. Weber will have his temporary assignment to the Interdepartmental Task Force on HIV/AIDS extended for an additional 60 days beginning May 1, 1998. While continuing in this assignment, CDR Weber will report to Mr. Todd Summers, Deputy Director of the Office of National AIDS Policy (ONAP). As described in the original assignment memorandum dated December 29, 1997, CDR Weber will work on projects related to HIV surveillance, domestic HIV prevention and prevention of HIV among the world's non-military maritime workers.

Sincerely,

Robert S. Janssen for

Kevin M. De Cock, M.D., F.R.C.P., D.T.M.&H.
Director
Division of HIV/AIDS Prevention,
Surveillance and Epidemiology
National Center for HIV/AIDS, STD, and
TB Prevention

THE WHITE HOUSE

WASHINGTON

MEMORANDUM FOR KEVIN DeCOCK

From: Sandra L. Thurman SLT
Director, Office of National AIDS Policy
(202) 632-1090

Date: June 2, 1998

Re: **CDR Jonathan T. Weber**

I wanted to thank you so much for extending Todd's stay with us as an agency representive. It has been great to have him here with us! I know that it has been a big sacrifice for you to have him with us so long, and want to make sure you know how much I have appreciated have his expertise so close at hand. Again, thanks!

MEMO

To: Todd Summers
From: J. Todd Weber, MD, FACP
Subject: 4/27/98 Meeting with SLT on HIV surveillance
Date: May 4, 1998

Summary of discussion (with supplementary information):

Performance criteria for HIV and AIDS surveillance: CDC has established performance criteria for HIV and AIDS surveillance to assure that surveillance data are of sufficient quality to target prevention and care resources and to detect emerging trends in the HIV epidemic. In 1996, the duplication rate of HIV and AIDS cases reported from different states to the national surveillance data base was less than 7% and 2% respectively. Based on evaluations of HIV and AIDS surveillance programs, the completeness of HIV surveillance (79-95%) and AIDS surveillance (85-95%) is high. The empirical evidence is that this level of completeness is adequate and 85% completeness is what CDC estimates will be required of HIV surveillance to allow for appropriate analyses. If reporting is less complete, there will be significant opportunity for differences in reporting among groups. This would make comparisons among groups problematic.

Different reporting systems among states: Historically, this has been unsuccessful. Problems with this possible mosaic of reporting systems includes difficulty in sharing data between states and difficulty in combining all data into a single, national system. If this requires CDC to have to have a new system for storing and analyzing data, there would be a several year delay before this would be operational. Personnel to support such a new system, as well as supporting states with different systems, are not currently available. The creation of a new system and hiring of new personnel would be costly, and given static funding, could require shifting resources from other research and prevention activities.

Distribution of Ryan White funds: Ryan White funding has been linked to the number of AIDS cases reported by grantees (incidentally, this has provided incentive to states for having as complete reporting as possible). With AIDS cases and mortality declining, this may pose problems for distribution of Ryan White funds in the immediate future (combined with lack of data from the survey of child-bearing women, states may not be able to meet application requirements) and Ryan White reauthorization in the near future. CDC prevention funds are not distributed strictly on the basis of surveillance data.

Next steps:

Determine if a "hybrid" system is feasible and how long information, including names, would need to be maintained in order to collect surveillance information and data that could be used without names to eliminate duplicates.

> *Weber will obtain an answer from Division of HIV/AIDS Prevention - Surveillance and Epidemiology*

Determine if the availability of anonymous testing can be required for funding. Determine at what stage the discussion is with the CDC general counsel's office and whether HHS GC involved.

> *Weber will obtain an answer from Division of HIV/AIDS Prevention - Surveillance and Epidemiology*

Determine if confidentiality requirements under the "recommendation" heading in the draft of the recommendations and reports MMWR can be moved to "required" heading. Determine if this is being discussed with the CDC general counsel's office.

> *Weber will obtain an answer from Division of HIV/AIDS Prevention - Surveillance and Epidemiology*

Generate an explicit statement that HIV surveillance is not sufficient for complete epidemiologic monitoring of HIV, but needs to be complemented by other studies, such as unlinked serosurveys.

> *Such a statement will be in the response to PACHA's December 1997 recommendations. This is anticipated to be cleared at CDC in advance of next PACHA meeting.*

Jonathan T. Weber
04/10/98 09:56:37 AM

Record Type: Record

To: Todd A. Summers/OPD/EOP
cc:
bcc:
Subject: Re: Do you want me to continue?

Todd hud.002

See attached and we can discuss what to do next.

jtw

Todd A. Summers

Todd A. Summers
04/10/98 09:50:36 AM

Record Type: Record

To: Jonathan T. Weber/OPD/EOP
cc:
Subject: Re: Do you want me to continue?

of course! letter looked fine. can we talk about the HUD thing? I think there's a ball in my court, but I'm not sure!

Todd

MEMO

To: Todd Summers
From: J. Todd Weber, MD, FACP
Subject: Manuscript submission to JAMA
Date: January 16, 1998

Attached is the abstract from a manuscript I will be submitting presently to the Journal of the American Medical Association for their special HIV issue to be published in July 1998. If you would like to see the entire manuscript, let me know.

Absence of HIV Seroconversion among Sex Workers at Legal Brothels, Nevada, 1990-1995

Running head: Absence of HIV Seroconversion

Authors: **J. Todd Weber, MD** (Prevention Services Research Branch [PSRB], Division of HIV/AIDS Prevention - Surveillance and Epidemiology [DHAP-SE], National Center for HIV, STD, and TB Prevention [NCHSTP], Centers for Disease Control and Prevention [CDC], Atlanta, Georgia), **Rick R. Reich** (Clark County Health District, Las Vegas, Nevada), **Rose Horsley** (PSRB, DHAP-SE, NCHSTP, CDC), **Randall L. Todd, DrPH** (Bureau of Disease Control and Intervention Services, Health Division, Department of Human Resources, Nevada)

Corresponding Author:

J. Todd Weber, MD, FACP

Centers for Disease Control and Prevention (E-46)

1600 Clifton Road, NE

Atlanta, GA 30333

Phone: (404) 639-2080 Facsimile: (404) 639-2029 E-mail: jtw5@cdc.gov

Word count: Text 1397 Abstract 217 Tables and figures: None

Key words: condoms, HIV seropositivity, Nevada, prostitution, sexually transmitted diseases

Context.- Female commercial sex workers (CSWs) at legal brothels in Nevada are required to have HIV testing monthly during employment and results are reported to the state public health department. CSWs are required to use condoms for any sexual contact at their place of employment.

Objective.- To determine whether HIV seroconversion occurred among women who worked at legal brothels in Nevada between 1990 and 1995.

Design.- Dynamic cohort.

Setting.- Nevada county public health department.

Participants.- A convenience sample of CSWs were tested for HIV and assigned unique identification numbers. CSWs with a negative screening test for HIV and at least one other HIV test result >90 days later were included in the analysis (n=440). CSWs with an initial screening test that was not negative or who did not have another HIV test result >90 days later were excluded (n= 892).

Main Outcome Measure.- HIV infection.

Results.- The estimated number of days worked by all participants was 49 845 (mean number of days worked per CSW=113, range 15-644) during which there were an estimated 249 200 acts of sexual intercourse. There were no positive HIV test results.

Conclusions.- The absence of HIV seroconversion may be attributable to lack of exposure to HIV infected customers or the consistent and correct use of condoms by CSWs with all customers.

Jonathan T. Weber
02/17/98 03:27:56 PM

Record Type: Record

To: Todd A. Summers/OPD/EOP

cc:
Subject: new

Todd

New password: katahdin

jtw

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002. form	re: Supplement to personnel action (2 pages)	02/02/1998	b(6)

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National AIDS Policy Office
Sandra Thurman
OA/Box Number: 40015

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Admin - Agency Representatives - Weber, Todd

2018-0764-F
jm1982

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Presidential Records Act - [44 U.S.C. 2204(a)]

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OFFICE OF ADMINISTRATION
INFORMATION SYSTEMS AND TECHNOLOGY

DOCUMENT TRACKING

REQUEST SUBMITTED BY (Point Of Contact):

Please Print: (Last ,	First	M. Initial)	DATE SUBMITTED:	PHONE:
SUMMERS	TODD	A.	12/30/97	(202) 632-1090

CUSTOMER, WORK TO BE PERFORMED FOR:

Please Print: (Last ,	First	M. Initial)	TITLE/POSITION: (As seen in the EOP Phone Book)
Weber	J.	Todd	Agency Representative

DEPARTMENT: (Agy/PAD) (Div/DAD) (Sub-Div/Branch)	BUILDING:	ROOM:	PHONE:
AIDS Policy / EOP	808 17th St	820	(202) 632-1090

CUSTOMER INFORMATION:

Pass Type: ☐ Permanent ☐ Temporary ☐ Access List ☐ Other Agency Rep

Emp Type: ☐ EOP Staff ☐ Detailee ☐ Intern/Student ☑ Other Agency Rep (e.g.. Volunteer, Fellow, ...)

CONTRACTOR & Non-EOP EMPLOYEES:

Company / Agency Name	Contract #	Purchase Order #	Co/Agy Phone #: ( ) -
Company / Agency Address	Co/Agy City	Co/Agy State	Co/Agy Zip:

ACTION REQUESTED: ☐ Check if Additional Documentation attached.

Please PRINT. If Customer is replacing out going staff, or should be setup SAME AS other staff, note same and staff members name. If you have any questions, please contact your Agency Administrator or COTR. Or, call Customer Support at #(202)395-7370.

Please create NT and Notes accounts, add to the ONAP NT workgroup, and model network drive access on user SUMMERS-T

(Specify ONLY when a Specific Date/Time is required and has been approved by ADMIN. MGMT). REQUIRED DATE: _____

ACCESS REQUEST:

☒ Create *(New Account)* ☐ Modify *(Update existing ID)* ☐ Delete/Disable *(Departing Staff)* ☐ Transfer *(Transfer Ownership)* ☐ Dial-In Access *(Justify above)* ☐ External Acces *(Internet & X.400 Mail)*

(Fill in the User Name, Server Name and IBM Mainframe ID assigned to customer for all but NEW ID Requests.)

☐ IBM Mainframe: _____ *(7 Char. ID)*

☐ User Name: _____ *(12 Char ID.(ALL-IN-1 &.or LAN))*

Novell Server Name: _____ *(E.G.: WHADMIN, OMB_A, IRMD,...)*

EQUIPMENT REQUEST: *(If request is for other than New Install, Bar Code# and Previous Equipment OWNER information is required)*

☐ New Install ☐ Upgrade ☐ Re-Assign ☐ Re-Allocate ☐ Return to Inv. ☐ Site Survey

PC Load Type: ☐ US-2000 ☐ OASIS 5.0 ☐ Stand Alone ☐ Other _____

CPU Bar Code #: _____ *(EOP BAR-CODE is located on Right Side of CPU)* CPU S/N#: _____

Previous or current OWNER of Equipment if not Customer: _____
(Owner is normally set as Default Login User Name)

Pager/Celluar ☐ Pager S/N#: _____ ☐ Celluar Phone S/N#: _____

AUTHORIZED/APPROVED BY

(The Customer has already printed their name above. However, we request the PRINTED names of all other signatures for effective identification.)-

	Print: (Last , First M. Init.)	Date
Signature of Customer:		_____
Signature of Supervisor or POC: (EOP Staff)	SUMMERS, TODD A.	12/30/97
Signature of AGY/PAD Admin. or COTR:	Print: (Last , First M. Init.)	Date

Form OA65 Revised 12/04/95

MAILMGT @ A1
01/13/98 11:08:00 AM

Record Type: Record

To: Todd A. Summers, Ashley L. Raines

cc: Paul F. Dagenais
Subject: J. TODD WEBER - WIND_NT OA65

FYI

REQUEST: 233629 CSAR Status: RESOLVED
Updated By : DAGENAIS #: 01 Received By: MCKAIG Recvd Time: 11:12 Date: 98/01
Last Name : WEBER First Name: J. TODD Userid: N/A
DEPUTY DIRECTOR

Phone: 6321090 Room: 808 17TH ORG: WH-Executive Clerk

Application: WIND_NT Area: OA65 Code: ID Device: N/A
Referred To: SEC-DAG Referred Time: 11 12 Date: 01 09 98
Reslvd By: SEC-DAG Type: P Stat: Y RESLV TIME: 11:03 Date: 98/01/13

Problem Summary: Create NT and Notes accts. Same as Todd Summers.
Problem Detail: Approved by Ashley Raines.

Resolution Summary: CREATED NT & NOTES ACCOUNTS
Resolution Detail: WEBER_JT = USERID

Password: mtmarcy

Additionally, I hereby acknowledge the following:

1. I will not enter classified information into the EOPDC computer systems.

2. I will create my own personal password the first time I logon to the EOPDC. I will not use personal identifiers (eg., name, family member's name, initials and/or date of birth, etc.) as a password.

3. I will protect my personal password from disclosure. My password is used to authenticate my identity and I will not allow its use by another person, code it into programs or write it down where it will be assessable to others.

4. I will logoff my terminal or personal computer when it is unattended.

5. I will immediately relinquish the LogonID when access is no longer required or upon request by the EOP/OA Information Security Officer, or designee.

6. I will report immediately to the EOP/OA Customer Support Help Desk at 202-395-7323:
   - Suspected or actual unauthorized use of my LogonID; and
   - A change in my employment status. This includes termination of employment, transfer to another group or leave of absence.

Weber, J. Todd	12/30/97
Print Name (Last, First MI)	Date
J. Todd Weber	Weber_T
Signature	LogonID
AIDS Policy / EOP	(202) 632-1090
Organization	Phone

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003. form	re: Other government employees [Personally Identifiable Information] [partial] (1 page)	12/30/1997	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Sandra Thurman
OA/Box Number: 40015

FOLDER TITLE:
Admin - Agency Representatives - Weber, Todd

2018-0764-F
jm1982

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

WHITE HOUSE OFFICE
OTHER GOVERNMENT EMPLOYEES

TO: OFFICE OF MANAGEMENT AND ADMINISTRATION

FROM: (Requesting official's name and department or office)
Todd Summers, Deputy Director AIDS Policy

THIS IS TO REQUEST THAT THE FOLLOWING INDIVIDUAL PERFORM DUTIES IN THE WHITE HOUSE OFFICE

NAME: Last: Weber | First: Jonathan | Middle Initial: Todd

BIRTHDATE: (b)(6) | SOCIAL SECURITY NUMBER: [003]

DATE AND TYPE OF APPOINTMENT IN EMPLOYING AGENCY:
07/04/90
Medical Officer III (Epidemiology Supervisor)

GRADE/STEP: 0-5

SALARY: $105,101.64

PARENT AGENCY:
Centers for Disease Control and Prevention

DESCRIPTION OF PROJECT OR DUTIES (PLEASE BE SPECIFIC). IF THIS IS AN EXTENSION, PLEASE NOTE BELOW
Assist in the development of policy related to HIV prevention and surveillance.

TYPE:

- [ ] DETAILEE
- [ ] ASSIGNEE
- [ ] PRESIDENTIAL MANAGEMENT INTERN
- [ ] HISTORICALLY PROVIDED SERVICE
- [ ] WHITE HOUSE FELLOW
- [x] AGENCY REPRESENTATIVE
- [ ] STUDENT VOLUNTEER
- [ ] OTHER_____

DRUG TESTING DESIGNATION:
TDP = TESTING DESIGNATED POSITION
- [ ] TDP
- [ ] Non-TDP

BEGINNING DATE (Mo/Day/Yr):

ENDING DATE (Mo/Day/Yr):

POSITION TITLE (At the EOP Complex):

APPROVING OFFICIAL IN PARENT AGENCY (Name & Telephone):
Kevin M. DeCock, MD, FRCP, DTM&H
(404) 639-0900

TYPE OF DETAIL (If applicable)
- [x] Non-Reimbursable
- [ ] Reimbursable

ASSIGNMENT LOCATION
(Office or Division, Building, Room Number, & Telephone):
808 17th Street, Ste 820
Washington, DC 20006
(202) 632-1090

IF REIMBURSABLE, FMD CERTIFICATION OF FUNDS AVAILABILITY:

WHO CONTACT PERSON (Name & Telephone)
Todd Summers, Deputy Director AIDS Policy

SIGNATURE OF WHO APPROVING OFFICIAL:

DATE
12/30/97

OFFICE OF MANAGEMENT AND ADMINISTRATION APPROVAL:

DATE:

WH FORM
Revised 5/94

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004. form	re: Drug testing (1 page)	12/30/1997	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Sandra Thurman
OA/Box Number: 40015

FOLDER TITLE:
Admin - Agency Representatives - Weber, Todd

2018-0764-F
jm1982

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

December 29, 1997

Ms. Sandra Thurman
Director, Office of National AIDS Policy
The White House
808 17th Street, NW, Suite 820
Washington, DC 20006

Dear Ms. Thurman:

This letter is to acknowledge that CDR Jonathan T. Weber will serve as an agency representative to the Interdepartmental Task Force on HIV/AIDS beginning January 1, 1998. While on this 120 day assignment, CDR Weber will report to Mr. Todd Summers, Deputy Director of the Office of National AIDS Policy (ONAP). I have selected CDR Weber because of his expertise in HIV/AIDS surveillance and epidemiology. While working in your office, he will:

- provide ONAP with information on how the epidemiologic data that are collected and analyzed by CDC are used to design and support prevention programs. The description of effective (and ineffective) prevention programs would provide a useful summary for ONAP and provide policy makers with a better understanding of the programs CDC supports.

- facilitate intra-governmental and external dialogues on the issue of the surveillance and prevention activities of CDC with respect to HIV reporting.

- collaborate with the Joint United Nations Programme on HIV/AIDS and the Civil-Military Alliance to Combat HIV and AIDS regarding HIV/AIDS prevention in the maritime sector.

Kevin M. DeCock, M.D., F.R.C.P., D.T.M.&H.
Director
Division of HIV/AIDS Prevention- Surveillance and Epidemiology
National Center for HIV/AIDS, STD, and TB Prevention

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Centers for Disease Control
and Prevention (CDC)

Memorandum

Date December 8, 1997

From Medical Epidemiologist
Division of HIV/AIDS Prevention - Surveillance and Epidemiology

Subject Detail to Office of National AIDS Policy

To Todd Summers
Deputy ~~Executive~~ Director, Office of National AIDS Policy

This describes the planned projects and duties during my assignment to the White House Office of National AIDS Policy (ONAP) for six months beginning January 5, 1998. The broad purpose of detail is to take on a project or projects of benefit to CDC and to ONAP. There are two projects which would satisfy these dual purposes.

HIV Prevention: To describe how epidemiologic science is being used to develop prevention interventions and to describe which prevention programs are effective and which are not. This would provide ONAP with information on how the epidemiologic data that are collected and analyzed by CDC are used to design and support prevention programs and would demonstrate that data are not collected for the sake of data collection alone. The description of effective (and ineffective) prevention programs would provide a useful summary for ONAP and provide a better understanding of the programs CDC supports. Accomplishing both of these objectives would require working closely with organizations that have already dedicated substantial time and resources to these areas, including the two HIV divisions at CDC (Division of HIV/AIDS Prevention - Surveillance and Epidemiology and Division of HIV/AIDS Prevention - Intervention Research and Support) as well as other groups (e.g., other government agencies, the Council of State and Territorial Epidemiologists, and state health departments).

HIV Reporting: To describe how HIV reporting will benefit the surveillance and prevention activities of CDC. In particular, how HIV reporting will effect prevention practices. This would have the purpose of facilitating intra-governmental and external dialogues on the issue.

Both these tasks would have as their product some kind of position paper for ONAP.

In addition, there is the issue of HIV/AIDS prevention in the maritime sector. The Joint United Nations Programme on HIV/AIDS and the Civil-Military Alliance to Combat HIV and AIDS have cited this as an area that has received relatively little study and attention from the international community. In the United States, this will require interdepartmental cooperation (Transportation and Health and Human Services). Several recommendations

were made during an inter-agency consultation (held in London in October 1997), including networking to utilize the individual capabilities and comparative advantages of agencies representing the maritime sector, given that no organized central effort exists currently. This would be appropriate to work on through ONAP, although there are few specifics as yet about what will be happening with this initiative.

J. Todd Weber, M.D., F.A.C.P.

cc:
Kevin DeCock, M.D.
David Holtgrave, Ph.D.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

Todd Summers
Deputy Director
Office of National AIDS Policy
808 17th St NW Ste 820
Washington, DC 20006

October 15, 1997

Dear Mr. Summers:

Enclosed is a copy of my curriculum vitae, as we discussed.

I look forward to talking with you on November 19 at noon. Please call me if you have any questions.

Sincerely,

Todd

J. Todd Weber, MD, FACP
Medical Epidemiologist
Prevention Services Research Branch
Division of HIV/AIDS Prevention - Surveillance and Epidemiology
Centers for Disease Control and Prevention (E-46)
1600 Clifton Road NE
Atlanta, GA 30333

Phone: (404) 639-2082, 2080
Fax: (404) 639-2029

J. TODD WEBER, M.D.
MEDICAL EPIDEMIOLOGIST

CDC

DIVISION OF HIV/AIDS PREVENTION
NATIONAL CENTER FOR HIV, STD, AND TB PREVENTION
CENTERS FOR DISEASE CONTROL AND PREVENTION
1600 CLIFTON ROAD, N.E., MS E-46
ATLANTA, GA 30333

PHONE: (404) 639-2080 FAX: (404) 639-2029

CURRICULUM VITAE

CDR JONATHAN TODD WEBER
PHS # 59252
October 14, 1997

Centers for Disease Control and Prevention, E-46
1600 Clifton Road, N.E.
Atlanta, GA 30333
Phone: (404) 639-2082 Facsimile: (404) 639-2029

EDUCATION

Year	Degree	University
1987	M.D.	College of Physicians & Surgeons Columbia University New York, New York
1980-82	None	School of General Studies (Pre-medical courses), Columbia University New York, New York
1980	A.B.	Princeton University Princeton, New Jersey

POST-GRADUATE TRAINING

1987-1990	Residency in Internal Medicine, Bellevue Hospital Center and Tisch Hospital, New York University; New York, New York

MEDICAL LICENSES

State	Number	Expiration Date
New York	175086	2/28/98
Georgia	036479	12/31/97
Drug Enforcement Administration	BW3498551	5/31/99

CERTIFICATIONS

Certificate	Board	Number	Expiration Date
Diplomate	National Board of Medical Examiners	336833	None
Diplomate	American Board of Internal Medicine	130305	2001
Fellow	American College of Physicians	52776	None

WORK EXPERIENCE

1995-current

Medical Epidemiologist, Clinic and Special Surveys Section, Prevention Services Research Branch (PSRB), Division of HIV/AIDS Prevention - Surveillance and Epidemiology (DHAP-SE), National Center for HIV, STD and TB Prevention (NCHSTP), Centers for Disease Control and Prevention (CDC), Atlanta, Georgia

- Major Duties
  - Project officer for nationwide data system of all publicly-funded HIV counseling and testing (reported from >9,000 sites)
  - Supervise project manager, data managers, public health advisor, and workstudy student
  - Provide technical assistance to 65 state, local, and territorial health departments
  - Design, initiate, and conduct epidemiologic studies; analyze data and prepare manuscripts for professional publications
- Accomplishments
  - Organized new team of data managers, public health advisors, and computer programmers to work on publicly-funded HIV counseling and testing data system.
  - Created plan for national, publicly funded, HIV counseling and testing to improve system's utility for monitoring testing trends and incidence of HIV infection among persons tested
  - Designed study for surveillance of HIV subtypes resistant to antiretroviral therapy in newly infected persons
  - Author and co-author of several manuscripts (published and in press) and presentations.
- Impacts
  - Provided technical assistance to project areas, improved data collection, collected information for annual summary, and provided data for research
  - Appointed by Director of National Center for HIV, STD, and TB Prevention to work group to review current system and propose new, inter-branch organization for HIV CTS.
  - Provided data on the cost-effectiveness of HIV CT in hospitals, on trends in testing patterns in HIV CTS, on the prevalence of HTLV-I/II in a hospital

WORK EXPERIENCE (continued)

1995-current (continued)

- Impacts (continued)

  population, on pregnant women not being offered HIV CT in hospitals, on HIV infected patients who receive hospital care without recognition of their HIV infection, on the lack of HIV infection among commercial sex workers who use condoms correctly and consistently, and on the first U.S. outbreak of diarrheal illness associated with *Cyclospora*, and the use of a new botulism immune globulin.

1993-1995

Medical Epidemiologist, Population Studies Section, HIVSB, DHAP, NCHSTP, CDC, Atlanta, Georgia

- Major Duties
  - Project officer for contracts and cooperative agreements with health departments and hospitals conducting research on the epidemiology of HIV
  - Supervise data manager
  - Design, initiate, and conduct additional epidemiologic studies and analyze data and prepare manuscripts for professional publications

- Accomplishments
  - Presentations at national and international conferences
  - Prepared several manuscripts for publication
  - Assisted center director in tracking health care reform legislation and formulating comments on health care reform proposals
  - Contributed to "For a Healthy Nation: Returns on Investment in Public Health"
  - Implemented expanded protocol for Sentinel Hospital Surveillance System for HIV Infection, collecting information on risks for HIV among hospitalized patients, and prevalence of diseases included in 1993 AIDS case definition

WORK EXPERIENCE (continued)

1993-1995 (continued)

- Impacts
  - Provided data showing that despite the efficacy of zidovudine in preventing perinatal HIV transmission, many pregnant women are not being offered HIV counseling and testing and infected pregnant women are not all taking zidovudine
  - Showed that prevalence of HIV among sentinel hospital patients is stable or declining in many age and race groups
  - Determined that cost of detecting HIV infection by providing counseling and testing in hospitals was lower than many other screening programs
  - Demonstrated very low prevalence of HIV infection among insurance applicants
  - Helped show that public health measures will provide future savings in medical care

WORK EXPERIENCE (continued)

1993-current

Attending Physician, HIV Early Care Clinic, Eleanor L. Richardson Health Center, DeKalb County Board of Health STD/HIV Program, Decatur, Georgia

- Major Duties
  - Diagnosis and treatment of patients in the early stage of HIV infection
  - Consultant to nurse clinicians

1992-1993

Medical Epidemiologist, Bacterial Studies Section, Clinical Research Branch, Division of Sexually Transmitted Diseases and HIV Prevention, National Center for Prevention Services, CDC, Atlanta, Georgia

- Major Duties
  - Evaluate standard and recently approved therapies for *Chlamydia trachomatis*
  - Development of guidelines for the diagnosis and therapy of *C. trachomatis*
- Accomplishments
  - Wrote budget initiative on the prevention of infertility in women by the early detection and treatment of sexually transmitted diseases
  - Wrote article on treatments for *C. trachomatis* genital infection (published 1995); wrote guidelines for the treatment of *C. trachomatis* genital infection
  - Chaired task force on technical developments in STD prevention, diagnosis and treatment for strategic planning
- Impacts
  - New guidelines for treatment of *C. trachomatis* published for clinicians
  - Provided results of "evidence-based" approach to the published literature in background paper published in 1995, from which published STD treatment recommendations were synthesized.

WORK EXPERIENCE (continued)

1992-1993

Attending Physician, Sexually Transmitted Diseases Clinic, Eleanor L. Richardson Health Center, DeKalb County Board of Health STD/HIV Program, Decatur, Georgia

- Major Duties
  - Diagnosis and treatment of patients with sexually transmitted diseases
  - Counseling regarding testing for HIV
  - Consultant to nurse clinicians

1990-1992

Medical Epidemiologist, Epidemic Intelligence Service (EIS) assigned to the Enteric Diseases Branch (now Foodborne and Diarrheal Diseases Branch), Division of Bacterial and Mycotic Diseases, National Center for Infectious Diseases (NCID), CDC, Atlanta, Georgia

- Major Duties
  - Investigating bacterial enteric disease outbreaks
  - Preparing manuscripts for publication
- Accomplishments
  - Investigated following outbreaks: *Cyclospora*-associated diarrhea in Chicago; hemolytic uremic syndrome in Twin Falls, Idaho; typhoid fever in Westmoreland Parish, Jamaica; type E botulism in Cairo, Egypt; and cholera in Ecuador and Honduras.
  - Published articles on investigations in medical journals
  - Designed "Voice Information System," an automated telephone response system for public inquiries
- Impacts
  - Results of typhoid epidemic investigation prompted Agency for International Development to earmark funds for water and sewage treatment in the area
  - Investigation of cholera in Ecuador revealed first multidrug resistant *V. cholerae* organism in hemisphere
  - Voice Information System instituted, allowing public to quickly obtain information on agents and vehicles of foodborne and diarrheal diseases

WORK EXPERIENCE (continued)

1982-1983

Legislative Assistant, U.S. Senate, Office of Senator Daniel Patrick Moynihan, Washington, D.C.

- Major Duties
  - Drafting health and education legislation
  - Responding to constituent inquiries
  - Following health and education legislation
- Accomplishments
  - Drafted legislation on HIV/AIDS, food stamps, and organ donation
- Impacts
  - Legislation was passed into law providing increased funding to U.S. Public Health Service to perform research on HIV/AIDS
  - Legislation was passed into law promoting organ donation

PROFESSIONAL ASSOCIATIONS

American College of Physicians
Commission Officers Association, U.S. Public Health Service
Infectious Diseases Society of Georgia

AWARDS

1995

Honor Award Certificate, NCID

1994

Honor Award (Outstanding Unit Citation), USPHS, Commissioned Corps

- for outstanding service to assist in the investigation, treatment and prevention of epidemic cholera in the western hemisphere

AWARDS (continued)

1994 (continued)

Honor Award (Unit Commendation), USPHS, Commissioned Corps

- for participating in the development of the 1993 STD Treatment Guidelines

James H. Nakano Citation, NCID, CDC

- for an outstanding paper published in 1993

Honor Award Certificate, NCID

1993

Honor Award (Commendation Medal), USPHS, Commissioned Corps

- for outstanding performance in investigations in Egypt, Honduras, and Jamaica and for developing a voice information system

Honor Award Certificate, NCID

1992

Honor Award (Achievement Medal), USPHS, Commissioned Corps

- for the investigation of epidemic cholera in Guayaquil, Ecuador

Honor Award Certificate, NCID

1991

Outstanding poster presentation (co-author), EIS conference, Epidemiology Program Office, CDC

- Diarrheal Outbreak Associated with a Cyanobacteria (Blue-Green Algae)-Like Body, Chicago

Foreign Duty Service Award, USPHS, Commissioned Corps (Jamaica)

Foreign Duty Service Award, USPHS, Commissioned Corps (Egypt)

Foreign Duty Service Award, USPHS, Commissioned Corps (Ecuador)

EDUCATIONAL ACTIVITIES - TEACHING

1994

Patient/Doctor Course (section leader for weekly seminar). Emory University School of Medicine, Department of Family and Preventive Medicine (Spring)

Implementing National HIV Sentinel Surveys (section instructor). CDC, International Course in Surveillance and Applied Epidemiology for HIV and AIDS

1992

Cholera in Ecuador (lecture). Epidemiology course, Columbia University School of Public Health

Diagnosis and treatment of botulism and discussion of a massive outbreak of botulism, Egypt, 1991 (lecture and seminar). Infectious Diseases Combined Conference (Columbia University affiliated hospitals)

1991

Epidemiology of Cholera (lectures). Course on diagnostic and laboratory methods for *Vibrio cholerae*. Panamerican Health Organization/Instituto Nacional de Higiene, Caracas, Venezuela

EDUCATIONAL ACTIVITIES - SCIENTIFIC REVIEWER FOR JOURNALS

American Journal of Epidemiology
Annals of Emergency Medicine
Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology
Journal of the American Medical Association
The Lancet
The Medical Letter
The New England Journal of Medicine
Social Science & Medicine

EDUCATION - COURSES TAKEN AT CDC

Assessing the Effectiveness of Public Health Programs
Basic Project Officer (Contracts)
Categorical Data Analysis
Effective Information Display, Statistical and Other
Genetics and Public Health : An Introductory Course
HIV Prevention Counseling/Training of Trainers
Manage and Control Multiple Priorities
Orientation to Grants Management for Program Officials
Preventing Sexual Harassment
Regression Modeling in Epidemiologic Research

EDUCATION - COURSES TAKEN AT CDC (continued)

SAS Basics for the Personal Computer
SAS Fundamentals for the Mainframe
Statistics II
Statistics III
Supervisory Survival Skills I (supervisory course)
Building Leadership Skills (supervisory course)

PRESENTATIONS AT NATIONAL MEETINGS

1997

Prevalence of Tuberculosis, Recurrent Bacterial Pneumonia, and Invasive Cervical Cancer among HIV-Infected Hospital Patients, 1994-1995 (poster),4th Conference on Retroviruses and Opportunistic Infections, January 22-26, Washington, DC (Session 23; Paper 188)

1996

Absence of HIV Seroconversion among Sex Workers at Legal Brothels, Nevada, 1990-1995 (oral), 124th Annual Meeting of the American Public Health Association, November 17-21, New York, N.Y.

1995

HIV-1 among Applicants for Life, Health, and Disability Insurance, 1991-1992 (poster). 2nd National Conference on Human Retroviruses and Related Infections, January 29-February 2, Washington, D.C.

Antiretroviral Chemotherapy and Undetected HIV Infection among Obstetrical Patients in U.S. Hospitals with High HIV Prevalence (oral). 35th ICAAC, September 18, 1995, San Francisco, CA

1993

Increasing HIV-1 Seroprevalence at Sentinel Hospitals (poster). First National Conference on Human Retroviruses and Related Infections, December 12-16, Washington, D.C.

1992

Investigation of Cholera Epidemic, Ecuador, 1991 (oral). EIS Conference, April 6

Massive outbreak of botulism, Egypt, 1991 (oral). EIS Conference. April 7

PRESENTATIONS AT NATIONAL MEETINGS

1992 (continued)

Cholera in the United States, 1965-1991: the Role of Domestic Shellfish, International Travel, and Imported Foods (oral). Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC), October 13

Multiply-resistant Epidemic Cholera in Ecuador: Transmission by Water and Seafood (oral). ICAAC, October 13

1991

Outbreak of Typhoid in Westmoreland Parish, Jamaica (oral, late breaking report). EIS conference, April 11

Diarrheal Outbreak Associated with a Cyanobacteria (Blue-Green Algae)-Like Body - Chicago (poster, co-author). EIS conference, April 11

PRESENTATIONS AT INTERNATIONAL MEETINGS

1996

Missed opportunities for HIV testing in a South Bronx community at high risk for HIV infection, New York, New York, U.S.A. (poster). XI International Conference on AIDS, July 7-12, 1996, Vancouver, Canada

1994

Trends in recent HIV-1 infection among patients at Sentinel Hospitals in the United States, 1988-1992 (poster). Tenth International Conference on AIDS, August 7-12, Yokohama, Japan

INTRAMURAL PRESENTATIONS

1994

Trends in HIV seroprevalence and $\beta_2$microglobulin at Sentinel Hospitals. Public Health Service workshop: AIDS case projections, and HIV seroprevalence and incidence estimates, February 23-24

1992

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CDR JONATHAN TODD WEBER
PHS # 59252

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CONTINUING EDUCATION/TRAINING SUMMARY: 1997

CDR JONATHAN TODD WEBER, M.D., F.A.C.P.
PHS # 59252

Date	Title/Sponsoring Organization	Outcome
1/22-1/26	4th Conference on Retroviruses and Opportunistic Infections; Centers for Disease Control and Prevention (CDC),National Institutes of Health, and the Infectious Diseases Society of America; Washington, D.C.	20
2/13	Improving the Management of HIV Disease; International AIDS Society - USA; Atlanta, GA	3
3/20-3/21	78th Annual Session; American College of Physicians; Presession course: Common Problems in Primary Care; Philadelphia, PA	14
3/22-3/25	78th Annual Session; American College of Physicians; Philadelphia, PA	25.5
4/14-4/18	46th Annual Epidemic Intelligence Service Conference; CDC; Atlanta, GA	22
6/25-6/28	International Workshop on HIV Drug Resistance, Treatment Strategies and Eradication; University of California, San Diego School of Medicine; St. Petersburg, FL	26.5
Various	Federal Practitioner; Albert Einstein College of Medicine & Montefiore Medical Center; New York, NY	4
Various	Epidemiology Grand Rounds, CDC, Atlanta, GA	5
	Total	120*

* Category 1 of the Physician's Recognition Award of the American Medical Association

Fax

To: Todd Summers

Of: ONAP

Fax: (202) 632-1096

Phone: (202) 632-1090

Re: Detail to ONAP from CDC

Pages: 1, including this cover sheet.

Date: December 18, 1997

Todd

I have not received any paperwork from your office. This, as well as still being without a memorandum to the DCP or orders, makes me think a starting date of January 5 is optimistic.

jtw

From the desk of..
J. Todd Weber, MD, FACP
Centers for Disease Control and Prevention, E-46
1600 Clifton Road, N.E.
Atlanta, GA 30333
Phone: (404) 639-2082 Facsimile: (404) 639-2029

Fax

To: Todd Summers

Of: Office of National AIDS Policy

Fax: (202) ~~254-9835~~ 632-1096

Phone: (202) 632-1090

Pages: 4 ~~5~~, including this cover sheet.

Date: December 12, 1997

Todd:

I am finding that no one here seems to have a clear idea of how to make my assignment happen. We did not discuss when you were here who you would be formally contacting at CDC or the Commissioned Corps to make the assignment.

Do you have anyone in the office now who is in the Commissioned Corps? How did you get them into your office? Were they already in Washington?

Attached are the guidelines for detailing a commissioned officer. Straight forward, but not simple or fast.

Please advise how to proceed from here.

Thanks.

jtw

Syndey Stephens
(301) 594-3396
3000

From the desk of...
J. Todd Weber, MD, FACP
Centers for Disease Control and Prevention (E-46)
1600 Clifton Road, NE
Atlanta, GA 30333
Phone: (404) 639-2082
Facsimile: (404) 639-2029

DETAILS

Key Concepts

1. A detail is the assignment of a PHS officer to a non-PHS organization. Its purpose is to foster cooperation with the non-PHS organization which has a similar health-related mission. Details are effected for the benefit of the PHS and not solely for the individual.

2. These organizations include other Federal Agencies, State, and local governments, non-profit institutions, and congressional committees.

3. There are 4 possible financial arrangements which can be made:

   1) A reimbursable detail in which PHS is reimbursed for salary and related expenses;

   2) A non-reimbursable detail in which the PHS can continue to fund the officer's salary and related employment expenses;

   3) A Leave Without Pay detail in which States, local governments, and non-profit institutions may pay the officer directly after he/she is placed in leave without pay status; and

   4) A grant-supported detail in which the reimbursement costs are defrayed from State grant funds.

4. Officers on detail continue to accrue retirement credit and fringe benefits. The PHS is implementing a phased-in reimbursement plan to cover these and administrative costs involved in the detail of officers to non-PHS organizations.

Procedures

1. The request for the detail should be submitted to the Director, DCP, for evaluation based upon specific criteria. DCP has developed standard formats for personnel agreement:

   The request must include:

   a. Purpose of the detail;

   b. Reasons for requesting PHS assistance;

   c. Number and disciplines of officers requested;

   d. Grade level or experience and training required by the position;

   e. The position title and brief description of duties to be performed by the officer;

   f. Proposed financial arrangements, i.e., fully reimbursable or non-reimbursable;

g. Name and position of non-PHS supervisor;

h. Rate of compensation and allowances to be paid by the non-PHS organization; and

i. Travel and transportation allowances if any, payable by the organization for travel of the PHS officer, travel incident to medical care and transportation of dependents, household goods, and personal effects to and from the place of detail.

2. The non-PHS organization wishing to obtain specific skills or expertise through the assignment of a commissioned officer must first develop qualifications/job criteria which will be used to advertise the position. The position must be advertised and competed among qualified and interested officers in the General Service Vacancy Announcement system and in the DCP Vacancy Announcement and Tracking System through which a maximum number of officers have access to compete.

3. The PHS Agency supporting the detail of the officer works with the non-PHS organization in developing a personnel agreement. This would describe funding arrangements, duties, length and location of assignment, PHS and non-PHS responsibilities.

4. The request for detail is submitted to the Director, DCP, for review and the Director's recommendation and the request will be forwarded to the Surgeon General for final decision.

Paperwork

1. Forward request of outside organization with justification/support of Agency head of the hosting Agency to the Surgeon General for approval (through Director, DCP).

2. Working with program management, management from the office from which the officer will be detailed, and the DCP specialist, prepare the detail agreement. Use the format described in the CCPM INSTRUCTION for the type of detail being arranged.

3. Forward the agreement through program channels to DCP for formal approval.

4. If a personnel order must be issued, follow the instructions described under the paperwork section of Appointment and Selection above.

Help

1. Contact the Detail officer, ODB, DCP, at 301-594-3360, for information and assistance with detail assignments.

2. Written sources of information about details include:

   a. CCPM, Subchapter CC23.5, INSTRUCTION 5, "Details of PHS Commissioned Officers to States and Nonprofit Institutions";

b. CCPM, Subchapter CC23.5, INSTRUCTION 6, "Details to Faculty Positions at the Uniformed Services University of the Health Sciences"; and

c. CCPM, Subchapter CC23.5, INSTRUCTION 7, "Details to Congressional Committees".

CONVERSION FROM CIVIL SERVICE TO COMMISSIONED CORPS

Key Concepts

1. A PHS civil service employee may be converted to an appointment as a commissioned officer if the individual meets all appointment criteria. Generally it is expected that the PHS civil service employee will be mobile, either at the time of conversion or in the immediate future (next 3 to 4 years). If compelling reasons make it necessary for the applicant to remain initially with the same PHS Agency/program, the Program Head must provide documentation of the benefits of the conversion. This must also include a cost comparison.

2. This policy encourages proper utilization of both personnel systems and deters individuals from changing systems solely for financial reasons or personal gain.

Procedures

The individual wishing to convert must make application for appointment as described in the section on Appointment and Selection. Consult with the TAB, DCP, about the feasibility of the conversion and need for approval by the Director, DCP.

Paperwork

1. Use the paperwork requirements discussed under the Appointment and Selection Section. If your program wishes to keep an individual in the same position and allow him/her to convert from civil service to commissioned corps, you must request approval from the Director, DCP.

2. If conversion is approved, follow the paperwork requirements explained under the Appointment and Selection section.

Help

1. For information about conversion, contact the TAB, DCP, at 301-594-3112.

INACTIVE RESERVE PROGRAM

Key Concepts

1. The individual ready reserve (IRR) program, a subset of the inactive reserve corps (IRC), is comprised of health professionals, most of whom have served on active duty as PHS commissioned officers, and

Fax

To: Todd Summers

Of: Office of National AIDS Policy

Fax: (202) ~~254-9835~~ 632-1090

Phone: (202) 632-1090

Pages: 3, including this cover sheet.

Date: December 8, 1997

Todd:

Attached is the memorandum. This has been approved through my division. Please let me know what the next steps are.

Thanks.

jtw

P.S. Chad has scheduled me to meet with you 9 am Tuesday.

From the desk of...
J. Todd Weber, MD, FACP
Centers for Disease Control and Prevention (E-46)
1600 Clifton Road, NE
Atlanta, GA 30333
Phone: (404) 639-2082
Facsimile: (404) 639-2029

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Centers for Disease Control
and Prevention (CDC)

Memorandum

Date December 8, 1997

From Medical Epidemiologist
Division of HIV/AIDS Prevention - Surveillance and Epidemiology

Subject Detail to Office of National AIDS Policy

To Todd Summers
Deputy Executive Director, Office of National AIDS Policy

This describes the planned projects and duties during my assignment to the White House Office of National AIDS Policy (ONAP) for six months beginning January 5, 1998. The broad purpose of detail is to take on a project or projects of benefit to CDC and to ONAP. There are two projects which would satisfy these dual purposes.

HIV Prevention: To describe how epidemiologic science is being used to develop prevention interventions and to describe which prevention programs are effective and which are not. This would provide ONAP with information on how the epidemiologic data that are collected and analyzed by CDC are used to design and support prevention programs and would demonstrate that data are not collected for the sake of data collection alone. The description of effective (and ineffective) prevention programs would provide a useful summary for ONAP and provide a better understanding of the programs CDC supports. Accomplishing both of these objectives would require working closely with organizations that have already dedicated substantial time and resources to these areas, including the two HIV divisions at CDC (Division of HIV/AIDS Prevention - Surveillance and Epidemiology and Division of HIV/AIDS Prevention - Intervention Research and Support) as well as other groups (e.g., other government agencies, the Council of State and Territorial Epidemiologists, and state health departments).

HIV Reporting: To describe how HIV reporting will benefit the surveillance and prevention activities of CDC. In particular, how HIV reporting will effect prevention practices. This would have the purpose of facilitating intra-governmental and external dialogues on the issue.

Both these tasks would have as their product some kind of position paper for ONAP.

In addition, there is the issue of HIV/AIDS prevention in the maritime sector. The Joint United Nations Programme on HIV/AIDS and the Civil-Military Alliance to Combat HIV and AIDS have cited this as an area that has received relatively little study and attention from the international community. In the United States, this will require interdepartmental cooperation (Transportation and Health and Human Services). Several recommendations

were made during an inter-agency consultation (held in London in October 1997), including networking to utilize the individual capabilities and comparative advantages of agencies representing the maritime sector, given that no organized central effort exists currently. This would be appropriate to work on through ONAP, although there are few specifics as yet about what will be happening with this initiative.

J. Todd Weber, M.D., F.A.C.P.

cc:
Kevin DeCock, M.D.
David Holtgrave, Ph.D.

To Todd

Date 10/21/97 Time 2:05

WHILE YOU WERE OUT

M Todd Webber

of e-mail: jtw5@cdc.

Phone 404 639 2082 90

Area Code Number Extension

TELEPHONED		PLEASE CALL	
CALLED TO SEE YOU		WILL CALL AGAIN	
WANTS TO SEE YOU		URGENT	
RETURNED YOUR CALL			

Message Did you receive his CV? → to clearance paperwork about his clearance & how soon he can get started

Operator

AMPAD EFFICIENCY® 23-023 CARBONLESS

Fax

To: Todd Summers

Of: ONAP

Fax: (202) 632-1096

Phone: (202) 632-1090

Re: Good news

Pages: 3, including this cover sheet.

Date: December 24, 1997

Todd

Memorandum assigning me to ONAP is completed and cleared (copy attached, it should look familiar). Orders can be written at any time. As of right now, I am able and planning to be in the office January 5. Is this possible without paperwork completed from your office?

Other, equally mundane matters: Will I have a computer in your office? Is there e-mail? What kinds of operating system and word processing program do you use?

Looking forward to getting there and getting to work,

jtw

From the desk of..
J. Todd Weber, MD, FACP
Centers for Disease Control and Prevention, E-46
1600 Clifton Road, N.E.
Atlanta, GA 30333
Phone: (404) 639-2082 Facsimile: (404) 639-2029

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

To: CDR Jonathan T. Weber (PHS #59252)

From: Director, Division of HIV/AIDS Prevention - Surveillance and Epidemiology, NCHSTP

Subject: Temporary Assignment to Office of National AIDS Policy
January 1 through April 30, 1998

Date: December 23, 1997

This describes the planned projects and duties of CDR Jonathan T. Weber during the temporary assignment to the White House Office of National AIDS Policy (ONAP). He is assigned for 120 days with the option to renew this assignment after this period.

The broad purpose of this temporary assignment is to take on a project or projects of benefit to CDC and to ONAP. There are two projects which would satisfy these dual purposes.

HIV Prevention: To describe how epidemiologic science is being used to develop prevention interventions and to describe which prevention programs are effective and which are not. This would provide ONAP with information on how the epidemiologic data that are collected and analyzed by CDC is used to design and support prevention programs and would demonstrate that data are not collected for the sake of data collection alone. The description of effective (and ineffective) prevention programs would provide a useful summary for ONAP and provide a better understanding of the programs CDC supports. Accomplishing both of these objectives would require working closely with organizations that have already dedicated substantial time and resources to these areas, including the two HIV divisions at CDC (Division of HIV/AIDS Prevention - Surveillance and Epidemiology and Division of HIV/AIDS Prevention - Intervention Research and Support) as well as other groups (e.g., other government agencies, the Council of State and Territorial Epidemiologists, and state health departments).

HIV Reporting: To describe how HIV reporting will benefit the surveillance and prevention activities of CDC. In particular, how HIV reporting will effect prevention practices. This would have the purpose of facilitating intra-governmental and external dialogues on the issue.

Both these tasks would have as their product some kind of position paper for ONAP.

In addition, there is the issue of HIV/AIDS prevention in the maritime sector. The Joint United Nations Programme on HIV/AIDS and the Civil-Military Alliance to Combat HIV and AIDS have cited this as an area that has received relatively little study and attention from the international community. In the United States, this will require interdepartmental cooperation (Transportation and Health and Human Services). Several recommendations were made during an inter-agency consultation (held in London in October 1997), including networking to utilize the individual capabilities and comparative advantages of agencies representing the maritime sector, given that no organized central effort exists currently.

During CDR Weber's temporary assignment he will be supervised by Todd Summers, Deputy Director of ONAP.

Kevin M. DeCock, M.D., F.R.C.P., D.T.M.&H.

cc:
Chief, Prevention Services Research Branch, DHAP-SE, NCHSTP
Staff Specialist, Commissioned Corps Section, OB, HRMO, OPS

Please send fed-ex to

Dr. Todd Weber
Centers for Disease Control
Building E-46
1600 Clifton Rd NE
Atlanta, GA 30333

Ph: (404) 639-2082

Sent 12/24/97 BA

WHITE HOUSE OFFICE
OTHER GOVERNMENT EMPLOYEES

TO: OFFICE OF MANAGEMENT AND ADMINISTRATION	FROM: (Requesting official's name and department or office) Todd Summers, Deputy Director AIDS Policy

THIS IS TO REQUEST THAT THE FOLLOWING INDIVIDUAL PERFORM DUTIES IN THE WHITE HOUSE OFFICE

NAME: Last First Middle Initial

BIRTHDATE:	SOCIAL SECURITY NUMBER:	DATE AND TYPE OF APPOINTMENT IN EMPLOYING AGENCY:
GRADE/STEP:	SALARY:	

PARENT AGENCY:

E BELOW:

Fill out above this

☐ STUDENT VOLUNTEER

☐ OTHER_____

and this line

Yr):

N PARENT AGENCY (Name & Telephone):

X

TYPE OF DETAIL (If applicable):

☒ Non-Reimbursable ☐ Reimbursable

IF REIMBURSABLE, FMD CERTIFICATION OF FUNDS AVAILABILITY:

ASSIGNMENT LOCATION
(Office or Division, Building, Room Number, & Telephone):
808 17th Street, Ste 820
Washington, DC 20006
(202) 632-1090

WHO CONTACT PERSON (Name & Telephone):
Todd Summers, Deputy Director AIDS Policy

SIGNATURE OF WHO APPROVING OFFICIAL: DATE:

OFFICE OF MANAGEMENT AND ADMINISTRATION APPROVAL: DATE:

WH FORM
Revised 5/94

Sign but don't date

I hereby acknowledge that my appointment to a position in the Executive Office of the President (EOP) is subject to the applicant drug testing requirement as set forth in the EOP Drug-Free Workplace Plan. I also acknowledge that I am responsible to present myself for a drug test prior to my appointment at a place and time to be determined. Should it be determined, under the requirements of the Plan, that I have a verified positive test result for any of the prohibited drugs, I understand that my appointment will be terminated.

Date	*Signature*
Social Security Number	*Typed or Printed Name*
Agency	*Telephone Number*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Substance Abuse and Mental
Health Services Administration
Rockville MD 20857

DEC 15 1997

Ms. Sandra Thurman
Director, Office of National AIDS Policy
The White House
808 17th Street NW, Suite 820
Washington, DC 20006

Dear Ms. Thurman:

This letter is to acknowledge that LCDR Brad Austin will serve ~~a detail~~ to the Intergovernmental Task Force on AIDS beginning December 16. While on this four month ~~detail~~, LCDR Austin will report to Mr. Todd Summers, Deputy Director of the Office of National AIDS Policy (ONAP). I have selected LCDR Austin because of his expertise with both HIV/AIDS and substance abuse treatment issues. While working in your office, he will:

- help coordinate a more effective response to collaborative efforts between the fields of substance abuse treatment, mental health, and HIV prevention efforts;
- provide expertise to The White House and ONAP on substance abuse treatment issues; and
- continue collaboration efforts between SAMHSA, CDC and NIH on issues concerning the intersection of HIV, substance abuse and gay and bisexual males.

LCDR Austin is well suited to provide expertise to your office and I am confident his service will be of great benefit.

David J. Mactas
Director
Center for Substance Abuse Treatment

need a letter like
this from Brian
1.1 - Landmark

MEMO

To: Todd Summers
From: J. Todd Weber, MD, FACP
Subject: Whereabouts
Date: January 16, 1998

My likely travel schedule from now until July. Subject to change.

January 31 - February 8	5th Conference on Retroviruses and Opportunistic Infections, Chicago, IL
February 13 - 16	CDC, Atlanta, GA
March 8 - 11	Emerging Infections Conference, CDC, Atlanta, GA
March 29 - April 1	HIV Prevention Summit, St. Louis, MO
April 1 - 5	American College of Physicians Annual Session, San Diego, CA
April 20 - 24	Epidemic Intelligence Service Conference, CDC, Atlanta, GA
April 30	Florida HIV Counseling and Testing Conference, Tallahassee, FL
June 28 - July 3	12th World AIDS Conference, Geneva, Switzerland

cc: D. Montoya

1/16/98

Todd

Abstract to be submitted to 12th World AIDS Caference, June 28 - July 3, 1998, Geneva.

jtw

Pulmonary Tuberculosis in HIV-infected and Uninfected Patients in Sentinel Hospitals in the United States, 1994-1995

Objectives: To compare prevalences of pulmonary tuberculosis (PTB) in persons with and without HIV infection, to evaluate the inclusion of PTB in the 1993 U.S. AIDS surveillance case definition and to compare the prevalence of TB antimicrobial susceptibility in persons with and without HIV infection.

Design: Unlinked serosurvey.

Methods: The Sentinel Hospital Surveillance System for HIV Infection collected data and serum specimens that remained after clinical testing of a sample of persons 15-54 years old who received inpatient or outpatient care in 11 cities at 14 hospitals with high HIV prevalence (≥ 1 case newly diagnosed AIDS per 1000 discharges). We collected information from the medical record for the visit during which the serum sample was taken. Identifying information was then removed (unlinked) and a single study number was assigned to the patient's specimen and medical record data. Specimens were then screened for HIV antibody. We analyzed data on HIV serostatus, PTB, and TB antimicrobial susceptibility. Multidrug resistance to TB antimicrobial agents (MDRTB) was defined as laboratory-confirmed resistance to isoniazid and rifampin.

Results: In 1994 and 1995, 8,566 (9.6%) of the 89,206 persons sampled had HIV infection. Of HIV-positive persons, 451 (5.3%) had PTB and of the HIV-negative persons 304/80,640 (0.4%) had PTB (Relative risk = 13.9, Confidence interval = 12.1-16.1). MDRTB infections were found in 20 (4.4%) cases of PTB among HIV-positive persons and in 3 (0.9%) cases of PTB among HIV-negative persons ($p < .01$).

Conclusions: HIV positive patients receiving care at hospitals were nearly 14 times more likely than HIV negative patients to have PTB. This finding supports the inclusion of PTB in the 1993 U.S. AIDS surveillance case definition. MDRTB was found approximately 5 times more often in HIV positive patients compared with HIV negative patients.

1/16/98

Todd

Poster to be presented at
5th Conference on Retroviruses
and Opportunistic Infections
Feb. 1-5, 1998, Chicago.

Please return to me. jtw

98-10

Invasive Cervical Cancer in Human Immunodeficiency Virus-infected and Uninfected Hospital Patients, 1994-1995

J. Todd Weber, MD, FACP, Kevin M. Chin, AB, Jasjeet S. Sidhu, MD, MPH, and Robert S. Janssen, MD for the Sentinel Hospital Surveillance System for HIV Infection Principal Investigators

Prevention Services Research Branch, Division of HIV/AIDS Prevention - Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention Atlanta, Georgia

Abstract

Objective: To compare prevalences of invasive cervical cancer in women with and women without human immunodeficiency virus [HIV] infection to evaluate the inclusion of invasive cervical cancer in the AIDS surveillance case definition.

Methods: The Sentinel Hospital Surveillance System for HIV Infection collected data and serum specimens that remained after clinical testing of persons who received inpatient or outpatient care at 14 hospitals with high HIV prevalence. We analyzed data on invasive cervical cancer status obtained from medical record review and HIV serostatus from white, black, and Hispanic women in the age groups 20 to 34, 35 to 44, and 45 to 54 years.

Results: In 1994 and 1995, 2684 (6.6%) of the 40,524 women sampled had HIV infection. Of HIV-positive women, 28 had invasive cervical cancer (10.4 per 1000 women) and of the HIV-negative women, 236 had invasive cervical cancer (6.2 per 1000 women, relative risk [RR] = 1.7, 95% confidence interval [CI] = 1.1 - 2.5). Prevalence of invasive cervical cancer was higher for HIV-positive than for HIV-negative black women aged 20 to 34 (RR = 3.8, CI = 1.7 - 8.5) and Hispanic women aged 20 to 34 (RR = 7.3, CI = 1.4 - 37.1) and 35 to 44 (RR = 3.9, CI = 1.1 - 14.7) years. Of the 28 cases of invasive cervical cancer in HIV-positive patients, 26 (92.9%) were in patients known to be HIV-positive during admission.

Conclusion: The prevalence of invasive cervical cancer was higher for women who were HIV-positive than for women who were HIV-negative. This lends support to the inclusion of invasive cervical cancer in the revision of the surveillance case definition for AIDS in 1993.

This study was carried out under cooperative agreements U62/CCU206208, U62/CCU306213, and U62/CCU406219 and under request for proposals 200-93-0622 of the Centers for Disease Control and Prevention.

Background

- Women with HIV have an increased frequency of cervical intraepithelial neoplasia (CIN).
- CDC expanded the surveillance AIDS case definition in 1993 to include HIV-positive women with invasive cervical cancer (ICC).
- ICC rather than CIN was chosen because the diagnosis of ICC is generally unequivocal and most CIN lesions do not progress to invasive disease.

Objective

- To compare the prevalences of ICC among HIV-positive and HIV-negative women in sentinel hospitals to determine if there is a greater prevalence of ICC among women infected with HIV as a way of evaluating the change in the surveillance case definition.

Materials and Methods

- Hospital selection: Fourteen hospitals that had participated in a previous phase of the Sentinel Hospital Surveillance System for HIV Infection and met the definition for high HIV prevalence in 1990-1991 (≥1 case newly diagnosed AIDS per 1000 discharges per year).
- Specimens: Inpatient and outpatient serum specimens remaining after clinical testing were systematically selected to meet predetermined quotas based on the distribution of age and sex in the U.S. Duplicate specimens from the same person during the calendar year were eliminated.
- Medical record data: Information collected from the medical record for the visit during which the serum sample was taken
- Delinking: After all information was collected, all identifying information was removed (delinked), and a study number was assigned. The same number applied to both laboratory and medical record data form the same patient.

- Statistical tests: Relative risks and Taylor series 95% confidence intervals were determined by using EPI Info, version 6.04b (CDC, Atlanta, GA., 1997).

Definitions

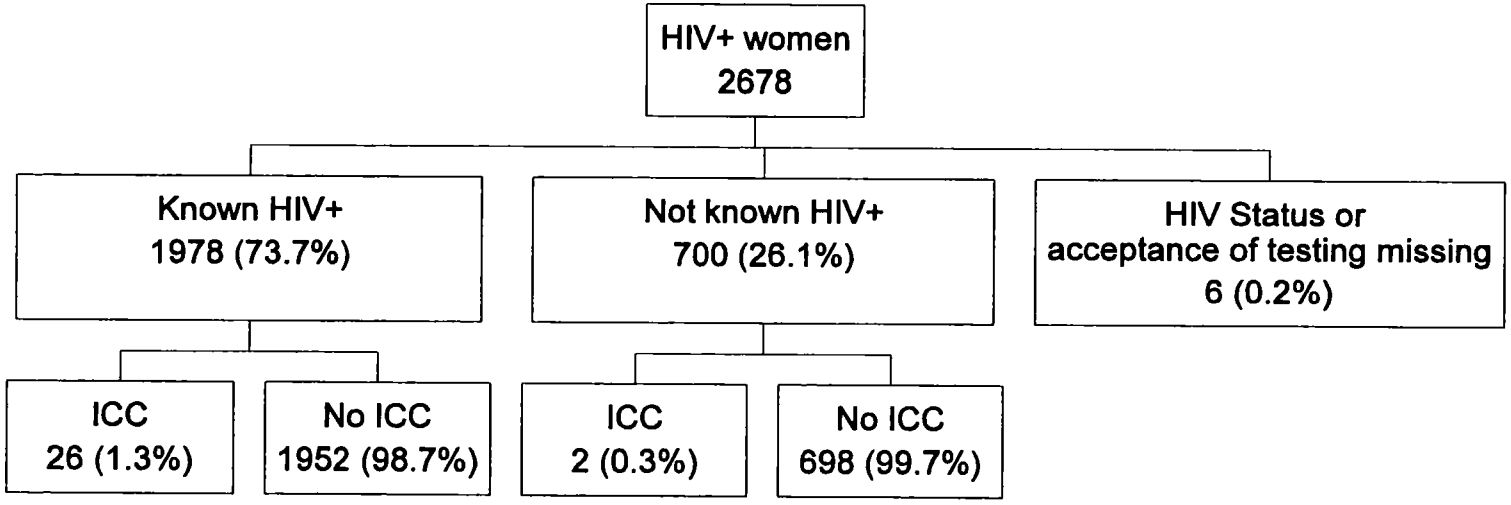
- ICC: a current diagnosis of ICC for which the patient had not been previously treated.
- No ICC: a negative or no Pap smear within the previous 3 years; cervix removed previously; successfully treated for ICC with a post-treatment, negative Pap smear in the previous 3 years; no mention of a Pap smear or a diagnosis of ICC.
- HIV infection: Positive result of HIV antibody test performed after delinking.
- Known HIV infection: patient known to be HIV-positive during the visit or the admission and positive test result for HIV after delinking.
- Racial or ethnic groups: white, black, and Hispanic. There were too few patients of other racial or ethnic groups for meaningful analysis.

Invasive Cervical Cancer in White, Black, and Hispanic Women in Sentinel Hospitals, 1994-1995

Race or ethnicity, by age group	HIV + women		HIV - women		Relative risk (95% CI)
	ICC cases (n)	rate* per 1000	ICC cases (n)	rate* per 1000	
White					
20-34	1 (122)	8.2	23 (5717)	4.0	2.0 (0.3 - 15.0)
35-44	1 (117)	8.5	55 (4376)	12.6	0.7 (0.1 - 4.9)
45-54	0 (28)	0	37 (3394)	10.9	. . .
all ages	2 (267)	7.5	115 (13487)	8.5	0.9 (0.2 - 3.5)
Black					
20-34	8 (875)	9.1	22 (9084)	2.4	3.8 (1.7 - 8.5)
35-44	9 (876)	10.3	31 (5625)	5.5	1.9 (0.9 - 3.9)
45-54	2 (268)	7.5	46 (3708)	12.4	0.6 (0.2 - 2.5)
all ages	19 (2019)	9.4	99 (18417)	5.4	1.8 (1.1 - 2.9)
Hispanic					
20-34	2 (174)	11.5	5 (3156)	1.6	7.3 (1.4 - 37.1)
35-44	3 (159)	18.9	8 (1664)	4.8	3.9 (1.1 - 14.7)
45-54	2 (65)	30.8	9 (1116)	8.1	3.8 (0.8 - 17.3)
all ages	7 (398)	17.6	22 (5936)	3.7	4.8 (2.0 - 11.0)
Total	28 (2684)	10.4	236 (37840)	6.2	1.7 (1.1 - 2.5)

ICC = invasive cervical cancer; CI = confidence interval. * Rates equal number of ICC cases per 1000 women in the specific subgroup

Invasive Cervical Cancer in HIV positive Women by knowledge of infection status



Discussion

- Women who were HIV-positive had a higher prevalence of ICC than women who were HIV-negative.
  - ☐ The highest risk was observed among young black and young Hispanic women.
  - ☐ This lends support to the inclusion of ICC in the revision of the surveillance case definition for AIDS in 1993.
- The prevalence of ICC was higher for women who were known to be HIV-positive than for those not known to be HIV-positive.
  - ☐ A possible explanation for this difference is that women who are known to be HIV-positive are more effectively screened than women who do not know they are HIV-positive.
- One fourth of HIV-positive women were not known to be infected at the time of their hospital visit and were not offered HIV testing.

- Women with unknown HIV infection who enter the hospital represent a lost opportunity for the detection of ICC as well as treatment for HIV.

Limitations

- Patients were not actively screened for ICC
- Patients may have had undetected ICC that was not reported in the medical record.
- Because of the cross-sectional design of the study, our data provide incomplete information on prevalence and cannot be used to infer incidence.
- The prevalence of human papillomavirus types associated with cervical cancer was not determined.
    - ☐ HIV-positive women have a high rate of persistent infection with these human papillomaviruses, which may explain our findings.

Recommendations

- All women aged 20 to 54 years who receive care in hospitals with high HIV prevalence be offered HIV testing.
- For women with newly diagnosed HIV infection, a complete history of cervical disease should be obtained, followed by a pelvic examination and a Pap smear.
- Prospective studies that include examination of HIV-positive and HIV-negative women and collection of data on immune status are needed. The results from these studies would clarify whether current screening recommendations should be changed.

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