AIDS Policy Center
For Children, Youth & Families

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AIDS Policy Center for Children, Youth & Families
Reauthorization of the Ryan White CARE Act
Summary of Policy Positions

AIDS Policy Center for Children, Youth & Families is a national, non-profit organization that was founded to help respond to the unique concerns of children, youth, women, and families who are living with, at risk for, or affected by HIV/AIDS. AIDS Policy Center conducts policy research, education, and advocacy on a broad range of HIV/AIDS prevention, care, and research issues.

AIDS Policy Center's membership includes over 500 community-based organizations in 30 states, the District of Columbia, and Puerto Rico, as well as individual young people, women, and family members throughout the United States. The majority of these organizations and individuals provide or receive HIV/AIDS services funded by Title IV of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Title IV of the CARE Act provides funding for medical care, social services, and access to research for low-income children, youth, women and families.

Continuing Need for Title IV of the Ryan White CARE Act

The HIV epidemic continues to have a devastating impact on women, children, youth and families in the United States. The Centers for Disease Control estimates that between 120,000 and 160,000 women are living with HIV in the United States, and that about 52,000 of them have AIDS. The proportion of new AIDS cases attributed to women tripled from 7% in 1985 to 23% in 1998. In recent years, new treatments for HIV have helped to reduce AIDS-related deaths among women. However, women with HIV have not benefited from the treatment revolution as much as men. While AIDS-related deaths among men declined by 44% from 1996 to 1997, AIDS-related deaths among women only declined by 32%. Women of color continue to be disproportionately impacted by HIV/AIDS. Although African-American women and Latinas make up about 21% of the U.S. population, they account for almost 80% of the AIDS cases reported among women in 1998.

From 1996 to 1998, the number of children who were newly diagnosed with AIDS declined by 43%. This positive trend is due in part to the availability of new medications that have helped to improve and prolong the lives of children who are living with HIV. The trend is also due to the declining rate of new HIV infections resulting from perinatal HIV transmission. Between 1992 and 1997, the number of infants who contracted AIDS from their mothers declined

by two-thirds. This decrease is thanks to the continued success of efforts to promote voluntary HIV testing and zidovudine therapy for pregnant HIV-infected women and their infants.

Some people have wrongly concluded that, as fewer children are born with HIV infection, fewer resources are needed for pediatric and maternal HIV/AIDS services. In fact, as the death rate among children with AIDS goes down, more children than ever before are living with HIV and AIDS and are in need of comprehensive services. In addition, it will be a major public health challenge to continue to reduce perinatal transmission as the number of HIV-infected women of childbearing age keeps rising. More resources are required to provide HIV-positive pregnant women with prenatal care, HIV counseling and testing, and access to treatment to improve their health and reduce perinatal HIV transmission.

Perhaps the most dire AIDS statistics are on the impact of the epidemic among our nation's young people. Through 1998, over 3,400 adolescents ages 13 to 19, 24,400 young adults ages 20 to 24 and 90,900 young adults ages 25 to 29 had been reported with AIDS. Unfortunately, these figures are but the tip of the iceberg. It is estimated that about half of new HIV infections in the U.S. occur in people under age 25, and one quarter occur in people under age 22. Because of the delay between infection with HIV and the development of AIDS, many - - perhaps most - - of the young adults who develop AIDS in their twenties were infected with HIV as teens. In addition, youth of color are disproportionately affected by HIV. Among young people with AIDS, 57% of males and 77% of females are African-American or Latino.

Young people are less likely to be insured by Medicaid or private insurance than any other age group. This lack of health care access, coupled with a lack of adequate HIV outreach, counseling, and testing programs targeting at-risk youth, have resulted in a large gap between the total number of HIV-infected youth and the number of HIV-infected youth in care. Studies indicate that HIV-infected young people tend to enter care only once they are already very sick. To counter this problem, adolescents need access to HIV/AIDS care and treatment services that can meet their unique needs.

The Ryan White CARE Act

The Ryan White CARE Act is a key federal resource for people living with HIV and AIDS. Congress enacted the CARE Act in 1990 by a nearly unanimous vote to provide emergency disaster relief to help states and communities respond to the AIDS epidemic. The CARE Act was reauthorized in 1996 through September 30 of the year 2000.

The CARE Act provides funding for a wide range of community-based services, including primary and home health care, access to medications, case management, substance abuse treatment, mental health services, dental care, nutritional services, and housing. The Act funds these services through several funding streams, known as titles, that direct funds to cities, states, and community-based programs. Each title targets a different aspect of the service delivery system for people with HIV/AIDS. Programs funded by different titles are required to work together in order to maximize coordination and reduce duplication of services. All Ryan White CARE Act programs are administered by the HIV/AIDS

Bureau of the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services.

Title IV of the Ryan White CARE Act

Title IV of the Ryan White CARE Act provides competitive grants to public and private nonprofit entities to develop and sustain comprehensive, coordinated systems of HIV care and services for low-income children, youth, women and families. Title IV funds may be used to provide a variety of critical services, including primary medical care, social services such as case management, and access to research. A unique aspect of Title IV projects is that they provide "family-centered care," which means that care and services can be built around the needs of whole families affected by HIV.

Although Congress first authorized the Ryan White CARE Act in 1990, the Title IV program was not funded until FY 1994. That year, community programs that had previously been funded through the federal Pediatric and Family AIDS Demonstration program were moved into Title IV. When the CARE Act was reauthorized in 1996, Congress made a number of important changes to Title IV. Most importantly, the reauthorized CARE Act made clear that the mandate of Title IV is to serve not only infants and children, but also HIV-positive youth and women, and the family members of these individuals.

Title IV currently funds 58 grantees in 27 states, the District of Columbia and Puerto Rico, and these grantees provide or arrange for direct HIV services at several hundred clinical sites. These projects are enrolling - - and retaining - - extremely vulnerable populations in care. In 1997, Title IV provided services to over 45,000 children, youth, women and families, and this number continues to grow. The Title IV program served 13% more individuals in 1997 than in 1996, with significant increases in all age groups.

Serving People of Color. Title IV continues to lead the Ryan White CARE Act in reaching people of color. In 1997, 58% of Title IV clients were African-American, and 23% were Latino. The number of African-American clients reported by Title IV projects increased by nearly 80% from 1995 to 1997, and continues to grow. The number of Latino and Asian-American clients has also steadily increased. In FY 1999, Title IV received a $2 million increase for services for African-American children with HIV, and this funding is helping the program to increase access to care for this underserved group of children.

Reducing Perinatal Transmission. A major success of the Ryan White Title IV program has been to help dramatically reduce the rate of perinatal HIV transmission in the United States. Title IV projects reduce perinatal transmission by providing outreach, counseling, and testing to women of childbearing age and health care to pregnant women and their children. The recent Institute of Medicine report to Secretary Shalala on efforts to reduce perinatal transmission identified the key role that Ryan White Title IV projects have played in this effort. The report also recommended that the existing infrastructure for providing perinatal HIV prevention and treatment should be strengthened by building on the Title IV service network.

Reaching HIV Positive Youth. Title IV projects are also leading the national effort to engage and retain HIV-positive young people in comprehensive health care. From 1995 to 1997, the number of young people ages 13-24 served by Title IV increased by 225%. Title IV projects have been particularly successful at reaching young women of color, one of the fastest-growing HIV risk groups in the nation.

In collaboration with the National Institutes of Health, the Title IV program has established the REACH Project, a research program that is studying the medical, psychosocial, and behavioral aspects of HIV in adolescents. With approximately 350 teens enrolled at 15 sites across the country, the REACH Project is the source of much of what is known about HIV disease in adolescents.

Last year, a new Title IV Adolescent Initiative was established to increase the number of HIV-positive youth receiving primary medical care and support services in a youth sensitive environment. This initiative currently provides funding to five model youth projects.

Providing Quality, Cost-Effective Health Care. Title IV has also proven to be remarkably efficient and cost-effective. Title IV is a very small program, representing only about 3% of FY 1999 funding for the Ryan White CARE Act as a whole. Yet the flexibility of Title IV funding enables HRSA to move resources quickly into the communities that are experiencing rising rates of HIV infections among children, youth, and women.

Title IV projects are also enabling low-income children, youth and women to take advantage of the promising new treatments for HIV. At the Women and Children HIV Program at Cook County Hospital, for example, a multidisciplinary team provides patient access to new HIV treatments and assists patients with adherence to the strict medication regimens. This effort has significantly improved the health of many clients. In 1997, the program saw a remarkable 60% decrease in the number of hospitalizations.

Reauthorization Policy Positions: Title IV of the Ryan White CARE Act

Reauthorization of the CARE Act is a high priority for AIDS Policy Center. Our main goal is to help ensure that the reauthorized CARE Act meets the needs of children, youth, women, and families affected by HIV.

Beginning in early 1998, AIDS Policy Center has been engaged in an extensive process to gather input on reauthorization from young people, women, families, service providers and advocates. This process has included surveys, focus groups, and meetings and forums at the local and national levels.

Following are some of the key questions that were raised during our discussions about reauthorization of the CARE Act, followed by answers that represent AIDS Policy Center's positions. AIDS Policy Center's Government Affairs Committee and Board of Directors approved these positions in May 1999.

A. Purpose/Scope of services provided:

Current status: the CARE Act states that the purpose of Title IV is (1) to provide "opportunities for women, infants, children, and youth to be voluntary participants in research" and (2) to provide "women, infants, children and youth with HIV disease, and the families of such individuals" with outpatient health care, case management, "referrals for inpatient hospital services, treatment for substance abuse, and mental health services; and referrals for other social and support services, as appropriate." Grantees must also provide "transportation, child care, and other incidental services as may be necessary to enable the patient and the family to participate in the program."

The CARE Act conference committee report further clarifies that Title IV funds "programs that provide or arrange for innovative comprehensive HIV care for children, youth, women, and families with or affected by HIV," in association with voluntary participation in research programs.

1. What should be the stated purpose of Title IV?

The stated purpose of Title IV should be modified to reflect the importance of health care and prevention services. The purposes of Title IV should be the following: to provide comprehensive family- and youth-centered care; to provide casefinding and linkage to care; to prevent HIV transmission, including prevention of perinatal HIV transmission, and to facilitate voluntary access to HIV-related research.

2. How should the legislation define "comprehensive care" for Title IV projects?

The legislation should state that Title IV projects must ensure client access (directly or by referral) to outpatient health care, inpatient hospital services, case management, mental health services, treatment for substance abuse, life planning, permanency planning, child

welfare services, services to support treatment adherence, and referrals for other social and support services, as appropriate. Grantees should continue to provide transportation, child care, and other incidental services as may be necessary to enable the patient and the family to participate in the program.

Report language could clarify that other support services "as may be necessary to enable the patient and the family to participate in the program" may also include services to assist patients with adherence to treatment regimens and research protocols.

3. What services, if any, should be provided directly (paid for with Title IV funds) by all Title IV grantees?

The legislation should use language such as "ensure client access, directly or by referral" in describing Title IV services, and it is not necessary to specify services that must be paid for with Title IV funds by all grantees. Title IV projects should be permitted to pay for medications for medical and financial reasons only as the payor of last resort. The legislation should continue to prohibit the use of Title IV funds to pay directly for research.

4. How should the Title IV legislation address family-centered care?

The current Title IV language has not been an impediment to providing family-centered care, but the legislation should more clearly reflect this philosophy. Principles of family-centered care should be included in the legislation or report language, as long as the legislation does not define a "family."

5. How should the legislation address youth-centered care?

The Title IV Adolescent Initiative should be continued and expanded to increase the number of HIV-positive youth in comprehensive care. However, the legislation should not set aside a percentage of Title IV funds specifically for youth projects. This should be accomplished through the annual appropriations process. Principles of youth-centered care should be included in the legislation or report language.

6. Should the legislation require all Title IV projects to serve children, youth and families, or may projects focus on one or more of these groups?

The legislation should not require all Title IV projects to serve all populations. It is important to retain flexibility for HRSA to fund projects that focus on youth, or that focus on women, children, and families, when this is appropriate. Therefore, the legislation should state that Title IV projects serve women, infants, children and/or youth with HIV disease, and the families of such individuals.

However, Title IV grantees should still be required to demonstrate linkages with programs that serve other populations, such as youth. In addition, if no youth projects exist in an

area, it would be appropriate to require the Title IV project to address youth. This could be stated in report language.

7. What should be the appropriate use of Title IV funds for prevention services?

Title IV projects should provide for or refer clients to the following types of prevention services:

- Perinatal prevention, including casefinding of HIV-positive and high-risk women, offering prenatal testing, reducing unintended pregnancies among HIV-positive women, providing treatment to reduce perinatal transmission, providing support services to help pregnant women adhere to treatment regimens, and creating linkages between HIV care providers and women's health providers to ensure that both have state-of-the-art knowledge;
- Primary HIV prevention for HIV-infected clients;
- Primary HIV prevention for HIV-affected family members;
- Information and/or training about universal precautions for settings that serve HIV-infected children, youth, women & families; and
- Casefinding (including outreach and HIV counseling and testing) with high-risk populations.

Title IV funds should not be used for general HIV education and prevention efforts (aside from casefinding). Title IV funds should also not be used for prevention case management.

8. Should Title IV projects be required to provide case management to all enrolled clients?

No. The legislation should continue to leave decisions about participation in case management to clients and health care providers.

B. Eligibility for services:

Current status: Title IV funds can be used to serve "women, infants, children and youth with HIV disease, and the families of such individuals." HRSA has adopted a broad definition of "family" that is defined by the client. The Title IV program defines youth as ages 13-24, although the Title IV youth initiative is focused on teenagers.

1. Should "affected" family members - - family members of Title IV clients - - continue to be eligible for services?

Yes. Affected family members should continue to be eligible for services such as peer support and mental health services. This is an essential component of family-centered care.

2. Should the Title IV legislation define "youth" or establish an age after which young adults become ineligible for Title IV services?

No. The matter of age eligibility for services is best left to HRSA and Title IV projects.

C. Research provisions

Current status: the CARE Act requires grantees to enroll a "significant number" of woman, infants, children, and youth patients into research protocols. These protocols must be on a priority list established by the Secretary. Care programs that fail to enroll enough clients into approved research protocols may lose their funding. HRSA is required to consult with the National Institutes of Health (NIH) in making grants. The Secretary is required to develop and implement a plan to coordinate NIH AIDS research activities and Title IV activities.

For the purposes of this statement, the term "research" does NOT include evaluation and quality assurance activities, which are addressed in Section G.

1. What is the appropriate role of research in Title IV?

Title IV projects should continue to facilitate client enrollment in HIV-related research. Access to research is a very important component of comprehensive HIV care. However, Title IV projects should no longer be required to enroll a "significant number" of clients into research protocols. This requirement creates an improper incentive for health care providers to encourage their clients to enroll in experimental research protocols. Access to health care under any part of the CARE Act should never be contingent upon enrolling in research. Title IV projects should continue to be required to provide education about and access to HIV-related research opportunities. HRSA should continue to require that Title IV projects document these important activities.

2. Is there a continued need for a Secretary's list of priority research protocols?

Since the purpose of the list of priority research protocols is to measure whether Title IV projects are meeting the "significant number" requirement, such a list is no longer needed.

3. Should the legislation require NIH-funded projects to work with Title IV grantees at the local level and show evidence of collaboration with Title IV projects?

Yes. Report language should direct the Secretary to require NIH-funded projects to collaborate with Title IV grantees at the local level.

4. Should NIH be required to involve HRSA and Title IV projects in shaping the AIDS research agenda?

NIH should be required to involve HRSA and Title IV projects in shaping the AIDS research agenda, including clinical trials and health services research. On the local level, NIH-funded projects should be required to include Title IV projects on community advisory boards. On the federal level, NIH should be directed to involve HRSA Title IV staff (and CDC staff as appropriate) in shaping the AIDS research agenda.

D. Non-program costs

Current status: Non-program costs for Title IV grantees are not limited by statute, but are monitored by HRSA.

1. Should there be a cap on non-program costs for Title IV grantees?

Yes. A reasonable limit should be established on the federally-approved indirect cost rates allowed to Title IV grantees and sub-grantees. If a project does not have a federally-approved indirect cost rate, costs that would otherwise be included in an indirect cost rate should be subject to the same limits. At this time, our position on the amount of this cap is to be determined.

Existing projects that have a federally-approved indirect cost rate that exceeds the cap should have a maximum of two years to adjust to the cap. It is very important that the cap on indirect costs be implemented so that patient access to care is not interrupted. The legislation should also allow exceptions to the cap on indirect cost rates for some projects, such as new and developing projects as well as smaller projects that have a limited administrative infrastructure.

Other "program administration" costs of Title IV projects, such as building systems of care, conducting evaluation, data collection and analysis, and quality improvement activities are not part of the indirect cost rate and a cap on these expenses should not be established in the legislation. HRSA should continue to monitor these costs on an individual basis.

F. Consumer Involvement in Title IV

Current status: Involvement of Title IV consumers in program planning, implementation, and evaluation has long been a high priority for the program. HRSA requires grantees to document steps they are taking to support consumer involvement. However, the legislation does not specifically require consumer involvement.

1. Should the CARE Act specify requirements for consumer involvement in program planning, implementation, or evaluation?

Yes. It would be appropriate for the legislation to formalize the requirement for consumer involvement in program planning, implementation and evaluation. Applicants for funding

should be required to plan, implement, and evaluate activities to promote meaningful consumer involvement.

G. Evaluation of Title IV Projects

Current status: Title IV projects are required to submit three-year and one-year goals, objectives and activities, and to conduct evaluations to determine whether these have been fulfilled. Grantees are required to submit and implement a program evaluation plan to measure process, quality, and health outcomes of their project. Finally, all Title IV grantees submit an annual, uniform, client level data report to HRSA.

1. Should Title IV projects be required to engage in program evaluation and quality assurance activities?

Yes. Evaluation and quality assurance activities are critical to improving the effectiveness and quality of care provided by Title IV projects. Title IV projects should be required to engage in process, quality, and outcome evaluations. The legislation must provide the necessary resources at HRSA to support grantees in implementing these activities.

CROSS-TITLE ISSUES

H. Distribution of resources:

Current status: under Titles I and II, a large portion of funds are awarded based on formula funding.

1. Does AIDS Policy Center wish to take a position on distribution of resources under Title I, II, or the CARE Act as a whole?

At this time, AIDS Policy Center does not have a position on distribution of resources under Title I, II, or the CARE Act as a whole. AIDS Policy Center staff may recommend to the Board that it revisit this issue at an appropriate time.

2. According to regulations issued by HRSA, Title I and II funds may not be used to serve HIV-negative individuals, including HIV-affected family members. Should this policy continue?

Title I and II grantees should be permitted to use their funds to provide services to HIV-affected individuals. At this time, AIDS Policy Center does not have a position as to which HIV-affected individuals should qualify. An option for further discussion would be to designate children, adolescents, and their caregivers as eligible for certain services. Report language could be used to alter current HRSA regulations on this matter.

I. Set-asides for infants, children, and women:

Current status: the CARE Act requires that EMAs spend Title I funds in accordance with the local demographics of AIDS, including proportionate allocations for infants, children, and women living with AIDS. Likewise, states must show that Title II funds are being spent proportionately on infants, children, and women. States are also required to demonstrate that consortia "meet the special needs of families with HIV disease, including family-centered and youth-centered care."

1. Should this requirement be altered?

Yes. The set-aside requirement should be expanded to include youth ages 13-24 living with AIDS. In addition, the legislation must clarify how the set-aside for children, youth and women is to be calculated, monitored and enforced.

2. Should the basis for the set-aside requirement be HIV statistics (not AIDS) in states with HIV reporting?

Changes to this requirement should be considered, but AIDS Policy Center has no position at this time.

J. Title I and II planning processes:

Current status: Title I planning council membership is to reflect the demographics of the local epidemic, with "particular consideration given to disproportionately affected and historically underserved groups and subpopulations." Councils must include people living with HIV/AIDS. Planning councils are also required to include a representative from a Title IV project, or if there is no Title IV project operating in the area, representatives of organizations with a history of serving children, youth and families living with HIV. Title II consortia must consult with Title IV grantees in their area in their planning processes.

1. Should planning councils be required to include HIV-positive youth, women, and/or HIV-affected family members?

Yes. The legislation should ensure that the membership of planning councils adequately reflect the demographics of the local epidemic with respect to HIV-positive youth, women and HIV-affected family members.

2. What changes, if any, should be made to the requirement for participation of a Title IV representative in Title I and II planning processes?

No changes are recommended at this time.

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Save the Date

AIDS Policy Center for Children, Youth & Families

Voices 2000

The National Conference on HIV/AIDS and Children, Youth & Families

May 20 - May 23, 2000

DoubleTree Hotel National Airport
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For information:
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"Voices for America" Mural
By muralist Xavier Cortada
Created at Voices '99
Washington, DC
Dedicated to children, youth, women and families

Medium: multimedia (oil on canvas and collage)

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The Challenge Ahead:

Renewing the Ryan White CARE Act in 2000

AIDS Policy Center for
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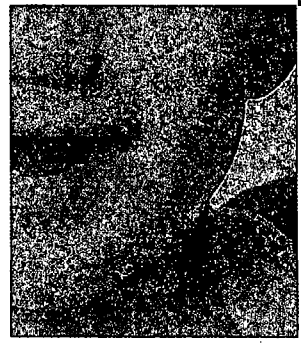
AIDS Policy Center for Children, Youth & Families

Annual Report

1998-1999



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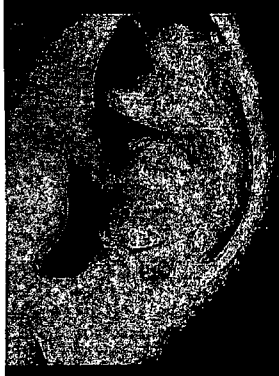
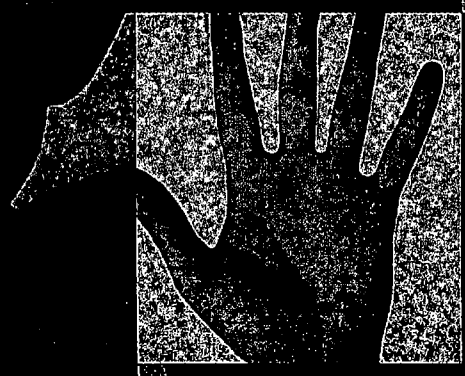
Conference Program

RENEWING
THE COMMITMENT





VOICES '99

May 23 - 25, 1999

Sponsored
through a grant by
Children Affected by
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AIDS Policy Center
for Children, Youth &
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Alliance

AIDS Alliance for Children, Youth & Families

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February 7, 2000

Sandy Thurman
Director
Office of National AIDS Policy
736 Jackson Place, NW
Washington, DC 20503

Sandy

Dear Ms. Thurman:

We are delighted to inform you that AIDS Policy Center for Children, Youth & Families has adopted a new name: ***AIDS Alliance for Children, Youth & Families.***

Our new name reflects our expanded mission to provide education, training, and advocacy on behalf of our national grassroots network – a network that includes youth, families, women, fathers, caregivers, and researchers. We are poised to act more vigorously than ever before to fight AIDS. Our plans include a national consumer education center, new training and technical assistance for providers, and continued advocacy for youth and families affected by HIV and AIDS.

We are proud of our new image and logo. The bright orange sun is warm, inclusive, and conveys hope for the future. It also reflects our core commitments: to build partnerships; to embrace diversity; and to provide high quality services to our community.

It has been a pleasure working with you in the past. We look forward to strengthening our relationship and forming new alliances as we work together to end the AIDS epidemic. Please get to know us better by visiting us on the web at www.aids-alliance.org.

Sincerely,

Mildred Williamson
President

David C. Harvey
Executive Director

Sandy, Thanks so much for all of your work and support!

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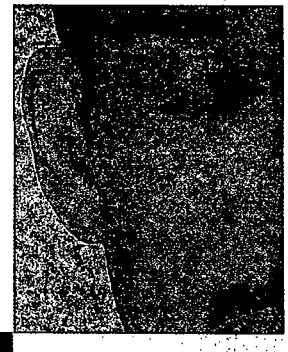
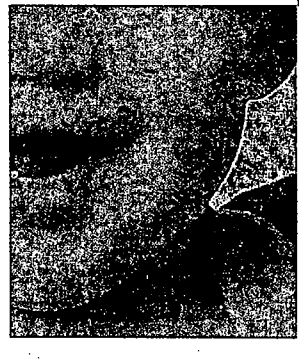
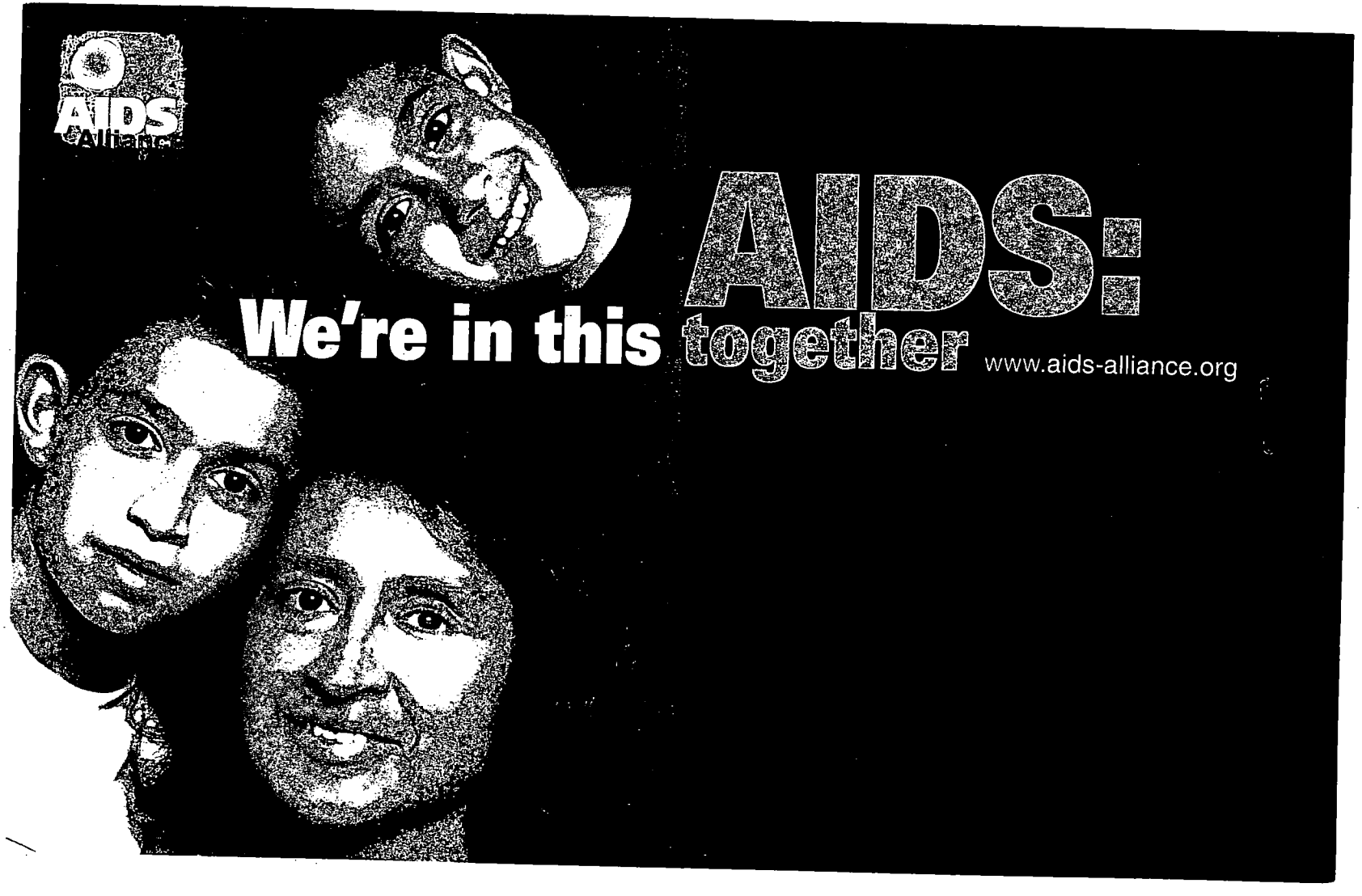
AIDS Policy Center for Children, Youth & Families

Annual Report

1998-1999






AIDS Alliance
We're in this
AIDS:
together
www.aids-alliance.org

AIDS Alliance
for Children, Youth Families

As ***AIDS Policy Center for Children, Youth & Families,*** we established ourselves as the leading advocates for families affected by HIV/AIDS. But today, we're much more than just a policy center — our work now includes education, training, and advocacy on a wide range of critical issues. That's why we have chosen a new name: ***AIDS Alliance for Children, Youth & Families***. The word "alliance" reflects the unity and commitment of our national grassroots network.

As ***AIDS Alliance***, we will continue to fight AIDS by:

- Providing education and support to youth and families with HIV/AIDS
- Supporting professionals on the front lines of the epidemic
- Speaking out on Capitol Hill

To get involved with AIDS Alliance, visit us on the web at:

www.aids-alliance.org

Our Mission

*Through education, training, and advocacy, **AIDS Alliance for Children, Youth & Families** addresses the needs of children, youth, and families living with, affected by, or at risk for HIV and AIDS.*

Alliance
for Children, Youth & Families
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AIDS Policy Center
For Children, Youth & Families

August 2, 1999

Todd Summers
Deputy Director
White House Office of National AIDS Policy
736 Jackson Place
Washington, DC 20503

Dear Mr. Summers:

I am writing to thank you for participating in the youth and HIV/AIDS working group meeting at the White House Office of National AIDS Policy.

This meeting was an important step in updating the report *Youth & HIV/AIDS: An American Agenda*. We are currently compiling the results of the meeting and following up on suggestions made by the working group.

Thank you for lending your expertise and ideas to this process. Please know that we will be contacting you to solicit additional information and comments as we develop the report. If you have any questions, please contact Clark Moore at cmoore@aidspolicycenter.org or (202) 785-3564, ext. 17.

Again, thank you for your participation in the working group meeting. We look forward to your support as we continue work on this important project.

Sincerely,

David C. Harvey
Executive Director

cc: Todd Summers
Joan Holloway

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TO: Sandy Thurman, Director
Office of National AIDS Policy
The White House

FAX: 202.456.2439

FROM: DAVID HARVEY
dharvey@aids-alliance.org

DATE: October 16, 2000

PAGES: 3 Pages (including coversheet)

SUBJECT: Proposed Youth Report Implementation Plan

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MEMORANDUM

TO: Sandy Thurman, Director
Office of National AIDS Policy
The White House

FROM: David Harvey, Executive Director
Kristin Braun, Senior Policy Associate

DATE: October 16, 2000

SUBJECT: White House Youth Report

Thank you for the opportunity of working with you and your staff to sponsor the Atlanta release of Youth and HIV/AIDS 2000: A New American Agenda. While we could have had additional national coverage, we were thrilled with the event and stand ready to assist in dissemination of the report and with follow-up activities to promote the findings of the report.

After meeting with May Kennedy, we wanted to follow-up our discussions with suggestions for next steps. At your earliest convenience, let us know your thoughts.

Dissemination

May Kennedy and AIDS Alliance have organized a detailed dissemination plan of the report, and we have ordered a second printing of the publication. Shortly, additional copies will be mailed to key care, prevention and research contacts throughout the country. In addition, the report is posted on the White House web page, with links to the page from other organizations, including AIDS Alliance. We will work with May to ensure that key tasks in this area are completed in the near future.

Additional Media Outreach

AIDS Alliance has hired James Millner and SCIENS Worldwide Public Relations to garner additional media coverage for the report. James will assist ONAP and AIDS Alliance with: (1) pitch letter for distribution with report to targeted media outlets, including broadcast media for follow-up stories; (2) follow-up phone calls to targeted media outlets: (3) comprehensive media coverage report; (4) assistance to ONAP and AIDS Alliance to prepare for additional media interviews.

Implementation Meeting

AIDS Alliance would be thrilled to work with ONAP to help support an implementation meeting before the end of the year. Such a meeting would include key national stakeholders and agency representatives, and would focus on key implementation questions and strategies. A one-day meeting would be sponsored by ONAP, with AIDS Alliance helping to do logistical work to organize and carry-out the meeting. Key tasks would include: (1) meeting agenda; (2) list of invites and preparation of letter of invitation; (3) preparation of background information; (4) meeting logistics, including meeting space, food, and arrangements for facilitation of the meeting; and (5) writing a meeting summary report.

The Alliance would be happy to cover the expenses for such a meeting either with support from our HRSA cooperative agreement and potential new support from CDC and NIH.

I look forward to talking with you soon. Thank you for your consideration of this memorandum.

cc: Michael Iskowitz
May Kennedy