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ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
415 Second Street, N.E., Suite 200, Washington, D.C. 20002
(202) 546-5400

February 2, 1994

The Honorable Edward M. Kennedy
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

On behalf of the Association of State and Territorial Health Officials (ASTHO), which represents the chief health officers in the states, the District of Columbia, and U.S. territories, I am writing to express strong support for the newly launched Prevention Marketing Initiative of the Centers for Disease Control and Prevention (CDC). ASTHO applauds CDC's efforts to apply fundamental public health principles to educate young Americans on HIV prevention and urges you to oppose any measure that restricts federal, state or local flexibility in applying these principles to preventing HIV in communities across the country.

ASTHO supports the CDC campaign's emphasis on the correct and consistent use of latex condoms while also advocating alternatives of delaying or abstaining from sexual activity. Each of these prevention messages is an integral component to any comprehensive HIV prevention program. In addition, according to CDC, studies have shown that levels of sexual activity have either decreased or remained the same after education programs which include information about condoms.

While abstinence is the only strategy which can totally prevent sexual transmission of HIV and other STDs, public health agencies must address the prevention needs of **all** segments of the population, including those who choose to be sexually active. This is especially crucial in the midst of a fatal epidemic which continues to claim the lives of Americans of every age in every geographic, socioeconomic, racial and ethnic sector of our population. In the absence of a vaccine, public health agencies and the communities they serve, must rely heavily upon **all** strategies proven to be effective in preventing infection, including correct and consistent use of latex condoms.

I urge you to oppose any legislation that restricts CDC's HIV prevention capacity and that of states, localities and communities across the country.

Sincerely,

Barbara DeBuono

Barbara DeBuono, M.D.
Chair, ASTHO HIV Committee

cc: ✓Kristine Gebbie, R.N.
David Satcher, M.D.

KRISTINE M. GEBBIE, R.N., M.N., F.A.A.N.
NATIONAL AIDS POLICY COORDINATOR
DEPARTMENT OF HEALTH & HUMAN SERVICES
Room 729H Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

DAY Thursday DATE July 22, 1993

TIME 1:00 p.m. LOCATION Rm. 703-A

SUBJECT Meeting w/Joint Council from ASTHO

PARTICIPANTS:

See attached materials.

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
415 Second Street, N.E., Suite 200, Washington, D.C. 20002
(202) 546-5400

July 6, 1993

Kristine Gebbie
200 Independence Ave., SW
Room 729H
Washington, DC 20201

Dear Kristine:

This is to confirm that you will be joining the Joint Council representatives from ASTHO, NACHO, and USCLHO on July 22 from 1:00-2:00 to discuss the infrastructure for Prevention under Health Care Reform.

We will be meeting in room 703A at the HHS building. Please call me if you have any questions. I look forward to seeing you.

Sincerely yours,

George K. Degnon

mt.06

CORE PUBLIC HEALTH FUNCTIONS

- Health-related data, surveillance, and outcomes monitoring
- Investigation and control of diseases and injuries
- Protection of environment, housing, food, and water
- Laboratory services
- Public information and education
- Targeted outreach and linkage to personal services
- Quality assurance
- Training
- Research, demonstration, and evaluation
- Leadership, policy development, and administration

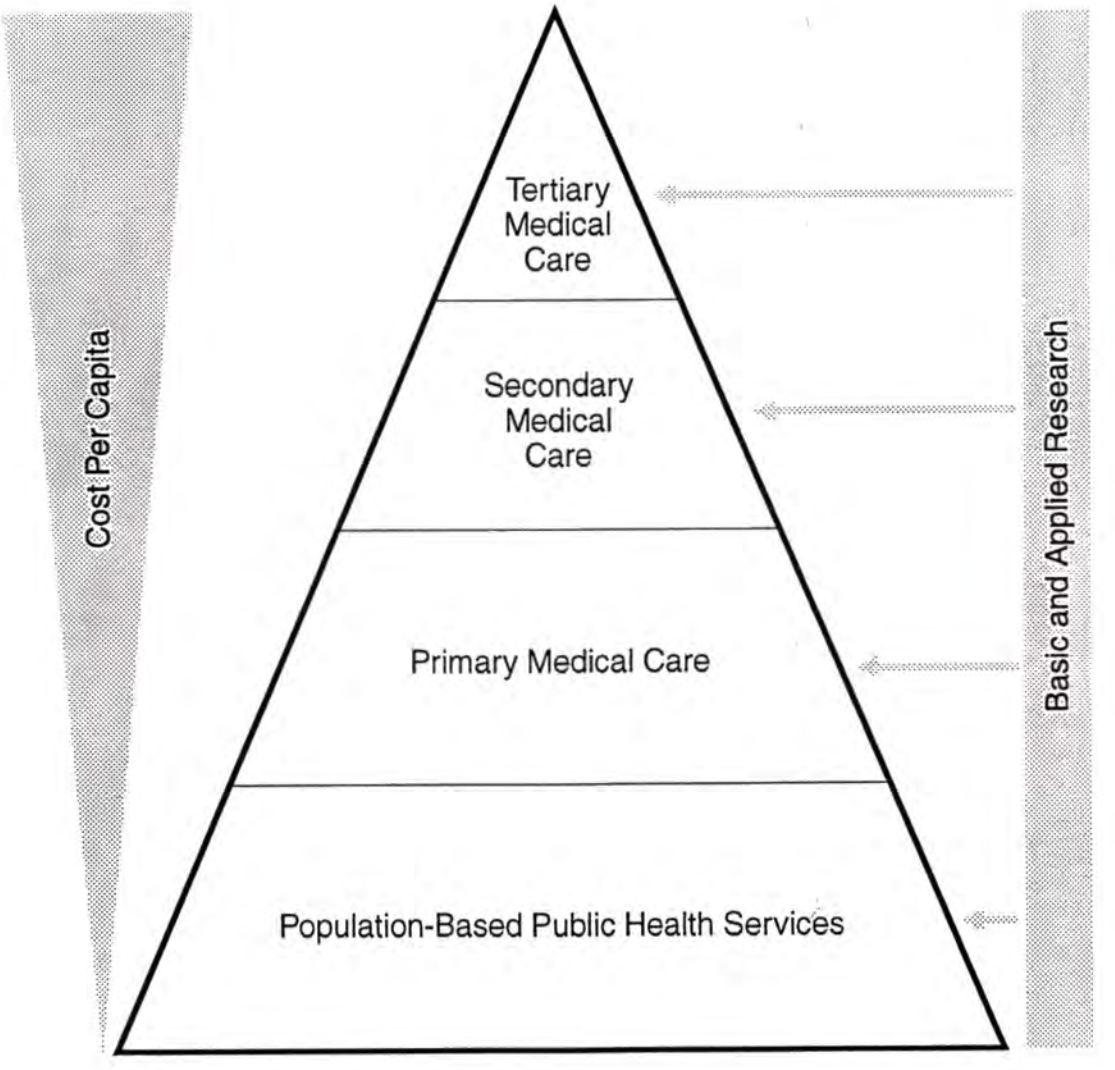
DRAFT

Figure 1. Economic Burden of Preventable Conditions

Condition	*Overall magnitude*	*Avoidable intervention* [1]	*Cost per patient* [2]
Heart disease	7 million with coronary artery disease 490,000 deaths/yr 265,000 bypass procedures/yr 298,000 angioplasties/yr	Coronary bypass surgery	$30,000
		Angioplasty	$15,000
Cancer	1,130,000 new cases/yr 520,000 deaths/yr	Lung cancer treatment	$23,000
		Cervical cancer treatment	$15,000
Stroke	600,000 strokes/yr 145,000 deaths/yr	Hemiplegia treatment and rehabilitation	$22,000
Injuries	2.3 million hospitalizations/yr 142,500 deaths/yr 177,000 persons with spinal cord injuries in the United States	Quadriplegia treatment and rehabilitation	$570,000 (lifetime)
		Hip fracture treatment and rehabilitation	$40,000
		Severe head injury treatment and rehabilitation	$310,000 (lifetime)
HIV infection	1-1.5 million infected 118,000 AIDS cases (as of Jan 1990)	AIDS treatment	$100,000 (lifetime)
Low birth weight baby	260,000 LBWB born/yr 23,000 deaths/yr	Neonatal intensive care for LBWB	$10,000
Inadequate immunization	Lacking basic immunization series: 20-30%, aged 2 and younger 3%, aged 6 and older	Congenital rubella syndrome treatment	$354,000 (lifetime)
	Hepatitis B	Acute hepatitis B treatment (hospitalized)	$6,386
Lead toxicity	200,000 children under age 6 with blood lead levels above 25 mg/dL	Medical cost of treatment	$13,000
Dental caries	21.69 million children aged 5-17 have one or more dental caries	Caries restoration	$38.50

[1] Examples (other interventions may apply).
[2] Representative first-year costs, except as noted. Not indicated are non-medical costs, such as lost productivity to society.

Figure 2. Health Care Pyramid



DRAFT

Figure 3. Comparison of Population-Based Public Health Expenditures,[1] by Source of Funds, Selected Years, 1981-1993

	Expenditures (in billions)				
	1981	*1985*	*1989*	*1991*	*1993*
PHS Agencies					
PHS expenditures, excluding Federal grants to health departments	$1.4	$1.3	$1.9	$2.8	$3.0
State and Local Health Departments					
Federal grants to health departments[2]	0.4	0.5	0.7	1.0[3]	1.3[3]
State funds	1.1	1.6	2.2	2.5[3]	2.5[3]
Local funds	0.6	0.7	0.9	1.3[3]	1.6[3]
Total	**$3.5**	**$4.1**	**$5.7**	**$7.6**	**$8.4**
Total U.S. health expenditures	$290.2	$422.6	$604.3	$751.8	$900.0
Population-based expenditures as a percent of total national health expenditures	1.2%	1.0%	0.9%	1.0%	0.9%

Notes: [1] Expenditures for services to individuals have been excluded. For State and local health departments, the exclusion totals 58.6% of total expenditures.
[2] Excluding WIC.
[3] Estimated based on preliminary reported figures.

Sources: DHHS, Assistant Secretary for Management and Budget (appropriations)
Survey of PHS agencies for public health functions
Public Health Foundation, ASTHO Reporting System for State and local expenditures.

Figure 4. Need for Investment in Population-Based Public Health Functions

	*Expenditures (in billions)**		
	Current	*Essential*	*Fully Effective*
Public Health Service	$3.0	$5.4	$8.5
Federal Grants to State and local health departments	1.3	5.9	12.4
State and local health departments	4.1	4.1	4.1
Total	**$8.4**	**$15.4**	**$25.0**
As a percent of total national health expenditures	0.9%	1.7%	2.7%

Note: Increments proposed to come from set aside. States and localities expected to maintain funding at inflation-adjusted $4.1 billion level (1993 dollars).

Source: PHS agencies and CDC survey of States

* Initial estimates still under review.

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
415 Second Street, N.E., Suite 200, Washington, D.C. 20002
(202) 546-5400

MEMO

TO: Molly Coye, MD, MPH
John Lumpkin, MD
Chris Atchison
FROM: George Degnon
DATE: June 29, 1993

In attempting to arrange the next meeting, I've put together the following information. The Joint Council will meet from 7:30 - 9:00 for breakfast at the Bellevue Hotel on July 22 to prepare for the meeting with the Assistant Secretary for Health-designee. We will then meet with Phil Lee from 10-12 a.m. After lunch, the Joint Council will meet from 1:00 - 4:30 p.m. There will be no meeting on Friday and Saturday as previously planned. The agenda for the Joint Council meeting is as follows:

1:00 - 2:00	Discussion of infrastructure for Prevention under Health Care Reform with Kris Gebbie, and follow-up actions for our organizations.
2:00 - 2:15	Discussion and Adoption of Access Statement by the 3 organizations.
2:15 - 3:00	RWJ Proposal: Scope of work, Fiscal/admin. agent for grant, Locus for staff.
3:00 - 4:00	Plan for JC Retreat -- September?
4:00 - 4:30	Other Business

Kris Gebbie has agreed to meet with us to discuss the infrastructure for public health preventive services under Health Care Reform. Kris, just designated as domestic policy council director for AIDS, will assume her new duties on August 1 and until then will be finishing up on this project which she is spearheading for Phil Lee.

We have reserved a block of rooms at the Bellevue Hotel located at 15 E St.,NW, Washington, DC 20001. You are responsible for making your own reservation. The toll free number is 1-800-327-6667.

On another matter, the nomination of Joycelyn Elders, MD to be Surgeon General will be presented to the Senate on July 2. We expect Senate hearings the week of July 12. The "Right Wing" is mobilizing an extensive nationwide letter writing campaign as part of its efforts to block her nomination (see Washington Times article of Sunday, June 27). ASTHO is now initiating efforts to have the public health community register its strong support for Dr. Elders as an established public health leader. You will be getting a more detailed letter from ASTHO asking for your help in communicating support of Dr. Elders to your Senators. Many thanks.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Health Resources and
Services Administration
Rockville MD 20857

JUL 19 1993

TO: Kristine Gebbie, R.N.

FROM: Associate Administrator for Public Health Practice

SUBJECT: Joint Council-Public Health Initiative Status Report

The Joint Council-Public Health Initiative Contract was signed on October 1, 1992. This is the first year of a planned three year contract. Total funding for the first year was $251,980. The breakdown was as follows:

HRSA		
	BPHC	$25,000
	BHPr	$25,000
	MCHB	$61,980
	BHRD	$25,000
	OA	$50,000
AHCPR		$15,000
CDC		$50,000

The goal for year two funding is $265,000. Thus far we have the following commitment of funds for year two:

HRSA		
	MCHB	$25,000
	OA	$50,000
CDC		$50,000

The difference between anticipated and current funding commitments for year two is $140,000. SAMHSA, AHCPR and other HRSA Bureau participation is critical to the success of the second year of the contract. HRSA Contracts Office has informed this office that all funding commitments and accounting information must be made available by August 1 or a mandatory phase-down of activities will occur.

In the first year of the contract, the Public Health Foundation organized three work groups: access to primary care services, human resources development and data systems. All three workgroups have drafted recommendations for further development. It is anticipated that for year two, the contractor will refine their recommendations and develop specific implementation plans outlining the benefits and detriments to each approach.

Douglas S. Lloyd, M.D.

Douglas S. Lloyd, M.D., M.P.H.

DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH RESOURCES AND SERVICES ADMINISTRATION

Public Health Service

Memorandum

Date JUL 2 1993

From Director, Division Grants and Procurement Management

Subject HRSA Contract No. 240-92-0052 with the Public Health Foundation (PHF) in Support of the Joint Council

To Associate Administrator, Office of Operations and Management

The Joint Council contract is scheduled to be completed September 28, 1993. For continued performance to occur, the first option year must be exercised prior to the contract completion date. Documentation from the Project Officer, Norma Brinkley-Staley was received requesting the option year be exercised and providing a revised Statement of Work and required deliverables for the option period of performance. A Request for Proposal (RFP) was forwarded to the PHF containing the SOW, deliverables and proposal preparation instructions. Proposals are due to HRSA June 30, 1993.

Currently, PHF is under the impression that the level of funding for the option year is roughly of the same magnitude as was available last year ($251,980). However funding availability for the option year is uncertain. We understand that there is a firm commitment of $125,000 ($25,000 from MCHB, $50,000 from CDC and $50,000 from OA). PHF is preparing a proposal based on the anticipated level of funding. If in fact the funding availability will be substantially less than anticipated, the SOW needs to be revised to reflect the decreased funding. In turn, PHF must be alerted so their proposal also reflects the decreased funding level. A request to Dr. Lloyd for a firm commitment on available funding was sent on May 7, 1993. In order to ensure there is no lapse in the current contract coverage and for FY93 funds to be used, the requested funding information should be received in the Contracts Policy and Operations Branch (CPOB) not later than August 1, 1993. If the full funding commitment is not available, the process of drafting a revised SOW reflecting the available funding, requesting new proposals from PHF, technical review, and cost analysis will begin again.

Following receipt of proposals, a technical review committee (TRC) composed of Chairperson Doug Lloyd, Samuel Kessel, Anita Eichler, Judy Teich, Neil Sampson, Rhoda Abrams, Bud Nicola, and Norma Brinkley-Staley will convene to review the proposal. An audit will be conducted by the Cost Advisory Branch (CAB). The information received from the TRC and audit will be used to perform a cost analysis by the Contract Specialist. Negotiations will be held culminating in an agreed upon effort at a fair and reasonable cost for performance of the SOW. Lastly, a modification will be issued exercising the Government's option for continued performance and incorporating the negotiated SOW and associated costs into the current contractual document.

The time involved in repeating this process may endanger obligating the FY93 funds currently available for the option year.

We will provide updates to you on the status of this procurement.

James J. Corrigan

cc: D. Lloyd

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
416 Second Street, N.E., Suite 200, Washington, D.C. 20002
(202) 546-5400

July 6, 1993

FAX copy to Debbie Maese

Kristine Gebbie
200 Independence Ave., SW
Room 729H
Washington, DC 20201

Dear Kristine:

This is to confirm that you will be joining the Joint Council representatives from ASTHO, NACHO, and USCLHO on July 22 from 1:00-2:00 to discuss the infrastructure for Prevention under Health Care Reform.

We will be meeting in room 703A at the HHS building. Please call me if you have any questions. I look forward to seeing you.

Sincerely yours,

George K. Degnon

mt.06

Post-it™ brand fax transmittal memo 7671 | # of pages ▸ 1

To Kristine Lebbre	From George Degnon
Co.	Co. ASTHO
Dept. 7-7-93	Phone #
Fax # 690-7054	Fax #

Moving to a Reformed System

1) Process plan –
   understanding concepts
   making "core fx" locally real – by level of government
   being honest about capacity by specific activity,
   our own programmatic staff as allies or enemies by relation other agencies do –
2) The personal care services
   to provide or not –
   how long
   special populations / special providers
   enablers / matching
3) The data systems
   definitions
   collection
   publication / dissemination
   privacy/access
   ~~Florence~~ Nightengale & her #'s re British army
4) The quality assurance fx
   reconsider traditional "inspection" fx
   identify new options re: care
5) Vision & leadership

Clinton Presidential Records
Digital Records Marker

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This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

1993 Annual Meeting

Framing Public Health in an ERA of Reform

9pgs

THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

1993 ANNUAL MEETING

FRAMING PUBLIC HEALTH IN AN ERA OF REFORM

September 8-10, 1993
Holiday Inn By The Bay
Portland, Maine

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
415 Second Street, N.E., Suite 200, Washington, D.C. 20002
(202) 546-5400

August 10, 1993

Kristine Gebbie, RN
National AIDS Policy Coordinator
750 17th St., NW
Suite 1060
Washington, DC 20006

Dear Kris:

Per our conversation, this correspondence is to confirm your participation as a speaker at the ASTHO Annual Meeting. You are scheduled to speak during a segment of the meeting entitled "Public Health as it Relates to Health Care Reform", scheduled for Thursday, September 9, at 8:00 a.m. Because of the critical impact health care reform will have on the future of public health in this nation, the ASTHO membership appreciates the opportunity to hear from you directly on the Administration's initiative. Prevention of disease and disability is an important factor to the success of any health care program both in terms of saving lives and controlling costs. Your thoughts and insights into how prevention fits into the Administration's plan will be extremely beneficial and informative for the ASTHO membership and other state leaders attending the conference.

Please use the attached form to indicate your audio visual needs and include with it a copy of your most current curriculum vitae and a photograph. We will need these items no later than Monday, August 16. If you are preparing notes for your presentation, please plan to provide a copy to ASTHO at your earliest convenience. We are preparing a report of the Annual Meeting and your input would be extremely helpful.

In addition to a final report, we are planning to develop a program book for participants providing supplemental information on program topics. If you have any articles or reports which complement your presentation, we would like to include them in the book. Please provide a copy, or the citation to ASTHO by Monday, August 16.

A preliminary program is attached for your review. A moderator is assigned to each session. The moderator for your session should contact you in late August prior to the meeting.

Should you require any additional information about the Annual Meeting, please feel free to contact Valerie Morelli with the ASTHO office. I'm looking forward to seeing you at what promises to be a truly memorable event.

Sincerely yours,

George K. Degnon
Executive Vice President

1993 ASTHO Annual Meeting

Speaker Audio-Visual Request Form

NAME: _____

TITLE: _____
(How you would like it to appear on the program)

List your audio-visual needs. Please be specific.

35mm Slide Projector: _____
Overhead Projector: _____
Pointer: _____
Other:

_____
_____
_____
_____
_____

Please return this form with a copy of your **current curriculum vitae and a photo by August 16, 1993** to:

ASTHO
415 Second Street, NE
Suite 200
Washington, DC 20002

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
415 Second Street, N.E., Suite 200, Washington, D.C. 20002
(202) 546-5400

TO: ASTHO Members and Friends attending Annual Meeting

FROM: George K. Degnon

DATE: July 30, 1993

We are pleased that you will be joining us at ASTHO's upcoming Annual Meeting in Portland, Maine. I have listed below some specifics about the weather, attire, transportation and social activities that may help you prepare for your trip.

DRESS

The key word is comfort. Dress for the meeting is semi-casual, suits and ties are unnecessary. It might be a good idea to bring along a light sweater as the New England evenings in the Fall can be quite cool.

WEATHER

The predicted forecast for the beginning of September is a high temperature of approximately 70° and a low of 50° in the evening.

GROUND TRANSPORTATION

The Holiday-Inn-By-The-Bay offers a free shuttle service to and from the airport. There is not a set schedule for the shuttle, therefore those who would like to use the service should call the hotel at (207) 775-2311 to arrange to be picked up. The pick up location is right outside the baggage claim area, and the hotel is 10-15 minutes away.

MEAL FUNCTIONS AND SOCIAL ACTIVITIES

TUESDAY - Welcome Reception: The National Public Health Information Coalition will be hosting a welcome reception at the Portland Museum of Art from 5:00p.m. to 7:00p.m.

WEDNESDAY - Freeport/L.L. Bean Trip: ASTHO is sponsoring a bus trip to the Freeport Outlet Shopping Area and L.L. Bean Factory. Buses will shuttle interested individuals from the hotel to the shopping area beginning at 5:30p.m. (shuttles will run to and from Freeport every 1/2 hour until 10:30p.m.) Freeport, located just 20 minutes north of Portland, is a classic New England village with handsome old architecture, a rich history, a picturesque harbor, and world-class shopping. Freeport boasts over 110 shops in all, from brand-name designer outlets to quaint Maine artisans, antiques, and specialty stores, including the famous L.L. Bean Factory and Store. There are several great restaurants too!

THURSDAY - Peaks Island Lobster Bake: An authentic Maine Lobster Bake has been arranged for the low cost of just $30 per person. Interested individuals will leave the Portland dock at 5:30p.m. for a quick boat ride to Peaks Island. The feast will include lobster, steamed clams and corn on the cobb in addition to other traditional lobster bake fare. Steak or chicken will be substituted for those who do not care for seafood provided advance notice is given.

MISCELLANEOUS

Please note any special food requests on the attached form. Contact the ASTHO office for information on spouse/family/guest rates for luncheons.

1993 ASTHO ANNUAL MEETING

ACTIVITY REGISTRATION FORM

Individual attending meeting: _____
Number of guests: _____

Special Dietary Requirements For Meeting Lunches:

_____
_____
_____

I plan to attend (please mark the # of attendees in all blanks that apply):

_____	Tues., Sept. 7, Welcome Reception, 5:00pm	no charge
_____	Wed., Sept. 8, Freeport/L.L.Bean, 5:30pm	no charge
_____	Thurs., Sept. 9, Lobster Bake, 5:30pm	$30 per person
	Please indicate choice 1) _____ lobster	
	2) _____ steak	
	3) _____ chicken	

TOTAL PAYABLE TO ASTHO _____

Please send form & payment to:

ASTHO
ATTN: Sandy Vanderpool
415 Second Street, Suite 200
Washington, D.C. 20002

TENTATIVE ASTHO ANNUAL MEETING AGENDA
SEPTEMBER 8-10, 1993
PORTLAND, MAINE

TUESDAY, SEPTEMBER 7, 1993

2:00 p.m.-5:00 p.m.	**Affiliate President's Meeting with Executive Committee Leadership**
5:00 p.m.-7:00 p.m.	**Opening Reception**

WEDNESDAY, SEPTEMBER 8, 1993

8:00 a.m.-5:00 p.m.	**Marketing of Public Health**
5:30 p.m. - 10:30 p.m.	**Bus service to Freeport/L.L. Bean**

THURSDAY, SEPTEMBER 9, 1993

8:00 a.m. - 9:45 a.m.	**Discussion of Public Health as it relates to Health Care Reform** Main presentation State response Questions and Answers
9:45 a.m. - 10:15 a.m.	**Break**
10:15 a.m. - 12:15 p.m.	**The Business of Public Health** Opening remarks by Moderator, outline purpose of session and structure The Future of Financing Public Health Services The Future Training Needs of Public Health The Future of Information Systems Moderator lead audience participation discussion
12:30 p.m. - 2:00 p.m.	**Lunch** Topic -- Perspectives of the Surgeon General
2:30 p.m. - 3:30 p.m.	**Public Health's Role in Comprehensive School Health** Panel Discussion
3:30 p.m. - 4:15 p.m.	**The Latest in Tobacco Control** Presentation on latest research on effects of tobacco
5:00 p.m. - 10:00 p.m.	**Boat Ride/Lobster Bake**

FRIDAY, SEPTEMBER 10

8:00 a.m. - 9:00 a.m.	**ASTHO Business Meeting**
9:00 a.m. - 10:15 a.m.	**Public/Voluntary Partnerships** Public/voluntary partnerships and their role in the future of public health.
10:15 a.m. - 10:45 a.m.	**Break**
10:45 a.m. - 12:00 noon	**Federal Update** CDC Acting Director HRSA Acting Administrator
12:15 p.m. - 2:00 p.m.	**Luncheon** HHS Assistant Secretary ASTHO Awards

Holiday Inn
West Brook
$67.00

Melissa
8/17/93

TRAVEL ITINERARY FOR KRISTINE GEBBIE
SEPTEMBER 8-9, 1993
WASHINGTON, D.C. TO PORTLAND, MAINE

WASHINGTON, D.C. (NATIONAL AIRPORT) TO PORTLAND, MAINE

SEPTEMBER 8, 1993

LV: 4:40 p.m. on NW Flight #38, Seat 25F

AR: 6:10 p.m. in Boston, MA

LV: 7:25 p.m. Boston on NW Flight #3854, Seat 8D

AR: 8:05 p.m. in Portland, Maine

HOTEL

Holiday Inn Portland West
81 Riverside Street
Portland, Maine
(207) 774-5601
Confirmation No. 67965072

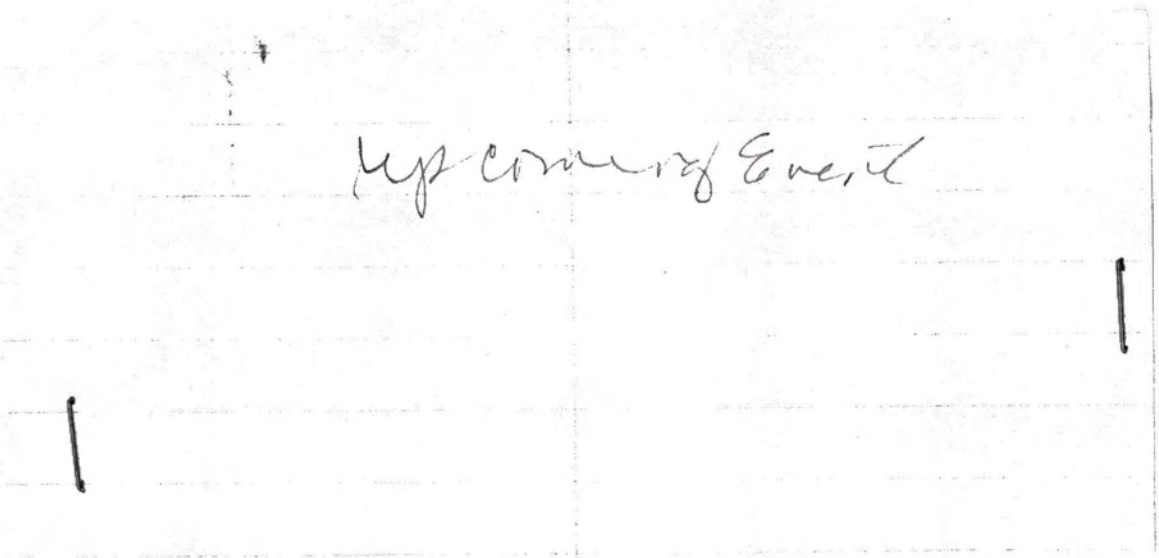
PORTLAND, MAINE TO WASHINGTON, D.C. (NATIONAL AIRPORT)

LV: 2:25 p.m. on NW Flight #3853, Seat 8D

AR: 3:05 p.m. in Boston, MA

LV: 4:05 p.m. on NW Flight #1873, Seat 21F

AR: 5:45 p.m. at National Airport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ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
415 Second Street, N.E., Suite 200, Washington, D.C. 20002
(202) 546-5400

June 30, 1993

Kristine Gebbie, R.N.
AIDS Policy Coordinator
c/o Office of Disease Prevention and Health Promotion
Switzer Building, Room 2132
330 C Street, S.W.
Washington, D.C. 20201

Dear Kris:

On behalf of the Association of State and Territorial Health Officials (ASTHO) I want to offer my congratulations to you on your appointment as the nation's first AIDS Policy Coordinator and to express the Association's strong interest in working with you to strengthen the federal-state partnership on HIV/AIDS.

As a previous State Health Officer, you are acutely aware of the multi-dimensional challenges that HIV/AIDS has engendered for public health agencies and the crucial role which states play in assuring prevention and treatment services for those affected by, and at risk for, HIV/AIDS and the concurrent epidemics of tuberculosis, sexually-transmitted diseases and substance abuse. You are also acutely aware that despite tireless public health efforts, the epidemic continues to escalate.

ASTHO's responses to recent HIV-related legislation and policy issues are enclosed for your information and future reference. We are also in the process of working with several of our affiliates, the National Alliance of State and Territorial AIDS Directors and the Council of State and Territorial Epidemiologists, to develop a "State Health Agency Vision on HIV Prevention." Other joint efforts underway include assessment of effective prevention modalities in the states and assessment of State Health Agency capacity for community-based health planning. ASTHO is uniquely situated to broker State Health Agency relations with your office and is very interested in working through the ASTHO HIV Committee to accomplish this. I would be happy to come to Washington to meet with you on August 9 to discuss this with you further. Please let me know if your schedule accommodates this.

ASTHO shares your vision that it is only through coordinated and collaborative efforts with our federal, state and community-based partners that the nation can adequately provide the necessary HIV prevention and AIDS treatment services needed across the nation. We look forward to working closely with you to make this vision a reality.

Again, along with our state colleagues and ASTHO affiliates, I wish you the greatest success in leading the nation's battle against HIV/AIDS.

Sincerely,

Barbara

Barbara A. DeBuono, M.D.
Chair, ASTHO HIV Committee

ASTHO HIV ADVISORY COMMITTEE
1992-93

CHAIR
Barbara A. DeBuono, M.D.,
Rhode Island Dept. of Health
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Providence, RI 02908
(401) 277-2231

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Lloyd F. Novick, M.D.
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June, 1993

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
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June 10, 1993

The Honorable Nancy Pelosi
U.S. House of Representatives
Washington, D.C. 20515

Dear Congresswoman Pelosi:

I am writing on behalf of the Association of State and Territorial Health Officials (ASTHO), which represents the chief health officers in the 50 states, the District of Columbia, and the U.S. Territories, to express state public health perspectives on the Comprehensive HIV Prevention Act of 1993. First, let me applaud your efforts to refocus the country's HIV/AIDS efforts on prevention. ASTHO strongly endorses efforts to foster collaboration among federal, state and local governments and the community to realize a more effective system of HIV prevention. Your leadership in introducing H.R. 1538 has served as an effective catalyst for deliberations across the nation on how best to improve our HIV prevention efforts.

States have been actively reviewing the Comprehensive HIV Prevention Act of 1993 and have been gratified by its increased recognition of the importance of prevention and of the leadership roles of state and local health agencies. However, three key areas of concern have emerged during these discussions: First, states perceive the requirements for establishing new planning councils to be an unnecessary duplication of planning infrastructure already in existence. Secondly, while states strongly support community input into HIV prevention, the legislation leaves unanswered the core question of how best to achieve a balance between public health responsibility and community-based knowledge and expertise to obtain the most effective prevention programs. ASTHO strongly believes that State Health Agencies, the entities statutorily responsible for the health of the nation's citizens, should have the determinative authority with regard to HIV prevention planning. Thirdly, the absence of a hold-harmless places states in the untenable position of being accountable for prevention programs for which they have no resources. A full hold-harmless for each State and U.S. territory is essential.

While many states are philosophically in agreement with the legislation, some continue to perceive it as potentially resulting in serious erosion of state and local public health authority. Other states have expressed concern about the categorical nature of the funding, particularly in the context of the parallel epidemics of TB, substance abuse and sexually-transmitted diseases. Still others believe the impact of these legislative requirements will be overly burdensome and inapplicable for lower-incidence, rural states.

Following is a synopsis of state comments on H.R. 1538 which I hope will prove useful to you as The Comprehensive HIV Prevention Act of 1993 progresses through the legislative process:

AUTHORITY OF STATE AND LOCAL HEALTH AGENCIES AND PLANNING COUNCILS

- The balance of authority between State Health Agencies and planning councils must be clarified in the legislation. States believe that achieving a balance between the knowledge and expertise at the community level and the public health responsibility for prevention and control of disease at the state level will result in an improved system of HIV prevention. As the statutory authority for health in the states, State Health Agencies should possess the determinative authority with regard to establishing priorities and making funding decisions. Community input into planning is crucial; such input should complement the efforts of health agencies rather than duplicate or undermine them.
- Health agencies strongly endorse community-based organizations as essential partners in HIV prevention and view their contributions as critical to the success of our prevention efforts; however, nongovernmental roles and authority must also be clarified.
- Clarification of the roles of local health agencies is also needed. Questions remain about the role of State Health Agencies in states which do not have a system of local health departments or in which local health departments are responsible for only a portion of the state.

PLANNING AND PLANNING COUNCILS

- Many states expressed serious concern regarding the apparent establishment of yet another layer of AIDS planning bureaucracy on top of those already in place in public health agencies, Title I planning councils, Title II consortia, Governor's task forces on AIDS, etc. States believe that the existing public health infrastructure combined with enhanced community input should provide the basis for prevention planning. States oppose diversion of prevention funding to establish and maintain additional decision-making infrastructures.
- States question the degree to which state and local health agencies will be capable of exercising their leadership and coordination authority, particularly in states that have one of the six directly-funded cities and/or a Ryan White Title I city. Clarification is needed on the role of states in coordinating these existing bodies with a potential additional planning council.
- Some states have recommended that the legislation describe the role of planning councils in terms of outcome rather than merely in terms of listing required participants.

FUNDING

- A full hold harmless for each state and U.S. Territory is essential.
- States are particularly concerned about being held accountable for legislative mandates without the concurrent funding necessary to implement programs.
- States are also seriously concerned about the possibility of implementing the Comprehensive HIV Prevention Act of 1993 with level funding. States would be forced to oppose implementation of this legislation under any scenario involving level funding.

EVALUATION

- Requirements to contract for technical services necessitates a whole new service industry for community-based organizations without recognizing the existing public health infrastructure already in place to evaluate programs. With adequate resources to fund public health infrastructure, State Health Agencies would be empowered to more cost-effectively conduct comprehensive evaluation projects.

LEGISLATIVE LANGUAGE

- States assume a population-wide perspective on "at-risk populations," and are concerned that the legislation appears to limit the definition of those "at-risk" to men having sex with men, intravenous drug users and their sex and needle-sharing partners.

- Community-based entities should be more broadly defined to include partners other than AIDS service organizations, such as local health departments and target populations frequently not represented by organized groups, such as the chronically mentally ill, incarcerated, parolees, homeless, migrants and others.
- In order to avoid even greater multiplicity of councils and duplication of problems similar to those experienced within the Ryan White CARE Act structure, states want assurance that they will maintain the authority to limit "political subdivisions" to the current six directly-funded cities.

LOW INCIDENCE STATE ISSUES

- The diversity of our nation must be reflected in legislative language which ensures flexibility for states to meet these diverse needs.
- Low incidence states have unique concerns including small numbers of community-based organizations and lack of available technical assistance for these organizations outside of the State Health Agency. Flexibility for states is crucial to ensuring that these issues are addressed for low-incidence states.
- Although community-based organization turnover is an issue across the nation, it creates unique hardships not easily overcome in smaller, lower-incidence and rural states. Planning council membership requirements should be reconfigured to accommodate the reality of many states.
- The grant application burden, which is considerable for understaffed smaller states, must also be considered as legislative language is crafted regarding application requirements.

IMPLEMENTATION

- States question what impact President Clinton's mandate to reduce federal advisory councils will have on the PHS-wide advisory council envisioned in the Pelosi legislation.
- States question how the transition into the Pelosi framework would be managed. (i.e. CDC is now in process of awarding three-year grants to minority community-based organizations and Pelosi proposes to fund special populations such as minority community-based organizations by 1995.)
- States question the impact of potential implementation of only a portion of the legislation. (i.e. The implications of implementation of Public Education (Sec. 2541) without the accompanying counseling and testing (Sec. 2533) or the specific populations (Sec. 2542) must be carefully considered.)
- States question what additional data collection will be required by the legislation. States believe it is critical to ensure that all HIV reporting requirements are coordinated across federal agencies to avoid unnecessary duplication of effort and cost associated with data collection.
- Clarification is needed on the roles of the proposed HIV prevention offices at the Health Resources and Services Administration and the Substance Abuse and Mental Health Services Administration and the relationships of these offices to CDC.

ASTHO appreciates your consideration of these issues as you work to refine The Comprehensive HIV Prevention Act of 1993. We welcome the opportunity to continue discussions with you and Steve Morin of your staff to address issues of concern to the states.

Sincerely,

Molly J. Coye, M.D., M.P.H.
President-Elect

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Overview of Public Health Infrastructure Needs
ASTHO Input Into Final Report of the National Commission on AIDS

Over the past several years, even as the Institute of Medicine's (IOM) report, ***The Future of Public Health***, was being praised for its insight, and the National Health Promotion and Disease Prevention Objectives of the Year 2000 were being developed to guide the country's direction on improving the health of Americans, the public health infrastructure has been steadily and progressively deteriorating. The advent of HIV disease has magnified, if not accelerated, this deterioration over the past decade.

The public health system of federal, state and local health agencies, already faced with the challenge of addressing mounting public health problems with severely inadequate resources, was overwhelmed by the HIV epidemic and its sequelae of increasing communicable disease rates. Despite the scarcity of necessary resources, which in large part resulted in the "disarray" of public health, State and Local Health Agencies continue to play a critical leadership role in communities' efforts to assure services for citizens. This role includes responsibility for overall assessment and planning, policy development, coordinating, administering, financing and assuring early intervention and care.

The IOM called State Health Agencies "the central force in public health which bears the primary public sector responsibility for public health." Despite being charged with overall coordination of services to prevent and control diseases within their states, State Health Agencies often see this authority by-passed by direct federal funding of community-based organizations. Because this funding stream excludes the agency responsible for oversight of health programs in the state, it serves to weaken, rather than strengthen or build the infrastructure necessary to effectively deliver prevention and treatment services. Such a funding mechanism establishes state, local and community-based organizations as competitive rather than cooperative partners and reduces their incentive to work collaboratively on delivery of preventive and health care services. State Health Officials must be involved in awarding of federal grants to local and community-based organizations within their state's purview. Such involvement enables the states to effectively coordinate service delivery and maximize leveraging of state and federal resources. Improved federal-state communication on direct-funding and involvement of state health departments in award processes will protect the public health infrastructure from added deterioration and will enable states to foster the strong, collaborative linkages necessary to effectively provide HIV services throughout the nation.

It must be recognized that the diverse organizational structures of state public health departments presents at once a source of strength and a challenge. State health departments must maintain this diversity in order to effectively meet the equally diverse health priorities of the nation's population. However, this same diversity challenges state public health departments as they work to develop and maintain the linkages necessary to fulfill their core missions of assessment, policy development and assurance as defined by the IOM report. Within these diverse structures, public health is confronted with the challenges of inadequate resources, recruitment and retention of appropriately trained public health personnel, need for improved public health training, demand for integrated data systems and communication capacity, and finally, the need for strengthening of state-local linkages. Each of these challenges is magnified by the fact that continuity of leadership is severely strained--the average tenure of State Health Officials is currently slightly under two years. Combined, these challenges to the public health infrastructure compromise State Health Agency capacity to address the critical health issues of our time, including HIV/AIDS.

In addition, restrictive legislative requirements attached to federal funding sources reduce state flexibility to develop state-local infrastructure and linkages in the ways that best meet the needs of their diverse populations. An example of this is the 5 percent administrative limitation on Title II of the Ryan White CARE Act. This cap on administrative expenses must be increased to enable establishment and enhancement of additional infrastructure for HIV care programs. The current redirection of funds from other sources, including prevention programs, weakens those infrastructures at the expense of maintaining Title II programs.

HIV/AIDS has, without question, highlighted the serious inadequacies of the U.S health care system to a greater extent than has any other single disease or social issue of our time. Principal among these inadequacies is the absence of sufficient preventive resources and the inequities in access to care for underserved populations. While these inadequacies are not unique to HIV/AIDS, they severely compound the challenges faced by the public health system in effectively addressing this epidemic. These inadequacies, coupled with deteriorating public health infrastructure, present immense challenges as the country reforms its health care system for all Americans. We must remember that these challenges also afford incomparable opportunities to build an infrastructure that will better serve the public by effectively integrating prevention into a reformed system of health care.

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
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November 30, 1992

Judith Feder
Clinton-Gore Transition Team
1120 Vermont Ave., N.W.
Washington, D.C. 20270

Dear Ms. Feder:

I would first like to take this opportunity to congratulate Governor Clinton and Senator Gore on their successful campaign and to welcome you and the transition team to the nation's capital.

I write to you today on behalf of the Association of State and Territorial Health Officials (ASTHO), which represents the chief health officers in the 50 states, the District of Columbia and the U.S. territories, to applaud President-elect Clinton for his decision to prioritize efforts to address the HIV/AIDS epidemic in his Administration.

ASTHO strongly supports the concept of an entity or individual charged with fostering collaboration among federal, state and local health agencies in combatting the epidemic, and we urge the Administration to rely on state health officials to provide input into the process of shaping the role this office or individual will assume.

As you are aware, the Institute of Medicine's report, The Future of Public Health, refers to states as "the central force in public health," and assigns them the "primary public sector responsibility for health." State Health Officials are mandated to assure that prevention and treatment services are available to HIV infected persons as well as those at risk for such infection. While state and territorial health agencies are principally concerned with HIV/AIDS prevention and control issues such as counseling, testing, health education, partner notification and behavior change interventions targeted to high risk populations, they are also accountable for assurance of access to health care services such as AZT, ddI, home and community-based care and insurance continuation programs for HIV infected individuals.

Because of the critical role which State Health Agencies play in controlling the HIV/AIDS epidemic, it is imperative that ASTHO be included in any discussions related to addressing the epidemic, particularly those which will define the activities and responsibilities of the AIDS entity envisioned by President-elect Clinton.

I have enclosed the key ASTHO recommendations presented last week to the National Commission on AIDS to assist the new Administration in shaping its response to the epidemic. My colleagues and I welcome the opportunity to meet with you to discuss HIV/AIDS issues and I encourage you to contact me at (501) 661-2111 to begin our dialogue.

Sincerely,

M. Joycelyn Elders, M.D.
Director, Arkansas Department of Health
ASTHO President

cc: Vernon Jordan
Warren Christopher
The Honorable Louis Sullivan, M.D.
James O. Mason, M.D.
Tim Westmoreland

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS'
HIV/AIDS RECOMMENDATIONS TO EXECUTIVE AND LEGISLATIVE BRANCHES

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1. The country **MUST** refocus its HIV/AIDS efforts on primary prevention of HIV infection. Prevention must be the nation's number **ONE** HIV/AIDS priority.

2. States are "the central force in public health" and **MUST** be consulted with regard to the administration's policies and positions on HIV/AIDS prevention and treatment.

3. ASTHO applauds President-elect Clinton for his decision to prioritize efforts to address the HIV/AIDS epidemic and urges consultation with ASTHO and its affiliates in defining the roles and responsibilities of the AIDS entity envisioned by the new administration.

4. Federal funding streams should reflect the fact that State Health Agencies are the entities charged with responsibility for the health of the nation's citizens.

5. The administration should look to State Health Agencies to fulfill the three principal roles defined by the Institute of Medicine (IOM):

   Needs Assessment
   Policy Development
   Assurance of Access to Services

6. Input which is representative of the communities within states is critical for successful programs; however, federal funding streams which by-pass State Health Agencies undermine state efforts to fulfill their mission as described by the IOM report. Federal funding streams which are not coordinated through the State Health Agency result in uncoordinated and often duplicative services.

7. The new Administration must provide resources to strengthen state, county and local health agency infrastructure to better enable the public health system to respond to the HIV/AIDS epidemic.

8. Linkages between CDC, HRSA, SAMHSA, NIH, HUD, FDA, HCFA and other federal agencies **MUST** be strengthened to foster a coordinated, integrated approach to HIV prevention research and treatment.

9. ASTHO advocates a federal/state partnership that allows state flexibility in designing prevention and treatment strategies that meet the diverse needs of states and their citizens.

10. CDC HIV prevention funding **MUST** be increased to enable states to respond to current demands. Prevention funds appropriated now will directly reduce the future burden on entitlement and treatment programs. In FY 93 State Health Agencies requested $181 million in CDC HIV Prevention Cooperative Agreement funds--CDC will only be able to award approximately $110 million to states--fully $71 million less that the demonstrated need.

11. ASTHO advocates for immediate implementation of an expanded AIDS case definition which includes HIV infected adults and adolescents with CD4 counts of less than 200, and HIV infected individuals with pulmonary tuberculosis, recurrent pneumonia and/or invasive cervical cancer. State and local health agencies **MUST** be provided the necessary resources to implement the expanded definition and to assure access to CD4 counts.

12. Restrictions on the content of AIDS related materials should be eliminated. The country's public health professionals and educators **MUST** be provided the flexibility necessary to address the HIV/AIDS epidemic with explicit frankness when necessary.

13. The new administration should foster opportunities for more open discussion of needle exchange as a means of reducing HIV transmission among intravenous drug users and their sexual partners.

14. To support the nation's HIV prevention efforts, drug treatment capacity **MUST** be significantly expanded to meet the demand.

15. ASTHO applauds the increase in tuberculosis funding in FY 93 and urges that higher levels of funding to states be a priority for the new administration. Tuberculosis funding should complement HIV funding--**NOT** replace it.

16. Ryan White CARE Act funding under Title II **MUST** be increased to enable equal access to treatment services in rural, suburban and urban areas of our country. The current disparity should be corrected in a supplemental FY 93 appropriation or in the FY 94 President's request. In addition, eight states, including New Jersey and Texas, will actually lost funding for AIDS therapies and other treatment services in FY 93 unless significant changes are made in the legislation itself.

17. The FY 94 budget should include **NEW** funding to State Health Agencies for early intervention programs for HIV infected persons. Early intervention funding should **NOT** be provided at the expense of primary prevention as is proposed in Title III(A) of the Ryan White CARE Act.

18. Vaccine development, clinical trials and development of a rapid drug susceptibility test for TB should be priorities in terms of new technology.

19. The nation **MUST** return to science-based public policy. Policy decisions such as immigration restrictions must be considered on the basis of scientific evidence. Science clearly demonstrates that there is no basis on which to restrict immigration of HIV infected individuals. The new administration should recognize the role of science in policy considerations and act to remove immigration restrictions for HIV infected persons.

20. Lastly, the health care reform debate **MUST** prioritize prevention and primary care for all citizens, including HIV infected individuals. (See attached ASTHO position on health care reform)

Association of State and Territorial Health Officials

HIV/AIDS UPDATE

Volume 4, Number 6 · June, 1993

LEGISLATIVE AND POLICY UPDATE

FY 94 APPROPRIATIONS: It is widely reported that the $45 million in HIV prevention funding included in the President's Budget looks promising. On the treatment front; however, the $310 million in care dollars has been reduced to $200 million with no definitive information on the distribution among CARE Act titles. AIDS housing under the House VA/HUD Subcommittee is said to have fared well with a higher mark than anticipated. The embargo on details of the House subcommittee mark-ups will likely be in effect through this week. Additional information on FY 94 appropriations will be provided to states as it becomes available.

STATE PREVENTION VISION: ASTHO, NASTAD and CSTE efforts to develop a state vision on HIV prevention continue as we work to integrate comments received from the working group, the ASTHO HIV Committee and ASTHO affiliate presidents. The working group hopes to solicit additional input from states on a draft vision document expected to be disseminated in the next few weeks.

MORELLA INTRODUCES WOMEN AND AIDS RESEARCH BILLS: Congresswoman Connie Morella (R-MD) reintroduced legislation this week which emphasizes HIV research and prevention for women. To date, H.R. 2394, which would amend the Public Health Service Act to establish programs of research with respect to women and HIV infection, has garnered 25 co-sponsors in the House. A second piece of legislation introduced by the Congresswoman, H.R. 2395, would amend the Public Health Service Act to provide additional programs targeting women and HIV. Both bills have been referred to the Committee on Energy and Commerce and Senator Paul Simon (D-IL) is expected to introduce them in the Senate shortly.

FY 1992 SURVEY OF STATE AIDS FUNDS: According to a 50 state survey conducted by George Washington University's Intergovernmental Health Policy Project (IHPP), states spent $401.9 million in FY 92 state only funds (excluding Medicaid) on HIV prevention and treatment. This 22% increase over FY 91 state only funds demonstrates states' strong financial commitment to combatting the epidemic, but must also be viewed in the context of a 26% growth in AIDS caseloads during this same period.

Although on average, states spent $7.9 million on HIV/AIDS programs in FY 92, nine states reported spending $10 million or more on HIV/AIDS: **CALIFORNIA, FLORIDA, ILLINOIS, LOUISIANA, MASSACHUSETTS, NEW JERSEY, NEW YORK, TEXAS AND WASHINGTON.** The highest per capita expenditures on HIV/AIDS prevention were identified in **DISTRICT OF COLUMBIA, HAWAII, CALIFORNIA, NEW YORK AND CALIFORNIA.** In contrast to most of the states with high per capita spending on HIV prevention, **HAWAII** is not a high incidence state. The survey suggests that such a contrast may provide a unique means of assessing the efficacy of state HIV prevention efforts.

Health care and support services accounted for fully half of FY 92 state expenditures on HIV/AIDS; with the remaining 50% divided among prevention services including education, information, testing, research, surveillance and administration. 70% of education and information funds were targeted to minorities, gay and bisexual men, injection drug users, women of child bearing age, adolescents and prisoners. In support of states' sound fiscal management was the finding that "only 4.9% of state only funds went to administrative activities--evidence that states concentrate their dollars on programs and services rather than overhead."

The complete 65-page report is available for $35 from IHPP Publications, 2021 K Street, N.W., Suite 800, Washington, D.C. 20006 (202) 872-1445.

STATE NEWS

- The **RHODE ISLAND** Department of Health has produced three versions of an HIV pre-test counseling videotape, each available in seven languages. Produced in 1989, the tapes have been useful in HIV pre-test counseling settings, especially for persons with language or reading difficulties. Each tape is 15 minutes in length with appropriate additions for each of the "generic," "prenatal" and "family planning" versions. Each version is available in English, Portuguese, Hmong, Laotian, Cambodian and Vietnamese. Contact Mary Lou DiCiantis, Ph.D. at (401) 277-2320 for additional information.

- In conjunction with the expanded AIDS case definition, **WASHINGTON** State will require state laboratories performing CD4+ tests to make reports to the Department of Health on specimens with CD4+ counts less than 200/mm3 or CD4+ percents of total lymphocytes less than 14. In addition to actual test results and provider name, these reports will use patient-specific or anonymous codes. A patient's name may be used only if authorized by the patient. Also effective May 2, the same requirements for confidentiality, consent and counseling requirements that accompany HIV testing will apply to CD4+ tests when used to diagnose HIV infection. For further information, contact the Washington State HIV/AIDS Office of Epidemiology and Evaluation (206) 464-5458.

- Birth certificates issued in **CONNECTICUT** have a supplemental portion designed to collect medical information which is confidentially maintained and not subject to public disclosure. Since 1988, the birth certificate's supplemental section has contained information about HIV status if the mother or newborn is known to be positive. Through this mechanism, the AIDS Section has received identifier-based information on all birth listings which include HIV infection as a medical risk factor for the pregnancy or as an abnormal condition of the newborn. ***AIDS In Connecticut: Annual Surveillance Report*** details this effort along with providing information on supplemental surveillance programs, evaluation of completeness of reporting, survival analysis, seroprevalence surveys, findings on HIV/TB co-reporting and a wide range of other surveillance efforts being undertaken by the state. For further information contact the Connecticut State Department of Health Services at (203) 566-1980.

- The **CALIFORNIA** Department of Health Services announces the release of guidelines for Preventing the Transmission of Blood-Borne Pathogens in Health Care Settings. The Department developed the guidelines in consultation with representatives of dental, medical, nursing, legal, public health and public policy disciplines. The guidelines stress the importance of the use of universal precautions as the primary means of preventing the transmission of blood-borne diseases and recommend voluntary rather than mandatory testing for HIV. In addition, the guidelines call upon health care workers infected with any blood-borne pathogen to consult with their personal physicians and expert review panels concerning the appropriateness of any practice restrictions. To obtain a copy of the guidelines, contact Jean Iacino, California Department of Health Services, Office on AIDS, (916) 324-9751.

- Intravenous drug use (IDU) continues to be the predominant risk factor in transmission of HIV infection in many states. **NEW JERSEY** reports that 50% of AIDS cases reported between April, 1992 and March, 1993 resulted from IDU behavior while 54% of the state's cumulative total AIDS cases are reported to be associated with IDU activity.

NATIONAL NEWS

- Plans are already underway for **World AIDS Day 1993**, scheduled for December 1. Kits embracing this year's theme, **Time To Act**, should be ready for distribution by late August. Some 180 countries around the world recognize **World AIDS Day.** ASTHO, as well as two of its affiliates, NASTAD and the National Public Health Information Coalition (NPHIC), are represented on the Advisory Committee, so there is ample opportunity for State Health Agency input into the project.

- States recently received correspondence from HRSA's Division of HIV Services in follow-up to the ASTHO project on HIV/AIDS Technical Assistance Needs of State Health Agencies. The correspondence outlines HRSA's proposed Title II technical assistance plan including efforts to produce and disseminate publications on key aspects of Title II implementation, synthesis of selected information from all Title II applications, convening of workgroups on selected HIV service delivery issues and site visits. States were also asked to complete brief questionnaires on program evaluation and peer technical assistance. The information will assist HRSA in compiling information on Title II program evaluation activities for distribution to all states and in designing a mechanism to accommodate states' interests in participating in peer-to-peer technical assistance. For additional information, contact Anita Eichler, M.P.H., Division of HIV Services, Planning and Technical Assistance Branch, Parklawn Bldg. Rm. 9A-05, 5600 Fishers Lane, Rockville, MD 20857 Phone: (301) 443-6745.

- At a June 2 ceremony conducted by The Institute for Advanced Studies in Immunology and Aging, **Dr. June Osborn and Dr. David Rogers, Chair and Vice Chair of the National Commission on AIDS** received the **Lifetime Humanitarian Award** in recognition of their efforts to provide leadership in addressing HIV/AIDS issues. **Dr. Michael Gottlieb and Dr. Robert Redfield** received the **Lifetime Science Award** commemorating their many contributions to HIV/AIDS research and treatment. The ceremony followed **A Town Forum on AIDS** at which Dr. Tony Fauci and Dr. Robert Gallo of NIH, Dr. Enrico Garaci of the National Research Council of Italy, Dr. Michael Gottlieb of UCLA and Dr. Robert Redfield of Walter Reed Army Medical Center held a public discussion moderated by Carole Simpson of ABC on the progress in AIDS research and vaccine development.

- The May 19 ***Federal Register*** announced a preapplication workshop held June 3 for $9.5 million in CDC cooperative agreements for national and regional minority organizations. Eligible applicants are tax-exempt nongovernmental organizations with multi-state/territory affiliates whose boards are comprised of greater than 50% racial and ethnic minorities. Funds may be used for technical assistance and training in support of HIV prevention, preschool immunization activities; and TB screening, prevention and treatment. See pp. 29227-29228 for details.

- The Robert Wood Johnson Foundation has announced the availability of TB funds for public and private organizations. Eligible areas include 32 states and the District of Columbia (as defined in the January 8 *MMWR*). An applicant workshop will be conducted **JULY 7** in Chicago, with concept papers due **JULY 21.** Applicants selected to submit full proposals will be notified by **JULY 29.** For additional information contact Philip Hopewell, M.D., Director, Old Disease, New Challenge, National Program Office, UCSF Box 1348, San Francisco, CA 94143-1348 (415) 476-9601.

- The June 4 ***Federal Register*** announces CDC's intent to provide funding to support nongovernmental organizations' HIV prevention projects through three cooperative agreement instruments:

  Announcement No. 305: Provides $9.5 million in FY 93 funds for regional/national minority Organizations for HIV/STD prevention, immunization and TB projects. Application deadline: **JULY 27.** See pp: 31721-31727 for details.

  Announcement No. 403: Provides $500,000 in FY 94 funds for national minority organizations to target school/college youth and youth in high-risk situations. See page 31720 for brief description; CDC anticipates that the actual announcement will be printed in the ***Federal Register*** later this month.

  Announcement No. 400: Provides $500,000 in FY 94 funds for national and regional minority organizations to conduct health communications and prevention marketing programs directed to racial/ethnic minority audiences. See page 31720 for brief description; CDC anticipates that the actual announcement will be printed in the ***Federal Register*** this coming fall.

- The June 14 ***Federal Register*** includes an advance notice of the **JULY 28** application deadline for HRSA's $1.2 million in Special Projects of National Significance (SPNS) funding. The full program announcement for this funding is expected to be published shortly. The 1993 SPNS programs will support innovative programs to advance knowledge and skills in the delivery of health and support services for adolescents with HIV/AIDS or who are at high risk for infection. See page 32958 or contact Glenna Wilcom at (301) 443-2280 for further information.

- Through its national challenge grant program, the National Community AIDS Partnership uses national funds to leverage matching grants at the local level by up to three times their amount. Over the past four years, 397 private, corporate and community foundations have contributed nearly $16 million to fund community-based HIV/AIDS service and preventive education programs. In 1992 alone, approximately $6 million was raised and 147 new local funders joined the Partnership. Contact NCAP at (202) 429-2820 for additional information.

INTERNATIONAL NEWS

- At the IX International Conference on AIDS in Berlin, Dr. Merson of the World Health Organization (WHO) called for significantly greater financial support to control the AIDS epidemic in developing countries. The ***New York Times*** reports that WHO estimates that "investing $2.5 billion a year would save nearly $90 billion in direct and indirect costs by the year 2000 and additional savings for the 21st century." The increased funding would make it possible to "cut in half the number of people who otherwise would be infected with HIV." Dr. Merson characterized the options as "either we pay now or we pay later." Approximately 15,000 persons attended the IX International Conference at which 800 lectures and 4,500 poster sessions were presented.

- In response to a resolution passed at the recent World Health Assembly, the World Health Organization's (WHO) Global Programme on AIDS will be integrated into a larger worldwide effort administered by the United Nations. The resolution was developed in response to the proliferation of HIV/AIDS programs competing for scarce HIV/AIDS resources and in an attempt to involve economic sectors beyond health in the fight against the epidemic. The UN HIV/AIDS program is expected to remain attached to the WHO, but will encompass a broader array of participating countries' programs and will report to a committee of sponsoring agencies. The resolution will take effect in January, 1994.

- According to WHO, 8 million people worldwide develop active TB and 3 million of them die. In 1991, CDC received reports of 26,283 active cases of TB in the U.S., an increase of 18 percent since 1985.

- To prepare for international trials of HIV vaccines, NIAID has given awards to six U.S. universities for work in 8 developing countries. The awards, known as the PAVE awards for Preparing for AIDS/HIV Vaccine Evaluations, provide funding for study of the rates of HIV infection and co-factors that contribute to HIV transmission in Africa, Asia and the Caribbean. The two year awards will provide for staff training and technology transfer to enhance the countries' abilities to conduct the trials. Contact NIAID for further information.

SURVEILLANCE NEWS

- CDC's ***HIV/AIDS Surveillance Report*** indicates that through March of 1993, 284,840 cases of AIDS have been reported in adults and adolescents. 4,480 cases have been reported in children, bringing the total of U.S. cases to 289,320.

- **Dr. Robert MacLean** of the **TEXAS** Department of Health represented ASTHO at a May 25-26 CDC meeting on Pediatric HIV/AIDS Surveillance. The meeting participants addressed the goals and uses of surveillance data in children, proposals for expansion of pediatric HIV/AIDS surveillance, confidentiality issues, follow-up, and the potential impact on mothers and families of children reported through HIV/AIDS surveillance. Progression to symptomatic infection and to AIDS occurs much more rapidly in young children than adults, permitting the current surveillance system which is limited to reporting of AIDS cases, to miss a significant portion of the HIV burden on health care facilities and communities. Currently, more than 20% of children with AIDS are being reported at death. For these reasons, consideration is being given to expansion of pediatric AIDS surveillance to more accurately capture the full spectrum of HIV disease in children 12 and under. To address the limitations of AIDS case surveillance and to improve public health planning and facilitate early intervention, 26 states have implemented confidential named reporting of HIV-infected children. Proponents of expanded surveillance believe that it would facilitate earlier institution of support services for the infant and family and would alert care givers to more rapidly recognize and aggressively treat symptoms. Public health authorities would be better able to target prevention activities and to estimate resources needed to address the HIV epidemic in this age group. Opponents of expanded surveillance are concerned about the absence of adequate resources necessary for increased surveillance, confidentiality issues, possible deterrence of pregnant women from seeking testing and the implications of HIV reporting during the indeterminate period prior to confirmation of infection status. ASTHO will continue to track this issue and provide information to states as it develops.

RESEARCH AND HEALTH CARE NEWS

- A new three drug combination therapy for HIV will be tested in 400 adults in 16 sites across the nation through ACTG 241. The AZT, ddI and nevirapine combination will be compared to the two drug combination of AZT, ddI plus a placebo over a 48 week period. Contact 1-800-TRIALS-A from 9 a.m. to 7 p.m. Monday-Friday for further details.

- A new procedure, which relies on the same "glow in the dark" substance in fireflies, can speed the diagnosis of TB and rapidly determine which drugs will be effective in killing the particular strain of infection. The procedure, known as luciferase phage assay, can detect the presence of TB bacteria in one to two hours rather than the several weeks required by the current diagnostic tests for TB. Within 48 hours the procedure can detect which drugs can kill a particular TB strain. For additional information, see the May 7 ***Science*** or contact the National Institute of Allergy and Infectious Diseases (301) 402-1663.

- The June 9 issue of ***JAMA*** contains a wide variety of HIV-related research articles which may be of interest to states. Topics range from "Risk for Perinatal HIV-1 Transmission According to Maternal Immunologic, Virologic, and Placental Factors" and "Trends in Death with Tuberculosis During the AIDS Era" to a message from the Surgeon General on "Condom Use for Prevention of Sexual Transmission of HIV Infection."

FOR YOUR CALENDAR

- The following meetings of the CDC HIV Prevention External Review subcommittees are scheduled in the next few weeks:

  JUNE 28-29 Preventing Risk Behaviors Among School Students (College Park, GA)
  JULY 12-13 Developing Partnerships for HIV Prevention (Memphis, TN)

  See the ***Federal Register*** or contact Connie Granoff at CDC (404) 639-2918 for additional information.

- The ***1993 Midwest AIDS Conference*** is scheduled for **JULY 7-8, 1993** in Chicago. Dr. Joycelyn Elders, Surgeon General Desigee, will be the keynote speaker for the conference which will address the theme of ***AIDS In the Black Community.*** Conference fee: $100. For additional information contact The Community Health Association, 333 N. Michigan Ave., Suite 2323, Chicago, IL 60601 (312) 201-1235.

- The ***15th Annual Lesbian and Gay Health Conference and 11th Annual AIDS/HIV Forum,*** sponsored by the National Gay and Lesbian Task Force and the George Washington University Medical Center, will be held **July 21-25** in Houston, TX. For registration information and a program brochure, call (202) 994-4285.

- The ***7th International Conference on AIDS Education,*** scheduled for August 1-4 in Denver, Colorado, will focus on the theme ***The Increasing Faces of AIDS: Inclusion with Diversity.*** Contact the International Society for AIDS Education Executive Office, Univ. of South Carolina, School of Public Health, Columbia, SC 29208 (803) 777-6217.

RESOURCES

- The National Conference of State Legislatures (NCSL) has published an April 1993 update on ***HIV/AIDS Facts to Consider,*** a compendium of epidemiologic, economic and policy information on HIV/AIDS and related problems of substance abuse and tuberculosis. The 20-page resource is a useful reference for legislators, public health officials, health care providers and administrators, and all those concerned with controlling the spread of HIV. Contact NCSL at (303) 830-2200 for additional information.

- The National Association of People with AIDS (NAPWA) produces a free bi-monthly publication, ***Medical Alert,*** which provides information on the latest therapies and vaccine trials as well as findings on research in progress. Contact NAPWA at 1413 K St., N.W., Washington, D.C. 20005 to be added to the mailing list.

- The U.S. Conference of Mayors (USCM) has just released a ***Local HIV Policies Resource Guide,*** which highlights information gleaned from a survey of 94 local health departments. The document addresses policies in the following areas: monitoring and assuring quality of services provided by organizations funded by the locality or local government agencies; early intervention, referral and follow-up; voluntary partner notification services; coordination between HIV prevention and STD services; tuberculosis prevention and control measures for HIV-infected individuals; and HIV prevention efforts targeting drug users. The 67 page resources is available from USCM, 1620 Eye St., N.W., Washington, D.C. 20006 (202) 293-7330.

- The National AIDS Clearinghouse has recently published a new catalog of materials available through the Clearinghouse. The ***Catalog of HIV and AIDS Education and Prevention Materials*** can be ordered, free of charge in limited quantities by calling 1-800-458-5231.

The ***ASTHO HIV/AIDS UPDATE*** is designed to facilitate communication among states on HIV/AIDS issues, and is made possible through a cooperative agreement with the Centers for Disease Control. Please send information on your state's efforts which might benefit other states in addressing HIV/AIDS issues to:

Margaret Skelley
Editor, ASTHO HIV/AIDS Update,
Association of State and Territorial Health Officials
415 Second St. N.E., Suite 200,
Washington, D.C. 20002
Phone: (202) 546-5400 **Fax:** (202) 544-9349.

M. JOYCELYN ELDERS, M.D.

PRESIDENT

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

TESTIMONY TO

THE NATIONAL COMMISSION ON AIDS

NOVEMBER 17, 1992

NATIONAL COMMISSION ON AIDS TESTIMONY
JOYCELYN ELDERS, M.D., ASTHO PRESIDENT
NOVEMBER 17, 1992

DR. OSBORN, DR. ROGERS, COMMISSION MEMBERS, COLLEAGUES AND FRIENDS:

I appreciate the opportunity to speak to you today on behalf of the Association of State and Territorial Health Officials (ASTHO). ASTHO represents the chief health officers from the 50 states, the District of Columbia and the U.S. territories on all public health issues including HIV/AIDS.

Let me begin by saying that if I leave you with one key point today, it is that this nation **MUST** refocus its efforts on primary prevention of HIV infection.

I wish I could appear before you today and tell you that public health officials had a vaccine or a panacea for HIV infection and the multiple social problems such as substance abuse, homelessness and lack of insurance that are all too often associated with HIV infection, but I can't. There is no magical means of preventing HIV infection--and there is no magical means of bringing back the estimated 1.5 to 2.1 million years of potential life lost due to AIDS.

Instead, state public health agencies must use our limited resources to prevent and control the spread of this deadly virus. As "the central force in public health," states are charged with "the primary public sector responsibility for health." Public health agencies play a critical leadership role in the community's efforts to assure prevention, early intervention and treatment services for all of their citizens. This role includes responsibility for overall planning, coordinating, administering, financing and providing prevention, early intervention and care. The cornerstone of these efforts with regard to AIDS is primary prevention of HIV infection.

As one of my colleagues stated recently, "It would be hard to even **guess** that HIV is transmitted predominantly through unsafe sexual activities and shared needles, based on most of the federally-funded educational pieces produced." We **MUST** be frank and explicit in our prevention messages regarding HIV/AIDS, particularly those targeted to adolescents. Our youth **MUST** be provided with specific, explicit, detailed information on how to avoid HIV infection. Vague messages and value judgements will not suffice--our youth **MUST** not be left to try to piece together for themselves what they must do to prevent HIV infection.

NATIONAL COMMISSION ON AIDS TESTIMONY
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State Health Agencies' HIV prevention initiatives vary widely throughout the country depending upon many factors including population, infection rates, federal and state resources, and existing state and local laws. The diversity of state health prevention efforts is dictated by the diverse needs of the populations served by the state. Some examples of the diverse health education, risk reduction, public information and minority initiatives of states include:

- outreach to minorities and other disproportionately affected populations, such as that targeted to African American and Latino men having sex with men in California,
- enhanced behavior change counseling such as that offered through Oregon's Seropositive Wellness Program,
- targeted HIV prevention education for low-income women enrolled in New Jersey's WIC program,
- training of peer educators to provide outreach to disenfranchised youth in Illinois,
- outreach to "shooting galleries" and provision of bleach and condoms in Connecticut,
- development of HIV prevention messages targeted to the Delaware beaches,
- HIV prevention, counseling, testing, treatment and post-release follow-up of correctional inmates in Rhode Island
- the many efforts across the nation targeting adult bookstores, adult theaters and gay bars with HIV prevention messages,
- mobile van distribution of prevention information packets and condoms to sex workers along Massachusetts' "strolls",
- and nationwide networks of counseling and testing centers providing both an entryway into early intervention and care systems, as well as rich surveillance data.

One of the fundamental mechanisms to prevent and reduce HIV transmission, and thereby minimize HIV/AIDS related morbidity and mortality, is the public health system of pre- and post-test counseling, testing and partner notification. State Health Agencies strive to maximize opportunities for counseling and testing by collaborating with STD, TB, family planning and drug treatment clinics. At-risk clients in these settings are offered services ranging from pre-test counseling to primary care through collaboration with local and community-based providers--all with paramount importance placed on confidentiality.

Counseling and testing sites also serve to link HIV infected clients to early intervention and care services and to provide opportunities for infected persons and their sex and drug using partners to receive behavior modification counseling to prevent the further spread of infection. Voluntary partner notification provides opportunities for sex and drug using partners of those infected, or at risk for HIV, to receive testing and early intervention services.

Availability of these services has become even more important with states being faced with an average 35 percent increase in demand for testing since "Magic" Johnson's announcement. Although hindered by cuts in CDC HIV prevention funding, state and local health departments have risen to the challenge. Without the accompanying resources to meet this increased demand, though, waiting lists have resulted in many instances.

The importance of the information obtained through surveillance cannot be overstated. It provides the basis on which we assess the impact the disease is having on our country, and is used both to plan future prevention efforts as well as to assess the efficacy of current efforts. Surveillance data provide valuable information on the changing face of the epidemic--they are the "evidence" for public health assertions that AIDS is a global epidemic with no geographic, racial, cultural or ethnic boundaries; that the nation's second 100,000 cases of AIDS surfaced four times as quickly as the first 100,000; and that minorities are disproportionately affected and account for almost 50% of cumulative reported cases. Surveillance data are critical to our ability to identify which populations may be most at-risk for HIV, and they provide the support for development of targeted prevention strategies.

ASTHO supports expansion of the AIDS surveillance case definition to include HIV infected adults and adolescents with CD4 counts of less than 200 per microliter, as well as HIV infected individuals with pulmonary tuberculosis, recurrent pneumonia and/or invasive cervical cancer. We believe that these additions to the definition will enable surveillance efforts to more accurately reflect the burden of HIV disease throughout the nation; however, state or local health departments **MUST** be provided the resources necessary to implement the new definition and assure access to CD4 counts.

The increase in the FY 93 CDC HIV prevention budget is largely comprised of $25 million in HIV-related TB control. Although TB funding is critically necessary, it cannot **replace** funding for primary prevention of HIV. This "increase" in the FY 93 CDC HIV prevention budget actually translates into level or fewer resources for state health agency use in primary prevention of HIV at a time of increased demand. CDC HIV prevention funding **MUST** be increased to enable states to respond to current demands. Prevention funds appropriated **now** will directly reduce the future burden on entitlement and treatment programs. In FY 93 State Health Agencies requested $181 million in CDC HIV Prevention Cooperative Agreement funds--CDC will only be able to award approximately $110 million to states--fully $71 million **LESS** than the demonstrated need.

It is critical to note that between 1986 and 1991, states contributed in excess of $1 billion of state general revenues to combat HIV/AIDS--not including state matching dollars for Medicaid. This is testimony both to the critical need for additional resources as well as to the priority states place on HIV/AIDS prevention and treatment. In 1991 alone, states contributed more than $330 million to efforts to control the HIV/AIDS epidemic.

The average cost for per HIV test is $25.
The average cost for pre-and post-test counseling is approximately $38.
The average cost of early intervention for HIV infected persons is approximately $5,904.
The average lifetime cost of treating a persons with AIDS is approximately $85,000.

Clearly, effective prevention programs **WHICH ARE ADEQUATELY FUNDED** have the potential not only to curtail the spread of the epidemic, but to do so cost effectively.

Again, I state that the nation **MUST** refocus its efforts on primary prevention of HIV.

The exorbitant cost of care is magnified by the fact that almost 30 percent of HIV infected individuals are uninsured. It is this very population that constitutes the vast majority of public health clients. The Institute of Medicine stated that "health departments have become the 'providers of last resort' for uninsured patients and those Medicaid patients rejected by or simply beyond the reach of private providers and institutions." HIV has in many ways highlighted and magnified the multiple, chronic health and social problems faced by our nation. Poverty, homelessness, teen pregnancy, discrimination, inadequate access to care, lack of insurance, substance abuse and tuberculosis are all deeply interwoven into this epidemic. Reform of our health care system **MUST** take these factors into consideration.
The Health Resources and Services Administration (HRSA) estimates the annual cost of caring for uninsured HIV infected persons is approximately $2 billion. The majority of this cost is attributable to HIV/AIDS drugs for which states have responsibility, **but severely limited resources**, to administer through Title II of the Ryan White Care Act. Although Title II has been referred to as "the most seriously under-funded Title of the Act," it remains under-funded, resulting in an estimated 22 states being required to disband or severely curtail their AIDS drug programs this year. Even HRSA, the administering agency for Ryan White, requested $170 million for states under Title II for FY 93. The final appropriation of $115.4 does not **BEGIN** to approach meeting the needs of the HIV infected persons not residing in Title I cities--nor does it approach the level of funding requested by the administering agency.

The disparity in funding between Titles I (emergency funding for cities) and II (treatment funding for states) of the CARE Act is of particular concern to ASTHO. Such disparity profoundly affects the level of care to which persons with HIV and AIDS have access throughout our country. Disparity in access to AIDS treatment services wholly undermines the intent of the Ryan White CARE Act and exacerbates the already critical problems this country faces in access to health care in general. FY 93 appropriations will result in average awards of close to $8 million to each of 25 cities (Ponce, Puerto Rico has been added) while states and territories must serve the remainder of the U.S. population not living in those 25 locales with an average award of less than $2 million for FY 93.

ASTHO strongly believes that access to services should not be determined by residency, but by individual need. Citizens in 37 states, or well over half of the nation, are ineligible for the services provided by Title I cities simply by virtue of the fact that they reside in non-Title I cities, or rural or suburban areas. In light of this, it is crucial to note that increases in many rural areas actually outpace those in Title I cities----between 1990 and 1991, for example, the numbers of AIDS cases increased by 57% in Little Rock, AR; 49% in Grand Rapids, MI; and 50% in Worcester, MA. These areas, like thousands of others throughout the U.S., have no Title I funds and must rely heavily on Title II resources to assist them in providing services to those affected by the epidemic.

Additionally, due to formulae in the legislation, eight states, including New Jersey and Texas, will actually **LOSE** funds to care for HIV-infected persons in their states during FY 93. The Title I formula, based on cumulative AIDS cases since the beginning of the epidemic, continues to award funds based on already deceased AIDS patients. By contrast, the Title II formula, based on AIDS cases during only the previous two years, actually **PENALIZES** states which are effectively controlling the epidemic and preventing the virus from spreading. These issues **MUST** be resolved during the re-authorization process.

I have spoken to you about prevention and about treatment. I cannot overemphasize the need for **NEW** funding to State Health Agencies to improve and expand early intervention services to link these efforts. Especially with the revised AIDS surveillance definition's emphasis on CD4 counts, it is imperative that states receive resources to provide CD4 testing to diagnose as well as to monitor disease progression in HIV infected individuals. These resources should not be provided at the expense of primary prevention as is proposed in Title III(a) of the Ryan White CARE Act. Requiring states to redirect 35% of their counseling and testing funds to early intervention simply does **NOT** solve the problems we face with this epidemic. A reduction in counseling and testing in order to fund early intervention will translate into a reduction in infected persons who know their status and are able to receive appropriate care. **NEW** funding to states ear-marked for early intervention services such as CD4 counts and therapeutics **MUST** be included in the FY 94 budget.

Because State Health Agencies are charged with coordinating and integrating systems of care throughout their state, the need for integration of federal initiatives and funding streams cannot be overstated. Linkages among CDC, HRSA, SAMHSA, NIH, HUD, FDA, HCFA and other federal agencies **MUST** be strengthened to foster a coordinated, integrated approach to HIV prevention, research and treatment. These linkages are even more crucial due to the co-morbidity increasingly associated with tuberculosis, substance abuse and sexually-transmitted disease.

In order to facilitate this coordination at the state level, State Health Agencies frequently contract with, or make grants to, community-based organizations to provide preventive and treatment services. Under Title II of the Ryan White CARE Act, for example, more than 200 consortia throughout the country comprised of AIDS services organizations, community-based organizations, service providers and persons with AIDS, work collaboratively with State Health Agencies in planning and prioritizing treatment needs of the state. These partnerships encourage community involvement in controlling the epidemic while preserving the states' role in coordinating services for their citizens.

Direct federal funding of community-based agencies which by-passes state health authority serves to weaken, rather than to build or strengthen the infrastructure necessary to effectively deliver prevention and treatment services. Funding mechanisms which circumvent State Health Agencies serve to establish state, local and community-based organizations as **competitive** rather than **cooperative** partners and reduce their incentive to work collaboratively on delivery of prevention and health care. Because of the multiplicity of entities providing services to AIDS patients, and the scarcity of federal and state resources needed to maintain these services, it is critical that a single agency in each state be responsible for coordination of service delivery and resource allocation. Traditionally, this role has been served by the State Health Agency and I'm here today to tell you that we intend to **CONTINUE** to fulfill this role!

It is evident that the AIDS epidemic is continuing to escalate; it is equally apparent that it is only through coordinated and collaborative efforts at the federal, state and community levels that the nation can adequately meet the prevention and treatment needs of those affected by, and at risk for, HIV. State Health Agencies must be the cornerstone of this effort.

Lastly, I'd like to take this opportunity to advocate for a return to science-based health policy. I applaud the Commission for joining forces with the scientific community in efforts to address the issue of prevention of HIV/HBV transmission from health care providers to patients. Although the science clearly demonstrated a minuscule risk of transmission from health care providers to patients, vast quantities of time and resources were diverted from high-risk prevention and treatment efforts in order to address the issue. The Treasury/Postal legislation which required states to institute CDC guidelines, or their equivalent, even included a penalty stripping non-compliant states of **all** federal health funds! The nation **MUST** return to science-based public policy.

Based on the issues I've discussed with you here today, ASTHO has provided the Commission with 20 recommendations for the new administration to address HIV/AIDS. Again, **FIRST** on the list is the need for the nation to refocus its HIV/AIDS efforts on primary prevention of infection.

I thank you for your attention and welcome any questions the Commission may have on the state public health vision of what the nation's response to the epidemic should be during transition to the new administration.

NATIONAL COMMISSION ON AIDS TESTIMONY
JOYCELYN ELDERS, M.D., ASTHO PRESIDENT
NOVEMBER 17, 1992

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS' HIV/AIDS RECOMMENDATIONS TO EXECUTIVE AND LEGISLATIVE BRANCHES

1. The country **MUST** refocus its HIV/AIDS efforts on primary prevention of HIV infection. Prevention must be the nation's number **ONE** HIV/AIDS priority.

2. States are "the central force in public health" and **MUST** be consulted with regard to the administration's policies and positions on HIV/AIDS prevention and treatment.

3. ASTHO applauds President-Elect Clinton for his decision to prioritize efforts to address the HIV/AIDS epidemic and urges consultation with ASTHO and its affiliates in defining the roles and responsibilities of the AIDS entity envisioned by the new administration.

4. Federal funding streams should reflect the fact that State Health Agencies are the entities charged with responsibility for the health of the nation's citizens.

5. The administration should look to State Health Agencies to fulfill the three principal roles defined by the Institute of Medicine (IOM):

   Needs Assessment
   Policy Development
   Assurance of Access to Services

6. Input which is representative of the communities within states is critical for successful programs; however, federal funding streams which by-pass State Health Agencies undermine state efforts to fulfill their mission as described by the IOM report. Federal funding streams which are not coordinated through the State Health Agency result in uncoordinated and often duplicative services.

7. The new Administration must provide resources to strengthen state, county and local health agency infrastructure to better enable the public health system to respond to the HIV/AIDS epidemic.

8. Linkages between CDC, HRSA, SAMHSA, NIH, HUD, FDA, HCFA and other federal agencies **MUST** be strengthened to foster a coordinated, integrated approach to HIV prevention research and treatment.

9. ASTHO advocates a federal/state partnership that allows state flexibility in designing prevention and treatment strategies that meet the diverse needs of states and their citizens.

10. CDC HIV prevention funding **MUST** be increased to enable states to respond to current demands. Prevention funds appropriated now will directly reduce the future burden on entitlement and treatment programs. In FY 93 State Health Agencies requested $181 million in CDC HIV Prevention Cooperative Agreement funds--CDC will only be able to award approximately $110 million to states--fully $71 million less that the demonstrated need.

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS'
HIV/AIDS RECOMMENDATIONS (CON'T.)

11. ASTHO advocates for immediate implementation of an expanded AIDS case definition which includes HIV infected adults and adolescents with CD4 counts of less than 200, and HIV infected individuals with pulmonary tuberculosis, recurrent pneumonia and/or invasive cervical cancer. State and local health agencies **MUST** be provided the necessary resources to implement the expanded definition and to assure access to CD4 counts.

12. Restrictions on the content of AIDS related materials should be eliminated. The country's public health professionals and educators **MUST** be provided the flexibility necessary to address the HIV/AIDS epidemic with explicit frankness when necessary.

13. The new administration should foster opportunities for more open discussion of needle exchange as a means of reducing HIV transmission among intravenous drug users and their sexual partners.

14. To support the nation's HIV prevention efforts, drug treatment capacity **MUST** be significantly expanded to meet the demand.

15. ASTHO applauds the increase in tuberculosis funding in FY 93 and urges that higher levels of funding to states be a priority for the new administration. Tuberculosis funding should complement HIV funding--**NOT** replace it.

16. Ryan White CARE Act funding under Title II **MUST** be increased to enable equal access to treatment services in rural, suburban and urban areas of our country. The current disparity should be corrected in a supplemental FY 93 appropriation or in the FY 94 President's request. In addition, eight states, including New Jersey and Texas, will actually lost funding for AIDS therapies and other treatment services in FY 93 unless significant changes are made in the legislation itself.

17. The FY 94 budget should include **NEW** funding to State Health Agencies for early intervention programs for HIV infected persons. Early intervention funding should **NOT** be provided at the expense of primary prevention as is proposed in Title III(A) of the Ryan White CARE Act.

18. Vaccine development, clinical trials and development of a rapid drug susceptibility test for TB should be priorities in terms of new technology.

19. The nation **MUST** return to science-based public policy. Policy decisions such as immigration restrictions must be considered on the basis of scientific evidence. Science clearly demonstrates that there is no basis on which to restrict immigration of HIV infected individuals. The new administration should recognize the role of science in policy considerations and act to remove immigration restrictions for HIV infected persons.

20. Lastly, the health care reform debate **MUST** prioritize prevention and primary care for all citizens, including HIV infected individuals. (See attached ASTHO position on health care reform)

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
415 Second Street, N.E., Suite 200, Washington, D.C. 20002
(202) 546-5400

April 16, 1993

James W. Curran, M.D., M.P.H.
Associate Director for HIV/AIDS
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E., Mailstop D-21
Atlanta, GA 30333

Dear Jim:

The Association of State and Territorial Health Officials (ASTHO) and the National Alliance of State and Territorial AIDS Directors (NASTAD) are writing in follow-up to our April 9 discussion regarding assurance of state, local and county health department involvement in application and approval processes for federal HIV funding of community-based organizations within their jurisdictions. We strongly believe that state and local health departments should be integrally involved in decisionmaking regarding HIV prevention funding of nongovernmental entities by the Centers for Disease Control and Prevention (CDC).

Because state, county and local health departments are statutorily responsible for the health of all of their citizens, it is critical that they be informed of, and involved in the process of, federal funding to entities within their jurisdiction. This population-based authority uniquely qualifies health agencies to serve in a leadership capacity to ensure that both governmental and nongovernmental efforts to prevent HIV are consistent with the overall plan for disease prevention and control for the state or locality. Further, health agencies must judiciously leverage state, local and federal funds. This is particularly important in this time of crisis in health care financing and is only possible through strong communication between federal, state and local governments and the nongovernmental entities with which they collaborate.

The public health system reporting requirements implemented last year, require that nongovernmental entities submit a copy of the face page of the application along with a one-page Public Health System Impact Statement including a description of the population to be served, a summary of the services to be provided and a description of the coordination plans with the appropriate state and/or local health agencies. These requirements are a solid foundation for ensuring that state, local and county health agencies are informed of applications being submitted by community-based organizations in their jurisdictions. To assure involvement of health authorities in consideration of these applications, the following six recommendations have been developed:

1. Each applicant should be required to send a copy of the application to the State Health Official before or at the time of submission to CDC. CDC, in collaboration with the states, should then be responsible for disseminating the application to the relevant local or county health departments. Documentation of compliance with this requirement should be obtained, as it is with any other requirement, through submission of an assurance form with the funding application.

2. Applicants should be required to document current funding from all sources, including municipalities.

3. Applicants should be strongly encouraged to confer with state, local, county HIV contacts in preparation of the application.

4. CDC should solicit comments from state and local health departments regarding their experience with the applicant and the degree to which the proposed prevention strategies complement the state or local HIV prevention plan. These comments should be included in the objective review panel's packets and provided to the relevant CDC project officer.

5. State and local health department HIV contacts should be significantly represented on objective review panels.

6. State, local and county health department HIV contacts should have an opportunity for independent input during pre-decisional site visits.

We believe that these recommendations will foster improved collaboration between health departments and nongovernmental entities and will serve to strengthen the Public Health System Impact Statement requirements recently instituted by the Public Health Service. We urge CDC to integrate these recommendations into all program guidance documents and to begin their implementation as rapidly as possible.

Sincerely,

Barbara DeBuono, M.D.
Chair, ASTHO HIV Committee

John Auerbach
Vice-Chair, NASTAD

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
Atlanta GA 30333

APR 23 1993

Barbara DeBuono, M.D.
Director of Public Health
Rhode Island Department of Health
3 Capitol Hill
Providence, Rhode Island 02908

Dear Dr. DeBuono:

Thank you for your letter dated April 16, 1993, regarding the need for state, local, and county health department involvement in making decisions regarding human immunodeficiency virus (HIV) funding of nongovernmental organizations by the Centers for Disease Control and Prevention (CDC). In response to the six recommendations made resulting from the CDC HIV Prevention Meeting in Atlanta on April 9 with representatives from the Association of State and Territorial Health Officials (ASTHO), the National Alliance of State and Territorial AIDS Directors (NASTAD), and the Council of State and Territorial Epidemiologists (CSTE), CDC proposes the following:

1. **Each applicant should be required to send a copy of the application to the State Health official before or at the time of submission to CDC. CDC, in collaboration with the states, should then be responsible for disseminating the application to the relevant local or county health departments. Documentation of compliance with this requirement should be obtained, as it is with any other requirement, through submission of an assurance form with the funding application.**

   In Program Announcement Number 303, "Cooperative Agreements for Minority Community-based Human Immunodeficiency Virus (HIV) Prevention Projects Program Announcement," applicants will be instructed to forward a copy of their proposal to the appropriate state health officer and to document compliance of this requirement on an assurance form. Furthermore, CDC will forward a copy of the application to the state HIV-prevention project director.

2. **Applicants should be required to document current funding from all sources, including municipalities.**

   Under current program announcement guidelines, applicants are required to disclose funding and income received (both CDC and other sources) to conduct HIV/AIDS programs and other programs targeting the population proposed in the applicant's program plan. In addition, the program announcement will state that funds cannot be used to duplicate or supplant already existing funds.

3. **Applicants should be strongly encouraged to confer with state, local, county HIV contacts in preparation of the application.**

   In the program announcement, applicants will be required to collaborate with state and local health departments as well as other organizations and agencies providing services to the target populations and coordinate HIV-prevention activities (e.g., developing needs assessments, identifying relevant resources, etc.) and educational programs. The state health department's HIV/AIDS coordinator will be noted as the resource person for such collaboration and coordination.

4. **CDC should solicit comments from state and local health departments regarding their experience with the applicant and the degree to which the proposed prevention strategies complement the state or local HIV prevention plan. These comments should be included in the objective review panel's packets and provided to the relevant CDC project officer.**

   CDC will request that state and local health departments, after receiving copies of applicants' proposals, provide written comments to CDC regarding the applicants and their project proposals. If CDC does not receive comments from state and/or local health departments, CDC will contact those health departments to facilitate their participation. The written comments received will be included in the objective review process for consideration.

5. **State and local health department HIV contacts should be significantly represented on objective review panels.**

   The CDC Procurement and Grants Office has advised that state and local health department representatives cannot serve on committees reviewing proposals from applicants within their jurisdictions because of potential conflict of interest, or the appearance of a conflict of interest. Therefore, CDC suggests involving health department representatives from state or local areas other than those in which the minority community-based organization (MCBO) applicants are located. CDC will contact NASTAD for suggested state and local health department representatives.

6. **State, local and county health department HIV contacts should have an opportunity for independent input during pre-decisional site visits.**

   CDC will provide relevant health department representatives with the opportunity to participate in the process of

assessing the applicant's capability to implement the proposed program, reviewing the application and program plans for current or newly funded HIV-related activities and determining any special programmatic conditions and technical assistance requirements of the applicant during the pre-decisional site visit. Furthermore, CDC staff will schedule an independent appointment with the appropriate health department representatives during the aforementioned visit.

We appreciate your help in our continuing efforts to improve collaboration among state and local health departments, nongovernmental entities, and CDC.

An identical letter is being sent to Mr. John Auerbach.

Sincerely yours,

James W. Curran, M.D., M.P.H.
Assistant Surgeon General
Associate Director for HIV/AIDS

Ronald O. Valdiserri, M.D., M.P.H.
Deputy Director (HIV), NCPS

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
415 Second Street, N.E., Suite 200, Washington, D.C. 20002
(202) 546-5400

May 10, 1993

James W. Curran, M.D., M.P.H.
Associate Director for HIV/AIDS
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E., MS D-21
Atlanta, GA 30333

Dear Jim:

On behalf of the Association of State and Territorial Health Officials (ASTHO), I wish to express our sincere appreciation for the Centers for Disease Control and Prevention's responsiveness to our letter of April 16 recommending a six step process by which states could be assured greater input into the decisionmaking process of awarding federal HIV prevention funding to nongovernmental entities within their jurisdiction. I know that the National Alliance of State and Territorial AIDS Directors (NASTAD) also appreciates your timely and comprehensive response.

I truly appreciate your efforts to collaborate with State Health Agencies and view your response as a solid indication of CDC's belief in strong federal-state partnership. We look forward to the opportunity for participation in the federal funding of community-based organizations through the mechanisms agreed upon and will be citing this arrangement as a successful model for other federal agencies to follow in supporting State Health Agency authority for the health of the nation's citizens.

An identical letter is being sent to Dr. Valdiserri.

Sincerely,

Barbara A. DeBuono, M.D., M.P.H.
Chair, ASTHO HIV Committee

cc: Julie Scofield

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
415 Second Street, N.E., Suite 200, Washington, D.C. 20002
(202) 546-5400

February 12, 1993

President William J. Clinton
1600 Pennsylvania Ave., N.W.
Washington, D.C. 20500

Dear President Clinton:

I am writing on behalf of the Association of State and Territorial Health Officials (ASTHO), which represents the chief health officers of the 50 states, the District of Columbia and the U.S. territories, to express our strongest support for lifting the ban on HIV infected individuals seeking entry into the U.S.

Because HIV infection is not spread by casual contact and immigration of infected individuals does not pose a direct threat to the health or safety of the population, ASTHO continues to support removal of HIV infection from the list of communicable diseases of public health significance upon which U.S. travel and immigration can be denied. The public health and scientific community has overwhelmingly and repeatedly stressed the fact that restriction of immigration will neither protect the health of the American public, nor will it prevent or control the HIV epidemic. We urge you to use your action of lifting the immigration ban as an opportunity to truly educate the American public about the facts of HIV transmission.

In addition, ASTHO firmly believes that removing travel and immigration exclusions for HIV infected individuals is not principally an economic issue, as some are contending. Because the Immigration and Nationality Act continues to exclude persons who "are likely at any time to become public charges," concerns about HIV-infected persons immigrating and becoming wards of the state, are grossly exaggerated.

We applaud you for taking this strong stand based on science and we look forward to moving forward with the new Administration to address the real HIV prevention and treatment needs of individuals affected by this devastating epidemic.

Sincerely,

George K. Degnon
Executive Vice President

cc: Dr. Donna Shalala
Senator Edward M. Kennedy
Congressman Henry A. Waxman

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
415 Second Street, N.E., Suite 200, Washington, D.C. 20002
(202) 546-5400

March 18, 1993

The Honorable Edward M. Kennedy
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

On behalf of the Association of State and Territorial Health Officials (ASTHO), which represents the chief public health officers of the 50 states, the District of Columbia and the U.S. territories, I commend you for your efforts to extend the authorities of the National Institutes of Health under the NIH Revitalization Act. During conference on this bill, I strongly urge you to also ensure that the authority for public health issues already vested in the Secretary for Health and Human Services and the federal, state and local public health system is relied upon to direct the nation in addressing the public's health. This is particularly relevant as you consider amendments upholding the ban on immigration of HIV infected persons.

As Congress is working so diligently to expand the authority of one of the Public Health Service agencies, it must carefully reconsider its use of the same bill, HR 4, as a vehicle to undermine the Secretary of Health and Human Service's authority. Specification of diseases of public health significance is most assuredly the responsibility of the Secretary of Health and Human Services and the public health community. This community has overwhelmingly and repeatedly advised Congress that HIV is not transmitted by casual contact and immigration of infected individuals does not pose a direct threat to the health or safety of the population. ASTHO urges you to reflect this determination in the NIH Revitalization Act.

Sincerely,

George Degnon
Executive Vice President

cc: Dr. Donna Shalala

DANIEL J. EDELMAN, INC.

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Public Relations Worldwide
EDELMAN

July 6, 1993

Ms. Kristine Gebbie
National AIDS Policy Coordinator
Hubert H. Humphrey Building
200 Independence Avenue SW
Room 738G
Washington, D.C. 20201

Dear Ms. Gebbie:

On September 9, 1993, Home Box Office (HBO) will host the Washington premiere of AND THE BAND PLAYED ON at the Kennedy Center. As you know, the film is the dramatization of Randy Shilts' best-seller chronicling the early years of the AIDS epidemic.

On behalf of HBO, I would like to arrange a private screening of the film for you. It is our hope that after viewing it we can discuss various ways in which you can participate in the evening.

We have reserved the Kennedy Center's Terrace Theater which will hold approximately 410 guests. HBO will be inviting to the premiere a diverse group of guests active in the AIDS field -- researchers and scientists, congressional leaders, activists and the media.

As we move toward the next century, President Clinton's leadership and your appointment as the National AIDS Policy Coordinator gives renewed hope to those who care so deeply about finding solutions to the AIDS crisis. While a film can not provide solutions to the full dimensions of this human crisis, it can unite us to move forward with compassion and understanding as we search for a cure.

I will follow-up with your office within the week to set up a screening for the film. We look forward to working together on what promises to be an important and provocative evening. Thank you.

Sincerel , y

Paul Costello
Senior Vice President

HBO PICTURES

AND THE BAND PLAYED ON

Production Notes

Matthew Modine stars in HBO Pictures' AND THE BAND PLAYED ON, the dramatization of Randy Shilts' best-seller chronicling the early years of the AIDS epidemic, when a handful of individuals fought indifference, prejudice, ignorance and politics to battle a deadly epidemic that would soon change the face of the world. Also featured in the all-star cast, in alphabetical order, are: Alan Alda, Phil Collins, David Dukes, Richard Gere, Glenne Headly, Anjelica Huston, Swoosie Kurtz, Steve Martin, Richard Masur, Sir Ian McKellen, Saul Rubinek, Charles Martin Smith, Lily Tomlin and B.D. Wong.

In the summer of 1981, reports appeared in medical journals and newspapers of an outbreak of rare opportunistic infections usually seen only in people suffering from extreme immune suppression. To a nation that had recently been through Toxic Shock Syndrome, Legionnaires' disease, and epidemics of Asian and Swine Flu, the scenario appeared familiar: a temporary scare that would soon be over. And, if anything, this new mystery disease, seemingly limited to gay men, did not look as if it posed much threat to anyone else. Even the media, which usually could be counted on to make the most of these situations, decided the story held little interest to their audience.

Twelve years later, this temporary crisis has become a worldwide catastrophe. Hundreds of thousands have died, tens of millions are infected, and there is no end in sight. How could it have happened? How could we have let it happen?

AND THE BAND PLAYED ON shows how it happened and why, focusing on the small band of researchers at the Centers for Disease Control, particularly Don Francis, who was assigned the task of finding out what was causing this strange new malady and how it could be stopped. Working with little funding, equipment, or manpower, and few allies, the dedicated band finds roadblock after roadblock in its path as the number of the dead and dying escalates exponentially -- a dozen cases, a hundred, a thousand, ten thousand, a hundred thousand, a million.

The press is uninterested. The administration appears to see the epidemic as a public relations

(more)

problem. The politicians see a divisive issue best ignored. The religious right sees an opportunity to exploit. The public is apathetic: this, after all, is not their problem. A segment of the gay community at times appears more concerned with maintaining civil rights than staying alive, while factions all around abandon or attack them. The blood banks refuse to admit to a potentially expensive problem with the blood supply, which, coupled with the confidentiality and lack-of-proof issues, exacerbates the problem.

At first, the "hotshot" scientists see little glory in diverting their attention to an obscure disease afflicting a despised minority; then, sensing it might be big, they quarrel over funding and compete for credit. A bureaucracy demands time-consuming procedures, statistics, and studies to confirm even the most obvious facts. And all the while, the clock keeps ticking. People keep dying. A disease is spreading invisibly to unsuspecting millions around the world. What will it take to wake us up?

Aaron Spelling and E. Duke Vincent are executive producers of AND THE BAND PLAYED ON. Midge Sanford and Sarah Pillsbury are the producers. Roger Spottiswoode is the director. The screenplay is by co-producer Arnold Schulman. In 1983, Randy Shilts, a journalist for *The San Francisco Chronicle*, became the first reporter assigned to cover the AIDS epidemic full time. He was shocked to discover just how politicized the reaction to the situation had become. Ideologies, agendas, egos, bureaucratic infighting and prejudices had all paralyzed the nation's ability to respond. The casualties were mounting, the disease was spreading, and it was clear this problem was not going to go away on its own, yet hardly anyone was paying attention.

"I was frustrated," Shilts says. "Nobody else was picking up the things I was writing about. I decided if anyone was going to tell the story of the politics behind the reaction to this crisis, I was going to have to be the one who told it." The result was the book AND THE BAND PLAYED ON, which exposed the often shocking story of a medical catastrophe allowed to run amok, ignited controversy and became a best seller.

Within weeks of its 1987 publication, Hollywood came knocking on Shilts' door. NBC won the battle. For the next two years, the project was under development at the network as a miniseries. Then, after the disappointing showing of ABC's Rock Hudson movie, NBC announced it was dropping AND THE BAND PLAYED ON, as well as a planned second Rock Hudson project. Conventional entertainment industry wisdom said that the public had no interest in movies about AIDS. Robert Cooper, senior vice president of HBO Pictures, disagreed. When veteran producer Aaron Spelling, who had been among

those who had shown early interest in the property, told Cooper that AND THE BAND PLAYED ON was again available, Cooper jumped at the opportunity.

"This seemed to be the ultimate example of an HBO Picture, a true story that was resonant, provocative, controversial and dramatic," Cooper says. In addition to optioning the rights immediately, he promised author Shilts that this movie would not simply be developed but would definitely be made. This is almost unheard-of in an industry where many projects are developed and few get made.

Turning the book into a script was a daunting challenge for screenwriter Arnold Schulman ("A Chorus Line," "Tucker: The Man and His Dream"). Shilts had woven a complex tapestry made up of many individual stories. The script needed to be true to his book, while establishing a dramatic focus. "Some early drafts worked as drama, but not as history," says Schulman, "while others worked as history, but not as drama. We needed to find the right balance."

In the end, Schulman's adaptation focused on Don Francis, a medical researcher for the Centers for Disease Control (CDC), who sensed the implications of the AIDS epidemic early on. Francis sounded the alarm, but was met with indifference and hostility. Focusing on Francis was a choice that captured both the drama and the complexity of the situation.

Eventually, Roger Spottiswoode came on board as director, and casting began. HBO Pictures felt that the subject matter of the movie was so important that many big-name stars would want to associate themselves with the project, even if it meant forgoing their usual salaries. Eventually, that proved true, but the first hurdle was to find the one person willing to be first to sign on. Shilts and Spottiswoode approached megastar Richard Gere at an AIDS fund-raiser in San Francisco. Gere was convinced and signed aboard. In short order, Matthew Modine was set for the lead, followed by Anjelica Huston, Phil Collins, Steve Martin, Alan Alda, Sir Ian McKellen and many others. When an upper respiratory infection forced Whoopi Goldberg to bow out of the movie at the last minute, Lily Tomlin saved the day by stepping in to play the key role of Selma Dritz, a battling San Francisco public health official.

Filming of AND THE BAND PLAYED ON began November 1992 in Los Angeles with sequences set at the Pasteur Institute in Paris and featuring noted French actors Nathalie Baye, Tcheky Karyo, Patrick Bachau and Ronald Guttman. Since Los Angeles offered the production the use of several unused hospital facilities, closed because of earthquake damage, the city was chosen over other alternatives as the filming

location. Settings were found in and about the city to stand in for Atlanta, San Francisco, Washington, D.C., New York and Africa.

Several AIDS support organizations were contacted for both HIV-positive individuals and actual AIDS patients to appear in the movie. Cast and crew took warmly to these brave people, who wanted very much to be a part of the filming of what had become, in a way, their story. Many associated with the production, from the biggest stars to the guys who made the coffee, had lost friends and colleagues to this killer over the past decade. This extra motivation came into play in a logistically difficult production that called for long, grueling hours.

Perhaps the greatest single test of endurance came near the end of the shoot, when the production moved to a ranch deep in the canyon country north of Los Angeles to film the African scenes that open AND THE BAND PLAYED ON. The script called for rain. Rain-making equipment had been brought along, but nature proved cooperative. Then it got over-cooperative. For four days of shooting the rain kept coming. The set had been built in a flood plain and, by the time the last shot was filmed, cast and crew were working in mud and water that swirled up around their ankles and complicated their every move.

Principal photography was completed in Los Angeles on January 11, 1993.

ASTHOFAX

415 Second Street, NE, Suite 200
Washington, D.C. 20002

Phone: (202) 546-5400 **Fax (202) 544-9349**

TO: Kris Gebbie
Tom Troxel

FAX: (602) 626-2030

FROM: E. Liza Greenberg, Director of Public Health Program Development

DATE: February 25, 1993

Number of Pages (including cover): 2

****

Message:

Attached per our discussion today is a draft abstract for a panel session at APHA. The Community Health Planning and Policy Development Section asked ASTHO to develop a session; I think it is important to discuss the interface between managed care and public health from the state and local perspective. At this point,I am not aware of other sessions addressing the impact of managed care on public health systems.

Since you are planning to be at APHA in San Francisco, are you interested in participating on the panel? I would be happy to make changes to the abstract based on items you think are important to cover during the session. Please fax back changes or revisions in the abstract and let me know if you are available. Thanks!

Tentative Participants:

Tom Troxel	Director, Clackamas County Health Department (managed care FQHC look-alike)
Kris Gebbie	Former Wash State Health Secretary and member of the Wash State Health Care Reform Task Force
Doug Campos-Outcalt	Acting Director, Arizona Department of Health Services
Pat Nolan	Director, Colorado Department of Health

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
415 Second Street, N.E., Suite 200, Washington, D.C. 20002
(202) 546-5400

MEMORANDUM

TO: **APHA Managed Care Session Presenters**

FROM: **E. Liza Greenberg, Project Director** Liza

RE: **Proposed abstract to APHA**

DATE: **March 11, 1993**

Enclosed is a copy of the abstract submitted to APHA Community Health Planning and Policy Development section for a session at the APHA annual meeting next fall. Thanks to all of you for agreeing to participate. I have learned from APHA that thus far there are no plans to devote any major sessions to managed care. Judging from the attendance at a similar session at last year's meeting, I think there will be a high level of interest in this issue.

I will let you know when we have a response from CHPPD/APHA. In the meantime, please give me a call if I can be of any assistance. Thanks again.

PROPOSED ABSTRACT FOR APHA 1993 ANNUAL MEETING 3/10/93

Public Health in a Managed Care Delivery System

Tom Troxel, Larry Hart, Doug Campos-Outcalt, Kris Gebbie Moderator: Liza Greenberg

Health care reform strategies rely heavily on managed care approaches to improving health care access and containing health care costs. It is anticipated that most personal health services will be delivered in the context of a managed care program. This panel discussion addresses the changing roles of state and local public health agencies. Issues to be addressed include the evolving role of local health departments in personal services delivery, the "core" public health role of assessment, policy development and assurance, defining non-insured community-focused services which are beyond the scope of managed care systems, and building political will to revitalize public health systems under managed care. Discussants will address innovations to assure that access is extended to hard-to-reach populations and approaches to assuring that important public health services are available. The panel draws from the experiences of the participants as state and local health department directors and participants in major state level managed care initiatives.

Panel Participants

Tom Troxel	Director, Clackamas County Health Department (managed care FQHC look-alike)
Kris Gebbie	Former Wash State Health Secretary and member of the Wash State Health Care Reform Task Force
Doug Campos-Outcalt	Acting Director, Arizona Department of Health Services
Larry Hart	Deputy Director, Arizona Department of Health Services, and former health officer for Santa Barbara County (an integrated managed care system)
Liza Greenberg	Primary Care Project Director, ASTHO

Submitted by Liza Greenberg to Community Health Planning and Program Development Section

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State Public Health Role in Primary Care in a Managed Care Environment

presentation

AN ASSESSMENT OF STATE PUBLIC HEALTH AGENCIES' ROLE IN PRIMARY CARE POLICY DEVELOPMENT

This ~~assessment~~ examines primary care activities conducted by ~~recipients~~ of ~~federal primary care funding through the Bureau of Primary Health Care program~~ of Cooperative Agreements for Primary Care. ~~This program provides a focal point for primary care issues in most~~ state and territorial departments of public health. ~~In Spring, 1993, the author, through~~ a project of the Association of State and Territorial Health Officials, ~~will be conducting an assessment of~~ state ~~primary care contacts to determine their level of~~ activity in the areas of reimbursement for primary care services, health professional recruitment and retention, coordination of public health and primary care programs, and development of statewide primary care policy. ~~State contacts will also be asked how~~ the state public health agency ~~is~~ responding to ~~or participating in~~ state health care reform initiatives. ~~The purpose of the assessment is to~~ identify the range of federally funded primary care activities conducted by the cooperative agreements, ~~to identify~~ innovative approaches to primary care development, and ~~to examine~~ the relationship between public health and primary care policy at the state level.

It will report on

will also be presented

Panelists will

Liza —

Sorry I'm slow —

Changes reflect what I think the panel will cover, rather than the study itself.

My proper listing:

Kristine M. Gebbie, RN MN

Former Wash. State Secretary of Health

Technical Consultant to Washington State Health Reform Commission

Thanks —

Kristine Gebbie FAX
206-459-4957 206 459-3705
606 Lilly Rd NE #723
Olympia, Wash 98506

ASTHOFAX

Association of State and Territorial Health Officials
415 Second Street, N.E., Suite 200
Washington, D.C. 20002
PHONE: (202) 546-5400 FAX: (202) 544-9349

TO: Kristine Gebbie (632-1096)
Sandra Massenburg (690-7560)
Steve Lee (632-1096)

FROM: Margaret Skelley

DATE: November 5, 1993

COMMENTS:

Attached is pertinent information regarding our November 8 meeting.

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
415 Second Street, N.E., Suite 200, Washington, D.C. 20002
(202) 546-5400

November 5, 1993

Kristine Gebbie, R.N., M.N.
National AIDS Policy Coordinator
750 17th St., N.W., Suite 1060
Washington, D.C. 20503

Dear Kristine:

On behalf of the Association of State and Territorial Health Officials (ASTHO), I thank you again for meeting with state and local representatives on November 8 from 1:00 p.m. - 4:00 p.m. to discuss state and local perspectives on key HIV/AIDS issues facing the nation. The following nine national organizations will be represented during the course of the meeting:

- Association of State and Territorial Health Officials (ASTHO)
- Association of State and Territorial Public Health Laboratory Directors (ASTPHLD)
- Association of State and Territorial Public Health Social Workers (ASTPHSW)
- Council of State and Territorial Epidemiologists (CSTE)
- National Alliance of State and Territorial AIDS Directors (NASTAD)
- National Association of State Alcohol and Drug Abuse Directors (NASADAD)
- National Association of State Mental Health Program Directors (NASMHPD)
- State Medicaid Directors Association (SMDA)
- U.S. Conference of Local Health Officers (USCLHO)

As the attached agenda details, from 1:00 p.m. - 2:30 p.m. you will be meeting with state and local health agency representatives to discuss several key HIV/AIDS public health issues. From 2:30 p.m. - 4:00 p.m., we will be joined by members and/or staff of national organizations representing state medicaid, mental health and substance abuse agencies for a discussion of "Health Care Reform and AIDS."

Attached for your information is the list of individuals who will be attending the meeting, as well as several recent ASTHO letters on health care reform which may provide useful background to our discussions.

ASTHO appreciates the opportunity to work collaboratively with your office to bring states together on these most important public health issues and we look forward to continuing this dialogue on a periodic basis.

Sincerely,

Margaret Skelley

Margaret Skelley
Project Director, HIV/AIDS

Tentative Agenda
MEETING WITH NATIONAL AIDS POLICY OFFICE
Old Executive Office Building
Indian Treaty Room (4th Floor)
November 8, 1993
1:00 p.m. - 4:00 p.m.

MEETING WITH STATE AND LOCAL HEALTH AGENCY REPRESENTATIVES

I.	INTRODUCTIONS	1:00 - 1:05
II.	MECHANISM FOR PERIODIC COMMUNICATION WITH STATES	1:05 - 1:20
III.	HIV PREVENTION COMMUNITY PLANNING	1:20 - 1:50
IV.	FY 95 BUDGET ·HIV Prevention ·AIDS Treatment	1:50 - 2:05
V.	QUESTIONS AND ANSWERS	2:05 - 2:30

JOINT HEALTH, MEDICAID, SUBSTANCE ABUSE, AND MENTAL HEALTH MEETING

VI.	INTRODUCTIONS	2:30 - 2:35
VII.	OVERVIEW OF NATIONAL AIDS POLICY OFFICE ROLE	2:35 - 2:45
VIII.	HEALTH CARE REFORM AND AIDS	2:45 - 3:30
IX.	QUESTIONS AND ANSWERS	3:30 - 4:00
X.	ADJOURNMENT	4:00

ATTENDEES TO NOVEMBER 8 MEETING WITH NATIONAL AIDS POLICY OFFICE
November 5, 1993

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ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
415 Second Street, N.E., Suite 200, Washington, D.C. 20002
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October 25, 1993

President William J. Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear President Clinton:

The Association of State and Territorial Health Officials (ASTHO) met this weekend with representatives of the National Association of State Alcohol and Drug Abuse Directors (NASADAD) to discuss our common concern that adequate resources for treatment of the alcohol and drug addicted be available under health care reform. Currently, twenty-five percent of all health expenditures are related to substance abuse; we are spending now $238 billion annually for conditions occasioned by substance abuse.

Since the efficacy of treatment services for patients with alcohol and drug abuse is well-established, ASTHO recommends that the policy of "treatment on demand" be adopted as a cornerstone of your health care reform effort. We further recommend the inclusion of comprehensive services for alcohol and drug abuse in the minimum benefit package. Unless specific initiatives are taken, it is estimated that only 50 percent of clients currently in treatment will be covered under health care reform.

In order to assure that these recommendations are enacted, we request that you commit to keeping the alcohol and drug abuse block grant in place. Furthermore, we recommend that you augment these funds by shifting the "out of country crop eradication" expenditure to the block grant for prevention and treatment services of the block grant.

Sincerely yours,

C Mahan MD

Charles S. Mahan, M.D.
President

mh

cc: Lee Brown, Ph.D.

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
415 Second Street, N.E., Suite 200, Washington, D.C. 20002
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November 1, 1993

President William J. Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mr. President:

The Association of State and Territorial Health Officials (ASTHO) represents the chief public health officials in the 50 states, the District of Columbia, and the U.S. Territories. We applaud the goals and design of the courageous health reform strategy that you and our First Lady will soon submit to Congress. In fact, we are busily preparing ourselves and our organizations to reinvent state health agencies to develop the accountability mechanisms needed both to monitor access, quality, and costs of health care, and to integrate and streamline public health services and outreach into the larger process.

We write you today to express our sincere and urgent concern about the need to fund states and governors adequately, both to bring the poor, the uninsured, the disenfranchised into the new system, and to assure that population-based public health and health education doesn't get lost, as always before, in the Congressional shuffle. We recognize that the funding priorities for small businesses, early retirees and deficit reduction in the reform effort have political merit. However, the most critically underfunded entities in the spectrum of competing constituencies are the states themselves.

States will need significant, as yet unidentified, resources to bring the at-risk populations into universal access. While there are significant efficiencies to be achieved in Medicaid, states are still woefully underfunded to effectively include the public assistance populations and the uninsured who will not be covered by an employer mandate into the proposed new system. Hawaii's real experience with an employer mandate indicates that the vast majority of small businesses can accommodate health insurance coverage of employees without subsidies. A means-test premium supplementation approach to small businesses in distress might free up 50 billion dollars to assist states and governors. Similarly, some of the 29 billion dollars proposed to be allocated to the National Health Board, alliances, and infrastructure set-up costs could be re-allocated to states without undermining the national effort, and while we are elated to learn of your support for significant additional funding to public health, we know from painful experience that such funding is unlikely to compete well against underfunded medical care needs.

Mr. President, we support you and recognize this letter likely seems presumptuous. However, we strongly advocate financing public health with at least 18 billion dollars of designated funding. We support re-allocating from planned subsidies an additional 50 billion dollars to states to bring the poor, the disenfranchised, and the unemployed into the alliances and new system with sufficient funding to make universal access an immediate reality.

As you and the First Lady have eloquently articulated, without universal acccess, we cannot have cost containment, and without an approach to universal access which emphasizes prevention, primary care, and public health, we will neither contain costs nor improve the health status of those most in distress.

We offer these suggestions with the full commitment to assist you in your efforts to advance reform. This includes using our membership to help convince the Congress as well as business and consumer constituencies that our goals should be theirs also.

Thank you for your consideration of these ideas.

Sincerely yours,

C. Mahan, M.D.

Charles S. Mahan, M.D.
President

mh

cc: Donna E. Shalala, Ph.D.
Philip R. Lee, M.D.
M. Joycelyn Elders, M.D.

ASTHO perspective -

Presentation to the IOM Study on AIDS policy

ASTHO represents the nation's 50 chief health officials given the structure of public health in this country. Have been involved in synthesizing emerging scientific info into guidelines useable at state level

Basic public health authority exists at the state level - ability to require reporting of cases of disease or certain laboratory findings

ability to assure protection to the public by providing some preventive services (immunization, treatment, education) or requiring isolation

local health authorities operate on a mix of delegated or derived State authority plus local ordinance while in lg. cities (like SF/NY) local h.d's provide direct treatment, that is not always the case

federal health authorities provide extensive technical assistance, and a mechanism for collaboration or joint action.

Relationships built up gradually

Some differences with regard to AIDS -

HTLV III infection was introduced in limited geographic areas - 3-4 local health depts had experience of hundreds (or thousands) of cases before many states had even 1

Those few local health depts (& the states in which they are located) moved into all

sorts of collaborative programs (including treatment services) based on the earliest science & have been adapting.

For the majority of jurisdictions in the country, program development has come later - often after introduction of the antibody test, and after community-based groups were well into education & service

Part of the policy tension - do we transplant what has emerged in high incidence areas, or pick & choose from that resource-requiring that the other areas have differing systems, values, resources.

~~If it's not useful due to migration~~

I see 3 major areas for continued development & for critique of policy →

1) basic & clinical science research -
are the $'s being directed in the right quantity at the right time to support the ~~essential~~ elements of research on the virus, on possible means of preventing infection, & on possible treatments for the ill ?

2) public health measures to control spread
are $'s & policies being coordinated to have the maximum public education benefit -
to reduce panic in those not at risk
& change behavior in those at risk

Encouraging/support creative/local tailoring

appropriate integration of laboratory, research, epidemiology, individual contacts with group efforts.

~~appropriate integration of surveillance, individual contacts & group efforts~~

coord of hospitalization
STD-/Drug Rx

3) treatment -

are services available & affordable for those who develop AIDS or ARC, & are they the right level of services (appropriate intensity, etc)

IOM seems to be focused on 1 & 2 -

1 research has long term payoff

2 public health programming is the one with the greatest potential for slowing reducing transmission -

3 treatment has short term benefit for individuals & A's

this is dependent on incorporating AIDS programming into structure of state / local h.d's in a sensible way -

using the best of known skills

developing new ones -

Collaborations at risk groups

Keeping a sense of proportion not discounted because there's "only one" case not exaggerated, alienating others

must be tailored to local capacity, social conditions etc

must be reasonably funded so as not to drain other efforts & let others problems grow - mixed responsibility

institutionalizing programming to lessen the need for special administrative arrangements, costs, staff integration into gen'l medical programming

State politicians respond to clear message when p.h. & risk group come together