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Kris Kirsthe et al Pre-publication draft Terry

Introduction.

This year, as we have since our founding in 1987, the National Organizations Responding to AIDS (NORA) coalition offers an alternative budget outlining what we believe to be the necessary spending levels to assure an appropriate federal response to the HIV/AIDS epidemic.

NORA is a coalition convened by AIDS Action Council and comprised of over 150 health, labor, religious, professional, and advocacy groups actively battling the AIDS epidemic. NORA advocates for fair and effective AIDS policy, legislation, and funding.

As a broad-based coalition, NORA understands the competing demands made on the federal budget. But unfortunately, AIDS is an epidemic on the rise, and communities of color and women are being hit especially hard. While we applaud President Clinton for his commitment to care and research in his FY 1995 budget requests, we were dismayed to see that that commitment did not carry over into prevention. We believe far more is needed to successfully contain this pandemic, particularly in the area of prevention, and we are looking to Congress to provide the increased resources needed.

This document proposes spending $3,491 million in AIDS-specific programs of the Departments of Health and Human Services, Housing and Urban Development, and the Veterans Administration, or $757 million more than the President's proposed budget. We fully recognize the economic constraints imposed by the federal deficit and the Budget Act; but we also firmly believe that deferring spending that addresses this epidemic assures that the budgetary impact of AIDS will be much greater in the years ahead.

AIDS is the leading cause of death for young American men, the fourth leading cause of death for young American women, and the fifth leading cause of death among children under the age of 15 in the U.S. Once a disease centered in large, urban areas, it is now an epidemic that is truly national in scope. Once stressing an already overburdened urban public health care system, it now is further eroding a rural health care system that has had difficulty providing access to health care in the first place.

Successfully attacking the HIV/AIDS epidemic in our nation and globally will require a commitment to a full-scale approach in three critical areas: prevention, research, and care.

• Absent a preventive vaccine our only hope of halting further HIV transmission is through a comprehensive, targeted approach to AIDS prevention throughout the nation. This can become a model of effective health promotion in a number of critical areas of public health. To that end, **we propose a $190 million increase over two years (with a minimum of $95 million for 1995) in prevention-related programs.**

• Ultimately, biomedical and behavioral research will provide the critical answers for treatment and prevention of HIV infection. Without a larger, concentrated, planned commitment to an effective research agenda, we will be unable to stem the tide of the epidemic. The United

States is unique in the world in having the resources and HIV research infrastructure to undertake this mission that can save literally millions of lives around the world. We must make the commitment to do so. To that end, **we support a $550 million increase in AIDS-related biomedical and behavioral research at the National Institutes of Health.**

• Poverty is the biggest single barrier to health care access. For those who have already become infected, we must ensure that they receive access to care and services. Progress in drug development through research is meaningless unless we can assure access to health care. **To that end, we propose $226 million in increases for discretionary health service programs, in the Ryan White CARE Act.**

Several other discretionary programs are of great importance if we are to stem the tide of this epidemic. This document contains a listing of all these programs.

Public Health Service Programs

Agency	FY 1994 Funding	FY 1995 President's Request	(+/-) over 1994	FY 1995 NORA Recommendation	NORA (+/- over 1994)
AHCPR	$11 million	$12 million	+$1 m.	$12 million	+1 m.
CDC	$543 million	$543 million		$638 million	+$95 m.
FDA	$72 million	$72 million		$72 million	
HRSA	$608 million	$701 million	+$93 m.	$836 million	+$228 m.
IHS	$4 million	$4 million		$4.42 million	+$0.42 m.
NIH	$1,301 million	$1,379 million	+$78 m.	$1,851 million	+$550 m.
OASH	$5 million	$5 million		$5 million	
SAMHSA	$28 million	$18 million	-$10 m.	$73 million	+$45 m.
Total	**$2,572 million**	**$2,734 million**	**+$162 m.**	**$3,491 million**	**+$919 m.**

Department of Housing and Urban Development

FY 1995 NORA Recommendation	$312,000,000
FY 1995 President's Budget	$156,000,000
FY 1994 Appropriation	$156,000,000

Department of Veteran's Affairs

FY 1995 NORA Recommendation	$5,500,000
FY 1995 President's Budget	$5,500,000
FY 1994 Appropriation	$5,000,000

Agency for Health Care Policy and Research (AHCPR)

FY 1995 NORA Recommendation	$12,000,000
FY 1995 President's Budget	$12,000,000
FY 1994 Appropriation	$11,000,000

The AHCPR is the lead agency concerned with the health policy implications of AIDS. We support the President's request for this agency. In early 1994, AHCPR issued practice guidelines for evaluating and managing patients with early HIV infection. This is an important contribution to the care of people with HIV/AIDS. AHCPR is now in the initial stages of a new program to monitor the cost of care for people with AIDS. In the context of health care reform, the research and evaluation conducted by AHCPR will take on added significance to assure that people with HIV/AIDS are assured quality and cost-effective care.

Centers for Disease Control and Prevention (CDC)

FY 1995 NORA Recommendation	$638,000,000
FY 1995 President's Budget	$543,000,000
FY 1994 Appropriation	$543,000,000

- Of the three strategies in the fight against AIDS -- prevention, care services, and research -- prevention has remained the most neglected in the federal response for the past half decade. While care and research received important increases in funding in the President's budget this year, prevention received none and remains the neglected stepchild of the AIDS budget, having increased only ten percent over the past four years. Ironically, with effective and well-funded prevention programs in place, we could successfully reduce the demand for care services in the future.

- Prevention works. Numerous studies show that HIV prevention interventions can change risky behavior, even in such "hard to reach" populations as injection drug users out of treatment, gay men in bars and homeless/runaway youth. Effective prevention programs reach people in a variety of settings (schools, churches, the workplace), are culturally specific, intensive, prolonged and provide populations at risk with the motivation and skills to change risky behavior.

- The increases we call for in this budget document are primarily targeted to support CDC's community-based prevention activities. CDC has recently redefined its HIV prevention activities to require greater community participation in HIV prevention program delivery. This process of community planning is an ongoing, collaborative process in which state and local health departments, other state and local social service agencies, nongovernmental agencies, other representatives of communities, and groups at risk for HIV infection work in partnership to plan and implement HIV prevention programs that are responsive to community-validated needs within defined populations.

We urge $233.7 million in funding (vs. the FY 94 level of $173.7 million for prevention services) be made available to state and local health departments to fund community-based interventions identified through the community planning process. Activities that support Community Planning should be funded at $19 million (vs. $15 million for FY 94) to provide special outreach and technical assistance to traditionally marginalized populations (people of color, women, youth) to ensure their participation in the community planning process and to state and local health departments in working with these special populations. Specific funding levels for Counseling and Testing and Health Education and Risk Reduction activities should be determined at the local level through the community planning process.

In addition, CDC and the NIH should work together to ensure greater collaboration between

behavioral research and community-based prevention services. Community-based prevention interventions must be grounded in behavioral research and be responsive to the needs of targeted populations. Prevention service providers must have access to effective and innovative approaches identified through the behavioral research programs at the NIH through training, technical assistance and other technology transfer mechanisms. We urge that $4 million in new funds be made available for a new collaborative grant making program co-funded by the NIH to carry out community-based prevention clinical trials.

The national education program sponsored by the CDC and known as the Prevention Marketing Initiative (formerly America Responds to AIDS) marks a significant step forward in raising the consciousness of the American people about the necessary behavior changes to halt the spread of HIV. These more aggressive and frank strategies provide long overdue federal leadership in the fight against AIDS. We support increasing funds for the Prevention Marketing Initiative and other national education programs (the National AIDS Hotline, National AIDS Clearinghouse, American Red Cross, etc.) to $24 million vs. $21 million in FY 94.

In addition, we support the following funding levels for other CDC AIDS programs:

- Epidemiology and surveillance, $135 million (vs. $131 million in FY 94), to assure better studies and needs assessment throughout the nation. New funds should be used to better study risk behaviors in a number of targeted communities with high seroprevalence rates (i.e. gay men, high-risk youth, drug users, women and people of color).

- Adolescents and school-based programs, $52.3 million (vs. $48.3 million in FY 94), are essential to stemming the increasing and tragic rate of HIV infection among our nation's youth. The National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) received $41 million in FY 94 for youth prevention programs. Over 14,127 cases of AIDS in the US are among youth ages 13-24. In addition, nearly twenty percent of all AIDS cases occur in adults in the 20-29 year old range. Given the eight to ten year delay between infection and the development of symptoms, most of these young adults were infected during their teen years. It is particularly important to reach adolescents at greatest risk both in schools and other community-based youth serving institutions (after school programs, runaway shelters, drop out prevention programs) with explicit, skills-based interventions. The increased resources should be directed to programs for youth in high-risk situations.

- Interventions for women at high risk, $49.9 million vs. $47.9 million in FY 94, through programs in several Centers at CDC (in the areas of childbearing women surveys, perinatal infection, perinatal prevention activities, and women and infants activities.) Of this amount, $22.1 million is accounted for in the epidemiology and surveillance figure cited above.

- Direct funding for HIV prevention services in 102 community-based agencies (particularly in minority communities) $28.7 million vs. $19.7 million for FY 94. Even with increased funding for state and local health departments and implementation of the community planning process, it will be important for the CDC to continue to directly fund community-based agencies

to fill gaps in state and local efforts.

- National and Regional Minority Organizations, $14.5 million vs. $9.5 million in FY 94. These programs provide important information, training and technical assistance to minority community-based prevention programs. Capacity building programs for minority community-based agencies are critical to reaching populations at great risk with effective HIV prevention interventions.

Non-AIDS Programs at CDC

Tuberculosis:

We support funding of the CDC's MDR-TB Elimination Plan at $484 million, rather than the $121 million in the President's budget. TB continues to pose an increasing threat to the public health and poses a special threat to persons with HIV infection, since those with compromised immune systems are most susceptible to TB. While clearly having serious implications for the HIV epidemic, the TB epidemic would be serious in and of itself without the underlying issues associated with HIV. Therefore, we believe these increases should be considered in the context of the TB control program, not the AIDS budget.

Without a complete program of TB control, the costs of ultimately controlling the epidemic will continue to rise, as have the estimates for the TB elimination program over the last several years. These funds should be provided to assure the availability of a continuum of services needed by persons with TB to allow prompt identification of those with TB and to assure their adherence to treatment regimens through voluntary means.

Sexually Transmitted Diseases (STD) Control

While not part of the AIDS budget, we support the recommendation of the STD Coalition for $140 million for the CDC's ongoing STD programs and direct operations, or $39 million over FY 1994. We also support funding at the fully authorized level of $25 million for the CDC's new program to prevent and treat STDs known to cause infertility. This has a direct impact on the transmission of HIV: the more that is done to control and prevent STDs generally, the more HIV transmission is likely to be prevented.

Food and Drug Administration
(FDA)

FY 1995 NORA Recommendation	$72,000,000
FY 1995 President's Budget	$72,000,000
FY 1994 Appropriation	$72,000,000

The major challenge at the FDA is the lack of staffing and space. We, therefore, endorse the overall efforts in support of increased personnel at the FDA. The FDA has done an excellent job of placing AIDS-related drugs on a fast track. We are concerned that this not occur at the expense of diverting staff from review of NDAs for other important diseases. We endorse the recommendation of the FDA Council for $895 million for FDA salaries and expenses, and $100 million for FDA consolidation.

Health Resources and Services Administration (HRSA)

FY 1995 NORA Recommendation	$836,000,000
FY 1995 President's Budget	$701,000,000
FY 1994 Appropriation	$608,000,000

• Expansion of the Ryan White CARE Act programs, to meet the full range of demand for services for people with HIV infection, remains our top priority for funding within HRSA.

• We continue to support a strengthened federal investment in programs such as the Community/Migrant Health Centers, and Title V Maternal and Child Health Services Block Grant. Though not part of the AIDS budget, these programs reach people at risk of HIV infection and in need of HIV-related services.

• We also support the dental reimbursement program's funding as a separate line item as was done in FY 94. For FY 95 this program should be funded at $9 million, rather than $7 million as requested by the President.

The continuing rise in AIDS cases and the changing epidemic places an increasing burden on the health care system developed for addressing the needs of people with HIV. Between 800,000 and 1 million Americans are infected with HIV. Over 103,000 new AIDS cases were reported to the CDC in 1993. The increase in reported cases was greater among females than among males, and greater among blacks and Hispanics than among whites. These numbers reflect only a portion of those in need of care services. An estimated one million Americans are HIV infected. As medical treatments for HIV advance, earlier intervention in the course of HIV disease becomes possible.

Ryan White Funding Levels

Title	Orig. Authoriz.	FY 1994 Level	FY 95 President's Budget	FY 1995 NORA Level
I	$275 million	$325.5 million	$364.5 million	$389.5 million
II	$275 million	$184 million	$214 million	$272 million
IIIB	$75 million	$48 million	$67 million	$82 million
IV	$20 million	$22 million	$27 million	$62 million
Total	**$645 million**	**$579.5 million**	**$672.5 million**	**$805.5 million**

The $389.5 million request for Title I, which provides emergency aid to high-incidence cities, would permit expansion of Title I cities (estimated at 5 new cities) without having to cut services in currently funded Title I cities. This would also allow for a small cost-of-living/caseload increase over the final FY 1994 level for currently funded cities, despite higher estimates of caseload increases and services eligibility due to the new CDC case definition.

We also support a separate line item of $1.5 million to permit HRSA to give advance planning funds to cities projected to be eligible for Title I funding in FY 1995. This type of planning grant is a wise investment in assuring rapid absorption of Title I funds once eligibility is achieved.

The $272 million request for Title II represents the level of need for this state-based program as identified by the National Alliance of State and Territorial AIDS Directors. It will permit a more adequate funding level for the essential drug purchase assistance program and will allow an expansion of care consortia in regions that have been underserved to date, as well as allowing for current services for a 15% caseload increase.

The $34 million increase in funds for Title IIIB will permit the support of early intervention services to poor clients being seen at community health centers and other federally qualified health centers. This program is a critical first step in providing earlier -- and therefore life prolonging -- care/preventive services for people with HIV. This program received flat funding last year, despite ever-increasing caseloads.

We support a $40 million increase for Title IV programs serving children, adolescents and families. This is an underserved population that unfortunately, constitutes a rapidly growing segment of the HIV population. In particular, Title IV should be expanded so that

comprehensive care programs that are developmentally appropriate are provided to youth infected or affected by HIV infection, and that social services are provided to the current estimated 30,000 children and youth orphaned by parents dying of AIDS. This program has been essentially level funded for three years despite a 40% increase in demand for services each year, and is an important model for demonstrating how readily research and comprehensive care can be coordinated to increase participation in clinical trials for children, adolescents and pregnant women.

Non-AIDS Programs at HRSA

We support a funding level of $675 for Community Health Centers, $42 million over last year.

We support a funding level of $750 million for the Title V Maternal and Child Health Services Block Grant, which is $63 million over last year. This program directly supports health services for millions of uninsured, and underinsured and Medicaid insured families, which includes providing for services not covered by private insurers or inadequately reimbursed by Medicaid. Title V support for health services, care coordination, and core public health functions are a critical element in the struggle to improve health outcomes for all women and children, including those who are HIV-infected.

Indian Health Service
(IHS)

FY 1995 NORA Recommendation	$ 4,420,000
FY 1995 President's Budget	$ 4,000,000
FY 1994 Appropriation	$ 4,000,000

• The central need for the Native American communities is for increases in HIV-related care and for increased substance abuse treatment for those who do not otherwise have access to such care.

The Indian Health Service is a major provider of care for Native Americans living on or near reservations. Its special relationship to the government of the First Nations of North America place it in a unique position to provide assistance to tribally-based programs. To date, IHS has focused its priorities on a joint CDC/IHS seroprevalence survey and the training of HIV antibody test counselors in each Area Office. It has played a relatively insignificant role in the initiation and funding of community-based Native American HIV prevention education activities for those at-risk across the nation. Prevention funding for Native American organizations and communities comes primarily from the Centers for Disease Control, state departments of health, the Office of Minority Health, and the U.S. Conference of Mayors. It is important that these efforts continue.

We support an increase of $420,000 over FY 1994 for the AIDS Drug program within the Indian Health Service. The program allows drugs to be purchased in bulk and distributed to those with HIV/AIDS. As the provider of medical services for many Native Americans who would not otherwise have access to care, it is critical that the IHS have adequate resources to allow it to meet generally acceptable standards of care for those who are HIV infected.

National Institutes of Health
(NIH)

FY 1995 NORA Recommendation	$1,851,050,000
FY 1995 President's Budget	$1,379,000,000
FY 1994 Appropriation	$1,301,050,000

• Our support for increased funding for AIDS research comes in the context of a call for an overall increase in our nation's commitment to biomedical and behavioral research.

• We believe that without the funding levels requested for NIH, important opportunities will be lost in all areas of research -- basic research and drug discovery, clinical treatments, vaccine development, behavioral research, and epidemiology -- all of which will result in more deaths and higher health care costs.

In passing the NIH Revitalization Act of 1993, Congress strongly enhanced the authority of the Office of AIDS Research to coordinate, plan and evaluate AIDS research throughout the institutes, centers and divisions that comprise the NIH. This represents a dramatic opportunity to realign the overall AIDS research portfolio, and for the first time, to set NIH-wide AIDS research priorities. The authority of the office hinges on its charge to develop a strategic plan for AIDS research and a bypass budget request -- and to receive directly from the President and the Office of Management and Budget, a consolidated appropriation for AIDS research throughout the NIH.

Basic biomedical research -- including virology, immunology, laboratory and animal studies of the pathogenesis of HIV and associated infections and cancers. An increase is critical to opening new doors of understanding that will ultimately lead to a cure. This is the backbone of all research at the NIH, and HIV is no exception.

Behavioral and social science research -- an increasingly important part of the NIH's AIDS research portfolio, particularly with the addition of NIMH, NIDA, and NIAAA to NIH. This is an opportune time to study the most effective prevention strategies, which must be incorporated into any assessment of candidate vaccines. (We must learn whether a non-medical prevention program is as effective as or more effective than a candidate vaccine.) Funds should be approved without restrictions on the content of materials developed or issues studied. Assessment of the appropriateness of issues of scientific inquiry should be left to the peer review process.

Drug discovery and clinical trials -- now conducted by NIH through several different drug discovery consortia and clinical research networks.

Vaccine development and clinical trials -- an increasing priority within the NIH's AIDS

program. Pilot vaccine feasibility studies are underway, and additional work is needed on basic immunology, animal models, and epidemiology to ascertain the correlates of protection from HIV and related retroviruses.

Epidemiology and natural history -- critical to designing effective public health measures and encouraging risk reduction, as well as tracking the changing demographics and clinical progressions of HIV disease.

Office of AIDS Research (OAR) discretionary fund -- authorized at $100 million in the NIH Revitalization Act of 1993, to provide OAR with an immediate means of filling gaps in current research efforts, responding to research emergencies, and supporting fast-track initiatives not originally foreseen in the two-year NIH planning and budgeting cycle. Funds should be appropriated in full to assure that OAR can support new research initiatives and successfully enhance coordination, evaluation, and planning at the NIH.

• Within this budget recommendation, we continue to highlight the importance of research into HIV disease in women, including: the Women's Interagency Human Immunodeficiency Study (WIHIS); virucide, microbicide, and other female-controlled barrier method research; and research exploring female specific manifestations of HIV disease. Results of a recent NIH protocol showed that the drug AZT reduced by two-thirds HIV transmission in a selected group of HIV-infected pregnant women.

Non-AIDS Programs at NIH

Tuberculosis: We support a total of $77 million for TB research at the NIH, which is $26 million more than the President's requested increase. Greatly improved diagnostic tests are needed for TB infection, especially in people with immune problems, as well as tests to rapidly diagnose TB disease and particularly to determine the sensitivity the organism has to various antibiotics used to treat it. Better treatments are needed, both to make adherence to treatment easier and to address the problem of multidrug resistant tuberculosis; and a better understanding of the epidemiology of tuberculosis is also needed. Currently, a substantial portion of TB research at NIH is being supported with AIDS research funds; while related epidemics, our understanding of one should not come at the expense of the other.

Sexually Transmitted Diseases: We also support the STD Coalition's recommendation of $91 million for non-AIDS STD research at the NIH, $37 million over the FY 1994 level.

Office of the Assistant Secretary for Health (OASH)

FY 1995 NORA Recommendation	$5,000,000
FY 1995 President's Budget	$5,000,000
FY 1994 Appropriation	$5,000,000

Funding through the Office of the Assistant Secretary for Health supports programs of the White House and PHS Office of National AIDS Policy (ONAP, formerly the National AIDS Program Office) and the Office of Minority Health (OMH). We support continuation of the programs of the OMH as requested in the President's budget. Last year, we recommended disbanding NAPO and redistributing the staff positions to the PHS agencies. While ONAP has taken on important responsibilities within the White House, we continue to believe that, overall, a policy office does not require 33 PHS staff slots. Therefore, we recommend that one-third of the staff positions allocated in this budget to ONAP be restored to the agencies, with first priority going to the NIH Office of AIDS Research, which has been given new authority under legislation passed last year requiring additional staff.

One major function of ONAP should be development of a federal strategy for HIV programs. It is essential that ONAP prepare and release, within six months of passage of the appropriations bill, a national plan for HIV based on the criteria established by the National Commission on AIDS.

Substance Abuse and Mental Health Services Administration (SAMHSA)

NORA FY 1995 Recommendation	$73 million
President's FY 1995 Budget	$18 million
FY 1994 Appropriation	$28,000,000

• With substance abuse linked to the largest percentage of new cases of HIV infection, the best method for preventing the further spread of HIV is to assure all substance abusers treatment on request.

• Mental health issues have been seriously neglected in the context of the organized federal public health response to the AIDS epidemic despite the importance of these considerations in prevention, research and services.

• AIDS programs at SAMHSA and each of its Centers need strong leadership and coordination, in addition to increased funding.

We were dismayed to see the President cut $10 million from the substance abuse outreach demonstration program. This ongoing community-based program seeks out drug users and their sexual partners to provide HIV/AIDS prevention services and to encourage drug users to enter treatment programs. This is the only identifiable outreach program to injection drug users at SAMHSA, and should be continued. We request not only that the $10 million be restored, but that an additional $5 million be appropriated to continue this program.

$15 million to support the AIDS mental health services demonstration program. Based on the Congressional appropriation of $1.5 million in FY 1994, the Center of Mental Health Services (CMHS) has undertaken a historic and unique collaboration with the NIH and HRSA, increasing funding for this program to over $4 million for FY 1994. These demonstrations, which will begin to address an enormous unmet need, will provide the first ever federal opportunity to evaluate the success of various mental health interventions in reducing the severe emotional and psychological impact of HIV.

$25 million for the substance abuse/primary care linkage initiative that encourages the development of comprehensive care demonstrations that link HIV/AIDS programs to the substance abuse, mental health, and primary health care systems.

$8 million for the HIV/AIDS education and training grant program focused on substance abuse service providers. Improved knowledge about HIV and how to incorporate HIV issues in ongoing substance abuse programs is critical to effective integration of HIV and substance

abuse prevention.

$8 million for the AIDS mental health clinical training programs for traditional and non-traditional mental health care providers. To successfully integrate HIV mental health services into mainstream mental health programs, such training is essential.

$2 million for the administration of AIDS activities at SAMHSA and each of the Centers in carrying out its national leadership responsibilities and supporting program activities.

Non-AIDS Programs at SAMHSA

The increasing proportion of AIDS cases attributable to drug and alcohol abuse and the compelling mental health issues in HIV makes substance abuse and mental health treatment and prevention important components of the federal campaign against AIDS. Accordingly, NORA requests that the following programs receive enhanced funding:

The Substance Abuse Services Block Grant should be increased to $1.7 billion from the current level of $1.2 billion. We were pleased to see that the President recommended an increase of $310 million. This block grant program mandates a set-aside for the provision of HIV/AIDS-related outreach and early intervention services. States are also required to provide tuberculosis counseling, testing and treatment services to persons receiving substance abuse treatment. To comply with these requirements, as well as to increase treatment capacity and enhance quality of services, a substantial increase in substance abuse block grant funds is warranted.

The Mental Health Services Block Grant should be increased to $450 million from the current level of $278 million. Historically this block grant has not been used for HIV funding. It is critical that the state mental health agencies dedicate funds from this block grant for targeted HIV services. The incidence of HIV infection among the seriously and persistently mentally ill has already attained a dramatic and alarming incidence. The absence of targeted dollars for AIDS services in this population has been a serious barrier for effective attention to those needs.

Non-AIDS Programs at HHS

Each year 1.3 million young people either run away or are homeless. They are disconnected from community life--from their parents, schools, churches or synagogues, and other institutions. The circumstances of their lives place runaway and homeless youth at significant risk for HIV infection. Street life for youth often involves drug and alcohol use, sexual abuse, and other exploitation. Lacking skills to support themselves, young people on their own may be forced to engage in survival sex to meet their basic needs of food and shelter. For these youth, a place to stay and services to get them off the street, away from pressures and exploitation that make them more susceptible to risky behaviors, is bottom-line HIV prevention.

We support an appropriation of $75 million for the Runaway and Homeless Youth Basic Centers Program, $50 million for the Transitional Living Grant Program for Homeless Youth, and $20 million for the Drug Abuse Education and Prevention Program for Runaway and Homeless Youth.

We support full funding, at $35 million, the Abandoned Infants Assistance Act, which provides funds to prevent the abandonment in hospitals of infants and young children, particularly those who have been perinatally exposed to HIV or drugs.

Department of Housing and Urban Development

FY 1995 NORA Recommendation	$312,000,000
FY 1995 President's Budget	$156,000,000
FY 1994 Appropriation	$156,000,000

We support funding of the Housing Opportunities for Persons with AIDS (HOPWA) Program at $312 million. This program was created by the AIDS Housing Opportunities Act of 1990, and provides new hope for addressing the critical and growing housing needs of people living with HIV and AIDS.

HOPWA is a formula grant program that gives states and localities the resources and incentives to devise long-term comprehensive strategies for meeting the housing needs of people with HIV/AIDS. HOPWA is designed to prevent homelessness among people with HIV infection, which is becoming an increasing problem and is one of the greatest impediments to providing good care and supportive services. Cities and states are eligible for HOPWA funds based on the cumulative number of AIDS cases reported. As the epidemic continues to grow, additional cities and states are eligible each year. Flat funding of this program therefore, necessitates cuts in existing programs to accommodate the new communities.

Because of their illness, people with HIV infection often lose their jobs and then their homes. Without housing, they are unable to access needed care, and may be forced to stay in acute care hospitals or go to shelters, where they may be exposed to other potentially fatal diseases like TB. Through rental assistance, mortgage assistance, and a variety of supportive housing models, HOPWA enables people with HIV/AIDS to better avoid the dangers of opportunistic diseases, remain in familiar surroundings, and receive necessary housing and supportive services.

Non-AIDS Housing Programs

In addition to HOPWA, HUD administers several housing programs for people with disabilities generally, including disabilities resulting from HIV infection. People with HIV infection are eligible for programs such as Shelter Plus Care and the Supportive Housing Program, as well as the Section 8 and Section 811 programs. These programs provide much of the housing for people living with HIV/AIDS, especially those who live in areas that do not qualify for HOPWA grants.

We were greatly dismayed, therefore, to see that HUD's FY 95 budget calls for defunding Shelter Plus Care and the Supportive Housing program so HUD can fund a new "Homeless Assistance Grants" program which doesn't exist yet. Even if this new program were to prove to be of enormous value to people living with HIV/AIDS (an extremely

optimistic prediction), HUD's own budget clearly states it only plans to provide $152.4 million for these new grants in FY 95.

We oppose HUD's plan to defund these programs, and oppose HUD's plan to flat-fund HOPWA and the Section 811 program. We support the highest possible funding levels for all of these programs, since they are important components of a longer-term solution to the housing problems faced by people living with HIV/AIDS.

Department of Veterans Affairs

Veterans Administration Health Research

FY 1995 NORA Recommendation	$5,500,000
FY 1995 President's Budget	$5,500,000
FY 1994 Appropriation	$5,000,000

AIDS is an important area of study for VA researchers. HIV infection and AIDS represent the most rapidly growing threat to the health of veterans. In 1993 alone, the VA cared for 7,306 HIV+ patients and 9,443 patients with AIDS. VA currently funds 59 separate projects looking at various aspects of AIDS at $5.0 million. An additional 145 projects at VA sites are funded by non-VA sources, the largest being the National Institute of Allergy and Infectious Diseases. The VA has four special centers focusing on AIDS research, located in San Diego, New York, Decatur (Atlanta), and Durham VA Medical Centers. In total, VA scientists are supported by $32.9 million to look at the causes of HIV infection and the treatment of AIDS.

We support the Friends of VA Medical Care and Health Research (FOVA) recommendation of $325 million for health research at VA, which is again based on the 1990 report of the Blue Ribbon Commission on VA research. This report clearly documented the need for a substantial increase in the medical, prosthetic and health service research programs of the VA. FOVA has determined its recommendation by adjusting the commission's recommendation for medical research inflation.

Department of Education

Protection and Advocacy for Individual Rights (PAIR)

The Rehabilitation Act Amendment of 1992 established the PAIR program as a formula grant program to provide legal advocacy services to persons with disabilities who were not eligible for other federal advocacy programs. This program fulfills a vitally important component of a comprehensive effort to provide advocacy services to all people with disabilities. In FY 1994, the program reached its trigger and became a full formula program with every state and territory receiving a minimum of $100,000. However, this amount remains far short of what is necessary for larger, more populous states to meet the increasing demand for advocacy services. We recommend funding this program at $20 million so that each state may receive allotments that more accurately reflect the demand in their state based on their total population.

This new program has already reported serving many people with HIV infection, especially in cases relating to the Americans with Disabilities Act, Fair Housing Act as well as discrimination in access to health care. NORA supports this funding increase to assure that people with HIV infection will have access to critical legal advocacy services.

DISTRICT HEALTH DEPARTMENT NO. 2

COUNTIES OF
ALCONA
IOSCO
OGEMAW
OSCODA

MAIN OFFICE
630 Progress
West Branch, MI 48661
Tel.: (517) 345-5020
Fax: (517) 345-7999

BRANCH OFFICE

Alcona County
Courthouse Annex
311 Lake St., P.O. Box 218
Harrisville, MI 48740
Tel.: (517) 724-6757
Fax: (517) 724-9975

Iosco County
Iosco County Building Annex
1795 Pine Street
East Tawas, MI 48730
Tel.: (517) 362-6183
Fax: (517) 362-7181

Oscoda County
393 S. Mt. Tom Rd.
P.O. Box 115
Mio, MI 48647
Tel.: (517) 826-3970
Fax: (517) 826-5386

January 5, 1994

Kristine Gebbie
"AIDS Czar"
The White House
Washington, DC 20505

will be in town March 25 - will call re: lunch or dinner -

Dear Kristine:

When I sat down to write this letter congratulating you on the inauguration of the campaign to promote use of latex condoms, I suddenly realized that I did not know your "official" title. Please accept my apologies for the flippant appearance of the address, and my appreciation for the breakthrough on condom promotion.

Ten years ago, I had to write to the major networks protesting their unwillingness to allow paid condom advertising. Now, if understand the reports correctly, they are carry some information for free.

Condom ads themselves won't stop the spread of HIV. But not advocating condom use by those who are sexually involved may leave such individuals with the notion that there is nothing they can personally do to keep from getting or spreading AIDS. The latter attitude is the one thing we cannot afford if we intend to stop the epidemic in our lifetimes.

Keep up the good work.

Very truly yours,

Charles P. Schade, MD, MPH
Health Officer

FAMILY AIDS NETWORK, INC.

Mary Fisher, Founder

RECEIVED
JAN 10 1994

John - fyi
I called Mary

January 6, 1994

Ms. Kristine Gebbie
Executive Office of the President
750 17th St., NW, #1060
Washington, DC 20503

Dear Kristine,

Congratulations to you, Donna, and all with you, on mounting a well-aimed advertising campaign. Anything that educates the public will save lives, which needs to be our primary objective.

You asked that I mention any observations I might have as you did your work. I noticed in coverage of a recent press conference that, perhaps in defense of your present course, you made reference to the lack of responsiveness of previous Administrations -- owing to "politics."

I would encourage you, as I encouraged those representing earlier Administrations, not to caricature others as less worthy than ourselves. It's critical that we not introduce more tensions or barriers by making unnecessary accusations.

With all best wishes,

Mary Fisher

1707 L Street, NW, Suite 1010; Washington, DC 20036; Tel: (202) 296-0966, FAX: (202) 296-0936
678 Front Street, NW, Suite 260; Grand Rapids, MI 49504; Tel: (616) 451-2361, FAX: (616) 451-9180

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Friday, Jan. 7, 1994

Contact: HHS Press Office
(202) 690-6343

The Centers for Disease Control and Prevention has ordered the immediate withdrawal of its AIDS prevention public service announcement for radio featuring "Red Hot Chili Peppers" singer Anthony Kiedis.

The CDC said it took the action upon learning from news reports that Kiedis was convicted of misdemeanor charges of indecent exposure and sexual battery.

"We do not feel he is an appropriate spokesperson," said David Satcher, CDC director. "I've ordered the advertising agency responsible for the ads, Ogilvy & Mather South, to provide us with a detailed report about the recruitment and selection of Mr. Kiedis."

HHS Secretary Donna E. Shalala said she was outraged when told about the background of Kiedis. She concurred with Dr. Satcher's decision to withdraw the ad. "We must not allow a single ad to overshadow the vital life-saving message in the campaign," she said.

###

Received too late for memo.
FYI.

↘ Interagency HIV/AIDS
Task Force

—

Department of Veterans Affairs

DATE: 1/7/94

TO: Iris Cotsburg

FAX: 632-1096

NUMBER OF PAGES: Cover + 1

PHONE:

MESSAGE:
OSW requested - updated paragraph on VA HIV/AIDS.

Bart

From: AIDS Service (116B)
Office of Environmental Medicine & Public Health
DVA Central Office
Washington, D.C. 20420
Phone: (202) 535-7571
Fax: (202) 535-7572

January 7, 1994

DEPARTMENT OF VETERANS AFFAIRS

The Department of Veterans Affairs (VA) conducts HIV/AIDS prevention programs and provides medical care to veterans with HIV/AIDS. In FY 1993 alone, the VA treated approximately 16,700 HIV/AIDS patients. Since AIDS Education is a training priority, conferences during FY 1993 brought together practitioners for information updates and the exchange of effective HIV/AIDS-related treatment strategies. Patient and staff education also is conducted at each VAMC. In addition to being the largest single source nationwide for direct care to HIV/AIDS patients, VA also is a leader in the field of HIV/AIDS Research. To provide an added dimension to VA's HIV/AIDS infection research, the Department established four AIDS research centers at VAMCs: New York City, San Diego, Atlanta and Durham.

WHITMAN·WALKER CLINIC INC

MAIN FACILITY
1407 S STREET, NW
WASHINGTON, DC 20009
202-797-3500
TTY 202-797-4449
FAX 202-797-3504

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3920 S. CAPITOL STREET, SE
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7676 NEW HAMPSHIRE AVENUE
SUITE 111
HYATTSVILLE, MD 20783
301-439-0731
TTY 301-439-0733
FAX 301-439-2983

January 7, 1994

Mr. Allan Horlick
General Manager
WRC-TV
4001 Nebraska Avenue, N.W.
Washington, D.C. 20016

Dear Mr. Horlick:

On behalf of Whitman-Walker Clinic, I would like to encourage you to air the new, "America Responds To AIDS" public service announcements from the Centers for Disease Control and Prevention. They urge young adults to reduce their risk of contracting the HIV virus by abstinence or, if sexually active, by using a latex condom correctly and consistently.

This past fall, after a very constructive and considered process, Channel 4 re-examined its policy on condom advertising and decided to air Whitman-Walker's prevention ads.

We hope Channel 7 will be responsive once again as we endorse the CDC's new Prevention Marketing Initiative and champion the broadcasting of their PSAs on your station. Although there are aspects of this campaign with which we do not agree, we believe that it is all the same an important step forward for the public health. Next month, the CDC will send you this PSA package customized with a Whitman-Walker tag line.

Thank-you again for your good support.

Bests
Sincerely,

Jim Graham
Executive Director

cc: The Honorable Donna Shalala
Secretary of Health and Human Services

cc: The Honorable Kristine Gebbie
National AIDS Policy Coordinator

CELEBRATING 20 YEARS

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301-439-0731
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FAX 301-439-2983

January 7, 1994

Mr. John Sawhill
General Manager
WJLA-TV
3007 Tilden Street, N.W.
Washington, D.C. 20008

Dear Mr. Sawhill:

On behalf of Whitman-Walker Clinic, I would like to encourage you to air the new, "America Responds To AIDS" public service announcements from the Centers for Disease Control and Prevention. They urge young adults to reduce their risk of contracting the HIV virus by abstinence or, if sexually active, by using a latex condom correctly and consistently.

This past fall, Channel 7 broadcast Whitman-Walker's AIDS prevention ad on condoms. We hope Channel 7 will be responsive once again as we endorse the CDC's new Prevention Marketing Initiative and champion the broadcasting of their PSAs on your station. Although there are aspects of this campaign with which we do not agree, we believe that it is all the same an important step forward for the public health. Next month, the CDC will send you this PSA package customized with a Whitman-Walker tag line.

Thank-you for your good support.

Sincerely,

Jim Graham
Executive Director

cc: The Honorable Donna Shalala
Secretary of Health and Human Services

cc: The Honorable Kristine Gebbie
National AIDS Policy Coordinator

CELEBRATING 20 YEARS

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January 7, 1994

Mr. Hank Yaggi
Vice President/General Manager
WUSA-TV
4100 Wisconsin Avenue, N.W.
Washington, D.C. 20016

Dear Hank Mr. Yaggi:

Thanks for taking the time to meet with us on the important issue of AIDS prevention in the D.C. area. I found the discussion to be constructive. I am pleased that in the future Channel 9 and Whitman-Walker clinic will be endeavoring to produce a new prevention ad. Whitman-Walker's Director of Communication,s Marcia Levy, and Mr. Pianki have scheduled a follow-up meeting for later this month.

The other purpose of this letter is to encourage you to air the new, "America Responds To AIDS" public service announcements from the Centers for Disease Control and Prevention. They urge young adults to reduce their risk of contracting the HIV virus by practicing abstinence or, if sexually active, by using a latex condom correctly and consistently.

Thank-you for all that you do.

Sincerely,

Jim Graham
Executive Director

cc: The Honorable Donna Shalala
Secretary of Health and Human Services

cc: The Honorable Kristine Gebbie
National AIDS Policy Coordinator

CELEBRATING 20 YEARS

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TTY 301-439-0733
FAX 301-439-2983

January 7, 1994

Mr. Jim Burke
General Manager
WTTG-TV
5151 Wisconsin Avenue, N.W.
Washington, D.C. 20016

Dear Mr. Burke:

On behalf of Whitman-Walker Clinic, I would like to encourage you to air the new, "America Responds To AIDS" public service announcements from the Centers for Disease Control and Prevention. They urge young adults to reduce their risk of contracting the HIV virus by abstinence or, if sexually active, by using a latex condom correctly and consistently.

This past fall, your predecessor, Tom Hurwitz, met with us in a constructive, community-minded manner, and then broadcast our AIDS prevention ads on condoms.

We hope WTTG-TV will be responsive once again as we endorse the CDC's new Prevention Marketing Initiative and champion the broadcasting of their PSAs on your station. Although there are aspects of this campaign with which we do not agree, we believe that it is all the same an important step forward for the public health. Next month, the CDC will send you this PSA package customized with a Whitman-Walker tag line.

Thank you again for your good support.

Sincerely,

Jim Graham
Executive Director

cc: The Honorable Donna Shalala
Secretary of Health and Human Services

cc: The Honorable Kristine Gebbie
National AIDS Policy Coordinator

CELEBRATING 20 YEARS

January 9, 1994

Dear Messrs. Pozner and Donahue:
RESPONDING TO YOUR Jan. 9 program on condom advertizing.

I heartily applaud Mr. Wykes strong stand against condom education and advertising. When birth control in the form of The Pill was touted, we saw an acceleration of promiscuity and illegitimate births....and myriad social problems, not to mention billions of taxpyer dollars to prop up the irresponsible element.
Deja vu!! Our nation's morals are already out of control, but we have not reached the point of no return.
FEAR AND RESPONSIBILITY need to be taught. Every sexually-active teenager should be shown a video of Rock Hudson, as an example, in the final stages of AIDS!!!!
Pusilanimous talk show hosts and columnists are only perpetuating a serious problem.

Catherine Mueller

Mrs. Catherine Mueller
2925 Charleston
Albuquerque, NM 87110

MR. PHIL DONAHUE
c/o CNBC & CBS
51 West 52nd Street
New York, NY 10010

Ellis Island
Centennial 1992

©USPS 1991

(copy) to Ms. Kristine Debbie

RECEIVED
JAN 19 1994

INFORMATIONAL SERVICES

National AIDS Hotline
800-342-2437
800-344-7432, Spanish access
800-243-7889, (TTY), deaf access

National AIDS Clearinghouse (NAC)
(and) AIDS in the Workplace
800-458-5231
800-243-7012 (TTY), deaf access
301-738-6616, FAX
Do not provide to the general public, refer to the hotline

National Clearinghouse for Alcohol and Drug Information
800-729-6686, Spanish available
301-468-2600, local in D.C. and Maryland
301-468-3433

AIDS Clinical Trials Information Service (a service of the NAC)
800-874-2572
301-738-6616, FAX
Do not provide to the general public, refer to the hotline

OASH, White House Bulletin Board System
202-690-5423

WHITMAN·WALKER CLINIC INC

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January 11, 1994

The Honorable Kristine Gebbie
National AIDS Policy Coordinator
Executive Office of the President
750 17 Street, N.W.
Suite 1060
Washington, D.C. 20503

Dear Ms. Gebbie:

On behalf of Whitman-Walker Clinic, I endorse the CDC's "America Responds To AIDS" public service announcements as an important step forward for the public health.

I am urging D.C. television and radio stations to broadcast the PSAs. Enclosed are copies of my letters to the General Managers of stations WRC, WTTG, WJLA and WUSA.

Sincerely,

Jim Graham
Executive Director

CELEBRATING 20 YEARS

Tim to join us?
yes

THE NATIONAL ALLIANCE TO END HOMELESSNESS, INC.

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January 13, 1994

Ms. Kristine Gebbie
National AIDS Policy Coordinator
750 17th Street, N.W.
Suite 1060
Washington, D.C. 20500

Dear Ms. Gebbie:

Thank you for agreeing to speak at the National Alliance to End Homelessness Leadership Roundtable. As we have confirmed with your office, the meeting will take place Wednesday, January 19, 1994 at 12:30pm at the law offices of Hogan & Hartson, 555 13th Street, N.W. It will be held in the Litigation Center Courtroom. Upon entering the building, you will want to take the spiral staircase down one level. There will be a light lunch served, followed by your remarks (around twenty-five minutes) and then a question and answer session. The program will be completed by 2:00 p.m.

We believe that the Roundtable offers you a unique opportunity to meet with representatives of all major national organizations working on the issue of homelessness. Our members would be interested in discussing the role of your office in setting policy regarding housing for persons living with AIDS. In addition, it would be helpful if your could discuss the direction your office is considering for national AIDS policy in general and how that fits into the national agenda for fighting poverty and homelessness.

On Tuesday afternoon, I will contact you or your staff regarding who will be attending. If you have any questions, please feel free to call me or Jill Rathbun of the Alliance staff. I look forward to seeing you on Wednesday, January 19th.

Sincerely,

Thomas L. Kenyon.

Thomas L. Kenyon
President

CC: Steve Lee

1518 K STREET NW SUITE 206 WASHINGTON, DC 20005 TELEPHONE (202) 638-1526 FAX (202) 638-4664

DEPARTMENT *of* POLITICAL SCIENCE
UNIVERSITY *of* CALIFORNIA *at* BERKELEY
BERKELEY, CALIFORNIA 94720
TEL (510) 642-6323
FAX (510) 642-9515

TODAY's DATE: 1-14-94

NAME of RECIPIENT: Kristine Gebbie

COMPANY NAME: Office of National AIDS coordinator

FAX NUMBER: 202-632-1096

LOCATION: Washington DC

DOCUMENT LENGTH: 4 PAGE(S), INCLUDING COVER SHEET

MESSAGE:

Cheers!

Todd

NAME of SENDER: T. LaPorte

TEL NUMBER(S):

CHARGE TO: PS01/DEPT PS12/COR KRM/PS12 PERSONAL
(circle one)

Please notify sender if there was a problem with transmission.

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DEPARTMENT OF POLITICAL SCIENCE
TEL: (510) 642-6323
FAX: (510) 642-9515

BERKELEY, CALIFORNIA 94720

Jan. 13, 1994

To: Members of the SEAB Task Force on Radioactive Waste Management
Bill Bishop
Bill Richkaem
Dan Kevles
E. Gebbie.
From: Todd La Porte
Re: The business of program re-organization.

Here we go again -- as I promised, though I'm late.

Attached you will find an attempt to put our case to the Secretary. Will it hold up? Is it put cogently, fairly, and with enough grace to withstand/get through bureaucratic roadblocks? Anything else? HELP!

I'd like to get this over with forthwith. Call me (510-283-0545 HM). fax me (510-642-9515), scribble on this copy and return, or whatever..

I'm off to the first O'Leary SEAB meeting next week after being more or less well received during a meeting of the Nuclear Waste Technical Review Board. At least we didn't bomb!

Cheers for the New Year!

Todd

DRAFT DRAFT DRAFT
On UC Berkeley letterhead

January 15, 1993

The Honorable Hazel O'Leary
Secretary of Energy
U.S. Department of Energy
1000 Independence Avenue, S.W.
Washington D.C. 20585

Dear Secretary O'Leary:

You have received, Earning Public Trust and Confidence: Requisites for Managing Radioactive Wastes, the final report of the Task Force on Radioactive Waste Management, and possibly the action memo suggesting first steps for implementation. Our work is formally concluded. However, there is one matter -- the question of substantially re-organizing the nation's radioactive waste management programs -- that, while falling outside our formal charter, was raised so frequently and with such intensity that the Task Force felt obliged to bring it to your attention. As a consequence of our experience, we urge you to initiate a rigorous inquiry ~~examining~~ the organizational and institutional forms appropriate, in advanced industrial democracies, for the effective public management of hazardous materials, especially radioactive wastes.

As you know, this matter is treated only briefly and somewhat obliquely in the report. After several sessions of intense debate and review of the analytical materials we developed, the panel found that:

> The behavior of organizations responsible for managing radioactive waste and the results they produce will be far more important in creating or inhibiting public trust and confidence than will be their organizational forms and structures (p. 38f).

The panel found itself in no position to make a judgment on analytical grounds vis-a-vis the utility of particular organizational arrangements and achieving and sustaining public trust and confidence. However, there may be other grounds for considering major organizational changes, though we conclude that these would be no more firmly grounded on strong analytical (as contrasted to political) bases. This issue, raised from time to time over the past twenty years, appears likely to be raised with the Department again. When this happens, it would serve the Department well if there were a much firmer basis for evaluation than is now available.

As you know, the Task Force deliberations were wide ranging and often involved intense, repeated contact with various stake holding groups, including those critical of the Department and those operationally involved in the industrial management of radioactive wastes. We repeatedly heard calls -- from nearly all stakeholders -- for fundamental re-organization of the nation's management of radioactive

wastes. Without exception, these proposals reflected deep frustrations with the Department, in general, and OCRWM, in particular, leading to the conclusion that the Department was neither managerially competent nor sufficiently removed from political pressures to do consistently rigorous technical work and assure timely systems development. Almost without exception, the remedies involved removing the management of civilian wastes from the Department altogether. Declining public trust and confidence, it was argued, was related to the delays in program development, apparent managerial and public involvement blunders, and insufficient skill in overcoming or accommodating political opposition. Other forms of public management, perhaps a public corporation or an independent agency, would surely be better than the present arrangement, in the view of the critics

Due to this steady drum beat of critique and proposals for major, potentially wrenching change, the Task Force felt it had to address this matter straight forwardly even though the question of major program re-organization was not in its charter. Indeed, some members of the panel are skeptical in general about major re-organization as a solution to internal managerial problems. But to ignore the issue or summarily dismiss it would have put the panel's credibility at risk.

We were dismayed when we found no systematic work examining the results of various program or agency re-organizations and the degree to which they achieved the objectives so sought. Hence, we commissioned a general literature review and subsequent analysis of the last major study devoted directly to proposals for re-organizing DOE's civilian waste program.[1] The review and analysis were thorough and, disappointingly, showed conclusively that there is at present no firm analytical or historical bases to support one form of government or program structure over another for managing programs involving high intrinsic hazard. Evidence is simply indeterminant.

The Task Force believes it is it prudent for the Department to initiate a rigorous effort to address the matter <u>before</u> it confronts proposals for major changes from Congress or other stake holding groups. We urge you to do so.

Sincerely,

Todd R. La Porte, Chairman
SEAB, Task Force on Radioactive Waste Management

[1]Respectively, Craig Thomas, "Reorganizing Public Organizations: Alternatives, Objectives, and Evidence," (recently published in <u>Journal of Public Administration Research and Theory</u>), and "AM-FM's Corporate Solution for Radioactive Waste Management: Appealing But Inappropriate." Both papers are included in our Report's appendix.

Office of the National AIDS Policy Coordinator

Executive Office of the President
750 17th Street, N.W. Suite 1060
Washington, D.C. 20500

Phone: (202)632-1090
Fax: (202)632-1096

Deliver To: Todd LaPorte

Sent From:

✓ **W. STEVE LEE, EXECUTIVE ASSISTANT**

Number of Pages: 2 + Cover Fax Number: 510 642 9515 Date: 1/20

Message:

Todd – Sorry about the my delay in forwarding this one to Kristine. Please call me of you have questions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

JAN 18 1994

Copy to N Hazelton
C. Rasco,
Cire.

Diane Dillard
Deputy Assistant Secretary
Bureau of Consular Affairs
Visa Services
U.S. Department of State
Room 1300
2401 E Street, N. W.
Washington, D.C. 20522-0113

Re: Waiver Procedures for HIV-Infected Persons to Attend the Gay Games IV in New York in June 1994

Dear Ms. Dillard:

This letter is for the purpose of requesting that you recommend to the Immigration and Naturalization Service (INS) the establishment of appropriate procedures to permit HIV-infected persons to enter the United States in June 1994 to attend the Gay Games IV in New York.

As you know, Section 212(d)(3) of the Immigration and Naturalization Act gives the INS discretionary waiver authority to temporarily admit as non-immigrants those aliens who would otherwise be inadmissible due to HIV infection. My understanding is that the waiver authority would most expeditiously be effected in connection with the Gay Games if an official recommendation were submitted to the INS from you.

The Gay Games is an international, noncommercial athletic event, modeled on the tradition of the Olympics. Some of the competitors will likely be persons with HIV disease. Denial of entry to persons with this disability, even though they are physically able to compete in a demanding sport, would be directly contrary to the public health policies of supporting participation by individuals with disabilities in our society, of acknowledging their achievements in a health-related context such as athletics, and of avoiding the stigmatization of persons with a particular disease.

Accordingly, I recommend that the INS put in place a mechanism to permit HIV-infected persons to travel to the U.S. under

procedures that will facilitate attendance by interested persons at this event. I suggest that attention be given by the INS to establishing procedures that avoid any permanent documentation in the alien's passport of the use of this special waiver authority, along the lines established by the INS in 1989 concerning persons with HIV infection.

Thank you for your consideration of this matter.

Sincerely yours,

Philip R. Lee, M.D.
Assistant Secretary for Health

cc:
Doris M. Meissner
Ron Acker
Michael D. Cronin

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

JAN 18 1994

NOTE TO: PHS Executive Secretariat
Through: Acting Director, NAPO

Subject: Review and Clear
Response from Dr. Elders to Thomas E. Dipko on his comprehensive AIDS prevention curriculum

I have reviewed closely the attached CDC-drafted response and attachments and I recommend approval/clearance without comment. If you have any questions, please feel free to contact me at 690-5560.

Carlos Velez, J.D.
HIV/AIDS Prevention Cluster Lead

Attachment

PHS CORRESPONDENCE

T63600

REFERRAL DATE: 2-16 **DUE DATE:** 2-18

TO:

- ☐ ASH
- ☐ DEPUTY ASH
- ☐ SG
- ☐ DASH-MO
- ☐ DASH-SE
- ☐ DASH-C
- ☐ DASH-DPHP
- ☐ DASH-IGA / RHA
- ☐ DAS-IH
- ☐ DAS-MH
- ☐ DASH-PA
- ☐ DAS-PHP
- ☐ ADAMHA
- ☐ AHCPR
- ☐ ATSDR
- ☐ CDC
- ☐ FDA
- ☐ HRSA
- ☐ IHS
- ☐ NIH
- ☑ NAPO
- ☐ NVP
- ☐ PCPFS
- ☐ OEEO
- ☐ OEP
- ☐ OGC / H
- ☐ OHL
- ☐ OHPE
- ☐ OM
- ☐ OSIR
- ☐ OWH
- ☐ ES / PHS _____
- ☐ OTHER _____

ACTION:

- ☐ SECRETARY'S SIGNATURE
- ☐ ASH SIGNATURE
- ☐ DIRECT REPLY
- ☐ _____ SIGNATURE
- ☐ DRAFT FOR OS SIGNATURE (WHITE HOUSE REFERRAL)
- ☑ REVIEW / CLEARANCE
- ☐ NECESSARY ACTION
- ☐ FOR YOUR INFORMATION

SPECIAL INSTRUCTIONS

PHS-5175
Rev. 4/92

PHS / ES
Rm. 710H

Phone: 690-3560

Routed by:

135

Mr. Thomas E. Dipko
Executive Vice President
United Church Board for
Homeland Ministries
700 Prospect Avenue
Cleveland, Ohio 44115-1100

Dear Mr. Dipko:

Congratulations to you and Mr. Bill Johnson on your comprehensive AIDS prevention curriculum for Christian educational settings. This curriculum, *Affirming Persons-Saving Lives*, challenges adults, parents, and youth to confront the realities of HIV/AIDS within the context of the church.

Churches can be a powerful force in educating the public on this important public health issue. We applaud your efforts and challenge other congregation-based churches to consider similar approaches for increasing HIV education and prevention activities at the national and local levels.

The Centers for Disease Control and Prevention (CDC), the Nation's prevention agency, has forged a number of partnerships with national, regional, and local religious organizations and denominations to increase public understanding of HIV/AIDS. I have forwarded your curriculum to CDC staff and asked that they contact you directly.

An identical letter is being sent to Mr. Johnson. Thank you for your leadership in these important efforts to stop the spread of HIV infection.

Sincerely yours,

M. Joycelyn Elders, M.D.
Surgeon General

cc:
OD
CDC/W
OHA
ES/PHS
H Official File
CDC Official File (Return to CDC, Atlanta)
Cleared:JCurran, CDC, OHA, 01/02/94
CDC:DSatcher:da:2/9/94; (404) 639-3291; ERH/02/09/94
Tracer T63606; CDC ID HCA82093; Doc. Name DIPKOJOH.SG
Spelling Verifier Used by:PGalusha:02/09/94
Prepared by:MLewis, CDC, OHA, (404) 639-0975
Contact:BCoker, CDC, OD, (404) 639-3322

IDENTICAL LETTER SENT TO:

Mr. Bill Johnson
Minister for AIDS Programs
and Ministries Coordination
United Church Board for Homeland
Ministries
700 Prospect Avenue
Cleveland, Ohio 44115-1100

Please reply for SG sig.

UNITED CHURCH BOARD FOR HOMELAND MINISTRIES

A Recognized Instrumentality of the United Church of Christ

December 3, 1993

The Hon. Joycelyn Elders, M.D.
Surgeon General of the United States
Parklawn Building Room 18-66
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. Elders:

We were very pleased to hear your televised comments on World AIDS Day concerning the need for comprehensive education concerning HIV and AIDS. We very much agree with your assessment of the quality of AIDS education that is needed in the midst of this tragic, expanding epidemic.

We want you to know that the United Church Board for Homeland Ministries (UCBHM) has produced a new, comprehensive curriculum for AIDS awareness and prevention education for people of all ages designed specifically for use within Christian education settings. We are pleased to present you with a complimentary copy of this groundbreaking resource, ***Affirming Persons - Saving Lives***.

Because nothing like this curriculum has existed until now, the co-authors worked with great care over a period of 3-1/2 years. They adjudged content by asking themselves, "What do people need to know in order to save their lives?" and "What are age appropriate ways to convey that information?"

This bold, graphic curriculum does not avoid discomforting issues. It presents factual, complete information within a context of Christian values and important skillsbuilding for personal empowerment. It incorporates much of what you have affirmed as essential components of effective AIDS education.

We are eager to hear your response to this resource and hope you will find it worthy of your public endorsement as an important contribution to the fight against ignorance about HIV and AIDS.

We pledge to you our suppport for your important contributions to the public health.

Faithfully,

Thomas E. Dipko
Executive Vice-President

Bill Johnson
Minister for AIDS Programs
& Ministries Coordination

700 PROSPECT AVENUE
CLEVELAND, OH 44115-1100
TELEPHONE (216) 736-3800
FAX (216) 736-3803

163606
TRACER

NEWS

UNITED CHURCH OF CHRIST • OFFICE OF COMMUNICATION
700 PROSPECT AVE., CLEVE., OH 44115-1100 • 216-736-2222

Embargoed for release
Tuesday, Nov. 30, 1993

United Church of Christ
Andrew Lang, press contact
216/736-2215 (office)
216/295-8280 (home)

Editors, please note: Fact sheets summarizing the 1,000-page AIDS curriculum are available from the Office of Communication.

The full curriculum and videotapes will be available for review at three sites: New York City, Washington, D.C. and Cleveland. Please call 216/736-2215 for further information.

New church curriculum on AIDS prevention aims to save lives

CLEVELAND — At least 12 million adults and 1 million children worldwide are infected with HIV — the virus that causes AIDS.

The epidemic, which threatens to spread to 40 million by the end of the decade, can be slowed only through education. But until now no comprehensive course in AIDS prevention has been designed for churches.

That changes in December with the release of *Affirming Persons — Saving Lives*, an ambitious 1,000-page curriculum published by the American Missionary Association, a division of the United Church Board for Homeland Ministries.

The Homeland Board is the U.S. mission arm of the 1.6-million member United Church of Christ.

"This is not only the first comprehensive AIDS prevention curriculum for churches," says Laura Lee Kent-Smith, executive director of AIDS Interfaith Network of New Jersey. "It's the best AIDS curriculum I've seen, period."

(OVER)

transmission can be identified and avoided. Lesson plans for teenagers and adults include information about HIV prevention through safer sexual behavior.

• The curriculum teaches decision-making and decision-keeping skills. Older children, teenagers and adults learn how to say "no" effectively to unwanted invitations to drug use or sexual intercourse.

• The curriculum nurtures self-esteem and teaches respect for others. Poor self-regard is often the root cause of behavior that exposes youth and adults to HIV.

• The curriculum is a complete package for AIDS education and prevention. Teaching resources include the latest research on AIDS from the U.S. Centers for Disease Control and other public health agencies. Special training is not required for the teachers who will use the curriculum.

Affirming Persons — Saving Lives was tested by teenagers, teachers and parents in regional workshops throughout the country. People living with HIV and AIDS also played a critical role in curriculum development.

"In the AIDS crisis, the church is confronted with discomforting realities," says the Rev. Thomas Dipko, executive vice president of the Board for Homeland Ministries. "Many would rather avoid these realities. But *Affirming Persons — Saving Lives* addresses the causes and prevention of AIDS truthfully, graphically and sensitively. We do not compromise the essential information necessary for saving lives."

"This is a balanced and honest curriculum we can use with confidence in our local churches," says the Rev. Linda Harle-Mould, a mother and UCC minister in Dublin, Ohio. "I mean it when I say that *Affirming Persons — Saving Lives* is going to give my baby girl a chance to grow up."

"As a person who has been living with HIV for a number of years, this

FACT SHEETS

"Affirming Persons — Saving Lives"
An AIDS Awareness Curriculum for Churches

Summary of the issue

• *Affirming Persons — Saving Lives* is the first comprehensive curriculum for AIDS prevention published for Christian churches. With lesson plans for every age — adults, teenagers and children — the curriculum is designed to help churches become learning centers to protect lives threatened by the AIDS epidemic. The curriculum is published by the United Church Board for Homeland Ministries, the U.S. mission arm of the 1.6-million-member United Church of Christ.

• *Affirming Persons — Saving Lives* is designed for use in Christian education settings from Sunday School to adult study groups. Sessions include Bible study, prayer and theological reflection. With two videos and 1,000 pages of lesson plans and fact sheets, the curriculum is a complete resource for AIDS education. Teachers using the curriculum will not need any special training.

• The curriculum addresses the root causes of the AIDS crisis — including low self-esteem that often leads to life-threatening behavior and ignorance about the causes of HIV infection. Centered in the assurance of God's love for every human being, the curriculum promotes the values of healthy self-esteem and respect for others. *Affirming Persons — Saving Lives* supports responsible choices by teaching practical decision-making and decision-keeping skills.

• *Affirming Persons — Saving Lives* affirms abstinence — both from sexual intercourse and drug use — as the most effective means to prevent HIV transmission. Teenagers also learn that the use of alcohol and other drugs can impair their judgment and magnify their risk of exposure to the virus. The curriculum teaches the skills to say "no" effectively to unwanted drug use or sexual intercourse.

• The curriculum recognizes that not everyone will choose abstinence. It therefore teaches adults and teenagers how to recognize behavior that increases the risk of HIV transmission. Students are warned not only against unprotected sexual intercourse but also against the use of injectable drugs, the sharing of needles by steroid users, ear piercing with unsterilized needles and bonding rituals that involve mingling blood.

• The curriculum includes sessions to help parents discuss AIDS effectively within their families. It urges parents to become knowledgeable about AIDS and to become partners in the education of their children. Parents and church school teachers are encouraged to

[MORE]

• The **Grades 1 and 2 Learning Series** nurtures children's self-esteem within the context of Christian values and provides age-appropriate information about HIV and AIDS. The series helps children understand that their bodies are a wonderful gift from God and should be treated with care and respect, that Jesus teaches them to be kind and loving to all people, and that they can make kind, safe and healthy choices in their own lives.

• The **Grades 3 and 4 Learning Series** nurtures children's self-esteem within a context of Christian values rooted in faithful discipleship, teaches important facts about HIV and AIDS, strengthens their ability to think about the consequences of their choices and teaches how to refuse pressure to engage in behavior that may be harmful to them.

• The **Grades 5 and 6 Learning Series** teaches effective ways to say "no" to unsafe or risky behavior, ensures a basic understanding of sexual intercourse, stresses the importance of sexual abstinence, promotes the idea that sexual intercourse is an adult activity not appropriate for children, affirms that human beings have the freedom to make choices and teaches skills for making healthy decisions.

• The **Youth Learning Series** for teenagers provides complete and factual information about HIV infection, transmission and infection, supports youth in making and keeping decisions informed by Christian values, and motivates youth to act with compassion and understanding towards persons living with HIV or AIDS. The series promotes healthy self-esteem, affirms abstinence, and underscores the value of intimacy and commitment in human relationships. Students learn how to say "no" to behaviors that transmit HIV, including unprotected sex and drug use.

• The **Intergenerational Learning Series** is designed for all generations in the church family. It gives children, youth and adults an opportunity to learn from each other and builds an awareness in the congregation that all ages can benefit from AIDS education.

• The curriculum includes **handouts** for students and a comprehensive package of **Teacher Support Resources**. Teacher's resources include a history of the HIV/AIDS epidemic, a guide to public speaking about AIDS education, a summary of the latest scientific research, a description of the pathology of HIV in the immune system, information about HIV antibody testing and statistics about sexual behavior among high school students.

For more information on this issue, please call Andy Lang at the United Church of Christ Office of Communication, 216/736-2215. Review copies of the curriculum and videotapes are available at three sites: Washington, D.C., New York City and Cleveland. For information on how to order the curriculum, call the UCC AIDS Ministry Office at 216/736-3271.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

JAN 18 1994

NOTE TO: PHS Executive Secretariat
Through: Acting Director, NAPO

Subject: Review and Clear
Response from Dr. Lee to Eileen Hansen on letters sent to Drs. Shalala, Satcher and Curran.
- NONCONCUR

Eileen Hansen sent a letter indicating that past and current prevention activities do not address the needs of women and people of color. I have reviewed closely the attached CDC-drafted response and attachments and I do not concur for the following reasons:

1. Ms. Hansen's letter specifically indicates that it is her belief that current prevention activities do not address the needs of women, gay men of color and youth. The CDC-drafted response cities past and current prevention activities, which are the same activities Ms. Hansen indicates are not responsive. Generalizations about the impact of past activities are inappropriate in view of the tone of the letter from Ms. Hansen.

2. Statements made about the Community Planning Process are appropriate but fall short of giving Ms. Hansen a satisfactory response. Ms. Hansen must be encouraged to get involved in the Community Planning Process by contacting her state AIDS coordinator as soon as possible. She must be encouraged to inform other members of the Women's AIDS Network to get involved in the process and to obtain technical assistance on her involvement in the process through the CDC-funded National Minority Organizations. The response must also either include a copy of the Community Planning Guidance or indicate to Ms. Hansen where she can obtain a copy.

3. The letter may also mention the Prevention Marketing Initiative and the fact that extensive focus groups were used in the framing of the PSAs. Reactions from women and people of color were incorporated into the overall strategy.

If you have any questions, please feel free to contact me at 690-5560.

Carlos Velez, saj

Carlos Velez, J.D.
HIV/AIDS Prevention Cluster Lead

PHS CORRESPONDENCE

T64381

REFERRAL DATE: 2-16 **DUE DATE:** 2-18

TO:

- ☐ ASH
- ☐ DEPUTY ASH
- ☐ SG
- ☐ DASH-MO
- ☐ DASH-SE
- ☐ DASH-C
- ☐ DASH-DPHP
- ☐ DASH-IGA / RHA
- ☐ DAS-IH
- ☐ DAS-MH
- ☐ DASH-PA
- ☐ DAS-PHP
- ☐ ADAMHA
- ☐ AHCPR
- ☐ ATSDR
- ☐ CDC
- ☐ FDA
- ☐ HRSA
- ☐ IHS
- ☐ NIH
- ☑ NAPO (1)
- ☐ NVP
- ☐ PCPFS
- ☐ OEEO
- ☐ OEP
- ☐ OGC / H
- ☐ OHL
- ☐ OHPE
- ☐ OM
- ☐ OSIR
- ☑ OWH (2)
- ☐ ES / PHS _____
- ☐ OTHER _____

ACTION:

- ☐ SECRETARY'S SIGNATURE
- ☐ ASH SIGNATURE
- ☐ DIRECT REPLY
- ☐ _____ SIGNATURE
- ☐ DRAFT FOR OS SIGNATURE (WHITE HOUSE REFERRAL)
- ☑ REVIEW / CLEARANCE (1-2)
- ☐ NECESSARY ACTION
- ☐ FOR YOUR INFORMATION

SPECIAL INSTRUCTIONS

PHS-5175
Rev. 4/92

PHS / ES
Rm. 710H

Phone: 690-3560

Routed by: [illegible]

135

Ms. Eileen Hansen
Women's AIDS Network
Post Office Box 426182
San Francisco, California 94142-6182

Dear Ms. Hansen:

I am responding to your letters to Secretary Donna Shalala, Dr. David Satcher, Dr. James W. Curran, and me. Thank you for sending your report, "Prevention Reform."

Many of the issues discussed in the report have been incorporated into the Centers for Disease Control and Prevention's (CDC) HIV Prevention Community Planning process. CDC's guidance outlines a process whereby the identification of high-priority prevention needs is shared between the health department administering the funds and representatives of the communities for whom the services are intended. To ensure an effective process, the guidance specifically addresses issues related to parity, inclusion, and representation in responding to the critical HIV prevention needs of people of color and women.

Beyond community planning, CDC has for several years directly funded national and regional minority organizations (NMOs) and community-based organizations (CBOs) to provide population-specific HIV prevention programs. In addition, the United States Conference of Mayors (USCM), with funds from CDC, has supported HIV health education/risk reduction programs in CBOs. USCM has also funded collaborative efforts between local health departments and non-governmental organizations in five cities to determine communitywide HIV/AIDS prevention needs/capacities as well as those of gay and bisexual men of color.

CDC is in the third year of a 5-year, eight-site project to prevent HIV infection in women 15-44. Three of the sites focus on a clinic-based approach which reaches and serves HIV-infected women and women at risk of HIV infection and, unplanned pregnancy in clinics, drug treatment centers, homeless shelters, and in their neighborhoods through street outreach. Five sites employ a community-based approach that reflects the different situations, motivations, and priorities of women who may be at risk for both HIV and unintended pregnancy. Successful perinatal prevention programs limit the spread of HIV infection among women of childbearing age and encourage the effective use of contraception among HIV-infected women and women at risk of becoming infected

who wish to avoid pregnancy. All of the sites have involved their communities in protocol development, implementation, and evaluation. These projects grew out of the perinatal HIV reduction and education demonstration projects which ended three years ago. They exemplify the level of benefit, when all work together, to target populations, the community, and project directors.

I am optimistic that lessons learned from these and other projects, as well as involvement and feedback from you, your colleagues, and others in the community will contribute toward creating programs that work.

CDC is constantly working on strategies that will stop the spread of HIV/AIDS in all sectors of our population. We continue to need partners that represent organizations such as yours to assist us in these efforts. We plan to use this document as a reference when addressing future HIV/AIDS policy issues.

Thank you for your interest in HIV prevention planning.

Sincerely yours,

Philip R. Lee, M.D.
Assistant Secretary for Health

cc:
OD
CDC/W
OHA
ES/PHS
H Official File
CDC Official File (Return to CDC, Atlanta)
Cleared by:WJones, CDC, OHA, 01/10/94
Tracer No. T64381; CDC ID HCA82518 & 82699; Doc. Name HANSEN.ASH
CDC:DSatcher:pkg:02/08/94; (404) 639-3291; CNL/02/08/94
Spelling Verifier Used by:PGalusha:02/08/94
Prepared by:WJones, CDC, OHA, (404) 639-0904
Contact:BCoker, CDC, (404) 639-3322

December 17, 1993

The Honorable Philip R. Lee
Assistant Secretary for Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Dear Assistant Secretary Lee:

Several months ago a number of individuals representing organizations of women and people of color gathered together to begin a dialogue about prevention reform. We came together out of a strong belief that prevention efforts to date have not come anywhere close to addressing the critical needs of people of color and women - in particular, gay and bisexual men of color, women of color and youth.

As Co-Chair of the Policy Committee of the Women's AIDS Network, I convened the meetings. The group, representing eight national organizations, decided to produce a brief document addressing our concerns and issues regarding prevention. This decision was made out of the experience we have all had for many years now regarding the lack of attention to women and people of color in the HIV pandemic. It also was made specifically out of our particular concerns with the lack of focus on women and people of color in H.R. 1538, The Comprehensive HIV Prevention Act of 1993 (Pelosi, D-CA). As much as we believe that the thrust of H.R. 1538 is a solid one, we remain concerned that the needs of women and people of color are not specifically dealt with. Our document - focused generally on prevention reform, rather than on any one bill or effort - is attached for your information.

We ask that you read the enclosed document and address these issues in any future policies regarding federal prevention reform. On behalf of the group of organizations signing off on this document, I offer our assistance in any of the areas covered. We would appreciate being included in any future discussions regarding prevention reform at the national or state/local level. Thank you for your attention to these crucial matters.

Very truly yours,

Eileen Hansen
Women's AIDS Network

T64381
TRACER

c/o S.F.A.F. • P.O. Box 426182 • San Francisco • CA 94142-6182 • (415) 864-4376 ext 2007

December 17, 1993

The Honorable Donna Shalala
Secretary, Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Shalala:

Several months ago a number of individuals representing organizations of women and people of color gathered together to begin a dialogue about prevention reform. We came together out of a strong belief that prevention efforts to date have not come anywhere close to addressing the critical needs of people of color and women - in particular, gay and bisexual men of color, women of color and youth.

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Very truly yours,

Eileen Hansen
Women's AIDS Network

T64381

c/o S.F.A.F. • P.O. Box 426182 • San Francisco • CA 94142-6182 • (415) 864-4376 ext 2007

9312300028

PREVENTION REFORM: EXECUTIVE SUMMARY

People of color and women - in particular, gay and bisexual men of color, women of color and youth - are hard hit by AIDS. We are populations that have burgeoning and particular needs with regard to HIV. Those needs have not been acknowledged or targeted with funding proportionate to our emerging, undercounted and at-risk numbers. *Any* HIV prevention effort must take special care to meet the requirements of these populations. Without that attention, people of color, gay and bisexual men of color, women and youth do not trust that our concerns will be addressed. We refuse to remain invisible in this epidemic.

Effective prevention strategies aimed at modifying behavior must take into consideration cultural and behavioral patterns, socioeconomic factors, social norms and the unique infrastructures of differing people of color communities and differing women's communities. Because the needs of communities of color and women have been so often overlooked, any comprehensive prevention planning efforts must specifically address the priorities and prevention needs of women and people of color, including specific groupings within those populations - as defined by those affected populations.

In order to adequately address the needs of people of color, gay and bisexual men of color, women and youth, these populations must be specifically targeted throughout *all* reform efforts. This does not mean that a "laundry list" must be developed. However, there are several ways in which we see this concern being addressed. For example, linguistically relevant and culturally competent approaches to prevention must be mandated. In addition:

Membership in any advisory councils, as well as any state, regional and local planning councils, must be inclusive of people of color, gay and bisexual men of color, women and youth ("people of color" should be defined to include the various ethnicities *within* particular categories of people of color - for example, the 29 distinct sub-groups within the grouping of "Asian" and the 20 distinct sub-groups within the grouping of "Pacific Islanders"), and inclusive of individuals *at risk* for HIV (including "emerging populations at risk" and populations traditionally undercounted). Among others, lesbian and bisexual women must be named, as must transgenders and transsexuals, sex industry workers and out of school youth. When we focus on "empowerment of communities," the variety of communities *within* diverse geographical communities should be acknowledged, thus noting the significance of class, gender, race, ethnicity, age and sexual orientation differences. We need to create the best possible climate for people of color, gay and bisexual men of color, women and youth - people who have expertise regarding their particular issues and communities - to fully participate in planning and fully compete for funding.

We must not continue to assume that when the needs of any one population are addressed, the needs of all others affected by HIV have been addressed. For example, meeting the needs of gay, white men - needs that everyone agrees are critical - does not mean that the needs of gay men of color have been met. To this end, on behalf of eight national organizations serving women and people of color, we offer a number of collective concerns and suggestions regarding five areas of prevention reform:

1) Resource Allocation

Funding allocations for primary HIV prevention must be directly linked to locally conducted needs assessments and must prioritize activities and/or interventions that are designed with the specific goal of preventing new HIV infections, especially those targeting populations that have been affected by HIV infection, yet have traditionally been excluded from policy and programmatic planning on all governmental levels. This prioritization calls for the shifting of prevention dollars from counseling, testing and reporting toward meaningful primary prevention efforts that are developed and implemented by and for communities of color, women, gay and bisexual men of color, women of color, gay and bisexual men and youth.

2) Direct CDC Funding

The legacy of discrimination against communities of color obstructs cooperative agreements with government bodies. In addition, organizations that focus specifically on the needs of women have not even begun to be included - for the most part - in the network of federally funded prevention initiatives and technical assistance. Therefore, direct CDC funding, as well as funding allocated through state or local health departments must continue to be made available to these affected communities, with a process of evaluation and recommendations to be developed and developed among both management and community advisory boards as to the CDC's future funding plans.

3) Needs Assessment

Any prevention reform should mandate a local needs assessment - *with uniform standards and methodologies* - as an integral part of any planning process, prior to the allocation of any funds. We believe that tying funds to needs assessments will result in more local dollars going in the same direction as the epidemic. To ensure that the local needs assessment be as inclusive as possible, uniform standards and methodology must specifically require that data be collected on populations such as women and people of color who are at increased risk of becoming HIV-infected. Community input is essential in developing appropriate needs assessments. Further, local health agencies must look to other data which may be more accurate indicators of the risk factors for specific populations, e.g. statistics from local family planning clinics on rates of teenage pregnancies; statistics from local women's health centers on lesbian/bisexual-identified women; statistics from local hospital emergency rooms and community-based clinics on the relationship of poverty rates to HIV; or such data as may be obtained from STD clinics. If the data is not available, funding must be provided to obtain such critically important data.

4) Prevention Planning Council Structure

Federal HIV prevention reform must recognize that the nation's HIV epidemic is made up of many local HIV epidemics which vary greatly depending on the geographical area. Reform must also recognize the diverse populations within geographical areas. While we support an approach that allows local and state coalitions to select appropriate prevention strategies and providers, it is also necessary to incorporate safeguards into local planning and decision-making processes regarding funding that will ensure that women from diverse racial and ethnic communities, youth and all people of color are able to equitably participate in planning and equitably compete for prevention funds. Contrary to the myth, rarely have individuals from low-income, disenfranchised communities been represented on planning councils because they are not politically empowered to begin with. The Ryan White Care Act Title I planning council model

must not be adopted wholesale for the purposes of prevention planning. It must be analyzed for its weaknesses and strengths and then a new model developed for prevention.

5) Counseling and Testing

HIV prevention activities would be furthered if counseling and testing responsibilities were removed from the CDC's jurisdiction and placed within HRSA, where they can be linked to health services. It is within HRSA that we can see counseling and testing become an effective tool in early intervention. Counseling and testing, by themselves, must not be viewed as primary prevention or counted as prevention dollars. Counseling and testing *must* be linked to services. Additionally, we oppose mandatory name reporting. It is essential that anonymous testing be as readily available as confidential testing to any person requesting it.

We refer you to the longer document attached, along with supporting background information, for more detail on these issues. We urge you to make time to read the complete document and to take these issues seriously in any future prevention efforts at the national or state/local level. As women and people of color, we are absolutely convinced that our communities' needs for prevention can not be met without full attention to these issues. We would be more than happy to discuss any or all of these areas with you at your earliest convenience and look forward to lending our voices to the ongoing discussion regarding prevention reform.

Signed,

Eileen Hansen, Women's AIDS Network
P.O. Box 426182, San Francisco, CA 94142-6182
415 824-8884
Rafael Chang, Asian/Pacific AIDS Coalition
995 Market Street, Suite 1112, San Francisco, CA 94103
415 243-8909
Gerald Lenoir, Black Coalition on AIDS
1042 Divisadero, San Francisco, CA 94115
415 346-2530
Steve Lew, Campaign for Fairness
1841 Market Street, San Francisco, CA 94103
415 575-3939
Leslie R. Wolfe, Center for Women Policy Studies
2000 P Street NW, Suite 508, Washington, DC 20036
202 872-1770
Helen Fox, National Minority AIDS Council
300 I Street NE, Suite 400, Washington, DC 20002
202 544-1076
Ron Rowell, National Native American AIDS Prevention Center
3515 Grand Avenue, Suite 100, Oakland, CA 94610
510 444-2051
Kerrington Osborne, National Task Force on AIDS Prevention
631 O'Farrell Street, San Francisco, CA 94109
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PREVENTION REFORM

1) RESOURCE ALLOCATION

Funding priorities must be directly linked to locally conducted needs assessments. Along with projections of seroprevalence among various groups, these assessments must also identify and document the socioeconomic factors such as gender, sexual orientation, nativity, language, ethnicity, race, age, income and indigence that impact upon the risk of HIV infection among groups characterized by these factors. This approach is essential to achieving a comprehensive prevention needs assessment that does not generalize the risk of infection based on transmission categories alone, but also includes the socioeconomic realities which further impede HIV prevention efforts among certain groups.

Resource allocation and the methods used to determine the same must recognize the existing - or sometimes just emerging - infrastructure within indigenous community-based organizations serving people of color, women, gay and bisexual men of color, women of color and youth, and provide funding for capacity building and community development within these communities.

Funding allocations for primary HIV prevention must prioritize activities and/or interventions that are designed with the specific goal of preventing new HIV infections, especially those targeting populations that have been affected by HIV infection, yet have traditionally been excluded from policy and programmatic planning on all governmental levels. This prioritization calls for the shifting of prevention dollars from counseling, testing and reporting toward meaningful primary prevention efforts that are developed and implemented by and for communities of color, women, gay and bisexual men of color, women of color, gay and bisexual men and youth.

2) DIRECT CDC FUNDING

The legacy of discrimination against communities of color obstructs cooperative agreements with government bodies. Lack of demonstrated commitment by state and local health departments to secure access to health care for communities historically burdened with poverty, addiction, infant mortality and premature morbidity exacerbates that trust. Moreover, communities of color traditionally have received an inadequate fraction of HIV-related funds channeled through state and local health departments because of 1) general neglect of community-based organizations serving communities of color; 2) inappropriate and inadequate mechanisms for determining need; 3) an unwillingness to expand the service delivery system to include harder to reach, disenfranchised people; and 4) absorption of funds through government administrative costs. Therefore, it is unacceptable that the funds targeted directly to organizations serving people of color from the Centers for Disease Control and Prevention now be allocated through state and local health departments. Both streams of funding - direct CDC funding, as well as funding allocated through health departments - must be available to people of color. Organizations targeting specific populations within communities of color such as gay men of color or women of color must be specifically included in this plan.

As important as direct CDC cooperative agreements are with community-based organizations serving people of color, organizations that focus specifically on the needs of women have not even begun to be included - for the most part - in the network of federally funded prevention initiatives and technical assistance. Special prevention program funding must be developed for organizations that specifically target women, including organizations whose mission is to target specific populations of women - for example, African Americans, Latinas or lesbians. Efforts must be made to ensure that women are also reached within *any* overall prevention effort - whether it be direct CDC funding or funding allocated through state or local health departments - so that prevention for women is not limited to or capped through direct women-specific agreements.

Therefore, direct CDC funding, as well as funding allocated through state or local health departments must continue to be made available to these affected communities, with a process of evaluation and recommendations to be developed and developed among both management and community advisory boards as to the CDC's future funding plans.

3) NEEDS ASSESSMENT

As previously noted under the section on Resource Allocation, it has been proposed in many forums that any prevention reform should mandate a local needs assessment as an integral part of any planning process, prior to the allocation of any funds. We believe that tying funds to needs assessments will result in more local dollars going in the same direction as the epidemic. Theoretically, we would then see an increase in prevention efforts targeting people of color, women, gay and bisexual men of color, women of color and youth, given that the epidemiological data reflects these trends. This makes sense, and the concept is a very good one; however, there are some concerns about the framework for the needs assessment.

Uniform standards and methodologies must be mandated in guidelines for needs assessments. These standards must include the various population groupings and sub-groupings (noted in the Executive Summary) and provide strong guidance to localities seeking to conduct a needs assessment. To ensure that the local needs assessment be as inclusive as possible, uniform standards and methodology must specifically require that data be collected on populations such as women and people of color who are at increased risk of becoming HIV-infected. Community input is essential in developing appropriate needs assessments. Further, local health agencies must look to other data which may be more accurate indicators of the risk factors for specific populations, e.g. statistics from local family planning clinics on rates of teenage pregnancies; statistics from local women's health centers on lesbian/bisexual-identified women; statistics from local hospital emergency rooms and community-based clinics on the relationship of poverty rates to HIV; or such data as may be obtained from STD clinics. If the data is not available, funding must be provided to obtain such critically important data. The thoroughness of any local needs assessment must be evaluated on criteria which mandate local health agencies to seek the assistance of local community-based organizations targeting people of color and women in identifying and determining local needs.

4) PREVENTION PLANNING COUNCIL STRUCTURE

Federal HIV prevention reform must recognize that the nation's HIV epidemic is made up of many local HIV epidemics which vary greatly depending on the geographical area. Reform must also recognize the diverse populations within geographical areas. While we support an approach that allows local and state coalitions to select appropriate prevention strategies and providers, it is also necessary to incorporate safeguards into local planning and decision-making processes regarding funding that will ensure that women from diverse racial and ethnic communities, youth and all people of color are able to equitably participate in planning and equitably compete for prevention funds.

While in theory, Ryan White CARE Act Title I planning councils provide an excellent venue for community-based planning and decision-making regarding funding, we are very concerned about the ability of advocates for women and people of color to participate fully in these local structures. By their very nature, planning councils are political bodies. In order to ensure some degree of fairness in the prevention planning structure process, representation of two overlapping communities whose needs require special consideration - that is, communities of color and women (for example, gay and bisexual men of color and women of color) - must be mandated.

An underlying concept of planning councils is that they are representative of the various communities and empower those affected by HIV/AIDS. This is rarely true of individuals from low-income, disenfranchised communities because they are not politically empowered to begin with. Frequently, representatives from smaller CBOs lack the expertise needed to be proficient at health care planning. Therefore, it is rare for such individuals to sit on planning councils or, even if appointed, to *effectively* participate in the planning council process. Thus, individuals on community planning boards may need intensive, ongoing training in health care planning. This should include education about health care systems, how publicly funded health care programs work, insurance programs, and a discussion of the responsibilities of the community planning board and the boundaries of their authority. Moreover, even health departments need training in some areas, such as translation of data from a needs assessment to priority-setting. Therefore, the guidance for community planning must include an intensive, ongoing training and educational process for the participants.

Another way to ensure that the needs of women, people of color and low-income communities are represented in this type of forum would be to mandate inclusion of categories of organizations that serve communities of at-risk individuals, but which may or may not currently be doing any HIV work. For example, regarding women: primary care providers, family planning clinics, battered women's shelters, and other specific categories of social service providers who work with low-income communities and with women should be targeted for inclusion in any prevention planning body.

HIV/AIDS disproportionately affects African Americans and Latinos/as, as compared to the general population in the United States. According to a recent report issued by the Centers for Disease Control and Prevention, the number of AIDS cases in women increased by nearly 10 percent last year - four times the 2.5 percent increase that men experienced. And not all women are threatened in equal measure; again, most of the women who have contracted the virus are African American or Latina. Additionally, in the first study of its kind (10/93), the AIDS Office

of the San Francisco Department of Public Health concluded that the seropositivity of lesbians in the San Francisco area was three times higher than that for women, in general, in the San Francisco area. Thus, these populations - along with, of course, gay and bisexual men and gay and bisexual men of color - must be specifically included in any prevention planning structure.

In an indication of the inability of current local or state planning councils to be genuinely representative of the community's needs and interests, the initial findings of an ongoing evaluation by the Center for Women Policy Studies of CARE Act Title I planning councils are that women's advocates and women's needs are too often absent. A Health Resources and Administration (HRSA) evaluation of Title II consortia, a similar local planning and decision-making structure, revealed an alarming tendency for a few large agencies to have a disproportionate influence on consortia decision-making and funding allocations.

5) COUNSELING AND TESTING

There has been much debate among service providers, policy-makers, prevention educators, state health officers and the Centers for Disease Control and Prevention as to the proper/appropriate/ actual function of counseling and testing within the framework of HIV prevention, surveillance and health services. The CDC defines counseling and testing as primary prevention and many state health officers share this perspective. In so doing, the focus is primarily on identifying infected individuals and maintaining accurate statistics. We define these activities as surveillance and the collection of epidemiological data, *not* primary prevention.

Primary prevention must focus on risk reduction and behavior change. Counseling and testing alone cannot accomplish this. Gathering and monitoring surveillance data does not, in any way, address the issues of individual risk behavior. To continue to equate counseling and testing dollars with prevention dollars belies the amount of federal dollars directed toward actual, targeted HIV prevention efforts.

In addition, an assessment needs to be conducted of points of entry for testing and counseling - in particular, for women. We believe that HRSA-sponsored programs generally make a more appropriate point of entry than CDC-sponsored programs. If women are to access anonymous HIV testing and counseling services, it is essential that these services be available at places women go for health care. Since women fill 70% of the nation's overall caregiving roles, they often must struggle to balance the many competing demands on time, energy and money created by these roles. It is often *impossible* to schedule child care, transportation, and time off from work and family to make multiple trips to different locations to meet their health needs. Thus, women are currently most likely to get their health care, including testing and counseling, at HRSA-funded sites for primary health care such as community health centers, women's health centers, family planning and prenatal care clinics. Women are not as likely to go to STD clinics, TB clinics and test sites that are not connected to other health services.

Given the above, HIV prevention activities would be furthered if counseling and testing responsibilities were removed from the CDC's jurisdiction and placed within HRSA, where they can be linked to health services. It is within HRSA that we can see counseling and testing become an effective tool in early intervention. Counseling and testing, by themselves, must not

be viewed as primary prevention or counted as prevention dollars. Counseling and testing *must* be linked to services.

Additionally, we oppose mandatory name reporting. It is essential that anonymous testing be as readily available as confidential testing to any person requesting it. While many states maintain some level of access to anonymous testing, it is often very limited and difficult to obtain. For example, in North Carolina, anonymous testing will no longer be available by 1994. HIV counselors there report that fewer numbers of individuals are getting tested, as anonymous test sites disappear. Additionally, the New Jersey Women and AIDS Coalition reports that New Jersey now has 200 HIV test sites but that anonymous testing is only available at seventeen of these sites. This has resulted in extremely long waiting lists at sites offering anonymous testing. It also results in frequent use of pseudonyms at confidential test sites by people wishing to obtain anonymous testing but who are unable to wait for an anonymous test site appointment. Anonymous test sites must be expanded. Name reporting must not be required or promoted.

PREVENTION REFORM: BACKGROUND

1) DIRECT CDC FUNDING

As of November 24, 1986, the CDC reported over 28,000 cases of AIDS in the United States. AIDS cases had been reported from all 50 states, the District of Columbia, the Commonwealth of Puerto Rico and four U.S. territories. Although racial/ethnic minorities comprised less than 20% of the overall population, they were over represented in the amount of reported AIDS cases. African Americans comprised 12% of the overall population and 25% of AIDS cases. Latinos/as amounted to 6% of the population and 15% of reported cases.

The imbalance was even more pronounced in women and children with AIDS. Cases among women represented 7% of the total, with African Americans accounting for 51% of those cases and Latinas for 21%. Of the pediatric cases, 57% were African American, 23% were Latino/a. Data was not collected on the Asian/Pacific Islander and Native American/Alaska Native populations.

Also at that time it was projected that:

by the end of 1991, total cumulative cases of AIDS would exceed 270,000;
by the end of 1991, total cumulative deaths would exceed 179,000;
most people who develop AIDS by 1991 were infected by the mid 1980s;
a dramatic increase in AIDS cases would occur among heterosexuals.

In light of the large number of individuals infected with HIV, and the projections of new AIDS cases in the years following 1986, it was unlikely that the rising incidence of AIDS in communities of color would slow or reverse itself in the foreseeable future. It was expected that disease and death from AIDS and HIV-related infections in communities of color would continue to mount as we approached the next century.

Direct funding of minority and other community-based organizations was thus created in fiscal year 1988 by Congress to respond to the mounting statistics. Because of a variety of reasons, racial and ethnic minority communities were not responding to the traditional public health model for STD prevention. This model, relying on testing, treatment and partner notification, proved unsuccessful in stemming the tide of new HIV infections. Although no data was available on why HIV was spreading so quickly among people of color (i.e., to this day, there is no behavioral data on people of color), it was believed that a new approach to dealing with prevention education in communities of color was necessary.

Starting in fiscal 1990, approximately 98 organizations working with specific populations and communities of color in need of HIV prevention information were selected to receive funding. The organizations received funding to educate their local communities, although no provision was made for the development of new prevention strategies. Funded organizations had to be creative in the approaches they would use to provide prevention education to their communities.

CBOs have succeeded in developing current educational techniques and materials that are the model for education in racial and ethnic minority communities. The organizations that have participated in this program have succeeded in supplementing the efforts of existing local health entities in carrying out their prevention message. More importantly, they have created an infrastructure within communities of color to continue the fight against AIDS.

Native Americans and Alaska Natives are both citizens of their tribes and nations and of the United States. Native people have a unique relationship with the federal government, based upon more than 350 treaties signed by the United States and the Indian nations and tribes between 1784 and the late 1800s. Native Americans numbered 1.92 million in the 1990 census.

The federal government has a "trust responsibility," based on treaties, that entitles Indian people to participate in particular federal programs such as education and health care. However, those tribes and nations that did not sign treaties with the United States are not federally recognized by Congress and are therefore not eligible to participate in federal programs.

That situation has a direct impact on health care services to Native people who are not recognized by the federal government. The Indian Health Service (IHS) has the primary federal responsibility of providing health care services, but *only* to those tribes and nations recognized by Congress. The IHS views this mandate as serving only federally-recognized Native Americans *living on or near reservations*. In fact, over half of all Native Americans now live in urban areas and only one quarter live on reservations. Thus, IHS actually serves only about 40% of all Native Americans. In addition, there have been numerous criticisms of the IHS regarding its provision of sub-standard health care, even to those it is mandated to serve.

The issues of self-determination and sovereignty became paramount for Native people and tribal governments in the 1960s. Public Law 93-638 (PL 638) of 1975 (The Indian Self-Determination and Education Act) gave tribes the option of managing IHS programs in their communities. Increasingly, more Indian governments are exercising that right and are operating hospitals, health centers and other health care programs.

Although PL 638 allows for self-determination with regard to health care programs, Native communities, until very recently, have relied solely on IHS for health care services. The Federal Government restricts which Native people can receive services, which means that many Native people must seek health care services from other providers. It is only very recently that any Native organization has been funded for public health services outside the IHS bureaucracy. It is imperative that Native organizations and tribes have the right to further self-determination by receiving funding from sources other than those that have been historically available to Native people.

State and local health care agencies incorrectly assume that all health care needs of Native people are met through the IHS. Often those entities refuse outright to provide HIV/AIDS funding to Native groups or follow passive outreach efforts to Native communities when funding opportunities become available to the general public.

CDC is one of very few funding sources for Native communities that are addressing health care needs for Native people. The fact that CDC can directly fund Native health care groups has meant that in very real numbers, Native people are receiving HIV education and prevention services who would not otherwise have access. HIV education and prevention for Native people was virtually non-existent until CDC awarded education and prevention grants to national and regional Native American AIDS organizations in 1988. Community-based organizations serving Native Americans have thus been funded primarily with funds from CDC, either directly through the U.S. Conference of Mayors, or by state and local health departments.

2) PREVENTION PLANNING COUNCIL STRUCTURE

Any federal prevention reform planning structure should include the following five mandates to help ensure that advocates for women and people of color can participate in prevention planning structures:

First, the needs assessment will be the basis for an approved, comprehensive prevention planning structure. Through the needs assessment, the needs of the various populations of women and people of color in the community will be formally researched and addressed in detail.

Second, regarding prevention planning structure composition: specific mandates must be in place requiring that membership be composed of a range of community-based organizations (including not only HIV/AIDS providers targeting women and people of color, but also key health and social service providers that already have a record of success at reaching women and people of color and are often themselves members of those communities). Requirements must also be created regarding the structure and composition of organizations asserting that they represent specific populations (for example, a requirement that at least 51% of board members and staff be members of the population the organization purports to represent). The term "community-based organization" (CBO) must be clearly defined, in order to facilitate appropriate membership in the prevention planning structure. (For example, in some cities, the public hospitals unfortunately consider themselves to be CBOs.)

Third, a formal grievance procedure should exist for members of the prevention planning structure. This procedure must be developed with community input.

Fourth, prevention planning structures should prepare a plan clearly establishing funding priorities that must be followed by the state or local grantee making final funding allocation decisions. However, the prevention planning structure should not be charged with the responsibility of selecting specific organizations or agencies to receive contracts.

Fifth, recognizing that community-based organizations are often operating with minimal staff and the proverbial shoestring budget, a specific small percentage of federal funding to each planning structure must be set aside to meet the expenses of prevention planning structure members who would, absent financial assistance, be unable to participate in prevention planning structure meetings. This financial assistance would not take the form of stipends to pay members for their participation. Rather, it would be used to pay for an individual's unavoidable expenses associated with planning structure participation (such as travel, child care costs, income

replacement, cost of replacing staff while at meetings, etc.) and would only be available to those individuals or organizations who can demonstrate that the assistance is necessary to their participation.

Evaluation pertaining to prevention planning structures should be defined on two levels: 1) Evaluation of planning and decision-making processes must be made by objective parties and not under a contract where the prevention planning structure being evaluated controls the evaluator; and 2) evaluation of funded programs should be done in such a way as to assist programs in creating better programs. Technical assistance should be provided, with a formative evaluation used to help the program establish or refine its program goals and stabilize and/or upgrade the program. A summative evaluation can be used to draw conclusions about the impact, outcomes or benefits of a program. However, caution should be exercised in comparing programs. Care must be taken to understand differences in program design and "outcome" based on the differences in communities' and population's needs. Additionally, many community-based organizations serving people of color and/or women are newly formed organizations or are new to the HIV/AIDS prevention arena and are just in the process of building an infrastructure that will be equipped to meet the demands imposed by the epidemic. Such agencies may view evaluation efforts by funders as hostile attempts to withdraw funds. Evaluations must therefore be conducted in such a way as to enhance programming and demonstrate or increase effectiveness.

THE WHITE HOUSE

WASHINGTON

January 18, 1994

MEMORANDUM FOR KAREN ABRAMSON
WHITE HOUSE INTERN OFFICE

FROM JOHN PAUL GURROLA
OFFICE OF THE NATIONAL AIDS POLICY COORDINATOR

SUBJECT Intern additions

Following, are "blue sheets" for all of my interns, except Tanya Dean. Tanya was an intern last semester for Scheduling and Advance and had a Blue hard pass. She needs to be kept on the access list and if it is possible for her to get her hard badge back...that would be great. We deal with the Domestic Policy Council often and it would be helpful to have an intern that could make deliveries for us.

In addition, I have included a page that list our interns and their schedules.

Thanks. If you have any questions, I can be reached at 202/632-1090.

Copy - President Clinton

PARK AVENUE CHRISTIAN CHURCH

(Disciples of Christ)

Ministers:
John Wade Payne
Allen V. Harris
Director of Music:
McNeil Robinson

1010 Park Avenue
New York, New York 10028

Telephone 212 288-3246
FAX 212 288-7602
Established 1810
An 'Open and Affirming' and 'Shalom' congregation
in Ecumenical Partnership with the United Church of Christ

RECEIVED

January 20, 1994

Bruce
Andrew
Carlos

Dr. David Satcher, Director
Centers for Disease Control and Prevention
1600 Clifton Rd., NE
Atlanta, GA 30333

Dear Dr. Satcher,

I am writing to thank you for your part in commissioning and developing the CDC's new AIDS public service campaign. One of my colleagues, the Rev. Jon Lacey, who is on staff at Michigan State University, was present for the unveiling of these ads. I was pleased with his report of the clarity and substance of this new campaign.

As a pastor of a local congregation I work one-to-one with individuals who are affected by AIDS. Not only do I counsel individuals who are HIV+ or who have AIDS, but I work with persons who are struggling with the decision-making processes around sexuality which involve issues around HIV.

I know that my influence, while extremely helpful, is only one element in a much larger process. The media, which has sizeable leverage for most Americans, must also reflect responsible choices. I applaude the explicit discussion of condoms in these public service campaigns and urge you to continue to get the word out about their use. Please include more focused ads for lesbian and gay persons. I urge you to continue to develop and support the airing of such ads, even as the right-wing spreads malicious information designed to repress their airing.

I am thankful that the Clinton Administration has gone beyond the Reagan and Bush Administrations in its effort to stem the AIDS crisis.

Thank you for your support.

Sincerely,

Rev. Allen V. Harris

cc. Local affiliates FOX, WNET

Illegal Immigrants

1.) One of the most divisive issues this country faces today has to do with illegal immigrants. There are an estimated 3 and 4 million people living in this country who will not be eligible for coverage under the President's bill because they are not citizens and are not residing permanently in the U.S. under color of law. This population is concentrated in certain areas of the country, including southern California. In the L.A. County hospital system, nearly two thirds of the births in 1991 -- some 29,000 -- were to mothers who were undocumented aliens.

Later today we will hear from the National Council of La Raza that two elements of the President's bill -- the denial of coverage to undocumented immigrants, plus the use of a health security card -- will, in combination, "create an enormous threat to the civil rights of all Latinos in the U.S.," whether they are U.S. citizens or not.

As an alternative, they recommend, among other things:

-- covering everyone who is legally working in the U.S.;

-- covering all children and pregnant women regardless of immigration status;

-- allowing each State to decide whether to cover additional undocumented people; and

-- issuing an identical health security card to everyone, with information as to who is not eligible encoded on the card.

What is your reaction to these suggestions?

no - ex. in P.H. clinics, ER. do. cont $

we fashioned will based on
this ?

On Specialized Services

For Ms. Gebbie or Dr. Feder:

I'm concerned about the range of specialized services that people with HIV and other disabilities need.

Since the President's plan does not provide sufficient subsidies to guarantee that poor people and working class people can get fee-for-service coverage, many people with AIDS or other disabilities may find themselves in a managed-care plan that does not have the right specialists on staff. While I understand that these patients may go outside their plan to get services they need, the additional costs may be substantial--and, as you know, most people with AIDS or other disabilities don't have a lot of disposable income. How will you guarantee that people with specialized needs get the specialized services they need?

[Expected Answer: The State will require adequate plan coverage for approval and patients will somehow scrape together the co-pays to go to a provider outside the plan.]

Some people have used the example of a hemophiliac who needs surgery; that patient needs a very specially trained provider. Do you think it's appropriate to require that a low-income person, who cannot afford to get into a plan with such a specially trained surgeon, be required to pay extra to get the basic services they need?

[Expected Answer: Yes.]

Guidelines focus us on good care —

It is in the interest of the plan to have ~~&~~ providers prepared to handle HIV well, since badly managed it not only costs the person in suffering, it costs the plan more in hospitalization. The essential provider feature means inclusion of knowledgeable providers during transition

On Innovative Treatments

For Ms. Gebbie or Dr. Feder:

I'm also concerned about the coverage of new and expensive prescription drugs, which is a particular problem for people with AIDS. As you probably know, when AZT was first approved, about half of the States had Medicaid programs with closed formularies. It took almost two years for all 50 States to cover AZT, and during that time some AIDS patients simply had to go without the only approved drug for their condition. Part of the delay was bureaucratic and part of it was, I believe, a function of cost containment. How will you assure that formularies will keep pace with the innovation in treatment that we are all hoping for in AIDS research?

[Expected Answer: Unknown. (The formularies are supposed to cover all necessary drugs.)]

assuming the new drugs provide step forward, coverage should be there

issue is timing

discrimatory

On Funding for New Initiatives
For Dr. Feder and Ms. Gebbie:

In your testimony, you have discussed a number of Public Health Service initiatives that are included in the President's plan--school-based clinics, health education, social and support services, expansion of primary care services, and others. But the Plan actually provides no money for these programs--only an authorization of appropriations. And, as we all know, last year's budget bill freezes appropriations for five years. If we enact these authorizations, how will you pay for them?

[Expected Answer: They'll say they'll work with us to find a way to pay for these, just like they said they'd work with us to find a way to pay for immunizations.]

Does the cost estimate for the President's Plan include offsetting savings in existing public health programs such as Ryan White clinics or family planning programs or community health centers?

[Expected Answer: Yes, as insurance revenues come in, grants to these sites will be cut. (Although the Administration has sometimes said different things about Ryan White funding.)]

Yes there is a limited amount of adjusting offset, based on best available #'s regarding care purchased by Ryan White. New #'s will come from improved reporting & we will monitor closely.
Will need to be taken into account in Ryan White reauthorization

For Dr. Feder and Ms. Gebbie:

Why doesn't your prevention package include counseling and testing for HIV and all sexually transmitted diseases? As I understand it, the PHS has for years been urging people to get HIV counseling and testing. In addition, there is widespread consensus that having an STD that causes a lesion makes it easier to get and transmit HIV. Why would you want to impose a cost on such services instead of encouraging everyone to get them?

[Expected Answer: Unknown.]

targeted health advice and counseling specifically covered 18 & 46

1) Counselling testing in primary care — covered as diagnostic / approp. prevention

2) P.H. improvement

THE WHITE HOUSE

WASHINGTON

Kristine M. Gebbie, R.N.,M.N.
National AIDS Policy Coordinator

January 24, 1994 Testimony
House Subcommittee on Health and the Environment

Mr. Chairman and Members of the Committee:

I am glad to have this opportunity to talk with you today about the impact of the President's health plan on people with special needs--those with HIV/AIDS, people with disabilities, Native Americans, rural residents, migrant workers, and others. These diverse men, women, and children each have unique and special gifts and characteristics. But they have one thing in common with all other citizens of this Nation; they have a right to secure health care that they and their families can depend on.

The health care system we have today leaves many of these people behind. It's a system that works well if you are reasonably healthy, reasonably insured or reasonably

wealthy. It's a system that falls short for millions of Americans who don't quite fit the mold. As individuals and as a Nation, we can no longer afford to leave anybody out in the cold because they are a "bad risk."

Today I want to tell you specifically what the Administration's plan will do to help individuals with special needs and their families. The Health Security Act can't offer miracle cures or alleviate the personal pain and suffering that often accompanies chronic illness, but it can offer secure health coverage for everyone. Health care that's always there.

I'd like to share with you the stories of some real people, to illustrate how devastating a chronic illness -- in this case HIV/AIDS -- can be. As you'll see, these people could be any one of us here in this room today. Right now, there are no guarantees in the system for any American.

Christina, a 25 year old woman, was covered under her father's insurance policy while a college student. During this time, she tested positive for HIV, the virus that causes AIDS. When her father disclosed this to his self-insured company, they pursued several strategies to get Christina off the company policy. Finally, the company solved its problem by firing Christina's father.

Charles has coverage, but he doesn't feel very good about what he has to do to keep it. Charles is a 37 year old man who was diagnosed with AIDS in 1985. At the time, he was working, but had no insurance because he could not afford the high premiums. He knew he would need some help with his medical expenses, so he turned to Social Security for help. Charles applied for disability and Medicaid, and quit his job,-- for this is how the system works, or fails to work, for people when they really need help. Charles wants to work, but in order to have his $4,000 monthly medication bill covered, he had to stay unemployed and disabled. Charles says he is "caught in a trap, always fearful that today will be the day the house of cards collapses on him."

The Health Security Act offers relief; universal coverage means everybody -- all the Charleses and Christinas -- regardless of their special needs to their relative risk, everybody, will be able to pay for health care. They will never lose their coverage for the crime of being too sick, they will never face up to a lifetime limit or exclusion, they will never lose their job over this, they will never have to lie or impoverish themselves to get something we believe is a fundamental right.

Let me share with you some of the many features of the Health Security Act that are of significance to people with HIV and AIDS:

Pre-existing conditions, such as testing HIV positive do not exclude a person from coverage. This is truly a universal program. Universal mean EVERYONE!

Medical specialists training to treat persons with HIV and AIDS will be deemed essential providers and available to everyone who needs them.

Prescription drugs, a significant cost for people with HIV and AIDS, will be covered under the plan.

Discrimination, redlining and other means to prevent coverage for all persons with special needs will be eliminated under the President's plan.

Confidentiality, a concern to all of us, will be protected and guaranteed in the Act.

The Ryan White CARE Act will remain as a safety net to provide needed supplemental services to people with AIDS, such as community based home care, case management and transportation.

The Administration is making the care and treatment of people with special needs a priority. Only last week, the Public Health Service released its new HIV treatment guidelines for use by health care providers nationally. These guidelines will assist our professionals in providing the most appropriate and highest level of care possible.

It is critical to discuss as well the plan to improve the nation's public health system at the same time health care benefits are extended to all. HIV infection is preventable, as are other conditions which may cause an individual to become disabled or enter a "special population." We should make every effort to prevent these conditions from occurring. The proposed public health improvements support will allow rebuilding the infrastructure of our prevention agencies so that they can be real partners with the care system and responsive to community needs.

Mr. Chairman, Members of the Committee: 37 million Americans, including many people who have special needs, go without health coverage. Far too many people most in need of services, such as those with HIV infection, are uninsured, or lose their insurance just when they need it most. We can either address the problem head on -- organize health care delivery and financing, so the system works for all Americans -- or deny the problem and let the system grow more and more unfair, expensive, and out of control. We must join forces and solve this problem. We must work together to create a rational system where those who need health care the most have secure health care that's always there.

Mr. Chairman, I have submitted a complete text of my testimony which further expands on what I have said here today. I am available to you and the Committee for your questions. Thank you.

effective

market
postability

Subcommittees of the Energy and Commerce Committee

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OVERSIGHT AND INVESTIGATIONS

2323 Rayburn House Office Building
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(202) 225-4441

Jurisdiction: Responsibility for: (1) Oversight of agencies, departments and all programs within the jurisdiction of the full committee; (2) Conducting such investigations within such jurisdiction. (This subcommittee does not have legislative jurisdiction. The committee's legislative subcommittees have parallel responsibility to conduct oversight in their assigned areas).

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(continued on next page

THE WHITE HOUSE

WASHINGTON

Testimony of

Kristine Gebbie, R.N., M.N.

National AIDS Policy Coordinator

Executive Office of the President

Before the

House Committee on Energy and Commerce

Subcommittee on Health and the Environment

January 24, 1994

Mr. Chairman and members of the Committee, thank you very much for this opportunity to share with you what the President's plan will do to help vulnerable populations -- those with HIV/AIDS, people with disabilities, Native Americans, migrant workers and others.

Their special circumstances, illnesses, and disabilities amplify their needs and illustrate poignantly the failures of the current system to provide the security of coverage when help is needed the most.

I'd like to share with you the stories of some real people, to illustrate how devastating a chronic illness -- in this case HIV/AIDS -- can be. As you'll see, because these people could be any one of us here in this room today, there are no guarantees in the system for any of us.

Christina, a 25 year old woman, was covered under her father's insurance policy while she was a college student. During this time, she tested positive for HIV, the virus that causes AIDS. When her father disclosed this to his self-insured company, they pursued several strategies to get Christina off company policy. Finally, the company solved its problem by firing Christina's father.

Charles has coverage but he doesn't feel very good about what he has to do to keep it. Charles is a 37 year old male who was diagnosed with AIDS in 1985. At the time he was working and had no insurance because he couldn't afford the high premiums. He knew he would need some help with his medical expenses, so he turned to Social Security for help. Charles quit his job in order to apply for disability and Medicaid. Charles would like to work, but in order to have his $4,000 a month medical bills covered, he had to stay unemployed and disabled. Charles feels that he is "caught in a trap" and fears the day when "the day the house of cards will collapse."

Fortunately, the President's plan provides universal coverage for every American, and that includes all the Charles's and Christina's out there, regardless of their needs or risks.

Congress -- particularly members of this Committee -- has demonstrated great concern about the ability of underserved populations to obtain access to health care services. The President recognizes, as you do, that a Health Security Card alone cannot guarantee that all Americans will receive necessary health care services. To achieve this goal, the Health Security Act includes additional measure that will provide special protections and secure access and quality for our vulnerable populations. Let me share them with you.

Security of Comprehensive Coverage

All Americans will have the security of comprehensive health coverage -- with no exceptions. People with disabilities or chronic illnesses will no longer be subject to the precipitous loss of coverage they face today. No one can lose their coverage. Under the Health Security Act, hospital services are covered; doctor visits are covered; prescription drugs are covered. In addition, certain extended care, hospice services, and outpatient rehabilitation services are covered. These services, and others offered under the benefit package become a crucial link for the very survival of people with certain disabilities or illnesses.

Mental illness and substance abuse treatment services are guaranteed elements of the comprehensive benefits package. By 2001, this coverage is without day or visit limitations -- on the same terms as other services.

From the onset, mental illness and substance abuse treatment benefits covered by the Health Security Plan (within certain guidelines and criteria) include: screening and assessment; inpatient and residential treatment; crisis services; intensive non-residential treatment; outpatient treatment; collateral services; and case management. Benefits are provided in variety of settings, including offices and clinics, residential treatment and intensive non-residential programs.

Continuity of Care

The Health Security Act assures that all Americans will have a choice in selecting their providers and health plans. Each individual will be able to enroll in a traditional fee-for-service plan, join a network of doctors and hospitals, or join an HMO. In addition, all health plans must offer a point-of-service option -- individuals will not be restricted to the plan providers.

To further guarantee continuity of care, all individuals will have access to medical specialists for unique services they need. All health plans most sufficient arrangements with providers to assure the provision of all items and services covered by the comprehensive benefit package. In addition, plans must contract with academic health centers for services that are rare and performed in enough frequency at these sites to ensure quality. Further, states may require plans to contract with centers of excellence they identify to further guarantee appropriate access to care.

The essential community provider provision guarantee services of federally-funded clinics and other providers delivering care in difficult-to-serve areas. Qualifying providers, e.g.

those being funded by Ryan White, Community and Migrant Health Centers, programs for the Homeless, family planning, and maternal and child health, are guaranteed payments for covered services from all health plans. This program assures that vulnerable populations have continued access to practitioners with experience in meeting their needs, regardless of which health plan they choose to enroll in.

Protections Against Discrimination

The Health Security Act assures that no individual is discriminated against in obtaining comprehensive coverage. Health plans will no longer have lifetime limits on coverage. Health plans will offer an open enrollment, accepting everyone applying for coverage at that time without charging a higher premium to those with a pre-existing condition. States and alliances further assure that no one faces barriers to care based on race, ethnicity, sexual orientation, age or gender.

To protect health plans that attract disproportionate number of vulnerable individuals, the Health Security Act assures proper payment through an alliance-based risk-adjustment and reinsurance systems.

To ensure confidentiality of patients, national privacy protection standards are established. These standards forbid the linkage of individual-specific information with aggregate data on patterns of care. Privacy protection as applied to health care information will be a continuing focus of the National Health Board.

Special Services

The Health Security Act leaves in place certain programs to address additional needs of these vulnerable populations.

Ryan White and other safety net providers. Current safety-net programs like Ryan White will continue to receive funding for services beyond the guaranteed package. Transportation, outreach, case management, translation, and personal support services remain critical for vulnerable populations and will be sustained under the Health Security Act.

Medicaid. All Medicaid eligible children will be eligible for a new federal program of wrap-around services that supplements the comprehensive benefits package. States will continue to receive matching payments for wrap around services for adults who receive SSI or AFDC benefits and dual eligible. Long term care Medicaid services (e.g., nursing home, ICF/MR, home health, personal care, etc.) continue to be available for all Medicaid eligible as under current law. In addition, all states will be required to take Medicaid expenditures into account in determining financial eligibility for Medicaid coverage of nursing home care. Also, Medicaid patients in institutions will be able to keep $50 per month for their personal needs, up from a minimum of $30 per month.

Transitional Insurance Reform

As you know, the reform will take a few years to fully implement. During the interim it is critical that we protect existing insurance coverage for employers and families. We must

assure that insurers do not drop the most vulnerable in anticipation of a system in which they are forced to compete based on price and quality, rather than their ability to attract the healthy and avoid the sick.

The Health Security Act, therefore, includes a series of transitional insurance reforms that guard against the most egregious abuses by health insurers prior to the creation of a fully reformed market and the formation of health alliances. These reforms include:

- Health insurers are prohibited from terminating or failing to renew coverage for a group or individual, except in cases of non-payment of premiums, fraud, or misrepresentation in an application for coverage or claim for benefits.
- Insurers are required to provide coverage for new employees of an employer that purchases insurance, regardless of health status.
- Premium increases cannot be varied according to the health status of the group or individual.
- Exclusions for pre-existing conditions are limited, and individuals who are continuously insured are not required to meet a new waiting period for pre-existing conditions when switching coverage.
- Self-insured health plans may not arbitrarily reduce benefits for high cost illnesses.
- The National Transitional Health Insurance Risk Pool is established to provide coverage to individuals who are unable to obtain private coverage because of their health status.
- Insurers are required to obtain prior approval for excessive premium increases.

These transitional insurance reform by no means represent comprehensive reform, as ultimately envisioned by the Health Security Act. They will, however, protect against the most extreme abuses we see in the insurance market today, and they will ensure an orderly transition

to a system that guarantees health security for all Americans and effective control of health costs.

Other Special Programs

School-Age Youth. The Health Security Act will address the problems of one of our Nation's most vulnerable groups: adolescents and young adults. The current health care system has failed to provide our youth with the information and services they need to avoid risky behaviors and make healthy decisions. Adolescents are also often reluctant to seek help, ignorant about what help is needed or where to get it, and concerned about confidentiality. These barriers contribute to the substantial problems with substance abuse, unwanted pregnancy, and HIV/AIDS among this age group.

The Health Security Act will reach out to school-age youth and adolescents in two ways. The Comprehensive School Health Education initiative will establish a national framework within which States can create school health education programs that improve the health and well being of students, grades K through 12, by addressing locally relevant priorities and reducing behavior patterns associated with preventable morbidity and mortality. This program will be targeted to areas with high needs, including poverty, births to adolescents, and sexually-transmitted diseases among school-aged youth.

The School-Related Services program will support the provision of health services -- including psychosocial services and counseling in disease prevention, health promotion, and

individualized risk behavior -- in school-based or school-linked sites. Grants will be made to states for the development and implementation of state-wide projects targeted at high-risk youth ages 10-19. In states that do not take this initiative, grants will be available to local community partnerships including public schools, experienced providers, and community organization

Severely Disabled Persons. The plan also includes a major expansion of home and community based services for individuals with severe disabilities. This new long term care program will offer significantly increased federal funding to help states to offer a wide array of personal assistance and related supports to people at home, in the community. Eligibility for this program is not limited by age, type of disability, or income. When this program is fully phased in, approximately $38.5 billion new federal dollars will be available to help people who have significant needs for assistance with activities of daily living to live more independent lives.

Migrant Workers. Migrant Workers are guaranteed a new level of health security under the Act. With their health security card, legal residents employed as migrant workers will be able to easily transfer their coverage from one geographic area to another. In fact, the portability will be assured by regional alliances whose job it is to keep track of employer payments and enrollment for all workers.

The Public Health Service Initiatives in the Act also provide a supportive framework for the benefit package coverage that is assured. The Community and Migrant Health Center Program is maintained, and as you know, Mr. Chairman, Migrant Health Centers are an

important source of primary health care for many migrant workers throughout the nation. These Migrant Health Centers are also protected as Essential Community Providers for at least the first five years of health care reform. The PHS Initiatives also contain a new grant program to assist providers in offering support services that will make their services more accessible, including transportation, outreach, and translation services. These services will be very important in helping providers offer more culturally appropriate services for migrant workers.

Indian health. American Indians/Alaska Natives receive special treatment under the Health Security Act in recognition of the historic obligations of the government-to-government relations that exist between the Federal government and Indian tribes.

Under the Act, Indians will receive an improved benefit package and new choices of providers. Indians may choose to enroll either with an Indian health program or with a health plan offered by an alliance. The health programs of the Indian Health Service will be maintained and expanded so that they will be able to offer the full range of the comprehensive benefit package services by 1999. All Indians, whether they enroll with an Indian health plan or an alliance health plan will remain eligible for supplemental services, such as environmental health, outreach, transportation, etc. The PHS Initiatives will reaffirm the emphasis on these important services.

Conclusion

Mr. Chairman, Members of the Committee: 37 million Americans, including many people who have special needs, go without health coverage. Far too many people most in need of services, such as those with HIV infection, are uninsured, or lose their insurance just when they need it most. We can either address the problem head on -- organize health care delivery and financing, so that system works for all Americans -- or deny the problem and let the system grow more and more unfair, expensive, and out of control. We must join forces and solve this problem. We must work together to create a rational system where those who need health care the most have security of care.

INSTITUTE OF MEDICINE
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February 8, 1994

KENNETH I. SHINE, M. D.

Dear Colleague:

I am pleased to invite you to a public briefing on the Institute of Medicine's forthcoming report entitled *Women and Health Research: Ethical and Legal Issues of Including Women in Clinical Studies*. The briefing and public release of the report will be held on Thursday, February 24, 1994, from 10:00 to 11:30 a.m. in the Lecture Room of the National Academy of Sciences Building, 2101 Constitution Avenue, N.W., Washington, D.C.

At the request of the National Institutes of Health's Office of Research on Women's Health, the Committee on Ethical and Legal Issues Relating to the Inclusion of Women in Clinical studies (a membership list is attached) evaluated ethical and legal implications of including women, particularly women of childbearing potential and pregnant women, in clinical studies. With the additional support of The Ford Foundation, the committee examined gender inequities in clinical research practices and developed ethical principles to guide decisions concerning gender composition of clinical studies. This report examines real and perceived barriers to achieving gender equity, such as liability, social biases, and scientific constraints of study design. It makes specific recommendations to the National Institutes of Health, study sections, institutional review boards and clinical investigators.

The briefing will provide an opportunity for members of the scientific community, policy makers, and representatives of the media to consider the committee's findings and recommendations. At the briefing, the report will be summarized by the committee co-chairs, Ruth Faden of the Johns Hopkins School of Public Health and Georgetown University's Kennedy Institute of Ethics, and Daniel Federman of Harvard Medical School, and several committee members, including Anita Allen of the Georgetown University Law Center, Shiriki Kumanyika of the Pennsylvania State College of Medicine, and Sheldon Segal of The Population Council. There will be a question and answer session.

I hope that you will be able to join us on February 24. For additional information, you may contact Thelma Cox at 202/334-1734.

Sincerely,

Kenneth I. Shine, M.D.

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The Institute of Medicine was chartered in 1970 by the National Academy of Sciences to enlist distinguished members of the appropriate professions in the examination of policy matters pertaining to the health of the public. In this, the Institute acts under both the Academy's 1863 congressional charter responsibility to be an advisor to the federal government and its own initiative in identifying issues of medical care, research, and education.

■■■

THE INSTITUTE OF MEDICINE

1993–1994

RICHARD AND HINDA ROSENTHAL LECTURE SERIES

PERSPECTIVES ON THE ROLE OF STATES IN HEALTH CARE REFORM

■■■

Tuesday, February 22, 1994
6:00 p.m. – 7:30 p.m.

Lecture Room
National Academy of Sciences
2101 Constitution Avenue, N.W.
Washington, D.C.

Through the generosity of the Richard and Hinda Rosenthal Foundation a lecture series was established in 1988 at the Institute of Medicine to bring to greater attention some of the critical health policy issues facing our country today. Each year a topic of special policy relevance is selected and addressed in three lectures held in conjunction with IOM Council meetings. The lectures are later published and distributed to a wider audience.

■■■

PROGRAM

February 1994

RICHARD AND HINDA ROSENTHAL LECTURE

Tuesday, February 22, 1994
6:00 p.m. – 7:30 p.m.

Perspectives on the Role of States in Health Care Reform

Welcome:	Kenneth I. Shine President Institute of Medicine
Moderator:	Jerome H. Grossman Chairman and Chief Executive Officer The New England Medical Center Boston, Massachusetts
Speaker:	Mark Chassin Commissioner Department of Health State of New York Albany, New York
Respondant:	Alan R. Weil Health Policy Advisor Office of the Governor State of Colorado Denver, Colorado
7:30 p.m. – 9:00 p.m.	Reception and Buffet

■■■

The February 1994
Richard and Hinda Rosenthal Lecture

Perspectives on the Role of States in Health Care Reform

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Joy Wilson
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Gina Young
Institute for Health Policy Solutions

The February 1994
Richard and Hinda Rosenthal Lecture

Perspectives on the Role of States in Health Care Reform

Speakers' Biographies

MARK R. CHASSIN, nominated by Governor Mario Cuomo, was confirmed as Commissioner of Health for New York state on June 9, 1992. Prior to being named commissioner, Dr. Chassin served as Senior Vice President of Value Health Sciences, Inc., a health services research and consulting firm that develops guidelines and software for health care quality assessment and utilization review. From 1981 to 1989 Dr. Chassin was a Senior Project Director for the RAND Corporation. While at RAND, he served as a principal investigator in a pioneering research effort that evaluated geographic differences in the use of health services as an indicator of possible inappropriate use. More recently, Dr. Chassin has worked on the development of practice guidelines to both improve health care quality and control costs.

ALAN R. WEIL has been the health policy advisor to Colorado Governor Roy Romer since February 1992. In this role he advises the Governor primarily on issues affecting access to health care and health care cost containment. Mr. Weil's work on national health care reform has included serving as one of seven state government representatives on President Clinton's health care working groups. He staffs Governor Romer in his role as co-chair of the Health Care Leadership Group for the National Governors' Association. In addition, Mr. Weil is the Project Director of a study of ColoradoCare, a proposal for comprehensive reform of health care in Colorado. Mr. Weil's experience includes serving as Program Director of the Colorado Children's Campaign, a non-profit group that monitors the status of children and advocates on their behalf. He also has served as legal counsel to the Massachusetts Department of Medical Security--the agency responsible for implementing that state's universal health care law.

THE WHITE HOUSE

WASHINGTON

February 1, 1994

MEMORANDUM

TO: Corlis Moody, Director, Office of Economic Impact and Diversity, Department of Energy

FROM: Kristine M. Gebbie, R.N., M.N. K. Gebbie for
National AIDS Policy Coordinator

SUBJECT: Donald Donaldson

This memorandum is written to request the detail of Donald Donaldson, Training Specialist, to the Office of National AIDS Policy through January 1, 1995. Mr. Donaldson would be responsible for the reporting, education, and coordination efforts of the President's Federal Workplace AIDS Education Initiative and reports to me.

As you know, the initiative includes many activities scheduled around World AIDS Day, December 1, 1994. This important initiative requires considerable national coordination, and it is important that all agencies receive assistance and direction from this office. Mr. Donaldson's past coordination work with the Department of Energy and other agencies demonstrates that he has the skills necessary to carry out this national initiative.

Upon your approval, Mr. Donaldson will be assigned work space and equipment at the Department of Health and Human Services in the Hubert Humphrey Building.

I look forward to your reply. Please call me (202) 632-1090 if you have any questions.

cc: Don Donaldson

February 1, 1994

Bill Clinton
President

Dear Mr. President:

I am not the type of person who writes the President letters, but in this case I felt I must. I have worked for the federal government, specifically, the Federal Labor Relations Authority for about the last ten years. In 1988 I was diagnosed as having HIV disease. Shortly thereafter I informed my agency of my health condition. Through the last four years my condition progressed and I have now have AIDS. Last week I applied for disability retirement.

However this letter is not to discuss me, but rather the fine and exemplary way I have been treated by my agency. When I was first diagnosed I needed no accommodation, but rather needed to be treated as a full productive employee. During this time the management of the Office of the General Counsel provided me with every opportunity, every responsibility and challenge that was available. When the time came for me to seek accommodation, whether it be to participate in an experimental treatment for my disease or for a shorten workweek due to my declining health, the management of the Office of the General Counsel was supportive. At no time was I ever treated like half a person or half an employee, rather I treated with respect and as a valued and productive member of the staff. As I retired on disability, I again found the management of the Office of the General Counsel to be supportive as well as compassionate.

I would especially like to commend Joe Swerdzewski, your appointment as General Counsel, Nancy Spieght, Deputy General Counsel, James Petrucci, Regional Director, Susan Jelen, Regional Attorney and the former General Counsel Kathy Koch, for all of these individuals set the tone, policy and procedures that made my health situation a much easier one to live and work with.

I bring this to your attention because I believe that their actions and conduct exemplify your policy on dealing with HIV and AIDS in the workplace. It is my hope that every employee who finds themselves in my situation would have the same kind of responsible, caring and decent employers. When government works right, it should be lauded and held out as a model for others. In this situation it worked right.

Sincerely,

Christopher J. Ivits

cc: Barney Frank, Representative, U.S. House of Representatives

Pat Shroeder, Representative, U.S. House of Representatives

CHRISTOPHER J. IVITS
2822 MAPLE SPRINGS
DALLAS TX 75235

Office of the National AIDS Policy Coordinator

Executive Office of the President
750 17th Street, N.W. Suite 1060
Washington, D.C. 20500

Phone: (202)632-1090
Fax: (202)632-1096

Deliver To: KRISTINE GEBBIE
ATTN. ALSO John + ANDREW

Sent From:

___ Kristine Gebbie, RN, MN, National AIDS Policy Coordinator
-✓ LANCE ALWORTH
___

Number of Pages: 5 + Cover Fax Number: 632 1096 Date: 2/25/94

Message:

Andrew
We need a "good job" letter from Pres to FLRB & copy to Mr Jutts

Tanya -

Andrew

6th Floor
Conf. Room
4-6p
Retina

5/13 c 1:30
~~150~~

February 2, 1994

INTERVIEW PROPOSAL
FOR
KRISTINE GEBBIE
NATIONAL AIDS POLICY COORDINATOR

ONAPC STAFFER:	John Paul Gurrola
DATE/TIME OF EVENT:	OPEN (Preferably Sunday, April 10) - you can appear live on Sunday from 11-11:30 p.m. or do a taping on a Friday afternoon
LOCATION:	Via satellite
ORGANIZATION:	Lifetime Television "The Marjorie Clapprood Show"
CONTACT:	Miranda Daniloff, Senior Producer (617)433-4304
PURPOSE:	Interview with the NAPC
OTHER PARTICIPANTS:	Undecided (possibly Mary Fisher)
MEDIA COVERAGE:	Lifetime Television
REMARKS REQUIRED:	Question and answer session with Marjorie Clapprood
BACKGROUND:	"Clapprood Live" is a weekly talk show focusing on major newsmaking events and people of the week with in-studio guests and viewer call-ins. The host, Majorie Clapprood, served in the Massachusetts State Legislature focusing on healthcare and poverty with an emphasis on women's issues. The show airs live every Sunday at 11:00 p.m. on Lifetime. Lifetime Television is a venture of Hearst/ABC-Viacom Entertainment Services (HAVES) and is available on more than 5,800 cable systems throughout the nation, serving over 57 million households.

FILE
Chronologically -
Most recent
in front

RECEIVED
FEB - 7 1994

DEPARTMENT *of* POLITICAL SCIENCE
UNIVERSITY *of* CALIFORNIA *at* BERKELEY
BERKELEY, CALIFORNIA 94720
TEL (510) 642-6323
FAX (510) 642-9515

TODAY's DATE: 2-5-94

NAME of RECIPIENT: Kristine Cabbie

COMPANY NAME: Office of National AIDS Coordinator

FAX NUMBER: 202-632-1096

LOCATION: Washington D.C.

DOCUMENT LENGTH: 5 **PAGE(S), INCLUDING COVER SHEET**

MESSAGE:

NOTE ENCLOSED Todd's Bio.

NAME of SENDER: Todd LaPorte

TEL NUMBER(S): see above

CHARGE TO: (circle one) PS01/DEPT PS12/COR KRM/PS12 PERSONAL

Please notify sender if there was a problem with transmission.

UNIVERSITY OF CALIFORNIA, BERKELEY

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DEPARTMENT OF POLITICAL SCIENCE
TEL: (510) 642-6323
FAX: (510) 642-9515

BERKELEY, CALIFORNIA 94720

Feb. 5, 1994

To: Members of the SEAB Task Force on
Radioactive Waste Management
From: Todd La Porte
Re: The business of program re-organization -- second round.
Info: Jake Stewart, Dan Metlay

Attached is another attempt to put our case to the Secretary. Thanks for the good assistance and corrections. I've heard from Gebbie, Zald, Wilson, and Landis (only minor editorial changes). Eichbaum, Kettl and Fri had modest suggestions reflected in the latter parts of paragraphs 2 and 3. Lester and Bishop forwarded written revisions helping to make the letter more crisp and sharpen the emphasis of radioactive wastes and consensus building processes.

I've shortening the letter (putting the details as an attachment) and clarifying several sections.

Does it cover the sense of our group? If it's too troublesome, let me know, otherwise I send it to the Secretary by Thursday, Feb. 10th. Call (510-283-0545 HM) or fax me (510-642-9515), scribble on this copy and return, or whatever..

The Secretary's first SEAB meeting was quite interesting and up beat with trust and confidence playing a prominent rhetorical role. My sense, however, is that they do not yet get it. Their emphasis is focussed exclusively on external relationships; necessary but by no means sufficient. Sigh. We shall see.

Cheers,

Todd

Todd

looks good to me —

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DEPARTMENT OF POLITICAL SCIENCE
TEL: (510) 642-6323
FAX: (510) 642-9515

BERKELEY, CALIFORNIA 94720

February 10, 1994

The Honorable Hazel O'Leary
Secretary of Energy
U.S. Department of Energy
1000 Independence Avenue, S.W.
Washington, D.C. 20585

Dear Secretary O'Leary:

You have received, Earning Public Trust and Confidence: Requisites for Managing Radioactive Wastes, the final report of the Task Force on Radioactive Waste Management. Our work is formally concluded. However, there is one matter that, while outside our charter, was raised so frequently and with such intensity that we feel obliged to bring it to your attention. This is the issue of substantially re-organizing the nation's radioactive waste management programs.

Most who raised the issue with the Task Force argued for change. But the panel concluded that analytical grounds were not sufficient for it to recommend a particular organizational arrangements either for recovering public trust and confidence or for improving program management. However, there may be other political or policy related grounds for considering major organizational changes. And this issue appears likely to be raised again. The Task Force believes it is prudent for the Department to initiate a rigorous, independent effort to address the matter before proposals for major changes are put forward by Congress or stake holding groups. (See the attachment for a brief rationale for our views.)

We urge you to initiate a full, independent examination of the organizational and institutional forms appropriate for the effective management of radioactive wastes. Its purpose should be, in part, to determine whether the political benefits of a major institutional change would be enough to warrant the costs when there is not yet a strong analytical reason to expect operational advantage.

We recommend a consensus building forum including stakeholders, and work to reduce the analytical deficit in this area. The effort could be extended to consider the Department's management of hazardous materials as well.

Sincerely,

Todd R. La Porte
Professor of Political Science and
Chairman, SEAB, Task Force on Radioactive Waste Management

cc: George Scalise, Jake Stewart

Task Force Rationale

In its final report, the Task Force treated the matter of re-organization only briefly though not for want of concern. It was brought to our attention repeatedly. But on the basis of sustained debate and close review of analytical materials, the panel found itself in no position to make a judgment on analytical grounds vis-a-vis the utility of particular organizational arrangements and achieving and sustaining public trust and confidence. Rather it found that:

> The behavior of organizations responsible for managing radioactive waste and the results they produce will be far more important in creating or inhibiting public trust and confidence than will be their organizational forms and structures (p. 38f).

Yet the question of organizational arrangements was high on the agendas of those who talked with us. Task Force deliberations were wide ranging and often involved intense, multiple contacts with stake holding groups, including Departmental contractors and those critical of the Department. Nearly all stake holders called for fundamental re-organization of the programs for managing commercial radioactive wastes. Without exception, their proposals reflected deep frustrations with the Department, in general, and OCRWM, in particular, leading them to conclude that the Department was neither managerially competent nor sufficiently removed from political pressures to do consistently rigorous technical work or to assure timely systems development. Almost without exception, their remedies involved removing the management of civilian wastes from the Department altogether. Declining public trust and confidence, it was argued, was related to the delays in program development, apparent managerial and public involvement blunders, and insufficient skill in overcoming or accommodating political opposition. In their views, other forms of management (e.g., a public corporation, an independent agency, or private contractor) would surely be better than the present arrangement.

Due to this steady drum beat of critique and proposals for major, potentially wrenching change, the Task Force felt it had to address this matter straight forwardly even though the question of major program re-organization was not in its charter. Indeed, some members of the panel are skeptical in general about major re-organization as a solution to internal managerial problems. Others held strong views about the need to change. But to ignore the issue or summarily dismiss it would have put the panel's credibility at risk.

We were dismayed to discover no systematic work examining the results of various program or agency re-organizations and the degree

to which they achieved the objectives so sought. Hence, we commissioned a general literature review and analysis of the last major study devoted to proposals for re-organizing DOE's civilian waste program (Thomas, 1993a, 1993b included in the Report's appendix).

The reviews and analyses were thorough and acute. They showed convincingly that there is at present no firm analytical or historical bases to support one form of government or program structure over another for managing programs involving high intrinsic hazard or for recovering public trust and confidence. Evidence is simply indeterminant.

Steps toward remedying this situation involve both consensus building among stake holders in the specification of the problems, and efforts to reduce the analytical deficit. The fact of this deficit does not mean that analytical work cannot be done. Nor does its absence give license to ignore the matter or treat the evolution of organizational arrangements solely as a question of political preference or power. Hence, the Task Force urges the Department to continue its initiatives both in consensus building and in analytical activities.

References.

Craig Thomas (1993a). "Reorganizing Public Organizations: Alternatives, Objectives and Evidence," Vol 3. Earning Public Trust and Confidence: Requisites for Managing Radioactive Waste, Task Force on Radioactive Waste Management, Secretary of Energy Advisory Board, Washington, D.C. December. (Published in Journal of Public Administration Research and Theory, Fall, 1993).

Craig Thomas (1993b). "AM-FM's Corporate Solution for Radioactive Waste Management: Appealing But Inappropriate." Vol 3. Earning Public Trust and Confidence: Requisites for Managing Radioactive Waste, Task Force on Radioactive Waste Management, Secretary of Energy Advisory Board, Washington, D.C. December.

fax file Dept of Education

THE WHITE HOUSE

WASHINGTON

February 9, 1994

MEMORANDUM TO RICHARD RILEY

FROM: KRISTINE M. GEBBIE, RN, MN for
NATIONAL AIDS POLICY COORDINATOR

SUBJECT: HIV/AIDS Talking Points for Upcoming Presentations

As I have mentioned in the past at the Domestic Policy Council and the Chiefs of Staff Meeting, it is critical in our fight against HIV/AIDS that all Cabinet level Secretaries speak openly for everyone in our nation to get involved. With that thought in mind, I looked through the calendar of public appearances by members of the Cabinet and saw that you will be making two presentations in the near future. The following are two points that I thought might be helpful in preparing your remarks. If you have any questions, or want additional information please feel free to contact me at 632-1090.

* It is essential that all of us assume responsibility for preventing the spread of HIV. After almost 13 years of this epidemic, with over one million infected Americans, it is incumbent on all of us to inform ourselves on how to protect our lives and the lives of those we care for. It is also our duty as educators, as the members of society entrusted with forming young lives, to use whatever means are available to us to educate young people about the risk.

* It is also important that we speak of preventing HIV in a non-judgmental fashion. After all, our goal should always be for young people to hear our message and learn to protect themselves. Statistics show that by age 20, 83% of young men and 77% of young women report having sex at least once. For our message to be effective, we must realize first that HIV/AIDS Prevention is not going to make everyone happy, but it is necessary for our students, it is necessary for our children.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Office of Disease Prevention and Health Promotion
Washington DC 20201

Plain Paper

Hazel O'Leary, Secretary
DOE

Dear Secretary O'Leary:

It has been my pleasure to serve as chair of the Dept of Energy's Environment, Safety & Health Advisory Committee. My ~~new~~ appointment as National AIDS Policy Coordinator makes it impossible for me ~~to~~ continue with the Committee, and I ask that you accept my resignation, effective immediately.

My departure from the ~~ESH~~ Committee does not mean an end to my interest in the

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Office of Disease Prevention and Health Promotion
Washington DC 20201

Dept of Energy's public health-related activities. If I can be of help in some other capacity, please let me know. ~~Best wishes to you.~~

Sincerely,

cc
Tara O'Toole, Asst Secy
Environment, Safety & Health
Members, ESHAC

TF members FYI
nearly the same as
last version

UNIVERSITY OF CALIFORNIA, BERKELEY

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DEPARTMENT OF POLITICAL SCIENCE
TEL: (510) 642-6323
FAX: (510) 642-9515

BERKELEY, CALIFORNIA 94720

February 10, 1994

RECEIVED
FEB 16 1994

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U.S. Department of Energy
1000 Independence Avenue, S.W.
Washington, D.C. 20585

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Most who raised the issue with the Task Force argued for change. But the panel concluded that analytical grounds were not sufficient for it to recommend a particular organizational arrangements either for recovering public trust and confidence or for improving program management. However, there may be other political or policy related grounds for considering major organizational changes. And this issue appears likely to be raised again. The Task Force believes it is prudent for the Department to initiate a rigorous, independent effort to address the matter before proposals for major changes are put forward by Congress or stake holding groups. (See the attachment for a brief rationale for our views.)

We urge you to initiate a full, independent examination of the organizational and institutional forms appropriate for the effective management of radioactive wastes. Its purpose should be, in part, to determine whether the political benefits of a major institutional change would be enough to warrant the costs when there are not yet strong analytical reasons to expect operational advantage.

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Professor of Political Science and
Chairman, SEAB, Task Force on Radioactive Waste Management

cc: George Scalise, Jake Stewart

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We were dismayed to discover no systematic work examining the results of various program or agency re-organizations and the degree

to which they achieved the objectives so sought. Hence, we commissioned a general literature review and an analysis of the last major study devoted to proposals for re-organizing DOE's civilian waste program (Thomas, 1993a, 1993b included in the Report's appendix).

The reviews and analyses were thorough and acute. They showed convincingly that there is at present no firm analytical or historical bases to believe that any one form structure, governmental or programmatic, is more likely than another to promote or recover public trust and confidence. There may be many other reasons to consider reorganization but strengthening public trust and confidence is not one of them.

Steps toward remedying this situation involve both consensus building among stake holders in the specification of the problems, and efforts to reduce the analytical deficit. The fact of this deficit does not mean that analytical work cannot be done. Nor does its absence give license to ignore the matter or treat the evolution of organizational arrangements solely as a question of political preference or power. Hence, the Task Force urges the Department to continue its initiatives both in consensus building and in analytical activities.

References.

Craig Thomas (1993a). "Reorganizing Public Organizations: Alternatives, Objectives and Evidence," Vol 3. Earning Public Trust and Confidence: Requisites for Managing Radioactive Waste, Task Force on Radioactive Waste Management, Secretary of Energy Advisory Board, Washington, D.C. December. (Published in Journal of Public Administration Research and Theory, Fall, 1993).

Craig Thomas (1993b). "AM-FM's Corporate Solution for Radioactive Waste Management: Appealing But Inappropriate." Vol 3. Earning Public Trust and Confidence: Requisites for Managing Radioactive Waste, Task Force on Radioactive Waste Management, Secretary of Energy Advisory Board, Washington, D.C. December.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

FEB 14 1994

NOTE TO SURAYYA RICHARDSON

SUBJECT: Designation of Property Custodians

In response to your telephone conversation with Sally Jones on February 3, I am submitting two names as Property Custodians at the HHH location and one at the 17th Street location. One person will handle ADP and one will handle furniture and non-ADP equipment at HHH. Following are the names:

Vesta Jones (ADP)
Computer Specialist
National AIDS Program Office
200 Independence Avenue, S.W.
Room 738G, HHH Building
Washington, D.C. 20201
Phone: (202) 690-6248

Sally Jones (furniture, non-ADP equipment)
Administrative Services Specialisst
National AIDS Program Office
200 Independence Avenue, S.W.
Room 738G, HHH Building
Washington, D.C. 20201
Phone: (202) 690-6248

Retina Holmes
Secretary
National AIDS Program Office
750 - 17th Street, N.W.
Suite 1060
Washington, D.C. 20503
Phone: (202) 632-1090

Arthur J. Lawrence, Ph.D.
Acting Director
National AIDS Program Office

THE WHITE HOUSE

WASHINGTON

February 15, 1994

MEMORANDUM

TO: Secretary Hazel O' Leary
Department of Energy

FROM: Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

SUBJECT: HIV/AIDS Talking Points for Upcoming Presentation

As I have mentioned in the past at the Domestic Policy Council and the Chiefs of Staff Meeting, it is critical in our fight against HIV/AIDS that all Cabinet level Secretaries speak openly of for everyone in our nation to get involved. With that thought in mind, I looked through the calendar of public appearances by members of the Cabinet and saw that you will be making a presentations in the near future at an African-American business leaders' meeting. The following are two points that I thought might be helpful in preparing your remarks. If you have any questions, please feel free to contact me at 632-1090.

* The Department of Energy recently made available previously classified files on the use of American citizens for research on the effect of radiation on human beings. This research, though deplorable, is not much different than research conducted by the federal government on African-American men in rural Alabama, the Tuskeggee Experiment. We are now living with the repercussions of that research project in our society, repercussions that include an inherent lack of trust in our public health system by minorities. This lack of trust has hampered our efforts to stop the spread of HIV.

* HIV/AIDS is like these experiments in that it affects the lives of those in our society that have traditionally lacked political power: minorities, women and gay men. Until as a society we begin to realize that the lives of each of our citizens is sacred, we will continue to abuse the trust of our fellow citizens and we will continue to see their lives as expendable. It is critical in the fight against HIV/AIDS and any other disease that disproportionately affects those without political power, that the role of government is not to increase their danger, but to protect care and build on that sacred trust.

DEPARTMENT OF ENERGY
Washington, DC 20585

February 15, 1994

MEMORANDUM FOR Kristine M. Gebbie
National AIDS Policy Coordinator

FROM: Corlis S. Moody
Director
Office of Economic Impact and Diversity

SUBJECT: Donald Donaldson

I am delighted that Don's efforts have been recognized, and he has already made the move to his new office space at the Department of Health and Human Services in the Hubert Humphrey Building.

Don is a great choice for your office, his space here is reserved when you have accomplished the mission.

I look forward to our continued partnership with you in support of this important initiative.

RECEIVED

FEB 28 1994

Printed with soy ink on recycled paper

FEB - 5 1991

THE WHITE HOUSE
WASHINGTON

Patsy —

Thought you'd be interested in this — covers my office staffing, starting with "inherited" staff & goes through other positions such as detailees, etc —

call me if you have questions —

Curtis

NATIONAL AIDS POLICY OFFICE
Staffing Elements
(2/16/94)

Of current NAPO staff those on duty on July 1, 1993:

Name:	Grade:
BART, Sandra	GS-15
FOOR, Ted	GS-12
FOX, Tim	CC-06
GELBERG, Iris	GS-15
HAZLETON, Nancy	CC-06
HOLMES, Retina	GS-10
JONES, Sally	GS-13
JONES, Vesta	GS-14
LAWRENCE, Arthur	CC-06
LITWINOWITZ, Alice	GS-14
MASSENBERG, Sandy	GS-11
MESSORE, Johanne	GS-13
MORAN, Robert	GS-14
RESIMONT, Bert	GS-07
SPEIGHT, Deborah	GS-07
WALTER, George	CC-06
WILLIAMSON, Karen	SIS/GS-5
WIRTH, Gretchen	SIS/GS-4

Career staff on PHS FTE added since July 1:

LEWIS, Lisa	GS-7/8
LLOYD, Katherine	GS-7/8

Non-career staff on PHS FTE added since July 1:

BARRER, Andrew	(Consultant - no cost to PHS; PHS FTE used)
BINGHAM, Claudia	(Consultant - off rolls 12/31)
GEBBIE, Kristine	(SES Exempt)
JACKSON, Robert	(Service Fellow)
LEE, Steven	(Consultant - expires 4/23)
MERRILL, Ben	(Consultant - off rolls 1/8)
VELEZ, Carlos	(Consultant - expires 10/1/94)

Non-career personnel accession actions in progress:

GURROLA, John	(Schedule C GS-11, press officer)
PAGE, Frances	(Service Fellow - Prevention)

Immediate actions needed, not yet approved:

Scheduler/Executive Assistant, GS-12/13
Senior Liaison Officer, GS-14/15 (External group liaison and Exec Sec for Presidential HIV Advisory Council)

Future actions, not yet approved:

Liaison Officer (NGO), GS-14
Liaison Officer (Budget/WH Affairs), GS-14

Personnel on duty at no cost to PHS and not PHS FTE:

ALWORTH, Lance	(Detail from SEC; HIV in the Workplace issues)
BESWICK, Terry	(IPA from Triangle Institute; research issues)
DONALDSON, Don	(Detail from Department of Energy; HIV education of federal workers)
SHAKER, Sam	(Detail from HCFA; health care reform issues - returns 2/18)
TRAN, Paul	(Detail from Department of Commerce, Patent Office; research issues)

Unpaid student interns:

CERRO, Marc	WH
DEAN, Tanya	WH
HANNAH, Amy	WH
HARRINGTON, Christopher	ONAP
LORD, Chad	ONAP
MEEUWISE, Chris	WH
PERKINS, Jeff	WH

Future accession of detailees at no cost/FTE expenditure (space required):

From:	Assignment:
Army/DoD	Research issues group member.
From DoD	Services issues group member.
From VA	Services issues group member.
Labor	Discrimination/ADA
Justice	Discrimination/ADA

Outplacements to other PHS agencies:

Name:	Recommended acquiring agency:
JONES, Vesta, GS-14	(information systems to FDA)
LAWRENCE, Arthur, 0-6	
LITWINOWITZ, Alice, GS-14	(health economist to AHCPR)
MESSORE, Johanne, GS-13	(research tech to NIH)
MORAN, Robert, GS-14	(Epidemiology/Planning to OHPE)

United States Department of State

Bureau of Oceans and International Environmental and Scientific Affairs

Washington, D.C. 20520

FACSIMILE

PAGES TO FOLLOW: 2

February 17, 1994

TO: Distribution (see attached list)

FROM: Ed Malloy, Acting DAS, Science, Technology and Health

SUBJECT: Follow-up to Tuesday, Feb. 15th interagency meeting on AIDS

MESSAGE:

Thank you for your participation in Tuesday's interagency meeting on AIDS. To summarize, it was agreed that five working groups will convene to develop strategy papers on key aspects of the HIV/AIDS issue. The main objective for each group is to identify ways in which the U.S. can leverage its efforts to stem the spread of HIV/AIDS. To following groups are identified:

1. Scientific research cooperation - chaired by HHS
   likely discussion items: how to broaden cooperation, how to more effectively utilize scarce resources

2. Prevention - chaired by Nils Daulaire, USAID
   likely discussion items: education, status of women, human rights

3. Diplomatic channels - chaired by John Boright, State/OES
   likely discussion items: available diplomatic fora, U.N., strengthening regional alliances, travel restrictions

4. U.S. security interests/concerns - chaired by CIA
   (name of group likely to change)
   likely discussion items: military concerns, including international peacekeeping forces, economic/commercial interests

5. Donor cooperation - chaired by Helene Gayle, USAID and will consist of the chairs of the four other groups.

In addition, the State Department has agreed to write the Preface to the document.

Fax to interagency group on AIDS (continued)

OES will follow the progress of the groups and will sit in on meetings as time allows. Groups 1 and 4: please inform Sharon Hemond (phone 647-4537) once a chairperson has been designated. Working group chairpersons are asked to make appropriate contacts to form their groups. The first draft of the five-part strategy paper should be prepared by COB March 28th. Please forward your submissions directly to Sharon Hemond. Mr. Wirth will schedule a second interagency meeting to discuss the draft. We are aiming for a date of April 1st and will keep you apprised.

To assist the working groups in their efforts, the following documents are being Express mailed to you or sent by courier:

1. The World Health Organization's "Global Strategy for the Prevention and Control of AIDS: 1992 Update"
2. Executive Summary of the World Bank's "World Development Report 1993: Investing in Health"
3. State Department White Paper "The Global AIDS Disaster: Implications for the 1990s"
4. "Time to Act!," a resource booklet published by the American Association for World Health
5. "HIV/AIDS: The Evolution of the Pandemic, the Evolution of the Response," published by USAID

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	re: Participants in Interagency Meeting on AIDS; [Partial] (1 page)	02/17/1994	P3/b(3)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 8302

FOLDER TITLE:
[Miscellaneous Memos and Correspondence - 1994] [loose] [1]

2018-0756-F
jp4860

RESTRICTION CODES

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

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

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RR. Document will be reviewed upon request.

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

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

Participants of February 15 interagency meeting on AIDS

	phone	fax
(b)(3)		
Mario DiStasio, DOL/OASP	202-219-6197	219-9216
Kristine Gebbie, White House	202-632-1090	632-1096
Nancy Hazleton, EOP/ONAP	202-690-5560	690-7560
Shelley Smith, Peace Corps	202-606-3765	606-3024
John Mazzuchi, OASD/HA	703-695-7116	614-3537
C.F. Tyner, US Army	301-619-7377	619-2982
Donald S. Burke, US Army	301-295-6414	619-6422
Shirley Jackson, Ed/OERI	202-219-2218	219-1966
Arthur Lawrence, HHS/OASH	202-690-6248	
Linda Vogel, HHS/OASH	301-443-1774	443-6288
Ken Bernard, HHS/OIH	301-443-9426	443-0742
Linda Reck, NIH/OAR	301-496-0357	402-7769
Ken Bridbord, NIH/FIC	301-496-2516	402-2056
Carol Lancaster, USAID	202-647-8578	647-1770
Helene Gayle, USAID	703-875-4494	875-4686
Nils Daulaire, USAID	202-647-8415	647-8595
(b)(3)		
Elinor Constable, DOS/OES	202-647-1554	647-0217
Ed Malloy, DOS/OES/STH	202-647-4075	736-7336
Prudence Bushnell, DOS/AF	202-647-4493	647-6301
Faith Mitchell, DOS/RP/POP	202-647-9718	647-8162
Sandra O'Leary, DOS/EAP	202-647-6904	647-7350
Sharon Hemond, DOS/OES/STH	202-647-4537	736-7336
Rich Bruno, DOS/OES/STH	202-647-9542	736-7351

[001]

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Caring Not Curing

"Hospice affirms life. Hospice provides support and care for people in the last phases of an incurable disease so that they might live as fully and as comfortably as possible. Hospice recognizes dying as a normal process whether or not resulting from disease. Hospice neither hastens nor postpones death." Hospice is not curative.

Hospice supports the belief that with appropriate care, and the ministry of a caring community sensitive to their needs, patients and their families may be free to attain mental and spiritual preparation for death .*

Hospice is not about dying. Our purpose is to make the most of living. Hospice makes every effort to help the terminally ill, by providing pain and symptom management, so the dying may live as fully as possible until death takes place.

**** The National Hospice Organization***

The Joseph Richey Hospice is a non-profit organization dedicated to caring for the terminally ill individual, primarily at home.

JRH is licensed by the State of Maryland, and is a member of the National Hospice Organization and the Hospice Network of Maryland .

The Joseph Richey Hospice provides highly skilled nursing/medical care 24 hours a day at home, in domiciliary facilities, nursing homes, and on an inpatient basis at Richey House.

Care Tailored to the Individual

JRH gives attention to the physical, emotional and spiritual needs of our patients and their families. Our staff and volunteers are trained to work with both home care and residential patients, offering comfort and companionship.

JRH offers an individualized care plan for each patient and expert training for caregivers, allowing most patients to remain at home.

Caring At Home

Home care provides a 24 hour a day care link for the home-bound terminally ill patient. Our staff trains family members so they may provide basic nursing care. Regular visitation by our nursing staff, social workers, volunteers and pastoral care team are essential components of our care link. Each care plan is approved by our hospice medical staff in consultation with the primary care physician.

Nursing Home Care

Home care services are available to nursing homes, mental health facilities, domiciliary institutions (including prisons) and group homes. Institutional care contractual arrangements are made between the care institution and JRH.

The Joseph Richey House Resident

Residential placement at Richey House is available for those who have no caregiver. Our Richey House patients are cared for by our medical/nursing staff at an ideal one to four staff to patient ratio. A team of 31 volunteer physicians supports our nursing staff. Social workers provide psychosocial counseling and bereavement guidance. Our pastoral care team offers spiritual support.

Bringing the Family Closer Together

We believe that the direct involvement of the patient and family members in the care and decision process is to be encouraged and supported. Richey House patients may be visited 24 hour a day, and children and pets are welcome. We encourage our home care patients to allow family, friends, pets and children to be part of dying as they are a part of living.

Patient Profiles

A Single Parent With HIV

Rose, a single parent of a young child, was diagnosed as HIV positive two years ago. She lives with her mother who cares for her and her child. JRH home care eases the grief and anxiety of Rose's child, provides expert nursing instruction to Rose's mother, and a 24-hour a day response to questions and crises. JRH home care means that Rose's mother has been able to grant her daughter's wish to die at home.

When Home is an Institution

Sue, a 25 year resident of a home for the mentally retarded, has terminal lung cancer which has involved several very confusing hospitalizations. When she entered the end stages of cancer her home contracted with JRH home care rather than send Sue to a critical care facility. JRH home care made it possible for Sue to remain at home until the day she died, surrounded by her friends and loved ones.

The Best Answer: Richey House

Mike's wife died suddenly of cancer. His children live far away and could only be home for mom's last week. After her death, Mike was alone, suffering from the disabling effects of a large malignant brain tumor.

Mike's son chose the Joseph Richey House for his father. Here Mike's pain was eased and he enjoyed a loving home for the last three months of his life. Without a caregiver at home, Mike found a safe haven as an inpatient at Richey House.

Our Caring Community

The Joseph Richey Hospice was begun in 1987 by Mount Calvary Church (Episcopal) and All Saints Sisters of the Poor. Conceived as a renewal of the original "charism" of All Saints founding sister, the church and convent founded JRH determined to offer love, comfort, pain relief and spiritual help to the dying.

To answer this need two 19th century rowhouses in downtown Baltimore were renovated to provide a 12- bed facility for those with no caregiver, whose terminal illness would result in death within a few months.

Richey House is a place where patients live their final days in peace and dignity surrounded by their family and friends.

In 1993, The Joseph Richey Hospice extended its services offering home care to the terminally ill who have a caregiver and who can be maintained at home.

Hospice is Affordable

Richey House and JRH home care are paid for by private insurance, Medicare, Medicaid and special arrangement for the uninsured. Our staff can help to assess what costs are covered.

Hospice is usually the least expensive means of providing quality care to the terminally ill, whether that care is provided at home, in a residential nursing or other care facility or as an inpatient at Richey House.

The generosity of our friends helps us care for needy patients with little or no financial support. Sliding scale rates are tailored to a patient's individual means. We make every effort to make care accessible to all, regardless of ability to pay.

Who is Eligible for Hospice?

Home care is provided to residents within the geographic boundaries of Baltimore City and most of Baltimore County. We accept residential patients (who have no caregiver) without regard to geographic boundaries.

Medical eligibility and residential placement is determined by the hospice medical staff and the patient's attending physician. A patient with a life expectancy of six months or less is medically eligible for hospice care. A patient with a life expectancy of less than three months, and who has no capable caregiver, is eligible for placement as a Richey House inpatient.

Volunteers are Needed

Whether as a homecare or a residential hospice volunteer, friends willing to comfort the dying are always needed. Our volunteers assist with caregiving and office tasks too.

Insurance reimbursements cover only a part of hospice home care or residential hospice. Our very survival has rested, and continues to rest, on the generosity of our friends.

We welcome your interest and time as a volunteer and appreciate your financial support.

All Saint's founder, Harriet Brownlow Byron was an innovator of her time, becoming one of the first to provide the "Florence Nightingale nursing method" to the needy.

Now, at the dawn of the 21st century, we are true to Mother Byron's vision. Hospice cares for the dying with love. Hospice eases suffering. Hospice comforts those in need.

Please call or write us to volunteer, or to make contributions.

Joseph

Richey

Hospice

820 North Eutaw Street
Baltimore, Maryland 21201

Telephone (410) 523-2150
Facsimile: (410) 523-1146

Joseph Richey Hospice

My Neighbor's Need
Is My Opportunity
To Serve

February 18, 1994

INTERVIEW SCHEDULED
FOR
KRISTINE GEBBIE
NATIONAL AIDS POLICY COORDINATOR

ONAPC STAFFER:	John Paul Gurrola
DATE/TIME OF EVENT:	March 1/10:00am - 10:30am
LOCATION:	Office of National AIDS Policy
ORGANIZATION:	Intergovernmental Health Policy Project
CONTACT:	Linda Demkovich 2021 K Street, NW Suite 800 Washington, D.C. 20006 (202)872-1445
PURPOSE:	Straight question and answer interview for "State Health Notes" and "State AIDS Reports"
OTHER PARTICIPANTS:	None
MEDIA COVERAGE:	"State Health Notes" and "State AIDS Reports"
REMARKS REQUIRED:	IHPP is interested in programs directed at the various population groups affected by AIDS and in the role of the states and the public health community in managing the virus and ministering to those who have it.
BACKGROUND:	"State Health Notes" is a biweekly publication that circulates to just under 2,000 subscribers in both the public and private sectors. "State AIDS Report" is published ten times a year and has about 300 subscribers. Both newsletters deal with health policy trends and innovations within state governments. The format of the interview is straight question and answer. You were featured in "State Health Notes" in December, 1992 when you were Washington State's health secretary. [SEE ATTACHED]

STATESIDE

DISCUSSIONS WITH HEALTH POLICYMAKERS FROM AROUND THE NATION

Gebbie: Strong Public Health System is Essential

As Washington State's health secretary, Kristine Gebbie has helped add a new dimension to the reform debate: the need to revitalize the public health system. Responding to that message, a 17-member Health Care Commission charged with drafting an ambitious universal access plan is recommending that the state's public health budget be doubled, to just under $500 million, as part and parcel of the broader restructuring. In an interview at the American Public Health Association's annual meeting last month, Gebbie talked about the emerging role of the public health community in the ongoing debate over health care financing and system reform. An edited transcript follows.

Q: Why has public health fared so well in the commission's proposals?

A: The commission is clear that members are not just dealing with financial access. In fact, its report includes a special section dealing with the public health infrastructure and recommending that funds for supporting it be doubled. The illness treatment system cannot be efficient and effective [without] a good public health system to back it up. We need to maintain safe drinking water and safe food supplies and ensure that kids get immunized and that TB gets controlled.

Q: Isn't a doubling of the public health budget an unusual step?

A: It's absolutely unique as far as we can tell. Even doubled, the percentage of money going into public health is only around 5 or 6 percent of the total. One member was fairly dramatic in pointing out that everybody had agreed that they wanted a good public health infrastructure but that without support for this funding, you are talking about balancing a $12 billion industry on a $200 million infrastructure and it just won't work.

Q: How will you spend the new money?

A: One activity would be to develop a good surveillance and assessment function to track what is going on—not just disease rates and outbreaks but also regarding the illness system. What care is the system buying and are we matching up resources to people who need the services? Another area would be to work with communities on policy development and implementation.

Q: Is that different from what the local health departments do now?

A: Yes. Many have had to become primary care providers. While public health people firmly believe in primary care, we are increasingly uncomfortable with the way money has been bled away from community prevention efforts. You only have to talk with somebody who is working with HIV infection to hear the agony of knowing you must provide treatment but feeling the frustration of not being out on the streets with enough community education and prevention.

Kristine Gebbie

People in emergency rooms are patching up kids with crushed heads, but the community has no money for a bicycle helmet promotion program. We have teen pregnancy programs that catch the moms only after they have a baby but no good aggressive teen health program to reduce early sexual activity or improve access to reproductive health services. We are sensitive to all of those gaps, but we just haven't had [the resources] to deal with them.

Q: How have TB and AIDS underscored the money problems?

A: We have one small county that at one point last year had 300 TB cases to track. They no more had the nursing staff to do that than fly to the moon. These [staffing shortages] are the result of a good 10 or 12 years of squeezing down the [budgets]. Then HIV came along and whatever new money came along had to go to that fight. That was certainly appropriate, but you put this huge new epidemic on top of an already tight system and it just crumbled.

Q: Do you think the economy will allow the new president to be any freer with public health spending?

A: I care less that we get some quintupling of the federal appropriation in the first year than that we quit artificially squeezing prevention and trying to pretend that the problems aren't there.

[President-elect Clinton] needs to have an administration that honestly owns the problems. If he is willing to get rid of the gag rule in the family planning program and get rid of some of the restrictions on HIV education because it might offend somebody, then that kind of liberated thinking, even with constrained resources, would be a help.

Q: So there are some very tangible things he can do to send the right signals?

A: Yes, but if he stops there it would be awful. Those early signals can't just be, "Well, I've taken care of the public health people, now I can forget them." It must be part of a plan that culminates in better financing.

Q: Such attention to public health requires an unusual relationship between the financing people and the public health people, doesn't it?

A: You absolutely have to see that they are an integrated part of a whole. It doesn't do any good to flap about the public health system if you don't fix the illness care system. But if you just fix paying for illness care, the whole system is going to collapse. Everyone has been distracted by the big bucks, and public health people have finally figured out that if we don't help solve the big bucks problem, we'll never get the other problems solved.

Q: On the broader issue of reform, what signals can Clinton send early on to indicate it's near the top of his agenda?

A: There are a couple of practical things he can do, like approving the Oregon waiver and getting HCFA stimulated to get out of the way of states on some of the other reforms they've proposed. That would be a message he takes reform seriously.

Q: Are you concerned that he seems to have backed away from his original play or pay plan?

A: I don't know how to interpret that. It may be that he discovered there are flaws in play or pay that he wasn't prepared to solve, [or] it may be that he backed off because it was costing him votes. You can construct a number of hypotheses. I am concerned that he doesn't fully understand the need for cost control and hasn't expressed that as firmly, but he did it far more so than his opponent.

Q: Have the public health issues changed much in, say, the last six or seven years?

A: We've been in a holding pattern for a decade in this country. We do little bits and pieces, and some states have done very creative things. But on the public health side of the enterprise, we have really made no spectacular gains in the last decade.

Q: There has been no progress?

A: I see progress at the local level. In Seattle, the number of kids who regularly wear a helmet while they bicycle has risen dramatically in a few years because of community-based prevention campaigns. We have made gains in immunization programs. We have done some effective HIV outreach. A number of communities have created alternatives to long-term care. Each of those pieces staggers on, on its own, though, instead of being part of a real system. We are all tired of pilot projects and would like to take what we've learned—which is a great deal—and say, "OK, let's just do it."

"On the public health side of the enterprise, we have really made no spectacular gains in the last decade."

Q: How difficult is it to persuade people of the importance of public health activities?

A: People who spend their lives analyzing medical costs seem to be the hardest sell, because they don't understand the kind of time frame and complexity it takes to look at community-based prevention projects. On the other hand, people committed to community-based projects have sometimes oversold their programs. They get so excited about them, they talk as if they could guarantee success.

Q: How does the time frame differ?

A: When you're weighing tradeoffs for specific treatments, you're looking at a closed system and any shift in the money is within that system. Is coronary artery bypass surgery a more cost-effective way of treating angina and blocked arteries than angioplasty? But if I spend $75,000 on a community-based bicycle helmet campaign, the money saved over the next year is [spread across] 15 different insurance plans that don't pay for a kid going through the emergency room. We don't have the data systems in place to show what the community got, and that's part of the struggle.

Q: Are there other examples?

A: The HiB vaccine for children is a moderately expensive vaccine that has taken a lot of energy to introduce. I have no doubt it's cost effective, and one measure is that pediatric hospitals in Washington now use pictures to teach medical students about babies with HiB meningitis. Until 2 or 3 years ago, they always had a patient who could be part of the teaching program. Again that doesn't translate to a real short-term cost savings and because public health works through networks and uses volunteers, you end up with 15 people who claim to be part of the success and who are. Unfortunately, that success just isn't as tangible.

Q: What are the lessons for public health activists?

A: Increasingly public health people are relearning that all politics is local and that whatever they would like to have happen in their state capital or in Washington D.C. depends on individual communities understanding it and telling their locally elected member of Congress and state legislators, "I want you to go take care of this for us." We can't wait for legislators to understand because, in many of these issues, the people are ahead of them. •CW

February 23, 1994

To: John Gurrola, Steve Lee
From: Lisa Bowleg, Linda Demkovich

The following is a list of some of the areas we hope to cover in our March 1 interview with Kristine Gebbie:

• A recent CDC report noted that in 1992 heterosexual contact replaced injection drug use as the leading cause of HIV transmission to women. How is the Administration responding to that news and to the fact the disease is spreading four times as fast in women as in men?

• A new NIH study found that AZT holds promise for stemming perinatal HIV transmission. While that's a hopeful development, some women's health advocates and AIDS activists say the zest with which the media covered that news is just another example of how women are viewed as vectors, that research on women with HIV for the sake of *women's* health is simply not a government priority. How do you respond?

• Several recent studies--including one by the GAO--have said that needle exchange programs show promise for reducing transmission of HIV among injection drug users. Still, needle exchange remains highly controversial. What's the Administration position on such programs?

• Substance abuse and its influence on risky sexual behavior continues to play a major role in HIV transmission, yet government appears to offer little in the way of treatment and prevention. How do you see the link between substance abuse/HIV transmission and what ideas do you have for eradicating it?

• Health policies are often said to be blind to the everyday realities of the people to whom they are targeted. In the case of HIV/AIDS, for instance, where those most likely to be affected are minority, poor, women and/or injection drug users, a policy that makes clinical trials more accessible might be futile if the disenfranchised have no transportation to get to the trials, no one to look after their children, etc. To what extent do you try to incorporate social support factors into your work and policies?

• It's been said that HIV/AIDS prevention messages sometimes end up stereotyping the groups they're meant to target. A PSA aimed at black urban men, for example, may support the impression that that population is more likely to contract the virus--and at the same time, that others are not at risk. How do you strike a balance between targeting special groups and getting the message out that anyone who engages in risky behaviors can contract the virus?

• You've long been a big booster of the public health community. What role should public health play in the AIDS epidemic--and how do you expect that role to change if the Administration's health reform plan becomes a reality?

• How, if at all, do you balance the money demands between research on the one hand and prevention and services to AIDS patients on the other?

• You said last fall that your job was to help government do a better job with AIDS. Are there any specifics you can cite to make the case that you've done your job well? And what are the biggest barriers to carrying out your mission?

February 25, 1994

INTERVIEW SCHEDULED
FOR
KRISTINE GEBBIE
NATIONAL AIDS POLICY COORDINATOR

ONAPC STAFFER:	John Paul Gurrola
DATE/TIME OF EVENT:	Monday, February 28 - 5:30pm
LOCATION:	Via telephone
ORGANIZATION:	UCLA Nursing
CONTACT:	Dan Gordon, Editor (310)670-0191
PURPOSE:	Interview for UCLA Nursing and to get background for the UCLA graduation commencement speech.
OTHER PARTICIPANTS:	None
MEDIA COVERAGE:	UCLA Nursing
REMARKS REQUIRED:	A ten to fifteen minute talk about your career as a public health official, the challenges you face in your current position, your views of nursing's role in the evolving health-care system, and your remembrances of the UCLA School of Nursing.
BACKGROUND:	Dan Gordon has interviewed you before.

January 11, 1994

Ms. Amy Hannah
White House AIDS Policy Office
Washington, D.C.

Dear Amy:

As a follow-up to our conversation this morning, I am requesting a 10-15 minute telephone interview with Kristine Gebbie. This would be for a profile of her to run in UCLA Nursing, a 32-page magazine published annually by the UCLA School of Nursing for its alumni, faculty and students as well as other interested parties, including legislators. The purpose of the article would be to highlight a successful graduate of the school (Ms. Gebbie earned her master's degree at the UCLA School of Nursing) and discuss her contributions to the field.

I would like to ask Ms. Gebbie to touch on her career as a public health official, the challenges she faces in her current position, her views of nursing's role in the evolving health-care system, and her remembrances of the UCLA School of Nursing. My deadline is Friday, ~~January 28~~. February 11

Please call me at (310) 670-0191 to let me know if we could schedule this interview. If so, I would also request that you send a copy of her C.V. and any press clippings that might provide useful background information in advance of the interview. I would also be interested in 1-2 photos, preferably showing her at work rather than a head-and-shoulders. My mailing address is P.O. Box 8097, Culver City, CA 90233-8097.

Thank you for your attention to my request. Let me know if you have any questions. I look forward to hearing from you.

fax (310) 670-0192

Sincerely,

Dan Gordon
Editor, UCLA Nursing