FOIA Number: 2018-0758-F

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Subgroup/Office of Origin: National AIDS Policy Office

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Subseries:

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Folder Title:
Correspondence - Todd Summers - Incoming - 3/99

Stack:	Row:	Section:	Shelf:	Position:
S	66	6	2	1

THE WHITE HOUSE

WASHINGTON

March 15, 1999

MEMORANDUM TO: Oval Office Operations, Office of the Vice President, Chief of Staff, Cabinet Affairs, Communications, Counsel to the President, Office of Policy Development, Intergovernmental Affairs, Legislative Affairs, National Security Council, Political Affairs, Presidential Personnel, Public Liaison, Scheduling, Staff Secretary, Office of Management and Budget

FROM: Charles F.C. Ruff
Counsel to the President

SUBJECT: REQUEST FOR DOCUMENTS

We have received a request for records and materials relating to certain individuals and entities. Please conduct a thorough and complete search of all your records -- whether in hard copy, computer form, or any other form -- for the following:

1. For the period July 1, 1994 through December 31, 1996, all materials referring or relating to communications or activities regarding an application to the Department of the Interior by the Sault Ste. Marie Tribe of Chippewa Indians to take land into trust for gaming purposes or by other means to develop a gambling casino in Detroit, Michigan.

2. For the period July 1, 1995 through December 31, 1996, any documents or objects referring or relating to communications or activities regarding an adoption ordinance of the Shakopee Mdewakanton Sioux (Dakota) Community under consideration by the Department of the Interior.

Every employee is responsible for searching his or her own files and records to ensure a comprehensive search. Each office head or Assistant to the President must certify that his or her staff has done a complete and thorough search.

In addition, if you believe that files from your office that have been sent to the Office of Records Management may contain responsive information, please advise us so that we may ensure that all responsive documents have been located.

All materials must be provided to Dimitri Nionakis (OEOB 479) by noon on Friday, March 26, 1999.

If you have any questions or anticipate any difficulty in meeting this deadline, please call Dimitri Nionakis at x65814.

SUMMERS, TODD A.
WHITE HOUSE OFFICE

DOMESTIC POLICY COUNCIL

736 JACKSON PL

U. S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
WASHINGTON, D.C. 20410-0001

March 2, 1999

THE SECRETARY
Mr. Todd Summers
Office of National AIDS Policy
808 - 17th Street, NW
8th Floor
Washington, DC 20006

Dear Mr. Summers:

Please join me for the next Community 2020 forum on March 23, 1999. This Community 2020 will be a special session that will focus on Appalachia and the unique problems facing this region. In addition to a panel of experts, we will also be screening a new documentary film on Appalachia, "American Hollow" by Rory Kennedy, which was previewed at the Sundance Film Festival. The forum will be held at the Department of Housing and Urban Development, 451 7th Street SW, at 5:00 p.m.

The Community 2020 series brings together dynamic leaders to explore the future of America's communities and regions: where they are headed and what they will be like in the next 25 years and beyond. We focus on tough issues facing neighborhoods and families today and discuss ways we can better prepare them to meet the challenges of tomorrow.

Our panel will focus on the history of transition in Appalachia's communities, their need and opportunities, and the most promising ways to effect change in partnership. The discussion will be followed by the screening of "American Hollow" which is the story of an Appalachian family struggling to survive in a disenfranchised and forgotten corner of America. The family lives in one of the poorest and most isolated parts of eastern Kentucky. Although life in the hollow proves extremely difficult and treacherous, "American Hollow" is ultimately a joyous, life-affirming exploration of the lives, hopes and dreams of a unique and distinctly American family.

This is the seventh in the series of Community 2020 seminars. Previous seminars have included discussions on: Jobs and the Economy; Race; Fair Housing; Public Safety; Education; and Homelessness.

Because seating is limited, please RSVP to 202-708-5029 or 800-647-4963, no later than close of business on Friday, March 19th. Please make plans to arrive early as the doors will open at 4:15p.m. I hope you will be able to join us for this very special Community 2020 session.

Sincerely,

Andrew Cuomo

OFFICE OF THE CLERK
UNITED STATES HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515-6601

JEFF TRANDAHL
CLERK

March 15 '99

Todd.

Great seeing you again. You should come up here for lunch (soon!).

Best wishes. Jeff

OFFICE OF Policy and PROGRAM DEVELOPMENT
Health Resources and Services Administration (HRSA)
HIV/AIDS Bureau

Charity H. Bracy, Special Assistant to the Director
Parklawn Building
5600 Fishers Lane, Room 7-20
Rockville, Maryland 20857
(301)443-6422 - Office
(301)443-3323 - Fax

FAX TRANSMITTAL SHEET

DATE: **March 17, 1999**

TO: **Todd Sommers**

AFFILIATION:
TELEPHONE:

FAX: **202-456-2438**
FROM: **Charity Bracy**

NUMBER OF PAGES: **14**

_____ACTION **_X_ PER OUR CONVERSATION** **_____AWAIT YOUR REPLY**
_____COMMENT **__FOR YOUR INFORMATION** **_____AS REQUESTED**
REMARKS:

Per your voice mail to John, here is the "draft" of the Tennessee state profile. This information has been sent to the respective states for corrections, etc so it is not ready for circulation. If you need any other information please let me know

Tennessee

State CARE Act Program Profile

CARE Act Funding History Since 1996

Fiscal Year	1996	1997	1998	Total
Title I	$0	$0	$0	$0
Title II (including ADAP)	$3,757,915	$5,736,623	$7,230,546	$16,725,084
ADAP	($547,955)	($1,830,152)	($3,205,877)	($5,583,984)
Title III	$0	$50,000	$97,444	$147,444
Title IV	$0	$0	$277,400	$277,400
SPNS	$0	$0	$0	$0
AETC	$73,944	$100,000	$100,000	$273,944
Dental	$10,047	$25,495	$17,435	$52,977
Total	**$3,841,906**	**$5,912,118**	**$7,722,825**	**$17,476,849**

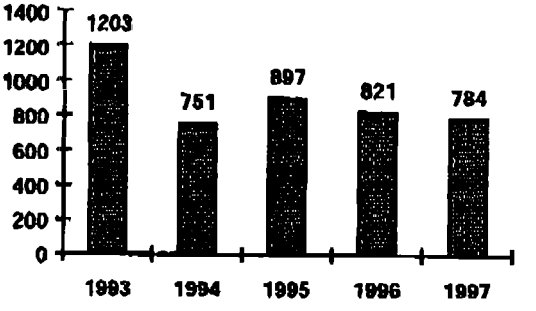
Number of CARE Act-funded Grantees in State (in addition to Title II and ADAP grants)

	1996	1997	
Title I	0	0	0
Title III	0	1	2
Title IV	0	0	1
SPNS	0	0	0
AETC (grantee or subcontractor)	1	1	1
Dental	1	1	1

HIV/AIDS Epidemic in the State: Tennessee (Pop. 5,368,198)

- Persons reported to be living with AIDS through 1997: 3,019
- Persons reported to be living with HIV infection (not AIDS) through 1997: 4,335
- State reporting requirement for HIV: Name-based reporting for HIV (initiated January 1992)
- State AIDS Cases (cumulative) since 1993: 4,456 (1% of AIDS cases in the U.S.)

- New AIDS Cases by Calendar Year, 1993-1997



Demographics of AIDS Cases Reported in 1997

	State-Specific Data	National Data
Men (13 years and up):	79%	78%
Women (13 years and up):	21%	22%

	State-Specific Data	National Data
<13 years old :	0%	1%
13-19 years old :	1%	1%
20+ years old :	99%	98%

	State-Specific Data	National Data
White:	39%	33%
African American:	59%	45%
Hispanic:	1%	21%
Asian/Pacific Islander:	0%	<1%
Native American/Alaskan Native:	0%	<1%

	State-Specific Data	National Data
Men who have sex with men (MSM):	44%	35%
Injecting drug user (IDU):	20%	24%
Men who have sex with men and inject drugs (MSM/IDU):	6%	4%
Heterosexual contact:	19%	13%
Other, unknown or not reported:	12%	24%

Pediatric Cases, by exposure category

	State-Specific Data	National Data
Hemophilia/coagulation disorder:	0%	<1%
Mother with/at risk for HIV infection:	100%	91%
Receipt of blood transfusion, blood components, or tissue:	0%	<1%
Other, unknown or not reported:	0%	8%

Co Morbidities

	State Cases per 100,000 Population	U.S. Cases per 100,000 Population
Chlamydia (1996)	250	194.5
Gonnorhea (1996)	223	124.0
Syphilis (1996)	16	4.3
TB (1997)	9	7.4

Statewide Coordinated Statement of Need (SCSN)

To enhance collaboration in HIV needs assessment and planning activities among CARE Act grantees and to maximize CARE Act resources statewide, Title II grantees were required to develop an SCSN by March 1998. SCSNs must include: a discussion of existing needs assessments; epidemiologic data; discussion of emerging issues in HIV care in the state; critical gaps in HIV medical and support services; and broad goals to address major service gaps.

- **Gaps:** programs for HIV-positive heterosexuals; comprehensive insurance coverage; transportation; housing; support groups in rural areas; access to HIV specialists; dental, nutrition, and vision services; respite care; alcohol/drug abuse treatment; physical therapy; holistic care; and burial support

- **Emerging Needs:** services for multiply-diagnosed, incarcerated, and adolescents; drug/alcohol abuse treatment; respite/adult day care; housing; employment services; health/financial planning; case management; and child care/foster care

State Medicaid Information

In 1998, Medicaid is estimated to have covered 55% of adults with AIDS and 90% of pediatric AIDS cases. Applying these percentages to the number of AIDS cases, at least 108,000 individuals with AIDS were covered by Medicaid in 1998.

Medicaid Income Eligibility Requirements

Eligibility Category	Income
Adult Aged/Blind/Disabled*	75% FPL
Pregnant Women	400% FPL
Medically Needy	23% FPL

*Income eligibility for State's ADAP program is 300% FPL.

Medicaid Prescription Drug Benefits Limits

Co-payment:	Yes
Limit on Rx per month:	No
Refill limit:	No
Quantity Limit:	No

Waivers

1115

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services broad authority to waive provisions in Title XIX, the Medicaid statute. Populations covered vary from waiver to waiver, as does the scope of coverage and the nature of the provider organization.

1115 waiver: Yes

Beneficiary groups: All Medicaid eligible persons are required to participate. Individuals unable to obtain health insurance due to existing health conditions; and uninsured individuals ineligible for an employer or government health plan and uninsured as of 7/1/94. Children in foster care and persons with chronic mental illness are not enrolled.

1915(b)

Section 1915(b) of the Social Security Act authorizes the Secretary of Health and Human Services to waive compliance with certain portions of the Medicaid statute that prevent a state from mandating that Medicaid beneficiaries obtain their care from a single provider or health plans.

1915(b) waiver(s): No

Title II: Tennessee

Title II funds are provided to States and Territories to improve the quality, availability and organization of health care and support services for PLWH. Since FY 1991, more than $1.9 billion in funding has been appropriated for Title II programs.

Funding History

Fiscal Year	1996	1997	1998	Total
Title II Formula Grant	$3,757,915	$5,736,623	$7,230,546	$18,571,961
ADAP (included in Title II grant)	($547,955)	($1,830,152)	($3,205,877)	($5,583,984)
Minimum Required State Match	$939,479	$1,912,208	$3,615,273	$6,466,960

Allocation of Funds

	1998
Health Care (State Only)	$5,559,177/77%
Home and Community Care	($0)
Health Insurance Continuation	($0)
ADAP/Treatments	($3,205,877)
Direct Services (State Only)	($2,353,300)
Case Management (State Only)	$0/0%
Consortia	$1,097,449/15%
Health Care*	($363,723)
ADAP/Treatment	($8,000)
Case Management	($451,019)
Support Services**	($274,707)
Administration, Planning and Evaluation (Total State/Consortia)	$573,920/8%

* includes: diagnostic testing, preventive care and screening, prescribing and managing medication therapy, continuing care and management of chronic conditions, and referral to specialty care.
** includes: counseling, direct emergency financial assistance, companion/buddy services, day and respite care, housing assistance, and food services.

Consortia Activities, FY 1997

Most States provide some services directly and others through subcontracts with Title II HIV care consortia. A consortium is an association of public and nonprofit health care and support service providers and community-based organizations that plans, develops and delivers services for people living with HIV disease.

Number of consortia in State: 5

Consortium Name	Location	Services Area	Funding, FY 1997
East/Northeast Ryan White Consortium	Telford		$157,600
Memphis Shelby County HIV & AIDS Care Consortium	Memphis		$365,600
Ryan White CARE Consortium, Region IV	Chattanooga		$112,600
Ryan White Community AIDS Partnership	Nashville		$415,200
West Tennessee Legal HIV/AIDS Consortium	Jackson		$75,000

Accomplishments

Clients Served (duplicated count), FY 1996:	7,260
Men:	77%
Women:	22%
Other, unknown or not reported:	1%

<13 years old:	4%
13-19 years old:	1%
20+ years old:	94%
Other, unknown or not reported:	2%

White:	54%
African American:	43%
Hispanic:	1%
Asian/Pacific Islander:	0%
Native American/Alaskan Native:	0%
Other, unknown or not reported:	2%

Men who have sex with men (MSM):	50%
Injecting drug user (IDU):	25%
Men who have sex with men and inject drugs (MSM/IDU):	0%
Heterosexual contact:	25%

4 Improved Patient Access:

- The CARE Act programs and the state's Medicaid managed care program (TENNCARE), have coordinated to establish an HIV Centers of Excellence program to improve access to state-of-the-art medical care and treatment. Most low-income and uninsured PLWH are able to access primary care and treatment through TENNCARE. Title II provides a "bridge" for those services during eligibility determination, and health and support services not available through TENNCARE to meet other needs and ensure continuity of care.

- The total number of Title II clients accessing primary health care, treatment, and support services increased 112% between 1995 (3,420 clients) and 1996 (7,260).

- Between 1995 and 1997, the total number of unduplicated clients accessing medications through ADAP, increased by more than 230 percent, from 180 to a total of 598 clients served during 1997.

- Client demographics include approximately 17% female, 52% African American, and less than 1% Hispanic or Native American. These figures are consistent with the overall epidemic within Tennessee.

- The ADAP formulary was expanded from 16 medications in 1996 to 24 in 1998.

- Five new medical case manager positions were funded in 1997, serving four predominately rural regions and the Nashville region, to facilitate improved access to primary medical and other health and support services.

4 Cost Savings:

- The ADAP participates in the Office of Drug Pricing's discount purchasing program for substantial cost savings.

4 Other Accomplishments:

- Information on the ADAP is routinely provided in the STD/HIV programs' quarterly newsletter, "The Messenger," and at the State's quarterly meeting of the Tennessee AIDS Council, composed of representatives of numerous HIV patient care and prevention education organizations.

AIDS Drug Assistance Program (ADAP): Tennessee

ADAPs provide medications to low-income PLWH with limited or no coverage from private insurance or Medicaid. ADAP is just one of multiple sources of public and private funding for HIV treatment, the largest source being Medicaid.

Funding History

Fiscal Year	1996	1997	1998	Total
Title II Funds	$547,955	$1,830,152	$3,205,877	$5,583,984
State Funds	$0	$0	$0	$0
Total	$547,955	$1,830,152	$3,205,877	$5,583,984

Program

- Administrative Agency: Dept. of Health
- Formulary: 24 drugs, 4 protease inhibitors, 5 other antiretroviral drugs.
- Medical Eligibility
  - HIV Infected: Yes
  - CD4 Count: No
- Financial Eligibility
  - Asset Limit: Yes
  - Income Cap: No
- Co-payment: No
- Enrollment cap: No
- Waiting list as of 10/98: No
- Waiting list for protease inhibitors as of 10/98: No

Clients Served

Clients enrolled, 10/98:	500
Number using ADAP each month:	169
Percent of clients on protease inhibitors:	30%
Percent of active clients below 200% of FPL:	85%

Client Profile, FY 1996

Men:	84%
Women:	16%

<13 years old:	0%
13-19 years old:	0%
20+ years old:	100%

White:	46%
African American:	54%
Hispanic:	0%
Asian/Pacific Islander:	0%
Native American/Alaskan Native:	0%

Title III: Tennessee

Title III provides funding to public and private nonprofit entities for outpatient early intervention and primary care services. Since FY 1991, $445.8 million has been appropriated for Title III programs.

Funding History

Fiscal Year	1996	1997	1998	Total
Number of Programs Funded in State	0	1	2	
Total Title III funding in State	$0	$50,000	$97,444	$147,444

Planning Grants

1998 - Chattanooga CARES - Chattanooga
1998 - Methodist Health Care-Haywood Park - Brownsville
1997 - Memphis Health Center - Memphis

Title IV: Tennessee

Title IV provides funding for the development and operation of family-centered systems of primary health care and social services for infants, children, youth, women, and mothers (including pregnant women) and also serves high-risk individuals affected by HIV due to their relationship to family members with HIV. Since FY 1991, $241.5 million has been appropriated for Title IV programs.

Funding History

Fiscal Year	1996	1997	1998	Total
Number of Funded Programs	0	0	1	
Total Title IV Funding	$0	$0	$277,400	$277,400

Title IV Grantees, FY 1998

Grantee Name	Location	Service Area	Type of Organization
Methodist Healthcare/Memphis Hospitals	Memphis		

AIDS Education and Training Centers: Tennessee

The AETCs are a network of 15 regional education centers (75 local performance sites covering all 50 states, Washington, D.C., Puerto Rico, and the Virgin Islands) funded by the CARE Act to train clinical health care providers, provide consultation and technical assistance and disseminate rapidly changing information for the effective management of HIV infection. Targeted providers are CARE Act-funded programs, federally funded community migrant health centers, and clinicians serving persons living with HIV infection. Since FY 1991, $171 million has been appropriated for AETC programs.

- Great Lakes to Tennessee Valley AETC
- States Served: Kentucky, Michigan, Ohio, Tennessee
- Primary Grantee: Wayne State University, Detroit, MI
- Subcontractors in State: Meharry Medical College - Nashville

Funding History

Year	1996	1997	1998	Total
Total AETC Funding for State	$73,944	$100,000	$100,000	$273,944

Training Highlights from FY 1997

- The AETC conducts HIV Mini Fellowships for Physicians, a one-week program of intensive training in prevention and care of HIV infection and its complications. The program includes small group lectures and discussions, interactive sessions and supervised patient care experiences. Participants gain experience in inpatient care by accompanying faculty on rounds. Outpatient care experiences involve seeing patients under the immediate supervision of faculty.

- The AETC's Case Management Certification Training Program involves four days of training and a certification examination. Topics covered include: medical update information; case assessment and care plan development, adherence, psychosocial issues, substance abuse and double and triple diagnosis, benefits, confidentiality and legal issues, partner notification, and prevention case management.

- Brown Bag Seminars are offered periodically for CARE Act-funded and other service agencies in the Cleveland area by the Ohio performance site. The one-to two-hour programs are offered during lunch hour to allow interested health care professionals to learn more about HIV care and prevention. Topics have included: quality of life issues for people living with HIV; post-exposure prophylaxis guidelines, people living with HIV-infection and substance abuse; viral load and new therapies; and HIV risk for African Americans.

- A Train-the-Trainer Program is conducted by the Kentucky performance site. The three-day training covers a variety of topics including: training techniques; legal and ethical issues; HIV diagnosis, progression, and transmission risk assessment; PHS treatment guidelines; managed care and its impact; adherence and post-exposure prophylaxis. Participants are certified through state health departments to provide two to four hours of HIV training in their facilities and communities and are provided training materials. They are required to attend a one-day update every two years.

- The Tennessee performance site's program, "Corrections and HIV/AIDS Issues" targets health care providers in the corrections system. Topics include: medical management of asymptomatic and early HIV disease; HIV and substance abuse; and the clinical manifestations and psychosocial issues of HIV.

HIV/AIDS Dental Reimbursement Program: Tennessee

The CARE Act HIV/AIDS Dental Reimbursement Program reimburses eligible dental schools and postdoctoral dental education programs for the reported, uncompensated costs of providing oral health care to PLWH. Since FY 1996 (when the program was first funded by the CARE Act), $22.2 million in funding has been appropriated for the program.

Funding History

Year	1996	1997	1998	
Number of Programs Funded in State	1	1	1	
Total HIV/AIDS Dental Reimbursement Program Funding in State	$10,047	$25,495	$17,435	$52,977

Accomplishments

Est. clients served, 1996:	67
Men:	87%
Women:	13%

<13 years old:	0%
13-19 years old:	0%
20+ years old:	100%

HIV/AIDS Dental Reimbursement Program Grantees, FY 1998

Grantee Name	Location
Meharry Dental School	Nashville

THE WHITE HOUSE

WASHINGTON

March 19, 1999

MEMORANDUM FOR BRIAN BARRETO
TODD SUMMERS
PAUL WEINSTEIN

FROM: ASHLEY RAINES

SUBJECT: NT 4.0 Roll-Out

Here is the memo from the Director of IS&T that I mentioned in my e-mail from Wednesday. It provides some basic information on the roll-out and what your staff can expect. The document outlines some steps staff must take if they have files on their hard drive that are not saved to the C:\WORK directory.

There is an attachment to the memo which gives a brief introduction to NT 4.0. IS&T is providing training for the new software that will be part of the NT 4.0 load and has included the training schedule in these materials. Please let me know if any of your senior staff need one-on-one training so we can schedule it in the next two weeks.

The OPD roll-out is currently scheduled to start March 29th and continue until mid-April. Please let me know if any of your staff would like to be in the first group or the last group for installation.

I recommend that you provide this document to all of your staff in order to ensure everyone has this information. Call me with any questions at x62023. Thank you.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF ADMINISTRATION
WASHINGTON, D.C. 20503

March 16, 1999

MEMORANDUM FOR OPD USERS

FROM: DOROTHY E. CLEAL Dottie Cleal
ASSOCIATE DIRECTOR.
INFORMATION SYSTEMS AND TECHNOLOGY DIVISION

SUBJECT: NT4.0 Roll out

As you know, IS&T is proceeding with the installation of NT4.0 to meet Y2K compliancy and provide enhanced functionality for the EOP community. The next phase of the installation will be executed by a contractor, TWD, and is scheduled to begin this week. I wanted to take this opportunity to pass on some preliminary information that I believe will be useful to you that will also address some of the concerns or questions some of you may have. I have also attached an NT4.0 fact sheet for your reference.

INSTALLATION SCHEDULE: A detailed schedule will be developed between representatives from your agency, IS&T and the contractor, but as of today, your agency's installation is scheduled to begin on or about March 29th, 1999.

INSTALLATION PROCESS AND WORK FILES: Briefly, the installation steps include the technician copying your C:\WORK data files up to the server, reformatting your PCs hard drive, installing the NT4.0 common software, and finally copying your work files back to the C:\WORK directory. This installation process is expected to take approximately one and a half hours, depending on the number of files copied up and back (this is the longest part of the process). I would suggest that if any work files are stored elsewhere on your hard drive, you move them to the C:\WORK directory under new sub-directories as this will 1) ensure they're not missed during the process, and 2) speed up the process.

SPECIAL FILES: If you have any critical or large files you are very concerned about, I recommend you consider backing them up on disk or to the network (especially if they're large). This is a 'just-in-case'.

WHAT'S ON THE NEW NT4.0 COMMON LOAD?: A new desktop that is Y2K compliant with a more friendly graphic look and feel, Microsoft Office, including Word, Excel, Access and PowerPoint.

SOME IMPORTANT CHANGES: All downloaded files will be saved to the WORK directory, user installed programs go into WORK directory only, single log-on/password synchronization, and you can change your screen size. Please note that All-in-1, Wordperfect, and Lotus 1-2-3 will not be available after Sept. 1, 1999.

NON-STANDARD SOFTWARE: You will be asked by your IS&T NT Coordinator to verify the continued use of any software you are currently using that is not part of the common load. In addition, licenses, purchase orders, media (CDS, disks) and Y2K compliance information will also be needed before the compliant software can be reinstalled on your NT4.0 PCs. Non-compliant software will not be installed on PCs. In the event of any questions, please be sure to contact your agency NT Coordinator, Jennifer Jones at X56469.

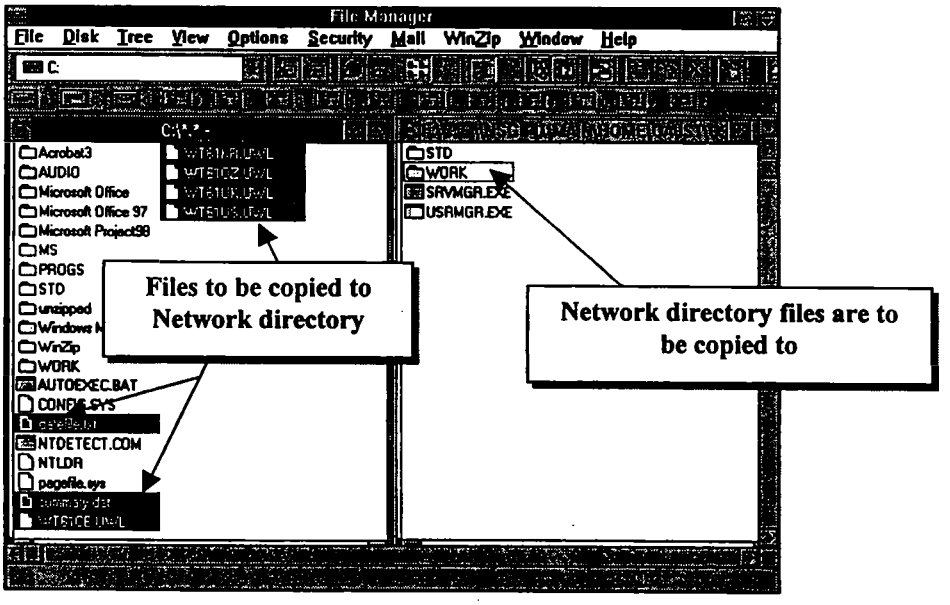
TIPS & INFORMATION: see attached sheet.

I hope I have addressed some of your immediate concerns. If you have any other questions or concerns, please address them to your agency contact or call Sheryl Hall, the NT4.0 Project Manager at X56460. I am also available to discuss this matter with your if needed and can be reached at X56401.

Attachment

1. **Directory Access:** You will **only** have access to save, delete, or create subdirectories (subfolders) in the "C:\WORK" directory (folder). You **will not** have access to save or delete files from any other directory (folder) on the hard drive. Current or new work files, data files, which are not located in your "C:\WORK" directory may not be backed up prior to the installation of the new load. Therefore, when the new load is installed data files stored elsewhere could be lost *forever*. The following are steps necessary to back up your files to the network:

   a) Open the file manager.
   b) Click on File, new on the menu bar to open another instance of the file manager.
   c) Click once on the "F" drive icon, then click in the other open file manager window.
   d) Click once on the "C" drives icon on the toolbar.
   e) Click on the first file or directory you want to save to the network.
   f) Hold down the Shift key and select the last file or directory you want to save to the network. Provided they are arranged one after another (contiguous). If the files or directory are not arranged one after another (non-contiguous), hold down the Ctrl key as you select them, by clicking on them once with your mouse.
   g) Drag the files over from the "C" drive to "F:\WORK". All files you want to keep should be saved to this network directory.



2. **Downloading Programs:** You will have minimal access to run, load or download non-standard programs. If the program has to write to the registry or place program or files in any other directories (folders) besides the work directory (folder), you will be unable to run or load the program.

3. **Printer Connection:** Primary printer connections will be restored during installation. Some remote printers will not be available immediately after installation. For access to those devices, please call the Help Desk at X5-7370.

4. **Screen Resolution:** Screen resolution is not supported above 1024 x 768. If you exceed this resolution your monitor will not work. Please call the Help Desk to put in a trouble call to place a trouble call on X5-7370.

5. **The Recycle Bin:** This will retain files of **up to 15%** of your total hard drive space until you empty the recycle bin. Once you exceed 15% of your total hard drive space, NT 4.0 **will permanently** delete that amount over 15%, starting with the oldest files first.

6. **DataBase:** In Lotus Notes 4.6, you will find a database called **Change Request**. This database is designed to log any problems you maybe experiencing with your NT 4.0 load and to provide quick user reference to problems, perhaps similar to what other users have experienced. To add this database to your Workspace at Office screen:

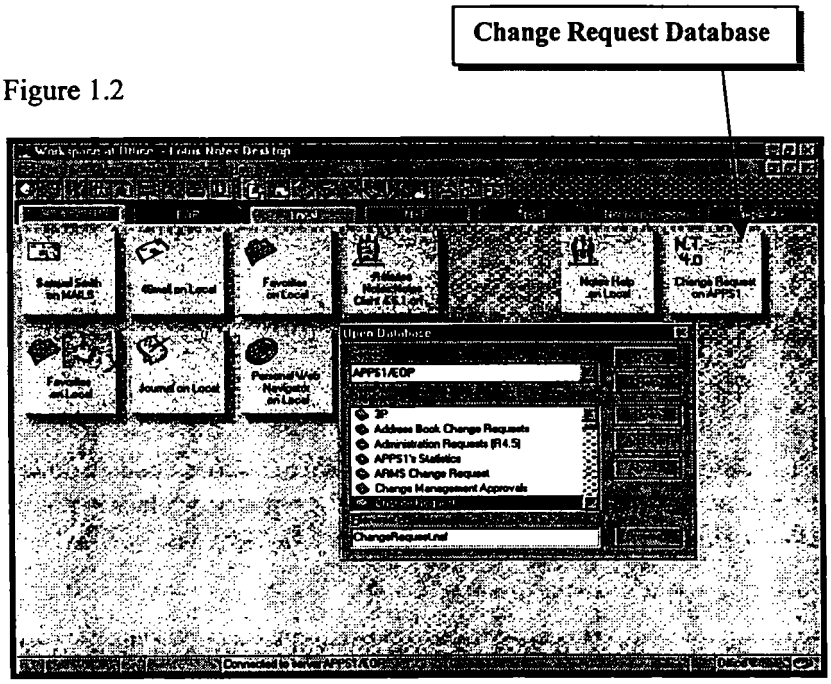
   a) Select File, Database Open from the menu bar.
   b) Change the server from local to Apps1/EOP.
   c) Click on the Change Request button on the power bar. Click on Done

   Once the database has been added to your Workspace at Office screen, double click its icon to open the database.

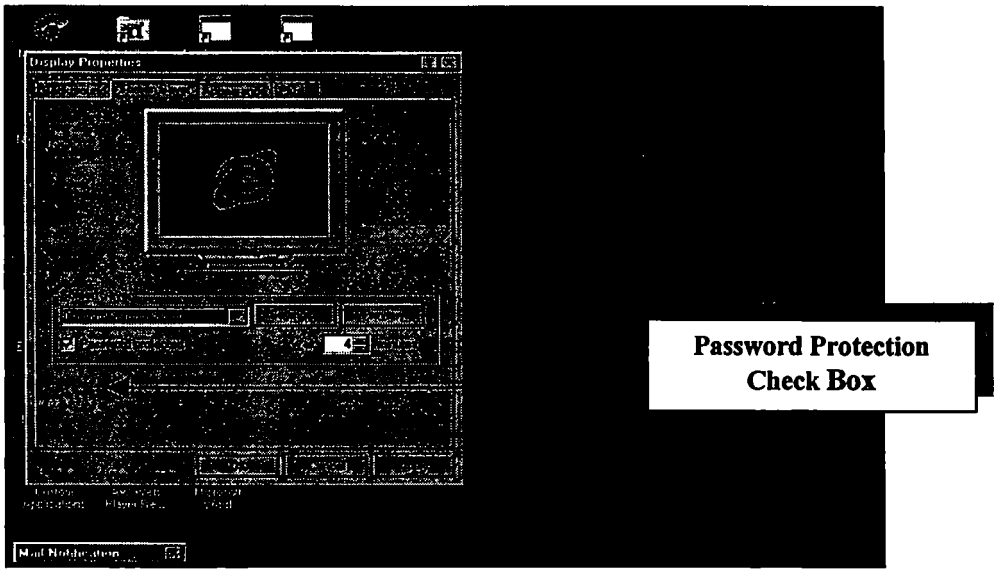
   a) To add a request select from the priority category.
   b) Click the New Request button to add an entry.
   c) Input your telephone number.
   d) And lastly input the problem you are experiencing with the load in the problem description field and then click Save, then Exit.

Figure 1.2 below shows the NT 4.0 Change Request on Apps1 being added to the Workspace at Office screen.

Figure 1.2



7. **Password Protection:** For security reasons, you are ***STRONGLY*** recommended to password protect your workstation. To do this Right click on the desktop, select Properties, then the Screen Saver tab in the Display Properties window and place a check in the Password Protected check box. Set the number of minutes you want your screen saver to activate the lock workstation feature. To unlock your workstation, hold the Ctrl + Alt keys down and press the Delete key and type in your NT logon password.



8. **Passwords:** Your username and password are important! Windows NT uses your username for identification and your password for verification. Based on your account, certain rights and privileges are assigned to you. Due to the sensitive nature of our work, everyone on the EOP network must have a valid account. Some simple Do's and Don'ts:

   - Do Change your password frequently (every 120 days)
   - Do use a mix of letters, numbers and special characters in your password.
   - Do notify the Security Office at (X5-6206) or the Help Desk at (X5-7370) if you believe your account has been compromised.
   - Do notify IS&T if you will be absent for longer than 90 days.
   - Do log out at the end of each workday.
   - Do not share your password with co-workers or any computer support staff.
   - Do not use any word (English or Foreign) as your password.
   - Do not use any "shared" or old accounts

   If you have any other security questions, please contact the EOP Information Security Officer, Jamie Borrego at x5-6297.

9. **Password Synchronization:** You have the option turning the password synchronization feature on, this feature is beneficial in two ways:

   1. Set your NT 4.0 password equal to your Lotus Notes password.
   2. Not require you to type in a password when you want to access Lotus Notes.

10. **Available Training:** Classroom, One-on-one, Computer Based Training (CBTs), Web Based Training (WBT), manuals and Quick Reference Guides for each applications are available. Registration for classroom training and web based training instruction is available by calling the Help Desk at X5-7370. Request for "one-on-one" training and Computer-Based Training is available by calling Samuel Smith at X5-6483.

Microsoft Office 97 Courses

Word 97 Excel 97 PowerPoint 97 Access 97 Project 98

OA/IS&T will be offering courses in Microsoft Word 97, Excel 97, PowerPoint 97, Access 97 and Project 98. Each class will be offered in a two-hour, compact and comprehensive session.

There will also be an "Microsoft QuickStart combination class" that will last approximately two hours to help start you on the road to using your new EOP NT 4.0 desktop. The curriculum will cover the differences between NT 3.51 and NT 4.0, and differences between WordPerfect 6.1 and Word 97, and a few other quick tricks and new options.

Classes will be offered in room 485 of the OEOB. Please contact the Help Desk at X5-7370 to schedule yourself for classes and to find out for any changes to the schedule, since the schedule will adjust according to demand. We look forward to seeing you in class.

	Monday	Tuesday	Wednesday	Thursday	Friday
10:00-12:00	MS QuickStart Combo	MS QuickStart Combo	**Intro ACCESS 97**	MS QuickStart Combo	**Intro PowerPoint 97 / Intro PROJECT 98**
1:00-3:00	**Intro WORD 97**	**Intro ACCESS 97**	MS QuickStart Combo	**Intro EXCEL 97**	MS QuickStart Combo
3:00-5:00	MS QuickStart Combo	MS QuickStart Combo	**Intro WORD 97**	MS QuickStart Combo	**Intro EXCEL 97**

NOTICE!

CURRENT NT 3.5 DESKTOP SOFTWARE IS BEING PHASED OUT!

WordPerfect 6.1, Lotus 1-2-3 ver.5, Lotus Approach and ALL-IN-1 will no longer be available as of September 1, 1999.

- Interim Date: August 1999
- Final day of availability: September 1, 1999

Runions
1403 McKenzie Ave
N'ville, TN 37206

Todd Summers, Deputy Director
Office of National AIDS Policy
736 Jackson Place, NW
Washington, D.C. 20503

3/21/99

Dear Todd—

I want to thank you for including me in your presentation at The Thomas Weaver AIDS Education Conference in Knoxville. It was very kind & generous of you. I had fun. Wish I hadn't been forced to leave so early. I enjoy your company. You do a great job at ONAP. I know it's hard work, but I feel safe here in TN knowing that you're there representing me.

— With gratitude, Bob Runions

THE WHITE HOUSE

WASHINGTON

March 30, 1999

MEMORANDUM FOR WHITE HOUSE STAFF

FROM: **CHARLES F.C. RUFF**
COUNSEL TO THE PRESIDENT

SUBJECT: **CONTACTS WITH AGENCIES -- A REMINDER**

The question of when and how it is appropriate for White House staff to contact Executive Branch or independent agencies about pending matters is an important and sensitive one, as is the question of how White House staff should deal with pending rulemaking proceedings. We have developed a set of rules and guidelines, summarized in the attached Memorandum circulated last November, that everyone must observe.

I want to emphasize two points in particular, because they have been the subject of some recent misunderstandings. First, we treat the Justice Department -- because of the sensitivity of its law enforcement functions -- differently from other Cabinet departments. Of course, you should not contact the Justice Department on pending investigations, prosecutions and civil litigation matters, or on the awarding of grants, but should direct any questions you have on these matters to the White House Counsel's office. Even on policy, legislative, and administrative issues involving the Department of Justice, however, you should check first with the Counsel's office, since such issues often touch on law enforcement or litigation matters. In short, where DOJ is involved, talk to the Counsel's office first.

Second, remember that the exclusive vehicle for participation by the Executive Office of the President in agency rulemaking proceedings is the Office of Information and Regulatory Affairs (OIRA), which is part of OMB. If you get a written communication from a member of the public about a pending rulemaking proceeding, you should forward it to the department or agency and to OIRA. You should not pass on to OIRA or to a department or agency any oral comments from members of the public. If anyone other than a federal employee asks to meet with you about a pending rulemaking proceeding, you must discuss with OIRA and the Counsel's office whether the meeting is appropriate and whether it must be made part of the rulemaking record.

Please review the enclosed Memorandum again and keep it for reference purposes. Do not hesitate to contact Dan Marcus, Cheryl Mills, or me if you have any questions.

THE WHITE HOUSE

WASHINGTON

November 24, 1998

MEMORANDUM FOR WHITE HOUSE STAFF

FROM: **CHARLES F. C. RUFF**
COUNSEL TO THE PRESIDENT

DANIEL MARCUS
SENIOR COUNSEL TO THE WHITE HOUSE COUNSEL

SUBJECT: **CONTACTS WITH AGENCIES**

This memorandum reiterates White House policies on contacts between White House Staff and federal agencies. Please review these policies and become familiar with them. A "quick reference" guide summarizing this memorandum is attached for your convenience. Do not hesitate to call the Counsel's Office if you have any questions.

BASIC PRINCIPLES

Some contacts between White House staff and federal agencies are permitted, and some are prohibited. Unless you are certain that a particular contact is permissible, consult with the Counsel's Office before making the contact. In general, the starting points for deciding whether a contact is appropriate will be:

- the type of agency involved (executive branch or independent), and
- the subject matter of the contact (policy or legislation, investigation or enforcement action, contract or grant, or rulemaking).

I. CONTACTS WITH EXECUTIVE BRANCH AGENCIES

Which agencies are covered by this section?

The principal Executive Branch agencies are the Cabinet Departments:

- The Departments of Agriculture, Commerce, Defense, Education, Energy, Health and Human Services, Housing and Urban Development, Interior, Justice, Labor, State, Transportation, the Treasury, and Veterans Affairs. Regulatory agencies within these Departments -- e.g., FDA, OSHA, the Surface Transportaion Board, and the Comptroller of the Currency -- are also covered.

Executive Branch agencies also include the Environmental Protection Agency, the Small Business Administration, the Equal Employment Opportunity Commission, and the Social Security Administration.

Boards and commissions are generally considered Executive Branch agencies if their members are appointed, and removable without cause, by the President.

As discussed in Section II, separate policies apply to contacts with so-called "independent" agencies, such as the FCC, the FTC, the CFTC, and the SEC.

Policy, legislation and administrative matters

General Rule: White House staff may communicate with Executive Branch agencies about policy, legislation or administrative matters.

Special Rule for DOJ: Because policy, legislative and administrative issues at the Department of Justice may touch upon law enforcement or other litigation-related matters pending at the Department, you should advise the Counsel's Office before you commence communications with DOJ on **any** subject, including policy matters. Once our office has agreed that your contact with DOJ on a particular subject is appropriate, you need not later inform us of subsequent communications on the **same** matter.

Special Rule for the IRS: Because of the sensitive investigation and enforcement powers of the IRS, and the confidential personal information the IRS handles, it is White House policy that **no member of the White House Staff should have any communication of any type with the IRS without prior approval of the Counsel,** except on their own tax matters. Note that any communication about tax policy or legislation normally can be directed to the Assistant Secretary of the Treasury for Tax Policy rather than the IRS.

Investigations, enforcement actions and adjudications

White House staff should **not** contact Executive Branch agencies concerning investigations, enforcement actions, or adjudications. This prohibition means White House staff should not ask an agency even for a status report about a pending matter of this type, or ask an agency official to meet with a private party or Member of Congress to discuss such a pending matter.

-- "Investigations" are matters related to investigating or reviewing potential or actual administrative, criminal, or civil charges for alleged violations of law or regulations by specific individuals or entities.

-- "Enforcement actions" are matters related to pursuing administrative, criminal, or civil charges for alleged violations of law or regulations by specific individuals or entities.

-- "Adjudications" are matters decided at an administrative or judicial hearing, or other proceeding, in which a department or agency determines the rights of particular individuals or entities. **Licensing decisions should be treated as adjudications.**

While there may be rare, special circumstances when it is appropriate for the White House to communicate with an agency about a pending investigation, enforcement action, or adjudication, only the Counsel's Office should undertake such communications. In the case of the Justice Department, any such communication must be initiated by the White House Counsel, the Deputy Counsels, or the Senior Counsel. There may be other matters in which the White House is participating directly (for example, civil litigation involving the Freedom of Information Act or other EOP decisions). The Counsel's Office will advise on a case-by-case basis regarding appropriate contacts in these types of matters.

Outside inquiries: If you receive a written or oral inquiry or request from an outside party -- including a Member of Congress -- concerning an investigation, enforcement action, or adjudication pending at an Executive Branch agency, **contact the Counsel's Office for guidance on how to proceed.** Normally, it will be appropriate to cite general White House policy against contacts on such matters, and to suggest that any inquiries concerning the pending matter be made directly to the relevant agency, if appropriate.

Contacts *from* agencies: By the same token, if anyone at any Executive Branch agency contacts you about any pending investigation, enforcement action, or adjudication (other than a routine background check), you should promptly advise the Counsel's Office, which will determine how to proceed and will report back to you as appropriate.

Contracts and grants

Many if not most government contracts and grants are awarded by Executive Branch agencies on the basis of competition or objective criteria specified by statute or regulation. In such cases, the rule of **no contact** described above for investigations, enforcement actions, and adjudications applies. Pure status inquiries may be permissible, but you should check first with the Counsel's Office.

In other cases, an Executive Branch agency may have discretion to determine the recipient of a grant on the basics of policy choices. In such cases, White House staff who wish to contact an agency about the grant should seek advice from the Counsel's Office as to whether the contact is appropriate.

In no event, however, should a White House staff member contact an Executive Branch agency about a contract or grant matter in which the staff member (or a relative, friend, or business associate of the staff member) has a personal financial interest.

Rulemaking matters

1. Status checks are generally permitted: White House staff may contact Executive Branch agencies regarding a pending rulemaking matter if the purpose of the communication is not to influence the outcome of a pending rulemaking proceeding (e.g., a status inquiry). You should state at the outset of the contact that you do not wish to influence the merits or the timing of the agency's decision, but merely are seeking information on its status.

2. Other contacts must be cleared in advance with your supervisor: If the purpose of the contact is to influence the outcome of a pending rulemaking, White House staff should, **prior to making the contact,** (a) obtain approval from the Assistant or Deputy Assistant to the President who is their principal supervisor, and (b) coordinate the contact with the Administrator of OIRA, who will advise on the appropriateness of the contact.

3. No "passing on" oral comments from outsiders: Input from the public -- that is, persons not employed by the Executive Branch, Congress, or the federal judiciary -- must be submitted in writing if it is to be incorporated into the rulemaking process. Thus, White House staff should not communicate non-written comments **from the public** to agencies, OIRA or anyone else involved in the rulemaking process. White House staff should forward oral comments **from Members of Congress or other federal employees** to the Administrator of OIRA.

If anyone other than a federal employee asks to meet with you regarding a pending rulemaking, or if you are considering organizing an outreach meeting with the public on a policy initiative that involves a pending rulemaking, you should **coordinate with the Administrator of OIRA and with the Counsel's office.** They will determine whether the meeting can occur and whether it must be made part of the administrative record.

4. Forward written comments from outsiders: You should forward any written communications from the public, or Members of Congress or other federal employees, on pending rulemaking to the relevant department or agency for inclusion in the public docket. A copy of any such written communications should also be forwarded to the Administrator of OIRA.

II. CONTACTS WITH INDEPENDENT AGENCIES

Which agencies are covered by this section?

Congress has created a number of so-called independent agencies. These agencies are called "independent" because of the quasi-judicial powers they have been delegated by Congress, and because commissioners or board members are removable by the President only for specific "cause."

The principal independent agencies are the Federal Communications Commission, the Federal Trade Commission, and the Securities and Exchange Commission.
Other independent agencies include:

Commodity Futures Trading Comm.
Consumer Product Safety Comm.
Federal Deposit Insurance Comm.
Federal Election Comm.
Federal Reserve Board
National Credit Union Administration
National Labor Relations Board
National Transportation Safety Board
Occupational Safety and Health Review Comm.
United States International Trade Comm.

Investigations, enforcement actions, adjudications, contracts and grants

White House staff should **not** contact any independent agency concerning a pending investigation, enforcement, action or adjudication. The same rule applies to contracts and grants.

Refer any inquiries concerning an investigation, enforcement action, adjudication, contract, or grant at an independent agency to the Counsel's Office.

While there may be rare, special circumstances when it is appropriate to communicate with an independent agency about an investigation, enforcement action, contract, or grant, **only the Counsel's Office may undertake such communications.**

Rulemaking proceedings

Congress has assigned certain rulemaking jurisdiction to independent agencies such as the FCC and the SEC. White House staff should **not** communicate with independent agencies about rulemaking matters without specific, advance approval from the Counsel's Office. Even checks are not permitted without advance approval.

Refer any inquiries concerning rulemaking by an independent agency to the Counsel's Office.

Policy, legislation, and administrative matters

Any other communications with independent agencies, including discussions of policy or legislation, should be approved in advance by the Counsel's Office to ensure that the communication is appropriate and that no special rules apply. (Advance approval can be provided for categories of contacts.) The sole exception to this policy is communication on routine administrative matters (e.g., obtaining an address or phone number, or requesting publicly available documents).

WHITE HOUSE CONTACTS POLICY: A QUICK SUMMARY

CONTACTS WITH EXECUTIVE BRANCH AGENCIES

TYPE OF CONTACT	GENERALLY PERMITTED?	STEPS TO TAKE
Contact executive branch agency about policy, legislation or administrative matter	Yes (except for IRS)--but advise Counsel's Office before contact with DOJ	No need to consult with Counsel's Office prior to contact (but advise Counsel's Office before contact with DOJ)
Contact executive branch agency about investigation, enforcement action, adjudication, contract or grant	NO	Seek guidance from the Counsel's Office. Refer written or oral inquiries about such matters to the Counsel's Office.
Contact executive branch agency about a rulemaking for purpose of influencing outcome of a rulemaking proceeding.	YES (except for IRS), IF prior approval of White House supervisor and the Administrator of OIRA. But do not "pass on" comments from outsiders, except when outsider comments are in writing. Send such written comments to the relevant agency for inclusion in the public docket, with a copy to OIRA. Coordinate meetings with outsiders about pending rulemaking through OIRA and White House Counsel. And advise Counsel's Office before contact with DOJ.	Obtain prior approval of the Assistant or the Deputy Assistant to the President who supervises you, and the Administrator of OIRA. NOTE: White House staff may not forward to agencies non-written comments from members of the public on rulemaking matters. Written comments should be forwarded to Administrator of OIRA.
Contact executive branch solely for status report on pending rulemaking proceeding.	YES (except for IRS)	No need to consult with Counsel's Office prior to contact (but advise Counsel's Office before contact with DOJ)

CONTACTS WITH INDEPENDENT AGENCIES

TYPE OF CONTACT	GENERALLY PERMITTED?	STEPS TO TAKE
Contact independent agency about investigation, enforcement action, adjudication, contract or grant	NO	Refer any inquiries about such matters to the Counsel's Office.
Contact independent agency about rulemaking matter	NO	Refer any inquiries about such matters to the Counsel's Office
Contact independent agency about policy, legislation or administrative matter	NO, unless approved in advance by White House Counsel's Office	Consult with White House Counsel's Office before any such contact. (Sole exception is routine administrative matters -- e.g. obtaining public documents or phone nos.)

Executive Branch Agencies

Department of Agriculture
Department of Commerce
Department of Defense
Department of Education
Department of Energy
Department of Health and Human Services
Department of Housing and Urban Development
Department of Interior
Department of Justice
Department of Labor
Department of State
Department of Transportation
Department of Treasury
Department of Veterans Affairs
Equal Employment Opportunity Commission
Environmental Protection Agency
Small Business Administration
Social Security Administration

Independent Agencies

Federal Communications Commission
Federal Trade Commission
Securities and Exchange Commission
Commodity Futures Trading Commission
Consumer Products Safety Commission
Federal Deposit Insurance Corporation
Federal Election Commission
Federal Maritime Commission
Federal Reserve Board
National Credit Union Administration
National Labor Relations Board
National Transportation Safety Board
Nuclear Regulatory Commission
Occupational Safety & Health Review Comm.
U.S. International Trade Commission

SUMMERS, TODD A.
WHITE HOUSE OFFICE

DOMESTIC POLICY COUNCIL

736 JACKSON PL

FUNDERS CONCERNED ABOUT AIDS

Mobilizing Philanthropic Leadership and Resources in the Fight Against HIV/AIDS

Fred Silverman
Chair
Formerly of
Apple Computer, Inc.

Nick Bollman
Vice Chair
The James Irvine Foundation

Vivian L. Beetle
Treasurer
Hoffmann-La Roche Inc.

Stuart Burden
Secretary
John D. & Catherine T. MacArthur Foundation

Joyce Bove
Chair Emeritus
The New York Community Trust

Paul A. Di Donato
Executive Director

Board of Directors:

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Karen Brosius
Philip Morris Companies Inc.
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Stephen Foster
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David Gould
United Hospital Fund
Kimberly A. Hamilton
The Howard Gilman Foundation
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The St. Louis Community Foundation
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Vincent McGee
The Irene Diamond Fund
Len McNally
The New York Community Trust
Karen Menichelli
The Benton Foundation
Carmen Price
United Way of New York City
Ruth Shack
Dade Community Foundation
Judy Spiegel
California Community Foundation
Lynn Stekas
Mutual of New York Foundation
Peter Teague
Tides Foundation/Colin Higgins Foundation
Richard Turner
People's Energy Corporation
Betty Wilson
The Health Foundation of Greater Indianapolis, Inc.

50 East 42nd Street
19th Floor
New York, NY 10017
Tel 212.573.5533
Fax 212.949.1672

March 23, 1999

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

RE: URGENT MAILING LIST UPDATE--RESPOND BY APRIL 15.

Dear Todd:

We recently sent you a letter requesting that you update your contact information and we have not heard back from you. Please take a moment to review how we have listed you in our mailing list. If there are corrections, please note them next to the current information. Also, please note if you have an email address and/or if your organization has a website.

As you know, FCAA's primary audience is the private grantmaking community. We have a strict policy of confidentiality concerning our mailing list. Aside from information sharing on substantive HIV/AIDS issues, we do not provide this mailing list information to external organizations.

Thank you for verifying this information and for your prompt response. **Please respond no later than April 15, 1999**. You can call us at 212-573-5533 if you have any questions, fax us at 212-949-1672, or email: earl@fcaaids.org.

Do you wish to remain on our mailing list? Yes ___ No ___

First Name: Todd
Last Name: Summers
Title: Deputy Director
Organization: Office of National AIDS Policy
Address: 736 Jackson Place, NW

City: Washington
State: DC
Zip: 20503 **Country:** USA
Telephone: 202-456-2437
Fax: 202-456-2438
Email:
Website: www.whitehouse.gov/ONAP

Is your organization involved in international HIV/AIDS grantmaking and/or interested in receiving information on international HIV/AIDS issues? Yes ✓ No ___

Affiliation:

Private Foundation___ Corporate Foundation/Giving Program ___

Community Foundation___ Health Conversion Foundation___ Affinity Group___

Family Foundation___ CDC BRTA/LRTA Member___ Individual___

Nonprofit/NGO___ Government/Public Agency ✓ RAG___

Press/Media___ Presidential HIV/AIDS Advisory Council___

Other (please specify)_____

APIAHF

Thanks Todd!
Ignatius

March 16, 1999

Kevin DeCock, M.D.
Division of HIV/AIDS Prevention – Surveillance and Epidemiology
Centers for Disease Control and Prevention Mail Stop D-21
1600 Clifton Road N.E.
Atlanta, GA 30333

Dear Dr. DeCock:

Thanks again to you and Dr. Fleming for leading the discussion of surveillance issues for Asians and Pacific Islanders and Native Americans at the CDC HIV prevention consultants meeting in Washington, DC last week. We were pleased with the identification of issues and the follow-up discussion about potential solutions. As promised, I am enclosing copies of the additional overheads about Asian and Pacific Islander populations that I used in my presentation.

As you know, Chad Martin was able to arrange an affinity session at the Community Planning Leadership Summit next week on Asian and Pacific Islander and Native American surveillance issues (on Friday from 5-6PM). We look forward to working with the CDC, CSTE and NASTAD to continue to discuss these issues at such venues, especially with some of the health departments that are less responsive. We also are confident that the project officers from the Community Assistance, Planning and National Partnerships Branch can be critical in assisting the health departments in improving their collection, analysis and dissemination of relevant surveillance data.

We also look forward to working with you on planning a session at the surveillance coordinators meeting in June. Please let us know how we can assist you in that planning.

I look forward to seeing you again next week in Pittsburgh.

Sincerely,

Ignatius Bau

Ignatius Bau
Policy Director

Encl.
cc: Dr. Patricia Fleming, CDC MS E-47
Dr. David Holtgrave, CDC MS E-35
Dr. Sam Dooley, CDC MS E-58
Todd Summers, Office of National AIDS Policy
Ron Rowell, Vince Sanabria and Paul Bouey, NNAAPC

942 Market Street
Suite 200
San Francisco CA 94102
415•954•9988
Fax 415•954•9999
E-mail: hforum@apiahf.org
http://www.apiahf.org

Asian & Pacific Islander American
Health Forum
National Advocates for Asian & Pacific Islander Health

Table US–T1

United States Population by Race and Ethnicity For 1990 and 1980

Race / Ethnicity	Total United States Population 1990	Total United States Population 1980	1980 to 1990 Number Increase	1980 to 1990 Percent Increase	Percent Total U.S. Population 1990	Percent Total U.S. Population 1980
Non–Hispanic White	188,128,296	180,602,838	7,525,458	4.2%	75.6%	79.7%
African American	29,986,060	26,482,349	3,503,711	13.2%	12.1%	11.7%
Native American Indian, Eskimo, Aleut	1,959,234	1,534,336	424,898	27.7%	0.8%	0.7%
Asian and Pacific Islander American	7,273,662	3,726,440	3,547,222	95.2%	2.9%	1.6%
Chinese	1,645,472	812,178	833,294	102.6%	0.7%	0.4%
Filipino	1,406,770	781,894	624,876	79.9%	0.6%	0.3%
Japanese	847,562	716,331	131,231	18.3%	0.3%	0.3%
Asian Indian	815,447	387,223	428,224	110.6%	0.3%	0.2%
Korean	798,849	357,393	441,456	123.5%	0.3%	0.2%
Vietnamese	614,547	245,025	369,522	150.8%	0.2%	0.1%
Hawaiian	211,014	172,346	38,668	22.4%	0.1%	0.1%
Laotian	149,014	47,683	101,331	212.5%	0.1%	**
Cambodian	147,411	16,044	131,367	818.8%	0.1%	**
Thai	91,275	45,279	45,996	101.6%	**	**
Hmong	90,082	5,204	84,878	1631.0%	**	**
Samoan	62,964	39,520	23,444	59.3%	**	**
Guamanian	49,345	30,695	18,650	60.8%	**	**
Tongan	17,606	6,226	11,380	182.8%	**	**
Other Asian & Pacific Islander	326,304	63,399	262,905	414.7%	0.1%	**
Hispanic*	21,113,528	13,935,827	7,177,701	51.5%	8.5%	6.2%
Non–Hispanic Other Race	249,093	264,015	(14,922)	–5.7%	0.1%	0.1%
TOTAL U.S. POPULATION	248,709,873	226,545,805	22,164,068	9.8%	100.0%	100.0%

* "Hispanic" includes those of "White" and "Other" races; Hispanic Origin does not include those of the other three races as it is negligible.
** Signifies less than one–tenth of one percent.

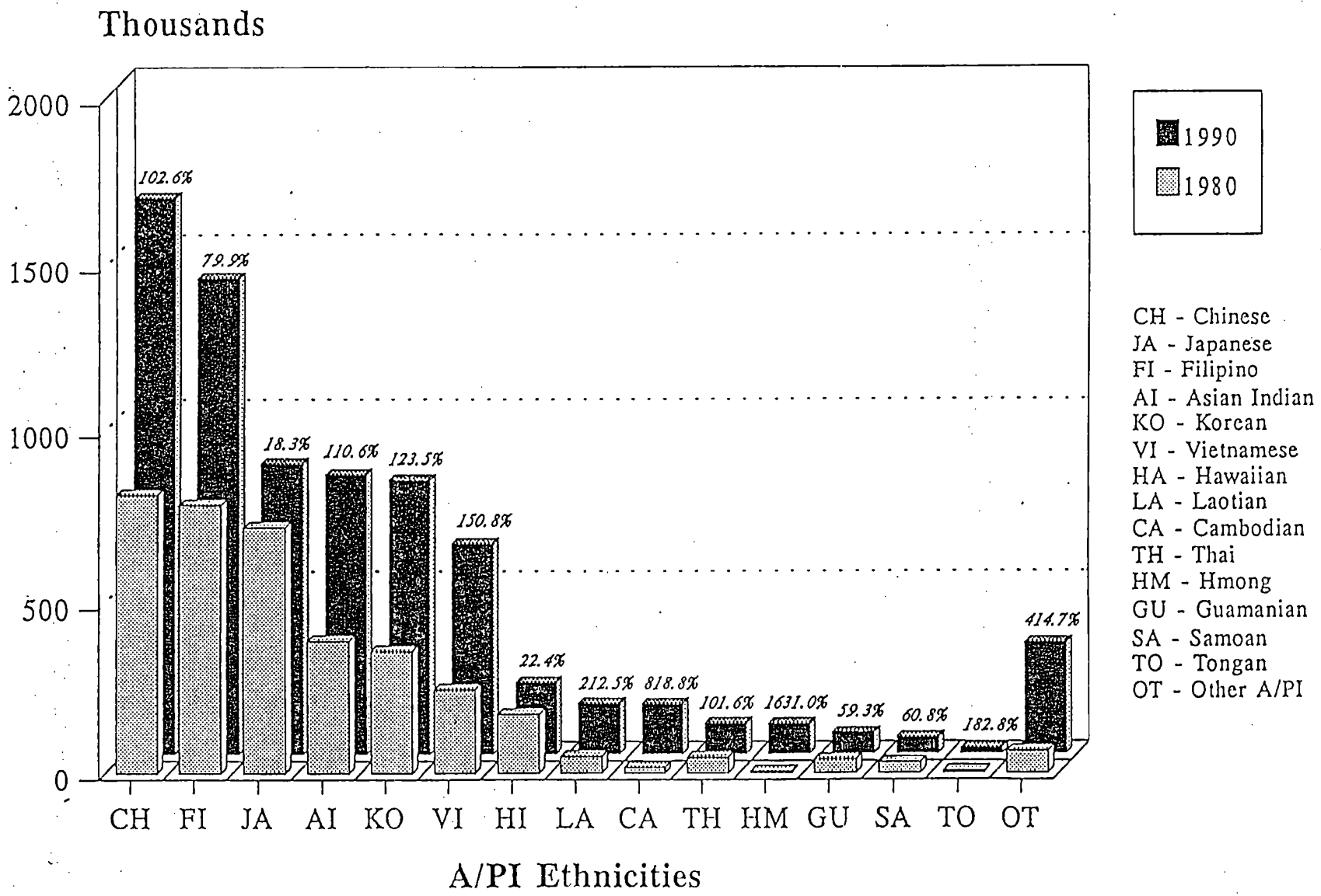
Source: U.S. Bureau of the Census, 1980 & 1990 Censuses

Asian/Pacific Islander Data Consortium – ACCIS; San Francisco, CA

Figure US-F3

United States Asian and Pacific Islander Population

Percent Ethnicity Increase: 1980 to 1990



Source: U.S. Bureau of the Census, 1980 & 1990 Censuses

Table US–T2

States with the Largest 1990 Asian and Pacific Islander Population

Rank	State	1990 Asian & Pac. Isl.	Percent of State Population	A/PI 1980–90 Percent Increase	% U.S. Asian & Pac. Isl. Population	Cumulative Total
1	California	2,845,659	9.6%	116.7%	39.1%	39.1%
2	New York	693,760	3.9%	109.6%	9.5%	48.7%
3	Hawaii	685,236	61.8%	16.0%	9.4%	58.1%
4	Texas	319,459	1.9%	137.6%	4.4%	62.5%
5	Illinois	285,311	2.5%	65.7%	3.9%	66.4%
6	New Jersey	272,521	3.5%	149.1%	3.7%	70.1%
7	Washington	210,958	4.3%	89.0%	2.9%	73.0%
8	Virginia	159,053	2.6%	125.4%	2.2%	75.2%
9	Florida	154,302	1.2%	146.8%	2.1%	77.4%
10	Massachusetts	143,392	2.4%	172.5%	2.0%	79.3%
	TOTAL	5,769,651		95.7%	79.3%	79.3%

Source: U.S. Bureau of the Census, 1980 & 1990 Censuses

Asian/Pacific Islander Data Consortium – ACCIS; San Francisco, California

Table US–T4

U.S. Counties & Places with the Largest 1990 Asian and Pacific Islander Population

[A]

Rank	State	County	1990 Asian & Pac. Isl.	% of Total County Population	% of 1990 State A/PI Population
1	CA	Los Angeles	954,485	10.8%	33.5%
2	HI	Honolulu	526,459	63.0%	76.8%
3	NY	Queens	238,336	12.2%	34.8%
4	CA	Santa Clara	261,466	17.5%	9.2%
5	CA	Orange	249,192	10.3%	8.8%
6	CA	San Francisco	210,876	29.1%	7.4%
7	CA	San Diego	198,311	7.9%	7.0%
8	CA	Alameda	192,554	15.1%	6.8%
9	IL	Cook	188,565	3.7%	66.1%
10	NY	Kings	111,251	4.8%	16.0%

[B]

Rank	State	Place	1990 Asian & Pac. Isl.	% of Total Place Population	% of 1990 State A/PI Population
1	NY	New York	512,719	7.0%	73.9%
2	CA	Los Angeles	341,807	9.8%	12.0%
3	HI	Honolulu	257,552	70.5%	37.6%
4	CA	San Francisco	210,876	29.1%	7.4%
5	CA	San Jose	152,815	19.5%	5.4%
6	CA	San Diego	130,945	11.8%	4.6%
7	IL	Chicago	104,118	3.7%	36.5%
8	TX	Houston	67,113	4.1%	21.0%
9	WA	Seattle	60,819	11.8%	28.8%
10	CA	Long Beach	58,266	13.6%	2.0%

Source: U.S. Bureau of the Census, 1990 Census

Asian/Pacific Islander Data Consortium – ACCIS; San Francisco, CA

P A U L M E N A R D

A S S O C I A T E S, A I A

March 12, 1999

Todd Summers
Deputy Director
Office of National AIDS Policy
736 Jackson Place, NW
Washington, D.C. 20503

Subject: White House Tour

Dear Todd,

Your February 6 tour of the Old Executive Office Building and the White House was one our most enjoyable experiences when we were in Washington D.C. at the AIA Grassroots Convention. Thank you so much for helping my sister, Barbara Menard, make our visit special. We know you took time from your weekend to show us around. Your kindness is much appreciated. Sigrid and I will always remember watching President Bill Clinton practice his putting on the White House lawn from a dormer window high up in the Old Executive Office Building on that Saturday afternoon.

Sincerely,

Paul R. Menard, AIA

PRMmsw
Copy: Barbara Menard

Architecture + Construction
+ Project Management

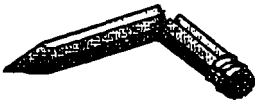
P.O. Box 1005
Carmichael, CA 95609

Telephone 916.489.7116
Facsimile 916.489.7075

License No. 638300

CDC

CENTERS FOR DISEASE CONTROL AND PREVENTION



FACSIMILE TRANSMISSION

ADDRESSEE:

Name: Todd Summers

Address:

National Center for HIV, STD, and TB Prevention
24 Executive Park
Building #24
Mail Stop #E-35
Atlanta, Georgia 30329

PHONE# (404) 639-5217
FAX # (404) 639-0897

ADDRESSEE FACSIMILE #: (202) ~~395-1442~~ 456-2438

ADDRESSEE PHONE #: (202) 395-1442

DATE: 3/17/99

FROM: OFFICE OF THE DIRECTOR DIVISION OF HIV/AIDS

Name: Chad Martin

Telephone: (404) 639-5217

Number of pages (Do not count this form): 7

Please Call if Retransmission is Necessary

MESSAGE:
As requested from David - talking points on TN - with some background information

Talking Points for Todd Summers
Knoxville, Tennessee

- As of December 1998 Tennessee has reported the following information regarding reported AIDS cases and reported HIV cases -

Category	AIDS	%	HIV	%	% of population
Reported Total	6,988		4,932		
White	3,861	55	1,912	38	83
Black	3,016	43	2,957	59	16
Hispanic	93	.013	53	.010	1
API	10	.0014	9	.0018	1
Native American	7	.001	1	.0002	>1
MSM	4,070	59	2,003	41	
IDU	996	14	795	16	
MSM/IDU	524	8	189	4	
Heterosexual	931	12	934	18	
Transfusion	84	1	25	1	
Hemophilia	106	2	10	.01	
NIR	229	3	928	19	
Female	925	13	1,294	26	
Male	6,015	86	3,590	26	
Pediatric	48	1	48	1	

December 1998 reported data
% are approximates
NIR- Non identified risk (can be high among HIV reporting)

Talking Points for Todd Summers

- The epidemic in Tennessee is an epidemic of Men who have Sex with Men (MSM), Injecting Drug Users, Young People, and Women.. The high rates of Gonorrhea, Syphilis, and Chlamydia among Young African American Black populations suggests the need for increased and sustained prevention activities among those populations.

- The community planning process in Tennessee is set-up on a regional structure which feeds into an overall state committee. The goal of Community Planning is to improve the effectiveness of HIV prevention programs by strengthening the scientific basis, community relevance, and population or risk-based focus of prevention interventions. The tasks are to analyze the course of the epidemic in their jurisdiction, assess prevention needs, and prioritize needs in order to develop a comprehensive HIV prevention plan that is responsive to the epidemic in their area.

- In Tennessee four populations are identified as priority populations for HIV prevention dollars. Those audiences are: Men who have sex with men, IDU, Women, and Adolescents. More specifically targeted are African American/Black sub-populations in each of the four target groups.

- In an effort to respond to the needs of these groups the health department receives dollars from CDC to mount prevention efforts in their states. Many states will in turn sub-contracts with community based agencies to mount prevention efforts in each of their jurisdictions to complement health department programs. In Tennessee last year 12 different community based organizations were funded to provide prevention outreach in TN. Those agencies were: AIDS Response Knoxville, Douglas Cherokee Economic Authority, Project Cope, Girls Inc Memphis, Kids on the Block, Friends for Life, Memphis Planned Parenthood, Nashville Cares, Chattanooga Cares, Project Hope, Midtown Mental Health Center, and Columbia Cares.

- Each of these agencies implemented a variety of prevention services in their community. These prevention efforts could be categorized in three ways: Individual level interventions which include counseling, testing and referral services, prevention case management, and one-on-one safer sex training; Small Group work, activities like group counseling, peer education, and street outreach; Community level projects which include in school efforts and community education projects. Finally TN has used a number of public information techniques such as mass media, magazines, billboards, and radio programs.

- TN has a number of specially focused CDC projects like the Prevention Marketing Initiative in Nashville TN, this project applied social marketing techniques to reach young African American teens in the Nashville area. What resulted was a highly successful radio soap-opera that still runs with minimal support from CDC, but huge support from the community. Finally, CDC currently funds directly, AIDS Response Knoxville to help fill the gaps in reaching with prevention efforts to minority populations. In late April CDC will make available additional dollars to support prevention efforts among African American populations in highly impacted areas. Community Organizations in Memphis and Nashville will be eligible to compete. Watch your federal register.

agencies, which impacted target populations in a variety of settings using a variety of methods. (See **Attachment E).**

3. Health Education and Risk Reduction Activities (HE/RR)

Health departments have provided community programs covering HIV prevention, STD information, and the transmission of blood-borne pathogens to groups who are at-risk due to sex-and needle-sharing behavior. Programs targeting pregnant teens have also been conducted by health department staff. As stated in the Program overview at the beginning of this document, a large portion of the health education/risk reduction activities are performed by CBOs through contracts with TDH. In 1998, 12 CBOs entered into such contracts to provide individual and group level counseling, street and community outreach, community level interventions and mobilizations, mass media efforts, social marketing, endorsement/testimonials, and hotline/clearinghouse services.

In order to maximize the effectiveness of HE/RR activities, the majority of targeted education programs across Tennessee for 1999 will be conducted through the contracts with CBOs already involved with the various at-risk communities. This allows programs to be conducted by those viewed as peers of the targeted audience, a method which has long been recognized to be most effective in reaching those at risk. The proposed contracted agencies have proven track records providing services to at-risk communities. The progress of these CBOs' activities are detailed in the next section of this application.

4. Contracted CBOs

AIDS Response Knoxville (ARK) - ARK has used television media to reach target populations and has continued to collaborate with the Knox County Health Department to provide client-centered counseling and testing in the community. ARK continues to distribute condoms, lubricant packets and educational materials to gay bars and area beauty and barber shops. They have hosted several health fairs, festivals and other special events. ARK has exceeded many of their objectives and anticipates exceeding all of their objectives by the end of the year.

Douglas-Cherokee Economic Authority (DCEA) - *DCEA* is a rural CBO, located north of Knoxville, in East Tennessee. DCEA provides street outreach and participates in public forums, health fairs and workshops to reach their targeted populations. This is DCEA's first year to be funded by TDH and they will meet all of their objectives for the year.

Project C.O.P.E. - Project C.O.P.E. conducts street and community outreach in public housing sites of Nashville and is working to reduce HIV-risk behaviors in individuals who abuse drugs, have multiple sex partners, and/or exchange sex for money/drugs in the targeted area. They continue to distribute literature and condoms and participate in health fairs in public housing sites. Their outstanding street outreach program will enable them to meet their objectives by the end of the year.

Girls, Inc. of Memphis - Girls, Inc. of Memphis continues to provide risk reduction programs to 320 women of child bearing age in the community, as well as in the school setting. They have three peer educators to conduct workshops, serve as role models and community advocates for HIV prevention, participate on other teen task forces, and serve as developers of other HIV prevention programs for youth. Although Girls, Inc. has gone through many recent staff changes, which has made it difficult for them to begin their interventions this year, it is anticipated they will meet their objectives for the year.

Kids on the Block - Kids on the Block has been serving the Middle Tennessee community for the past 16 years and educates children primarily in grades two through six. Their target audience includes youth in high risk situations, including institutionalized and African American youth, and women of child bearing age. They continue to do an outstanding job in delivering the message regarding prevention and education of HIV/AIDS. During the first half of the year, Kids on the Block has traveled to 32 schools and four treatment centers in eight counties in Middle Tennessee and presented 61 Smart Choice programs to 6,492 fifth and sixth grade students and 346 professionals. Kids on the Block is ahead of schedule in reaching their stated grant objectives for 1998.

Friends for Life (FFL) - FFL has provided services for people living with HIV/AIDS in the Memphis/Shelby County area for 12 years. Services address the practical and emotional needs of clients and provide education to the public and targeted populations to prevent the transmission of HIV. It is anticipated their objectives will be met by the end of the year.

Memphis Planned Parenthood - Through the Male Responsibility Project, Memphis Planned Parenthood has been able to work directly with youth at high risk, African-American adolescents, adults and institutionalized persons to increase their factual knowledge of HIV/AIDS. Memphis Planned Parenthood hired a new Director of Education and a new HIV/AIDS educator at the beginning of the year, and therefore, they were unable to provide the Male Responsibility Project during the first quarter. During the second quarter, they had 196 participants in their group education series. It is anticipated they will meet their objectives by the end of the year.

Nashville CARES - Nashville CARES continues to make presentations and to provide street outreach and prevention intervention. For the first half of the year, 11,045 people have been reached with client-centered prevention. Nashville CARES has provided seminars, workshops, etc., to 14,525 people for the first half of the year. They are meeting their objectives.

Chattanooga CARES - Chattanooga CARES continues to work closely with the Chattanooga-Hamilton County Health Department to provide counseling and testing to clients at three area gay bars. Chattanooga CARES, along with the health department, provides monthly street and housing development outreach in the African-American community to distribute materials, such as condoms and brochures. Chattanooga CARES has exceeded many of their 1998 objectives and will exceed all objectives by the end of the year.

Project H.O.P.E. - Project H.O.P.E. serves eight rural counties in East Tennessee. This is their second year of funding through TDH. Their target populations are youth and men who have sex with men. They have provided services to over 10,000 persons. Through street outreach and collaboration with Parks and Recreations, they have distributed brochures and other information to clients. They will achieve their objectives by the end of the year.

Midtown Mental Health Center (MMHC) - MMHC is the oldest mental health center in Tennessee and offers a wide variety of outpatient psychiatric services to the Memphis community, in addition to an AIDS education program, H.O.P.W.A. (Housing Opportunities for People with AIDS) and case management/therapy to people with AIDS. To date, MMHC has provided prevention services to 10,000 clients through individual and group level counseling and street outreach. They will meet their objectives by the end of the year.

Columbia CARES - Columbia CARES serves the rural South Central Region of Middle Tennessee. This is their first year of funding from TDH. They reach their target populations of youth and African American women of child bearing age through individual level intervention, group level intervention, and community outreach programs. They will meet their objectives by the end of the year.

5. Public Information

During 1998, public information activities have continued to promote awareness of HIV disease, the availability of client-centered counseling and testing services, community planning, and other programs that address the specific needs of individuals and organizations. These activities will continue during 1999. A significant activity in 1998 has been the publication of the Communicable and Environmental Disease Services Section's (CEDSS) newsletter, Epi-News, which provides HIV/AIDS morbidity, mortality and updated information to approximately 7,000 readers.

The STD/HIV Program AIDS Hotline continues to operate daily from 8:00 a.m. through 4:30 p.m. Calls to the Hotline have increased slightly over the same period last year. During the first half of the grant year, 206 calls were received, with 38 percent from females and 62 percent from males. Just as in previous years, there are two peak times for hotline calls: 9:00 a.m. thru 11:00 a.m. (74 calls or 36 percent) and 1:00 p.m. thru 3:00 p.m. (66 calls or 32 percent). One hundred forty five (70 percent) callers gave sexual contact as their risk exposure. More than three-fourths of the callers lived in one of Tennessee's metropolitan areas, about one-eighth in rural areas, and the remainder were not identified. The most frequently requested information related to personal concerns, such as symptoms, risk behaviors, and testing sites. Most callers (77 percent) identified the telephone directory as their source for the hotline number, 11 percent their local health department, 7 percent from a brochure, and 5 percent learned of the hotline number from television. The majority of calls (41 percent) lasted six minutes or less.

AIDS RESPONSE KNOXVILLE

HIV PROJECT NAME(S): Education, Service and Support ti Individuals Affected By HIV/AIDS

109 Northshore Drive, Suite 411
Knoxville, Tennessee 37919
Phone: (423) 450-2437 **Facsimile:** (423) 450-2435

WEB SITE: www.arksite.org

KEY STAFF: *Kevin Jeske, Keith Chandler, Meredith Schitt, and Adrianne M. Clayton*

PROJECT MANAGER: Kevin E. Jeske

✦ MISSION AND GOALS ✦

Education, service, and support to individuals affected by HIV/AIDS.

✦ TARGET POPULATION(S) AND RISK BEHAVIOR ✦

13% - African-American
100% - Hispanic/Latino
<1% - Asian/Pacific Islander
<1% - Alaskan/Native American
85% - Caucasian
<1% - Other

30% - MSM
10% - IDU
60% - Sex Partners of At-Risk Individuals

✦ PRIORITY INTERVENTION(S) ✦

Street/Community Outreach; Individual Level; Group Level; and Community Level.

✦HIV PREVENTION PROJECT - SCOPE AND ACTIVITIES✦

This program expands services to 3 target populations: Men who have sex with men (MSM), Women of Child-Bearing Age (WCBA), and youth in providing 1) Individual Level Intervention through Education /Skills-Building & Support Groups. ARK will provide Prevention Case Management - one-on-one client services designed to assist both uninfected persons and those living with HIV. ARK's prevention case management will follow the model described by the CDC, providing intensive, individualized support and prevention counseling to assist persons to remain HIV-negative or to reduce the risk for HIV transmission to others by those who are HIV-positive. Five separate modules of information and training related to HIV/STDs, self-esteem, mind/body health, relationships, and safer sex techniques will be provided. Incentives will be provided and may include any of the following: refreshments at retreats, condoms, condom key-chains, quality T-shirts, and other donated incentives.

assistance, including documents and workshops on media relations, issues management, coalition building, promoting abstinence, and condom effectiveness.

Local Demonstration Sites

PMI funds five community-based efforts to apply prevention marketing at the local level. The five communities are: Sacramento, California; Phoenix, Arizona; Nashville, Tennessee; Northern Virginia; and Newark, New Jersey. Interventions are being developed by the communities with intensive, ongoing technical assistance from CDC. As the five sites move through the prevention marketing process, the lessons they learn will be shared with the Prevention Collaborative, HIV Prevention Community Planning groups; other local, state, and national organizations; and the National AIDS Clearinghouse to facilitate the development and/or enhancement of similar programs across the country.

Collaboration with Community Planning

HIV Prevention Community Planning is the process through which CDC provides funding for state and local health departments. This document has been designed to complement that process and to assist community planning groups in implementing prevention marketing programs. CDC will provide technical assistance to community planning groups in prevention marketing and its specifics, such as formative research components, marketing mix selection, and intervention evaluation.

KATHLEEN LYONS
439 Farmington Avenue, #202
Hartford, Connecticut 06105
(860) 231-9969

March 9, 1999

Mr. Todd A. Summers
Deputy Director
Office of National AIDS Policy
The White House
1600 Pennsylvania Avenue
Washington, DC

FAX (202) 456-2438

Dear Todd:

It was a pleasure meeting you at the ProVisions Conference in Springfield, Massachusetts in November. I sat next to you, wearing a black and white suit. I did a presentation on Women and HIV at that conference.

I am interested in continuing my work in the area of Women and HIV and I am sending you this material in the hopes that you might be able to provide some advice, suggestions or recommendations. I have excellent speaking and training skills. I am able and willing to relocate.

Thank you very much for you consideration. I hope to hear from you.

Sincerely,

Kathleen Lyons

Kathleen Lyons

KATHLEEN LYONS

439 Farmington Avenue, #202
Hartford, Connecticut 06105
(860) 231-9969

PROFILE Accomplished, multi-talented professional, offering 10+ years of achievement in diverse, challenging positions. Outstanding organizational, administrative, marketing and project management skills. Extensive work in non-profit environments. PC proficiencies include *MS Word* and *WordPerfect*. Enrolled in training courses for *MS Access* and *MS PowerPoint*.

PROFESSIONAL EXPERIENCE WITH HIV+ COMMUNITY

1997-1998 THE LIVING CENTER - Hartford, CT

Services Coordinator - Performed diverse organizational, programmatic, service and operational functions for this non-profit organization which serves the HIV-infected population. Coordinated volunteer training. Obtained guest speakers. Planned, organized and implemented special informational, training and fundraising events. Represented the organization at numerous conferences.

Selected Achievements

- ***Outside Presentations*** *- "Living with HIV" workshop, Women's Conference (Hartford Health Department), March 1998. "Transitional Linkage to Community", Community Partners in Action on Women with HIV, (Yale University), May 1998. 'Women and HIV", AIDS and Epidemiology course, (St. Joseph College), September 1998. "Women and HIV", Regional ProVisions Conference, (Springfield, MA), November 1998.*

- ***Representing Organization at Conferences*** *- "Volunteerism" Conference, (Central Connecticut State University), May 1997. "National AIDS Minority Council", (Miami, Florida), September 1997.*

- ***Event Planning/Coordination*** *- Organized 3rd Birthday Party (hosted Volunteer Appreciation; presented awards; worked with State Representative), August 1998. Coordinated International Teleconference from Geneva, Switzerland in collaboration with Gay and Lesbian Health Collective, (Hartford, CT), October, 1998. Organized two-day Volunteer Training, (Hartford, CT) November 1998.*

VOLUNTEER

- Hartford Primary Care Consortium, Hartford, CT - Member (1998-Present).
  Elected to Steering Committee (November 1998)
  - Women's Committee, Wadsworth Athenaeum (1999-Present)
  - Member, Ryan White Planning Council (1999-Present)

OTHER PROFESSIONAL EXPERIENCE

- **Assistant to the President,** World One, Inc.
- **Personal Secretary to Assistant Director,** Visiting Nurse Association
- **Executive Secretary to Director of Marketing Development,** Metropolitan Property and Liability Insurance

EDUCATION

JOHNSON & WALES COLLEGE - Providence, Rhode Island
Coursework towards Bachelor of Arts degree in General Studies.
Currently enrolled at Capital Community Technical College.

March 12, 1999

The Honorable David N. Dinkins
Chairman of the Board
National Black Leadership
Commission on AIDS, Inc.
Suite 711
105 East 22nd Street
New York, New York 10010-5413

Dear David:

Thank you very much for your letter on behalf of the National Black Leadership Commission on AIDS. I'm sorry that I was unable to respond sooner. I appreciate having your insight on HIV/AIDS in the African American community, and I have shared your correspondence with my staff in the Office of National AIDS Policy.

As you know, I recently declared that the increase in HIV/AIDS infections in minority communities is a severe and ongoing health care crisis. As a result, my Administration unveiled an investment of $156 million to address this urgent problem. Working with the Congressional Black Caucus and many community members, we fought successfully in the 1998 budget negotiations to secure funding for investments in prevention, care, and research, and this special initiative builds on the great success achieved in the fiscal 1999 budget process. Although this is a step in the right direction, there is still much to be done if we are to put an end to this terrible epidemic.

I am grateful for your personal involvement in this endeavor. You and Joyce have my best wishes.

Sincerely,

BILL CLINTON

BC/KMB/SH/DC/ckb-bws (Corres. #4169405)
(2.dinkins.dn)
cc: DWB/PMC, 94 OEOB/Neal Sharma, 97 OEOB
cc: Sandy Thurman, 736 Jackson Pl.

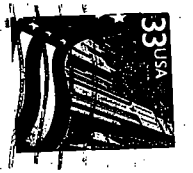
Todd:

A good Southern boy knows it is never too late to say Thank-you.

I truly appreciate your letting me contribute to all that you accomplished while I was at ONAP. It was a great experience. I hope I only contributed at least half of what I learned.

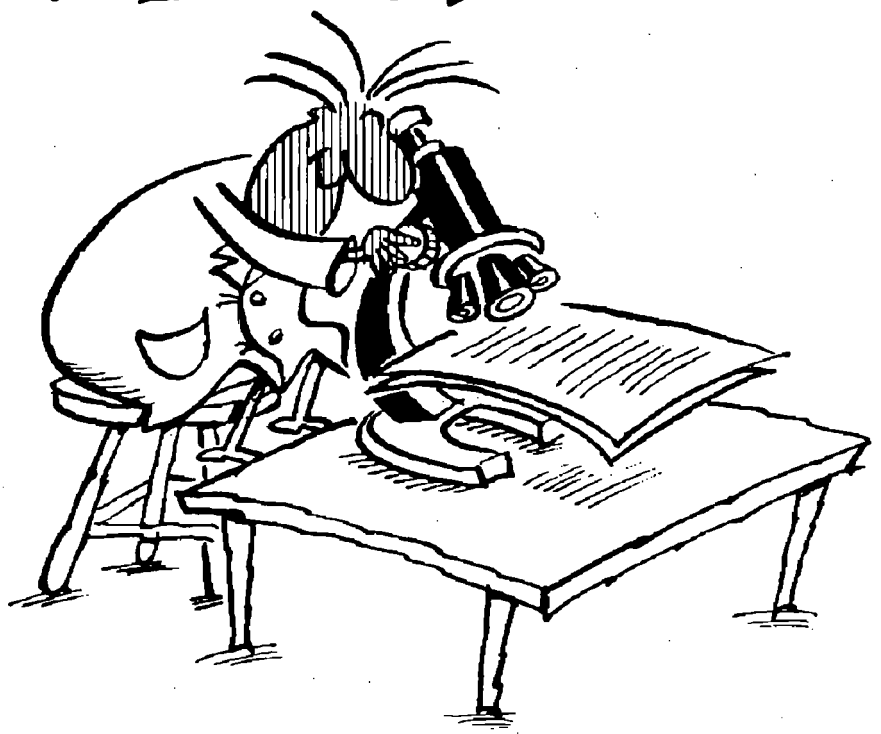
Matthew Munguía

Todd Summers
ONAP
736 Jackson Pl. NW
WDC 20503



WinFax PRO Cover Page

PLEASE EXAMINE THE FOLLOWING



AND:

MESSAGE:

FrOm William E. Arnold

CORR

Jill CANN, Phone: 202-588-1775, Fax: 202-588-8868

To: Sandra Thurman	Fax Number : 456-2439	
From : Larry Casey	Pages: 4	Date: 3/29/99

Los Angeles Times

Monday, March 1, 1999 p. D1

INTERSCIENCE

Global Warning

Health • AIDS, tuberculosis, malaria: Why the world's relentless threats continue to frustrate modern medicine.

By LAURIE GARRETT
NEWSDAY

While science foresees major advances in the next millennium in treating cancer and heart problems, genetic disease and even mental illness, infectious diseases—the No. 1 killers worldwide and No. 3 in the United States—remain a major sticking point within the so-called Biological Revolution.

Within the next five to 10 years, no crucial advances are in sight with the potential to slow expansion of the global epidemics of HIV, drug-resistant tuberculosis, or malaria, scientists say.

"We're on the verge of the 21st century with all this modern technology," says Larry Gostin, a professor of law at Georgetown University and expert on AIDS and human rights, "and yet we're as vulnerable to pathogens as we were decades ago."

Perhaps the best example of this is acquired immune deficiency syndrome. As the numbers of AIDS cases and deaths in America continue their sharp decline since 1994, it's tempting to view the epidemic's future optimistically. But experts interviewed earlier this year outlined a disturbing two-tiered future in which, lacking a vaccine, the disease continues to grow at an alarming rate among the poor in both the United States and throughout the world, exacting huge tolls on society in most Third World countries.

This gloom may come as a surprise to those familiar with recent HIV treatment developments involving combinations of three or more antiviral drugs. Called HAART, for highly active anti-retroviral therapy, the treatment has revolutionized HIV care since being introduced in summer 1996.

But as the 21st century dawns, experts say that HAART is clearly not the answer for all: Its price tag alone—$10,000 to $60,000 a year for the drugs—renders the therapy inaccessible for more than 90% of the world's HIV-infected population, now estimated by the United Nations AIDS Programme at 33.4 million people.

Even in North America and Western Europe, where hundreds of thousands are currently on HAART, trouble is brewing. Many—about 50%, depending on which studies are cited—fail their initial rounds of therapy because they can't tolerate its toxic side effects or adhere to its rigorous daily dosage schedules. And missed doses promote emergence of drug-resistant viruses, allowing the human immunodeficiency virus infections to swell and sicken the individual.

Finally, there is a realization that what was initially whispered about as a possible cure is now seen as no more than another difficult palliative, a treatment that keeps symptoms at arm's length. In 1997 and 1998, studies found evidence of vast, hidden reservoirs of HIV in successfully treated patients that experts now say will still plague the patients 25 to 30 years down the road.

Worse yet, it now appears that these reservoired viruses continue to reproduce and even mutate, despite seemingly effective HIV treatment.

"There's ongoing replication and cell-to-cell infection even in the presence of HAART," explains Dr. Mario Stevenson of the University of Massachusetts in Amherst. "So it may not be [HIV] latency. It may be continued viral production. And how that occurs in the face of effective drugs is a mystery. All we know is the pattern: continued low-level replication and virus evolution."

ADAP Working Group
1775 "T" Street, NW
Washington, DC 20009

1015 18th Street NW, Suite 730 Washington, DC 20036 Tel (202) 973-0360 Fax (202) 467-5352

Los Angeles Times
Monday, March 1, 1999 p. D1
INTERSCIENCE

India's Huge Number of Cases Affects Forecast

For more than a decade, epidemiologist Jim Chin executed HIV forecasts for the World Health Organization and UNAIDS. Now retired and living in California, he believes that there will continue to be from 25 million to 30 million people with HIV alive each year for the next 25 years.

By then, he says, "hopefully, the African countries can get their act together and begin significantly reducing their annual incidence of new infections so that 50 years from now . . . the global prevalence will begin to drop to about 10 to 20 million—with well over 95% in developing countries and the vast majority [80% or more] in Africa."

Grim as that scenario may be, Chin concedes that India, with a population of nearly 1 billion people, is the "wild card" that could throw off the forecasts.

A recent joint publication of the World Health Organization, Harvard School of Public Health and the World Bank, titled "Health Dimensions of Sex and Reproduction," predicted that much of Africa wouldn't see its HIV epidemic peak until 2005 to 2010. Asia's epidemics, the paper said, wouldn't peak until a decade later.

If true, and if an adult infection rate higher than 30% indeed constitutes society's HIV bell peak, the world could have nearly half a billion people living with HIV and AIDS by the year 2020.

Dr. Anthony Fauci, director of

Ancient Diseases Account for Half of All Deaths

But AIDS is not the only problem faced by medical experts dealing with infectious disease. The helplessness felt in the face of HIV is mirrored in battles against a host of bacterial and parasitic diseases, many of which are either not treatable or, for a variety of reasons, are not being properly treated. And so ancient scourges, such as malaria and scarlet fever, continue to account for nearly half of the world population's annual deaths. Dr. Bernard Pecoul, of the humanitarian organization Doctors Without Borders, is convinced that a key solution is lowering the cost of essential drugs for poor countries.

If the world's top pharmaceutical companies follow their current cost trajectories, "they will end up only focused on the 300 to 400 million people in the richest countries," he says. "We cannot accept that, for most of the world, the essential drug list is now things from the 1950s and '60s, many of which cause drug resistance."

What's at stake? A time bomb, Pecoul warns, of resurging infectious disease—strengthened by drug resistance—that will explode not just in the world's poorest countries, but in Europe and America as well. The global village will be affected, he says.

Indeed, a forecast by researchers at UC San Francisco predicts that by 2070, the world will have exhausted all antimicrobial drug options, as the viruses, bacteria, parasites and fungi evolve complete resistance to the human pharmaceutic arsenal. It is a vision that remarkably is shared by many of the world's top microbiologists and infectious diseases experts.

"People are looking at new targets for antimicrobials," Dr. Stanley Falkow of Stanford University says. "But it's not clear they will work."

Although several laboratories are working on novel ways to kill bacteria and viruses, Falkow says, no fundamentally new approaches are expected to be available within the next 10 years. And if such drugs do reach the marketplace they will undoubtedly follow the financial pattern set with antibiotics: Each newer drug costs far more than its predecessor. And the newer agents are usually more toxic, their use fraught with fierce side effects.

The biggest concern is staphylococcus, for which only one drug is left, Falkow says. If that were incurable it would be devastating, because the bacteria, which cause a wide range of life-threatening diseases, are highly contagious.

Fauci warns that mutated microbes resistant to beats of drugs are the real crises looming for the 21st century.

The drug companies, meanwhile, are banking on vaccines. They say innovative products, such as vaccines made from the DNA of viruses or bacteria, will be available for tuberculosis, malaria, the diarrheal disease schistosomiasis and other killers within 20 years. And, they say, these vaccines will be affordable.

But Dr. Phillip Lee, former second-in-command at the U.S. Department of Health and Human Services, says he's heard that before.

"Here we are, 100 years after Pasteur identified the cause of rabies and [Robert] Koch the cause of tuberculosis," Lee says. "Yet we did more to control TB by social factors" than by any vaccine, and today more people globally die of tuberculosis than in Koch's day.

"One hundred years out," he says, "and we still don't have a vaccine for tuberculosis or malaria."

1015 18th Street NW, Suite 730 Washington, DC 20036 Tel (202) 973-0360 Fax (202) 467-5352

ADAP Working Group
1775 "T" Street, NW
Washington, DC 20009

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INTERSCIENCE

Time Still Major Enemy for People With HIV

Dr. Emilio Emini, of the Merck Research Laboratories in West Point, Pa., says time remains the major enemy of people with HIV.

"There are patients who, even though they've suppressed virus for years, will fail," Emini says. "So what does that tell you? It tells you it's not an easy consideration to, quote-unquote, cure a patient. Even after a long time of suppression . . . the virus will cycle up."

So is there a solution? Experts hold out little hope of a final cure, differing significantly in their outlook only on one point: How many decades will pass before an effective, affordable vaccine is developed for use worldwide?

"We've said from the beginning this is a nasty little virus," Emini says. "My fundamental hope is that in the end we'll be able to make a sincere shot at a vaccine here."

The National Institutes of Health also have reached the conclusion that a vaccine is the only thing that can slow HIV's seemingly relentless expansion. Currently, half the agency's $1.8-billion HIV budget is aimed at the search for a vaccine, says Neal Nathanson, director of the Office of AIDS Research.

"We're in it for the long haul," he says. But he argues that the private sector lacks similar long-term commitment to the problem: "None of the big players [the world's large pharmaceutical firms] are seriously involved in developing a vaccine at this time," he says. "They don't see the profit in it."

At Glaxo Wellcome, the world's largest multinational pharmaceutical company and a major player in HIV drug development, Peter Young, the vice president for HIV therapeutics, only shrugs: "I think we're probably as far away from treatment cures as we are from vaccines."

One problem is that each time the virus population cycles up, that means it's managed to mutate to resist one or more of the HAART drugs. Doctors then must change the patient's combination, drawing from a list of more than 250 drug triads currently licensed in the United States. But most mutations confer HIV resistance not only to just one individual drug, but also to that entire class of drugs.

So each new HAART combination lasts for less time than its predecessor, and eventually patients run out of treatment options as their highly resistant viruses overwhelm the body, explains Dr. Michael Saag of the University of Alabama.

"So now we've evolved from a cure paradigm back to a palliative care one," Saag says. "Perhaps the biggest difference . . . is we now should expect failure with whatever [combination] we first use."

With the bloom clearly off the HAART rose, AIDS advocates are calling for rapid development of drugs that hit novel targets on HIV, possibly outwitting the virus' awesome mutation capacities. But Emini says there isn't much in the drug development pipeline, and it's impossible to answer when such novel agents might be ready.

"Where will we be in 10, 20 years?" asks Dr. Peter Piot, the director of UNAIDS, the United Nations' program on HIV-AIDS. "It's really, really hard to say. We haven't done [forecasts] going out more than to 2005. We've learned that the projections turn out to be awfully wrong."

Wrong, in that the epidemic has consistently outpaced worst-case scenarios.

The key question for forecasters, experts say, is the proverbial bell-shaped curve. Most, if not all, epidemics start at a low level, rise rapidly and then naturally slide back down the bell-shaped curve as society responds, ending up permanently at a modest endemic level in the population. The reasons for that downward curve are multitudinous and vary from epidemic to epidemic. But the curve is always there.

Is there evidence of a bell curve for HIV? Piot believes that HIV has hit the top of its bell in some hard-hit African countries, such as Uganda, Tanzania, Zambia and Zimbabwe. But the top of that curve was reached only after upward of a third of all adults under 50 years old were infected, he pointed out.

The first community to reach an HIV bell curve was San Francisco, where the bell peaked in the mid-1980s with the infection rate exceeding 50%. Now, due largely to education programs in the gay community, the disease claims less than a fifth of the San Francisco gay population.

For more than a decade, epidemiologist Jim Chin executed HIV forecasts for the World Health Organization and UNAIDS. Now retired and living in California, he believes that there will continue to be from 25 million to 30 million people with HIV alive each year for the next 25 years.

By then, he says, "hopefully, the African countries can get their act together and begin significantly reducing their annual incidence of new infections so that 50 years from now . . . the global prevalence will begin to drop to about 10 to 20 million—with well over 95% in developing countries and the vast majority [80% or more] in Africa."

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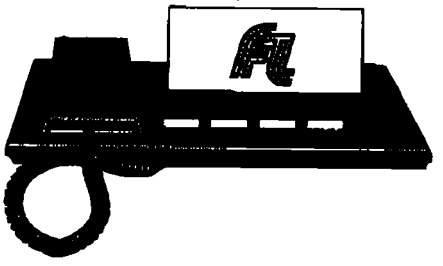
Guidance FAX



Todd

From:
Counseling Department
Fair Lawn High School
1400 Berdan Avenue
Fair Lawn, New Jersey 07410

FAX: (201) 475 - 1849

Date: 3/3/99

No. of pages, including cover: 2

To: attn. Sarah

Phone: _____

Fax: 201/456/2438

Remarks:

In regards to setting up an interview relating to Needle exchange programs

Counselors:
(all telephones area code 201)

Ken Deblock ..... 794 - 3278
Darth Piaget ..... 794 - 5445
Andrew Sachs ..... 794 - 5446
Susan Sawyer ..... 794 - 5444
Jacki Schwartz ..... 794 - 5447
Gerry van Koolbergen ..... 794 - 5448

Matt Markman ..... 794 - 5443
Student Assistant Counselor

Secretarial Staff

Lisa D'Elia ..... 794 - 5440
Ann Manica ..... 794 - 5441
Genny Van Kruiningen ..... 794 - 5442

41-15 Jean Terrace
Fair Lawn, NJ 07410
Phone number: 201 794 6971
Email address: emeryam@worldnet.att.net

Attention: Sarah

Dear Sir/Madam,

I'm writing in regards to arranging an interview on either Tuesday 23rd, Wednesday 24th, or Thursday the 25th at your convenience. However if possible sometime before about 3 p.m. I'm doing a thesis on needle exchange programs for a Political Institute class and am interested in obtaining some general information on the current status of this program.

The main points of my paper will be about any current legislation as it relates to needle exchange programs, the obstacles its facing in receiving federal funding, and its effectiveness in the reduction of AIDS/HIV.

Any time that you can make available will be greatly appreciated. Thank you very much.

Sincerely,

Eda Meryam