

WITHDRAWAL SHEET

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Date: 3/25/04

DOCUMENT NO. & TYPE	SUBJECT/TITLE	DATE	RESTRICTION
1. Form	SF 171 for Patricia Fleming (2 copies), 18p	nd	P5 , P6/B6
2. Note	Handwritten note re: appointment, 1p	nd	P5, P6/B6
3. Memo	To Carol Rasco from Kevin Thurm, 1p	5/5/04	P5
4. Resume	Ruby Hearn, 1p (partial)	nd	P6/B6
5. Memo	To Carol Rasco from Bob Boorstin re AIDS Czar, 1p	4/24/91 [sic]	P5, P6/B6

RESTRICTIONS

P1 National security classified information [(a)(1) of the PRA].
P2 Relating to appointment to Federal office [(a)(2) of the PRA].

P3 Release would violate a Federal statute [(a)(3) of the PRA].
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA].

P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA].

P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA].

C. Closed in accordance with restrictions contained in donor's deed of gift.

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B2 Release could disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA].

B3 Release would violate a Federal statute [(b)(3) of the FOIA].

B4 Release would disclose trade secrets or confidential commercial financial information [(b)(4) of the FOIA].

B6 Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA].

B7 Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA].

B8 Release would disclose information concerning the regulation of financial institutions [(b)(9) of the FOIA].

B9 Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA].

AMFAR
1828 L ST NORTHWEST SUITE 80
WASHINGTON DC 20036

WESTERN
UNION MAILGRAM[®]



009053000298 04/21/93

WHSB

file - AIDS czar

▶ CAROL RASCO
DOMESTIC POLICY DIRECTOR
WHITE HOUSE
WASHINGTON DC 20500

I TAKE THE LIBERTY OF WRITING YOU CONCERNING THE POSITION OF "AIDS CZAR" WHOSE APPOINTMENT APPEARS IMMINENT.

I FEEL THAT THE ISSUE OF THE CZAR SHOULD BE MADE INDEPENDENTLY OF WHAT MAY BE PERCEIVED AS POLITICAL PRESSURE DUE TO THE UPCOMING MARCH ON WASHINGTON.

I URGE YOU TO CAREFULLY CONSIDER AIDS EXPERIENCE AND KNOWLEDGE OF THE FEDERAL GOVERNMENT, INCLUDING THE STANDING SUCH A PERSON SHOULD HAVE IN THE PUBLIC EYE, AS CRITERIA FOR AN AIDS CZAR.

AMFAR IS WILLING TO HELP IDENTIFY POSSIBLE CANDIDATES AND WOULD BE AVAILABLE AT ANY TIME TO DISCUSS THESE MATTERS WITH YOU.

THANK YOU FOR YOUR CONSIDERATION.

SINCERELY,

MATHILDE KRIM, PH.D.
FOUNDING COCHAIR AND CHAIRMAN OF THE BOARD
AMERICAN FOUNDATION FOR AIDS RESEARCH
1828 L ST NORTHWEST SUITE 802
WASHINGTON DC 20036
(202) 331-8600

14959

22:13 EST

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MEMORANDUM
OF CALL

Previous editions usable

TO:

CR

YOU WERE CALLED BY-

YOU WERE VISITED BY-

Tom Higgins

OF (Organization)

PLEASE

AUTOVON

P6/(b)(6)

WILL CALL AGAIN

IS WAITING TO SEE YOU

RETURNED YOUR CALL

WISHES AN APPOINTMENT

MESSAGE:

DOB

P6/(b)(6)

*WILLIAM
6/15/93
(10)*

*10:30 a.m. Fri,
6/18/93*

RECEIVED BY

AG

DATE

6/15

TIME

11:05

63-110 NSN 7540-80-634-4018

STANDARD FORM 63 (Rev. 8-81)

☆ U.S.G.P.O. 1992-312-070-40024

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* NOTE: An oath
has been
made to
Mr. Higgins
that this
information not
be made even
semi-public.

THOMAS HIGGINS

P6/(b)(6)

(410) 998-5470 (office)

PROFESSIONAL EXPERIENCE

September, 1990 Blue Cross and Blue Shield of Maryland
to
Present Senior Vice President

Responsible for Divisions including Information Technology, Provider Relations, Medical Policy, Human Resources, and New Business Development. Additional responsibility for negotiating merger and acquisition activity for subsidiary companies.

Vice President

Responsible for Divisions including Strategy Planning, Public Policy, Government Affairs, Community Relations.

September, 1985 Co-Founder and Editor-In-Chief, HealthWeek Publications
to
July, 1990

Co-Founder of HealthWeek, the only national newspaper covering America's health industry. Newspaper commenced publication in July 1987 as a joint venture with CMP Publications. Forty-five employees, 100,000 circulation, \$7 million annual revenues. Second newspaper, Managed HealthCare, launched in July 1989 with 30,000 circulation.

Major Accomplishment - With my partner, took HealthWeek from idea stage to dominance in the market as the standard source of business news about the health industry. Established Managed HealthCare for similar position in its market niche. CMP exercised its option to buy out our interest after profitability was achieved.

Thomas Higgins
Page Two

February, 1984 **President and Publisher, The Business Journal**

to

September, 1985 Founding publisher of a weekly newspaper, which covers the economic news of the greater Portland area. Forty-one employees, 17,000 circulation, \$2 million plus annual revenues.

Major Accomplishment - Created a very successful newspaper, which has become an influential resource for the community. The newspaper is the seventh largest of its kind in the country. It is owned by American City Business Journals, which purchased my interest after profitability was achieved.

February, 1981 **Director, Multnomah County Department of Human Services**

to

February, 1984 Was responsible for the overall direction of a department, which encompassed 35 programs, 700 employees and a budget of approximately \$40 million. Programs included: community health services, mental health, health care financing, public health protection, alcoholism treatment, and social and rehabilitative services for aging, mentally retarded and developmentally disabled populations.

Major Accomplishment - Created several model programs of national significance, including a primary health care network and an innovative de-institutionalization project for the mentally ill. Organized successful community-wide strategies to deal with health care cost containment and human services advocacy. Established several new private agencies as alternate delivery systems.

August, 1980 **Deputy Secretary to the Cabinet of President Carter**

to

January, 1981

Senior Staff, The White House

Managed a wide range of projects and activities for the President of the United States, including problems related to the Cuban/Haitian influx, natural disasters, government-wide coordination of special projects, etc. Served also as a principle link between the nation's governors, mayors, other elected officials and The White House on the most sensitive intergovernmental problems. Conveyed the President's directions to Cabinet members on these matters.

Thomas Higgins
Page Three

January, 1980
to
August, 1980

Associate Commissioner, Social Security Administration
Administrator, U.S. Family Assistance Administration

Managed the Family Assistance Programs of the Federal Government, including AFDC, Low-Income Energy Assistance. Budget exceeded \$14 billion. Line management responsibility for 350 employees. Served as a member of the Executive Committee for Social Security Administration, advising the Commissioner on wide range of issues facing SSA.

Major Accomplishment - Set up the Low-Income Energy Assistance Program to assist needy individuals. Responsible for creating the administrative structure, writing the regulations, working with Congress and negotiating department's policy and procedures. Also, established a new process for error rate reduction and appeals in the AFDC Program.

September, 1977
to
December, 1979

Regional Director of HEW, Region VII

Coordinated the department's activities in the four-state area (Kansas, Missouri, Nebraska and Iowa). Line management over 150 people and functional supervision over programs employing 5,500. Chief intergovernmental and public affairs representative, as well as director of administrative support and evaluation of HEW's programs.

Major Accomplishment - Significantly advanced the department's priorities in health care. Stimulated HMO development, state legislation for health planning and community action for cost containment.

June, 1979
to

December, 1979

(Acting) Regional Director of HEW, Region VI - Dallas

Major Accomplishment - At the Secretary's request, assumed direction of an office plagued by low morale and mismanagement; within six months reorganized operations and restored sense of mission. Worked successfully with states to resolve a number of outstanding disputes in the human services area.

Thomas Higgins
Page Four

January, 1973
to
September, 1977

**Member, Iowa House of Representatives
Chairman, Human Resources Committee**

Author of a wide range of important legislation in the area. Frequent spokesman for National Conference of State Legislatures. Directed committee staff. Member of Appropriations, Education, and Judiciary Committees.

Major Accomplishment - Authored and passed successfully some of the most sweeping reforms in the human services area in the state's history. Juvenile Justice Code is regarded as a national model. Also passed adoption reform, State Housing Authority, major health planning law, Community Corrections Act, etc.

January, 1971
to
January, 1973

Executive Director, Quint Cities Drug Abuse Council

Managed a Multi-faceted substance abuse treatment and rehabilitation program in the Metropolitan Area of 500,000.

Major Accomplishment - Started the agency and built it to one of the most successful of its kind in the Midwest. Led it into United Way, got federal and state funding and used it as a base for successful community organizing in health and criminal justice matters. It still exists as a successful agency.

August, 1969
to
November, 1978

**Campaign Manager, Gannon for Governor
Press Secretary, Fulton for Governor**

Summer, 1968

Reporter, Quad City Times

Summer, 1967

Reporter, Illinois State Register

EDUCATION

1967 - 1969

Iowa State University, Graduate Study, Political Science

1967

St. Ambrose College, B.A., Political Science Cum laude

Thomas Higgins
Page Five

HONORS

Carnegie Foundation, Family Forum, Fellowship, July, 1983
Aspen Institute Executive Seminar, Fellowship, March 1983
European Community's Visitor's Program, Fellowship, September, 1982
Secretary's Special Commendation, 1979
Who's Who in Government; in Politics; in the Midwest; In Commerce, 1975 - 1989
Outstanding Iowa Legislator, Human Resources Coalition, 1976
Outstanding Young Men of America, 1974
Student Body President, St. Ambrose, 1967

CORPORATE BOARDS

Americom Technology, Atlanta, Georgia, 1983 - 1986
Health Choice, Inc., Portland, Oregon, 1984 - Present
BestCare HMO, Portland, Oregon 1984
HealthWeek Publications, Inc., 1987 - 1990
GreenSpring Mental Health Services, Inc., 1991 - Present
Managed HealthCare News Editorial Board, 1991 - Present

COMMUNITY SERVICES AND ACTIVITIES

PORTLAND

Board of Directors, The Civic Theatre
Board of Governors, The City Club
Board of Directors, United Way
Commissioner, Metropolitan Arts Commission
Member, The World Affairs Council
Member, Rotary Club of Portland
Adjunct Associate Professor, Portland State University
Board of Directors, Janis Youth Programs
Member, Central City and Downtown Planning Committee, City of Portland
Board of Directors, Artquake
Faculty Affiliate, University of Oregon Health Sciences Center, 1984
President, Board of Trustees, Keith Martin Dance Company, 1981 - 1984
Board of Directors, Northwest Oregon Health Systems Agency, 1981 - 1982
Director, The Cascade Conference, 1981

Thomas Higgins
Page Six

PORTLAND (Continued)

Member, Metropolitan Business Association, 1984
Board of Directors, Oregon ACLU, 1984
Board of Directors, Oregon Council on Alcoholism, 1984

KANSAS CITY

Board of Directors, United Way of Kansas City
Board of Regents, Conception College
Board of Directors, St. Augustine Neighborhood Revitalization Program

IOWA

Commissioner, Eastern Iowa Crime Commission
Board of Directors, Iowa Chapter, ACLU

BAY AREA

Board of Trustees, St. Luke's Hospital Foundation
President, Board of Directors, Continuum HIV Services
Community Advisory Board, Alta-Bates Hospital

BALTIMORE

Board of Director, BCAS
Public Policy Committee, GBC
Science and Technology Committee, GBC

NATIONAL

Advisory Board, Center for National Policy
Principal, Council for Excellence in Government

DEC - 1 REC'D

To: Kris Gebbie, Carol Rasco
cc: Mack McLarty, Bruce Lindsey, Phil Lader, Jan Piercy
Fr: John Emerson
Dt: December 1, 1993
Re: AIDS Advisory Board

Dr. Scott Hitt, of Los Angeles, has been recommended as a member of the AIDS Advisory Board. He may also be appropriate for your task force on drug treatment, announced in this morning's papers.

I know you have received letters of support regarding Scott, who runs one of the largest AIDS treatment clinics in Southern California. He was also an early and active supporter of the President, and is a consensus choice of the gay and lesbian community for a slot on the Board. While others have been openly critical of the President on gays in the military, for instance, Scott has kept quiet. He has the expertise and the political support to make him a valuable member of the Board. I cannot understate how damaging it would be for our relationship with the moderate gay community if Scott were not to be appointed.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington D.C. 20201

*Sent Red dot
Aug 2*

FACSIMILE

*11 45am
to V. Biggins
CEB
153*

DATE MAY 27 1993

TO: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Carol Rasco
Assistant to the President
for Domestic Policy

456-2216

FROM: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Kevin Thurm
Chief of Staff

690-6133

RECIPIENT'S FAX NUMBER: () 456-2878

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET): 10

COMMENTS:



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington D.C. 20201

Siv: Fleming

FACSIMILE

DATE MAY 27 1993

TO: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Carol Rasco
Assistant to the President
for Domestic Policy

456-2216

FROM: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Kevin Thurm
Chief of Staff

690-6133

RECIPIENT'S FAX NUMBER: () 456-2878

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET): 10

COMMENTS:

THIS FORM MARKS THE FILE LOCATION OF ITEM NUMBER 1
LISTED IN THE WITHDRAWAL SHEET AT THE FRONT OF THIS FOLDER.

NATIONAL
LEADERSHIP
COALITION
ON AIDS

May 5, 1993

BOARD OF DIRECTORS

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Service Employees International Union

Jerald A. Breitman
Burroughs Wellcome Co.

Sharon Canner
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Sex Information & Education
Council of the U.S.

Glenn E. Haughe, M.D.
International Business Machines Corp.

James Hawes, III
US West Communications, Inc.

Stanley G. Karson
Center for Corporate Public Involvement

Larry J. Kessler
AIDS ACTION Committee of Massachusetts

Bryan L. Knapp
Shearson Lehman Brothers

Michael Lauber
Tusco Display Company

Bryan Lawton, Ph.D.
Wells Fargo Bank

Jose I. Lozano
La Opinion

Jonathan Mann, M.D., M.P.H.
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L. Jay Marshall
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American Federation of Labor &
Congress of Industrial Organizations

Stephen T. Moskey
Aetna Life & Casualty

Enoch J. Prow
NationsBank Corporation

Paul A. Ross, Ed.D.
Digital Equipment Corporation

Mervyn Silverman, M.D., M.P.H.
American Foundation for AIDS Research

John R. Taylor
The Principal Financial Group

The Rt. Rev. Douglas E. Theuner
Bishop, Diocese of New Hampshire
of the Episcopal Church

Carol Rasco
Assistant to the President
for Domestic Policy
The White House
West Wing, 2nd Floor
Washington, D.C. 20500

Dear Ms. Rasco:

I am pleased that our paths are converging finally, and look forward to our meeting tomorrow at 10.

In the interest of trying to use the limited time we have together most productively, I thought it may be useful for you to have in advance of our meeting the enclosed document. In it, I have tried to highlight and state succinctly a number of my perspectives. These are not prescriptive, obviously, and I am providing them in advance of our discussion as one additional way of focusing on the decisions at hand.

As I presume you know, I share with many others a strong belief and hope that the voices on AIDS during the Clinton Administration will be those of the President himself, and those key officials in HHS and the White House charged to manage HIV/AIDS as a part of the nation's health programs and services. My sole interest is to enable those voices be strong, consistent, and effective, toward bringing this terrible tragedy to an end.

I look forward to our meeting, and the opportunity to consider how best to involve the nation's business and labor leaders in a more effective national AIDS education and prevention effort.

Sincerely,



Lee C. Smith

LCS/dc
Enc.

1730 M Street, NW
Suite 905
Washington, DC 20036
202/429-0930
FAX: 202/872-1977

HIV/AIDS....A Perspective

May 1993

The HIV/AIDS Problem

The scope and pace of the HIV pandemic in the United States of America have outstripped the discretionary resources made available to fight it. Throughout the first decade of our struggle there have never been sufficient moral, financial, medical, or human resources to adequately meet the ever expanding challenges of the disease.

HIV disease feeds on our weaknesses--discrimination, gender inequality, poverty, the crying inadequacies of our health and social systems. The tragedy is that HIV disease has spread so far; the hope is that so many are still uninfected.

The Facts

- It took nearly ten years for the first 100,000 deaths from AIDS to occur among Americans, but the next 100,000 will occur in only two years.
- One in 250 Americans, 1 million in total, are living with HIV disease.
- People with HIV disease and AIDS often suffer severe discrimination and hatred that emerge from lack of understanding about the disease and how it is transmitted.
- The cost of treatment is projected to increase each year to 1995 when an estimated \$15.2 billion will be spent on care for those infected.
- HIV disease is preventable, it is treatable, and it is increasingly manageable.
- Each statistic, every horrible number, represents a life, a son, a mother, a child, an employee or a colleague.

The Twin Goals

We must marshal the collective resources of our nation to prevent the spread of HIV disease and to provide appropriate care for those who are already infected. We are not helpless. We must choose life over death.

Some Obstacles

The obstacles to the success we seek in effective prevention and treatment are numerous and can be daunting. For instance, they are ignorance, fear, judgment, discrimination and evasion.

We should not accept the fingerpointing and labeling that comprise our past discussions about this terrible national tragedy. Too much of our "war" against

AIDS has been a battle of language, accusations, and caricaturing of others. Politics and self interest have penetrated the very core of our current efforts against this disease.

HIV disease is currently winning the war because, at times, we have forgotten that the virus is our enemy, not each other.

The Priorities

Given the combined challenges of HIV disease it is imperative to simultaneously expand resources for Prevention (CDC's primary responsibility), Research (NIH's primary responsibility), and Care (HRSA's primary responsibility). This "triple tracking" is essential in order to achieve our twin goals of stopping the spread of the disease and providing care for those already infected.

- Our best hope of halting further HIV transmission is by mounting a comprehensive, targeted approach to AIDS prevention throughout this nation. The educational effort must be culturally and linguistically relevant, frank, non-judgmental and accessible.
- Ultimately biomedical and behavioral research will provide the critical answers for prevention and treatment of HIV disease. Without an enhanced and coordinated commitment to a strategic research plan we will fail to stem the tide of the pandemic.
- Economics and discrimination are two of several blocks to health care access for those already infected with HIV disease. We must insure that they receive all needed and appropriate care within the context of the emerging health care reform plan.

A National Strategic Plan

The critical first action must be to put in place the best organizational framework to enable us to achieve our twin goals and at the same time optimize the federal government's overall HIV response. Ultimate success, to a large extent, turns on this pivotal question.

There are several models to look at. The "drug czar" was first established in 1988 and was:

- to be the central organization to coordinate the anti-drug work of agencies through out government, reining in rivalries, eliminating duplication,
- to oversee others, urging them to be more effective,
- never to have budgetary authority.

It was determined recently by President Clinton that this model was not able to bring its influence to bear on other agencies. Accordingly he recently decided to reduce staffing, increase authority, and move the director to the cabinet level. The nation's drug effort will now focus on education, treatment, and local/state law enforcement.

Two other models, the National Security Council and the National Economic Council may prove beneficial in looking at the most effective response for our nation to HIV disease.

The organizational model that is ultimately chosen must not invite jurisdictional or turf wars between the persons primarily responsible for HIV disease and the various Cabinet Secretaries with resultant, potentially paralytic delay, misuse of scarce resources and further deaths.

One person is not enough, a collaborative effort of massive proportions is required. One person acting outside the health care reform debate will not achieve the twin goals. This modern plague cannot be permitted to be separated from the rest of public health which has dealt with other plagues in the past very successfully. Broad, consistent, clear, and continuous leadership and commitment from the President, key Cabinet officials, and the Surgeon General are essential.

The Investment

While large monetary sums have been invested in HIV disease thus far, most now agree that more is required. With a \$2.1 billion current annual level of federal investment for AIDS prevention and research we must be absolutely certain that the funds are applied strategically to achieve the best possible returns. This is a highly complicated economics model and we need to carefully and efficiently allocate the scarce resources of money and human talent in order to achieve our twin goals.

Global Opportunities

In his inaugural address, President Clinton said "We earn our livelihood in peaceful competition with people all across the Earth." Why not harness the power and resources available to us worldwide and initiate a global, coordinated, peaceful collaboration to find a cure for HIV disease?

The objective would be to create a consortium of internationally recognized leaders and organizations drawn from the relevant scientific disciplines.

Their purpose would be to provide informed guidance in the development of therapeutic programs for the medical management of HIV disease, to focus research on vaccine/immune modulator protocols that can restore the immune system, to place more emphasis on the prevention of opportunistic infections, to work toward preventing overlap in the scientific explorations around the world, and to point the way toward a breakthrough that will lead to the reversal of the disease process entirely.

The World Bank's 1993 World Development Report is due to be published in June. It will identify and assess the global impact and costs of health care. Perhaps this initiative can set the stage for a truly global response from the world leaders.

We know that the World Health Organization estimates that 10 to 12 million people worldwide are now infected with HIV, the virus that causes AIDS, and that as many as 30 to 40 million will be infected by the year 2000. Seventy-five percent of all new infections will occur in developing countries where HIV transmission occurs principally through sexual intercourse. In the absence of effective medical treatments, most if not all of those infected will eventually develop AIDS and die prematurely.

Some early signs of renewed collaboration and cooperation are evident and it would be regrettable to let these opportunities lapse. Two initiatives emerge as examples.

First, President Clinton has received a letter dated January 8, 1993 from Professor Luc Montagnier of Institut Pasteur in France. As one of the researchers known for his discoveries in AIDS, he asked for President Clinton's help and support in a new worldwide action against the epidemic. He appears willing to let the dispute between his institution and NIH be set aside for new international collaboration in AIDS research.

Further, Dr. Montagnier and Dr. Robert Gallo, another preeminent researcher in the U.S., have recently met and have said they can work together to help find the answer to HIV disease. While the two have had some harsh words in the past they felt they should forget about their feud and collaborate actively. Both gentlemen now care most about a more intense, more cooperative international research effort to find a cure for AIDS.

The second example of interest surrounding a global approach comes from Japan and is an outcome of a collaborative effort between the National Leadership Coalition on AIDS (in the U.S.) and a group of Japanese business and industrial leaders who have just launched their own war on AIDS.

One of the leaders of that group, Mr. Kazuo Kamiya, Chairman, Council for Countering AIDS, the Tokyo Chamber of Commerce & Industry has corresponded with our Chair in order to develop the idea of a new international effort to promote research and development of HIV disease. Their objective is to get this topic on the agenda for the upcoming G7 summit in Tokyo in July.

Supposedly Prime Minister Miyazawa has been approached regarding this borderless cooperative development for an AIDS vaccine and both he and his Cabinet would commit to it if the United States would also join in the effort. Allegedly, at an official pre-conference meeting in Hong Kong recently, "the response of the American officials was very negative."

Summary

It's time to call a halt to the disgraceful effort to pit one disease against another. It is unseemly to hold one segment of HIV disease hostage to another. We should not accept the leveraging of those who may be spared from AIDS in the future against those who are already infected. If we cannot achieve this at a time when international tensions have eased, our borders may remain secure but humankind will be increasingly imperiled.

The history of the HIV pandemic thus far is a compilation of stories about disease progression, early and painful deaths, heroic responses from a steadily growing army of dedicated people and fragmented stabs of leadership. Our collective presence and actions today can alter, for all time, how the next chapters develop.

Lee C. Smith
Chair, The National Leadership Coalition on AIDS
Former President, Levi Strauss International

117 Hacienda Drive
Tiburon, CA 94920
(415) 435-2318 Tel/fax

THIS FORM MARKS THE FILE LOCATION OF ITEM NUMBER 2
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INFORMATION.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington D.C. 20201

FACSIMILE

DATE May 5, 1993

TO: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Carol Rasco
Assistant to the President
for Domestic Policy

456-2216

FROM: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Kevin Thurm
Chief of Staff

690-6133

RECIPIENT'S FAX NUMBER: () 456-2878

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET): 2

COMMENTS:

THIS FORM MARKS THE FILE LOCATION OF ITEM NUMBER 3
LISTED IN THE WITHDRAWAL SHEET AT THE FRONT OF THIS FOLDER.

THIS FORM MARKS THE FILE LOCATION OF ITEM NUMBER 4
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WITHDRAWAL SHEET AT THE FRONT OF THIS FOLDER FOR FURTHER
INFORMATION.

12-17-1992 13:12

6094521865

RW JOHNSON FDN

P.02

EDDY FURVYAR HEARN, Ph.D.

HOME

[Redacted]
P6(b)(6)

BUSINESS

The Robert Wood Johnson Foundation
P.O. Box 2316
Princeton, New Jersey 08543-2316
(609) 243-5911

EDUCATION

Yale Graduate School*	Biophysics	Ph.D.	March 1969
Yale Graduate School	Biophysics	M.S.	June 1964
Skidmore College	Biology-Chemistry (double major)	B.A.	June 1960

COLLEGE AND GRADUATE SCHOOL AWARDS AND ACHIEVEMENTS

College

Outstanding Alumna Award (Skidmore College)	April 1972
Skidmore College Scholarship	1956-1960
Coleman B. Cheney Scholarship	1957-1958
Glancy Foundation Scholarship	1956-1960
Member, Periclean Honor Society	
Graduated with Honors	

GRADUATE SCHOOL

Public Health Service Trainee	Sept. 1966 - Oct. 1968
Public Health Service, Pre-doctoral Fellow	Sept. 1961 - Jan. 1965
Board of Missions of the United Presbyterian Church in the USA	Scholarship 1960 - 1961
Yale Summer Language Institute Fellowship	

*I was granted an 18-month leave of absence from Jan. 1965 to Sept. 1966.

12-17-1982 13:13

6094521885

RW JOHNSON FDN

P. 03

RUBY PURYEAR HEARN, Ph.D.

Page 2

WORK EXPERIENCE

Jan. 1983 - Present	Vice President The Robert Wood Johnson Foundation
Aug. 1980 - Dec. 1982	Assistant Vice President The Robert Wood Johnson Foundation
Mar. 1980 - July 1980	Senior Program Officer The Robert Wood Johnson Foundation
Jan. 1976 - Feb. 1980	Program Officer The Robert Wood Johnson Foundation
Aug. 1972 - Dec. 1976	Director, Content Development, Health Show Project Children's Television Workshop: Future Works Division
Nov. 1968 - Apr. 1969	Postdoctoral Research Associate Dr. J.M. Sturtevant, Yale University
Aug. to Sept. 1965, 1964, and 1963	Seminar Assistant for Life and Earth Sciences, Yale Foreign Student Institute
Sept. to June 1960, 1959, and 1958	Laboratory Assistant for Physics, Anatomy and Physiology, and Biology, Skidmore College
June 1959 - Sept. 1959	Laboratory Instructor in General Chemistry, Atlanta University
June 1958 - Sept. 1958	Laboratory Technician Dr. H.P. Carter, Carver Foundation, Tuskegee Institute

DISSERTATION

"Thermodynamic Parameters in the RNase-S System"

Advisors: Dr. F.M. Richards
Dr. J.M. Sturtevant

12-17-1982 13:43

6094521865

RW JOHNSON FDN

P.04

RUBY FURYEAR HEARN, Ph.D.

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PUBLICATIONS

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"The Use of Medicaid to Expand Public Hospital and Health Department Services for the Poor", (1981). Commonwealth Fund Forum: Medical Care for the Poor: What Can States Do in the 80's.

Brooks-Gunn, J. and Hearn, R.P.
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Cluff, L.E., Hearn, R.P., and Jellinek, P.S.
"Responding to AIDS: The Robert Wood Johnson Foundation's Experience", AIDS and Public Policy Journal, Volume 4, No. 4, 1990.

Jellinek, P.S. and Hearn, R.P.
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MEMBERSHIP

- American Association for the Advancement of Science (1976 -)
- Board of Trustees, Meharry Medical College, Nashville, TN (1981 - 1986)
- Ambulatory Pediatric Association (1982 -)
- Institute of Medicine, National Academy of Sciences (1982 -)
- Board of Overseers, Dartmouth Medical School, Hanover, NH (1986 -)
- The Mayor's Commission on the Future of Child Health in New York City (1987 - 1989)
- Advisory Committee to the Director, National Institutes of Health, Washington, DC (1989 - 1992)
- American Council of Life Insurance: INSURE Board of Directors (1990 -)
- AMA National Coalition on Adolescent Health (1990 -)
- Board of Directors, Grantmakers in Health, NY (1990 -)
- Council on Foundations Research Committee (1990 -)
- National Forum on the Future of Children and Families (1990 -)
- New York City Mayor's Advisory Council on Child Health (1990 -)
- NY State AIDS Advisory Council, W. T. Grant Foundation (1990)
Committee on Adolescents and HIV
- Independent Sector Forum Research Committee (1991 -)
- National Advisory Panel - Institute for Research on Women and Gender
Stanford University (1991 -)
- Steering Committee - Community Anti-Drug Coalitions of America -
President's Drug Advisory Council (1992 -)
- National Infant Mortality Commission (1992 -)
Dr. Louis Sullivan, Secretary of Health

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BIOGRAPHICAL INFORMATION

Ruby E. Hearn, Ph.D. is a vice president of The Robert Wood Johnson Foundation, the largest health care philanthropy in the United States. The Foundation has awarded over a billion dollars in grant funds since its inception as a national philanthropy in 1973. Dr. Hearn has had the major responsibility for oversight and program development of initiatives in maternal, infant and child health, AIDS, substance abuse and minority medical education. Dr. Hearn received her M.S. and Ph.D. degrees in biophysics from Yale University and is a graduate of Skidmore College. She recently was elected a Fellow of the Yale Corporation. She serves on the advisory committee to the director of the National Institutes of Health; is a member of the Institute of Medicine; National Forum on the Future of Children and Families; the Board of Directors for Council on Foundations, Board of CADCA, (Community Anti-Drug Coalitions of America) President's Drug Advisory Council and serves on the Executive Committee of the Board of Directors for the 1995 Special Olympics World Summer Games in Connecticut.

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POLITICAL AND PUBLIC POLICY EXPERIENCE:

AIDS Action Foundation

Washington, DC

Director of Public Policy and Program Development, 1993-

Direct policy analysis and development for related foundation to AIDS Action Council; major policy areas under study now include development of alternative structures for federally funded AIDS prevention programs, assessment of Ryan White CARE Act programs, analysis of health care reform proposals as they affect people with HIV infection, and development of model early intervention programs for people with HIV infection.

AIDS Action Council

Washington, DC

Director of Government Affairs, March 1991-1993

Chief public policy officer for national advocacy organization representing community based organizations responding to AIDS epidemic. Design every aspect of agency's AIDS public policy agenda, from research and drug development/regulation issues to health care financing and public health responses. Oversee lobbying, policy analysis, research, and grassroots organizing functions of five-person department; founding co-chair of 150-member coalition National Organizations Responding to AIDS; extensive media work on various AIDS issues. (Previously one of incorporators and early board members of the Council.)

Health Policy Consultant

Self-employed

Washington, DC

August 1989-

Consulting services provided to a number of organizations, including U.S. Congress Office of Technology Assessment, two committees of the National Academy of Sciences/Institute of Medicine (IOM), Robert Wood Johnson Foundation, AIDS Action Council, and Gay Men's Health Crisis. Member of advisory panel to OTA study on Government Policies and Pharmaceutical Research and Development (1990-). IOM projects included organizing a two-day public hearing of constituency groups for the committee studying the AIDS research program of the National Institutes of Health and preparation of a paper on the decision to permit early release of the drug ddI, an AIDS therapy, before all clinical trials were completed for The Committee to Study Decision Making Regarding Biomedical Innovation in

a Pluralistic Society, which is examining a range of issues from the decision to cover end-stage renal disease under Medicare to the decision to ban importation of RU486 (1989-90). Several site visits performed for the Robert Wood Johnson Foundation AIDS Prevention and Service Program (1990-). Work with the AIDS Action Council and GMHC included preparation of the alternative AIDS appropriations recommendations for the coalition National Organizations Responding to AIDS (NORA) and representation on drug development and access issues (1989-91).

National Gay and Lesbian Task Force

Washington, DC

Executive Director, 1986-1989

Director of Governmental & Political Affairs, 1985-86

Washington Representative, 1983-85

Chief spokesperson and administrator for the nation's oldest gay/lesbian civil rights advocacy organization (formerly the National Gay Task Force). Oversaw lobbying, education, and community organizing efforts related to the civil rights and other concerns of the nation's gay/lesbian community -- from AIDS to antigay/lesbian violence. Represented the gay community to Congress, the federal bureaucracy, state and local officials, and other interest and advocacy groups. Co-founder of now 150-member coalition National Organizations Responding to AIDS (NORA). Extensive media appearances (including the ABC Nightline Town Meeting on AIDS in June 1987 and This Week with David Brinkley in August 1985) and speaking engagements; presenter at numerous professional conferences on AIDS and other issues; participant in numerous consensus meetings on AIDS policy issues sponsored by the Centers for Disease Control, the Association of State and Territorial Health Officials and others. Considerable travel and speaking among gay/lesbian community organizations around the nation. During tenure as executive director, NGLTF membership, budget, and staff more than doubled and crippling debt erased.

Gay Activists Alliance of Washington, DC

President, 1981-83

Vice President, 1981

Secretary 1980-81

Oldest nonpartisan gay political organization in the District of Columbia. Lobbies city government, both legislative and executive on civil rights and AIDS issues. (Now Gay and Lesbian Activists Alliance.)

Jim Smith for Congress

Lynn, Massachusetts

Issues Director, 1978

Prepared issue papers, speech writing for congressional primary campaign.

OTHER PROFESSIONAL EXPERIENCE:

National Clearinghouse for Bilingual Education
Newsletter Editor, 1981-83
Washington, DC

Carrollton Press
Editor, 1976-77, 1980-81
Washington, DC

Frontier Press
Editor
Columbus, OH

EDUCATION:

Cornell University
M.A. in Government, 1976
Ithaca, NY

Oberlin College
B.A. with Honors in Government, 1975
Oberlin, OH

High School of Music & Art, 1972
New York, NY

SELECTED PUBLICATIONS AND PAPERS:

"Homophobia and AIDS Public Policy," in *Homophobia: How We All Pay the Price* by Warren J. Blumenfeld, Beacon Press, (1992).

"Unproven AIDS Therapies: The Food and Drug Administration and ddI," in *Biomedical Politics*, National Academy of Sciences Press, (1991).

"HIV Testing and Access to Health Insurance," presentation at American Bar Association meeting, Toronto, Canada, August 1988.

"The Watkins Report: Where Do we Go from Here?," lecture as part of Institute for Policy Studies Winning America series, Washington, DC, July 27, 1988.

Roundtable presentation on "The Use of HIV Antibody Testing as Part of an AIDS Control Program," Fourth International Conference on AIDS, Stockholm, Sweden, June 1988.

"Access to Care Issues and AIDS," closing plenary speaker, American Public Health Association annual meeting, October 1987.

"What's Ahead for the Gay and Lesbian Rights Movement," National Press Club Morning Newsmakers Series, October 9, 1987.

"Access Issues Associated with AIDS: Discrimination, Services, Care," panel organizer, Third International Conference on AIDS, Washington, DC, June 1987.

"Public Health and the Gay Perspective: Creating a Basis for Trust," in *AIDS: Facts and Issues*, edited by Victor Gong and Norman Rudnick, Rutgers University Press, 1986.

"The Politics of AIDS," paper presented at American Public Health Association annual meeting, October 1986.

"The Invisible Minority: Guaranteeing Gay/Lesbian Rights," *Urban Resources*, Spring 1985.



MEMORANDUM

To: Interested parties

From: Jeff Levi

Re: Prevention blueprint

Date: March 31, 1993

Attached is a copy of the latest (third) draft of the prevention blueprint. As you can tell, it is significantly different from the previous version you may have seen -- a result of considerable consultation and input from a very diverse group of individuals and organizations.

I hope you will consider the substance and the options considerably improved over the last version. Those improvements could not have occurred without your assistance. Please review this document and forward to me -- either in writing (mail or fax) or by phone (I am extension 17) -- your comments and suggestions as soon as possible. We hope to complete this phase of commenting by April 15th.

Thanks again for all your time and assistance.

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AIDS ACTION FOUNDATION
BLUEPRINT FOR CDC HIV PREVENTION PROGRAMMING
DRAFT 3

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Executive Summary

A. Context of CDC Prevention Programming

The two key elements of successful HIV prevention in the United States should delineate the top and the bottom of a pyramid: the base of the pyramid is active community involvement in the planning and implementation of programming, while the top of the pyramid is strong and courageous national leadership. Thus, the power should "bubble up" from the community level rather than "trickling down" from the top.

The leadership must begin with acknowledgement by the President of the seriousness of the HIV epidemic and clear articulation of the specific behavior changes that can stop the spread of HIV. The President's messages must be reinforced by the Surgeon General, the Special Advisor to the President (Czar), the Secretary of Health and Human Services, Assistant Secretary for Health, the Director of the CDC, and the AIDS Director within the CDC. Whenever a new situation or crisis arises that raises public concern, these leaders must aggressively respond with consistent, uncompromising messages that can then be reinforced by grass roots HIV prevention workers at the community level.

Active community involvement must be sought at every level of HIV prevention, beginning with a strong community advisory capacity at the Federal administrative level. People from all communities affected by HIV as well as from community-based organizations (CBOs) involved in implementing HIV prevention programming must be represented in all HIV planning, policy development and oversight activities. Specifically, the voice of the community should inform the development of the national AIDS plan, through full participation and representation of communities who are at risk of HIV infection.

There should be representation by people at risk for HIV on a Community Advisory Board of the President's Special Advisor for AIDS. The Intergovernmental Task Force on AIDS, convened by the President's Special Advisor for AIDS, should have a Prevention Working Group that is heavily representative of people at risk of acquiring HIV infection.

B. Overview

CDC HIV prevention programming currently occurs in two CDC centers and the Office of the Deputy Director for HIV/AIDS. Most funding is concentrated within the National Center for Prevention Services (NCPS). Funding targeting adolescents occurs within the Center for Chronic Disease Prevention and Health Promotion (CCDPHP), in the Division of Adolescent and School Health. Funding of programs targeting the general public occurs within the Office of the Deputy Director for HIV/AIDS. (See Diagram One for the HIV Prevention Programming within each Center.) The Blueprint focuses primarily on one section of the NCPS program: Health Education/Risk Reduction (HE/RR) and Counseling, Testing, Referral and Partner Notification (CTRPN).

AIDS prevention experts accept that the most effective HIV prevention is accomplished by targeting at-risk individuals within their own communities. Therefore, the largest proportion of HIV prevention programming should be implemented at the community level. This should be done by putting a much higher proportion of HIV prevention funds into the cooperative agreements to states under the existing category of Health Education and Risk Reduction (HERR). These funds should be contracted almost entirely to agencies (CBOs and, to a lesser degree, local health departments) functioning in communities at risk.

Although NCPS also has a highly regarded program to contract funding directly to CBOs, this federal-to-local level approach is technically untenable on a large scale. Therefore the Blueprint specifies mechanisms to assure that the HE/RR CTRPN Cooperative Agreements indeed reach the community.

C. Characteristics of Revised HE/RR and CTRPN Programming

The revisions recommended in section three of this document will change HE/RR and CTRPN programs to incorporate the following characteristics:

1. HIV prevention programming in each state is guided by a statewide prevention plan based on regional needs assessments and prevention plans. The plans specify the proportion of funding to be targeted to each population at risk.
2. The proportion of funding for each population at risk is determined not only according to distribution of AIDS cases, but also taking into consideration the estimated present and projected distribution of HIV infection. This is based on an analysis of available HIV surveillance data (not aggregated voluntary HIV test data but based on prevalence and incidence data from population studies), and other indicators as determined by the SPPC to be appropriate for the state (for example, teen pregnancy rates, STD rates, socioeconomic data for various populations).
3. All affected communities participate at the local, state and federal levels in planning, implementation and evaluation of HIV prevention programming. Specific mechanisms for participation include representation on State Prevention Planning Councils (SPPC) and Regional Prevention Planning Councils (RPPC).
4. Affected communities are represented in proportion to relative risk of HIV in each community. This is determined not only according to AIDS case rates, but also according estimated distribution of HIV infection, as described in 2 above.

5. CBOs are the primary recipients of money for performing targeted outreach to populations at high risk for HIV infection.
6. Anonymous HIV testing is available to all people, particularly those at high risk of HIV.
7. Both local health departments (LHDs) and community-based organizations (CBOs) provide Counseling, Testing, Referral and Partner Notification (CTRPN).
8. Administration of the CTRPN/HERR cooperative agreements or grants stipulates that there be:
 - timely allocation of money to CBOs and LHDs;
 - coordination of programming with prevention and treatment services;
 - an expedited appeals process regarding state administration of funding;
 - in the event of inappropriate administration of funds by a state health department, appointment by CDC of an alternative administrator for the funds;
 - no content restrictions on educational materials;
 - technical assistance and timely dissemination of new information to CBOs.

II. BACKGROUND

A. Development of the Blueprint

This Blueprint, based on two years of background work and research, is a series of recommendations to improve the effectiveness of the HIV prevention programming administered by the Centers for Disease Control and Prevention (CDC). The Blueprint recommends changes in how the funding is implemented

at federal, state and local levels.

In 1991, the AIDS Action Foundation (AAF) implemented a study of CDC HIV prevention funding. The study concluded that while the CDC staff had good intentions, the CDC HIV prevention program had several serious flaws. These include: an inadequate proportion of funding targeted to the population most infected with HIV, men having sex with men; lack of attention to the socioeconomic issues that face people of color and women who are at risk; failure to evaluate the impact of behavioral interventions, particularly Counseling, Testing, Referral and Partner Notification (CTRPN); lack of collaboration and cooperation among federal agencies involved in HIV prevention activities; allocation of an inappropriately large proportion of HIV prevention funds to CTRPN.

As a result of the 1991 study, AAF determined to develop a blueprint for effective HIV prevention. Accepting that the most effective HIV prevention is targeted to high risk populations at the community level, AAF wanted in particular to identify mechanisms that would ensure that funding reaches community-based organizations (CBOs) that function within populations who are at risk for HIV. In 1992, through structured interviews and focus groups, a consultant gathered and synthesized the collective wisdom of public health professionals working in HIV prevention education and administrators of agencies that do HIV prevention at the community level. A strong mandate emerged for community level involvement at all levels in the planning and implementing of federally funded HIV prevention programming.

The December 1992 draft of the Blueprint was circulated to federal officials, health departments, CBOs and HIV policy and prevention experts throughout the country, and in early 1993, revisions were made based on reactions and responses to the 1992 draft. The current iteration of the blueprint

presents options for HIV prevention that take into consideration this wide array of input.

III. Health Education/Risk Reduction (HE/RR) and Counseling, Testing, Referral and Partner Notification (CTRPN) Programming

A. Summary

HE/RR and CTRPN funds should continue to be apportioned through cooperative agreements to state and territorial health departments and designated city health departments . (From now on these state, territorial and local health departments all will be referred to as SHD. The designated city health departments will be discussed under Options A and B below.) The funding should be apportioned to the SHDs through a combination of formula (80%) funding and qualitative (20%) review. The formula should not be based solely on number of diagnosed AIDS cases, but should be devised to take into consideration the shifting foci of new infections. A combination of indicators should be used, including: estimated prevalence and incidence rates based on HIV sentinel surveillance surveys (not aggregated voluntary HIV test data) and other indicators, such as STD and poverty rates, as determined by the CDC to be appropriate on a national level.

Within each state, territory or municipal area, the HERR/CTRPN funds are to be allocated according to a Prevention Plan developed by a state-wide prevention planning council (SPPC) representative of the various at-risk communities in a state.

The plan specifies the proportion of funding to be targeted to each population at risk in the state. This proportion is determined by the SPPC based on analysis of a combination of indicators, besides AIDS case reports, including: estimates of prevalence and incidence rates based on HIV sentinel surveillance

surveys (not aggregated voluntary HIV test data), and other indicators as determined by the SPPC to be appropriate for the state (teen pregnancy rates, STD rates, socioeconomic data for various minority populations). This should concentrate programming within subpopulations such as minority men having sex with men and women who are sexual partners of injecting drug users. These funds should then to be contracted out by the SHD to community-based organizations and local (city and county) health departments for actual implementation of prevention programming.

There are two levels of Prevention Planning Councils within most states: the Regional Prevention Planning Council (RPPC) and the Statewide Prevention Planning Council (SPPC). (The exception is small states and the local health departments receiving funds directly from the CDC, in which there is a single Prevention Planning Council with the consolidated responsibilities of the RPPC and the SPPC.) The SHD divides the state into geographic regions, each with its own Regional Prevention Planning Council (RPPC). (See Diagram Two) The RPPC broadly represents all communities at risk of HIV, agencies providing prevention interventions, local health departments, and other HIV and public health experts and epidemiologists. At least fifty percent of the seats are filled by people representative of at-risk populations within the region. (The proportion of representation should not be based solely on AIDS case reports, but also take into consideration factors such as described above.) Members of the Regional Prevention Planning Council may be selected by the local health departments but not by any elected political official. In some communities, the Title I Planning Council may fulfill these criteria, or may be the basis for a prevention planning body. The Planning Council may be convened by one of the local health departments in the region. However, the decisionmaking process of the RPPC should be participatory and democratic.

Each RPPC implements a needs assessment for the region. Based on this information, the RPPC develops a regional prevention plan which is submitted to the SPPC. A key element of the plan is the delineation of what proportion of funding should be targeted to each population at risk. This must be based on an analysis of HIV serosurveillance data, including seroprevalence and comparative recent incidence rates in various populations, and indicators that can be used as surrogate markers for risk of HIV transmission, such as teenage pregnancy rates, STD rates, and measures of poverty. Each regional analysis should take into consideration its unique set of sociodemographic factors. Technical assistance in needs assessment and planning may be provided by the local or state health department, agencies with appropriate expertise, and/or national organizations.

The Statewide Prevention Planning Council is composed of designated members from each of the Regional Prevention Planning Councils. The SPPC functions closely with the SHD according to Option A or Option B below.

B. Option A

Under Option A, the SHDs include all state and territorial health departments and the city health departments that already receive direct funding from CDC (Chicago, Houston, Los Angeles, Miami, New York, San Francisco, and Washington DC). In the six cities, prevention money is not passed through the state but allocated through cooperative agreement directly to the city health department, which functions in the same way as the SHD.

Under Option A, allocation of resources is based on the recommendations of a Statewide Prevention Planning Council (SPPC) to the SHD. The SHD convenes the SPPC whose composition is described in Part A above. Together the SHD and the SPPC review the regional prevention plans and, taking into consideration the overall needs of the various regions of the state, develop a

State Prevention Plan.

The SHD develops a budget for implementation of the Prevention Plan. If the budget diverges from the Prevention Plan, the SHD must provide sound justification for the divergence. However, the SHD can diverge from the plan in administration of the funds if it has strong rationale. The SHD then submits the budget to the CDC for consideration for funding as a cooperative agreement. If the SPPC does not agree with the budget, its recourse is to submit an appeal to the CDC, which should have in place an expedited review process for direct appeal with a heavy bias toward SPPC recommendations. When the money is awarded to the SHD, the SHD disburses the money through an RFP process by which contracts are awarded to LHDs and CBOs throughout the state. The contracts should target various communities according to the priorities articulated in the Statewide Prevention Plan. The SHD provides contract oversight as well as technical assistance to contractors in implementation and process/formative evaluation of programming on an ongoing basis.

A complete listing of the contract awards is made available to the Regional Planning Councils, who provide the regional mechanism for assuring cooperation and coordination among local contractors in implementation of prevention programming.

One advantage of Option A is that the SHDs are directly involved in all levels of needs assessment, planning, implementation and evaluation of local programming. Another advantage is that SHD involvement assures better integration of prevention programming with existing public health services at the community level. A third advantage of Option A is that it can be immediately achieved administratively through changes in the cooperative agreement structure rather than requiring legislative changes.

A disadvantage of Option A is that it does not give full control of

programming to the community. A second disadvantage is that the failsafe mechanism for community grievance is dependent upon the CDC exercising strong oversight in relation to the states, which it has not done in the past.

C. Option B

Under Option B, the CDC would fund grants or cooperative agreements with all state and territorial SHDs as well as all the city health departments receiving Ryan White Care Act Title I funding. The Ryan White cities would function as SHDs in the description below, without the requirement for regional planning councils.

Under Option B, the SPPC holds ultimate decisionmaking authority over the Statewide Prevention Plan and the SHD must administer the plan exactly as written. The SHD also convenes a Statewide Prevention Planning Council (SPPC) whose composition is discussed in Part A above. The SPPC independently reviews the regional plans, and, taking into consideration the overall needs of the various regions of the state, develops a State Prevention Plan. Each Ryan White city would be a regional planning council for state planning purposes. They would sit on the SPPC to assure coordination of programs.

This plan is submitted to the SHD, which develops a budget for the plan, subject to the approval of the SPPC. The SHD budget must reflect the plan developed by the SPPC. This budget is then submitted to the CDC for funding as a grant or cooperative agreement. The SHD then administers the funds, which are contracted through an RFP process to LHDs and CBOs. If the SPPC does not feel the SHD has complied with the State Prevention Plan, its recourse is to submit an appeal to the CDC, which should have in place an expedited review process for direct appeal with a heavy bias toward SPPC

recommendations.

An advantage of Option B is that it provides more direct community control of prevention programming through representation on strong regional and state prevention planning councils.

A disadvantage of Option B is that it disempowers state health departments. Another disadvantage is that implementation of the plan would require legislation, because it departs from the traditional relationship between the federal government and the states, meaning that implementation would not occur until FY 1995.

D. Other Stipulations

1. CBO and LHD Programming

In principle, CTRPN funds should be contracted partly to CBOs and partly to LHDs (except in states with low seroprevalence, where it may be more cost-effective for the state to maintain this function). The proportions should be determined in the Statewide Prevention Plan by the SPPC with input from each RPPC during the needs assessment.

The primary HIV prevention function of LHDs should be CTRPN, particularly within STD and primary care delivery systems. The Regional Planning Council may decide whether other types of prevention programming are appropriate for the LHD, but for the most part, CBOs should be awarded HE/RR funding, even if the programming is within health department facilities.

In implementation of HE/RR-funded contracts, the selection of appropriate prevention interventions should be determined by the CBO seeking funding, and should be based on needs assessments, knowledge of the target audience, sociodemographic information and the expertise, characteristics and personality

of the CBO.

2. Coordination with other services

The applicant for funds must be required to demonstrate effective coordination of CTRPN services with other resources for at-risk individuals such as STD services, family planning and perinatal services, substance abuse treatment programs and other services. At a maximum this may involve full prevention case management, or at a minimum it may involve referral mechanisms with these programs. The result in either case should be a comprehensive range of services to assist clients coping with the socioeconomic and cultural problems contributing to risk taking. The provision of incentives is an acceptable means of obtaining client participation in prevention programs.

In addition, applicants must be required to demonstrate effective coordination of programming with services for HIV-infected individuals, including early intervention services.

3. Anonymous testing

The option of anonymous testing must be accessible to all residents of every state, in a form readily available to populations at high risk for HIV.

4. Specific target populations

Categories of risk which are used for needs assessment and planning should be based on local seroprevalence and incidence data and other relevant indicators and should include specific categories when appropriate, particularly to define populations not reached by more generic categories. For example: 1) men who have sex with men but do not identify as gay or bisexual; 2) African American men having sex with men; 3) women having sex with male injecting

drug users; 4) female injecting drug users; 5) Latino injecting drug users; 6) high-risk youth; 7) high-risk gay male youth.

When CBOs (or local health departments) are funded to target subcommunities with whom they may be unfamiliar (specific populations within a larger cultural group, such as African American men having sex with men), potential cultural biases in the agency towards the targeted subcommunities should be addressed by the SHD, both during contract negotiations and throughout the life of the contract.

5. Monitoring SHDs

Mechanisms must be in place for the CDC to monitor SHDs to assure that prevention programming is being implemented in accordance with accepted public health principles and in accordance with the stipulations of the grant or cooperative agreement. Mechanisms should include an established grievance procedure for Planning Councils, agencies and individuals within a state to appeal to the CDC. The appeals process must be expedited within a specified, reasonable time frame. If a SHD is found to be administering funds inappropriately, (whether because of ineptitude, legislative mandate or local community pressure), CDC must appoint an alternative administrator for the funds.

6. Other Stipulations in the Cooperative Agreements

Disbursement of money to CBOs and local health departments must be mandated to occur in a timely fashion, according to a specific timeline. There must be no changing of reporting requirements during the contract year.

SHDs must be required to provide detailed information to the community regarding funds that are allocated, deliverables that are required of contractors

(CBOs and local health departments) and the outcomes that are to be produced. The reports submitted by contractors to the state and by states to the CDC should be easily accessible to other contractors and to the public.

7. Educational Content Restrictions

For educational materials developed with CDC funds, there should be no content restrictions and requirements for review by the Office of Management and Budget (OMB).

8. Technical Assistance

The CDC should allocate prevention capacity enhancement funds to appropriate contractors or agencies to provide technical assistance to CBOs. This should not be a function implemented directly by the CDC.

Effective mechanisms must be established for large-scale, up-to-the-minute, and ongoing information dissemination and technology transfer of research findings by CBOs, CDC, NIDA, NIMH and universities to state and local health departments and CBOs, especially regarding effective prevention strategies. Various suggestions and existing systems that could be amplified (within this and other CDC prevention programming) include computer-based information exchange, and conferences. There is a continued need for technical assistance to small CBOs in areas such as grant writing and program planning and evaluation.

9. Roles of the SHD

The primary HIV prevention roles of SHDs should be to coordinate state prevention activities, administer funds to CBOs and LHDs, and to provide them with technical assistance in needs assessment, in analysis of HIV seroprevalence

and sociodemographic data for planning, in implementation of prevention programs, and in process/formative evaluation.

10. Small CBOs

Large and small agencies should be measured by different yardsticks rather than being expected to demonstrate the same capabilities; a pool of money should be maintained for supplementing small CBO costs such as overhead and proposal-writing costs, which are more easily absorbed by large agencies. Assuring small CBOs sufficient funding for operating costs is problematic, particularly in low prevalence states which have small prevention budgets and which must target not only several discrete populations at risk for HIV but also rural areas. However, it is imperative to maintain grass-roots HIV prevention programming. Funding of CBOs to do HIV prevention should be sufficient to enable the agencies to provide their staff with competitive wages and benefits packages. In addition, in many states funding should take into consideration the higher health insurance rates charged to agencies with known HIV infected people on staff.

11. Evaluation

For the purposes of this blueprint, we will separate evaluation into two broad categories: process/formative evaluation, which should be included in the LHD or CBO contract; and outcome evaluation, which should not be included in the HE/RR-CTRPN cooperative agreements or grants at all.

Process evaluation determines whether the project was implemented as planned and usually involves easily measurable objectives such as training of a certain number of people and improvement of pre- to post-test scores by a specific amount. If the investigation involves rapid feedback to the project staff

so that changes can be made in the program to better achieve the objectives, the term formative evaluation is used.

In the contracts granted by SHDs, process evaluation should be enhanced by formative evaluation, and technical assistance should be provided to enable CBOs to implement both. Process indicators should not be defined in the RFP but should be determined jointly by the CBO and the funding agency during the process of contract negotiations. This type of evaluation should at most require a small amount of additional staff time for documentation and monitoring, and thus does not require large amounts of additional funds.

Outcome evaluation identifies consequences of an intervention or project and establishes that consequences are attributable to the intervention or project. This type of evaluation must be carefully designed and implemented, usually by experts in evaluation research, and it is expensive and takes time. It needs to be built into programming during the planning stages. The CDC has been criticized for doing insufficient outcome research on HIV prevention interventions and has received extensive recommendations from the National Research Council on how to implement proper outcome research. The NCPS Community Demonstration Projects comprise the existing evaluation research being done on HIV prevention interventions. (See Item IVB Below)

Targeted community-based interventions should be a priority for evaluation, but in general priorities should be determined only with strong input from a representative community advisory group. For the most part outcome evaluation should examine prevention interventions rather than specific prevention programs, and thus can be done across sites. The source of funds for outcome evaluation should be a separate budget item from the HIV prevention programming itself (for example, the funds for CTRPN or HE/RR) and should not exceed 5% of the overall prevention budget. Evaluation activities should be

contracted out to agencies with evaluation expertise, not implemented by CDC staff.

CTRPN receives nearly one quarter of all CDC HIV prevention funds although it has not been determined to be an effective prevention intervention. An expert panel which includes behavioral scientists should examine all the research that has been done on the effectiveness of CTRPN as a prevention intervention, including the NCPS Community Demonstration Projects. The report of these findings should be presented to Congress as it considers the 1995 budget for HIV prevention to assist in determination of appropriate allocation of prevention funds.

IV. OTHER HIV PROGRAMMING IMPLEMENTED BY CDC

A. National AIDS Information and Education Program (NAIEP)

As a program administered directly out of the CDC AIDS Office, NAIEP should exhibit leadership in the dissemination of accurate, up-to-date and forthright information, both to the general public and to on-the-ground AIDS prevention programs who require access to constantly updated resources. This office must not bow to political pressure by withholding or watering down vital HIV prevention information. NAIEP should set the standard and the pace for community prevention programs: they need support in addressing local community resistance to accurate HIV information.

The single most important campaign that NAIEP must mount is condom social marketing. This should encompass both an information campaign directed to the general public and technical assistance to community HIV prevention programs (both local health departments and CBOs) in how to implement locally based, community-appropriate condom social marketing.

The National Hotline should remain in place as a 24-hour number available to persons in crisis and to those seeking information and local resources. The program should be directly accountable to a community advisory group representative of communities at high risk of HIV infection. More effective quality control mechanisms need to be in place to assure that hotline callers receive consistently accurate responses from Hotline staff. The National Hotline could be a source of technical assistance to local hotlines, many of which have problems maintaining accurate information, up-to-date referrals, and counseling skills.

The National Clearinghouse should also be accountable to a community advisory board to assist it in restructuring its programming to meet the needs of programs targeting a diversity of populations at risk for HIV infection.

B. Community Demonstration Projects

The current Community Demonstration Projects should receive funding until their completion in 1994 with three stipulations. First, each Project site should participate in the planning process in its city and communicate with other CBOs and the LHD regarding its activities. Second, early findings should be provided to local communities and should also be communicated to HIV prevention programs throughout the country through conferences, reports, and other established mechanisms for technology transfer. Third, a principle outcome of each project should be evaluation reports, and if the interventions are found to be effective, technical assistance manuals and model educational materials should be developed and made easily available to enable CBOs and LHDs to adapt and replicate these projects.

A strong community advisory component should be utilized in determining whether and how to continue the Community Demonstration

Projects. One strong possibility is to incorporate the funding into condom social marketing demonstration projects being undertaken by NAIEP.

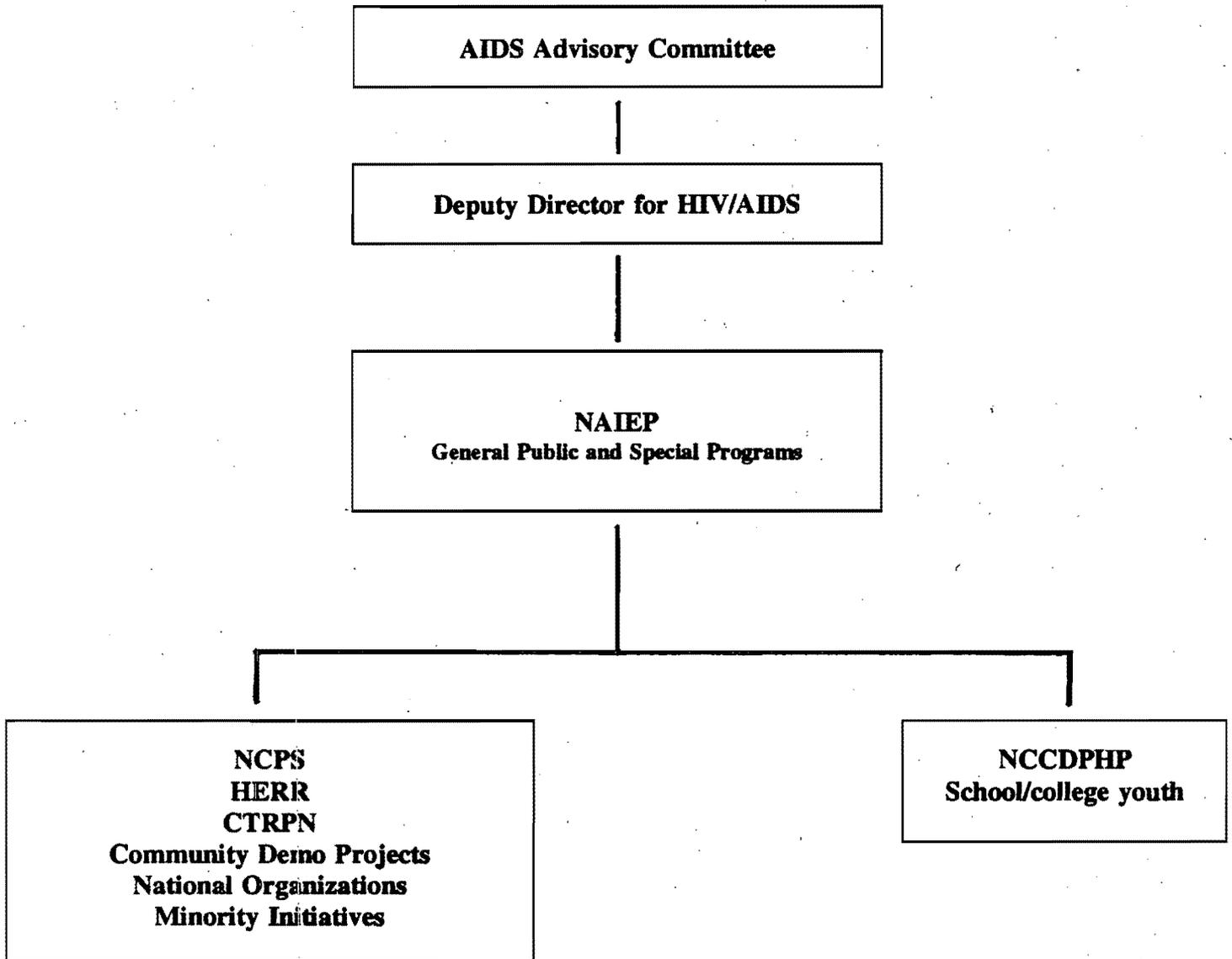
C. School and College Aged Youth

All of the programming targeting in and out-of-school youth has been critical, albeit pathetically insufficient to have a significant impact. Any funding added to this budget line should be directed to programming for high-risk youth, particularly runaway youth and gay youth.

D. National Organizations and Minority Initiatives

Specific national organizations, including minority organizations, should continue to be funded. The U.S. Conference of Mayors is an example of a national organization that provides strategic funding of CBOs for capacity building and infrastructure building; the National Minority AIDS Council is an example of a minority organization that provides technical assistance to CBOs. These functions are useful on a national level.

Centers for Disease Control Prevention Programming



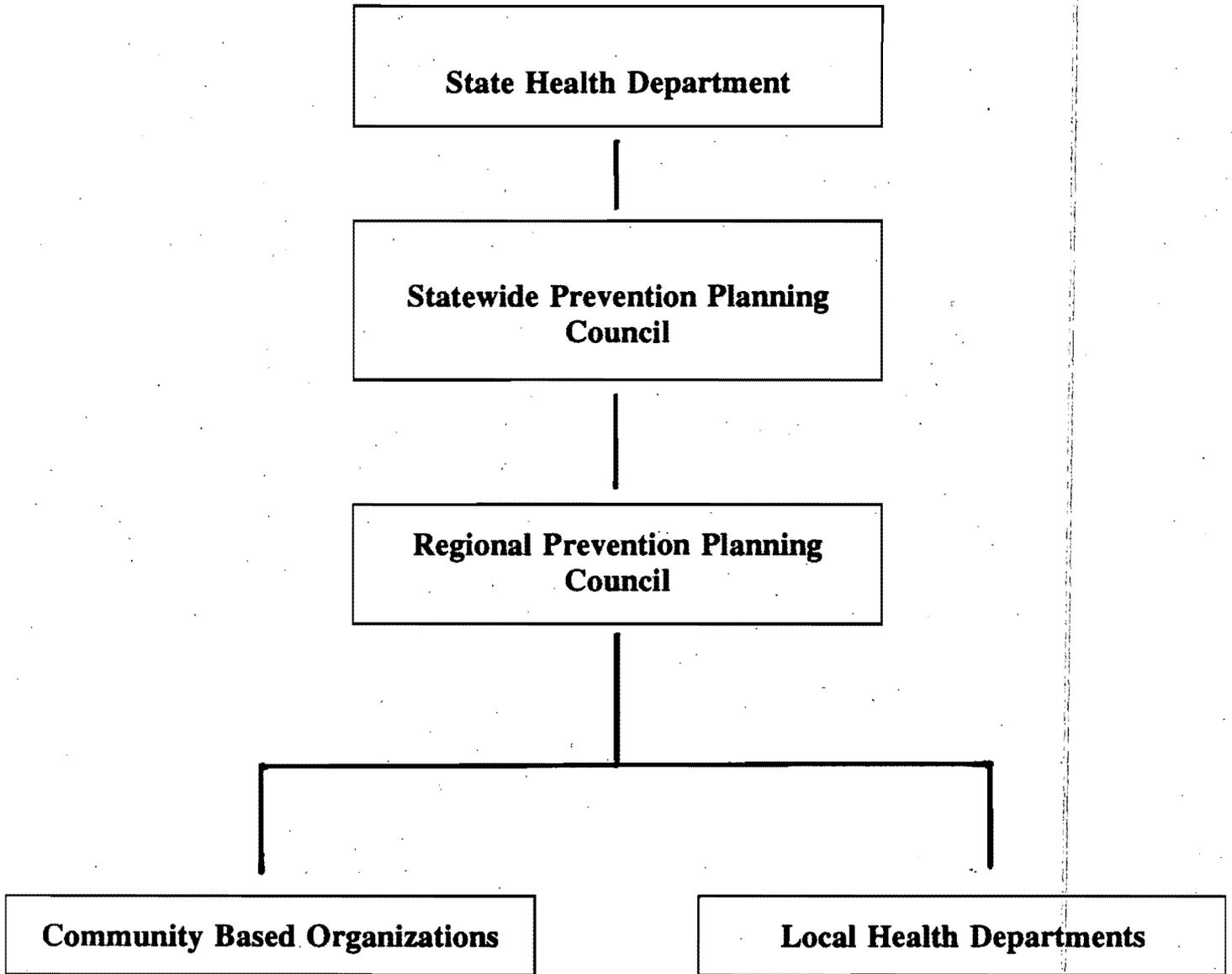
State Health Department

**Statewide Prevention Planning
Council**

**Regional Prevention Planning
Council**

Community Based Organizations

Local Health Departments





DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington D.C. 20201

FACSIMILE

DATE APR 20 1993

TO: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Carol Rasco
Assistant to the President
for Domestic Policy

456-2216

FROM: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Kevin Thurm
Chief of Staff

690-6133

RECIPIENT'S FAX NUMBER: () 456-2878

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET): 3

COMMENTS:



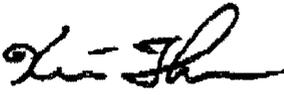
DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

APR 20 1993

TO: Carol Rasco

FROM: Kevin Thurn 

SUBJECT: Lee Smith

Conversations with Lee Smith about the position of AIDS Advisor began in mid-February. Since then he has met with Secretary Shalala, Assistant Secretary-Designate Phil Lee and other staff at HHS including Tom Goodwin, Special Advisor to the Secretary for Personnel. These conversations took place prior to our agreeing on a structure and role for the Advisor and while they were helpful we were unable to discuss specifics and answer some of his questions. Since then we have sent him a memo describing the position. Your conversation with him should be much more specific since we have resolved many of the organizational questions.

Lee is a thoughtful man who will have further questions about the role and expectations. His questions should not be interpreted as negative but rather as reflective of his desire to ensure that there is clear understanding of responsibilities and that there is good rapport among himself and senior White House staff.

One issue he feels strongly about is his view that issues related to AIDS should be separated from those around gay rights. Though he appreciates the overlap of those affected by the two issues and is supportive of rights of gays and lesbians, he feels that more headway can be made if the two are not tied to each other.

Lee will want to hear your view of the position and discuss how his views mesh with yours. He is likely to want to be more of an inside person than a cheerleader, though he is an accomplished public speaker and has good public presence. He does not want to be the only person in the Administration speaking on AIDS issues, but sees part of the responsibility of the Advisor to get others to address the issues as well.

He has also expressed interest in why we have stopped pursuing the "medical model," i.e., Peggy Hamburg and Mark Smith. Why are we now pursuing someone quite different? He has been told that there was never a decision to pursue only candidates with a medical degree and that it is only speculation that the Administration had adopted that model as ideal. As you may recall, we have urged that if Lee is chosen that someone with a medical degree is selected as his deputy.

He may raise issues about meeting in with the President before his decision and access to him afterwards. I believe the AIDS Advisor's credibility and position will be enhanced if such a meeting took place and some level of access in the future is assured.

If you have any questions, please give me a call.

THIS FORM MARKS THE FILE LOCATION OF ITEM NUMBER 3
LISTED IN THE WITHDRAWAL SHEET AT THE FRONT OF THIS FOLDER.