

National HIV Prevention Conference 2009
Monday August 24th, 2009 Morning Plenary Sessions

Yo no sabía nada de VIH
porque no se hablaba

en mi escuela
y no se hablaba en mi casa.

Cuando el doctor me dijo
que yo era positivo de VIH,

yo no le dije nada a nadie.

Ya yo sé como la comunidad trata
a la gente que tiene el VIH.

Yo no quería ser tratado así.

Y ahora yo tengo VIH
y tengo 17 años.

¿Cómo eso pasa?

Woman: Buenos días.

Si requiere servicios
de traducción,

por favor vaya a la final
de la sala

para recoger su equipo
de traducción.

Muchas gracias y tenga
una buen conferencia.

I'm back.

[Laughter and applause]

Good morning.

Attendees: Good morning.

Bates: I do not hear you.
Good morning.

Attendees: Good morning!

Bates: And welcome to Day 1 --

well, I should say
the beginning of Day 1/2,

the second day
of this conference.

Because last night
was really the kickoff night,

it was fabulous,
and I think, right now,

for all of you
who were here last night,

let us give a round of applause

to all the PWAs
who spoke to us last night

and shared their stories.

It was amazing.

We have a great panel today
and we're going to take you

through an experience to talk
about the strategic plan

for HIV/AIDS in the U.S.

But before we go there,
they gave me the mic.

Now, the last time I spoke
at this conference,

I got into a lot of trouble.

I'm assuming I won't today.

Eight years, folks.

It was eight years
of budget cuts.

It was eight years of
abstinence-only.

It was eight years
of "condoms don't work."

It was eight years of

"bad people do bad things,
so bad things happen to them."

It was eight years
of "monogamy until marriage."

It was eight years of
fear of terrorism in America,

which continues.

And it was eight years
of your voices somewhat silent.

But we made it.
We're here.

[Applause]

And we're fiercer than ever,

and if that's the best
you can do, go home.

Give us a round of applause,
because we made it!

[Cheering and applause]

I believe in you.

I never stopped
believing in you.

I believe that you
will take advantage

of the opportunity
that sits before us

with this new administration,
this new President,

and with renewed energy
that I have felt

for the last six months
in this nation.

I believe in you.

I believe that you will hold us,
the federal government,

hold our feet to the fire
and make us come through.

is that the best you can do?

I believe in you.

I believe in the fact that

you will not be afraid

to speak up, to speak out,
to speak often,

to communicate with us,
to tell us your problems,

to tell us your challenges,

to tell us your hopes
and aspirations

for us moving forward
in our response

to the domestic
HIV/AIDS epidemic.

I believe that you believe
we can make change.

[Applause]

I believe that you believe
that we will fight back,

we will fight strong,
and we will fight hard.

This economic downturn

is going to be
a big challenge for us.

The coming back from it

is probably going to be
very slow.

Already,
we see state governments

pulling back
and cutting back on resources

that are very, very important
to the survival of organizations

and to the services
that you provide.

We have to hold everybody
accountable, so you,

each and every one of you
who work in this arena,

have an obligation
to educate your communities,

not just about AIDS

and the importance
of being tested,

but the importance
for your work to continue,

for the importance
of your work to be scaled up,

for the importance of leadership
all across this country

to give HIV its due.

I believe in you.

I believe each
and every one of you

will step up to the challenge,
become partners with us,

and we will move this HIV
domestic agenda forward.

Because I believe in you.

[Applause]

This exercise we're
going through this morning

is really to highlight
where we hope to move

in terms of
a National HIV/AIDS Strategy.

We will hear
from each of the panelists.

After their remarks,
we will come

and have an opportunity
to field questions,

and then I will ask questions
of them, and, if time permits --

which it probably won't,

because this is a tight panel --

we may take one or two
questions from the audience.

But first and foremost,

let me introduce
the members of the panel.

Our first speaker will be
Jeffrey Crowley,

Director, Office
of National AIDS Policy

and Senior Advisor on
Disability, the White House.

[Applause]

The next speaker will be
Faye Malitz,

Director, Division of
Science and Policy,

Bureau of HIV/AIDS,

Health Resources and Services
Administration.

[Applause]

Carl Dieffenbach,
Director of the Division of AIDS

at the National Institute of
Allergy and Infectious Diseases,

National Institutes of Health.

[Applause]

Beverly Watts Davis,

Senior Policy Advisor on
Substance Abuse Policy and AIDS,

Office of the Administrator,

Substance Abuse and Mental
Health Services Administration.

[Applause]

David Vos, Director of

the Office of HIV/AIDS Housing,

U.S. Department of
Housing and Urban Development.

[Applause]

And our beloved friend,
guru, counselor, mentor

Kevin Fenton,
Director, National Center for

HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.

[Applause]

Mr. Crowley.

[Applause]

Thank you, Christopher.

It's a real pleasure to be
here today and talk to you

about our important work
together.

I first, though,
want to just applaud SAMHSA

and Beverly Watts Davis
and CDC and Kevin Fenton

for a great conference --
it feels like

a great opportunity,
that we're all coming together,

really doing some important work
over the next few days.

So, as you all may know,
during the campaign,

the President made a commitment
and I've been tasked with

helping develop
a National HIV/AIDS Strategy.

It's really the President's
top domestic HIV/AIDS priority

and it's something that he,

personally,

is really committed to.

I also think it's really
an important opportunity

for all of us, for the HIV
community, where we can --

See, it's not about, to me,
just what the end product is.

So we'll produce a report,
but we really shouldn't be

looking at
and judging our success

by what are the words on
the page at the end of the day.

It's really about the process
that will lead us

from here to there
and getting there.

It's our hope that we can really have a real important

national dialogue
that involves all of us,

but we really broaden this to,
really, a national conversation

and ask some tough questions
about where are we

in response to the HIV
epidemic in 2009.

You know,
I always start with this idea

that we are doing lots
of things right,

so it's not that we're starting
from failure, but it's really

a good time to assess
and, really, how can we

sharpen our focus and really do
a better job responding?

I want to give a plug

for something we're all doing
tomorrow night.

You may have heard --
we're holding our first

community discussion,
here, in this ballroom,

tomorrow night at 6:30.

I hope you all come.
I urge you to come early.

We're expecting
a pretty good crowd.

We'll also have other people
from the Atlanta community.

If you've registered
for the conference,

you've registered
for this discussion,

so I hope you can join us.

So when we think about this
strategy that we're developing,

we really envision a process
that, you know, I'm working on,

certainly, from the White House,
but it's much broader.

And, you know, I'm really happy
to be joined on the stage

by this great panel
of federal experts.

And we need to remember

that these aren't just
people in jobs,

these are key national leaders
and they have a lot of expertise

and they're just some
of the people,

across our federal government,

that we're really going to be
turning to as key leaders,

as we work together
to develop the strategy.

So I'm just really happy
to be with them today.

Now, in doing this work
from the White House,

I actually feel like
I have a lot of support.

You know, as I said,

the President's deeply
committed to this issue.

I had a chance
to talk to him once

and, you know, he sort of briefly just said, you know --

to paraphrase --
he's doing lots of things.

He's like, I want you to help me
help the American people

understand how important
this is to me.

And I really believe that.

But also, just within my world,

I work in what's called
the Domestic Policy Council.

My boss is Melody Barnes,

she is an assistant
to the President;

she is the Director of
the Domestic Policy Council.

She, personally, is really
invested in helping us develop

a better response
to the HIV/AIDS epidemic.

But I'm also really excited.

You know, some of you
may have heard --

I'd been on the job
about six months

and I've spent time building
a team and I'm starting

to get them in place
and so I'm really excited

about a number of distinguished
and qualified people

that have joined me

at the Office of
National AIDS Policy.

They're down here today.

The first is Greg Millett,
who is on detail from CDC.

[Cheering and applause]

I think many of you know Greg.

He's already contributed so much
to ending this epidemic.

He's done really important
work at CDC.

You know,
his cutting-edge research

on black and Latino MSMs,
in particular, stands out

as something that will really
make an important contribution

to what we're doing as we
develop this national strategy.

And he's serving as
our Senior Policy Advisor.

We're really expecting
a lot from him, but so far,

he's been about a month
on the job,

he hasn't disappointed yet.

The next person is James Albino,
who's a week on the job.

He comes to us
from the Hispanic Federation.

[Cheering and applause]

And he's going to be serving
as our Senior Program Manager.

In effect, one of
the key roles for him is

to really make the trains
run on time.

And, you know, when I started
this job, I didn't know James,

but I've had the opportunity
to interact with him

over a number of occasions.

He's brought groups in.

And, I mean,
we can joke about it,

but the way he managed
these groups and made sure

he kept them on task --
I really took a mental note,

I said, I need someone like that
to make sure

we make things happen
in our office.

So we're really happy
to have him join us.

He's also done important work
on health disparities.

He's going to lead a lot
of our efforts there,

doing outreach and working
with the Latino community,

but really working a much

broader range of policy issues.

So we're really happy
to have James.

And then the next person,
I'm also really excited about,

and that's Adelle Simmons;
she's joining us --

[Applause]

She's on detail from ASPE;
this is the part of HHS called

the Assistant Secretary
for Planning and Evaluation,

but it's really the policy arm

for the Department of
Health and Human Services.

And she has really broad
health policy expertise,

but it's also grounded in HIV,
and so we're really excited.

She's going to be leading
our work in a number of areas,

including our work on looking
at how we respond

to issues around women
living with HIV.

She's jumped in, she's really
our technical expert on a lot

of health issues, including
the Ryan White Program.

She's been working
on prison and other issues.

So, again, we're really excited
to have Adelle join us

and this really sort of
rounds out our policy team.

I have a couple more people
coming, so, hopefully,

within a couple weeks, we'll
sort of fully be staffed up.

But I have to tell you,
it's just, personally,

just a privilege to be working

with such smart, strategic,
and really passionate people.

And so I think you can expect
a lot from them,

but I also think they're
going to deliver for us.

So now, I want to talk about how
we sort of get there from here.

So we've been tasked
with developing

a National HIV/AIDS Strategy
and, I have to tell you,

in some respects, I'm daunted.

It's a big challenge and I know,

just all the ideas and energy
we have in this room,

it's hard to think that
we'll all come together

and make it --
we'll all come together

and there'll be a perfect
product at the end.

But I really think
we've laid some groundwork

to do some good work and we're
really going to get there.

So I spent the last six months

really thinking about
what do we need to do.

You know, there are probably
thousands of key issues

around HIV

that we could focus on,

but I think the question,
for me, is what do we do

that really is strategic,
you know?

I said, before, that, you know,
my plan for the strategy

wasn't to produce
a coffee table book.

So what I mean by that is
you shouldn't expect

to see from us
a report at the end of the day

that has 300 objectives

so you're just lost
in the minutiae.

I would consider that,
quite frankly, a failure.

I hope that
we produce something,

at the end of this process,

where we can see
a clear set of priorities.

So someone not in this room,

some member
of the general public

that isn't overly focused
on AIDS

can pick up what we do and say,
"Okay, now, I understand.

"This is where we are and these are the top priorities

for the nation
for moving forward."

Now, that will be challenging,
but I believe we can get there.

So I spent time talking
to people and sometimes,

I have to say,
I would joke about this,

but it felt like my head hurt
because everybody would come in

and say, you've got to
deal with this,

then you've
got to deal with this,

and there's just so many issues.

But what we're really
going to focus around is

the President's identified
three goals for the strategy,

and I think that's how

we're going to focus our work,
going forward.

So I think he's going to
evaluate our success

to the extent we set aggressive
but achievable targets

for achieving his goals,

and that's really grounded
in the best available evidence.

So the President's goals are
reducing HIV incidence,

getting all people
living with HIV into care --

and, by that,
we think expansively,

so that also means
improving health outcomes.

And then also, addressing
and, really, reducing

HIV-related health disparities.

Now, I recognize each one
of these issues is huge,

but I also think
it gives us a focus.

So we're saying we're focusing
on these three goals --

reducing incidence,
getting people into care,

and addressing
health disparities.

So reducing incidence.

Now, I have to say that
I have a lot of questions

about what that means,
what do we need to do?

I think we can start
with recognizing that,

with more than 56,000
new infections each year,

we just have to say
that's unacceptable.

So we need to do more
and we need to do better.

But we also have to be mindful
and I think we also,

when we talk about our work,

we have to tell the story
so people understand

we're not starting
from a point of failure.

You know, CDC, there are state
and local health departments,

community-based organizations,
schools, churches, many others,

we've been hugely successful

at lowering HIV incidence
from its previous highs.

And sometimes
how we talk about things

really affects
how people respond to us.

So when we talk about

lowering incidence
and really reducing this 56,000,

it's really important
that we start with this idea

that we're building on success,

but we expect all of us
to do better.

Now, I don't want to have
any of my ideas

sort of narrow the focus
of what we look at when we say

"reducing incidence,"
because, again,

it's really
a national conversation.

But one of the issues
I really want to look at is

how can we do better

in reducing HIV infection
among gay and bisexual men?

You know,
I think we've always heard,

from the beginning
of the epidemic,

that they've been
dramatically affected,

but sometimes I hear a lot
of talk, not necessarily

in our community, but more broadly, that HIV's moved on,

there's these other
populations of focus.

I think, if you asked
the average American,

they wouldn't believe

that more than half
of all infections today

are in gay and bisexual men,

and I think we really need
to look at these issues.

But if you look just
in this population

of men who have sex with men,

there's a lot of problems
we need to tackle.

There's huge racial disparities.

You know, black gay men
are far more likely

to be infected with HIV
than white gay men.

And issues like that,
we need to tackle head-on.

And then there's
huge disparities like

Latino MSM are much more
heavily impacted.

So we need to come up with
a strategy where we're prepared

to not ask just those questions,

but those are questions
we can't run away from.

How can we do better

about lowering incidence
across all MSM,

but really focus
on these populations that

are disproportionately
being impacted?

I don't know how
we navigate this.

You know, inevitably,

you have these discussions

where it feels like one group
is pitted against another

and that, really,
we can't let happen.

I think we all
have to be prepared

to have honest discussions,
trust each other, and recognize

we're going to ask
some tough questions

and, at the end of the day,
we'll get to a better place.

I also think we need
to remember that,

for this to be
a national strategy,

it can't just be
all of us in this room.

It's a pretty big room,
but, really,

we need a strategy
that's much broader

than just the HIV community.

We need to figure out ways
to reach out and engage,

broadly, the American public.

One of the things I think
the President has recognized is

we really lost our focus
on the domestic epidemic

and I think he's committed
to spotlighting that.

And for us to do that,
it can't just be

about what we say in this room,
it's really about how

we all engage more broadly
with people.

So, again, the issue of MSM
is just one issue,

but we have a lot of tough
issues, but, hopefully,

we can really come up
with some clear priorities

about how we're going to
reduce HIV incidence.

The next big issue is

increasing access to care
and improving health outcomes.

Now, before I talk
about the strategy,

I do want to raise one issue
that I know is

of significant concern
to many people,

and that's
the Ryan White Program.

So as many of you know,
this program currently has

what's called a hard sunset
at the end of September.

So without Congress
taking any action,

that program
would theoretically go away.

And let me just reassure you
that the Obama administration

is fully committed
to continuing this program

beyond the end of September.

[Applause]

As we get closer,

I think it's helpful

for people to raise attention.

So while we're busy doing
so many things,

addressing so many
national issues,

that we're reminding
our policymakers

that the deadline is nearing,
but I also want to convey to you

that this is
a top priority for us.

We're determined
to let it continue.

I know there's some questions.

Well, what if this happens?
What if this happens?

We don't always have budgets
by the end of the fiscal year.

We're committed to working
with Congress and we have been

working with the Congress
extensively already,

so we're on a good path
but we're going to make sure

that these vital services
will continue.

Now, as we think about
the strategy and what is it

we do to get all people
living with HIV into care,

it's actually really interesting

because we're really
at a time of flux.

If you haven't noticed,

we're having a major national
conversation about health reform

and that's really important

and part of our challenge

about HIV,
getting people into care,

is really affected
by this dynamic.

But we also have to recognize

there's some urgency
in what we're doing.

We can't sit back
and wait four years

to say, okay, how is this health reform going to play itself out
and then we'll do stuff.

But I think that health reform

also creates
important opportunities.

I do believe that
we're going to get

comprehensive health insurance
reform enacted this year.

Certainly, it's a top priority

for the President
of the United States,

so we will get this done.

[Applause]

But no matter what happens
with health reform,

we're still going to need
HIV-specific responses.

We're still going to
need the Ryan White Program.

We're still going to need
the important work

of SAMHSA, HUD, CDC,
all these other agencies.

So I still also think that we
have a lot of positive lessons.

You know,
it's fascinating to me,

when I think about
the health reform debate,

one of the ideas
that's caught hold is this idea

we need to give everybody
a medical home.

So to do a better job

integrating care,
coordinating care,

people have a place that
they call a medical home.

And we can say, from HIV,
well, hey,

we have some experience in this,

in the Ryan White Program,
we have some lessons for you.

But I'd also say that
what we need to do,

as part of the strategy,
it's not just about

following on the health
reform conversation

and getting everybody covered.

You know, if we're going to
improve health outcomes,

there's a lot more
we need to do.

You know, I'm glad to have
David here from HUD so that,

you know, this is not
an HHS conversation,

this is much broader.

But, clearly, looking at housing has to be a big priority for us.

You know,

since I've been on the job,

I've heard a lot from people,
people with AIDS and others,

that just say, my biggest
barrier to getting services

is the lack of housing.

Or, you know, people telling personal stories

about how they want
to stay in care,

but if they have
no place to live,

it's really challenging.

So one of the things we need
to do in our strategy process is

really take a look at,
well, what is the role

and how can we bolster that,
what we're doing,

to provide stable,
safe housing for people,

and how can we integrate this
into our efforts

to provide health care?

So that's just one thing
that we plan to do.

So in that,
I would also just say that

there are several
other questions.

So one of the things
I've heard a lot from

is that we've had a big push,
recently, on HIV testing

and we think
that's really important.

We need to identify people
to get them into care.

But are we doing
everything we can

to strengthen this linkage
from an HIV test into care?

And that's something I know
that the Department,

across the agencies, are really
committed to looking at.

And so, again, this is not
an internal conversation here,

it's a national conversation,
so we welcome your input.

So the third goal is also one
that is huge.

What are we going to do

about reducing HIV-related
health disparities?

And this is one, I have to say,
there's so much we need to do.

I think part
of what we need to do is,

we need to frame out
what are our priorities.

Because we know
so many disparities exist.

You know, I mentioned, earlier,
the disparities

in infection rates of MSM

on the basis of race/ethnicity.

We know
there are huge disparities

in infection rates among women.

Black women are 15 times more
likely to be infected with HIV

than white women.

That is just appalling, and it

really calls out for a response.

But I also say we're
not looking at this solely

through the lens
of race/ethnicity --

there are a lot of other
disparities we need to look at.

We know that, again,
gay and bisexual men

have significant barriers
in access to care.

We need to do a better job
reaching, not only gay youth,

sexual-minority youth,
but all youth.

Are we doing enough?

There's not a single formula
to how to do this.

Also, I know there's huge
geographic disparities.

So, you know, we're going to
spend a lot of time

getting to all parts
of the country,

but really looking,
in particular, at the South --

[Applause]

And what are we doing here
and how can we provide

some national leadership
to really address

some of these disparities
and inequities?

And I can't end this discussion
about disparities

without talking about stigma,

and I would just say

one thing --

I know that,
during the campaign,

the President met a number
of people living with HIV

and he's really touched
by the stories

of their experiences and what
they said about their lives.

And he himself has said,
you know, he doesn't think

we do a good enough job
addressing stigma.

You know, he said we don't talk
about it enough

in our schools, in our churches.

And that's something
we're committed to doing.

So as we develop this strategy,
we're going to be talking

about stigma and I think
we welcome your thoughts

on how we address this because
it really is a priority for us.

So that's sort of the scope
of what we're trying to do.

I want to just quickly sort of
tell you the mechanics

of how we're going to do this.

The people here and others
are going to have a key role

in that, to develop
the strategy, we're planning

to convene, at the White House,
what we're calling

a federal HIV interagency
working group that'll work

with me and my office
to develop the strategy.

And this, I think,
is really important.

You know, I can joke about it,
but there's some seriousness.

I can sit in meetings

with people that have been
career employees

and know that a lot of these
people can look at me and say,

"I was here before he got here,
I'll be here when he leaves."

And they'll come to meetings
and smile.

I want to make sure
that we have a process

to develop the strategy

that really respects
their valuable input,

but also that they own,
because, from the White House,

I can't make
all this stuff happen.

It's about all these agencies

that we're going to be counting
on doing a lot of stuff.

So I think it's really
appropriate and important

that this interagency group
is really the core

that's really going to
develop this strategy.

But we couldn't do it alone
at the federal government.

You know, it wouldn't work
if it was just us

having a federal conversation.

The success of this
really depends on engaging

all of you
and many other people.

And we plan to do this
in a number of key ways.

For years, going back
to the Reagan Administration,

presidents have relied on

Presidential Advisory Councils
on HIV and AIDS.

This President intends
to continue to rely

on a Presidential
Advisory Council on HIV/AIDS.

You'll be hearing more from us
in the near future about that,

but this is an entity
that we plan to look to

for really significant
leadership.

Additionally -- you know,

I mentioned
our community discussion.

I think, before I got this job,

the HIV community said,
in developing the strategy,

they hoped we'd get to
a couple of places.

We've grown the list.

Now, it's a big country,
we can't get everywhere,

but we're planning
14 community discussions

between now
and the end of the year.

So we're starting
tomorrow night, here --

again, I hope you all come --
at 6:30 in this ballroom.

But we're going to be holding
them in Washington, D.C.;

New York City;
San Francisco; Oakland --

Man: Yeah!

Crowley: Los Angeles; Houston;
Albuquerque;

Jackson, Mississippi;
Fort Lauderdale; Minneapolis --

Woman: Whoo!

Crowley: We're going to get
to Puerto Rico;

we're going to get
to the Virgin Islands.

[Cheering and applause]

So there are many places
we can't get to

through these
community discussions,

but again, as I've said, over
and over, this isn't all on me.

So I'm doing
my 14 town hall meetings --

what are all of you going to do?

We really need to have

an important
national discussion.

My staff are also
getting out on the road,

listening to people,
and, hopefully, you'll see

we're not trying to do

the minimum here,

we're trying to do the maximum
and really listen

to the American people
and get their best ideas.

Now, another way we plan
to get these ideas is,

we recognize, no matter how many
of these town hall --

these community discussions
we have,

some people won't be able
to make it,

they won't feel comfortable
standing up at a forum like this

and telling us
what they really think.

So we want to build on something that we've done successfully

with health reform, but we plan
to issue a call to action.

And we really do want
every church, school,

AIDS service organization,
PWA organization, business --

anybody that's interested --
have your own discussion,

come up with
your own recommendations

for this
National HIV/AIDS Strategy,

and send them to us.

We're putting in place
the technology,

through our web page
at whitehouse.gov

and the week after Labor Day,
we plan to issue

this call to action and we're
going to give the public

about 30 days
to have these discussions

and then
send in recommendations.

Then we'll have someone
synthesize these

so we can really get
a good sense

of what people are saying
at these community discussions

and these community discussions
we hold across the country.

So, hopefully,
you'll work with us

and send us lots
of good recommendations.

And then the last thing --
you know, for me,

it's a huge privilege
to be at the White House

and I recognize that

it's sort of a unique place
to be, to do business,

and it's also
a unique opportunity

to convene something,
so one of the things

we also plan to do is
use our convening power.

Now, I can't just hold meetings
day after day,

but, on some critical issues,

we plan to hold meetings
at the White House.

So we know, for example,

we want to have a meeting
on women and HIV

and really have a detailed look
on how what's going on.

You know, I mentioned stigma
was a big priority.

We're going to do some work
around stigma,

where we're going to call
some experts together

and really try to have
a helpful conversation.

We're planning to look
at a number of areas.

You know, again, I can't commit
to doing a hundred of these,

but if you have suggestions
on key issues

you think we should look at,
please send them my way.

So I'll close by just saying,
you know,

I've been on the job
for six months,

we've been doing a lot of work,
but this really feels like

we're now getting
into the meat of our job.

And it's not what I'm doing,
it's what we're all doing,

so I look forward to working
with you over the coming months.

Thank you.

[Applause]

Good morning, everyone.

It's a pleasure to be here,
representing

the Health Resources
and Services Administration

HIV/AIDS Bureau
and as the Administrators

of the Ryan White
HIV/AIDS Program.

Thinking about the goals of
the National HIV/AIDS Strategy,

we think about the statistics
we hear each year

on HIV incidence,
on the number of people

who are infected
who haven't entered care,

and on the disparities
that people still face,

in terms of getting services
and the stigma that they face.

And this,
to me and to my colleagues,

means that we need
to refocus our efforts.

We need to refocus them
as a federal government

and as a nation,
at the state and local level.

And this emphasizes the need

for the strategy
that we're discussing today.

But in order to reduce incidence

and to improve and increase
access to care

and to reduce
health disparities,

we need to think in new ways
so that the strategies

we come up with are innovative
and can meet the goals

of the people
we are attempting to serve.

So in thinking about it
in terms of the work we do

as a department
and as a federal government,

we need to have better linkages.

There needs to be a continuum
that goes from prevention

to people who may be infected
or those who are at risk,

to the general public,

so that they have information
about HIV and AIDS.

We need to link prevention
and testing,

and once people test positive,
we need to link them to care.

And this needs to happen
at the federal level,

at the state and local level.

It needs to happen
in the private sector as well,

because there are people being
served in the private sector.

We're not sure where everybody
is being served

and we need to know
that type of information.

So I think one of the ways
that we can start is

by linking what we do
in a more comprehensive way.

We have to think
about the services

that each of our agencies offer.

We need to work
with our grantees

so that they
can collaborate as well.

We each have authority
to provide

the programs and services
that we offer --

through legislation,
through regulation, however,

we still can provide
that continuum of care

by working together.

I think there are a number
of ways in which we can do that.

We often have
overlapping authority

so that we need
to work together to assure

that we have coverage
of all areas

in the services that we provide.

I'm just going to use SAMHSA
and HRSA as an example.

We both offer substance abuse
and mental health services,

but we've not been
really proactive

in working together to make sure
that we're not offering

too many services in one area

and not enough services
in other areas.

[Applause]

So we need to do
a better job of that.

We also need to have links

between surveillance
and testing and care.

[Applause]

We need to have programs
where people are handed off --

and I don't mean physically,
but there needs to be

a continuum there
that helps people.

There are barriers.

People are shocked when they're
diagnosed with HIV and AIDS.

And they may not be ready
to enter medical care,

but we need to help them
overcome that barrier

so that they enter care
before they're symptomatic,

as many people
who enter care today are.

So I would like to see
those linkages be formalized.

There are a number of projects
that CDC and HRSA and others

have worked on
that have examined ways

to ease people into care
to overcome those barriers,

and we need to more widely
implement them.

So at HRSA, we acknowledge
the need for the strategy

and we look forward
to the development

and implementation
of the strategy

and we would hope that some of

the things I talked about today

could be part of that
to more effectively serve

people living with HIV
and people at risk

and the general public,
in general.

So I thank you for listening
to me today and look forward

to further discussion
from the panel.

[Applause]

Good morning, everybody.

I'm Carl Dieffenbach.

I'm the Director of
the Division of AIDS

at the National Institute of
Allergy and Infectious Diseases

at NIH.

It's a pleasure to be here and I
want to thank the organizers

for the opportunity to speak
to you today about how we view

the NIH's role in participating
in this important event,

the National Aids Strategy.

Jeff Crowley has been out
to the NIH to meet with us

and talk about how we can play
a role in this.

And our primary mission
is research.

And as we heard from Jeff,
the important priorities

that the President has laid out
for the AIDS research

and care and treatment
and prevention communities is

to reduce incidence,
get more people into care,

and reduce stigma.

As we think about what we can do
at the NIH, in terms of building

evidence-based tools that can be
integrated and implemented

into improving
the prevention strategies

that are currently being used
around the nation,

it's not about
search and replace,

it's about an addition
of new tools

to add to the toolbox
that you are already using

so that we can, as Jeff said,

continue to improve the outcomes
for people who are at risk

as well as improve access
to prevention services.

So moving forward, the NIH
is testing, as you've heard

at this conference already,
Pre-Exposure Prophylaxis,

but that, in and of itself,
is not enough.

We have to be able to take
the findings we have

in Pre-Exposure Prophylaxis,
link it

to the best behavioral
prevention strategies,

in a way that
really optimizes both.

At the end of the day,
PrEP is probably

not right for everybody,
behavioral modification is,

so we need to be able
to make sure

that we do this
in an effective way.

Furthermore,
there is the issue of stigma.

And as we look
at the populations

that are at greatest risk,
those are the ones

that are most marginalized
in our society.

As a research organization,
we have a responsibility

to try to figure out how
we can access these populations

in more effective ways
so that we can take better care

of these individuals,
moving forward, in the future.

Let's talk a moment
about treatment itself.

The NIH has had a large role
in proving and improving

the care of people with HIV.

Right now, we have treatment
guidelines that are set up

in a way that,
as people who are infected,

their CD4+ count falls
below 350,

they are eligible for access
to HIV drugs.

As the field of HIV therapy
moves forward,

the drugs have become safer
and safer and it's getting to be

clearer, from research,
that it may be time to raise

the CD4+ level at which point
we treat individuals.

So that also plays a role
in prevention.

The more people who are tested,

the more people
who get into care,

the more people who are
on therapy,

the lower the community
viral load,

the better the chance is
to control --

help control the HIV epidemic.

At the end of the day,
the NIH is committed

to integrated approaches to
prevention, treatment, and care

that can inform groups like
SAMHSA and HRSA

and then also the guidelines,
moving forward.

So with that,

it's my pleasure to be here
and to participate, as the NIH,

in the activities that
the White House is implementing.

Thank you for your attention.

[Applause]

Well, good morning.

Attendees: Good morning.

Watts Davis: It's so good
to see you all again.

And today, I really want to be
able to talk about

\$112.6 million worth
of opportunities.

What I want to ask is,

all the people who are
SAMHSA grantees, please stand.

Just very quickly.

Okay, now, I want you all
to just kind of quickly look

around the room.

The next time that we come --
thank you all for standing

and thank you all
for being here.

The next time that we have
this conference

and I ask that question --

That's about a little,
maybe a third of the room?

The next time we have
this question,

it ought to be
half of the room.

So you all know --

[Applause]

Many of you all
did not even know

that SAMHSA has a portfolio
for HIV/AIDS.

And it makes no sense,
when we think about

the comprehensive care for

all the people that we serve,

that someone would not walk
into your offices

and also be able to have
the option of getting --

whether it be a referral
to substance abuse --

and, more importantly,
I challenge anyone in this room

to tell me or to show me
or to demonstrate that

the people who you are serving,
when you are working with them,

that they do not need mental
health services -- anyone.

And so it is very important
that we begin to truly do

exactly as Jeff
has talked about.

It's about integration,
it's about coordination,

it is about communication,
and it is about collaboration.

The fact that SAMHSA is here,

that all of our HIV/AIDS
grantees are here,

merging our grantees
within this conference

so that they can intersect
so that we can truly have

research and practice
meeting up,

so that we can truly have people
who are in the same city

who don't even realize that

you have different sources
of funding,

but you should be
joining together.

And the next time
that we come together,

we hope to have
not only our grantees,

but the other grantees from NIH

and certainly the other
grantees from HRSA.

We should all be
in this room together

as we join together
to form this army

that needs to be able to carry out the National Aids Strategy.

[Applause]

As we talk about coordination
and collaboration,

we also really have to talk
about something

very, very important,
and that is integration.

I am so thankful
for the leadership,

for Kevin Fenton at CDC;
I am truly thankful

for Chris Bates
at the Secretary's Office;

and I am so thankful for Jeff
because all of these

are people who really
understand integration.

You all, for the longest time,
we've all functioned

in our specific silos
and we've heard from you all.

You all are out there, doing it,
you make it happen.

Because when someone comes
to your door,

you're going to stay after 5:00,
you're going to find them help,

and you're going to
make that referral

when it needs to happen.

But what's really key --
and we've heard this

from everyone and I remember,
as a community provider --

when we make that referral,

how many of us know
if that referral ever happened?

Did that person get care?

So we've got to figure out
how do we do some things,

such as collocating?

Maybe we need to cut some of our
costs on the brick and mortar

and figure out how
we can all come together

to have that true
one-stop servicing.

[Applause]

For all of us, we need to make
sure that, in this field,

that we are joined together

with those who might be
unlikely partners.

I was so pleased to hear
Magic Johnson talk about,

last night,
about we need to make sure

that there are not only
housing opportunities,

but there are economic
opportunities.

We know that
our communities are better

when they are healthy and safe
and economically viable.

That means we must be creative.

And with the kind of leadership
that we have in Jeff Crowley,

we can be creative.

It's like the shackles are off.
As Chris did -- the tape is off.

We can now stand
and do what we need to do

to do the right thing.

And let me just give you
an example.

As we talk about services,

there should be no wrong door
that someone walks in

to be able to get the services
they need from us.

No wrong door.

[Applause]

Surveillance, that Faye
just talked about.

And I recognize that research
is so important.

CDC leads us in surveillance,
but I can tell you all

there are studies
that are out there

and when I think about some
of the dollars that are spent

on some of the surveys,
asking, quite frankly,

very similar questions, there's
at least \$50 to \$60 million

we could put back out
in there for services

because we don't need to ask
the same question

two or three times,
of the same audience.

[Cheering and applause]

You all could do a lot
with that money.

And thirdly, we must be creative

about how we create
those economic opportunities.

Someone who is not
in this audience

and who has not been one of our partners but needs to be --

both Department of Labor,
Small Business Administration,

and the Corporation
for National Community Services.

I remember,
back in San Antonio --

and I really want to just give
a real shout-out

to Linda Tippins, who is here.

This is a woman who helped us
realize how we used AmeriCorps,

how we use this
as an economic opportunity

for people who were coming
out of treatment,

people who were living
with HIV/AIDS,

how we helped create
an entire Corps

that helped those people live

and add
to their quality of life,

helped them find
economic opportunities.

We truly had
a mini grant program

that helped some of those people

actually start
their own businesses.

It's so important for us
to figure out

how we take all
the wonderful tools we have

and the great leadership, thank
God, to help change things.

Now, I want to be able
to just end

because, quickly, we only have
5 to 7 minutes.

I need for you all
to do something for me

and you have to do this
quickly -- do we promise?

Okay, stand up, real quick.

Because this demonstrates
everything we need to do.

Those of you who have ever
heard me speak

know what you're going to get.

Very quickly, I want everybody
to face that wall.

Okay, very quickly,

put your hands on the shoulders
of the person in front of you.

All right. You don't have to
move, that's okay.

Now, you all, this field,
as Chris said,

we are still standing.

So, right now, I want everybody
to pat each other on the back

and give each other a massage
because we need to celebrate.

[Laughter and applause]

Okay, all right.
Now, hold on, hold on.

Psst! Stand up.

Now, what I want you to do is,
I want you to turn around.

And now, you're going to wish
you did a better job.

Pat each other on the back
and --

[Laughter]

All right. Now --

Now, I just want you all
to go ahead and take your seats.

First and foremost,

I want to thank you all
for doing that.

You did not know what
you were getting ready to do,

but that is one of the key
things that many of you all --

I noticed this as many
of you all stood up --

you quickly joined,
some of you held hands.

It really is about
the connections, in this field.

As I said, it is about all of us
supporting each other.

When I asked you all
to turn to that direction,

I have to just tell you, some of
you were still looking at me,

some of you were looking
at that back wall,

and some of you
were looking over there.

And isn't that the way it is
in our communities?

I mean, we know people are
coming together for good things,

but we're not always going
in the same direction.

So it's important for us --
and it's important to us

to recognize how important it is
for us to have Jeff Crowley.

We actually have a President
who believes we need

a national strategy --
uh, duh.

[Cheering and applause]

And that is to help us all

get on the same board
and go the same direction.

The other thing that was
so important is the fact that,

when we connected up,
inside of those three seconds --

y'all were really good,
maybe lasted three seconds --

how we were able to make
everybody in this room

feel good
for just a quick moment.

To acknowledge, to celebrate,
to appreciate, to value --

all the things that we need
to do for each other.

And then when I asked you all
to turn around,

it was to do for someone else
what someone did for you,

that power of reciprocation.

And, you all, this is really
the key lesson.

We've talked
about economic times,

but I always believe --
I'm a true optimist --

that all things happen
for a reason.

This has forced us

to think about how
we do things different.

This has forced us to figure out
who do we need to partner with

so we can all keep
our doors open.

Doing for each other is what's
going to keep us still strong

eight years from now.

And what's really key?

This is about the next time one
of your fellow partners

in your community asks you
for a letter of support.

It's not about you writing them
a letter, saying,

"Gee, I like you and I think
you do a good job."

No, no, no, no more
foo foo letters like that.

It is about you sending
a letter over, saying,

"Not only do we believe in what
you're doing, but here's

what we're going to do
to help you be successful,"

because your time
will come as well.

[Applause]

And lastly, you all, I ask us
to sustain and maintain,

and, in many cases,
not complain without solutions.

We now have great leadership
and it is a chance for us

to run and run
as fast and hard as we can.

Because we may not
necessarily have

this kind of great leadership
here again.

Recognize that we are all
going to be moving fast

and if you've got
a suggestion, make it.

As Mr. Crowley's talked to you
all, he's offered those.

As Kevin leads us,
as Chris leads us,

as all these people lead us.

Make sure you figure out how
to use technology

and get those ideas out
and not only just complain,

but figure out how you come up
with a solution.

This is about all of us
and it is such a pleasure

to be here with you
because it really is about you.

Godspeed and God bless
and thank you all

for the great work that you do.

[Cheering and applause]

[Whistle]

Ah. Well, it is a new day.

I'm David Vos; I work for HUD,

the Housing and Urban
Development Department,

as Director of the Office
of HIV/AIDS Housing.

My office manages
the HOPWA program,

Housing Opportunities for
Persons With AIDS,

and many of you, hopefully,
know about it

and also many of you
probably know the need

for housing for our clients.

When thinking
about the strategy,

we can go back to 1992 --

the National Commission on AIDS
made the simple statement

"Housing as a base...
to receive care."

And I think, really,
that's the vision we have.

Housing is a base.

We know where we'll be tonight,
we have housing,

and we know we recover

in that housing

to get ready for the journey
of tomorrow.

So housing as a barrier
is a terrible thing,

and issues of homelessness
and risk of homelessness

have prevented people
from accessing care

in a meaningful way.

So by putting housing
in the national strategy,

in a clear way, along with
the other federal issues

that come from
the other departments,

I think that will be something

that this strategy
can really contribute.

But also, integrating,
within the departments,

the mission that we have.

You know, it's not just housing
in one program, HOPWA,

but it's also housing
in our Section 8 programs

and homeless programs
and affordable housing programs.

And Secretary Donovan,
the new leader of HUD,

has made it clear that all
of HUD needs to step up

and all of HUD
should be concerned

that we're helping
people with special needs,

and we need to be clear

about how we're doing that,

to be part of an overall team
that responds to the needs.

And it's also the case
that our Recovery Act funds --

the Department has received
about \$14 billion

to help with the economic
recovery of the nation,

and those are directed
to help your communities

and to help your providers, too,
to help renovate housing,

to help connect people to care,
and to prevent homelessness.

So in HOPWA, our resources

are about 1%
of the federal housing budget.

We're also connected
to homeless assistance,

and there, we've seen
some tremendous progress.

The focus on helping people
with chronic homeless issues

get a better deal and get
the support they need

and to develop housing
has been proven to work.

So we have the technology
of how to reach our clients.

Now, we need to expand it
to those

who are still presenting
with needs.

Because people present,
not necessarily with their HIV,

they present with homelessness,
with affordable housing crises,

and other issues.

And so how do we reach them
and then connect them to care?

And I'm going to be
really pleased

to work with these partners
and the others to make sure

that that seamless connection
of support

is there and makes sense
so that people don't have to

disclose their HIV status
to a housing official,

that's not necessary,
but they do know how

to connect to the support
where it is important

to know what your HIV status is.

Also, in my department,
the programs

that help homeless clients
and help people with AIDS

have shown to have
clear outcomes

and our partners have really
stepped up to bat

to help us prove that story,

where some of
the highest-rated programs,

in the sense of being able
to measure performance

and to work with
an extremely large network.

There are 850 organizations
around the country

that work on HOPWA.

There are 7,000
that work on homeless grants.

These are the organizations
that can help work

with your communities, if you're
not involved in housing,

to make the bridge
of how housing

can be at the table
in your community,

with the planning
and prevention and care.

So let's figure out how
to make those things work, too,

to integrate our efforts
more clearly.

For instance, by proving
that stable housing

is a really important base
to care,

we've also started looking
at access to care issues.

And half the clients in HOPWA

seem not to have
a stable source of income.

Let's break down those barriers

to qualifying people
for their SSI and SSDI.

Let's figure out how
to make that work better.

The other thing about HUD is,

the new leadership
isn't just the Secretary.

The people who care
about supportive housing,

who've worked in the field,
people who care about

efficiency and use of housing,
people who run the HOPWA program

in the city of Los Angeles,
for instance,

are there, now, on the spot,
making decisions.

And they really are thinking about how to integrate

the special-needs issues
within all of our programs,

how to make the capital
to be able to develop

new housing work
to help our clients,

how to use operating costs
and rental assistance

in an equitable manner to reach
clients with presenting needs.

And also, how to connect
to services.

And I know Secretary Donovan,
the Secretary of HHS,

have talked,
we're going to be having

some internal task forces, too,

between the federal agencies
on that, connections.

Keeping people stable
where they are,

reducing their risk
of homelessness,

intervening as soon as possible,
so that no one has a long-term

experience of homelessness
and deteriorates.

But, ultimately, you know,
in working in our field,

we've been able to show
that evidence is there.

In our partnerships with
the CDC, we've done a study,

which is being reported
in this conference,

health and housing study,
which really shows

that housing is an intervention,
housing is prevention,

people in stable housing are
much better off

and much less likely to be
engaged in risky behavior.

That, also,
housing is health care.

Stable housing means
participation in care

and just wellness, from not
being exposed to the elements.

But, ultimately,
at the end of the day,

housing is housing,
it is about dignity and life

and being able
to manage your life

and to have a point
of recovery every night

and get ready
for the journey of tomorrow.

So, in working together,
it's the journey of tomorrow

that the strategy is about
and I'm very pleased,

from the Department of
Housing and Urban Development,

to be part of this team.

Thanks.

[Cheering and applause]

Good morning, everyone.

Attendees: Good morning.

Fenton: Now, you know
why I love my job.

It's such a fantastic pleasure
and an honor and a privilege

to work with such great leaders

and I think the promise
of a National HIV/AIDS Strategy

is one that promises
to bring us together,

that promises
to hold us accountable,

and that promises to achieve

real and bold results
for HIV in the United States.

So I'm Kevin Fenton.

I'm the Director
of CDC's National Center

for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.

And let me begin by saying

that the prospect
of a National Aids Strategy

represents a tremendous
step forward in the prevention,

elimination, and control
of HIV in the United States.

And I believe that such
a strategy should martial

a coordinated, accountable,
and bold leadership

in the fight against HIV
at home,

quite similar
to the fight that we're having

against HIV/AIDS
around the world.

[Applause]

So let me begin
by telling you a story.

Some of you know that I actually
trained and worked

in the United Kingdom before
coming to the United States,

and I was very privileged
in being part of developing

the British National HIV
and Sexual Health Strategy.

We were also involved
in developing

the Implementation Action Plan,
and just before leaving

to arrive in the United States,
I was a part of

the Independent
Advisory Committee

that oversaw the implementation
of the British Strategy

and held government workers,
community organizations,

everyone in the United Kingdom,
accountable for results.

So I know what can be achieved
by a National HIV Strategy.

And if I have one thing
to say now, at the beginning --

I'd love to see the name change, Jeff, to broaden the strategy

for a National HIV
and Sexual Health Strategy.

Because we know that HIV
does not exist in a vacuum

and we know that we're going to
have to deal with the syndemics

of sexually transmitted
infections,

the syndemics of hepatitis,

the syndemics of mental
ill health and substance abuse,

poor reproductive
health outcomes.

We're going to have to deal
with all of these

in the strategy.

So I know it may be
a difficult plea,

but, as we develop
the National HIV Strategy,

I do not want us to forget
about the importance

of integrating across diseases
and integrating across health

for optimal outcomes.

So CDC is looking forward
to working with

the Office of
National AIDS Policy

on the development
of this strategy.

We believe that only by working
together can we bring together

the expertise
and the coordinated approach

that is needed for
a truly comprehensive plan.

CDC is going to have an active
role in developing the strategy,

as it is the lead agency

for monitoring the course
of the epidemic,

and we will play a lead role
in providing data

to ensure that we are on target
in meeting the bold goals

that we've included
in the National AIDS Plan.

Certainly, our efforts at CDC
will also be informed

by a rigorous peer review
of CDC's HIV prevention efforts,

which we actually
have been undergoing,

and by your past experience
in developing

a national HIV prevention plan.

So we're going to be bringing

that expertise
and that passion and commitment

to developing
the National Aids Strategy.

Some of you know that CDC
has provided

the White House Office of
National AIDS Policy

with a full-time detailee

from our Division of HIV/AIDS
Prevention, and this person,

Greg Millett, will assist
with developing the strategy.

And we also know that there
are many critical components

which need to be considered

in a successful
National Aids Strategy

to strengthen our impact
on the HIV epidemic.

And I believe that there are

a number of components

that CDC will be pushing for
in this national AIDS plan.

So, first of all, we are certainly going to be pushing

for an escalation
and an enhancement

of routine HIV screening.

The plan must escalate
our efforts to ensure

that all Americans are aware
of their HIV status

and that we remove barriers
to HIV testing,

both in the community level,
in federally funded sites,

and, in fact, in all sites
across the United States.

Another consideration
that would have to be included

in the national strategy is

ensuring that there is
confidential HIV testing

in nonclinical
and community-based settings

serving people who are at risk
of HIV infection.

And it remains important
to ensure that

HIV screening of pregnant women
and the use

of antiretroviral therapy
to prevent onward transmission

from infected mothers
to their infants

are a crucial part
of that strategy.

As you heard from Jeff,

linkage to care

is certainly a key presidential
priority for the strategy

and it is also a priority
for us at CDC.

So in concert with testing,

it's going to be
critically important

to improve linkages of
HIV-infected persons to care,

not just to receive care
and treatment for HIV,

but to ensure that they
also receive adequate care

and screening for
sexually transmitted diseases,

for viral hepatitis, STDs,
reproductive health services,

and, as Beverly has said,
mental health services

and substance abuse services
as well, and where appropriate.

Another key component
of the strategy,

and a key ask
that we will have,

and as you heard from
the CDC Director last night,

is that we base the strategy
on the best available evidence.

So evidence-based interventions
are going to be a key ask

for the CDC, as part of
the national strategy.

We need to increase access
to evidence-based interventions

for people living with HIV

and for people
at risk of HIV infection,

and this includes
age-appropriate,

comprehensive sexuality
and sex education for youth.

[Cheering and applause]

[Whistling]

And it is going to be important,
as part of the strategy,

that we look at leveraging
all resources

to scale up
these effective interventions

to truly have an impact
on the epidemic

in the United States today
and tomorrow.

Further, we need to ensure
that there's adequate funding

for research which is related

to newly identified biomedical
interventions, such as PrEP,

and we look forward to working
very closely with NIH

on thinking through
the research strategy

that will be required to support
the National HIV Strategy.

Third, capacity-building --
and I spoke about this

last night -- the need
for us to invest in leadership

at the state, local,
and federal level

so that we can have
more effective

delivery and implementation
of our HIV programs.

It will be vitally important
in the National Aids Strategy

that we have an effective delivery of interventions

to those who are most
at risk.

And therefore the national strategy needs to focus

on capacity building
and technical assistance

to strengthen and maintain

the ability
of health departments

and community-based organizations

to deliver the most efficacious
interventions.

You've heard this morning
from the panel

about the importance of
surveillance,

and you also heard
the importance

of it from Doctor Frieden
last night.

We need to be able to do
a better job

of tracking the epidemic

and evaluating the impact
that we're having

as a result of the application
of our prevention programs.

We now have a much more robust
surveillance system

in the United States.

We're looking at HIV diagnoses,
AIDS diagnoses, HIV incidence.

We're now tracking risk behaviors,

and we're now looking at
the effectiveness

of program data.

But as you've heard from all of our colleagues this morning,

we need to do a better job
at integrating data sources,

removing duplication,
reducing the burden

at local level,

and ensuring that the data
which are derived

from these systems are fed
back to you

so that you can improve
your systems

and improve your programs.

And that will be a commitment
from CDC,

and we'll be looking for this
in a national strategy.

Finally, there are two more
"asks" that I will have,

and I know my CDC colleagues
have as well,

as part of
the National Aids Strategy.

Federal partnerships
are going to be key,

and this is really going to be where we make or break

a national strategy.

Because our ability to work
across borderlines,

across boundaries, will have
a huge impact

on national leadership

that will influence leadership

at the state and local level.

As you know,
CDC works very closely

with all of the agencies represented here,

and we look forward
to continuing that

as part of the National
AIDS Strategy,

and we look forward to enhancing our collaborative roles,

both with HHS sister agencies
but also other agencies

outside of HHS, moving forward.

And then finally, I think,
from CDC's perspective,

a critical component of what we'd like to see in a strategy,

and we will be
actively involved

in ensuring that this
takes place --

is that any national plan
should have measurable goals,

measurable objectives
tied to resources.

[Applause]

We have seen too many
strategic plans

which have been developed
without any new resources,

or without looking critically
at how we leverage

existing resources to truly ensure that resources

are targeted to areas
where they're most needed,

or where we can have
the greatest impact.

So as we think about
the national strategy,

we need to ensure that there's perfect synergy

and alignment between
our goals,

our objectives,
our strategies and tasks

and the resources that will be given to us to ensure

that we're successful with
the national strategy.

So I'm completely excited
about the national strategy,

and this is something that many of us in this room

have been calling for
for decades.

And we have been calling for,
certainly at CDC,

since I've been there,
for the last four years.

So this is the moment
we've been waiting for.

Your leadership will be crucial as we move forward

in developing the strategy.

Your voice will matter.

Our voices will be
important as well.

And we look forward to working
with all of you

and supporting the leadership
of Jeff Crowley

with the development
of this strategy.

Thank you very much.

[Applause]

Well, colleagues,

you've heard from one another.

I'd like to give you
an opportunity

to react to some of what you've heard this morning.

And if you get a little sluggish in your responses,

I have a series of questions
I'd like to ask you.

So I'll give you
an opportunity first.

Anyone can begin.

[Laughter]

Man: Why don't we
hear from you?

All right.

I'll start.

Thank you.

I really just want
to acknowledge the --

Can you hear me?

Yes, okay, I just really
want to acknowledge

the passion that you saw
today from the panel,

and especially from
Beverly Watts Davis.

[Applause]

Beverly has been
an amazing partner

working with us
at the CDC

in the development of
this conference.

But the passion that
you see here --

and not only from Beverly,

but from all of us
on this podium --

really will be the passion
that we'll be bringing

to the development
of this strategy

and the hope that we have
as federal leaders

on the success
of this strategy.

And I just want
to acknowledge that,

and I hope that all of you
in the room feel this

because we'll need this as we go through difficult times

but also the good times with
developing this strategy.

So thank you, Beverly.

All right, well, let's begin.

I think I'll pose my question
to you, Carl.

We conducted a lot of biomedical
and behavioral research already.

As we work to reduce incidence,
improve health outcomes,

and address health disparities,

how can our broad research efforts be directed

to provide timely new
information

to help us answer
key questions

as we develop
the strategy?

That's an excellent
question, Chris.

Can you all hear me?

Good.

So I think one of the things
this National Aids Strategy allows us to do
is to try to do
a little bit better job
of focusing the research
on the key questions
that come out of the strategy.

So, working with Kevin
and his group, for example,
can we talk about, not just pre-exposure prophylaxis,
but how that would be implemented
in terms of rolling out
into state and local
health departments?

It's not just enough --
the NIH's role is to prove
the concept.

Our approach in the past
has been,
prove the concept and then
undergo a handoff.

But we want to make sure that,
like what we've done for
mother-to-child transmission,
we have an effective handoff to all our sister organizations
and agencies so that it is done
in a creative,
collaborative way.

So at the end of the day,
it benefits

the most people
in the United States.

Can I do a follow-up
on that?

Of the research
already conducted,

are there any
approaches

that deserve
a relook?

So, most of the --
there's a fair amount

of behavioral research
that has gone on to date.

I think as we go forward,
we need to go back

and look at how to capture

the best behavioral research
that has been done.

And as more biomedical interventions come through,

particularly in the area
of prevention,

we can do a lot
in terms of integration.

Additionally, there's probably
a lot more we could do

on adherence research,

to improve compliance with people and pill taking.

Particularly as we expand
the number of people

who are taking antivirals.

Because really,
that's going to be the key.

As the first- and second-line regimens have improved

to a point where it's one pill, once a day,

how can we then maximally improve adherence

and compliance with taking
those kinds of medications

so we don't run into

the situation

where we have out-of-control
drug resistance

in this country?

Thank you.

There is one that I do
hope that,

in terms of the national strategy,

that we will take a look,

and that, it's a little bit along surveillance

but it's more to what I think
many of our providers

and community-based agencies
have to do.

I would love to be able to see some uniform national measures

for the reason so that when
anyone out there receives

a grant from any of us,

that they have one set of measures,

and if they receive
multiple sources,

they can develop one report that they send to 12 agencies

instead of developing 12 reports

that they send
to everybody else, so...

[Applause]

I think...

And for us to utilize
technology,

so that what we can
begin to have

is very much what CDC
and Chris

has really tried

to help us do,

is to have a database where
everyone is reporting up

in realtime data.

Because when you all are getting data directly from

the clients and the consumers
that you are working with

and you're reporting it up
to us,

we have a realtime assessment
of what's going on.

And I simply say that because
I think that realtime data

will tell a different story
than --

or, will tell us a better story than sometimes data

that we're going to receive
two years later.

Okay, thank you.

[Applause]

David.

Given the three goals of
the National HIV/AIDS Strategy,

where do you see housing
fitting in?

I know you gave us quite a bit
of an example over there.

But I just think that there
might be one or two points

that you may have not raised

and I want to give you
an opportunity to do that.

Well, we mentioned it,
I think a couple things

that are very important,
you know.

The healthcare reform
that's going to happen

and the economic recovery
that's going to happen

will change the way
this country is.

And we'll get back
to the real goal

of then helping persons with,

presenting challenges
of special needs,

and people in poverty,
really address poverty.

In housing, of course,
we have a financial crisis,

we had a housing crisis.

How do we get back to expanding
the number of affordable units

that are available to people
at low incomes?

This is something that
Secretary Donovan

wants to put on the table
and work on.

And we're working now with OMB on looking at the next budget.

So integrating the strategy
at the very time

the department is planning
our strategy

for the whole department
is very great timing.

And I think that we'll be able
now to integrate

the issues of special needs
with the rest of HUD.

And that's really exciting after these many years

of seeing special needs
on its own.

And as we talk
about special needs,

I do think that we have
to acknowledge the fact

that HUD really needs
to be working closely

with HRSA,
because it's HRSA

that fills in
those gaps.

And, are there any
opportunities at HUD

in terms of some of
these funds

that you all have
available,

that can be linked up

with what's happening
at HRSA,

in terms of
those special needs?

Things like transportation,

like case management services
and nutrition.

Yes, and I mentioned
the task forces

that we're working on.

One of the big ideas is,
for instance, "aging in place."

Keeping people in their communities,

making communities more livable,
figuring out that connection.

If we're able to somehow
link up

the service delivery network

of AIDS issues,

imagine how that would
make life better,

not only for clients,
but, you know,

now the system,
customary care, sort of relies

on the individual to sort
around town their services,

or to work with a case manager
to try to put it together.

These are kind of daunting
processes.

If we could figure out
a better way

that this linkage -- with technology and other tools --

I think it will make
those connections,

and I think we've seen that

in a lot of
the special needs programs,

that they are thinking
about that.

And one of the things that we're already talking with HRSA about

is joint training of our staff,
so that the networks

of persons who run
the programs

are much more aware
of what's out there

and how to coordinate locally
and nationally.

Great, thank you.

Okay, Faye, I will not
put you on the spot,

around the reauthorization
of the CARE Act.

I think Jeff's already
made a reference to that.

However, I do think it's important that we take a moment

to really hear from you,

in terms of what policies
and program steps

would ensure that HRSA
and the Ryan White Programs

be more tightly integrated

with the departments
and the clinics

that are screening people
for HIV?

I think that goes back
to what I said in our remarks.

We need to have clear
linkages.

And the linkages need to start
at the federal level,

and we need to be role models
for our grantees,

so that we can help them
and build capacity

for those linkages
between testing sites,

including free-standing, community-based testing sites,

those run by state and local health departments.

And also STD clinics and other points of entry into care --

emergency rooms
and things like that.

We're actually doing some formative research

with money that we received

from the Secretary's
MAI funds this year

to look at best practices

in linkages

from emergency rooms
and STD clinics

for people who test positive
into care.

We need to have formalized linkages

between care settings,

and with support
of case managers,

to help people overcome
those barriers

that prevent them from entering care that I mentioned

during my talk.

We also need to build
capacity to treat people,

and I want to --

one point that Beverly made is that not everybody

who should be in this panel
is here.

And as we think about
providing care at HRSA,

we also think of our colleagues
in our other bureaus.

Under the Recovery Act,
there's been

massive expansion of
community health centers,

and we need to help
those community health centers

by building capacity for
HIV testing

and HIV treatment
in those settings.

[Applause]

We also need to think about
the workforce.

And that we can do
through HRSA's

Bureau of Health Professions.

We need to develop more providers who can treat HIV

and new methods of treating it

that might involve
a medical home,

or people who receive treatment
in a community health center,

but periodically receive care

from an infectious disease specialist in another setting.

So those are other things that we need to look at.

Okay, you talk about,
you know, the fact

that we need
to do this.

But I'm curious,
what are some

of the obstacles
that you see

that have caused us not
to be able

to make that happen?

Is it the legislation,
is it the will?

I don't think it's the will.

And I don't really think
it's our legislation.

Like I said in my remarks, again, we each have

specific authority,
but there is overlap.

And there can't be these silos,

there needs
to be those linkages.

And there has been work done
in these areas

where it's been done.

For example, Lytt Gardner
and his colleagues at CDC

and in the community did
the ARTAS Project,

and that dealt with linkages
from testing to care.

And that project has completed.

It is being packaged so that other people can adopt it,

but I think the important thing
to remember is that

it is ongoing in settings

that participated
in that project.

They did a more rigorous
development

of that intervention
at first,

but then they did sort of
a feasibility and replication,

because despite the efficacy
of a project,

they often need to be tailored for the settings

they're being --
that are going to adopt them.

So they can't always be done
so rigorously because

there are restrictions

on times for visits
with physicians.

There's limited resources,

so they have to be tailored
for the organization.

And I think we need to take

some lessons from that.

It can be done,
and we need to have --

we really need to sit down
with each other

and plan how we can help
our grantees

and the communities
build those linkages

that provide people with
the services they need

to enable them to enter care
without facing

the barriers that they are...

that are issues for them.

I want the audience
to know this.

And I can say this
for a fact.

We have already started

conversations
within the department

where we have brought all
the principal agencies together

that have HIV portfolios,
and they are in dialogue.

It's already started.

And our promise to you is that it will continue.

And we've already seen
new relationships established,

in part by virtue
of the fact that,

when we changed the HIV
testing policy

and we moved HIV prevention
into clinical settings,

the movement started there.

And what we've done constantly is we have pushed that envelope

and we've expanded
those opportunities,

but that work isn't done yet.

We need you to help us identify
those places

where it isn't happening.

We need routinization of HIV
to happen,

and already we've seen changes.

The...

The VA has just most recently
made it such

that they do oral consent.

There's no form to sign.

And so this is normalizing it,
it's taking the stigma away.

Things are starting to change,
and I'm very pleased.

Kevin, I want to take you on
for a minute, if I can.

[Laughter]

If we start from the premise
that CDC is doing a lot more,

a lot of important work
and being proactive

by conducting external assessment of HIV programs,

how do we leverage CDC resources to evaluate

competing prevention priorities

and build a data-driven
consensus

for how to move forward
to dramatically reduce

HIV incidence?

So, there's so much
in that question.

And, colleagues, I haven't looked at this question before,

so I want to unpack
that question,

because on the one hand,
you're talking about

competing priorities for
resources for prevention.

And, you know, I attended
the PrEP pre-meeting yesterday

and in that room there was
a lot of concern

about new prevention technologies

which are coming in

and how do we,
in a zero-sum environment,

integrate new prevention
technologies

and make tough choices
when it comes to

identifying which population
subgroups

are likely to benefit
from which interventions

at which time, and which phase of the epidemic?

So CDC is very much
aware of this.

And there are a number of things that we have been doing.

The first is looking at models,

what we call
"resource allocation models."

In other words, thinking
at an empirical level on,

given the phase of

the epidemic,
given the existing resources,
and given the characteristics
of the epidemic,

what are the best ways
of investing

in the prevention tools
that we have

to have the best impact?

So the solution for
Washington, D.C., for example,

is going to be very different
to the solution for Chicago,

which is going to be
very different

to the solution for Miami.

So using models.

At the present, it's only available at the national level,

but thinking more critically about the type of epidemic

which we're seeing
in a local jurisdiction,

characterizing that epidemic,

and then looking
at the available resources,

the evidence for effectiveness in dealing with that epidemic,

is certainly a way that we'd
like to move forward.

The second part of your question had to do with resourcing

of the various prevention interventions

that are coming onto the table,
and I think one of the benefits

of having a National HIV/AIDS Strategy is, as I mentioned,

our ability to look
more critically

at the existing resources for HIV investments domestically.

But also our ability to leverage additional resources
from other sources as well.

So we need to think critically about the public/private options
for collaboration
and integration,

and I would hope that as part of the National HIV Strategy,

we would be looking at
a very robust pathway

of engaging the private sector
in bringing resources

to the domestic HIV epidemic,

and, of course, leveraging
those resources

for maximal impact.

I also think,
as Beverly has said,

that there are inefficiencies
within the system.

And there is likely to be great gains to be made

by looking critically at our prevention, treatment, care

and research investments
and looking for opportunities

to reduce duplication,
for realigning investments

to populations that are
in greatest need,

and, of course, evaluating
how we're spending resources

so that we can ensure that we're using those resources maximally.

So you asked a complex question.

I wanted to sort of unpack
both of them,

both in terms of how do we incorporate new investment,

new interventions, and then how do we resource them.

Okay, I'm not done.

[Laughter]

You have a lot
of leverage

over the people you
directly fund.

But I don't know how --
and I want you tell me --

how do you impact
state decisions

about how they use
their funds

and that you get
the alignment

with what you're trying
to accomplish

and support
by the state governments?

So, you know, Christopher,
that's a great question,

and it's one that we are certainly committed

to looking at,
even more critically

as we move forward in this new phase with a national strategy.

CDC is not a regulatory organization

so we can't tell states
what to do,

although we do have our grants
and cooperative agreements,

and within those we set
the guidance and the framework

for what we want to achieve.

And we work in partnerships
with states to ensure

that they're meeting

the targets and that they're

performing on those grants
and cooperative agreements.

Now, as you heard
from Doctor Mermin yesterday,

there are ways in which we can actually improve performance
toward strategic goals

in working with state and local health departments.

One method which was highlighted by Doctor Mermin last night

was ensuring that the data which we're receiving from CDC

actually compiles in a much more faster and a more timely manner

and that are fed back to states
so that states can begin

to understand how they're performing,

both relative to other states,
but also relative

to the grants that are being funded for.

So a great example of that
would be

our HIV testing initiative
at CDC --

when we know that we have

asked states to reach certain targets for HIV testing.

Yet, initially, the timeline

for us feeding back these data
to states and saying, listen,

you're meeting your targets or you're not meeting your targets,

this is something we've been able to improve over time.

Finally, I think having
a committed

and concerted pathway for us

to build these relationships
with states,

in which states understand that we're going to increase
the level of accountability for spending prevention resources,
will be critical.

And that's part of
Doctor Frieden's commitment,

moving forward, that CDC will be doing more of this.

You'll be hearing some changes that will be made at CDC

to strengthen our relationships
with states

and local health departments.

And a part of those changes
at CDC are really being driven

towards better accountability,
better resource management,

and better outcomes
at the state level.

So I'm very hopeful about that
moving forward.

Okay, great.

Well, Jeff, you don't
get off the hook.

[Laughter]

I heard you describe
your opportunities

for the public to come
to these town hall meetings.

I also heard reference
to an opportunity

maybe to e-mail you.

But I've already gotten
four or five different comments

from people just being here
last night and this morning.

They want more.

So I know that we have

an opportunity,

much like the President did
with the Internet,

to reach out to people
and to get people engaged.

But one clever or, I think,
novel idea, too, was

more conference calls,

where you would have
an opportunity to meet

with an extended number of people from all over the country

from all of those places
that you have not

added to your list of cities
to visit.

Would you be willing
and interested

in entertaining that as one of
the strategies,

and could you
provide more?

Certainly. I think that's
an important question.

I actually was talking
to someone last night

who asked me if I could be
on a conference call

that their organization
was sponsoring.

We're certainly open
to doing that.

But I know there have been
some concerns about

that this isn't just
a one-way thing,

that they give us recommendations and we say,

"Oh, we'll get back to you."

We really see this as
a dialogue with the public.

I think there's a distinct role for the federal government,
but every step of the way,
you'll be engaged,
and I think part of your job is to put pressure on us
if you think we're veering off.

So, as we use this federal interagency working group,
it's not that we're going to go into a back room
and we'll come out in December
and then come up with something.

You know, you'll be hearing
about this.

Now, I will tell you that,
you know, I introduced my staff,
they're relatively new.

We've been understaffed, we've just been bringing people on.

Your ability to answer
or ask questions about

how we're going from step
to step

is faster than our ability
to answer them.

We're putting our team together.

We're making
key decisions still.

With this interagency
working group,

these people and this level
of people will be a core.

But above them, like there's
the 'Doctor Frieden's,

there's the administrators
of these agencies,

there's the Secretaries --

across the government,
we want to engage them.

There's people below them that have a lot to contribute.

We want to figure out how we engage all these people,
respect everybody's time.

We're still figuring that out.

Similarly, I said that you'll hear more about PACHA,
the President's Advisory Council
on HIV and AIDS.

That will be a critical input,
and they'll be interacting

with this interagency
working group.

Certainly once we develop sort of the outline of the strategy,

it's not that it's going to be presented as final

and you'll just have to sort of

sit back and wait
and hope you like it.

There will be many points
in time along the way

where you'll have a chance
to weigh in.

And we may not do everything
the way everybody wants

or hopes we'll do,
but we'll certainly have

opportunities to hear you

and if we can, we'll be
as responsive as we can

as we develop this.

Thank you.

This has been a great
opportunity for us

to really have a dialogue

and to share amongst
ourselves.

I, personally,
am looking forward

to many of your opportunities
to be in the community.

This morning I started off
with about what was.

And I'm not looking back
from this day forward.

I'm looking ahead.

We have an opportunity
to change the trajectory

of HIV domestically
in this country.

Our expectation is that
we are partnering with you

and that you are going to
help us move this epidemic

to a place where we have

the fewest possible
new infections,

where we have everybody
who's infected

connected with care
and treatment,

and that we have
a general public

that is highly knowledgeable
and highly sensitive

to the opportunities about education

and what it means to be
at risk for HIV and AIDS.

I'd like to thank you for
this opportunity

to be with you this morning,

and I hope God bless
each and every one of you.

[Applause]

Good morning, everybody.

Don't leave because I have
some very important

announcements for you
this morning.

My name's Bob Kohmescher,
I'm your conference coordinator.

I deal with all of
your problems.

Let's start off
with a long line.

No, that's okay.

First thing I want to announce
is, uh...

I want to remind all of you about the new feature
in our program guide called
"my schedule at a glance."

We have worked hard to plan
a very, very full

and a very tight agenda.

You really won't have much time to do planning,

but I want you to take
a few minutes this morning

or certainly this evening planning for tomorrow's,

to actually fill out
the "schedule at a glance."

It's meant for you to write in so that you know

which sessions
are most relevant to you.

The other thing that you're missing is a five-pound tome
called "The Abstract Book."

That is now online.

And that is a result of
the evaluation feedback

that we received from
our 2007 conference,

which leads me to the topic
of evaluation.

We are not going to be
handing out

evaluation sheets
at this conference.

All of our evaluation
is online.

So be expecting an e-mail.

When you leave this conference
on Wednesday,

we're not forgetting about you.

You're going to be receiving
a number of e-mails from us

encouraging you to provide feedback to us.

The other thing that I want you to be aware of is that

our CDC National Prevention Information Network --

more fondly known as NPIN --
will be providing

and is providing
a text-messaging service.

Stop by their exhibit.

Also want to remind those individuals

that are living with HIV/AIDS
that we have a lounge for you.

That's in room 226.

For those of you who are interested in using

Web 2.0 strategies to reach out
to your clients,

we have a social media lab where you'll actually get a chance

to learn, hands-on, how to use Web 2.0 strategies.

That's a few doors down
in room 219.

Now, the really important
information.

Lunch.

We have box lunches
prepared for you.

They are going to be
at the Exhibit Hall.

We have a session that begins
at 10:30 and ends at noon.

Between noon and 12:15,

3,000 people need to pick up
their lunches

and move into here
as quickly as possible.

And the Secretary of Health
and Human Services

will be here to greet you immediately following
the 12:15 to 1:00 plenary.

Kathleen Sebelius will be speaking from 1:00 to 1:30.

And then this is
what is important,

is that all of our
afternoon sessions

are moved back 30 minutes.

So that means that our concurrent sessions

that were scheduled to begin
at 1:30

will begin at 2:00.

The session that was planned
to begin at 3:30

is beginning at 4:00.

And finally we have roundtables that are beginning,

not at 5:30 but at 6:00.

And then most important,
at the end of the day,

our NGOs and community-based organizations --

these, of course,
all of you know,

are the people who get
the work done.

And they have a chance to show

what they have been doing
in our NGO Village.

We'll have food
and entertainment

at that event also.

The other thing I want
to let you know --

for a number of you,
about 20 or 30 of you,

here in the room, I have
a meeting scheduled with you

at 5:30
in the Fairleigh Room.

That is now scheduled
for 5:45.

For those of you who were meeting with me at 5:30,

it's at 5:45
in the Fairleigh Room.

The other thing.

Yesterday, Magic talked about
the importance of exercise,

keeping yourself
physically fit.

We want you to
jump start your day

with morning movement
and meditation.

Representatives from

the Holistic Stress Control Institute

will be providing a morning movement and meditation class

on Tuesday
and Wednesday mornings

from 6:30 in the morning
to 7:15,

in the lobby level of
the Marriott Hotel,

which is right behind us.

And that will be in room
706 and 707.

We'll have signs over there.

And then we have
a correction.

We have a session entitled,

"Implementation of
Routine Testing

in High Resource Countries
with Mixed HIV Epidemics."

That is scheduled
for a-703.

It was incorrectly stated that that was going to be held
in this hotel.

It's going to be held
in the Marriott,

instead of, of course,
2:00, 2:30,

since we've moved every --

Yes, at 2:00
in the Marriott.

And then finally, don't forget to attend our roundtables.

This is where you actually
have a chance to really do

a lot of interaction
with the speakers

and actually discuss topics.

And those are scheduled
early in the morning

and late in the evening.

The other thing that we've,
unfortunately,

because we had so much to share with you at this conference,

we ordinarily would have
exhibit space and poster space

open at noontime.

We want you to try to attend
the exhibits and posters

whenever you get a chance.

There is a lot of information
in the posters.

We have 240 posters
on display today and tomorrow,

so please try
to get through there.

Our exhibitors are --

offer a lot of very
interesting information,

so be sure to visit
their booths.

So, the marathon begins.

Let's move to your first session,

concurrent session
of the day.

And I want to thank
all of our speakers.

[Applause]

Have a great day.

We'll see you back in here

at 12:15.