

**2005 National HIV Prevention Conference  
The Practice of HIV Prevention  
June 15, 2005**

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**JANET L. COLLINS:** [Applause] – and a very inspiring conference. Thanks. Our plenary session will lead in straight to the closing session, so if you'll just stay with us through the end of the conference, we'd appreciate that. This has truly been a whirl wind few days and I hope you've found many reasons to be very hopeful and inspired in the work that you do. The conference supports and celebrates prevention and in that light, this morning's plenary ends on exactly the right note. We're really going to take a close look at the practice of HIV prevention from a number of very interesting perspectives. I'm going to introduce each speaker in turn just before they speak. Our first speaker is Dr. Bart Aoki. He is Associate Director of the University Wide AIDS Research Program at the University of California's Office of the President. The program provides grants and support to HIV/AIDS related research to investigators throughout California. Dr. Aoki is trained as a trained as a clinical community psychologist and has been involved for more than 25 years as a provider, evaluation researcher, community member, and funder in the delivery of community-based prevention services. This morning, Dr. Aoki will speak to the issue of what does it take to implement a scientifically sound intervention in a community setting. Please join me in welcoming Bart Aoki. [Applause]

**BART AOKI:** Thank you Janet. Good morning. I'd like

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to thank the conveners of the conference for the opportunity to talk to you about the issue of implementing scientifically sound interventions in community settings. I'd like to also acknowledge my colleagues from the University of California and the California Department of Health Services Office of AIDS: Roy McCanlis [misspelling?], Steve Truax [misspelling?], Anthony Lemel [misspelling?], and George Lemp, who all contributed to this presentation.

What does it take to implement a scientifically sound intervention in the community setting? Over the last couple of days, there have been a number of sessions at this conference addressing this and related issues. The question is critical because despite a huge amount of resources being invested in the development and evaluation of scientifically sound HIV prevention interventions, it appears that many of our most vulnerable communities have not been able to fully benefit from these advances. Communities may not be adopting these interventions for a variety of reasons, but once an organization chooses to adopt a new intervention, we see increasingly that difficulty with implementation is a critical dimension, limiting a community's ability to either evaluate its actual usefulness or to realize its full potential benefits. Many of you are probably all too familiar with the issues that I'm about to discuss. In that case, I appreciate your patience during the next few minutes.

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In order to try to address this question, we'll be looking at what we appear to know about the successful adoption and implementation of scientifically sound interventions. I will review with you the State of California's effort to support development and evaluation of evidence-based HIV prevention interventions and end with some conclusions and some specific recommendations.

Out in the fields, community providers and practitioners are facing the reality of limited resources, a continued sense of urgency that sometimes unavoidably affects priorities, and a real need to champion identities and uniqueness in the face of the ongoing effort to gain acknowledgment, sufficiently tailored and effective services, and sufficient resources at a time of level or diminishing resources. "All of our programs are science-based, but there's been limited full replication of evidence-based intervention such as the Debbies. Stopping and taking time to document work or train on a specific intervention will mean clients just won't be served." Youth have been harmed by institutions and standard curricula just don't respect the identities and experience of our youth. The issues that community providers are raising speak to factors that the research literature identifies as being associated with the organizational adoption and implementation of evidence-based interventions. I've grouped them into 4 broad areas. First is organizational

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capacity. Strength and maturity of organizational service systems, including training and program evaluation systems, are critical to the successful implementation of innovative interventions. As important is the climate for implementation and innovation, which refers to the shared perceptions of the extent to which using a specific new intervention is rewarded, supported, and expected within the organization, i.e. perceptions by the staff of their own organization's openness to change. However, even with high levels of organizational capacity, without the intervention fitting with the organization's and community's values, the implementation may be resisted or be unsuccessful. For example, if an organization was found to help make visible the unique experience and needs of a particular ethnic, racial, sexual orientation, or gender group, but a given evidence-based intervention does not allow for or is not built upon a real understanding of the centrality of these experiences, communities may actually resist or only half-heartedly comply in implementing a new intervention. Even with high levels of organization capacity, climate, and a fit with values, if an intervention is costly and complex and without the flexibility to be integrated into the practices of the community setting, the implementation may not succeed. Finally, even with organizational capacity, climate, fit with the values of the organization and community and a flexible and cost-efficient

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intervention, the external policy environment has to provide leadership, followed by the necessary and consistent resources to support the ongoing implementation, as well as the provision of mechanisms that synthesize science, disseminate practical and useable information in engaging formats, and provide for active training and transfer of skills and knowledge.

In an effort to address issues related to each of these 4 areas, the State of California developed the California HIV/AIDS prevention evaluation initiative about 10 years ago. It's overall goal was to increase the impact of state supported, the HIV/AIDS prevention evaluation research, and to develop and sustain a culture of community-science collaboration through evaluating existing community interventions and adapting evidence-based interventions and developing and strengthening organizational capacity to implement and evaluate sound interventions.

The 4 components of the initiative are aimed at, as I was saying, developing and evaluating evidence-based interventions, providing guidance for transition for translation and adaptation of interventions for unique, local community and service context, supporting dissemination through specific mechanisms, and monitoring the process and impact of the delivery of prevention services throughout the state. For the next few minutes, I'd like to focus on what we've learned about implementation from our community collaborative

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prevention research grants and our 2 translation projects.

First, our community collaborative projects: all 42 feature balanced collaborations between scientific and community investigators. They involve direct grants to all of the collaborators, including each community-based organization. They require that there be a collaborative conceptualization, development, and implementation of the intervention to be evaluated and support is provided for both research and prevention infrastructure at the community agencies. These projects have focused on diverse and highly vulnerable communities in California. As of this year, 21 of the 42 have completed the implementation phase of their projects. In order to begin to understand the extent to which certain factors contributed to successful implementation of interventions in these projects, we categorize the 21 projects on the extent to which they were implementation successes and whether they were high or low on 7 specific factors thought to contribute to this success. They were highly successful in implementation if there was a high congruence between their original work plan and their actual performance. They were high on each of 7 specific factors if there was a collaboration between the agency and a researcher or evaluator that predated the current project that was being implemented, if funds allocated a direct services exceeded 30% of the total, if substantial and consistent collaboration existed during the development phase

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of the intervention, if the intervention was integrated with currently existing services at the organization, if the intervention was delivered within the community and/or afforded easy community access, if the organization was community-based versus a large health provider or health department, and if the organization providing the services had been in existence for more than 10 years. Although with this size of a sample, we found no statistically significant associations. This graph gives some suggestions about the relative importance of the respective factors to implementation success. Clearly a project where the community organization and academic partner have a history of prior collaboration on similar projects appears almost twice as likely to be successfully implemented. The next 5 factors also appear to contribute to an increased likelihood of implantation success, increasing the likelihood of success by about 1.5 times. Well, the last factor, age of CBO, does not appear to increase the likelihood of implementation success, at least in this case. In addition to implementation success, these factors also appear to be related to intervention success. Here we've grouped 13 of the 21 projects that are experimental or quasi-experimental evaluations and have completed their analysis into 3 levels of achieving statically significant changes by their participants. 5 A to E achieved statistically significant changes in their intended or primary outcomes. 6 F to K achieves statistically

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significant changes in secondary and/or related outcomes. And, 2 projects L and M demonstrated no statistically significant changes. The dots indicate for each project the presence of a high level of each of the 7 factors that we were interested in. First, it's important to note that the majority of completed and fully analyzed community implemented interventions achieved statistically significant changes in their participants and that the projects that achieved statistically significant changes were also characterized by high levels of a number of these facilitating factors. In contrast, the 2 projects that did not document statistically significant changes lacked high levels of many of these facilitating factors.

The preliminary findings of our 2 ongoing collaborative prevention translation research studies also give some indication of what will be necessary to tailor and adapt demonstrated interventions for implementation with specific communities and community settings. Both projects share some key features. These projects are intended to study the process of translating evidence-based interventions, an area of prevention science that has often been neglected or undervalued. They involve collaborative research partnerships, as did the other projects. They are intended to document factors related to organization, intervention, technical assistance, and consumer input, and ultimately they're intended to produce guidelines for adaptation for use in the State of

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California.

These 6 collaborating organizations led by George Ayala at the AIDS project Los Angeles are studying the adaptation of street smart, one of the Debbies, for use with young, Latino MSM. These 4 organizations led by Susan Kagless [misspelling?] at the University of California at San Francisco are studying the adaptation of the empowerment project for specific use with young, African-American MSM. I showed these 2 slides to acknowledge their efforts, but to also underscore the extent of the collaboration in the translation research we are supporting.

While these projects are currently ongoing, here are some relevant preliminary findings. Both evidence-based interventions, street smart and empowerment clearly require significant adaptations in order to be adopted and implemented by community agencies serving young Latino and African-American MSM. These include incorporating culture, identity, and importantly processes aimed at empowering MSM who experience multiple oppressions, and increasing flexibility and consistency in integration with the agency and staff philosophy, values, and practices. Even with these adaptations though, implementation has been challenged by a very volatile funding environment and a high staff turnover. It's also been challenged by competing interests, sometimes between the researchers themselves and the agencies and sometimes by the

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agency administration and the agency frontline staff. At the same time, the adaptation and implementation has been facilitated in larger and more experienced agencies and with active training and transfer methods.

So, what does this all appear to be saying about what it takes to implement scientifically sound interventions in community settings? This is a graphic representation of the factors that appear to facilitate implementation in community settings. The yellow boxes represent a model of implementation of innovations developed by Klein and Sora [misspelling?]. The blue, the added components, are the components that seem critical in the context of HIV. Our experience suggests that consistent policy and resource support and consistent and ongoing community science collaboration are critical in our HIV context. It's likely that ongoing, high quality community science collaboration helps create a culture of inquiry within community settings that affect climate, while the consistent policy and resource support enables this culture to be sustained and to thrive over time. We believe that this wholly consistent with the creativity and activism that drove HIV prevention in the early years of the epidemic.

So, question again, what will it take to implement scientifically sound interventions in community settings? For communities, it will take active involvement in collaborative research and development until commitment to the intervention

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and not mere compliance is reached. It will also take a level of professionalism without sacrificing the creativity and activism that has been HIV's gift to the business of science. For scientists, it will take research into indigenous processes and community and service context to add what Rafael Diaz called a couple of days ago "intrventions to our armamentarium of interventions". It will take rigor without rigidity and a willingness to engage in cross-discipline collaboration, including moving beyond public health to include organizational sciences, health economists, and others. And finally for funders and policy makers, it will take sufficient and consistent support of community-centered collaborative approaches to research and development. It will take policies and interventions that affirm and are consistent with diverse community values, in particular those communities who experienced multiple oppressions of racism, poverty, gender inequities, and homophobia.

Just a few final thoughts – all humans are caught in an escapable tepid of mutuality tied in a single garment of destiny. Whatever affects one directly affects all indirectly. At the same time vision without resources is a hallucination. [Laughter- Applause] And, finally, if you don't change your direction, you're going to end up where you're headed.

[Laughter]

I'd like to acknowledge several research colleagues:

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those at the California State Office of AIDS, those on the University of California Task Force on AIDS, and those on the University of California Office of the President for their leadership and support on these important issues. Thank you for listening. [Applause]

**JANET L. COLLINS:** Thank you for that excellent summary of the science behind implementing science-based interventions. That was very, very helpful. Our next speaker, Julian Hernandez will address creating youth friendly programs. Julian Hernandez has engaged the HIV prevention field in a variety of roles and each of these roles has truly contributed to his understanding of the epidemic. These roles include client, student, worker, volunteer, critic, and supporter. He works at the AIDS project Los Angeles where, as he so nicely puts it, he is advancing his own education as it continues under the guidance of a group of dynamic youth that challenge and nurture his understanding of prevention. Please welcome Julian Hernandez. [Applause]

**JULIAN HERNANDEZ:** Good morning. Buenos días. It's nice to be here. I was put with the task of trying to address how you create youth friendly spaces. One of the things that came out of that when I was thinking about how to put this together is to really look at what makes programs succeed [inaudible] and more importantly, what makes programs stay with the youth that go through these interventions. Why I remember

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some of the stuff that I did, about 8 years ago now, and when I came up with this creating youth space, I want to thank a lot of the people before I start. All of the people that I've worked with throughout the year and a lot of the organizations in Oakland, San Francisco, and now L.A., and especially the youth that I've encountered. Being a youth and also growing out of being a youth technically by the restrictions, I don't qualify for a lot of programs now. One of the things that I came about to phrase simply was that trying to remember how we all grow up from being in kindergarten to coming over as an immigrant to going into prevention and asking for a test the first time. A lot of the things that happen are we have a lot of questions. The youth that come into our programs do the same thing. We have a lot of questions. We don't know a lot about the world, the immediate surroundings and with the point where we're confused about where we're going to go and how we're going to end up there and if we even want to be there. Through that confusion, develops change. We take action in one form or another. Maybe we can't do it physically, but we do it mentally. That really runs the gamete of what I've experienced as a youth in programs. From going back and just reiterate knowing where you're going you have to see where you've been. I remember looking for answers at bars, places filled with alcohol, places filled with opportunities that probably weren't the best choices at the time, but also led to good experiences.

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Looking for space as a youth, walking into the Castro in San Francisco and realizing that this wasn't my space, this meca that I went to and searched for some type of answer, some type of mentor. They weren't there because I was young. I couldn't connect with the people around me. I didn't have money, so I couldn't connect, I couldn't buy some of the stuff, I couldn't engage. On top of that, I was a person of color and none of that connected at that moment. So, I went away from that and the lucky thing is that I was also at a university. As a youth at the university, I had opportunities to ask a lot of question. I read a lot. The most I read was the Chicana Queer Feminist Theory. It is wonderful reading; I would recommend chatting what I got to anybody. Audrey Lord, Bell Hooks, a lot of people: a lot of people that informed my experience. But, I still didn't find what I was looking for and I was looking for community. When I started looking for community, it brought up the question that I still think I ask and I think all of the youth that I work with ask the same question: what is prevention? To me, prevention was a lot about finding where I fit in. It's interesting to see myself as a consumer of prevention. These services that we fund, these services that we spend so much time, even putting a conference together to really look at exactly what we are doing and what is effective and for me at the time, prevention really meant trying to find a space where I fit in and answering the question who my

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community is. That is how I started putting the pieces together that kept me safe and kept me protected in terms of HIV infection and also in terms of a lot of things: homelessness, drug addiction. The reason why I was able to maneuver all that stuff is because I was trying to ask those questions to myself: why was I coming to this group? What did it give me? Prevention was intertwined in all of that because that was one of the few spaces that was funded directly to challenge assumptions and to really create a space where I could ask the type of questions that I wasn't able to in other settings.

One of the things that I was able to do and I was happy to experience as a youth was producing a video project with a group of 4 to 5 youth. It took about 3 months; 3 months of intense work; 3 months of community mobilization; 3 months of trying to figure out how we get a group of 4 people from the same community suppose ably – gay Latino – and looking at what our motivation for and what we wanted to communicate to other people in our groups, basically peer education. Out of that came a video project where I had 3 things that stuck in my mind from that video. One of them was 3 brief quotes and one of them was a young man who had a gay brother and his gay brother told him to not be gay, life is too hard. That was a moment of crystallizing for me of how difficult it is to be somebody on the outside of the mainstream. Trying to find your way through

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it and then to have on top of that the risk of becoming infected and trying to maneuver that through bars, social groups, through everyday life and to be told by somebody who is from your community that life is hard. The other one is I put up with it. I don't pay rent. This was a Latino in front of a bar, a young man with a crucifix hanging from his neck. Bien católico, very catholic, about to go into a bar to have a good time with a friend and just telling us that he could put up with the rejection from his family because he didn't pay rent. He knows if he challenged it, he would be on the streets. How many of us go through that in different ways? The other one is don't tell your younger brothers. I don't want you to influence them. So, you've done all of this work to come out and to really find yourself, but you can't really share it with the people that you most love because it's dangerous. Some of the things that I took from that and the reason I share those is because I look at the Debbies now and the Debbies are wonderful. They are actually amazing amount of work that people have put behind them to look at statistics, outcomes, to connect variables, causes, all of these things that sound wonderful. But, what I'm worried about is that the Debbies, how they are taken by different community-based organizations, especially with capacity that hasn't been built up because they're taken at the last word. Also, models of prevention. One of the things that I've learned is that none of the models

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that we have right now, especially none of the Debbies, can fully capture the complexity of what it means to be at risk. They don't. They capture maybe one angle of it, but they can't capture the 360° life of any individual, especially a group of individuals. Taking that and looking at life as being a complex and dynamic process of change, I'm afraid sometimes of some of the stuff I hear, especially the [inaudible]. The only reason is not because I'm necessarily against it completely. Abstinence could be a good goal. But, it's just like condoms only, where you're attaching that "only" part to anything, you're basically limiting the options in life and life doesn't work that way. You're going to get situations [Applause] - thank you. You're going to get to a point where you're setting up people for failure when you use that "only" term. You can see that with drop out rates in high school, with the fact that they graduate from high school what type of dollar opportunities they have. We narrowly define anything in life. You're setting people for failure because life does not work that way.

The key to success and I was thinking about this - what makes a person successful at the fundamental level? Going back before anything and part of it is that willingness to change with the person you're serving and that dynamic relationship that you have. I hope to God, I hope that every time that I go into the office or every time I work with somebody new that I

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know my relationship with that person is going to change. Eventually, they might be the person who's going to replace me while I move on in my career and they take over. A real community-based approach, where your committee has the tools to take over the intervention that you propose and to change, adapt it, and everything.

So, the critical questions – some of the things that I ask myself when I look at youth programs, any programs, but specifically now youth programs, is do you have a vested interest in building community. I think a lot of effective prevention work is about building community because your funding might get lost in about a year, 2 or 3 years, so then the people who went for that intervention, if they actually connected, they'll continue the work far beyond the funding cycle. If you don't have that part there, if you don't have a way to communicate that, to enforce that, to nurture that then your prevention work – 3 years down the line, somebody can make a decision after that third year, although you've been technically successful based on your report. What type of decision-making par do the youth participants possess? Are you taking the time to look at your board of directors? Are you taking the time to look at who actually makes the decisions in your agency and seeing how you can change the structure or the way you interact with them to include youth participants in there – not just that, but client feedback. I've heard a lot

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of stuff from a lot of different agencies where they actually take the time. It's a lot of work. It's a lot more work, but I think it's beneficial in the long run.

The last thing is how do you actually address social realities of youth? If somebody comes into your office or into any type of intervention, except a youth program, and a referral is your setup. A referral never is good, but before you even go to the referral network, where are you sending these youths? Some of them might be homeless; some of them might have experienced homophobia. If you refer them to testing and they go to a clinic where automatically they experience the same type of oppressive reactions that they experienced from home, especially the transgender, then really they might go to testing, but they might never come back for the results. They might just walk out of that clinic. So, the referral [inaudible] have to built, have to be changed, and have to be challenged. Some of these places we refer to, we have to do the work of actually going there and educating the staff.

The empowerment project: let me talk about that one. The reason I chose the empowerment project and this is before I came to APLA but I was glad that APLA actually was working on this too, was that one core element. Out of all of the core elements that were there, it was just the core element of recruiting a group of young, gay men to design and carry out

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project activities. I thought it had the potential to create a safe space where youth can be creative. At APLA, it's something that I've actually witnessed. In the last couple of months, I've seen what the potential for empowerment is. Beyond the specific things – project space, outreach chains, social event, all of these core elements that we've worked on, we're trained on. The key is that how much input do the youth actually have; how much does that turn into actual action. I've seen that in a couple of instances. One of them and this is the one that made me stop, think, and flash me back to when I was younger, was at Long Beach Pride. These are a couple of the youth participants and they're smiling, posing, right in front of signs, in front of the protestors that are classic at every pride event. I'm glad to say they've gotten smaller and smaller over the years. But, they're smiling in front of posters that are condemning them to hell; that are telling them that they're not worthy of the life that they live. They're standing there; they're not afraid; they're actually having a good time taking the picture. To me, that is a powerful statement of what empowerment can be, in terms of being able to stand your ground in the face of a lot of oppressive factors, a lot of things that are telling you that you're not going to survive. They're surviving there. More than that: they are living. They're enjoying life. The other rigor part, the one that talks about community empowerment – the youth that we work

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with, around 20, it's a network. We're funded for specifics to work with young, gay men. As you can see in the picture, there are some women there, from different backgrounds. Not all of them are gay. The beautiful part about that, just like it says, not just a target population; this is a network of people making connections that are going to last longer and beyond this program. They learn from each other. They share some of the most incredible things. There's a couple of people in there - there's a young woman who's in high school who questioned some of the racially motivated fights that have been going on in her school. There was a whole hour on discussion and to me that was prevention. There was a whole discussion about romantic relationships and how we treat the people we went out with, how the youth treated each other, and at the basic level, how do we treat the people that are in our communities that we're going to see 5 or 10 years from now. Our actions have repercussions in the long run. To me, that was prevention. The beautiful part of all of that and this is the emphasis I want to make on this is that this all happens, those 2 pictures, my experience through prevention, all of it happened with limited resources. We never had enough money. There was never enough money in the budgets to do everything we wanted to. Never. But, we were creative, just as we're creative in our families. We're very creative in stretching resources. We all had multiple needs. None of the needs that

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we had, none of it was resolved completely. Some of it at some point, some of it at others, and some of it continuing.

Homelessness is not going to get resolved for an intervention that lasts 7 weeks. Unemployment is not going to get resolved for an intervention that lasts 7 weeks. But, all of those things feed into why somebody's at risk. They're there: the multiple needs are there, but we work through them. The thing that is going to address those is those connections again: that connection between people that you can discuss life about. The funniest one is we actually don't have a drop-in center. I think that is one of the major components of empowerment. We have a semi drop-in center space and that is in an office building. If you can imagine 20 youth from at least 45 minutes away on our metro system in L.A., which is new, expanding, and not adequate – but they get on that metro system and they get to our office building in the financial district. These are youth in high school and I remember back in high school: anything that was taller than 3 stories, 4 stories, was huge. I can just imagine their reaction to being stopped by a security guard and asked, "Why are you here? Aren't you supposed to be in school?", and having to negotiate that space. They are willing to come there and they're willing to come there because we're willing to listen. We're willing to listen to them and actually create that space where they listen to each other and grow from each other. The other one is that

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this all happened despite the restrictions on expression. We're living in a climate right now that restricts our expression. That is not new. That has been happening forever. Especially abstinence only: I was thinking about abstinence only and one of the reactions that I had after awhile was that I've been given abstinence only education from the very start. As a young, gay man, I've been told not to explore my sexuality from the very start. It hasn't worked. It's still here. [Laughter - Applause] That is a personal account. We can do a study.

What I want to leave with, just food for thought: I want to reiterate that I think Debbie interventions and a lot of the work that is being done is good, sound work. We have to be able to cover our entire basis. But, one thing that I really believe in is this sense of empowerment and really taking it to heart and really put statistics to that. It's really hard. It's not the easiest thing to track. That is where I'm going with the experience I have right now with the expression from the youth, is to look at how we can create these interventions that allow for critical thought. That is where I look at somebody like Paula Freda [misspelling?] and I hope I pronounced that right. It's just a practice of freedom and choices. I'm afraid we're limiting our choices and the more we do that, the more we're going to end up failing. We want to try and combat that at some level. I'll leave with a

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couple of things. I wanted to keep asking questions just like the youth keep asking me questions. I want to keep asking questions and never be satisfied. There won't be just one answer; there will be multiple answers. I don't just want to placidly accept a narrow definition of effectiveness. I think we have to broaden our definition of effectiveness before people start telling us what we do and what we know works doesn't work. Thank you. [Applause]

**JANET L. COLLINS:** Thank you for that very personal and thoughtful account of the real meaning of prevention. Our next speaker, Mr. Ray Daw will present on integrating drug treatment and HIV prevention programs. Mr. Daw is a member of the Navajo nation and executive director of the Na'Nizhoozhi Center in Gallup, New Mexico. I'm probably not saying Na'Nizhoozhi quite correctly, but I did learn this morning and I thought you would find it interesting as well that the meaning of this word is the crossing places in a river. I just thought the visual imagery there was very nice. Na'Nizhoozhi provides both residential and outpatient services and is one of the largest providers of behavioral health services in Indian Country. Please join me in welcoming Mr. Ray Daw. [Applause]

**RAYMOND DAW:** Good morning everyone. Yati is my people's way of greeting everyone and I wish to welcome and extend my appreciation to the Center for Disease Control for allowing me spend a few minutes with you and also to greet my

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relatives who are out there. There are probably Navajo relatives out there in the audience. On their behalf, I do need to tell them that I am a member of the Keha'atiinii clan and born for the Kinlitsonii [misspelling?] clan.

As an administrator of the largest residential behavioral health program in Indian Country, it has really come important for me and the team of folks that I work to really look closely at prevailing trends in the region that we work in. The region that we work in is the 4-corners area, also into most of New Mexico and Arizona. To really work at understanding the different ethnic population that we work with, which is largely Native American, but also includes significant proportions of the Hispanic community, Mexican, and Spanish-descended people, but also White Americans and other folks that come into the area.

Native Americans are not segregated or isolated onto the reservations. A majority of our people live off reservations. This has been a trend that has been developing for 2 decades, where most of our people now live off of reservations. The United States census in 2000 did a nice job at depicting on a map where there were high densities of Native American people. You'll see the Western part of the United States being highly representative of where most of our people live; largely in the urban communities, the states of California, the cities like Phoenix, Denver, Minneapolis, Salt

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Lake City, Portland Oregon, for example, Dallas, Chicago are places where we have a large number of Native Americans who live now as a result of poor economic conditions on the reservations and poverty. It is not uncommon for Native Americans to commute on weekends several hundred miles to go to their communities where they work and to commute back to their homeland on the weekend, and to commute back and forth from places like San Francisco to Navajoland every other month. That kind of movement is very common, which creates an interesting trend for Native Americans because the majority of our people do live in urban communities and it unfortunately puts our people at greater risk for the same kind of ills, trials, and problems that occur in urban settings: drug abuse for example and different problems that put us at risk as a result of drug or alcohol abuse. One of those things that come into our lives that puts us at risk is HIV and other infectious diseases. We're finding in Indiana Country that our people who do get infected commonly get infected while they are in these urban cities. When they become infected, it is not uncommon for them to come back home to the reservations that they come from. So, we have this migration that is occurring. It puts service providers like myself, tribal governments, and state agencies in an extremely difficult position of working towards developing strategies that really do look at preventing increased incidents of HIV and other infectious diseases among

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our people.

The program I direct looks like this: it's a 150 bed facility with a significant proportion of our population being Native American. We provide residential services to people from across Arizona and New Mexico, largely around the 4-corners area. It has been consistent in findings and research studies that it is effective to provide HIV prevention services and drug treatment settings. That is pretty much a no brainer. The question is how to get that done and how to do that in a culturally appropriate and culturally sensitive way, particularly when working with Native Americans who are somewhat acculturated to the western way of life after having resided in urban settings and coming back home to families who are less acculturated and to communities that are less acculturated in the western ways. Our 2 spirited populations, we don't use the word "gay" because my impression is that it's not a word because it further stigmatizes. We use the word 2 spirited to describe folks who have both feet in the male and female aspect of life. In my culture and my religion, we do all carry, whether we're 2 spirited or not, aspects of the female and the male within us. Another thing that becomes important is that the program that I direct is a program that really targets the chronic substance abuser. So, once again, there are a whole plethora of research studies that show that chronic substance abuse is a significant risk factor for HIV

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infection and other infectious diseases and all other kinds of conditions that come with it: homelessness, unemployment or lack of employment, family dysfunction, disintegrated social systems, things like that. When looking at that, it is important to look at how to provide HIV prevention services in the context like the program that I work in. The program that I run, because a significant part of our population is Native American, we have worked strongly at emphasizing indigenous values and indigenous teachings. In the foreground of this picture you see an area that is fenced in. This area that is fenced in is an area we call the healing grounds. It's an area where we have traditional providers, medicine men. Indigenous healers provide indigenous interventions to people who come in, including folks who are at high risk for HIV and other infectious diseases. We've worked really hard at understanding the impact of HIV infection on our people and we work hard at understanding the problem associated with that and working hard at making sure that the entire program is included in the practice of HIV prevention. That has been one of the key features that we've worked at accomplishing over the last few years. One person who is funded to do HIV prevention work is an accepted part of the entire treatment team, as well as a part of the prevention team in the community and the program that we work in.

The process of putting in place HIV prevention services

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and a drug program begins with seed money. We'll seek and sometimes obtain seed money to do that. The program I run is no different. We began our work several years ago with funding from CDC and HERSA to implement prevention services and to begin to develop a better understanding of prevention models that are out there in this field. Through the course of the years, we've begun to wean ourselves away from those kind of [inaudible] monies so we are better able to incorporate our services in this 100 treatment program that we have, which also does a lot of community work not only in the town that we work, but across the 4-corners region. To do that, we've had to work extremely hard at developing a regional provider network that includes federal providers, state providers, Native American providers, and non-profit program providers in a regional collaborative that really looks at keeping a good hold on how we do prevention work in giving us feedback and everyone else in the system feedback on how things are going in the region. That is important in terms of looking to development for structure that sustain these services. Our goal is not to be reliant on federal funds to do this kind of activity because that is how important prevention services are and how underfunded prevention services are. It is my philosophy personally that because there is a lack of funding, not only for HIV prevention but other prevention services, that it's important for me and my program to wean ourselves away from

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these prevention suff [misspelling?] funding opportunities that are there and allow other programs and other communities to be able to access those monies. That is been one of our main motivators to developing our infrastructure and looking at doing these things ourselves. That becomes important towards us emphasizing in a governmental collaboration with the different tribal state, county, and governmental entities that do exist in the area. That is been a major emphasis of ours. This picture by the way is a picture of the after effects of a snow storm that went through our region about 3 years ago. Everything was white and clean. Some of the activities that we do are pretty basic things. In the last two and a half days, we've gone to workshops and had opportunities to hear other people talk about how they do HIV prevention and I don't believe that we do anything that much differently. However, the difference we offer to our at risk people is that we do daily group presentations and education to our chronic substance abusers. I run a program that meets every year, 17,000. We have a high turnover. We have a lot of people coming in and coming out. Within this context of a high turnover, it is important for us to make sure that our HIV education and prevention activities and presentations are occurring on a daily basis. That is one of the priorities that we have in the program that we have. We also do a significant amount of individual counseling on sexually transmitted

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diseases. We have one provider who does that solely as her function, but also does that as a technical assistance provider to other counselors or other providers that we have on staff. She basically works at helping other providers include that in their discussions with relatives and clients of ours that come into our program. Of course, we do health risk assessments on all clients who come in, regardless of how long they stay with us, whether it's 24 hours or 2 months. We have our relatives waiting testing on a regular basis. We do drug blood draws. We work with federal agencies and state agencies in the area to have the blood and samples tested in order to be handled in a culturally appropriate way. For example, in the Navajo way, body fluids that are drawn are not destroyed, they're not thrown away in the trash, and they are not discarded in an inappropriate way. They are handled with care and they're handled with respect. That is an aspect of Native culture that is really strong among all Native people I think. Taking that into consideration, we have to be really careful of how we approach our relatives and clients about consenting to allow us to do blood draws and to take samples of them, whether it be or some other process. We also work really hard for our relatives who do test positive are tracked and referred to very appropriate agencies in the region who work with the populations that come into our program.

As I mentioned before, our interventions are

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intentionally culturally specific. The majority of us who work in this program are Navajo-speaking, as well as having speakers in a number of different languages: tribal languages and Spanish language as well. Most of us also are ready to provide language-specific services to primarily English-speaking people as well. We do that. We have a real strong affiliation with the University of New Mexico in Albuquerque, which is one of the most efficient, and effective research institutions on behavioral health and substance abuse and all of the problems associated with them. We've been able to adapt motivational interviewing as a technique with folks that come in to obtain counseling about the possibility of whether to get tested or not. We use the motivational interviewing approach as a main strategy for our relatives. Of course, we work very hard at insuring privacy and confidentiality. This is a particularly difficult thing to do in Native American country because many people know each other. A majority of the people that live around the Gallup community are related to me. So, protecting their confidentiality and their privacy is a real important aspect of protecting them and insuring that what their looking to consent to participating in is protected. We put a good amount of time in psychiatric education. We look at literature and video that are being made available. We screened them out to see what the messages are like and we talk about whether they may or not be appropriate for the populations that we work

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in. We intentionally target them that way. We do work on environmental prevention. For example, there was a local bar that we identified as being one of the hotspots as a place where we saw a significant proportion of infectious occurring from. We began work a couple of years ago to communicate with this liquor establishment so that they would join this collaborative. Eventually what this liquor establishment ended up allowing us to do is to have some of our providers go into the bar in the evenings when most of the people were there and give out literature and talk to the clients who were consuming alcohol in the bars, as well as giving out condoms. Eventually that activity has grown and we do that now in about 6 other bars in the city of Gallup as a way to address prevention from a different kind of context. Newspapers and radio are important parts of our work because we are heavily rural and we rely on radio and media to transfer and translate a lot of messages for us.

Outcomes: well, one of the outcomes was shown as a 75-78% of people tested come back for the results and complete post-test counseling. Also, I believe we've created a very positive environment for HIV prevention services that is showing some good impact and we've been able to identify the effectiveness of motivational interviewing as one of the strategies to be incorporated in HIV prevention. Some of the resources that we rely on as we grow and we learn are resources

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like this: SAMSHA, NIDA, HERSA, CDC of course, and Indian Health Services. I want to thank you for your time and hope you have a good day. Thank you. [Applause]

**JANET L. COLLINS:** Thank you Ray for sharing some of the challenges in HIV prevention, but also some of the unique values, beliefs and resources that can be drawn on to achieve HIV prevention among native cultures. Our last speaker on this morning's plenary is Humberto Cruz, who is the executive deputy director for the New York State Department of Health AIDS Institute. He's been working on HIV/AIDS issues since 1987 and has been instrumental in developing innovative initiatives, seeking to better meet the needs of persons living with HIV/AIDS. He is a national leader on policy development related to prevention and care in the interface of prevention and care. As such, Mr. Cruz will address us this morning on incorporating HIV prevention into HIV care settings. Please welcome Humberto Cruz. [Applause]

**HUMBERTO CRUZ:** Welcome all. It is both an honor and pleasure to be here. I want thank CDC for giving me the opportunity to be with all of you here today. One of the challenges as we get older, as some of you are feeling it, is that we have difficulty in multitasking. I have to read, talk to you, press a button, and remember all that I am supposed to say. I don't know if I'll be able to do all of that.

[Laughter] But, let's move forward. I think it has been an

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interesting time to be here and I want to begin by saying that when you are the last speaker of such a wonderful activity such as this one, it is very difficult to bring something new to you because most of the issues have been discussed and presented. We had a wonderful opportunity to listen to many of the wonderful activities that are happening across the nation and regarding New York State which I'm going to have the honor to present to you some of the activities that we have done. Many colleagues and staff from New York have been presenting specific areas related to what we have done. Every time I see this side, New York as the epicenter of the epidemic, it's nothing to be proud of. What we have to do is base upon the necessity of dealing with having an epidemic of 16% of all of the cases in New York State. When you have more than 160,000 individuals who have been reported with AIDS, it's a monumental task. It is very difficult. What we have done is born out of necessity and it is something that we have to deal with on a continuous basis. Prevention in New York State has worked, however we have a great challenge ahead of us in how to continue to face what we are seeing in our state and in the programs that we have been developing. The reason why I'm showing to you the evolving continuum of cares, HIV continuing, you see there, is that we call it the evolving continuum of care because we have to be conscious that we have to change the way in which we both deliver prevention and care as the

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epidemic changes and as new discoveries and treatments come in. What is critical from these diagrams is that we have integrated prevention across the whole component of our service delivery system. What the challenge for us, and one of the things that I had to remember is to put my glasses because you noticed that I forgot [Laughter], is how we assure as we move forward that our continuous continues to provide effective prevention across all of the components. The way that we evolve to the prevention system that we have in New York is that we had to do a policy decision 15 years ago. That decision was that we needed to integrate prevention into all parts of the continuum. That has been something that has worked for us because by integrating early on, prevention to all parts of our continuum of services, it helped us integrate services and move forward as the epidemic changed. Some of our models include the following activities: multilevel coordination between states, city, and local governments; private agencies; and health and medical care providers. Basically, you cannot do things alone. You need to work with others at all levels and you need to have the flexibility required for you to have effective models. The second one: linkages with and referrals to a specialty for behavioral care and support providers. Support is reimbursement tailored models of care, appropriate education and training, and monitoring and quality assurance mechanism. I began by supporting reimbursement, funding. Do you remember

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the quote from our friend here? Mission without resources is an illusion. One of the things we [inaudible] is that using funding from CDC, using funding from HERSA, and using local resources, we put together a system of care and prevention that have tried to address the members and tried to address them monumental need that we are facing today. The basic components of our model cover the following activities: prevention services including partner notification; harm and risk reduction; outreach and education; client services such as case management, mental health, housing and legal assistant; health care services including community-based HIV prevention and primary care, acute care which means designated AIDS centers, and clinical education guidelines.

What I'm going to try to do now is to go through the different models and setting and what we need and in some instances, what we have been able to achieve by implementing prevention in these settings. What we did was very early on and you see it there, established in 1989, that we began a process of grant funding health care programs in which we provide settings with the necessary resources to integrate prevention, primary care and support services. Within these settings, very early on in 1989, we included risk and harm reduction services and partner notification assistance. We sponsor or participated in community education outreach and health promotion activities. We coordinate care related to

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prevention needs through contracts and linkage agreement and we participate and offer educational programs. Just now, we are developing a new initiative, which is a pilot of new models such as Optimum in New York. But, what is critical about this in each of these it was that it was established in 1989, but it was not rigid. It was not static. It continues to evolve and to change. I think that's one of the critical elements that we have to remember when we are talking about implementing prevention in different settings. The needs for the population change, so we went back and revised the models. We needed to be more effective in how we were reaching the population. We did focus groups; we talked to the community, we talked to the service providers, we talked to the PLWA community and together, we redesigned, reevaluated, re-coordinated, redirected resources and programs such as were able to continue to evolve and change and try to address the continued need.

One of the most innovative activities that we did with the community was that facing the situation that we had, escalating costs in all levels while reduction of funding was in the horizon is that we tried to develop a system [Laughter] to provide both care and prevention within a structure of managed care. We call it HIV Snips. I used to say, "Snip, snip, snip, cutting costs", but it didn't happen that way. The important aspect of this initiative was that we were trying to address between 30,000 to 50,000 medicated HIV individuals in

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the state of New York. We wanted to develop a program that incorporated both health care and prevention and that will bring together the community, the PLWA, into a system of care that will provide all of the needs that individuals will need related to both prevention and care. We did that by including a benefit package that included access to HIV primary and secondary prevention and risk reduction activities. We started the program 2 years ago. Rumbo Disario was telling me, "Humberto, bring outcomes." Well, Rum, I'm sorry. I don't have them. But, I promise you that in the next 2 years we will be able to do that.

Prenatal care: every time I hear the statement that prevention doesn't work, I get furious. To be quite honest, I think it's an insult to you, to me, and to all of us because we have been working [Applause] very hard to make it work and we have shown that it works. Can we say that it works in every place? Can we say that it works in every population? No. That would be lying. However, we have successes and we have been effective in many settings. We continue to be effective in many settings. I think one of the most difficult parts for any type of prevention activity is how to demonstrate something that never happened. How do you tell Congress we did not get people infected in the United States by this percentage because you can measure what never happened. But, that doesn't mean that it did not happen and it doesn't mean that it was not

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effective. We have worked hard! [Applause] One of the examples that we have that we can feel so proud is the importance of our prevention of prenatal transmission in the HIV/AIDS infected woman. To go from a rate of 10.9% in 1997 to 1.2% in 2003, that's a big success and I say too [Applause] politicians who love to carry babies, now you have more babies to carry because they are not infected. [Applause] We did it all of us working together.

Our prevention with positive: our colleague from New Mexico was talking about how they have been able to provide services to the population who is using substances. I never can get between substance abuse and substance use because you are supposed to be politically correct and sometimes I forget that because I'm getting old to be politically correct. [Laughter] But, what is critical about what we did earlier as part of that 1989 program that I told you before is that we began to integrate prevention activities and primary care within substance abuse treatment settings. What we did is we medicalized these settings and we brought to them the primary care and the prevention into one, single area where you in a way have a captive audience. We provide to them condom distribution, behavioral change, risk reduction counseling, primary care, mental health, case management, and just recently we are creating a peer driven partner identification campaign. What is most important from all of these is the dramatic

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reduction in the incidence within these populations. You know that in the 1990s, using blinding studies which is the critical part, we have an incidence of between 50-60% within the injection drug user population. Today is 12-15%. That's a dramatic [Applause] change in how we impacted a population. Once again, we can mention it, we can demonstrate it, and we can show it to you. But, you know what we cannot show to you? The number of people who were not infected and that today are walking free of these terrible disease. [Applause] Another aspect of what we have tried to do lately is to develop prevention with positive workshop in which we bring providers to help incorporate the prevention message in routine primary care. These have been sponsored by New York/New Jersey AIDS education and training center. The basic premises is that it provides strategies in primary care settings to reduce risk behavior. It just begun, so I don't have anything to show how effective it has been, but I promise to keep in touch with you.

Lessons learned: I don't want that stop sign to be put in front of me, so I'm wrapping up. [Laughter] One of the critical issues is community input. Community input is a critical element of what we do and how we do things. We need to develop training and information material for providers. But, I have to tell you, the training material that you used 3 years ago may not be useful today. You need to, when you are dealing with prevention, to continue to update your material,

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based on the changing needs of the population. Reaching out to all of the government agencies, other states, and academic communities, we need to learn from each other. We need to incorporate what others have done successfully. You remember that I mentioned Options? Options was not developed in New York. We developed it because some other state developed an initiative that worked with our population and we incorporated it of course. Did we copy the model exactly as it is? No. You don't. You modify. You change it, but you learn from the experiences that others have, coordination, and collaboration. We had a meeting yesterday with CDC in which we reemphasized the importance of coordination and collaboration with each other. Sometimes we fight. Sometimes we disagree, but that doesn't mean that we cannot work together towards a common goal. The common goal is in front of all of us: what to do to reduce this infection in all populations.

One thing that I have to say that is critical for us to realize is that when we are dealing with incorporating prevention within health care settings, we have to face some realities and some difficulty. Time is a major consideration. The productivity requirements and the limitations sometime in which you are asking a physician or a clinician to do more and more with less and less time and more and more people to be seen, some times are very difficult and need to be on the astute and recognize that sometimes to do all of the things

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that we want a clinician to do, may not be able or possible. The messages have to be tailored, have to be modified in order for us to be able to do what we need to do. Documentation on interventions, on outcome measures, are important, yet difficult. I have to say to you that sometimes the need, and I consider it to be a need because we have to prove that we don't work, to prove what we are doing. But, when you have to do continuous documentation, sometimes the intervention or the documentation, what takes precedence, we say both. When you are sitting in front of a client and you are providing a service, sometimes it is very difficult. I just want to bring it to you as an acknowledgement of one of the major challenges for which I don't have an answer. Yes, I do have one. In risk clinical involvement of model of care are critical for effective implementation and we are going to have to speed up.

What are the challenges before us? The challenges are many and I may not cover all of them, but I think that we have worked in these settings in this conference to try to identify what works in different settings and what doesn't work. It's clear that we have to identify and develop interventions to reduce transmission. When we listen to what is happening in the black communities, we have to acknowledge that there is still plenty of work in that area for us to do. I also want to mention that not only in the black community, where the need and the numbers show the greatest impact, but there are many

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other communities, Latino communities and other communities as mentioned by my colleagues that we cannot forget that we need to continue to improve what we are doing. We have to assure a [inaudible] to care and how to remain treating people into care. That continues to be something that we have to work with. I remember in New York with its studies related to the number of people who are identified as being on AIDS diagnosis when they first go into their first entry into the program. That is unacceptable. That is something that we have to improve and to do better. We have to use not only Medicaid and [inaudible] resources; we have to use local resources. We have to use CDC resources. We have to use a multitude of innovative ways of getting the necessary funding to provide the services that we need to do. We need to know how to effectively target our population, meet the needs of an increasingly diverse population, incorporate behavior and clinical risk factors, revise and improve partner notification, and create programs that address mental health, substance abuse, and other variables while being sensitive to stigma and discrimination. I want to acknowledge all of you who are here. I want to acknowledge the people to contribute to this presentation. And, before I close I have to say this: prevention works. It takes time. It takes effort. [Applause] It takes coordination and collaboration and we have a big challenge ahead of us. Not only do we have the challenge of continuing

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the difficult work that we have, but we have to work against the public perception that have been posted in each one of those newspaper and TV announcements that we have not worked. We have worked hard and we will continue to work hard. Thank you. [Applause]

**JANET L. COLLINS:** Thank you Humberto for your inspiring talk and for sharing your successes and recognizing the successes of everybody here today. Thank you. Gentlemen, it has been my true honor to moderate this fine session and I know the audience would like to give you another round of applause and thanks for all of the fine presentations. Thank you. [Applause]

[END RECORDING]