In heterosexual groups, the health education process should begin at the sites where high-risk groups are likely to be seen, e.g., family planning clinics; prenatal clinics; Women, Infants, Children (WIC) food supplement programs, sexually transmitted disease clinics, free clinics, drug programs. All history forms should contain questions designed to educate clients about risk factors. Health education materials appropriate to this group should be available for distribution. Providers should be alerted to ask questions and use health education materials. Screening should be encouraged in those identified as high-risk (the usual groups) as well as women in high-risk areas with multiple and/or anonymous partners. The rationale is to prevent transmission to new partners and to prevent in utero transmission in case of pregnancy.

For children: Clinicians serving children should solicit a history for high-risk status from all mothers. Children of high-risk mothers should be screened if mothers have not been.

Since the State funds many of these programs already, the history-taking and health education guidelines could be mandated.

The above should, of course, be done according to principles of confidentiality as mandated by State law.
MEMORANDUM:

TO: Executive Committee, California AIDS Strategic Planning Commission

FROM: Bruce B. Decker, Chairman
       Peter Scott, Vice-Chairman

RE: November 8th Meeting Follow-up

Shortly, you and all other invited members of the Commission will receive copies of the objectives developed at our November 8th meeting along with a list of members by region.

Please share the recommendations with experts in your specialty within your region, who may or may not be members of the Commission, seeking their input.

Please meet with your regional counterpart and communicate any additional information by November 29.

As soon as we have all the additional input we will communicate it to Dr. Kizer. When the Department releases the first draft of the plan we will send it to you. Shortly thereafter, we will schedule regional hearings (NoCal/SoCal) and follow with an Executive Committee session to consider preliminary recommendations.

Thank you for your help and interest.
TO: AIDS Service Organizations & Community Leaders

FROM: Stan Hadden

RE: Comprehensive AIDS Plan

DATE: October 15, 1985

A requirement in the state budget approved last June was for the State Department of Health Services to develop a comprehensive plan to address the information and education, testing, mental health, research, and treatment needs resulting from the AIDS epidemic.

On November 8th the department will present the plan to the state AIDS Advisory Committee, members of the Legislature and representatives of the executive branch. Teams with expertise in AIDS research, treatment, and prevention will also review the plan and submit input. A draft of the outline that is being used is attached for your information.

I have also enclosed notes for your review from one meeting that has already taken place to develop input into the state's plan. I am very interested in your comments on these ideas.

Plans developed by state agencies go through extensive departmental review. Often, portions of reports that suggested additional funding is needed are eliminated by the department before the report is released. In order to address issues that may not be fully covered by the department's plan, the Senate Health Committee has scheduled hearings in Los Angeles on December 16th entitled "AIDS: Implications for Health, Treatment and Long Term Care." Additional information on this hearing will be sent to you in the near future.

I am interested in any written comments you might have on the items in the attached outline and memo, or suggestions for additional areas to be addressed. Please contact me if you have any questions.
TO: Robert Anderson, M.D.  Robert Benjamin, M.D.
Larry Bye                                      Marcus Conant, M.D.
Bill Filante, M.D.                           Martin Finn, M.D.
Donald Francis, M.D.                        Neil Schram, M.D.

FROM: Stan Hadden

RE: STATEWIDE AIDS PLAN

DATE: October 7, 1985

These are my notes from our planning session to assist in the development of a statewide California AIDS strategic plan. We agreed to discuss these items further with our associates, with a goal of developing and prioritizing recommendations that can be addressed at community and county levels throughout the state. The programs and priorities established in California should serve as a model for other states, and for the federal government. Please let me know of additional information or changes you would like to make to this document.

COUNTY PLANS - County governments will bear the largest financial impact from AIDS for some time to come. Some county health departments have implemented education and patient care programs, others have been thwarted by county supervisors who are unwilling to take responsibility in addressing AIDS.

Recommendation: Class "A" counties (high incidence of AIDS) should be charged with producing and implementing comprehensive prevention, public education, care and surveillance plans. Class "B" or "C" counties (medium or low AIDS incidence) should be provided with a plan by the state. Standards should be set for local program elements. Inter-county cooperation for resource and program development should be engineered for Class "B" and "C" counties. Policy and recommendations from the state to counties should be developed, and funding necessary to implement programs should be pursued.

STATE RESPONSIBILITY - The approach to AIDS by the state, to date, has been largely reactive. Research and education efforts have been funded, but comprehensive, proactive programs have not been developed. Each day, there are conflicting messages coming from different state and federal agencies which promote unwarranted fear of AIDS in the general public. What can the state do to better educate people that is not being done now?

Recommendation: A Governor's cabinet level position should be established, responsible for coordination of AIDS policy among all state agencies. The position must have access to the legislature and the Governor, with enough authority to develop and implement interdepartmental policy coordination.
PUBLIC EDUCATION - There are effective communication channels that are not being used to promote prevention & healthy living or public education about AIDS. These include public service announcements, media inserts, political mailings, junior and community college adult education courses.

The issue of casual contact in schools must be addressed, both from the standpoint of students with AIDS and teachers who are in high risk groups. Active programs for crisis intervention are needed at all schools and hospitals before problems arise.

Recommendation: The most effective approach to public education would be sophisticated public service announcements. Local health educators should meet with publishers and editors to discuss pertinent problem area, solicit input and learn what messages are acceptable to mass media outlets. People with communications expertise should be pulled together to develop messages. Issues about AIDS in the workplace need to be addressed.

PREVENTION & TRANSMISSION INTERVENTION - What is the best scientific approach for stopping the spread of AIDS? Present belief is that 10% of those exposed to the virus may contract AIDS. Another 25% of those exposed may exhibit symptoms, and the remainder of exposed people may remain asymptomatic, but probably infectious.

Recommendation: Prevention messages must address extended populations -- not just current high risk groups. Children today will be the at-risk populations of tomorrow.

Program design must include target audience evaluation and feedback from the biomedical community. Different messages for each audience are needed.

High Risk Individual Prevention - A continued increase (approximately 10% per year) of seroconversion showing exposure to the AIDS virus in San Francisco and Los Angeles research cohorts indicates that although people are having fewer sexual partners, they are not always having safe sex. Therefore, existing prevention efforts have been inadequate. Much data indicates enormously high behavior changes regarding the number of sexual partners, but the seroconversion rates show this is not enough. Physicians continue to see patients experiencing denial and engaging in high-risk sexual behavior. If we simply tell people to have safe sex, we are deceiving ourselves. Can people sustain long term safe sex practices? Can people be better motivated to avoid disease transmission?
Recommendation: Prevention messages must be stated loud and clear -- do not allow individuals to continue denial. One to one sexual behavior information counseling is needed, not just distribution of brochures. This information must come from physicians or counselors. Pro-active programs such as focused target media and interpersonal approaches for gay and bisexual males must be funded.

What messages can be used for gay and bisexual men, intravenous drug users, hemophiliacs, blood transfusion recipients, prostitutes, sexual partners of high risk or seropositive individuals and people with multiple sexual partners? Can people be categorized into "high, medium & low risk" groups?

Current public perception is that infection is not that serious. As high risk individuals stop having multiple partners and settle into primary relationships the issue of safe sex within relationships must be addressed. All high risk individuals currently in relationships and those forming new relationships must understand that HTLV-III infection is serious.

Guidelines to date have categorized "safe", "possibly safe" and "unsafe" sexual activities. Fundamental positive messages that empower people must be developed. Messages must be both informational and motivational; nothing is achieved by telling people what to do. If people are engaging in sex, the safety of sexual activity can be improved through the use of condoms and through development of serostatus guidelines. Recommendations: Drop the "possibly safe" category of sexual activities because of confusion regarding sharing of body fluids, continued denial and continued seroconversion rates.

Prevention messages:
(1) HTLV-III infection will have a profound, terrible impact on your life.
(2) We are losing the battle against AIDS.
(3) We can/must do something to stop AIDS virus transmission.
(4) If you are not infected, keep from getting infected. If you are infected, don't pass the virus to others and don't create additional exposure for yourself.
(5) If you want to avoid AIDS or other sexually transmitted diseases, avoid sex. Be celibate or have safe sex with antibody/virus negative people. If you are antibody negative and cannot sustain safe sex practices, find an uninfected partner.
Does low risk sexual behavior work? People are capable of cutting down on the number of partners, but it is difficult to sustain "low risk" sex. Data on low risk sexual activity is soft. Are options such as sex with the protection of a condom and sex with antibody/virus negative people really safe?

**Prostitutes & Their Clients** - Do not moralize on the rightness or wrongness of prostitution -- present the message that exposure to AIDS is deadly. The history of female-to-male transmission is not clear. However, messages to prostitutes should be:
(1) Continued high-risk sex is not good for your health
(2) If high-risk sex is continued, a condom should be used.

Message to clients should be:
(1) Some prostitutes are infected with HTLV-III virus.
(2) To avoid exposure, don't use prostitutes.

**Intravenous Drug/Needle Transmission** - will require better financial resources to institute an effective approach.

**Mother/Infant Transmission** - the decision to undergo prenatal testing for women who may have been exposed should be made between the woman and her physician. There is little data on the prevalence of the virus in children. Educating pediatricians about AIDS should help develop a larger body of knowledge in this area.

**Donor Transmission (Blood, Semen, Organs)** - testing for exposure to AIDS virus in these settings.

**HEALTH CARE PROVIDER EDUCATION** - The Hospital Council of Southern California is working to train 600 individuals who could then provide training to 77,000 health professionals in Southern California. Many physicians are not well educated on examination issues related to AIDS, and certainly are not well educated on policy or treatment issues. Educated physicians should help develop better statistics and data.

Recommendation: Education for health professionals should include case management of people with AIDS both in and out of the hospital. In-house AIDS committees at all hospitals should be formed. Training should take place at hospitals before any AIDS-related problems arise.
SURVEILLANCE & TESTING - Is testing a realistic process for interrupting transmission of the disease? Should every high risk person be tested? How should such a testing program be implemented, and how should this information be used? People must understand the value of the test and denial that exists should be overcome.

Surveillance is passive (the reporting of AIDS cases) in all but three counties of the state. In San Francisco, Los Angeles and Orange counties active surveillance is taking place through investigation of hospital admissions, laboratory work, etc.

Recommendation: A plan for state and county surveillance of AIDS cases, ARC cases and incidence of seropositive people should be developed. A trend line establishing a risk assessment for California's population would be important. This basic demographic data could be used in developing prevention and education programs.

Active serologic surveillance should be undertaken at all blood banks, VD clinics, methadone clinics, and within selected populations (i.e. prostitutes, gay organizations) to accumulate additional information. Data on seropositive rates would not require any personal identifiers. A state databank would include only demographic data such as zip code, sex, date of birth, sexual orientation. Serologic surveillance would be done in a research context. If large scale anonymous screening takes place, more people would become part of surveillance program. For groups with high seropositive rates counseling and education would be necessary. Screening for exposure could be an important motivational factor.

Attitudes toward testing are changing, but there is resistance to testing from some gay community leaders. If we advocate testing, we must ensure that civil rights are protected. Anonymous testing must continue, with counseling for seropositives. Moving ahead with testing may divide people into "positive" and "negative" groups, but could stimulate the push for vaccine development and antiviral drug trials.

Large numbers of gay men are not always having safe sex. These men should be counseled and tested, in hopes that it may make a difference in behavior. A public health and gay community goal must be to keep uninfected people uninfected.
At the federal level, National Institutes of Health, program people are under pressure to push into basic research, vaccine development, and immunomodulator areas. Additional support will be needed for surveillance. It is the responsibility of public health officials to know how widespread AIDS infection has become.

**TREATMENT & CARE** - Eighty-eight percent of Medi-Cal cost is for hospital care. If people with AIDS or ARC can be cared for out of the hospital, less will be spent. Medi-Cal's current position is that if person has to be hospitalized because of illness, the cost of hospitalization would be covered. However, the cost of admission is not covered if the person is admitted to the hospital in order to receive experimental treatments.

Recommendations: The medical definition of AIDS should be broadened to include anyone with evidence of infection that is disabled. The state should approve Medi-Cal payment for experimental drugs. Funding to pay for hospital care when trying experimental drugs should be a necessary part of research funding. There should be independent diagnostic codes for AIDS and ARC. Symptoms could be divided into severe, moderate and mild.

What should be done for individuals with lymphadenopathy? Lymphadenopathy often indicates that the person has been infected and the body is fighting the virus. Before people become symptomatic, what type of care is needed? What can be done for seropositive individuals? Early clinical intervention is better than late -- planning must begin. Seropositive individuals represent a vague area. They must be included as target groups for positive, healthy lifestyle promotion, just as is done with people with high cholesterol, smokers, drug users, etc.

Care in non-hospital facilities such as extended care facilities, skilled nursing facilities, hospice and in-home nursing care must be provided. Of current Medi-Cal expenditures, 1% is for home health care. Can AIDS be used politically to impact long term care? Contracting for Medi-Cal on a community basis is helpful.

**Mental Health** - Because of the high morbidity of the illness, stress and mental health issues affect those who are sick, those who are in at risk groups and are worried, and health care providers. Burn out among providers will be a problem of increasing proportion. Patients in terminal stages of the disease often have impaired central nervous systems. What sort of care will these people need? Planning must take place and programs must be developed.
Recommendation: Mental health programs and support for asymptomatic carriers or seropositive individuals are needed. Programs must also be developed for health care providers and patients.

RESEARCH - State research funds are allocated through the University of California. State funding for research is unusual. The UC process must be more accountable -- what are UC's priorities? UC does not want to be accountable to the legislature. They want the money with no strings attached.

Recommendation: UC should prioritize research proposals received and report on where the money is spent. UC must be approached to solicit their suggestions and involve them in this planning process.

Vaccine Development - Companies are moving slowly on vaccine development. The Center for Disease Control is not likely to request such a purchase order from the current federal administration. The state might approve a purchase order for vaccines if a spending limit is set. The money would not be spent immediately and we have the numbers of people who could benefit from a vaccine, such as prison populations, other institutionalized populations, health care workers, high risk groups. All would likely be eager to participate once vaccine efficacy is established.

Liability and indemnification are problems that must be addressed. California Trial Lawyers Assn. is currently working on problems of several and joint liability -- once this area is settled the gates for responsible private research should open up.

Recommendation: An incentive for vaccine development at state and federal levels must be established. This could be done through a state or federal purchase order for a specified number of safe vaccine at $100 each. A purchase order would stimulate the vaccine & pharmaceutical industry, which currently consider development of and AIDS vaccine as a high risk venture with an unknown market.
Antiviral Drug Trials - Laboratories lacking facilities for culturing the virus are going to hold up drug trials in California. Approximately $300,000 would be sufficient to make necessary improvements in state laboratories for viral cultures.

cc: Bruce Decker
    Sal Roselli
    Dick Pabich
    James Chin, M.D.
    Michael Roth, M.D.
    Michael Gottlieb, M.D.
    Richard Hamilton, M.D.
    State AIDS Contractors
OUTLINE: AIDS COMPREHENSIVE PLAN

I. Background
   A. Mandate for the Report
   B. Current Status of the AIDS Problem
      1. Incidence and Prevalence
      2. Risk Groups
   C. Strategies and Interventions
      1. Prevention/Community Education
      2. HTLV III Antibody Alternative Test Site Program
      3. Diagnosis and Treatment Services
         a. Medical
         b. Mental Health
         c. Other
      4. Research and Surveillance

II. Prevention and Community Education
   A. Description of Services
      1. Health Education for Target Groups
      2. Professional Education for Health Care Providers
      3. Education for the General Public
   B. Trends in State Funding (FY 83/84 - FY 85/86)
   C. Impact of Services/Unmet Needs
   D. Recommendations

III. HTLV III Antibody Alternative Test Site Program
   A. Status of Program Efforts
      1. State/Federal Funding
      2. Operational Sites/Persons Tested
      3. Reimbursement to Counties
   B. Status - California's Blood Supply
1. Percentage of Positive Results
2. Notification of Positive Blood Donors

C. Policy Issues
   1. Confidentiality of Test Results
   2. HTLV III Antibody Test as a Screening Device

D. Impact of Services/Unmet Need

E. Recommendations

IV. Diagnosis and Treatment Services
   A. Diagnosis
   B. Outpatient Care
   C. Acute Care (Hospital)
      1. Service Trends/Utilization
      2. Cost of Care/Reimbursement
      4. Availability of Facilities
   D. Long Term Care
      1. Service Trends/Utilization
      2. Cost of Care/Reimbursement
      3. Availability of Facilities
   D. Home Care
      1. Home Health Care
      2. In Home Support Services
      3. Cost of Care/Reimbursement
      4. Availability of Facilities
   E. Hospice Care
      1. Service Trends/Utilization
      2. Cost of Care/Reimbursement
      3. Availability of Facilities
   E. Recommendations
V. Research and Surveillance
   A. Epidemiological Research
   B. Vaccine Development
   C. Clinical Research
   D. State and Federal Roles/Funding
   E. Unmet Need
   F. Recommendations
November 7, 1985

SUBJECT: Consensus Proposal for inclusion in the Statewide AIDS Plan

TO: AIDS Strategic Planning Commission
   California AIDS Advisory Committee

FROM: San Francisco Community Partnership on AIDS
      Ms. Laurie McBride, President

Enclosed is the proposal of the San Francisco Community Partnership on AIDS for inclusion in the Statewide AIDS Plan.

The document was the result of three lengthy meetings in which all of the members of the Partnership and representatives of other concerned organizations discussed, debated, and developed consensus on key issues surrounding the AIDS crisis.

Organizations which participated in the discussions retain the right to address additional concerns during the development of the Statewide AIDS Plan.

The Partnership was formed in September 1984 to set community standards for AIDS Education in San Francisco and represents most of the leadership of the Gay/Lesbian/Bisexual Community of San Francisco. Its members include: The San Francisco AIDS Foundation, People with AIDS and AIDS-related Complex -- San Francisco, Bay Area Physicians for Human Rights (as medical consultants), Bay Area Lawyers for Individual Freedoms, Golden Gate Business Association, Concerned Republicans for Individual Rights, Alice B. Toklas Lesbian/Gay Democratic Club, Stonewall Gay Democratic Club, and the Committee to Preserve our Sexual and Civil Liberties.

In addition to the members of the Partnership, the consensus proposal reflects the participation and agreement of the Lesbian/Gay Caucus of the ACLU -- San Francisco, and Mobilization Against AIDS.

For more information about the San Francisco Community Partnership on AIDS, contact Ms. Laurie McBride, (415) 564-5252, or write to the Partnership c/o the San Francisco AIDS Foundation, 333 Valencia Street, San Francisco, CA 94103.
CONSENSUS PROPOSAL OF THE SAN FRANCISCO
COMMUNITY PARTNERSHIP ON A.I.D.S.
FOR INCLUSION IN THE STATEWIDE A.I.D.S. PLAN

Adopted November 6, 1985

County Plans

-- Class "A" counties (high incidence of AIDS) should be charged with producing and implementing comprehensive prevention, public education, and care and treatment plans.

-- Class B counties (those adjacent to Class A counties) and Class C counties (all remaining counties) should draw their program model and technical assistance from Class A counties within geographic areas (e.g., Northern California counties will look to San Francisco for support).

-- Funding for necessary programs should be provided by both the State and counties.

-- Counties should be encouraged to work together on a regional level to avoid duplication and provide better and more efficient services.

State Responsibility

-- Promote the Chief of the AIDS Section to the status of Deputy Director, Department of Health Services.

-- Consolidate and coordinate the activities and responsibilities of all the State's myriad AIDS task forces, committees, advisory bodies, etc., into the California AIDS Advisory Committee which will be supported in its needs by the AIDS Section.

-- People with AIDS/ARC should be made statutory members of the AIDS Advisory Committee.

-- The AIDS Advisory Committee will be empowered to determine where State Grants (and Federal monies distributed to the State) for Education programs, Research, and Patient Services will be distributed.

-- The State bears a special responsibility to provide in State penal institutions general education for prison personnel and inmates about AIDS, AIDS prevention programs, and full treatment for people diagnosed with AIDS and ARC.
Public Education

-- The State should develop a forum and encourage the timely release of epidemiological and clinical data to AIDS educators so that this data can be incorporated into education programs.

-- The State should encourage and fund research into the efficacy of current education programs in California.

-- The State Department of Health Services should fund and promote statewide educational efforts which are specifically designed to reduce the general public's concerns and fears around casual contagion. Such efforts should complement the highly specialized AIDS prevention education campaigns funded by the State through various contract agencies and community-based organizations.

-- Prevention education should continue to be the responsibility of local community-based organizations in counties. Community-based organizations should continue effective education efforts through proven techniques such as safe-sex seminars, presentations and workshops, creation of support groups, peer counseling, streetworkers, hotlines, circulation of risk-reduction pamphlets, advertisements, public service announcements, etc.

-- The issue of casual contagion should be addressed -- whether in the schools, hospitals, workplace, and public accommodations. Local speakers' bureaus should be funded by the state to conduct education countering AIDS hysteria and should target labor, business and professional groups, PTA's, churches, etc.

Prevention and Transmission Intervention

-- The Sero-conversion rate (those who tested negative for the HTLV-III antibody who later retested positive) in San Francisco for 1985 as determined by the Men's Health Study (Winklestein/Wiley) indicates a significant decrease from the 18% rate per year for 1980-84 reported in the Hepatitis Cohort Study of the San Francisco Department of Health. This fact, along with the data developed by Larry Bye and Associates -- R&D, and Leon McKussick, et. al, that a significant behavioral change towards lower risk behavior is taking place, and the 85% reduction in the rate of rectal gonorrhea in the past five years in San Francisco, strongly suggests that the vast majority of gay men today in San Francisco are engaging in low risk sex, indicating general success in the San Francisco's AIDS prevention education campaign.

-- The fact that people are still sero-converting indicates that diversified and intensified prevention education is warranted toward people who are continuing to engage in high-risk sex. Possible themes include:

(1) Re-exposure to the AIDS virus can increases your chances for AIDS.

(2) It's not who or where, but what you are doing that counts.
-- Safe sex guidelines should continue to use three distinct categories (however they may be redefined) which show the relative risk of certain behaviors.

-- The safe sex guidelines developed jointly by the Bay Area Physicians for Human Rights, the San Francisco AIDS Foundation, and the San Francisco Department of Health need to be continually refined based on the latest medical research, not on the basis of moral judgments or non-AIDS related criteria. There is a need to examine whether to redefine the degree of risk of some practices as "unknown at this time".

-- Safe sex education should continue to stress a sex positive approach.

-- Sex-negative education and advocacy of celibacy as a means to prevent AIDS will not work and will undermine the credibility of the State's education program.

-- Groups not currently targeted for AIDS prevention education, needing such education, include:

--- Teenagers
--- Third World Populations
--- Drug users
--- Heterosexuals who are not mutually monogamous
--- Sexual partners of people from high-risk groups
--- Bisexuals
--- Prostitutes and their clients
--- Individuals in correctional institutions and custodial settings
--- People considering parenthood.

Care should be taken to seen that such efforts reach all social-economic groups of the above populations.

Health Care Provider Education.

-- To preclude the need for Regional Treatment Centers which would remove people with AIDS/ARC from familiar settings and their loved ones, family, and friends, and reinforce the mentality of Quarantine, it is important that medical authorities in each county
be able to provide adequate medical care and follow-up for people with AIDS or AIDS related complex in their own counties. To this end, the State should institute a massive education effort among health professionals throughout the State of California on the diagnosis, care and treatment of PWA/PWARC.

--- The State shall fund through appropriate community agencies information clearing-houses to provide the most up-to-date facts about drugs and treatment protocols to clinicians, PWA/PWARC, and other interested persons. The clearing-houses will monitor and record treatment developments both nationally and internationally.

Surveillance and Testing.

--- Regardless of negative or positive HTLV-III antibody test results, people should limit themselves to safe behavior. A negative HTLV-III antibody test result is not a license to engage in high risk behavior.

--- There is a need to strengthen the protections contained in AB-403 to preclude the HTLV-III antibody test from being used to deny individuals employment, insurance or civil rights.

--- Testing for the HTLV-III antibody should remain a matter of individual choice. The State should not advocate or promote the wide-scale use of the test.

--- Serologic surveillance may have theoretical value in an isolated research setting, but even limited surveillance of any group is fraught with dire civil rights and emotional ramifications.

--- If individuals believe that they may be placed on a state-wide list, thus jeopardizing their employment, insurance, and/or civil liberties, they may not seek necessary health care. Thus, an effort of state-wide surveillance would become self-defeating.

Research.

--- There is a need to research the effect of co-factors (e.g., stress, drug-use, exposure to other viruses, parasites, etc.) in causing the development of AIDS-related complex and CDC-defined AIDS. The results of this research should be disseminated to AIDS educators, clearinghouses, the medical profession, and the rest of the population, on a timely basis.
November 6, 1985

Mr. Jeff Amory
Special Assistant to the Director for AIDS Programs
Department of Public Health
City and County of San Francisco
101 Grove Street
Room 323
San Francisco, California 94102

Dear Jeff,

I am writing at this time in response to the memo entitled "Comprehensive AIDS Plan" which I received from you mailed October 17th. The memo is the work of one Stan Hadden, an individual unknown to myself. There are a number of issues raised in this memo which, I believe, warrant some further consideration or comment.

Some of my concerns begin with the notes found on page 3 of the memo. Certainly in my position I do agree that "HTLV-III infection is serious." At this time, we are told by various sources that 10 to 20% of people infected with the virus develop life-threatening AIDS, another 20% develop AIDS-related conditions. The exact outcome of the 60 or 70% not mentioned remains speculative. Presumably, there may be some people who have been infected with this frightening virus who are, in fact, done with it. That is, perhaps their antibodies will be their only evidence of having been in contact with the virus and their immune system may remain intact forever. Such certainly is the case with regards to hepatitis-B in the gay male population. The majority of gay men have antibodies to the virus while only the minority have ever had a bout of hepatitis. I personally have not yet been convinced that there is no hope that any neutralizing antibodies to the AIDS virus are present in any individuals who have been infected.

With this in mind, I do support the current safe sex guidelines that have been adopted by the high-risk male homosexual community. I believe that a "possibly safe" category is necessary as it is the only honest thing that we as medical professionals can do at this time. Removing the "possibly safe" category need not be done. I think that the "confusion" regarding sharing of body fluids can be best addressed by suggesting that what we are dealing with are fluids from below the belt, i.e., genital secretions, as the most likely source of transmission of this disease.

I found the prevention messages at the bottom of page 3 to be particularly of concern. Again message #1 is certainly true at this time. However, we do not know that in the long run some people will merely have been infected with HTLV-III without suffering "profound terrible" consequences.
Prevention message #2 suggests that we are losing the battle against AIDS. Most, even those unsophisticated in epidemiology, were predicting that by October 1985 we would have at least 240 new AIDS cases diagnosed in San Francisco each month. In October 1984, we had a total of 59 cases diagnosed for the month. Over the past 12 months we have averaged somewhere between 62 and 65 new cases reported each month. This suggests that, in fact, we have plateaued. I would like to think that the aggressive AIDS education program aimed at the gay community that was initiated in May 1983 is now translating into the plateau that we are currently seeing. Certainly I would be wrong and we could see a marked increase in the number of AIDS cases through this winter. However, I do think that so far 1985 has been a mild victory against this disease.

No one can disagree with point #3 or #4 in the prevention messages. Point #5, again I believe is a bit extreme. Certainly there are other activities that can occur between two people which are intimate and can be considered to be sexual that are entirely safe. I think that this message is a bit reactionary. Certainly the advice of an antibody negative person to find an uninfected partner may be misleading if that person is, in fact, antibody negative and virus positive.

I definitely agree with the need to convince donors of organs and semen to be tested for exposure to the AIDS virus prior to donation.

On page 4, the section on health care provider education suggests that "educated physicians should help develop better statistics and data." Certainly educated physicians should also be called upon to eradicate fear and hysteria in both the medical and lay public regarding this disease.

On page 5, a recommendation is made that a plan for a state and county surveillance of AIDS cases, ARC cases and incidence of seropositive people should be developed. I think this is of some concern if this moves out of the setting of academic research into a state policy issue. Even the fact that the state data bank would include only demographic data is currently unacceptable. Certainly we are already seeing discrimination against single men on the basis of their zip code in San Francisco. Such a program reminds me very much of the Colorado program to identify seropositive people. At this time, I fail to see any need for such a compilation of data. I think this becomes an invasion of privacy and can only be misused, in my opinion.

I agree with the recommendation on page 6 that the "medical definition of AIDS should be broadened." I think most of us at this point agree that AIDS, as defined by the Centers for Disease Control, is just a surveillance definition and is somewhat limited. The current suggestion is to think of AIDS as recommended as a spectrum of infection. I agree and support the recommendation that anyone who is disabled secondary to their infection with the AIDS virus should be so treated. I also would wholeheartedly support Medi-Cal payment for
experimental drug therapies. However, whether that would ever be considered by Medi-Cal is another question.

Certainly the question, "What should be done for individuals with lymphadenopathy?" is one that I have been struggling with over the past four years. In my prospective study at this time approximately 90% of these patients have remained stable. However, there is a definitely identifiable cohort of lymphadenopathy patients that are at risk to develop bona fide manifestations of AIDS. Whether any of the currently available immunomodulatory antiviral drugs are effective in preventing this transformation is a question we have been evaluating in carefully designed placebo-controlled studies. This work continues, however, recognizing that the vast majority of patients with lymphadenopathy at this time do not appear to warrant any intervention.

On page #7, the recommendation is made that the University of California should "prioritize research proposals received and report on where the money is spent." It is my understanding that, as all granting agencies, the University-wide Task Force on AIDS, in fact, has been very strict in their prioritizing of the research proposals and has released information on what studies have been funded when this has been requested.

I could not agree more with the final recommendation that further funding be made available to support laboratory facilities for culturing the AIDS virus. Without such facilities readily available, providing standardized culturing techniques, effective antiviral therapy will be difficult to evaluate. The establishment of statewide culturing facilities are imperative and of first-rank priority.

Thank you for sending me a copy of this memo. I hope my comments are not too late to be of any use. If I can answer any further questions, please feel free to contact me.

Sincerely yours,

Donald I. Abrams, M.D.
Assistant Director, AIDS Clinic
San Francisco General Hospital

DA/nc
October 18, 1985

Mr. Stan Hadden
C/o David Roberti, President Pro Tempore
STATE OF CALIFORNIA - SENATE
Sacramento, California 95814

Dear Mr. Hadden:

Thank you for the opportunity to comment on the proposed comprehensive statewide AIDS Health Plan. We at the AIDS Health Project are both intensely interested and uniquely qualified to address these issues.

We would like to comment on the following sections:

County Plan:
You have highlighted the issue of prime concern, i.e., what about those counties that may be thwarted by their Board of Supervisors? We feel this is a clear statement of the need for state monies/programs for AIDS education. We suggest that the state add extra muscle to its suggestions to counties regarding AIDS education by tying it in some way to other state monies/programs. In this way, a financial incentive will exist for counties to spend some of their money on AIDS programs.

Secondly, we have a concern that those counties which have been responsive to the crisis may be penalized by losing or not being considered for state funding of various programs.

State Responsibility:
We feel the recommendation should be strengthened, to include a recommendation for AIDS education to be taught in public schools right along with other sex education. The AIDS Health Project, through its Youth Program, is sponsoring a workshop in November 1985, to train public school officials and teachers about AIDS and ways to incorporate AIDS education into existing curricula.

Public Education:
We agree that a comprehensive plan for public education and information dissemination is important to ensure that consistent, accurate, and effective messages are presented to the largest extent possible. This speaks to the need for coordination and planning on the local and state level.
Prevention & Transmission Intervention:

It is very important to understand the complex social and psychological factors affecting behavior change when broad public messages regarding AIDS are disseminated. At the AIDS Health Project we have examined several of these relationships in our work. These include:

1. The role that mind altering substances play in the perpetuation of high risk sexual behavior, i.e., drugs and alcohol cloud one's judgement.

2. The role that hopelessness and helplessness have upon the prevalence of high risk sexual behavior. If a person feels that there is nothing that can be done -- or that the battle against AIDS is lost -- why bother changing pleasurable behavior?

3. For the gay population, messages interpreted as anti-gay or anti-sexual will be ineffective, if not counterproductive.

4. Emphasis on positive alternatives which will enhance a person's enjoyment of life, while protecting them from contracting AIDS, will be more effective than an approach which requires giving up cherished activities without suggested positive substitutions.

5. Health promotion efforts need to utilize the cultural expertise of representatives from various minority communities to establish messages appropriate to these communities; specifically, Third World populations, women, and substance abuse specialists should be consulted.

Specific feedback on "prevention messages" in AIDS Memo.

1. Beware of doomsday projections which may lead to resignation and futilism. Be specific about what AIDS Antibody infection means in a balanced way.

2. This message is terrible - it discounts a great deal of hard work on the part of both those at risk and those dedicated to helping them. A better message might be...we've done a lot of good work, unhappily there's still more to be done.

3. This is a good general message -- a little banal at this point.

4. A good message.

5. This is an awful message -- celibacy won't fly as a general community message - seen as anti-gay (anti-sex, religious). "Find an uninfected partner" is much too risky.
AIDS Health Project
Page Three

General Suggestion: A two-prong approach - public messages to stimulate concern (without creating panic), and more in-depth health education to deal with specifics and to focus on decision-making and behavior change. It is important to do specific and extensive outreach to those of highest risk. At the AIDS Health Project, we have identified several avenues to locate persons who are at high risk for contracting AIDS.

1. A counselor on-site at an AIDS screening clinic -- identify antibody positive, ARC, worried well individuals, clarify risk issues, and support behavioral change.

2. A counselor on-site at City Clinic (sexually transmitted disease clinic) — targets individuals with recent STD which indicates high risk sexual behavior. The anxiety generated by the current infection can be utilized to help individuals understand their risk and make positive behavioral changes to both reduce their own vulnerability and decrease spread.

3. The AIDS Health Project counseling program at the AIDS Antibody Alternative Test Sites -- identify persons who are AIDS Antibody Positive, clarify risk issues and support behavioral changes.

4. Another important consideration is the need to evaluate all of these services. While we believe in the efficacy of our services and we receive positive anecdotal feedback on their worth, we would encourage the expenditure of funds to systematically evaluate the effectiveness of different intervention modalities in achieving positive behavioral changes.

Intravenous Drug/Needle Transmission:
This is a large, complex issue which needs to be addressed now to prevent or forestall the East Coast experience. In developing our AIDS and Substance Abuse Program, we have found it particularly important to include specialists from minority communities to advise us in the best way to reach those communities in which IV drug use has a high prevalence. We have also found that it is imperative to use specialists in substance abuse to develop and implement the program. Finally, we would recommend the funding of a full-time position to coordinate AIDS training for substance abuse agencies under the State Department of Alcohol and Drug Programs or through the State AIDS Activity Office.

Health Care Provider Education:
We strongly agree that a comprehensive plan needs to be developed to make sure that all health care workers understand the basic information related to the care of those with AIDS and with the whole range of AIDS concerns. This not only requires information dissemination, but also attention needs to be paid to the emotional barriers which block professionals from delivering optimum care.
At the AIDS Health Project, we have developed effective strategies for assisting professionals in both of the above areas. We have also recently contracted with the State of California to develop a newsletter digesting recent medical and psychological literature relevant to AIDS. We are unfortunately limited by our contract in distributing this newsletter beyond San Francisco; however, we believe a state-wide distribution of this letter is warranted.

**Surveillance & Testing:**
We agree with the need for accurate surveillance and testing for AIDS/ARC and AIDS Antibodies. We also have had experience with the difficult ethical and political ramifications related to this. From a prevention point of view, it is very important to maintain the trust and confidence of the communities served. Surveillance and testing programs should include community representatives in developing and implementing these programs.

**Treatment & Care:**
We applaud your interest in the ARC category. We also see that this is a service need which is growing. For the past year, we have run groups for two ARC populations: mild to moderate and serious/debilitating ARC. The mental health needs of this group is particularly acute with many experiencing depression, suicidal ideation, as well as severe anxiety (see next section).

In the area of sub-acute care, we want to underscore the need for funding in the area of skilled nursing facilities for those dual diagnosis patients that we are seeing with increased frequency. These include patients with major psychiatric disorders and medical problems, as well as the problem of those patients with organic brain disease and subsequent behavioral disorders. These patients are currently receiving long-term care in very expensive and inappropriate acute psychiatric care settings. This is a problem currently under study here in San Francisco and a proposal is being submitted to begin a pilot project to care for these patients.

**Mental Health:**
Of course, this is one of our primary missions. We would be glad to share our experience with others. It is important to have mental health professionals identified in the community with special expertise in working with persons with AIDS concerns. These professionals need to understand the special stress that AIDS imposes on persons in high risk groups. They must also be able to identify serious mental disorders among these persons and be able to either treat these disorders or make appropriate referral. Plans need to be in place to provide both mental health provider education as well as services to those directly effected by the disease.
Conclusion:
I hope these observations are helpful. Once again we applaud your efforts to develop a comprehensive statewide plan. If I can be of further assistance, please feel free to contact me.

For the Project Staff,

James W. Dilley, M.D.
Project Director
October 30, 1985

Mr. Jeff Amory
AIDS Activity Office
Department of Public Health
101 Grove Street
San Francisco CA 94104

Dear Jeff,

Thanks for the opportunity to comment on the State's Comprehensive AIDS Plan memo. I'll limit my comments to the education/prevention part of the document. The comments expressed are entirely my own, and not those of the AIDS Foundation, which will undoubtedly comment for itself.

The essential problem is that the doctors and health officials still can't decide what message they want to deliver to the highest-risk population. It's as if they really want to say "don't have sex", but can't face saying it. Their reluctance is justified, of course, since the message won't sell anyway, and since there is no epidemiological basis for the message.

Gay men, at least here, have responded to what they were asked to do: reduce number of partners, and reduce risk. Those were the goals of the medical specialists; those were the educational messages, and gay men responded as requested.

Now we find that the request was insufficient, not that the response was insufficient.

The message should be "cease having Unsafe Sex."

The problem with that message is that there is a unfortunate panic overreaction building among a number of AIDS experts toward the goal of eliminating the "Possibly Safe" category and dumping all those acts into the "Unsafe Sex" category without any evidence to support the change, thereby making the goal of ending
Unsafe Sex virtually unachievable. The evidence of sexual transmission barely even supports the unsafeness of all of the acts currently listed as "unsafe".

If there is to be a change in the Safe Sex Guidelines, all acts in the Safe and Possibly Safe categories should be lumped into a new category called " Probably Safe", which leaves the educators to concentrate on the real problem behavior, namely really "Unsafe" acts. Then our message is simple and clear, and gay men can be quite clear on the response we're asking for -- no rimming, fisting, intercourse without a condom, or oral sex to climax. Period.

The specific messages suggested in the memo reflect the continuing lack of understanding on the part of the AIDS medical profession about what will or won't motivate people, are amateurish, childish, ineffective and prove the case that there must be "civilian control" of any medical information included in educational programs.

Finally, as the plan is worked out, I hope two issues will be constantly kept in mind: (1) effective education plans cannot wait on approval from multiple layers of bureaucracy (especially in the absence of any evidence that any improvement would result from the delay;) and (2) Censorship kills -- any attempt to water down educational materials in the name of protecting the sensitivities of some portions of the population is clearly irresponsible and will cost thousands of lives and perhaps millions of dollars.

Major local AIDS organizations will need considerable freedom over the next year or so to develop education programs that are fast-moving, gutsy, creative and hard-hitting. Some programs will work, others may not. The option is bureaucratically controlled statewide programs that have virtually no chance of working at all.

Sincerely,

Sam B. Puckett
Consultant
October 21, 1985

Jeff Amory
AIDS Activity Office
Department of Public Health
101 Grove Street, Room 323
San Francisco, CA 94102

Dear Jeff,

Thank you for sending me a copy of the State Comprehensive AIDS Plan. My comments on this plan are as follows:

Public Education

I question that "the most effective approach to public education would be sophisticated Public Service Announcements." Our project is based on the idea that passive education is not enough. Not only must attitudes change but behavior as well. Also, Safe Sex Guidelines must be published. We must give up the notion of offending people's sensibilities.

Prevention and Transmission Intervention

"Prevention messages" are not enough. People must be engaged in some form of action.

High Risk Individual Prevention

One-to-one sexual behavior information counseling seems absurd. Of course, it needs to be available to those who would seek it out, but large numbers must be reached in as short a period of time as possible. Peer pressure and mutual support are important factors in long-term, sustained behavioral (primarily sexual) changes.

What does dropping the "possibly safe" category mean? Would these activities be considered "unsafe?" Somehow, telling people to "avoid sex" does not seem positive, even in the fact of a life and death issue. Since sexuality is such an integral part of being human, telling people to be celibate is self-defeating and conjures up a "leper" or "untouchable" image. Let's be proactive, not reactive.

Prostitutes and Their Clients

There is a double message: "Do not moralize...." Then, prostitutes should use condoms, but clients should not use prostitutes. To be consistent, the message to clients should be: "To avoid exposure, if you continue to use prostitutes, use a condom."
I hope these comments are helpful. Thanks for the opportunity to respond.

Sincerely,

Bill Folk
Project Administrator
Memorandum

To: Ed Mendoza
Assistant Deputy Director
Public Health

Via: Donald O. Lyman, M.D., Chief
Preventive Medical Services Division

Kathleen Acree, M.D.
Assistant Chief, PMSD

James Chin, M.D., Chief
Infectious Disease Branch

From: AIDS Section
1812 - 14th St., Rm. 200
5-0553

Date: October 22, 1985
Subject: Draft-Comprehensive
State AIDS Plan

Attached is the first draft of the Information and Education component
of the Comprehensive State AIDS Plan for review.

Staff is also reviewing for additional revisions.

This document is for review only. Do not circulate!!

Juan Chacon, Manager
AIDS Program

Attachment

cc: C. L. Hopper, M.D.
Vice-Pres. Health Affairs
University of Calif., Berkeley
Berkeley, CA 94720

Lois Lowden, M.D.
Planning, Research, Evaluation & Program Development Branch
Department of Mental Health
Division of Hospitals

Robert E. Anderson, M.D.

Ken Brock
Information and Education Plan

1. BACKGROUND

The demographic distribution of AIDS cases in California differs significantly from that seen nationally. While homosexual/bisexual males constitute 72 percent of the U.S. cases, they account for 93 percent of California cases. IV drug users, Haitians, and other high risk group cases are proportionately much lower than elsewhere in the country. These proportions have remained fairly stable during the first four years of the pandemic. However, there is indication that the heterosexual population, including females, is now at much greater risk. In the Journal of American Medical Association, issue dated August 23/30, 1985, Dr. Haverkos from the National Institute of Health states: "It is alarming that the proportion of reported cases of AIDS attributed to heterosexual transmission and where no definite risk group can be identified is remaining constant. This suggests that heterosexual transmission is increasing at the same rate as transmission among the established high-risk groups. Female prostitutes probably contribute to this increase." In addition, "we believe that female-to-male transmission is highly likely". Consensus within the AIDS-related medical community is that, while medical technology is currently unable to prevent the disease, education and community consciousness in minimizing the activities which are considered at risk can reverse the growing number of cases.
In the August 23, 1985, issue of the MMWR published by the U.S. Department of Health and Human Services, the editor noted that: "In the absence of an available vaccine or specific therapy for the treatment of AIDS, broadscale prevention and control activities must revolve around risk reduction and programs that positively affect behavioral changes and reduce transmission of human T-lymphotropic virus type III infection. Information on adolescent awareness of AIDS is important for designing programs to prevent the adoption of risk-taking behavior, such as high-risk sexual practices or abuse of IV drugs.

History of State Response

AIDS became reportable in California in 1981. By the end of that year California had 37 reported cases and a 75% fatality rate. By June of 1983 that figure had increased to 276 reported cases.

In 1983 the State of California responded to this growing health crisis by developing

- an AIDS Task Force
- an AIDS Advisory Committee
- providing funding for research and education grants.

The AIDS Task Force and Advisory Group to the Director of DHS is composed of experts in the field, community leaders and representatives from official and professional organizations and was convened to review available data on AIDS and to place the risk of AIDS in proper perspective.

The AIDS Advisory Committee was established to advise the Director of the State Department of Health Services in preparing a statewide plan for AIDS related treatment and services.
With the allotment of funds, California became the first state to provide for AIDS related research and education activities. $2,900,000 was awarded to the UC System for research and $500,000 was awarded to county health departments and community agencies to provide AIDS education.

By Fiscal Year 1985-85 the funding levels for research and education were each over $7,000,000. The Department of Health Services is now contracting with 28 local community organizations and health departments. 1985 also saw $5,000,000 administered through the Department of Health Services for HTLV-III testing and $600,000 to the Department of Mental Health for AIDS related mental health services. In 1985 the State AIDS' budget totals over $20,000,000.

On July 1, 1985, AIDS activities separated from the Sexually Transmitted Disease Section and became its own independent section. The DHS AIDS Section is now charged with the responsibility of coordinating, monitoring and otherwise administering all state funded AIDS activities.

The Information and Education (I&E) component of the AIDS Program is charged with assuring the responsible expenditure of public funds regarding AIDS education. There are currently contracts with 28 local health departments and community agencies to provide education to persons at risk for AIDS - Gay/Bisexual men, IV drug users, hemophiliacs, and the sexual partners of anyone in these groups in addition to educating health care and service providers and the general population.
Health educators working with the I&E component coordinate, monitor and evaluate state funded educational programs as well as provide consultation and assistance, as needed. In support of this activity an educational material lending library is being developed which will make written and audio/visual materials available to contractors and other interested parties.
INTRODUCTION

The education staff of the AIDS Section will be comprised of Masters level and Bachelors level health educators who are primarily responsible for monitoring and evaluating the AIDS community education grants. In addition to monitoring, much of their time is spent responding to other related AIDS activities, e.g., responding to requests for information from Administration staff, the Legislature and Advisory Committee members and the public; preparation of I&E program justification documents for budget hearings; RFP preparation, program development and proposal reviews; and, responding to I&E related Control Correspondence. Time spent with new contractors often requires consultation and training to assist in basic administration, management, and fiscal accountability procedures.

Health Educators provide written follow-up letters to contractors with their findings and recommendations as a result of on-site visits which are conducted. Health Educators are responsible for other direct contract evaluation activities such as the review of monthly invoices for program fiscal accountability and proper utilization of resources (personnel and operating expenses). The Health Educators must read, evaluate, and provide feedback on quarterly and final narrative reports from each contractor which are required as part of the contract with the State.

Other than direct contract monitoring responsibilities and responding to Department or Legislative requests, I&E staff are also required to:

1. Promote and execute interagency cooperation and coordination of resources, ideas and information between contractors, local
health departments, and inter-department State Programs. This often involved scheduling and attending meetings and public hearings with local agencies and local government Task Forces in areas serving the same populations.

2. Offer assistance and consultation to agencies which are attempting to establish services where no services presently exist.

**PROGRAM**

Each of the AIDS Community Education contracts provide services that address at least one of the State's targeted populations stated in the Request for Proposal (see Appendix ) i.e., individuals at increased risk for AIDS, health care providers and the general population. Since AIDS is a new and unique public health threat and a sexually transmitted disease primarily affecting gay and bisexual men who are a disenfranchised subculture, new and innovative I&E approaches are used. This makes the program monitoring, planning and coordinating responsibilities more complex.

The education program objectives are to educate individuals at increased risk for AIDS to modify their sexual practices which put them at risk for contracting AIDS; educate health care and service providers to decrease their risk of contracting AIDS to alleviate their fears of treating people with AIDS; provide information on referral sources for additional services; and educate the general public, by providing accurate and understandable AIDS information in order to decrease AIDS hysteria, anxiety and homophobia.
The objectives are accomplished using several individual modalities: either by themselves or in combination with each other. The modalities used are small group education of high risk individuals, community forum/workshops, literature distribution, media education (printed and electronic), videos, volunteer recruitment, reference library, hotlines, coordination information provider, and evaluation studies.

There are 28 contractors and 9 subcontractors providing information and educational services in local communities. Appendix details the various contractors, the geographical areas covered, modalities used, the dollar amount of the contract and which population served. This is an increase in funding and activity from $1,000,000 in 1984-85 to $7,182,169 in 1985-86. (See Appendix)

For a review of contractors and activities in 1984-85 see Appendix.

The vast majority of direct education services are provided to local communities through contracts with private non-profit organizations and county health departments.

Most agencies cover services in the respective counties in which they are located. There are several programs which have a broader geographical base. It is worth discussing these programs as there is a need for more statewide education monies in order to reach as many Californians as possible.

1. Hemophilia - The Hemophilia Council of California provides educational services to hemophiliacs, their families and significant others throughout
the state. They are based in Sacramento and have regional officer providing
direct services. Appencix shows the geographic division with names
and addresses for each area.

2. Computerized AIDS Information Network (CAIN) is administered by the
Gay and Lesbian Community Services Center, Los Angeles. It is a nation¬
wide computer information access system specifically for AIDS information,
referral resources and an interactive bulletin board. See Appendix for
location of subscribers who are a resource for their community.

3. Southern California Cares is an education program using printed and
electronic media which covers Southern California. The program is
administered by the largest AIDS agency in the country, AIDS Project Los
Angeles.

4. The toll free information hotline using two (800) numbers is connected
to AIDS Project, Los Angeles for Southern California and San Francisco
AIDS Foundation for Northern California. The majority of calls on the
hotline are from the general public.

5. The San Francisco AIDS Foundation (SFAF) Northern California Outreach
Program covers six counties presently not being served by other contractors
and consultative services to ten contract agencies. The SFAF has several
years of experience and a trained staff who have the experience to help
new agencies with resources and consultation to fill geographical gaps
until smaller agencies are able to cover larger areas.

6. UC Berkeley is developing a model program for college campuses. A
training manual will be distributed to all UC and State colleges through
campus health services. This will address young people who may be sexually
active and health care providers in student health services.
Prior to the award of a grant the Information and Education staff is required to review proposals to determine their merit and assess whether the proposal complements the statewide plan as outlined in the RFP. Duplication of effort is eliminated as much as possible and a review of the overall coverage is accomplished by reviewing where services are being provided. The health educator, through this planning strategy, determines that the comprehensiveness, completeness and standard of service is a uniform and consistent as possible.

The I&E Health Educators are primarily responsible for monitoring contracts by:

1. Ensuring that contracts are being implemented as specified in the contract and evaluating the implementation and effectiveness of the contract objectives.

2. Addressing deficiencies and provide suggestions for correcting deficiencies.

3. Being aware of programs within California and the Nation on risk reduction strategy and education material and programs to provide consultation to state AIDS contractors.

4. Giving feedback to contractors after each site visit. Currently four per year are planned.

5. Providing input into modification of project objectives in order to eliminate duplication of effort and effective services.

6. Providing feedback on quarterly and final reports.

The above activities are accomplished through on-site communication, by letter, telephone, regional coordination meetings and conferences.
A recent example of regional coordination was the AIDS Prevention Conference held on October 3rd and 4th and brought together new and continuing contractors and others working in AIDS prevention to accomplish the following objectives:

1. To provide general information dissemination sessions conducted by recognized experts to educate contractors and others working in AIDS prevention on the latest medical and psychological data on AIDS.

2. To provide an opportunity for health educators and other working in AIDS prevention to form links of communication with each other, DHS staff and the AIDS Advisory Committee members.

3. To provide an opportunity for health educators and other working in AIDS prevention to exchange prevention strategies and information with AIDS service organizations across the country.

4. To provide workshops facilitated by contractors and DHS staff on prevention strategies.

5. To facilitate a video and poster session to offer participants an opportunity to become familiar with existing education material.

During the remainder of FY 1985-86 there are several programs that the education staff will accomplish once a full complement of health educators are hired.

During the remainder of FY 1985-86 there are several following program activities that relate to the I&E component which will receive administrative attention in their development and implementation:
1. **TRAINING**

Since scientific research, medical data, and health education regarding AIDS is developing and changing relatively quickly, an ongoing training program will be developed. This training program will be for current and new staff in order to provide them with updated and relevant data and materials so that their roles as resource person and consultant the I&E contractors will be strengthened.

Part of the training will focus on the characteristics of the target and high-risk groups so that all staff have a clear understanding of and sensitivity to the individuals and organizations whom they will come in contact with.

Additionally, training will be conducted on contract monitoring and technical assistance. An administrative protocol will be established for conducting site visits and a basic standardized approach, to be modified to meet individual contractor needs, for technical assistance will be developed.

2. **AIDS REFERENCE LIBRARY**

The establishment of an AIDS reference library is seen as an absolute necessity in support of the I&E component. Through this library, literature searches and document retrieval will be facilitated so that current trends in AIDS medical research and education can be reviewed and utilized to assist in State program development and in providing the most relevant information to contractors and the general public.
3. EDUCATION MATERIALS REVIEW

A Department of Health Services Committee is being formed to develop criteria for evaluating and approving the appropriateness of I & E contractor produced AIDS education material which is produced or distributed, in whole or in part, with funds provided by the State.

It is projected, along with the projected increase of funding for I & E purposes, that a significant amount of health educator staff time will be spent on collecting and reviewing the materials being produced by I & E contractors.

The charge of this committee will be to balance the credibility of a piece of educational material, with its use of specialized terms and graphics, which are designed to ensure that it will be seen and read by the target groups against the standards of acceptability of the State and of the public at large.

Guidelines for contractors' covering material development and dissemination will be distributed and administrative procedures will be developed for reviewing material for acceptability and approval.

4. MATERIALS DEVELOPMENT

The I & E Health Educators will begin to develop State educational material which would have wider application, allow savings on material development and reproduction costs, provide better control of the information disseminated thereby insuring accuracy and conformity to State guidelines, and allow a wider distribution of materials.
The types of material being developed will be brochures, public service announcements, videos, and reference books. Target groups will be persons with AIDS, the media, health professionals and agencies working with people with AIDS.
There will be three additional RFPs as a result of money budgeted in SB1251. These RFPs will cover an IUDA project; a contract to evaluate the effectiveness of AIDS information and education progress; and the development and implementation of pilot programs of professional education and training for hospital, home health agency, and attendant care workers.

4. Interdepartmental development of education programs will be accomplished through establishing liaison with each department of State government. Contact will be made to either educate department personnel, programs/clients.

With funds being allocated through SB1251 to the Department of Mental Health the DHS need to have a closer relationship with them in consultation, program planning and working toward complementary education programs.

Progress has begun with the California Youth Authority, Department of Education and the Department of Social Services. Priority will be to cooperate with the Department of Corrections and with the Department of Social Services.

5. Liaison with other State and County Health Departments to exchange information, prevention strategies and informational material.

6. Interdepartmental Development of Education Programs to develop education and information programs within the other components of the AIDS/STD Sections, i.e., STD education program through VD clinics, HTLV-III Alternative Test Sites and Surveillance programs.
7. SB 1251 will help with some of the holes in education services for IVDA; however, 95% of IVDA will not be covered under this bill and is inadequately covered in existing contracts. These are the drug abusers who are "on the streets", not in treatment. This includes gay male prostitutes who also abuse drugs.

8. Another area that needs more attention are teenagers who are experimenting with drugs and sex which includes gay and non-gay sex. Funds shall be appropriated for outreach to high schools.

9. With the growing evidence that anal sex is significantly correlated with the transmission of the HTLV-III virus, we should promote the use of condoms.

The majority of educational services are being contracted out resulting in the State's exemplary response to AIDS often being perceived as lax. In the past we have not closely reviewed material produced under contract to insure that the State is being given proper credit for funding the project. The new review process should include this in its guidelines.

The State should be pleased with the leadership position it has taken toward AIDS prevention. Every State and county concerned about AIDS comes to California to review its prevention programs.

A slide presentation with a complimentary conference display will be prepared by the education staff that will give an overview of the State's response to risk reduction/preventive education programs. This can be presented to the AIDS Advisory Committee, Department of Health Services staff, community groups and at conferences.
With the increase in funding by the State and the potential of federal education dollars becoming available, broader and more intensive programs to educate the general public is possible. In addition, as this disease continues to increase within the designated groups at increased risk, there is preliminary epidemiological data which suggests that it will spread into other vulnerable groups, as well. This perceived threat to a broader range of the population has caused a knee-jerk reaction by the general population. Much of this hysteria can be minimized through educating the public through the media and other appropriate teaching modalities.

The Director of the Department of Health Services has earmarked $150,000 to produce a video and television public service announcements addressing this issue to be released sometime in the Spring of 1986.

Health care providers and service providers such as policement and emergency medical technicians are particularly concerned as they come in contact with blood and other body fluids of HTLV-III positive individuals. There are documented cases where health and service providers have refused to care for people perceived to or known to be gay or IVDA or have taken unwarranted precautions. A special outreach on a statewide basis is needed to educate these groups about AIDS and the gay lifestyle. The Director of the Department of Health Services has chosen to use a $100,000 contingency fund for this purpose.
ISSUE

Until recently the majority of education money has been contracted to local health departments and community based organizations.

An attempt has been made for these agencies to cover geographic areas larger than the county in which they reside. There is a need to have programs which have a statewide base. This assures smaller communities are covered and decreases the duplication of similar programs being developed with state money several times within each contract area.

The question in this issue is whether the I&E Unit in the AIDS Section should take a larger role in program development. For example, should a brochure on IVDA/AIDS be developed by the State, translated into appropriate foreign languages, then duplicated and distributed by the contract agency.
ISSUE

Mixed messages being given to public as to the contagiousness of the AIDS virus.

Messages being given to non-high-risk individuals is that AIDS is not casually transmitted and that they should not be concerned about high risk individuals who are health care or service providers such as waiters, nurses, etc. On the other hand, we are telling health care/service providers to use gloves and masks when coming in contact with fluids of AIDS patients and HTLV III positive individuals. This causes a perception by the general public that AIDS can be transmitted by other than through sexual contact and intravenous drug abuse. Our prudent recommendations, combined with a general mistrust by the general public, actually feeds the hysteria presently being observed.
Approval of Education Material produced or distributed by AIDS community education contractors

The issue of appropriateness and acceptability by public standards of AIDS education material has come to the attention of government agencies and the public on several occasions. With an increase in funding of education programs resulting in more programs and more material, an increase in this situation will also increase. See Appendix ______ which is an article written by Michael Helquist which outlines recent controversy on this issue.

The crux of the issue is to balance the credibility of a piece of education material with the use of terms and graphics which will result in its being read or seen and keep within the standards of acceptability by the funding source, i.e., the public and their elected officials.

**ACTION BY DEPARTMENT OF HEALTH SERVICES**

A review committee has been established by the Department comprised of DHS staff and knowledgeable community members who will develop guidelines for contractors when developing material and will set up procedures for reviewing material for its compliance to the guidelines.
ISSUE

During the past two years, responses from Request for Proposals for AIDS education money have been primarily by community non-profit organizations. There has been an increase in the number of proposals submitted for review and the willingness by county health departments to play a larger role, especially in coordinating education programs.

There are some pros and cons to counties providing direct education services and to community based organizations having overall county responsibility for coordination of services. There are several factors which determine decisions on who will be funded including 1) who responds to RFPs; 2) county government willingness to be involved; 3) politics; 4) history of responsibility of providing services; 5) number of agencies competing for funds, et al. Community based organizations tend to be more innovative and respond more quickly to changes in educational needs. County health departments are less flexible; however, have experience and fiscal responsibility which does not require as much monitoring from DHS staff.

Do we support coordination of county-wide AIDS activities, requiring matching funds by county health departments with a requirement that direct services be subcontracted to appropriate agencies.
ISSUE

With the licensing of the antibody tests and the establishment of alternative test sites for testing individuals at risk for AIDS, we have a better understanding of the degree and progression of the HTLV-III proliferation. It is questionable whether education alone is going to stop the spread of this disease. In some areas already half of the gay population have been infected.

Should outreach to sero negative individuals be attempted to make a special effort to educate this group to maintain their negative status?

Should special education programs be set up for known sero positive individuals about early signs of the syndrome and education about their possible infectivity?
Memorandum

To: Ed Mendoza  
   Assistant Deputy Director  
   Public Health

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From: AIDS Section  
      1812 - 14th St., Rm. 200  
      5-0553

Date: October 22, 1985
Subject: Draft-Comprehensive State AIDS Plan

Attached is the first draft of the Information and Education component of the Comprehensive State AIDS Plan for review.

Staff is also reviewing for additional revisions.

This document is for review only. Do not circulate!!

Juan Chacón, Manager  
AIDS Program

Attachment

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Information and Education Plan

1. BACKGROUND

The demographic distribution of AIDS cases in California differs significantly from that seen nationally. While homosexual/bisexual males constitute 72 percent of the U.S. cases, they account for 93 percent of California cases. IV drug users, Haitians, and other high risk group cases are proportionately much lower than elsewhere in the country. These proportions have remained fairly stable during the first four years of the pandemic. However, there is indication that the heterosexual population, including females, is now at much greater risk. In the Journal of American Medical Association, issue dated August 23/30, 1985, Dr. Haverkos from the National Institute of Health states: "It is alarming that the proportion of reported cases of AIDS attributed to heterosexual transmission and where no definite risk group can be identified is remaining constant. This suggests that heterosexual transmission is increasing at the same rate as transmission among the established high-risk groups. Female prostitutes probably contribute to this increase." In addition, "we believe that female-to-male transmission is highly likely". Consensus within the AIDS-related medical community is that, while medical technology is currently unable to prevent the disease, education and community consciousness in minimizing the activities which are considered at risk can reverse the growing number of cases.
In the August 23, 1985, issue of the MMWR published by the U.S. Department of Health and Human Services, the editor noted that: "In the absence of an available vaccine or specific therapy for the treatment of AIDS, broadscale prevention and control activities must revolve around risk reduction and programs that positively affect behavioral changes and reduce transmission of human T-lymphotropic virus type III infection. Information on adolescent awareness of AIDS is important for designing programs to prevent the adoption of risk-taking behavior, such as high-risk sexual practices or abuse of IV drugs.

History of State Response

AIDS became reportable in California in 1981. By the end of that year California had 37 reported cases and a 75% fatality rate. By June of 1983 that figure had increased to 276 reported cases.

In 1983 the State of California responded to this growing health crisis by developing

- an AIDS Task Force
- an AIDS Advisory Committee
- providing funding for research and education grants.

The AIDS Task Force and Advisory Group to the Director of DHS is composed of experts in the field, community leaders and representatives from official and professional organizations and was convened to review available data on AIDS and to place the risk of AIDS in proper perspective.

The AIDS Advisory Committee was established to advise the Director of the State Department of Health Services in preparing a statewide plan for AIDS related treatment and services.
With the allotment of funds, California became the first state to provide for AIDS related research and education activities. $2,900,000 was awarded to the UC System for research and $500,000 was awarded to county health departments and community agencies to provide AIDS education.

By Fiscal Year 1985=85 the funding levels for research and education were each over $7,000,000. The Department of Health Services is now contracting with 28 local community organizations and health departments. 1985 also saw $5,000,000 administered through the Department of Health Services for HTLV-III testing and $600,000 to the Department of Mental Health for AIDS related mental health services. In 1985 the State AIDS' budget totals over $20,000,000.

On July 1, 1985, AIDS activities separated from the Sexually Transmitted Disease Section and became its own independent section. The DHS AIDS Section is now charged with the responsibility of coordinating, monitoring and otherwise administering all state funded AIDS activities.

The Information and Education (I&E) component of the AIDS Program is charged with assuring the responsible expenditure of public funds regarding AIDS education. There are currently contracts with 28 local health departments and community agencies to provide education to persons at risk for AIDS - GAY/Bisexual men, IV drug users, hemophiliacs, and the sexual partners of anyone in these groups in addition to educating health care and service providers and the general population.
Health educators working with the I&E component coordinate, monitor and evaluate state funded educational programs as well as provide consultation and assistance, as needed. In support of this activity an educational material lending library is being developed which will make written and audio/visual materials available to contractors and other interested parties.
INTRODUCTION

The education staff of the AIDS Section will be comprised of Masters level and Bachelors level health educators who are primarily responsible for monitoring and evaluating the AIDS community education grants. In addition to monitoring, much of their time is spent responding to other related AIDS activities, e.g., responding to requests for information from Administration staff, the Legislature and Advisory Committee members and the public; preparation of I&E program justification documents for budget hearings; RFP preparation, program development and proposal reviews; and, responding to I&E related Control Correspondence. Time spent with new contractors often requires consultation and training to assist in basic administration, management, and fiscal accountability procedures.

Health Educators provide written follow-up letters to contractors with their findings and recommendations as a result of on-site visits which are conducted. Health Educators are responsible for other direct contract evaluation activities such as the review of monthly invoices for program fiscal accountability and proper utilization of resources (personnel and operating expenses). The Health Educators must read, evaluate, and provide feedback on quarterly and final narrative reports from each contractor which are required as part of the contract with the State.

Other than direct contract monitoring responsibilities and responding to Department or Legislative requests, I&E staff are also required to:

1. Promote and execute interagency cooperation and coordination of resources, ideas and information between contractors, local
health departments, and inter-department State Programs. This often involved scheduling and attending meetings and public hearings with local agencies and local government Task Forces in areas serving the same populations.

2. Offer assistance and consultation to agencies which are attempting to establish services where no services presently exist.

PROGRAM

Each of the AIDS Community Education contracts provide services that address at least one of the State's targeted populations stated in the Request for Proposal (see Appendix ) i.e., individuals at increased risk for AIDS, health care providers and the general population. Since AIDS is a new and unique public health threat and a sexually transmitted disease primarily affecting gay and bisexual men who are a disenfranchised subculture, new and innovative I&E approaches are used. This makes the program monitoring, planning and coordinating responsibilities more complex.

The education program objectives are to educate individuals at increased risk for AIDS to modify their sexual practices which put them at risk for contracting AIDS; educate health care and service providers to decrease their risk of contracting AIDS to alleviate their fears of treating people with AIDS; provide information on referral sources for additional services; and educate the general public, by providing accurate and understandable AIDS information in order to decrease AIDS hysteria, anxiety and homophobia.
The objectives are accomplished using several individual modalities: either by themselves or in combination with each other. The modalities used are small group education of high risk individuals, community forum/workshops, literature distribution, media education (printed and electronic), videos, volunteer recruitment, reference library, hotlines, coordination information provider, and evaluation studies.

There are 28 contractors and 9 subcontractors providing information and educational services in local communities. Appendix______ details the various contractors, the geographical areas covered, modalities used, the dollar amount of the contract and which population served. This is an increase in funding and activity from $1,000,000 in 1984-85 to $7,182,169 in 1985-86. (See Appendix ____)

For a review of contractors and activities in 1984-85 see Appendix______.

The vast majority of direct education services are provided to local communities through contracts with private non-profit organizations and county health departments.

Most agencies cover services in the respective counties in which they are located. There are several programs which have a broader geographical base. It is worth, discussing these programs as there is a need for more statewide education monies in order to reach as many Californians as possible.

1. Hemophilia - The Hemophilia Council of California provides educational services to hemophiliacs, their families and significant others throughout
the state. They are based in Sacramento and have regional officer providing direct services. Appendix shows the geographic division with names and addresses for each area.

2. Computerized AIDS Information Network (CAIN) is administered by the Gay and Lesbian Community Services Center, Los Angeles. It is a nationwide computer information access system specifically for AIDS information, referral resources and an interactive bulletin board. See Appendix for location of subscribers who are a resource for their community.

3. Southern California Cares is an education program using printed and electronic media which covers Southern California. The program is administered by the largest AIDS agency in the country, AIDS Project Los Angeles.

4. The toll free information hotline using two (800) numbers is connected to AIDS Project, Los Angeles for Southern California and San Francisco AIDS Foundation for Northern California. The majority of calls on the hotline are from the general public.

5. The San Francisco AIDS Foundation (SFAF) Northern California Outreach Program covers six counties presently not being served by other contractors and consultative services to ten contract agencies. The SFAF has several years of experience and a trained staff who have the experience to help new agencies with resources and consultation to fill geographical gaps until smaller agencies are able to cover larger areas.

6. UC Berkeley is developing a model program for college campuses. A training manual will be distributed to all UC and State colleges through campus health services. This will address young people who may be sexually active and health care providers in student health services.
Prior to the award of a grant the Information and Education staff is required to review proposals to determine their merit and assess whether the proposal complements the statewide plan as outlined in the RFP. Duplication of effort is eliminated as much as possible and a review of the overall coverage is accomplished by reviewing where services are being provided. The health educator, through this planning strategy, determines that the comprehensiveness, completeness and standard of service is a uniform and consistent as possible.

The I&E Health Educators are primarily responsible for monitoring contracts by:

1. Ensuring that contracts are being implemented as specified in the contract and evaluating the implementation and effectiveness of the contract objectives.
2. Addressing deficiencies and provide suggestions for correcting deficiencies.
3. Being aware of programs within California and the Nation on risk reduction strategy and education material and programs to provide consultation to state AIDS contractors.
4. Giving feedback to contractors after each site visit. Currently four per year are planned.
5. Providing input into modification of project objectives in order to eliminate duplication of effort and effective services.
6. Providing feedback on quarterly and final reports.

The above activities are accomplished through on-site communication, by letter, telephone, regional coordination meetings and conferences.
A recent example of regional coordination was the AIDS Prevention Conference held on October 3rd and 4th and brought together new and continuing contractors and others working in AIDS prevention to accomplish the following objectives:

1. To provide general information dissemination sessions conducted by recognized experts to educate contractors and other working in AIDS prevention on the latest medical and psychological data on AIDS.

2. To provide an opportunity for health educators and other working in AIDS prevention to form links of communication with each other, DHS staff and the AIDS Advisory Committee members.

3. To provide an opportunity for health educators and other working in AIDS prevention to exchange prevention strategies and information with AIDS service organizations across the country.

4. To provide workshops facilitated by contractors and DHS staff on prevention strategies.

5. To facilitate a video and poster session to offer participants an opportunity to become familiar with existing education material.

During the remainder of FY 1985-86 there are several programs that the education staff will accomplish once a full complement of health educators are hired.

During the remainder of FY 1985-86 there are several following program activities that relate to the I&E component which will receive administrative attention in their development and implementation:
1. **TRAINING**

Since scientific research, medical data, and health education regarding AIDS is developing and changing relatively quickly, an ongoing training program will be developed. This training program will be for current and new staff in order to provide them with updated and relevant data and materials so that their roles as resource person and consultant the I&E contractors will be strengthened.

Part of the training will focus on the characteristics of the target and high-risk groups so that all staff have a clear understanding of and sensitivity to the individuals and organizations whom they will come in contact with.

Additionally, training will be conducted on contract monitoring and technical assistance. An administrative protocol will be established for conducting site visits and a basic standardized approach, to be modified to meet individual contractor needs, for technical assistance will be developed.

2. **AIDS REFERENCE LIBRARY**

The establishment of an AIDS reference library is seen as an absolute necessity in support of the I&E component. Through this library, literature searches and document retrieval will be facilitated so that current trends in AIDS medical research and education can be reviewed and utilized to assist in State program development and in providing the most relevant information to contractors and the general public.
3. EDUCATION MATERIALS REVIEW

A Department of Health Services Committee is being formed to develop criteria for evaluating and approving the appropriateness of I & E contractor produced AIDS education material which is produced or distributed, in whole or in part, with funds provided by the State.

It is projected, along with the projected increase of funding for I & E purposes, that a significant amount of health educator staff time will be spent on collecting and reviewing the materials being produced by I & E contractors.

The charge of this committee will be to balance the credibility of a piece of educational material, with its use of specialized terms and graphics, which are designed to ensure that it will be seen and read by the target groups against the standards of acceptability of the State and of the public at large.

Guidelines for contractors covering material development and dissemination will be distributed and administrative procedures will be developed for reviewing material for acceptability and approval.

4. MATERIALS DEVELOPMENT

The I & E Health Educators will begin to develop State educational material which would have wider application, allow savings on material development and reproduction costs, provide better control of the information disseminated thereby insuring accuracy and conformity to State guidelines, and allow a wider distribution of materials.
The types of material being developed will be brochures, public service announcements, videos, and reference books. Target groups will be persons with AIDS, the media, health professionals and agencies working with people with AIDS.
There will be three additional RFPs as a result of money budgeted in SB1251. These RFPs will cover an IUDA project; a contract to evaluate the effectiveness of AIDS information and education progress; and the development and implementation of pilot programs of professional education and training for hospital, home health agency, and attendant care workers.

4. Interdepartmental development of education programs will be accomplished through establishing liaison with each department of State government. Contact will be made to either educate department personnel, programs/clients.

With funds being allocated through SB1251 to the Department of Mental Health the DHS need to have a closer relationship with them in consultation, program planning and working toward complementary education programs.

Progress has begun with the California Youth Authority, Department of Education and the Department of Social Services. Priority will be to cooperate with the Department of Corrections and with the Department of Social Services.

5. Liaison with other State and County Health Departments to exchange information, prevention strategies and informational material.

6. Interdepartmental Development of Education Programs to develop education and information programs within the other components of the AIDS/STD Sections, i.e., STD education program through VD clinics, HTLV-III Alternative Test Sites and Surveillance programs.
7. SB 1251 will help with some of the holes in education services for IVDA; however, 95% of IVDA will not be covered under this bill and is inadequately covered in existing contracts. These are the drug abusers who are "on the streets", not in treatment. This includes gay male prostitutes who also abuse drugs.

8. Another area that needs more attention are teenagers who are experimenting with drugs and sex which includes gay and non-gay sex. Funds shall be appropriated for outreach to high schools.

9. With the growing evidence that anal sex is significantly correlated with the transmission of the HTLV-III virus, we should promote the use of condoms.

The majority of educational services are being contracted out resulting in the State's exemplary response to AIDS often being perceived as lax. In the past we have not closely reviewed material produced under contract to insure that the State is being given proper credit for funding the project. The new review process should include this in its guidelines.

The State should be pleased with the leadership position it has taken toward AIDS prevention. Every State and county concerned about AIDS comes to California to review its prevention programs. A slide presentation with a complimentary conference display will be prepared by the education staff that will give an overview of the State's response to risk reduction/preventive education programs. This can be presented to the AIDS Advisory Committee, Department of Health Services staff, community groups and at conferences.
With the increase in funding by the State and the potential of federal education dollars becoming available, broader and more intensive programs to educate the general public is possible. In addition, as this disease continues to increase within the designated groups at increased risk, there is preliminary epidemiological data which suggests that it will spread into other vulnerable groups, as well. This perceived threat to a broader range of the population has caused a knee-jerk reaction by the general population. Much of this hysteria can be minimized through educating the public through the media and other appropriate teaching modalities.

The Director of the Department of Health Services has earmarked $150,000 to produce a video and television public service announcements addressing this issue to be released sometime in the Spring of 1986.

Health care providers and service providers such as policement and emergency medical technicians are particularly concerned as they come in contact with blood and other body fluids of HTLV-III positive individuals. There are documented cases where health and service providers have refused to care for people perceived to or known to be gay or IVDA or have taken unwarranted precautions. A special outreach on a statewide basis is needed to educate these groups about AIDS and the gay lifestyle. The Director of the Department of Health Services has chosen to use a $100,000 contingency fund for this purpose.
ISSUE

Until recently the majority of education money has been contracted to local health departments and community based organizations.

An attempt has been made for these agencies to cover geographic areas larger than the county in which they reside. There is a need to have programs which have a statewide base. This assures smaller communities are covered and decreases the duplication of similar programs being developed with state money several times within each contract area.

The question in this issue is whether the I&E Unit in the AIDS Section should take a larger role in program development. For example, should a brochure on IVDA/AIDS be developed by the State, translated into appropriate foreign languages, then duplicated and distributed by the contract agency.
ISSUE

Mixed messages being given to public as to the contagiousness of the AIDS virus.

Messages being given to non-high-risk individuals is that AIDS is not casually transmitted and that they should not be concerned about high risk individuals who are health care or service providers such as waiters, nurses, etc. On the other hand, we are telling health care/service providers to use gloves and masks when coming in contact with fluids of AIDS patients and HTLV III positive individuals. This causes a perception by the general public that AIDS can be transmitted by other than through sexual contact and intravenous drug abuse. Our prudent recommendations, combined with a general mistrust by the general public, actually feeds the hysteria presently being observed.
ISSUE

Approval of Education Material produced or distributed by AIDS community education contractors

The issue of appropriateness and acceptability by public standards of AIDS education material has come to the attention of government agencies and the public on several occasions. With an increase in funding of education programs resulting in more programs and more material, an increase in this situation will also increase. See Appendix _____ which is an article written by Michael Helquist which outlines recent controversy on this issue.

The crux of the issue is to balance the credibility of a piece of education material with the use of terms and graphics which will result in its being read or seen and keep within the standards of acceptability by the funding source, i.e., the public and their elected officials.

ACTION BY DEPARTMENT OF HEALTH SERVICES

A review committee has been established by the Department comprised of DHS staff and knowledgeable community members who will develop guidelines for contractors when developing material and will set up procedures for reviewing material for its compliance to the guidelines.
ISSUE

During the past two years, responses from Request for Proposals for AIDS education money have been primarily by community non-profit organizations. There has been an increase in the number of proposals submitted for review and the willingness by county health departments to play a larger role, especially in coordinating education programs.

There are some pros and cons to counties providing direct education services and to community based organizations having overall county responsibility for coordination of services. There are several factors which determine decisions on who will be funded including 1) who responds to RFPs; 2) county government willingness to be involved; 3) politics; 4) history of responsibility of providing services; 5) number of agencies competing for funds, et al. Community based organizations tend to be more innovative and respond more quickly to changes in educational needs. County health departments are less flexible; however, have experience and fiscal responsibility which does not require as much monitoring from DHS staff.

Do we support coordination of county-wide AIDS activities, requiring matching funds by county health departments with a requirement that direct services be subcontracted to appropriate agencies.
ISSUE

With the licensing of the antibody tests and the establishment of alternative test sites for testing individuals at risk for AIDS, we have a better understanding of the degree and progression of the HTLV-III proliferation. It is questionable whether education alone is going to stop the spread of this disease. In some areas already half of the gay population have been infected.

Should outreach to sero negative individuals be attempted to make a special effort to educate this group to maintain their negative status?

Should special education programs be set up for known sero positive individuals about early signs of the syndrome and education about their possible infectivity?
OUTLINE: AIDS COMPREHENSIVE PLAN

I. Background
   A. Mandate for the Report
   B. Current Status of the AIDS Problem
      1. Incidence and Prevalence
      2. Risk Groups
   C. Strategies and Interventions
      1. Prevention/Community Education
      2. Surveillance
      3. HTLV III Antibody Alternative Test Site Program
      4. Diagnosis and Treatment Services
         a. Medical
         b. Mental Health
         c. Other
      5. Research

II. Surveillance
   A. Scope of Current Efforts
   B. Anticipated Needs
   C. Recommendations

III. Prevention and Community Education
   A. Description of Services
      1. Health Education for Target Groups
      2. Professional Education for Health Care and Emergency Care Providers
      3. Education for the General Public
   B. Trends in State Funding (FY 83/84 - FY 85/86)
   C. Impact of Services/Unmet Needs
   D. Recommendations
IV. HTLV III Antibody Alternative Test Site Program

A. Status of Program Efforts
   1. State/Federal Funding
   2. Operational Sites/Patients Tested
   3. Reimbursement to Counties

B. Status - California's Blood Supply
   1. Percentage of Positive Results
   2. Notification of Positive Blood Donors

C. Policy Issues
   1. Confidentiality of Test Results
   2. HTLV III Antibody Test as a Screening Device

D. Impact of Services/Unmet Need

E. Recommendations

V. Diagnosis and Treatment Services

A. Diagnosis

B. Outpatient Care

C. Acute Care (Hospital)
   1. Service Trends/Utilization
   2. Cost of Care/Reimbursement
   4. Availability of Facilities

D. Long Term Care
   1. Service Trends/Utilization
   2. Cost of Care/Reimbursement
   3. Availability of Facilities

D. Home Care
   1. Home Health Care
   2. In Home Support Services
   3. Cost of Care/Reimbursement
4. Availability of Facilities

E. Hospice Care

1. Service Trends/Utilization
2. Cost of Care/Reimbursement
3. Availability of Facilities

E. Recommendations

VI. Research

A. Epidemiological Research

B. Vaccine Development

C. Clinical Research

D. State and Federal Roles/Funding

E. Future Directions

F. Recommendations
State close to determining AIDS cost

By ANNE RICHARDS
SACRAMENTO UNION STAFF WRITER

State numbers crunchers are wrestling to put a price tag on treating AIDS patients and think they are close to having the costs pinned down.

Within a few weeks California will be the only state with firm figures on the public expense incurred in treating the fast-expanding and fatal syndrome, said Ben Thomas, Department of Health Services division chief.

Data from a sample of AIDS sufferers on Medi-Cal show the cost per case is rising rapidly. But widely quoted figures on total medical expenses — as much as $140,000 for the duration of the disease — may be significantly overestimated.

About one-third of California's 3,400 diagnosed victims may have had bills paid by Medi-Cal, according to unrelated studies.

AIDS, or acquired immune deficiency syndrome, is spreading rapidly from a population of predominantly gay men to other groups, so the mushrooming number of cases will mean millions of added dollars in state expense.

Victims of the disease often end up on public assistance after they are too sick to work and lose their medical insurance.

Department of Health Services analysts face an obstacle course in gathering data on AIDS, said actuary Gary McHolland.

McHolland and his colleagues went to the AIDS section of the vast Health Services department for a sample of 220 cases to study.

"We ran into some questions of right to privacy," McHolland said. "So we got the cases, but the names were blacked out. Then we had to match the birth dates and other data against existing Medi-Cal cases."

Next, data-gatherers faced the problem of identifying which of the Medi-Cal cases were actually AIDS.

Patients may be diagnosed as having Kaposi's sarcoma, immune system disorder, pneumocystis pneumonia, and 13 other conditions that often afflict AIDS sufferers.

Health Services actuaries were also hampered by spotty reporting during the early years of the crisis, when physicians were less knowledgeable and more likely to shield a patient from scrutiny.

Judging from the sample results, however, facts are emerging that throw light on AIDS and contradict some assumptions about the disease.

- The average cost per month per person is $2,800, or about $67,200 for what was commonly believed to be the two-year course of the disease.

"Of all the cases in the sample, the largest expenditure we saw was $78,000," McHolland said.

The federal Centers for Disease Control in Atlanta has quoted a $140,000 price tag on the disease, from diagnosis to death.

McHolland cautioned that the study did not cover early costs that may have been covered by health insurance. Nor did the sample take into account the fact that Medi-Cal pays less than what the hospital will charge a non-Medi-Cal patient.

- AIDS patients appear to be dying more quickly than the average two years believed to be the course of the disease, McHolland said.

"The cases we knew of where people died in the hospital didn't show up with two years in Medi-Cal claims. In fact, some didn't go back further than six months," he said.

- Thirty-five percent of the victims are men of about 35 years of age with another 23 percent near 30 years old.

- Only 1 percent of the sample was made up of women.

- California spends an average of $400,000 a month on treatment for AIDS victims. The figure does not include clinics, education, testing, research or welfare.

- Victims are hospitalized an average of three times a year and stay 12 days. The average hospital cost per stay is $6,900.

- San Francisco, which is acutely aware of the disease due to its high percentage of gays, is treating the disease more economically than Los Angeles.

The number of hospital visits in each city is the same, but the average cost in Los Angeles is $10,000, while in San Francisco it is $6,500.

Patients in Los Angeles stay an average of 17 days; San Franciscans stay 11.2 days.

San Francisco has initiated an aggressive plan that emphasizes home health care rather than long-term hospitalization. According to the sample, only 1 percent of the health-care costs paid by Medi-Cal went to home health care.
November 1, 1985

From: Jeff
To: State Planning File
Re: Meeting on November 7 and 8

Ken Brock has organized a meeting of prevention folks for these two days, which will be hosted by Pacific Center.

Participants include: Mitch Bart (SFAF), Judy Spiegle and John Mortimer (APLA), John Peterson (PC), Hal Frank (APSD), Michael Helquist, and myself.

I cannot be there on the 8th—conflict with meeting of the State Planning Commission—and have been asked to send a "representative of my staff" for the second day.

Since Sam Puckett is particularly knowledgeable about research on high risk populations and education for high risk populations is the major agenda item on November 8, I have asked Sam to represent me that day.

Meetings will begin at 8:30 AM and run all day.

Ken will mail confirmation and details.
ACQUIRED IMMUNE DEFICIENCY SYNDROME IN CALIFORNIA:

A PRESCRIPTION FOR MEETING THE NEEDS OF 1990

March 1986
PREFACE

This report has been developed to outline current state government-related activities and projected needs related to the Acquired Immune Deficiency Syndrome (AIDS) in California.

As the lead state agency designated to coordinate AIDS-related state activities, the Department of Health Services compiled and edited this report after receiving input from the University of California Systemwide AIDS Task Force and the State Departments of Mental Health, Alcohol and Drug Programs, and Corrections.

Since 1983, state support for activities aimed at controlling the spread of AIDS has dramatically increased. For example, with the proposed FY 1986-87 augmentations, the University of California’s budget for AIDS research will have more than tripled since 1983, and the Department of Health Services’ budget will have increased from $500,000 to over $13.5 million, a twenty-seven-fold increase. Likewise, the number of personnel within the Department of Health Services dedicated specifically to AIDS activities will have increased from none in 1983, to over eighty in the upcoming fiscal year. With the proposed FY 1986-87 augmentations, total state funding for AIDS-related activities will have increased nearly 700 percent since 1983.

Substantial progress has been made in controlling the spread of AIDS in California, but additional efforts are needed as outlined in this report. Given the rapidly expanding knowledge about AIDS, though, any report such as this must be viewed as tentative, and it must be realized that our efforts have to remain flexible and will be continuously changing. Similarly, it is important that our efforts be coordinated with those of other departments in state government, as well as the academic community, in order to achieve the most effective control of this tragic affliction.

Kenneth W. Kizer, M.D., M.P.H.
Director
State Department of Health Services
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EXECUTIVE SUMMARY

This report has been developed pursuant to FY 1985-86 budget control language, which required the Department of Health Services to develop a comprehensive plan to address the information and education, testing, mental health, research, and treatment needs relating to AIDS and to address the identified needs in the FY 1986-87 budget.

Currently, there is neither a vaccine nor a cure for AIDS. Consequently, the most effective intervention available today is prevention through education. This is especially important for high risk groups, but the need for education about AIDS also exists for the general public, as well as for health care providers, public safety personnel, social workers, and other persons likely to come in contact with AIDS patients.

It is estimated that the medical care costs alone for the 4,000 AIDS cases that have occurred to date in California totals approximately $250 million. It is projected that medical care expenditures for the approximately 30,000 AIDS cases that are expected to have occurred in California by the end of 1990 will approach $3.5 billion, with about $270 million coming from the Medi-Cal program. Total public health and medical care expenditures for AIDS virus infections in California during this same time period are expected to exceed $5 billion.

As a result of the needs assessment carried out by the Department of Health Services, the University of California, the Department of Mental Health, the Department of Alcohol and Drug Programs, and the Department of Corrections, the following new or expanded activities are proposed for FY 1986-87:

- expansion of the AIDS preventive education program, especially for intravenous drug users;
- expansion of state and local AIDS surveillance programs;
- increasing the number of epidemiological investigations conducted on AIDS and AIDS-related problems;
- expansion of the pilot projects program for providing less costly treatment of AIDS;
- expansion of preventive education services available through the HTLV-III antibody alternative test site program;
- expansion of the state's laboratory support services to cover confirmatory testing for the alternative test sites and virus culturing for clinical and research purposes; and
- creation of special AIDS researcher positions at the University of California;
To implement these proposals, it is recommended that the Department of Health Services' budget be augmented by $6,388,000 and 73 PYs and that the University of California's budget be augmented by $2,000,000 and 10 PYs in FY 1986-87. These augmentations reflect a nearly 50 percent increase in state spending for AIDS-related activities in FY 1986-87, compared to FY 1985-86. (This excludes the $5 million appropriated for the Alternate Test Site program.) Total proposed state funding for AIDS control in FY 1986-87 will exceed $26.6 million.

Major metropolitan areas and counties where AIDS cases have been reported in California are also encouraged to designate AIDS treatment centers (similar to trauma or burn centers), and, in addition, it is recommended that statutory changes be enacted to allow mandatory AIDS virus antibody testing when compelling public health needs exist, as well as allow reporting of individual AIDS virus antibody information to public health and medical authorities when indicated.
I. INTRODUCTION

The Acquired Immune Deficiency Syndrome (AIDS) was first recognized as a distinct clinical entity in June 1981, when an unusually high frequency of Pneumocystis carinii pneumonia was noted among homosexual men in California and New York. This protozoal infection was previously seen primarily in persons with an impaired immune system due to immunosuppressive treatment. The resultant investigation of these patients, none of whom had any known cause for immune impairment, led to the recognition of AIDS.

We now know that AIDS is not a new disease, but one which was only recently introduced into the United States. As of the beginning of 1986, AIDS had spread from its likely source in central Africa into many large urban areas of industrialized countries worldwide and to many urban areas of developing countries. Indeed, AIDS cases have been reported from all 50 states in the U.S., the District of Columbia, Puerto Rico, and more than 35 other countries. From what has been documented to date, there is little doubt that AIDS is one of the most severe human infectious diseases ever seen.

AIDS, as defined by the Centers for Disease Control (CDC), is an irreversible immune deficiency which is not due to an inherited immune disorder or immunosuppressive treatment and which, because of this immune deficiency, is characterized by infections with opportunistic agents such as *Pneumocystis carinii* or cancers such as Kaposi's sarcoma.

Since 1981, a basic understanding of the clinical features and epidemiology of AIDS has developed. Compared to many diseases, knowledge about AIDS has accumulated at an amazingly fast rate. Despite the rapid progress, though, there remain substantial gaps in our understanding of this disease, and, to date, there is no cure or preventive vaccine for the underlying immune deficiency of AIDS.

As of February 1986, nearly 4,000 AIDS cases had been reported in California, with cases having been reported from 37 of California’s 58 counties. The medical costs alone for caring for these patients is estimated to have been approximately $250,000,000.

The Etiologic Agent (The AIDS Virus)

Since AIDS was first recognized in 1981, scientists have isolated the causative agent, which is a human retrovirus. This virus was first isolated in 1983, by Dr. Luc Montagnier at the Institute Pasteur in Paris, where it was named the lymphadenopathy associated virus (LAV). Months later, Dr. Robert Gallo and co-workers at the U.S. National Institute of Health (NIH) reported isolating a virus which they initially labeled as a type III human T-cell leukemia virus (HTLV-III). At about the same time, Dr. Jay Levy, working at the University of California San Francisco, isolated a virus which he called the AIDS Retrovirus (ARV). In this report, all of these viruses, which are considered to be the same agent and are referred to as the AIDS virus.
Clinical Spectrum and Incubation Period of AIDS

As with other infectious diseases, infection with the AIDS virus results in a spectrum of illness, ranging from asymptomatic infection to irreversible immune deficiency and death from opportunistic infections. In between these ends of the clinical spectrum are mild to severe illnesses consisting of various non-specific symptoms - e.g., fever, fatigue, anorexia, weight loss, diarrhea, and lymphadenopathy (diffuse enlargement of the lymph glands). These illnesses have been referred to as AIDS-Related Complex (ARC). Some persons with ARC may progress to fulminant AIDS, although most will not.

At present, laboratory and clinical studies of cohorts of homosexual men indicate that about 70 percent of AIDS virus infected individuals are asymptomatic; 2 percent have abnormal blood counts; 3 percent have nonspecific manifestations such as fever, night sweats, weight loss or diarrhea; 25 percent have generalized lymphadenopathy; and 3 percent have AIDS. It has been estimated that 5-20 percent of infected persons among high risk groups will develop AIDS within 5 years.

The incubation period for the development of clinical AIDS ranges from several months to over five years, averaging between two and three years.

Transmission Patterns and Risk Groups

The AIDS virus is transmitted by sexual contact and/or through exposure to blood of an infected person. Collected public health data and controlled studies have confirmed these routes of transmission in homosexual men, intravenous drug users, hemophiliacs, transfusion recipients, infants born to infected women, and heterosexual partners of infected persons.

There is no evidence to suggest that AIDS is spread by insect bites (e.g. mosquitoes), air, water, food or casual social contact.

Current medical opinion holds that the risk of acquiring an infection with the AIDS virus is directly related to the extent of exposure to this virus by sexual contact and/or by sharing contaminated needles. Recent studies have shown that as many as 75 percent of gay men attending a VD Clinic in San Francisco and close to 90 percent of "hard core" drug addicts in New York have already been infected with the AIDS virus.

About 1,700 health care workers in the United States have been reported to have had needle-stick or mucus membrane exposure to patients with AIDS. Most of these workers have been followed for a year or longer, and, of this total, only three workers have acquired an infection to the AIDS virus due to their occupational exposure. All have been the result of needle stick exposures and resulted in antibody conversion only. None of the three have developed AIDS. This and other information has led experts to conclude that the risk to health care providers from such occupational exposures is very low, especially when compared to similar exposures to the hepatitis B virus.
A number of other observations support the conclusion that AIDS virus infection is difficult to transmit. For example, over 200 female nurses who have worked on the AIDS ward at San Francisco General Hospital for several years have been tested for antibody to the AIDS virus, and none have yet demonstrated any evidence of infection. In addition, there has been only one documented case of infection due to household contact - other than sexual contacts. (In this case, the contact involved extraordinary exposures without employing routine precautions.) Included in this latter category are foster mothers of infants and children with AIDS and household contacts of transfusion-associated AIDS cases.

Although public health and medical experts are confident that infection with the AIDS virus will remain essentially confined to persons with known risk factors, many people remain unconvinced. Consequently, the public needs to gain confidence that they are not at risk of being infected with the AIDS virus unless they have sexual contact with multiple partners (especially homosexual partners) or share needles with persons in AIDS risk groups.

Current Patterns of Reported AIDS in California

In March 1983, California became one of the first states to make AIDS, as defined by CDC, a mandatorily reportable condition. Figure 1 (Page 39) shows the rise of reported cases in California for 6-month periods beginning in 1981. California has, during this period, consistently reported about a quarter of the national total of AIDS cases.

Table 1 (Page 44) shows the distribution by risk groups of nearly 4,000 reported AIDS cases in California as of the end of January 1986. About 92 percent of California's AIDS cases have occurred in homosexual or bisexual men, in contrast to the national percentage of about 70 percent. Intravenous (IV) drug users account for only 2 percent of California's cases, whereas nationally over 17 percent of AIDS cases are IV drug users. Females constitute less than 2 percent of California's cases, and cases in hemophiliacs and transfusion recipients account for a little over 2 percent. The 2.5 percent of AIDS cases in the none apparent/unknown group is misleading because virtually all of these cases are in this group because of limited data, primarily because many were reported from death certificates which precluded the collection of personal risk factor information. Table 2 (Page 45) shows the distribution of AIDS cases and deaths by county of residence. As can be seen, the majority of California's AIDS cases have occurred in large urban areas.

If it is assumed that for each reported AIDS case there may be up to 3 times that number of ARC cases, then there were an estimated 12,000 ARC cases in California as of January 1986. In addition, it has been estimated that there are over 1 million persons infected with the AIDS virus in the United States, and, thus, in view of California's share of the AIDS problem, there are likely to be at least 300,000 asymptomatic AIDS virus infected persons in California (See Figure 2, Page 40).
Projected Incidence of AIDS in California, 1986-1990

The rate of increase in the number of reported AIDS cases in California has consistently decreased since 1981. The number of cases quadrupled between 1981 and 1982, tripled between 1982 and 1983, and less than doubled between 1983 and 1984. There was only a 50 percent increase between 1984 and 1985. If this trend were to continue, there should be an increase of only 25 percent between 1985 and 1986, and 12.5 percent between 1986 and 1987. If one assumes a similar decreasing rate of increase and extrapolates to 1990, then a cumulative total of over 18,000 reported AIDS cases in California would be projected by the end of the decade (Figure 3, Curve A, Page 41). At this time, however, such a projection should be viewed as the most optimal.

In contrast to the above best case scenario, it is possible to project a rate of increase of about 50 percent each year for the next several years because of the large number of persons already infected with the AIDS virus (especially among risk groups) and the long incubation period of the disease. If this trend were to continue there would be a cumulative total of AIDS cases in California in 1990 of approximately 40,000 (Figure 3, Curve B, Page 41). At this time, this should be viewed as a worst case scenario.

It is reasonable to predict that the actual incidence of AIDS will lie somewhere in between the above best and worst case scenarios. Consequently, for planning purposes, the Department of Health Services is projecting a cumulative total of AIDS cases in California in 1990 of about 30,000 (Figure 3, Curve C, Page 41). Using this projection and current case fatality rates over time, then the number of AIDS cases requiring health care each year in California for the rest of this decade can be projected as shown in Table 8 (page 51). As can be seen, using these assumptions there will be over 12,000 AIDS patients in California in 1990, requiring in excess of $1.2 billion in direct medical care expenditures. Indeed, it is projected that the medical care costs alone for treating AIDS in California for the remainder of this decade will approach $3.5 billion.

The above numbers are believed to be reasonably conservative and consider the costs of health care services to AIDS patients only. For planning purposes, though, it is also necessary to include the public health and medical care costs for ARC patients as well as asymptomatic persons infected with the AIDS virus. Further, the above projections are based on the clinical spectrum of illness attributed to the AIDS virus at this time; however, concern has been expressed by some medical scientists, based on limited clinical and experimental data, that the AIDS virus may eventually cause chronic neurologic damage which would necessitate institutional care of some persons. It is not possible to quantitate all of these costs at this time, but it is reasonable to conclude that the total public health and medical care expenditures related to AIDS in California will probably exceed $5 billion dollars during the next five years.

California State Government AIDS Organization

The organization of AIDS activity in California state government is shown in Figure 4 (Page 42). Many units of state government are
involved with the AIDS problem to some extent. Primary responsibility for state funded research on AIDS has been given to the University of California. This research is reviewed and evaluated by the University Task Force on AIDS. The State Department of Health Services (DHS) has primary responsibility for coordinating all other state efforts on AIDS.

In 1983, the legislative AIDS Advisory Committee was established (SB 910) to advise and assist the State in addressing the public health issues associated with AIDS. This committee was also directed to work with DHS in statewide efforts to promote primary prevention, public education, and the advancement of knowledge regarding AIDS. Also in 1983, the Director of DHS appointed a State AIDS Task Force to provide technical assistance for the development of AIDS recommendations and program guidelines. In addition, the Director of DHS has more recently convened an Interdepartmental Advisory Committee on AIDS to facilitate communication and to better coordinate AIDS activities among the different state departments.

In July 1985, as part of an internal DHS reorganization, a separate AIDS section was created within the Infectious Disease Branch. This section and the State's Viral and Rickettsial Diseases Laboratory are the primary state units involved with the public health surveillance and prevention of AIDS in California.

Current and prior year government funding of AIDS activities in California is shown in Table 3 (Page 46). State funding increased over 400 percent in the 1985-86 Fiscal Year (FY) from the preceding year. (Of note, the $5 million for the Alternative Test Site program is for a three-year period.)

**Federal Government AIDS Organization**

The majority of the federal government's response to AIDS has come from the Public Health Service (PHS), Department of Health and Human Services, and especially the Centers for Disease Control (CDC), the National Institute of Health (NIH), and the Food and Drug Administration (FDA) (Figure 5, Page 43).

CDC has been given responsibility for the public health aspects of AIDS. Within CDC, the Center for Infectious Diseases (CID) and the Center for Prevention Services (CPS) are the primary centers involved with AIDS. The AIDS Branch of CID has been the focal point of surveillance, epidemiologic and laboratory research, while the Host Factors Division has centered its work on immunologic and pathologic studies along with detailed work with hemophiliacs. The Sexually Transmitted Disease Division of the CPS has recently assumed responsibility for the control-oriented aspects of AIDS.

NIH has been responsible for basic research regarding AIDS. Much of the basic virology has been done at or funded through the National Cancer Institute and much of the basic immunology, epidemiology, and virology has been done at or funded through the National Institute of Allergy and Infectious Diseases. The National Heart, Lung and Blood Institute has funded transfusion-related studies.

The FDA has been central in regulating blood and blood product use.
II. RESEARCH

During the university research funding cycles beginning in 1983-1984, an increasing number of grants have been funded for each of the respective funding periods (Refer to Table 3, Page 46). In the Spring of 1985, 110 grant applications were received and reviewed; of these, sixty were funded for 1985-1986, covering the following areas: basic science, virology, immunology, infectious disease, clinical epidemiology, clinical trials, and descriptions of new clinical entities.

In FY 1985-86, investigators from non-University of California institutions were invited to submit proposals for State funding for the first time. However, only nine proposals from non-University of California investigators were received, probably because the information regarding proposal and submission requirements was not optimally disseminated and the lead time for submission of grant applications was only 6 weeks. A much larger response is expected for FY 1986-87.

Ongoing Projects of the University-wide Task Force

The latest development in the University's efforts towards AIDS has been the development of Clinical Trial Centers. These centers are charged with conducting innovative testing of new antiviral, antibacterial, and antifungal chemotherapeutic agents and prospective vaccines. Proposals were evaluated during December 1985, and awards were made in January 1986. By funding such centers, the Task Force hopes to develop highly competent and responsive investigative teams — with adequate numbers of patient referrals and sufficient expertise in study design, statistical analysis, and pharmacokinetics — to conduct clinical studies yielding significant and meaningful results. Since these centers will be prospectively funded, the competition among them for conducting clinical trials with experimental agents, as they become available, will be great. It is anticipated that this realm of research will undergo tremendous growth in the years ahead and that the State funds allocated to these centers will allow California investigators to be in a most competitive position to attract Federal research monies when such are available.

The Task Force has also established a central laboratory facility at which serologic studies and virus isolation will be conducted to support AIDS-related research projects. Centralizing these functions has effectively reduced the cost of the laboratory tests. The projected operational cost of this laboratory is approximately $500,000 per year.
Proposed New Research Activities

The Task Force believes that a support program for new AIDS investigators would have a very positive effect and that a career development program to accomplish this goal should be established. This program would fund from ten to fifty career development awards annually, at $50,000 per investigator. These monies would be appropriated for salary support in order to provide the investigator with protected time to conduct AIDS-related research. This is a time-proven mechanism for stimulating investigators in various areas of science and has been used by the NIH for many years. If a decision is made to implement this program, the plan would be to extend the awards for three to five years at a cost of approximately $0.5 million during the first year of the program, $1.5 million during the third, and so on, with incremental increases of $0.5 million each year, to a cap of $2.5 million.

Funding for AIDS Research

AIDS research is evolving rapidly, especially in the area of clinical drug trials. Therefore, additional funding should be allocated to the University of California AIDS research budget in FY 1986-87 to allow funding of meritorious proposals received during the FY 1986-87 funding cycle.

It is believed that much of the research being conducted in California will be important to the eventual development of new and more effective therapeutic modalities for AIDS and/or an AIDS virus vaccine.
III. MEDICAL TREATMENT

Diagnostic and Treatment Services

The spectrum of disease produced by the AIDS virus has been partially described earlier in this report, but this discussion will be expanded here to assist in understanding the diagnostic and treatment problems confronting the health care system.

AIDS represents the final stages of a progressive viral infection. Although the host cell range of the virus has not been fully established, it has been determined that the virus specifically infects and destroys the T helper-inducer cell, a key cell responsible for regulation of the immune system. It has also been shown that the virus is present in glial cells of the brain. The degree of immunodeficiency produced by the AIDS virus is one of the most severe ever observed.

Intervention Prior to Infection

The best means of preventing the spread of AIDS is to preclude infection by the virus. Education and resultant behavior modification directed at interrupting transmission is covered in another chapter (Chapter IV) and is presently considered the most effective method of controlling transmission of the AIDS virus.

A safe and effective vaccine would also be an excellent mechanism to interrupt virus transmission, but no such vaccine is expected to be available in the near future for a number of reasons. For example, the AIDS virus tends to mutate frequently, and, hence, any effective vaccine will have to induce protective antibodies to the more constant features of the virus (e.g., the part that binds to the helper cell receptor). Despite such technical problems, though, the major barriers to developing an AIDS vaccine seem to be economic and social. Illustrative of this, a number of law suits are currently pending against vaccine manufacturers, and, consequently, many pharmaceutical companies have stopped making commonly used vaccines and few are actively developing new vaccines. Also, the market for an AIDS vaccine is uncertain. Only three health care workers have had possible infection through occupational exposure (needle sticks). Homosexual and bisexual men and intravenous drug users are currently the major at-risk groups. Vaccination of the general population is not currently indicated. Whether a selective immunization program would produce a sufficient market is unclear. Finally, the companies with technological capability to develop the vaccine are often small. They may require direct support to sustain the necessary research and development costs to develop the vaccine, and many could not sustain the substantial costs (at least $20-40 million) necessary to bring a vaccine to market. For these reasons, most experts believe that development of a vaccine should be encouraged at the Federal level.

At the present time, no studies have been conducted to determine if antiviral chemotherapeutic agents would prevent establishment of the infection in an exposed seronegative individual. If effective and non-toxic, such medication might be given regularly to individuals who
choose not to limit their sexual or intravenous exposure, or might be effective in single dose or short course before or after unsafe exposures.

Knowledge of the serological status of individuals would take on new importance if a vaccine or chemotherapeutic measures to prevent infection become available.

**Intervention During Early Infection**

Most infections with the AIDS virus are believed to produce no symptoms. However, an acute "infectious mononucleosis-like" syndrome consisting of fever, fatigue, lymphadenopathy, and skin rash occurs in some infected individuals several weeks to months after infection with this virus. This represents the earliest clinical manifestation of HTLV III-related disease. Development of the anti-AIDS virus antibody probably occurs at about this time, and is generally thought to occur in most infected individuals between one and six months following infection. (Of note, though, an estimated one to four percent of infected individuals do not have detectable antibodies to the AIDS virus.)

Whether accurate diagnosis and/or treatment of early AIDS virus infection can be achieved is unclear. The non-specific nature of the early findings make the diagnosis confusing. Indeed, many patients with lymphadenopathy have undergone biopsy to rule out lymphatic malignancies or other infectious diseases. (Overall, about 3 percent of seropositive individuals have had lymph node biopsies.)

It is not known whether an early antiviral chemotherapeutic treatment in infected individuals might restrict infection to the lymphoid cells. Theoretically, it would seem reasonable to treat this infection before massive destruction of T-cell function occurs. However, current experimental antiviral drugs appear to only inhibit viral replication and do not eliminate the virus, indicating that life-long therapy with a drug of low toxicity might be required. Pilot studies on this issue would provide useful information.

**Progression to AIDS and AIDS Related Diseases**

Many prospective studies of AIDS virus infected individuals have begun during the last two years. These studies should determine the percentage of infected individuals who will eventually develop clinical AIDS or AIDS Related Complex (ARC). At the present time, this infection has a demonstrated potential for producing AIDS in 5 to 10 percent of infected persons within five years. The presence of AIDS and milder ARC related opportunistic infections is associated with low T-helper cells, and it is reasonable to assume that those individuals who are unable to maintain adequate numbers of T-helper cells in the face of ongoing viral infection may be the group most at risk for developing AIDS. Depending on the time of introduction of the virus into a particular population, the percent of infected individuals with AIDS or AIDS related diseases that suggest significant immunodeficiency (e.g., thrush, viral leukoplakia, herpes zoster, etc.) is about 5-10 percent. Because they are ill or symptomatic, most health care resources are now being directed toward these individuals.
The case definition for reporting of AIDS is included in Table 4 (Page 47). The definition of ARC is less standardized but does give some basis for describing the non-AIDS spectrum of medical disease which must be dealt with clinically. These conditions are summarized in Table 5 (Page 48). There are therapies which can and are being applied to most of these conditions. The effectiveness of these therapeutic interventions vary according to the degree of immunodeficiency present. Many of the drugs for opportunistic infections are proven therapies used in non-AIDS patients having these infections; others are experimental. A list of these drugs is provided in Table 6 (Page 49). At the present time, there is no antiviral drug or immune restorative therapy that has proven effective in treating the underlying viral infection or the resultant immune deficiency. A list of the more promising experimental antiviral and immunomodulator drugs is given in Table 7 (Page 50).

Diagnostic techniques necessary to determine the presence of a particular opportunistic infection or type of cancer vary widely depending on the particular infection involved. Some require hospitalization, while others can be performed on an outpatient basis, provided the individual is well enough. Staging and monitoring the actual viral disease and the immunodeficiency produced can be done with a number of expensive, complex, and not fully established diagnostic tools. Laboratory techniques using monoclonal antibodies for determining the number of functional T-helper cells are well established, although procedures for monitoring individuals over long periods of time with these techniques are not well standardized. Most physicians monitoring infected persons with lymphocye studies tend to refer to a single laboratory, as interlaboratory variability on these tests is substantial. Culture techniques for determining the presence of virus are very difficult and beyond the scope of most hospital and clinical laboratories, which may have culture facilities for other viruses. Hence, the capability to culture the AIDS virus will, for some time to come, be very restricted. At the present time, four university laboratories (University of California at San Francisco, University of California at Davis, University of California at Los Angeles, and the University of Southern California) and the California Department of Health Services (Viral and Rickettsial Disease Laboratory) are at various stages of setting up viral culture capabilities. Since the endpoint of antiviral drug intervention is inhibition and/or eradication of the virus, the presence of viral culture capability is necessary for both monitoring drug therapy and for staging of individuals to properly qualify them for drug trials. These techniques are experimental; reimbursement is uncertain; and use often occurs in research protocols not covered by third party reimbursement. State and federal support is being given to foster the development and increased availability of these virology and immunology services, and the State laboratory is expanding its capacity.

Outpatient Care

The spectrum of services that are needed to provide outpatient care depends on the clinical status of the patient population. AIDS patients require more extensive and medically sophisticated outpatient services than many other conditions.
A recent survey in San Francisco revealed that nearly half of AIDS patients require some degree of medical or social support at any given time. This survey found that 54 percent of AIDS patients were living without assistance, although only 28 percent were employed. Six percent were hospitalized at any given time, while another 6 percent were in a hospice. Approximately 30 percent of the patients were sufficiently debilitated so as to need assistance in performing routine activities, with about half of that assistance coming from professional attendants.

The demand for AIDS outpatient services is expected to increase in proportion to the increased number of cases.

Additional demands for outpatient immunological testing services are also likely to be caused by increasing HTLV-III antibody testing. Currently, HTLV-III antibody prevalence in California is about 50 percent in the urban gay community, less than 10 percent in the urban IV drug using population, and 60-90 percent in hemophiliacs. As increasing numbers of these individuals are tested at alternative test sites or by private physicians, they will desire immunological evaluation and medical follow-up. Some of these individuals will suffer acute and chronic stress reactions and may require psychological and other support services.

Health Care Services for Persons with AIDS and Severe ARC

Acute Care

There are approximately 100,000 general acute care hospital beds in California, of which, overall, only about 60 percent are occupied at any given time. Consequently, the acute care hospital bed capacity for AIDS patients in California is not likely to be exceeded in the foreseeable future. However, the availability of acute care hospital beds may not always be matched with the location of AIDS patients and the type of bed may not always be the type needed for AIDS patients. Such disparities may become a significant issue in the future.

Despite the general availability of acute care hospital beds, there have been some problems regarding hospitalization of AIDS patients. Early on, some hospitals refused AIDS admissions. With increased awareness of the disease, however, such resistance to undertake the care of AIDS patients has diminished. Indeed, education of hospital staffs and development of hospital procedures to deal with AIDS patients have been found to be important prerequisites to hospital staff acceptance of AIDS patients. At present, some of the state education contractors have programs for health professionals, and recent legislation (SB 1251, 1985) includes additional funding of $250,000 for the education of hospital, home health care, and attendant workers. In addition, the Southern California Hospital Council is currently designing a comprehensive training program for hospitals that might serve as a model for similar educational efforts statewide. DHS is currently reviewing a set of hospital guidelines developed by this organization.

The impact of AIDS on individual patients is profound, and in caring for AIDS patients there is a need to provide comprehensive and coordinated medical and psychosocial services. Indeed, the need for sophisticated and multidisciplinary medical services and for extensive
social support systems is analogous to what exists for severe trauma, burns, organ transplants, and premature infants. The development of treatment centers for these conditions has been very effective. It is believed that this "center" model is applicable to AIDS and that the major metropolitan areas and counties where AIDS cases have been reported in California should be encouraged to designate specific AIDS treatment centers.

Analysis of Current Cost of Care

The projected cost to Medi-Cal and private insurance for the health care of AIDS patients through 1990 is shown in Table 8 (Page 51). These costs are based on a recent study conducted by the Department of Health Services and reflect the best data currently available on the cost of care of AIDS patients in California. About 12 percent of AIDS patients are Medi-Cal beneficiaries. Total Medi-Cal reimbursement for care of AIDS patients is estimated to have been about $5 million in FY 1984-1985, but this is expected to rise to over $96 million by 1990. Over 90 percent of all AIDS-related Medi-Cal costs are associated with acute hospital care. Assuming that charges are about 1.6 times Medi-Cal reimbursements and that all AIDS patients are receiving care similar to that delivered to Medi-Cal patients, the total medical care expenditures for AIDS patients through 1990 have been estimated and listed in Table 8. As can be seen, Medi-Cal reimbursements through 1990 (assuming the current mix of services) are expected to exceed $270 million, and private sector health care costs are expected to approach $3.2 billion.

In the DHS study there were significant regional differences in length of stay and the total amount reimbursed for hospitalization. The average Medi-Cal reimbursement per hospitalization in San Francisco was $6,700; in Los Angeles it was $12,300; and in the rest of the state it was $8,500. The mean length of stay in San Francisco was 12.1 days; in Los Angeles it was 17.9 days; and in the rest of the state it was 14.2 days. Forty-one percent of AIDS patients are in San Francisco; 36 percent are in Los Angeles; and 23 percent are in the rest of the state. In San Francisco, the average AIDS patient had 4.4 hospitalizations; in Los Angeles that average was 3.8 hospitalizations; and in the rest of the state the average AIDS patient was hospitalized 4.4 times. At this time, it is believed that the differences in length of stay between San Francisco and Los Angeles are due primarily to the greater availability of alternative types of care in the San Francisco area.

Table 9 (Page 52) projects the savings to the Medi-Cal system if length of stay could be reduced in Los Angeles and the rest of the state to the 12.1 days observed in San Francisco. As can be seen, over the next five years this would amount to nearly $55 million, although a significant part of this would have to be allocated to skilled nursing and intermediate care facilities. In order to achieve these savings, it will be necessary to develop appropriate non-acute care hospital services in areas of high AIDS incidence.
Skilled Nursing and Intermediate Care

Utilization of skilled nursing facilities (SNF) and intermediate care facilities (ICF) for AIDS patients in California has been limited. Implementation of reimbursements by diagnostic related groups (DRGs) by the federal government has encouraged the discharge of patients from acute care hospitals at the earliest possible time, and exacerbated the overall shortage of SNF beds. Utilization of these services is further affected by the general reluctance of these institutions to provide care for AIDS patients. (These institutions generally feel that there would be substantial problems associated with admitting AIDS patients into a facility which was otherwise primarily serving elderly patients.) At the same time, the number of AIDS patients for whom SNF or ICF level of care would be appropriate is increasing. Due to better management of opportunistic infections, many AIDS patients are surviving longer and require shorter hospitalization for their infections.

As indicated earlier, about 30 percent of AIDS patients in a San Francisco survey required in-home care assistance. Since the spectrum of disability is great, the degree of care needed varies from a part-time attendant to assist with household chores to intensive nursing care required by a patient with dementia and chronic diarrhea, who may require and nasogastric feeding and intravenous fluids. With adequate support, many patients can be maintained in their own homes or, if displaced, in community-based housing.

Home Health Care

A rather unique experience in home health care has developed in connection with AIDS. Since many AIDS patients cannot return to their homes, residential units have been established for AIDS patients in some cities. Volunteer counseling and living assistance (e.g., food preparation, shopping, and transportation) have been provided by the community. When necessary, home health care services are brought into the household in support of the patient at home. The monetary value of the volunteer component of these services is often not quantified. Some counties have seeded these programs with sufficient administrative support to recruit and train the volunteer staff. However, in counties with the highest AIDS incidence, the cost of underwriting home health care systems is reaching a point where state or federal assistance may be required to maintain an ever increasing number of cases in these alternative programs.

Hospice Care

Development of hospice facilities specifically for AIDS patients has not occurred in California, or elsewhere, although one county is considering this option. The hospice services have been integrated into the total care of AIDS patient in San Francisco, with volunteer counseling and home health care being integrated into the home environment, whether the AIDS patient lives at his own home or in a separate house for AIDS patients. Federal reimbursement for hospice care has been set at $6,500 per case, and substantial subsidy of this program through private and public sources has been required in most instances.
SB 1251 (1985) contained a $1 million appropriation for block grants to assist in the development of home health and hospice care services for AIDS patients. These program funds are earmarked to assist with the development and start-up costs of these programs. Additionally, $250,000 was allocated to assist in the education of workers in the home health industry. These funds have been allocated. Additional funding for pilot projects for these types of less costly AIDS treatment services would be useful.

**Issues Specific to the Medi-Cal System**

**Payment for Experimental Services**

Current California law (Health and Safety Code Section 150 and Welfare and Institutions Code Section 14000) and regulations (Title 22, California Administrative Code, Section 51303 [a]) do not allow Medi-Cal coverage of experimental services, including drugs and equipment. Whenever a patient is hospitalized solely because the administration of an experimental service requires a hospital setting, Medi-Cal is precluded from covering the cost. This is a significant issue with regard to AIDS, since so much of the treatment of AIDS and its complications is experimental or investigational.

Conversely, if a patient is in a hospital, or is admitted to a hospital not specifically for an experimental treatment, and the patient receives or participates in some form of experimental treatment the hospitalization and non-experimental treatment costs are eligible for Medi-Cal coverage.

Traditionally, patients who are hospitalized for experimental treatment(s) are covered by specific research funds. For example, if a pharmaceutical company is trying to develop a "breakthrough" drug (and subsequently reap financial benefit), the company typically subsidizes the research and development work for that drug.

The fundamental issue underlying Medi-Cal coverage of AIDS experimental treatment costs is one of equity - i.e., how can Medi-Cal cover experimental treatment costs for AIDS and not for numerous other equally debilitating and complex diseases.

DHS is currently gathering data and reviewing its options with regard to Medi-Cal coverage of AIDS patients.

**Delay of Care Under Medi-Cal While Awaiting Disability**

Although formerly a problem, this has been resolved. In March 1985, the DHS established a policy of Medi-Cal Presumptive Disability for AIDS patients.

**Loss of Private Health Coverage Plan**

Most AIDS victims are young males, and prior to their illness most have been employed and had employer-paid health insurance. However, as these persons gradually succumb to AIDS, they become unable to work and sometimes lose their group or private health insurance. Consequently, they may become dependent on Medi-Cal. To date, though, only 12 percent of AIDS patients have been found to require Medi-Cal.
Determining the Cost of AIDS Care

There is no nationally or internationally accepted unique ICD-9 CM code for AIDS and, consequently, it has been difficult to determine precisely the cost of AIDS medical care. In response to this, DHS established specific codes for AIDS and ARC in December 1985. These became effective on January 1, 1986. California was the first state to do this. Of note, the Department can only mandate use of these codes for Medi-Cal patients, although it is hoped their use will become more widespread and, hopefully, be adopted in the next revision of the International Classification of Diseases.

Proposed Activities

Recognizing that the care of AIDS patients is a complex and new phenomenon, additional pilot projects need to be established in high incidence areas to insure that comprehensive care is available for AIDS patients. These pilot programs should be structured so that patients are routed to the most appropriate and cost effective level of care. In particular, pilot projects should include provisions for the development of sufficient SNF/ICF beds and home health care services for AIDS patients.

Additional viral and immunological diagnostic facilities also need to be developed so that drug trials can be initiated rapidly and so that the clinical course of HTLV-III positive individuals can be monitored.

Education of health care workers about AIDS should also be expanded.
IV. COMMUNITY EDUCATION

Since there is no effective clinical treatment or prophylactic vaccine for the basic immunodeficiency of AIDS, the best "treatment" is prevention. The strongest tool in prevention is education.

Health educators have had experience in addressing difficult problems such as sexually transmitted diseases, death and dying, and outreach to hard-to-reach groups. However, problems such as these have never been linked together as closely as they are in AIDS. Since all of these components are combined in AIDS, considerable difficulty and complexity is involved in educating affected persons about this disease. However, at this time, preventive education is the key to controlling transmission of HTLV-III infection, since the illness is not casually transmitted, the number of infected Californians is large, and virtually all new infections are the result of voluntary sexual and drug use behaviors.

**Target Groups**

**The General Population as a Target Group**

Historically, there have been relatively few health education programs targeted to the general public. However, the general public has to be targeted in order to effectively deal with AIDS.

Given the effectiveness of mass media communication and the far-reaching effects of the AIDS problem, the mass media offers public health officials and health educators a good vehicle with which to educate large numbers of people about AIDS. However, paramount to the success of mass media efforts is the message about AIDS. The messages developed and utilized in media outreach should be consistent, accurate, from reliable sources, support behavior change, when necessary, and provide an understanding of risk reduction behavior.

**Occupational Groups**

Persons working in a wide number of settings need to be educated about AIDS, its transmission, and the prevention and control of the disease. Similarly, training programs are needed in workplace settings to reduce fear about working with people at risk of contracting AIDS, as well as those with AIDS or AIDS-related conditions. The occupational target groups are diverse and include those listed on Table 10 (Page 53).

Development of preventive education programs should take into consideration the experience of community education contractors in order to accurately determine the education and training needs of the particular employee groups. In addition, these programs should be adaptable to other worksites with similar employee groups. Of course, the program should also take into consideration the employees preexisting attitudes and knowledge about the subject.
Education programs should include modules which address basic information about AIDS (e.g., its epidemiology and risk groups, transmission, and prevention), facts and myths which contribute to AIDS-related anxiety, and information about sexual practices which are safe and unsafe and other sexually transmitted diseases.

**Populations at Increased Risk**

Within the general population, there are certain groups who are at increased risk for contracting AIDS. These groups need special attention and information resources tailored to their particular risk status.

Individuals considered to be at increased risk include: sexually active homosexual men; bisexual men; prostitutes; heterosexual persons having multiple sexual contacts; hemophiliacs; and intravenous (IV) drug users. The sexual partners and offspring of these persons are also at increased risk. Intravenous drug users warrant particular targeting of efforts at this time.

**Current Preventive Education Efforts**

**Program Overview**

DHS contracts with 28 counties and community-based organizations to provide preventive education services. Funding for these activities has increased from $1 million in FY 1984-1985 to $5,109,500 in FY 1985-1986.

Although most of the contract agencies provide services in the counties in which they are located, several programs have a broader geographical base. These include the following:

- The Hemophilia Council of California provides educational services to hemophiliacs, their families and significant others throughout the State. They are based in Sacramento and have regional offices providing direct services.

- The Computerized AIDS Information Network (CAIN) is administered by the Gay and Lesbian Community Services Center in Los Angeles. It is a nationwide computer access system specifically for AIDS information and referral resources.

- Southern California Cares is an education program which covers Southern California using printed and electronic media. The program is administered by the largest AIDS agency in the country, i.e., the AIDS Project, Los Angeles. This program plans to expand throughout the State next year.
Toll-free information hotlines are connected to the AIDS Project, Los Angeles, for Southern California and the San Francisco AIDS Foundation for Northern California. The majority of calls on the hotline are from individuals at low risk.

The San Francisco AIDS Foundation (SFAF) Northern California Outreach Program covers 6 counties presently not being served by other contractors and provides consultative services to 10 contract agencies.

The University of California, Berkeley, is developing a model program for college campuses. A training manual will be distributed to all UC and State colleges through campus health services. This will address sexually active young people and health care providers in student health centers.

In addition to the above, the Department's AIDS program will develop and implement several activities during the remainder of FY 1985-86. These include:

- **Ongoing Training of AIDS Section Staff**

  Since knowledge about AIDS is developing rapidly, an on-going training program is being developed. This training program will be for current and new staff of the AIDS section in order to provide them with the most current data about the disease. Part of the training will focus on the characteristics of high-risk groups so that all staff have a clear understanding of and sensitivity to the individuals and organizations with whom they will come in contact.

  Additionally, training will be conducted on contract monitoring and provision of technical assistance. An administrative protocol for conducting site visits will be established and a basic standardized approach for providing technical assistance will be developed.

- **AIDS Information Center**

  The establishment of an AIDS Information Center is necessary to support preventive education activities. Through the center, literature searches and document retrieval will be facilitated so that current trends in AIDS medical research and education can be reviewed and utilized to assist in State program development and in providing the most relevant information to contractors and the general public.

- **Educational Materials Development**

  The preventive education health educators will begin to develop State educational material which will have wider application, allow savings on material development and reproduction costs, and provide coordination for the dissemination and distribution of materials. Among the types of material being evaluated are brochures, public service announcements, videos, and reference books.
Proposed Activities

Proposed activities to accomplish the Department's expanded preventive education objectives include the following:

1. Development of a statewide educational campaign for the general public.

2. Development of educational programs for occupational groups (Refer to Table 10, Page 53) who interact with people with AIDS or who are at increased risk of contracting AIDS.

3. Continued contracting with various community AIDS agencies and county health departments to provide preventive education programs to groups at increased risk for contracting AIDS. Increased attention needs to be focused on intravenous drug users and HTLV-III negative individuals in high-risk groups. These efforts should be coordinated with the Department of Alcohol and Drug Programs.

4. Expansion of the Department's clearinghouse function for AIDS educational materials.

5. Evaluation of comprehensive risk reduction programs in order to provide educational programs with empirical data to support risk reduction messages.
V. ANTIBODY TESTING

Beginning in 1982, there was increasing recognition that, in addition to transmission by sexual contact and intravenous drug abuse, some cases of AIDS were associated with blood transfusions. Appreciation of this potential hazard resulted in the development of blood bank donor screening policies in 1983. All persons who were in population groups considered at increased risk for AIDS were asked to refrain from donating blood. Blood banks throughout the country began to routinely ask all donors to self defer if they were in these AIDS risk groups. This resulted in a substantial reduction of blood transfusion-associated AIDS.

Following the isolation of the AIDS virus in 1983, medical research was directed toward the development of a screening test to detect infections to this virus. In March 1985, an antibody test for the AIDS virus was licensed for use in the United States. The primary initial use of this test was to screen blood or plasma intended for human transfusion. However, from the outset, concerns were expressed regarding the accuracy of this test as well as the meaning of positive test results. The accuracy of the test in detecting infections to the AIDS virus (i.e. the sensitivity of the test) had to be extremely high in order that all infected blood would be screened out. On the other hand, the accuracy of the test in not identifying false positives (the specificity of the test) also had to be extremely high in order not to unnecessarily waste blood. Equally, or more important, was the potential harm that would be done when a blood donor was informed that his/her blood was infected with the AIDS virus when it was not (false positive antibody test). Thus, an antibody test for the routine screening of all donated blood has to be both extremely sensitive and specific.

The Accuracy of the Antibody Test

The sensitivity and specificity of the currently licensed antibody tests (enzyme immunoassay or EIA) are very high, both being 99 percent or higher. These antibody tests are as good or better than most other serologic tests which medical practitioners routinely use for other infectious agents. However, as good as these licensed tests are, there has been persistent confusion about their accuracy and significance. The basis for this confusion is related to the different prevalence of infection with the AIDS virus in populations with low risk for AIDS versus those populations having an increased risk of AIDS virus infection.

An understanding of the technical details regarding what is termed the predictive value of a positive test is needed in order to appreciate the difficulties in the interpretation of a "positive" EIA test in a blood bank setting versus the interpretation of a "positive" EIA test in a non-blood bank setting, e.g., an alternative test site.
Use of the Antibody Test in the Blood Bank Population

If it is assumed that the sensitivity and specificity of the EIA test are 99 percent and if it is further assumed that no AIDS virus infection (and, therefore, no antibody) is present in a hypothetical blood bank population, then 10 false positive results can be expected out of 1,000 blood donors, because the specificity of the test is 99 percent - not 100 percent. Although the prevalence of AIDS virus infection in any large blood donor population should be very low, it cannot be assumed to be zero (if it were zero there would be no need to use the EIA test for routine screening). If it is assumed that only one in a thousand (i.e. 0.1 percent) blood donors truly has antibody to the AIDS virus (a fairly reasonable assumption) and if 1,000 of these blood donors are tested, then eleven positive results can be expected. One is the person with antibody to the AIDS virus (the true positive), and the other 10 are false positive because the specificity of the test is 99 percent. In this situation, the predictive value of a positive test is only 9 percent accurate (i.e., only one of the 11 positives is a true positive).

The predictive value of a positive EIA test is low in a population with a very low prevalence of infection. Therefore, the national recommendations are that, at a minimum, the EIA test should be run twice on each sample, and only if the result is positive on both should the unit of blood be considered positive for antibody to the AIDS virus. However, in practice, some blood banks elect not to use any unit of blood which shows any positive EIA result. In addition, the two largest national blood bank organizations have adopted criteria for rejecting a unit of blood for transfusion and more stringent criteria for notification of a donor that his or her blood tested positive for antibodies to the AIDS virus. The latter criteria include repeatable positive EIA tests plus a positive result on an additional supplemental test such as the Western blot or the indirect fluorescent antibody (IFA) test.

Use of the Antibody Test in Populations At Risk for AIDS

If the HTLV-III antibody test is used in known AIDS risk groups, the predictive value of a positive test is very high (i.e., very accurate). If this test were applied to 1,000 homosexual men in San Francisco, where it is known from other studies that 50 percent may have been infected with the AIDS virus, the predictive value of a positive EIA test will be about 99 percent. If 1,000 of these men are tested, about 500 with true positive results can be expected; ten false positive results may also be expected since the specificity of the test is 99 percent. Thus, of the 510 positive results, virtually all (i.e. 500 out of 510) will be true positives. The predictive value of a positive EIA test in this situation is in excess of 98 percent.

Because the predictive value of a positive EIA test is so high in a population with a moderate to high prevalence of infection, additional supplemental tests such as the Western blot or the IFA test when the EIA test is repeatably positive, will prevent only a small percent of persons being misinformed that they are antibody positive when they are not.
Significance of Antibody Test Results

The other major confusing aspect about the HTLV-III test is the belief that a positive test for antibody to the AIDS virus (even a true positive) has no significance because the test is not diagnostic for AIDS. While it is true that a positive antibody test result (if it is a true positive) cannot by itself be used to make a diagnosis of AIDS, it is inaccurate to say that a positive antibody test has no significance. A positive antibody test means that the person has produced antibody against the AIDS virus, and this only occurs if the person was both exposed to and infected with the AIDS virus. Although the majority of persons infected with the AIDS virus do not develop ARC or AIDS, all future cases of ARC or AIDS will come from this population of infected persons. In addition, laboratory studies have shown that the majority (about 60%) of asymptomatic antibody positive persons have the AIDS virus circulating in their blood and, thus, should consider themselves as potentially infectious to others by sexual contact or by sharing needles.

Testing for Antibodies to the AIDS Virus in California

On March 2, 1985, the EIA test for antibody to the AIDS virus was licensed for use in the United States. The routine use of this test in blood banks to supplement the donor self-deferral procedures which was begun in March 1983 was needed to eliminate the very low but finite risk of AIDS virus transmission by blood transfusion. During March and April 1985, blood banks throughout the U.S. began testing as the EIA antibody test kits became available. However, several problems surfaced with regard to the routine use of this test for screening of blood donors.

One immediate problem was the concern that persons who might be at risk for AIDS might donate blood just to be tested for AIDS virus antibodies if blood banks were the only source of free and easily accessible testing. Because the test is not 100 percent sensitive, some antibody negative but virus positive persons could have made the blood supply less safe by donating their blood just to get the test. In response to this concern, IMS filed emergency regulations on March 8, 1985, requiring blood banks to use the test but prohibiting them from notifying any person of their antibody test result for a period of up to 6 months. (California was the first state in the U.S. to do this.) This delay in notification of blood donors of their test results allowed development of testing capabilities at sites other than blood banks (i.e., alternative test sites).

In March 1985, the federal Department of Health and Human Services announced that about $12 million would be made available to states and some local jurisdictions to support, for the first 90 days, the development of alternative test sites. California applied for and received in April 1985, about $2.5 million from the Centers for Disease Control for the development of such alternative test sites. In addition, two emergency pieces of legislation (AB 403 and AB 488) were passed by the California Legislature at the end of March and were signed into law by Governor Deukmejian on April 4, 1985.
AB 403, an informed consent law, requires the written permission of an individual in order to perform the AIDS virus antibody test and specifies, under civil and criminal penalties, that test results can be disclosed to a third party only after obtaining the written consent of the tested party. In addition, it prohibits the use of antibody test results to determine insurability or suitability for employment, and allows the State to require blood banks to submit statistical reports of the test results of donor antibody screening.

AB 488 dealt primarily with increasing the safety of the State's blood supply. It did this by requiring blood banks to screen donor blood for antibodies to the AIDS virus and prohibiting the transfusion of blood or blood components that are found to be antibody positive; expanding the State Deferred Donor Register to include blood donors who are confirmed reactive for antibodies to the AIDS virus; providing for confidentiality of antibody test results in donors; limiting antibody testing to only those laboratories specifically approved by the State Department of Health Services; and requiring counties designated by the Director of the State Department of Health Services to establish alternative test sites and referral services for persons with reactive tests. The tests and referral services at alternative test sites are to be provided without charge. When federal funds for this testing program are exhausted, state funds from AB 488 ($5 million) will be used to continue testing at alternative sites.

The Alternative Test Site (ATS) Program in California

Assembly Bill 488 appropriated $5,000,000 from the General Fund for a three (3) year period to the State Department of Health Services for the purpose of administering AIDS antibody testing at alternative test sites (ATS). On April 22, 1985, California was also granted federal funds ($2,455,578) for this testing program for a three-month period extending from April 26 to July 24, 1985. Requests to extend this funding to October 22, 1985, and later to April 27, 1986, were approved.

Federal funding was based on what the Centers for Disease Control (CDC) estimated to be reasonable costs for performing the necessary laboratory test(s) and providing pre- and post-test information to persons who might want to be tested for antibodies to the AIDS virus. Nationally, a reimbursement schedule of about $15 to $16 per person tested was provided. In addition, local health departments in California were asked to estimate how many persons in their jurisdiction might seek testing during the first 90 days of such a program; their collective estimates were used to request the State allocation from CDC.

In April 1985, the Director of the Department of Health Services designated 31 health jurisdictions in California as having to establish ATS programs. During May and June 1985, Standard Agreements were negotiated with most of these jurisdictions. The original Standard Agreement provided an initial conservative reimbursement of $11.00 per person tested. These agreements were subsequently modified to assure local health departments that within 90 days of the start of the program the Department of Health Services would conduct a study to determine the reasonable costs expended for testing as required by the state and that reimbursement for these reasonable costs would be
provided retroactively to the start of the program. This study has
been completed and the Department has determined that reimbursement at
a level up to $40.00 per test is reasonable given the necessary pre-
test and post-test education that is being provided.

As of the end of February 1986, nearly 32,000 persons had been
tested at ATSs, with about 20 percent of the completed tests positive
for antibody to the AIDS virus. Thus, it is clear that the ATS program
is being utilized by persons at risk for AIDS. The numbers of persons
seeking testing has been steadily increasing, presumably as a result of
increasing confidence of risk group members in the validity of the test
and confidence that the programs are providing absolute
confidentiality.

Blood Bank Testing and Notification of Positive Donors

As specified by AB 488, blood banks were not permitted to inform
donors of their test results until three months after an ATS program
became operational in their county. This provision was intended to
further dissuade persons from seeking this test at blood banks.

Blood banks in California began to screen all units of blood as
the initial supplies of the antibody test kits were distributed in
April and May 1985. Since then, over 500,000 units of donated blood
have been tested and, overall, 0.25 percent have been rejected,
although probably only about 0.10 percent (i.e., one in a thousand) are
true positives. As of November 1985, all California blood banks began
to inform donors of positive test results, although such notification
is not given until 60 days after the date of blood collection. This
fixed delay in reporting test results to blood donors was mandated by
AB 488 in order to continue to divert persons who may be at increased
risk for AIDS to go to an ATS where they will be able to get test
results much sooner.

AB 488 prohibits blood banks from disclosing identifying
information on blood donors found to be positive for AIDS virus
antibodies. However, DHS does require blood banks to provide overall
statistical information. Forms to obtain data which will provide
continuing surveillance of the prevalence and pattern of seropositivity
to the AIDS virus in the blood donor population have been developed and
distributed to blood banks. The language in SB 1251 specifically
permits use of ATS funds to provide education for HTLV-III positive
persons. Since persons who test positive at the blood banks feel that
they are not "at risk", they may not be reached by other educational
programs.

The ATS program in California appears to be very successful in
accomplishing its major objective of diverting persons from AIDS risk
groups who want to be tested for antibody to the AIDS virus away from
blood banks. This program will need to be continued until such time as
other arrangements are developed to provide testing to persons who are
at increased risk for infection with the AIDS virus. Such testing
sites should be used to the maximum extent possible to educate persons
to eliminate behaviors which increase the risk of acquiring an
infection to the AIDS virus.
HTLV-III Antibody Testing as a Public Health Control Measure

In the past, public health control of infectious diseases has often relied on screening of either the general population or selected high risk population groups to identify infected persons and implement measures to limit further transmission of infection. For infectious diseases where no effective treatment is available, screening programs have not been routinely developed. For example, serologic tests for infections with the hepatitis B virus, which is transmitted from person to person by the same routes as the AIDS virus, have been routinely available since the mid 1970s. However, aside from the routine use of this test to screen all blood intended for transfusion and to screen all pregnant women who may be carriers of hepatitis B virus (in order to provide immunobiologics to their infants at birth) no other screening for hepatitis B virus infections have been routinely implemented or advocated.

Similar to hepatitis, widespread screening of the general public for AIDS virus antibodies is not warranted at this time.

The antibody test for the AIDS virus was developed for the initial primary purpose of screening all blood intended for transfusion. As experience has been gained with this test, there has been an expansion of its use for other public health purposes, such as screening tissue, semen, and organ donors (when feasible). Further selectively expanded use of this test should be considered on a case-by-case basis in the future.

In California, the Alternative Test Site program was developed for those individuals wanting to know their antibody status to the AIDS virus. Studies have been proposed which would evaluate the relative effectiveness of specific education and counseling of persons in AIDS risk groups, based upon or linked with their antibody status. Additionally, the psychological impact of a positive test is under evaluation. Current California law prohibits the testing of anyone for antibody to the AIDS virus without his or her specific written consent. As a result, all screening programs (except blood bank screening) which may be proposed would have to obtain such consent.

HTLV-III Antibody Testing for Other than Public Health Purposes

Current California law (AB 403) specifically prohibits the use of the antibody test to the AIDS virus to determine insurability or suitability for employment. Use of AIDS virus antibody testing for other similar purposes is believed to be also precluded by this statute.

Proposed Activities

Given the above discussion, the following activities are felt to be indicated.

1. Expand the preventive education activities of the alternative test site program during FY 1986-87.
2. Clarify the respective role(s) of blood banks and health departments regarding the notification and necessary follow-up of positive donors.

3. Evaluate the effectiveness of antibody test-linked education programs among persons at risk of infection.

4. Modify existing law (AB 403) to permit the testing of persons at risk of AIDS without their written consent when compelling public health reasons warrant it or when persons are not mentally capable of giving consent for the test (e.g., mentally ill, criminally insane or developmentally disabled persons). Legal safeguards to keep such testing confidential and used only for public health purposes should be strengthened if need be.
Public health surveillance includes but is not limited to the collection, analysis and dissemination of all data relevant to controlling a public health problem.

Current public health surveillance of AIDS virus infection in California is focused primarily on collecting data on AIDS patients. However, as previously discussed, clinical AIDS, as defined by CDC, represents only a small percentage of all infections to the AIDS virus. Therefore, public health surveillance needs to become more comprehensive.

Reporting Requirements

Health care providers in California are required by state regulation to report AIDS cases to their local health departments, who in turn transmit the information to the State Department of Health Services. This reporting system is "passive", since (except for a few counties) there is no routine contacting of physicians, infection control nurses, laboratories or hospitals to ensure that all of AIDS cases or suspect cases are being reported. Passive reporting systems have historically gathered incomplete statistics for communicable diseases, although studies have indicated that reporting of AIDS cases is more complete than for many other diseases. Nonetheless, there is often a considerable delay in the reporting of this information, and the Department of Health Services recent quantitative analysis of AIDS in California has delineated some problems with the current reporting system.

In June of 1985, CDC, with the concurrence of the Conference of State and Territorial Epidemiologists (CSTE), decided that only the very severe manifestations of AIDS virus infection (i.e., AIDS as defined by CDC) would continue to be reported nationally. Milder disease associated with infection to the AIDS virus (e.g., ARC) and asymptomatic infections are not now reported nationally. These conditions are not required to be reported in California, nor could they be reported under existing law.

Surveillance of ARC and Asymptomatic Infections

The incubation period for AIDS is several years. Thus, surveillance of clinical AIDS only measures infections acquired several years earlier, and the Department of Health Services believes that this information is not sufficiently timely for planning, implementing, and evaluating intervention measures for the prevention of transmission of this virus. Furthermore, in order to monitor the possible spread of this virus to population groups who currently are not known to be at increased risk for AIDS, there is a need to more completely monitor the incidence and pattern of AIDS virus infections. Consequently, the Department believes that an active surveillance system for AIDS should be implemented.
As previously described, current California law prohibits the testing of a person for antibody to the AIDS virus without first obtaining the written consent of the person. In addition, for those persons who are tested there can be no disclosure to a third party (including local or state health officials) of the result of this antibody test without the prior written consent of the person tested. This latter prohibition also applies to results of routine antibody testing which is now carried out in all blood banks and plasma centers in the state.

Blood banks, however, are required to provide to the Department of Health Services a list of persons (with identifying information) who have tested positive for hepatitis B surface antigen (HBsAg) and/or for antibody to the AIDS virus. Such a listing, which is to be entered into the blood donor deferral register maintained by the Department of Health Services, cannot specify why a person is included on the list (i.e., whether because of hepatitis or because of AIDS antibodies).

The Department of Health Services requires blood banks to provide statistical information on antibody testing in the blood donor population. This information is needed to monitor antibody trends in this population, which should not include persons in known risk group for AIDS.

Under current procedures, if a significant increase in antibody positive donors is noted in any blood bank, that blood bank would be requested to provide detailed follow-up information on the positive donors in order to determine whether the epidemiology of AIDS virus infection is changing. Such an indirect public health investigation is necessitated by the existing law which prohibits blood banks from disclosing to the Department of Health Services personal identifying information on donors who test positive for antibodies to the AIDS virus.

In addition to monitoring and investigating the trends (by time and geographic area) of infection to the AIDS virus in the blood bank population, there is also a need to monitor the prevalence and pattern of infection with the AIDS virus in the known AIDS risk groups, and to evaluate prevention programs directed to these latter groups. Presently, such public health surveillance would have to be carried out with the permission of those tested or done blindly, since current law prohibits the testing of any person without their written consent. Statistical data from the Alternative Test Site program, which tests persons anonymously, will be of limited use for this purpose since the population utilizing this program is highly self selected and the proportions of different AIDS risk groups seeking this test varies significantly with time and geographic area. Testing of blood specimens which are routinely collected at sexually transmitted disease clinics and drug abuse treatment clinics, as well as other selected sites, should be considered.

Special Epidemiologic Investigations

Continued efforts to identify sources, modes of spread and host factors (risk factors) involved in acquiring and transmitting infection of the AIDS virus are needed. Current field studies will permit a more detailed evaluation of specific sexual and other risk factors and may
identify new risk groups. These studies will better define risks of heterosexual transmission, as well as specific sexual practices involved in both homosexual and heterosexual transmission of the AIDS virus. However, current studies should be expanded, or new studies initiated, to evaluate risks of sexual transmission from infected women (e.g., from prostitutes), transmission from infected mothers to newborns, and risk of transmission from infected persons in special facilities (e.g., institutions for the developmentally disabled and hemodialysis centers).

As new risk factors are identified and as risk behaviors are modified, reassessment of the degree of risk in specific risk groups should be made. There is also an ongoing acute need for prompt and thorough investigations of any case which appears to have no known risk factor(s) for acquiring AIDS. Likewise, continued epidemiologic investigations, especially epidemiologic assessment of intervention measures, must also be given high priority.

Other Control Measures

Control of Environmental Sources and Vehicles of Transmission

Intervention through environmental control measures have included testing for antibody to the AIDS virus in blood and plasma and the heat treatment of Factor VIII and Factor IX concentrates, which have been vehicles for infection of hemophiliacs. Additional possibilities for environmental control relate to the stability and inactivation of the AIDS virus. The AIDS virus appears highly susceptible to many antiseptic/disinfectant compounds, and certain spermacides may be of additional benefit due to antiviral activity. The use of barrier protection such as condoms to reduce the exchange of semen is likely to be of benefit in preventing infections with the AIDS virus.

The low risk of infection in laboratory personnel and medical care workers through occupational exposure suggests that fomites and environmental sources are not likely causes of spread of infection, but continued monitoring of such exposures with adjunctive use of antibody testing should continue. Possible risks associated with hemodialysis needs to be evaluated but, even in the absence of any documented risk, preventive measures similar to those taken for eliminating hepatitis B virus transmission in such settings should be instituted.

Contact Tracing

In California, over 90 percent of infections to the AIDS virus are acquired through sexual contact (mainly homosexual). Since most infectious persons are asymptomatic, it follows that most sexual contacts of infected persons are unlikely to be aware that they may have been exposed to the AIDS virus.

Contact tracing of sexual partners of gay men would, in most situations, not be considered productive or cost effective because of the very large number of anonymous sexual partners usually involved and because there are no effective prevention measures available after a person is exposed. However, the practicality of contact tracing in selected situations to interrupt transmission of infections should be given serious consideration. Contact tracing could be an especially...
effective intervention strategy when there are only a limited number of
sex partners of an infected person or when female contacts (especially
if they are of child bearing age) are involved. Contact tracing should
also be considered for recipients of contaminated blood and users of
intravenous drugs who have shared equipment with an infected person.
Once such episodes are identified, all exposed persons could be
contacted, advised to be tested, and then counseled in accordance with
their antibody status. While contact tracing strategies could be
applied to any situation in which an infection to the AIDS virus is
documented, such strategies should be tailored to the risk group
involved and must carefully consider confidentiality issues.

Confidentiality Issues

When involved in surveillance and control of infectious diseases,
public health authorities have always had access to personal
identifying information on individuals who are infected or who may have
been exposed to a severe infectious disease agent. For example, all
household contacts of a leprosy case are identified and examined to
evaluate whether they are infected. Similarly, the screening of
hemodialysis patients to determine whether they may be carriers of the
hepatitis B virus is a routinely recommended and accepted procedure.

AIDS is, without question, one of the most severe human
communicable diseases ever known. However, because of concerns that
the AIDS virus antibody test might be inappropriately used, access to
personal identifying information on anyone seeking this test has been
prohibited by law. Thus, public health investigation into the spread
of AIDS virus infections requires the consent of the individuals
tested. As such, public health surveillance mechanisms for this
disease are constrained at present. They have to follow more closely
the model of university research.

Legislation to assure the confidentiality of medical research data
on AIDS (SB 292, 1985) has been enacted. This law will permit vitally
needed research studies on AIDS to continue relatively unhampereby
concerns of confidentiality. There is, however, a general distrust
among AIDS risk groups of government agencies, including public health
agencies, regarding the collection of identifying information related
to AIDS. This will continue to be a controversial issue. Nonetheless,
access to personal identifying information is needed for public health
purposes, and existing laws should be modified to allow public health
investigation to proceed unhindered. This may require strengthening of
the confidentiality requirements of public health data on AIDS, similar
to the legal safeguards provided for the confidentiality of medical
research data on AIDS.

Proposed Activities

Based on the above considerations, the following things are proposed
for surveillance and control of AIDS virus infections.

1. The current passive surveillance of AIDS and ARC cases
in California should be reinforced by adding active
surveillance in high incidence areas, as well as
selectively in other areas as needed.

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2. The clinical surveillance of AIDS should be supplemented with a serologic (antibody) testing system. At a minimum, the prevalence of infection in blood donors, in sexually transmitted disease clinics, and in drug abuse treatment clinics should be systematically monitored.

3. The security of public health records should be assured (by additional legislation, if needed) so that affected individuals are confident that personal identification data are maintained strictly confidential and used only for appropriate medical or public health purposes.

4. State support to counties should be provided to assist in AIDS surveillance and prevention activities. Support from the federal government should be actively sought to develop local and state AIDS surveillance and control activities similar to programs now funded for other sexually transmitted diseases.

5. Public health laboratories should be expanded to provide support for the laboratory surveillance of AIDS, ARC and asymptomatic infections. Support should be provided for rapid field investigations of potential public health problems related to infections with the AIDS virus.

6. Programs should be developed to identify and test women who are at increased risk of exposure to the AIDS virus and to provide information to them regarding risks to their fetus if they become pregnant.
VII. MENTAL HEALTH

The Department of Mental Health (DMH) is responsible for a closed community of approximately 4,500 mentally ill patients in five state hospitals located in Atascadero, Camarillo, Napa, Norwalk (Metropolitan), and San Bernadino (Patton). Forty percent of the patients, the "penal code patients," have been judicially committed because they have engaged in or have been charged with criminal activity. Most of the rest are civilly committed because they are dangerous to themselves or others or are so gravely disabled they cannot care for themselves. Overall, 35 percent of the patients have a history of drug abuse, and 70 percent are males housed for the most part in male-only units, often dormitory style. Although some patients may stay only 2 or 3 days, at any one time about one-half the patients are younger than age 35 and three-quarters are younger than 45. Forty percent are considered dangerous by the staff caring for them (25 percent have a history of attempted murder, and 15 percent have assaulted someone within the past 30 days).

There are no known AIDS patients in California's state mental hospitals, nor have there been any to date. However, there has been one patient with AIDS related complex and twelve AIDS virus seropositive patients. In addition, two hospital staff persons have died of AIDS, although, importantly, both persons were among recognized high risk groups and are not believed to have contracted the disease through their work.

Historically, the state mental hospitals have not been confronted with the need to treat patients having both psychiatric and physical health problems of the type seen with AIDS. Consequently, existing facilities will probably need to upgrade and expand their staff, equipment and physical plant if they are to treat AIDS patients. Hospital staff, in particular, will need instruction and training about AIDS and infection control procedures. These same needs also apply to county mental health programs.

To address the identified needs, DMH has developed a treatment policy and protocol for state hospital psychiatric patients suspected of having AIDS virus infection. Similarly, the Chief of Professional Education at each hospital has been charged with developing an AIDS training program for all staff at their hospital. Further, procedures and facilities are currently being developed at Atascadero (for certain forensic patients and prisoners) and Napa State Hospitals to allow special treatment of patients having AIDS virus infection and whose behavior might spread the infection to non-infected patients or personnel. This action should be completed by July 1986. Of note, though, statutory change is needed to allow AIDS virus antibody testing of patients not competent to give informed consent, and such testing is necessary in some cases to identify patients who might transmit the infection.

In addition to the state mental hospitals, California also has a well developed system of mental health services within its counties, with each of the 58 counties offering an independent and separate program. A local system usually consists of inpatient, outpatient, day care, and case management services. The current mental health
system is effective and nationally recognized for its efficacy and is well-equipped to address the new challenges posed by the AIDS problem. Those local jurisdictions that have a disproportionate share of AIDS cases will, in their local planning processes, determine the need for services to this population.

To specifically address the mental health aspects of AIDS, the DMH's Division of Community Programs was allocated $600,000 in the FY 1985-86. These funds have been divided among three programs: $300,000 for a media campaign emphasizing the relationship between stress and the immune system, the use of support groups, and means of dealing with grief; $200,000 for education and training programs for mental health personnel; and $100,000 to study AIDS-related mental health needs. Future mental health needs will be delineated by the current needs assessment survey, which should be completed by the spring of 1987, and unmet needs will be addressed as discovered.
VIII. SURVEILLANCE AND CONTROL WITHIN THE CORRECTIONS SYSTEM

The Corrections System

The California Department of Corrections is responsible for the care and custody of over 50,000 prisoners in 12 major correctional institutions, 28 minimum security conservation camps, 2 community correctional centers, and 50 local parole offices. The 12 correctional institutions include 10 prisons for male felons, one for female felons, and a center for civilly committed narcotics addicts and selected male and female felons. There are four hospitals within the system, and nine infirmaries. At present, there is substantial overcrowding in all of these institutions.

Inmate Profile and AIDS Risk

The Corrections System population in California consists mostly of young males, a majority of whom have been in the criminal justice system before and who are imprisoned for violent crimes. More specifically:

- Approximately 95% of inmates are male.
- Approximately 58% of inmates are between the ages of 18 and 29. (The median age fell from 31.6 years in 1970, to 28 years in 1983).
- Approximately 78% of inmates have been previously incarcerated in prison, jail, or the juvenile justice system. (Of the 31,341 admissions to California prisons in 1984, 11,977 of those were parole violators.)
- Approximately 60% of inmates are imprisoned for homicide, rape, robbery and/or assault.

Based on several factors unique to prison life, inmates have a higher than average risk of contracting AIDS virus infection. The reasons for this include:

- Homosexual activity

Due to the nature of prison confinement, some inmates who do not consider themselves homosexual do engage in homosexual activities while incarcerated. (This activity is in addition to that engaged in by acknowledged homosexuals.)

- Needle sharing and intravenous (IV) drug abuse

The very limited access to hypodermic needles and the necessarily surreptitious nature of IV drug use both contribute to the shared use of needles in prisons.
The incidence of needle-sharing for tattoo applications

It is a common practice in prisons for inmates to apply tattoos. Again, because of the lack of access to needles there is much needle-sharing involved in this activity.

A significant number of inmates have a history of IV drug abuse

Of male felons newly received from court in 1982, 7,800 had a record of narcotic use (excluding marijuana). This included use of heroin (3,848), non-heroin opiates (1,383), and other dangerous drugs (2,569).

Overview of AIDS in the California Corrections System

Given the overcrowding of California's prisons, a population with a probable higher than average risk for contracting AIDS virus infection, and the need to maintain adequate security with regard to AIDS patients of varying classification levels, there has been concern about how to handle AIDS patients in California's Corrections System. However, present and planned activities appear to be meeting the needs of the system.

As of the end of February 1986, twelve diagnosed cases of AIDS, 24 cases of ARC and 1 other known HTLV-III positive person had occurred in California's Corrections System. Housing for these inmates is provided in the hospital at the California Medical Facility (Vacaville), and current facilities are meeting present needs. Expansion and upgrading of this facility may be needed in the future as the caseload increases. In addition, the Department of Corrections is working with its staff and the Department of Health Services to develop an AIDS education program for its employees and inmates.
Intravenous (IV) drug use is a primary risk factor for contracting AIDS because the AIDS virus may be transmitted through the sharing of needles contaminated with AIDS virus infected blood.

Less than 2 percent of AIDS cases in California have IV drug use as their primary risk factor, although about another 10 percent of cases are known to have this as an associated risk factor. Nationally, about 17 percent of AIDS cases have IV drug use as their primary risk factor. Sexual contact with IV drug users (e.g., prostitutes and bisexual men) is a primary concern for the spread of AIDS into the general heterosexual population.

In California, residential alcohol and drug treatment programs (RDTPs) have increasingly voiced concern about their capacity to treat AIDS virus infected drug addicts. This concern is based on several factors, including possible medical needs of these patients, their different counseling needs, and fears about becoming liable should a resident of these programs contract AIDS while undergoing, or subsequent to, treatment at the RDTP if AIDS virus infected patients are also undergoing treatment.

To address these concerns, the Department of Alcohol and Drug Programs (DADP) is pursuing a number of efforts. These efforts include developing a protocol that may be used by drug abuse treatment programs. This protocol will provide advice about general precautions needed to prevent AIDS virus transmission, recognition of AIDS signs and symptoms, and other matters relating to the treatment of AIDS virus infected patients who are IV drug users.

Similarly, efforts are underway to develop training programs for the staff of drug abuse treatment programs to increase their ability to deal with AIDS virus infected patients.

In addition, DADP is considering new prevention and education strategies targeted for IV drug users and is working with the Department of Health Services to address these needs.
X. PROPOSED IMPLEMENTATION PLAN, 1986-87

It is proposed that the following activities and budget augmentations be implemented for FY 1986-87.

Department of Health Services ($6,388,000)

1. DHS proposes a $2,600,000 local assistance augmentation to expand the scope of epidemiologic investigation and surveillance activities of local jurisdictions.

This augmentation would be implemented as local assistance block grants to local health departments, and would provide for the development of active surveillance programs at the local level. These would be coordinated with other local health education programs; the HTLV-III antibody Alternative Test Site program; and other county health, mental health, and drug abuse programs.

2. DHS proposes a $1,304,000 staff and operating expense augmentation to fund 31 new civil services positions to operate an expanded surveillance program and 7 positions to operate an expanded HTLV-III alternative test site preventive education program.

This augmentation will allow DHS to:

a. Develop an active surveillance program which includes outreach to medical care providers likely to come in contact with AIDS/ARC patients, periodic review and evaluation of the AIDS case registry and other data bases, and briefing/training of personnel in other state agencies (e.g., Departments of Corrections, Mental Health and Social Services).

b. Conduct special studies to determine the demographic trends of the incidence and prevalence of AIDS, ARC, and asymptomatic infections and to maintain a comprehensive AIDS case surveillance system.

c. Perform local surveillance activities in those geographic regions where the incidence of AIDS is not high enough to warrant a dedicated program in the local health department.

d. Expand its technical support for the Alternative Test Site program.

3. DHS proposes a $500,000 augmentation and an $595,000 redirection of staffing dollars to fund an expanded preventive education contract program.

This augmentation will allow DHS to expand its preventive education activities targeted toward the general public, the intravenous drug using population, health care providers, ethnic minority populations, and high risk groups.
4. DHS proposes a $498,000 staff and operating expense augmentation to fund 14 additional civil service positions in the Department's AIDS preventive education program.

These staff will be utilized to develop and maintain an information clearinghouse, issue periodic updates on the status of clinical drug trials, conduct needs assessments, monitor state and federal budgets and policies, and support the Computerized AIDS Information Network. They will also be utilized to provide ongoing development, monitoring, and evaluation of the Department's preventive education efforts, including the provision of technical assistance to local providers, development of educational materials, and evaluation of local programs. They would also implement the Department's expanded preventive education contract program.

5. DHS proposes a $730,000 augmentation to fund pilot projects for the development of skilled nursing services for AIDS patients.

a. At least one pilot project should be located in both Los Angeles and San Francisco.

b. The second year of the two-year cost of care study mandated by SB 1251 (Chapter 767/85) should include an assessment of the cost effectiveness of this level of care.

6. DHS proposes a $227,000 augmentation to fund 7 positions to implement the pilot projects described above and to evaluate those pilot projects initiated in 1985-86.

7. DHS proposes a $479,000 augmentation and a redirection of $230,000 of contract dollars to fund 14 staff laboratory positions and additional operating expenses necessary to provide confirmatory testing for the HTLV-III antibody Alternative Test Site program and virus culturing for research and clinical purposes.

8. DHS will elevate the existing AIDS Section of the Infectious Disease Branch to the status of an Office of AIDS. The Chief of this Office will report directly to the Deputy Director for Public Health.

University of California ($2,000,000)

1. UC proposes a $500,000 augmentation to support 10 new AIDS investigators.

2. UC proposes $1,500,000 to fund additional AIDS research projects.
XI. FIGURES AND TABLES
The AIDS Problem in California - 1986

4,000 reported AIDS cases

About 12,000 estimated ARC cases

About 300,000 persons infected with the AIDS virus
Reported and Projected AIDS Cases in California

Actual incidence figures are used through mid-1985
Table 1

California AIDS Cases by Risk Group*

<table>
<thead>
<tr>
<th>Risk Group</th>
<th>Male</th>
<th>Female</th>
<th>Total Cases</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homosexual</td>
<td>3,261</td>
<td>0</td>
<td>3,261</td>
<td>81.89</td>
</tr>
<tr>
<td>Bisexual</td>
<td>407</td>
<td>0</td>
<td>407</td>
<td>10.22</td>
</tr>
<tr>
<td>Intravenous Drug User</td>
<td>68</td>
<td>13</td>
<td>81</td>
<td>2.03</td>
</tr>
<tr>
<td>Hemophiliac</td>
<td>26</td>
<td>3</td>
<td>29</td>
<td>0.73</td>
</tr>
<tr>
<td>Heterosexual Contact of Persons in Risk Groups</td>
<td>15</td>
<td>6</td>
<td>21</td>
<td>0.53</td>
</tr>
<tr>
<td>Transfusion</td>
<td>51</td>
<td>26</td>
<td>77</td>
<td>1.93</td>
</tr>
<tr>
<td>Parent at Risk</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td>0.18</td>
</tr>
<tr>
<td>None/Apparent/Unknown</td>
<td>81</td>
<td>18</td>
<td>99</td>
<td>2.49</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>3,912</td>
<td>70</td>
<td>3,982</td>
<td>100.00</td>
</tr>
</tbody>
</table>

*as of January 31, 1986
Table 2
AIDS CASES BY COUNTY OF RESIDENCE AT ONSET OF ILLNESS


<table>
<thead>
<tr>
<th>County</th>
<th>Cases</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Francisco</td>
<td>1,528</td>
<td>673</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>1,447</td>
<td>577</td>
</tr>
<tr>
<td>San Diego</td>
<td>175</td>
<td>67</td>
</tr>
<tr>
<td>Orange</td>
<td>150</td>
<td>76</td>
</tr>
<tr>
<td>Alameda (ex. Berkeley)</td>
<td>147</td>
<td>51</td>
</tr>
<tr>
<td>Santa Clara</td>
<td>73</td>
<td>31</td>
</tr>
<tr>
<td>Riverside</td>
<td>69</td>
<td>43</td>
</tr>
<tr>
<td>San Mateo</td>
<td>54</td>
<td>23</td>
</tr>
<tr>
<td>Contra Costa</td>
<td>46</td>
<td>15</td>
</tr>
<tr>
<td>Marin</td>
<td>46</td>
<td>22</td>
</tr>
<tr>
<td>Sonoma</td>
<td>42</td>
<td>14</td>
</tr>
<tr>
<td>Sacramento</td>
<td>40</td>
<td>14</td>
</tr>
<tr>
<td>Monterey</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td>Santa Barbara</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>San Bernardino</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>Fresno</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>Ventura</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Kern</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Santa Cruz</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>San Joaquin</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Out of State</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>San Luis Obispo</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Mendocino</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Solano</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Berkeley</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>El Dorado</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Napa</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Lake</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Stanislaus</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Imperial</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Placer</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Shasta</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Yuba</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Butte</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Humboldt/Del Norte</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Madera</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Merced</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>San Benito</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Trinity</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**TOTAL**                  **3,982**                  **1,682**
### Table 3
#### AIDS BUDGET SUMMARY

<table>
<thead>
<tr>
<th>State Funds</th>
<th>FY 1983-84</th>
<th>FY 1984-85</th>
<th>FY 1985-86</th>
<th>FY 1986-87</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Research</td>
<td>$2,900,000</td>
<td>$3,094,000</td>
<td>$7,514,000</td>
<td>$9,514,000</td>
</tr>
<tr>
<td>Department of Health Services</td>
<td>500,000</td>
<td>1,000,000</td>
<td>7,192,587</td>
<td>13,229,264</td>
</tr>
<tr>
<td>Department of Mental Health</td>
<td></td>
<td>600,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HTLV-III Testing</td>
<td></td>
<td></td>
<td>1,130,915</td>
<td>3,869,085</td>
</tr>
<tr>
<td>TOTAL STATE FUNDS</td>
<td>$3,400,000</td>
<td>$4,094,000</td>
<td>$16,447,502</td>
<td>$26,612,349</td>
</tr>
</tbody>
</table>

| Federal Funds*               |            |            |            |            |
| Surveillance                 | 102,891    | 196,996    | 196,996    | *          |
| HTLV-III                     | --         | --         | 2,455,578  | *          |
| Los Angeles                  | 117,461    | 186,045    | 186,045    | *          |
| San Francisco                | 144,860    | 587,266    | 687,266    | *          |
| TOTAL FEDERAL FUNDS          | $365,212   | $970,307   | $3,425,885 |            |

a $1 million to be distributed to universities outside the UC system

b Includes $799,494 for State Program Support and Contract Services, $4,333,093 for Community Education Grants and Contract Services, and $2,060,000 for SB 1251 (Chapter 767/85) implementation.

c A total of $5,000,000 was appropriated by AB 488 (Chapter 23/85) to support this program. It is expected that $1,000,000 of this amount will be expended in FY 1985-86, in addition to the $2,455,578 shown under federal funds to cover a $40 per test reimbursement rate. $130,915 of the total was allocated to provide state laboratory support services for this program in FY 1985-86.

d Includes special study for blood transfusion and Hepatitis B follow up.

e Base $6,841,285; augmentation $6,387,979.

*The amount of federal funds for California in FY 1986-87 is not known, but is estimated to be at least several million dollars.
Table 4

DISEASES WHICH OCCUR WITH AIDS*

Intestinal cryptosporiosis
Pneumocystis carinii pneumonia
Strongyloisis pneumonia, CNS infection, or disseminated infection
Toxoplasmosis pneumonia or CNS infection
Aspergillosis - CNS or disseminated infection
Candidia esophagitis
Cryptococcosis - pulmonary, CNS, or generalized infection
Disseminated mycobacterial infection due to "atypical" strains
Cytomegalovirus infection - pulmonary, GI, or CNS
Herpes simplex infection - pulmonary, GI, disseminated, or chronic mucocutaneous ulcers
Progressive multifocal leukoencephalopathy
Kaposi's sarcoma
Lymphoma limited to the brain

The following occur among people with antibodies to the HTLV III virus:

Disseminated histoplasmosis
Bronchial or pulmonary candidiasis
Isosporiasis
Chronic lymphoid interstitial pneumonitis
Small non-cleaved lymphoma (Burkitt's or Burkitt's-like tumor)
Immunoblastic sarcoma

*AIDS is an irreversible immune deficiency which is not due to an inherited immune disorder or immunosuppressive therapy and which, because of the immune deficiency, is characterized by the presence of one or more of these opportunistic diseases.
Table 5

**AIDS RELATED COMPLEX (ARC)**

The following signs, symptoms, and laboratory abnormalities present in varying combinations, constitute the criteria for diagnosing AIDS Related Complex.

1. Fever > 100 degrees for 1 or more months
2. Night sweats
3. Weight loss of 15 pounds or 10% of body weight
4. Lymphadenopathy involving 2 or more extrainguinal sites > 3 months
5. Diarrhea for 3 months without identifiable causes
6. Fatigue with decreased physical or mental function
7. Low absolute T helper cells or low helper/suppressor cell ratio
8. Anemia, leukopenia, absolute lymphopenia, or thrombocytopenia
9. Elevated serum globulins
10. Depressed blastogenesis
11. Abnormal skin test reactions
<table>
<thead>
<tr>
<th>Infection</th>
<th>Existing Treatment</th>
<th>Experimental Drugs or Drugs not Previously Used for this Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumocystis</td>
<td>Pentamidine</td>
<td>Dapsone</td>
</tr>
<tr>
<td></td>
<td>Trimethoprim Sulfa</td>
<td>DFMO</td>
</tr>
<tr>
<td>Toxoplasmosis</td>
<td>Pyrimethamine</td>
<td>Clindamycin</td>
</tr>
<tr>
<td></td>
<td>Sulfadiazine</td>
<td>Spiramycin</td>
</tr>
<tr>
<td>Cryptosporidium</td>
<td>None</td>
<td>Spiramycin</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DFMO</td>
</tr>
<tr>
<td>Candida</td>
<td>Nysatin</td>
<td>None Identified</td>
</tr>
<tr>
<td></td>
<td>Clotrimazole</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ketoconazole</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Amphotericin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5-FC</td>
<td></td>
</tr>
<tr>
<td>Cryptococcus</td>
<td>Amphotericin</td>
<td>Katoconazole</td>
</tr>
<tr>
<td>Herpes</td>
<td>Acyclovir</td>
<td>Under Development</td>
</tr>
<tr>
<td>Cytomegalovirus</td>
<td>None</td>
<td>DHPG</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BW 759</td>
</tr>
<tr>
<td>Mycobacterium avium intra-cellulare</td>
<td>Non Documented to be Effective</td>
<td>Ansamycin</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clofazimine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Others</td>
</tr>
</tbody>
</table>
## Table 7

**INVESTIGATIONAL ANTI-VIRAL AND IMMUNOMODULATOR DRUGS**

**Antiviral Activity**

1. Alpha-A interferon  
2. Phosphonoformate  
3. HPA-23  
4. Suramin  
5. Ribavirin  
6. Ansamycin

**Immunomodulator activity**

1. Interferon Alpha and Gamma  
2. Interleukin-2  
3. Various Thymic Hormones  
4. Isoprinosine
## Table 8

**PROJECTED COST OF CARE FOR AIDS PATIENTS IN CALIFORNIA**

by calendar year (1985-1990)

<table>
<thead>
<tr>
<th>FISCAL YEAR</th>
<th>ESTIMATED LIVING AIDS PATIENTS</th>
<th>MEDI-CAL REIMBURSEMENTS*</th>
<th>PRIVATE SECTOR CHARGES*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984-85</td>
<td>1,150</td>
<td>$ 5.0</td>
<td>$ 59.1</td>
</tr>
<tr>
<td>1985-86</td>
<td>2,200</td>
<td>$ 10.6</td>
<td>$ 124.4</td>
</tr>
<tr>
<td>1986-87</td>
<td>3,500</td>
<td>$ 18.6</td>
<td>$ 217.8</td>
</tr>
<tr>
<td>1987-88</td>
<td>5,000</td>
<td>$ 29.1</td>
<td>$ 342.2</td>
</tr>
<tr>
<td>1988-89</td>
<td>7,000</td>
<td>$ 44.9</td>
<td>$ 527.0</td>
</tr>
<tr>
<td>1989-90</td>
<td>9,500</td>
<td>$ 67.0</td>
<td>$ 786.7</td>
</tr>
<tr>
<td>1990-91</td>
<td>12,400</td>
<td>$ 96.3</td>
<td>$ 1,129.6</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>$ 271.5</td>
<td>$ 3,186.8</td>
</tr>
</tbody>
</table>

*In millions of dollars

Medi-Cal costs are based on the finding that 12% of AIDS patients are covered by Medi-Cal.

Private Sector charges are estimated to be 1.6 x Medi-Cal reimbursements and assume that 88% of AIDS cases are covered by private insurance.

Cost figures are inflation adjusted at 10 percent per year, and estimated AIDS cases are at mid fiscal year.

Projected costs have been partially adjusted for underestimation of cases; refer to A Quantitative Analysis of AIDS in California, California Department of Health Services, March 1986, for a more detailed explanation of Medi-Cal expenditures for AIDS.
**Table 9**

**Utilization and Projected Savings from Increased Utilization of Home Health Care Facilities for AIDS Patients.**

By location in California and calendar year (1985-1990)

<table>
<thead>
<tr>
<th></th>
<th>San Francisco</th>
<th>Los Angeles</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Length of Hospital Stay</td>
<td>12.1</td>
<td>17.9</td>
<td>14.2</td>
</tr>
<tr>
<td>Mean Medi-Cal Reimbursement Per Stay</td>
<td>$ 7,370</td>
<td>$ 13,530</td>
<td>$ 9,350</td>
</tr>
<tr>
<td>Average Numbers of Admissions Per Patient Per Year</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Average Reimbursements Per Year</td>
<td>$ 29,480</td>
<td>$ 54,120</td>
<td>$ 37,400</td>
</tr>
<tr>
<td>Reimbursement for 12.1-Day Stay</td>
<td>$ 7,370</td>
<td>$ 9,146</td>
<td>$ 7,967</td>
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<tr>
<td>Reimbursement, Home Health Care/Adm.</td>
<td>0</td>
<td>$ 580</td>
<td>$ 210</td>
</tr>
<tr>
<td>Savings Per Admission</td>
<td>$ 4,964</td>
<td>$ 1,593</td>
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</tr>
<tr>
<td>Savings Per Year</td>
<td>0</td>
<td>$ 19,856</td>
<td>$ 6,371</td>
</tr>
<tr>
<td>Cost with Home Health Care</td>
<td>$ 29,480</td>
<td>$ 34,264</td>
<td>$ 31,029</td>
</tr>
<tr>
<td>Medi-Cal Cases</td>
<td>100%</td>
<td>41%</td>
<td>36%</td>
</tr>
<tr>
<td>FY 1985-86</td>
<td>264</td>
<td>108</td>
<td>95</td>
</tr>
<tr>
<td>FY 1986-87</td>
<td>420</td>
<td>172</td>
<td>151</td>
</tr>
<tr>
<td>FY 1987-88</td>
<td>600</td>
<td>246</td>
<td>216</td>
</tr>
<tr>
<td>FY 1988-89</td>
<td>840</td>
<td>344</td>
<td>302</td>
</tr>
<tr>
<td>FY 1989-90</td>
<td>1,140</td>
<td>467</td>
<td>410</td>
</tr>
<tr>
<td>FY 1990-91</td>
<td>1,488</td>
<td>610</td>
<td>535</td>
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<tr>
<td>Medi-Cal Reimbursements*</td>
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</tr>
<tr>
<td>FY 1985-86</td>
<td>$ 10.6</td>
<td>$ 3.2</td>
<td>$ 5.1</td>
</tr>
<tr>
<td>FY 1986-87</td>
<td>18.6</td>
<td>5.6</td>
<td>9.0</td>
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<tr>
<td>FY 1987-88</td>
<td>29.1</td>
<td>8.8</td>
<td>14.1</td>
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<tr>
<td>FY 1988-89</td>
<td>44.9</td>
<td>13.5</td>
<td>21.8</td>
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<tr>
<td>FY 1989-90</td>
<td>67.0</td>
<td>20.2</td>
<td>32.4</td>
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<tr>
<td>FY 1990-91</td>
<td>96.3</td>
<td>29.0</td>
<td>46.7</td>
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<tr>
<td>Total Reimbursements</td>
<td>$ 266.5</td>
<td>$ 80.3</td>
<td>$ 129.2</td>
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<tr>
<td>Savings with Home Health Care*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY 1986-87</td>
<td>$ 3.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY 1987-88</td>
<td></td>
<td>5.2</td>
<td>1.1</td>
</tr>
<tr>
<td>FY 1988-89</td>
<td></td>
<td>8.0</td>
<td>1.6</td>
</tr>
<tr>
<td>FY 1989-90</td>
<td></td>
<td>11.9</td>
<td>2.4</td>
</tr>
<tr>
<td>FY 1990-91</td>
<td></td>
<td>17.1</td>
<td>3.5</td>
</tr>
<tr>
<td>Total Savings</td>
<td>$ 54.8</td>
<td>$ 45.5</td>
<td>$ 9.3</td>
</tr>
</tbody>
</table>

*in millions of dollars
### Table 10

**AIDS Education Occupational Target Groups**

**Health Care Workers**
- Physicians
- Nurses
- Dentists
- Paramedics and emergency medical technicians
- Physical therapists
- Dental hygienists
- Laboratory technicians
- Acupuncturists
- Hospital administrators

**Public Safety**
- Peace officers
- Security guards
- Correctional officers
- Firefighters
- Morticians and embalmers

**Housekeeping and janitorial personnel**

**Teachers and school administrators**

**Drug Abuse Treatment Program Personnel**

**Personal Services Industries**
- Restaurant and food services
- Employee assistance programs
- Travel services and airlines

**Real Estate**

**Mental Health Counselors/Social Service Counselors**
definitions of primary prevention

1. Primary prevention is defined as: constructive processes designed to promote personal and social growth of the individual toward full human potential and thereby inhibit or reduce physical, mental, emotional or social impairment which results from AIDS.

2. An aggregate of community education and social action programs which within an identified length of time and for specified groups of people are able to measureably reduce the likelihood, frequency, seriousness, or duration of problems related to AIDS. These are programs other than treatment or service systems related to treatment (secondary prevention systems).

3. Primary prevention of social behavioral problems is accomplished through ongoing processes that provide opportunities for individuals, small groups and organizations to increase: 1) knowledge or awareness of personal and collective potentials; 2) skills necessary to attain those potentials; and 3) creative use of resources to the end that all people have the ability to effectively cope with AIDS-related Problems (life problems) and recognize, reduce or eliminate unnecessary or debilitating stress in their group or community without exposing themselves or others and hopefully prior to the onset of further incapacitating individual, group problems.