

## DEPARTMENT OF HEALTH SERVICES

714/744 P STREET  
P.O. BOX 942732  
SACRAMENTO, CA 94234-7320



March 8, 1989

Dear CALC Subcommittee Co-Chairs:

The HIV prevention and treatment plan will be presented to the CALC on March 15 in Los Angeles. As co-chairs from each of the subcommittees you are invited to attend to help in the review process of the plan. Please let me know as soon as possible if you will be coming. As noted in Thelma Frazier's enclosed letter, it is requested that you do not reproduce, distribute, or share the enclosed document with others until after the March 15, 1989 meeting.

If you need travel arrangements please contact Linda McCord at (916) 323-7410.

Lura Franzella  
Executive Officer  
California AIDS Leadership Committee

Enclosure

- ① make attempt to predict  
# of HIV infx  
+ # of ARC, etc - we can help  
data
- ② Blood bank - window period  
HIV-2
- ③ p 19 - breast milk
- ④ p 24 - need to mention crack/syphilis
- ⑤ p 27 Rec 323 - need to be more aggressive  
offering dx to p
- ⑥ p 43 - also use WHO recs
- ⑦ Rec 61 reimbursement  
p 47
- ⑧ 63 p 48 - need to  
mention Medial

## DEPARTMENT OF HEALTH SERVICES

714/744 P STREET  
P.O. BOX 942732  
SACRAMENTO, CA 94234-7320

Office of AIDS  
(916) 323-7415



March 8, 1989

Dear California AIDS Leadership Committee (CALC) Members and Subcommittee Co-Chairs:

Enclosed is a preliminary draft copy of California's comprehensive HIV prevention and treatment plan. It represents a consolidation by the Executive Committee of the approximately 250 recommendations received from subcommittees and others.


This draft will be discussed at the California AIDS Leadership meeting on March 15, 1989 in Los Angeles. As you review it please be alert for pertinent issues and recommendations that may have been left out; unnecessary recommendations; and those recommendations which you feel are not adequate to address the problem. We probably will not have sufficient time at the meeting to address specific wording or grammar changes. If you have comments of this nature, please provide your recommended changes in writing prior to or at the meeting. To mail comments, send them to:

Department of Health Services  
Office of AIDS  
P.O. Box 942732  
Sacramento, CA 94234-7320

Attention: April Roeseler

It is requested that you do not reproduce, distribute, or share the enclosed document with others until after the March 15, 1989 meeting.

Sincerely,

  
Thelma Frazier, Chief  
Office of AIDS

Enclosure

cc: Kenneth W. Kizer, M.D., M.P.H.  
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April Roeseler/OA

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State of California  
Three-Year Comprehensive  
HIV Disease  
Prevention and Treatment Plan

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## EXECUTIVE SUMMARY

This report has been developed pursuant to FY 1988-89 budget control language which required the California Department of Health Services (CDHS) to develop a comprehensive HIV disease prevention and treatment plan. To assist the Department in this endeavor, the California AIDS Leadership Committee (CALC), other state agencies, community groups, and professional organizations were invited to take a critical look at California's HIV disease program and to make recommendations to the direction the public and private sectors should embark upon during the course of the next three years.

Over 100 recommendations are presented in the plan for areas of new or expanded activity. While it is clearly desirable for these recommendations to be implemented as soon as possible, it will take time for the public and private sectors to act upon all of the recommendations made. To provide guidance to those in leadership and policy making positions, the following issue areas are offered in order of priority:

1. Implement coordinated state-local HIV disease planning throughout California.

RECOMMENDATION 1A: The Office of AIDS (OA) should continue to serve as the center of expertise and the main resource for local and state authorities implementing HIV disease prevention and treatment programs.

2. Develop a comprehensive statewide system of ambulatory, community-based health care for persons with HIV infection, expanding existing models and programs where needed and focusing on elevating the role of primary care physicians within managed care systems.

RECOMMENDATION 54A: Adequate counseling services for persons with HIV disease, families, and significant others should be available in hospital and outpatient settings. Services provided should ensure that the unique needs of minority persons are met.

RECOMMENDATION 54B: California Department of Mental Health (CDMH) should conduct a statewide needs assessment and make recommendations regarding the need for additional emotional support services, the threshold level at which it is feasible to institute emotional support services, recommend standards for the provision of emotional support services and methods to improve coordination and linkages between emotional support and other support services.

RECOMMENDATION 58B: The state should continue to take advantage of Medicaid waivers; assess and support cost-effective methods of outpatient care such as case management, and RAS; develop and support foster care for HIV infected children; subsidize day care for infected children and adults; and promote innovative programs such as the Health Insurance Premium Payment Program.

3. Assure the financing of health care for HIV infected persons through a combination of public and private means that distributes the burden equitably among payers and that encourages cost-effective and compassionate delivery of services.

RECOMMENDATION 58A: The Directors of the California Department of Insurance and CDHS should convene a working group with the insurance industry to develop and implement a solution that will provide adequate health insurance coverage for persons with HIV infection. Until this issue is resolved, HIV testing for the purpose of determine eligibility for health insurance should be prohibited.

RECOMMENDATION 60: California should adopt its own "mini-COBRA" to require employers with fewer than 20 employees to provide continuation coverage on the same terms as COBRA.

4. Continue to emphasize prevention of HIV infection through education, taking particular advantage of the worksite. Specific activities in this regard should include continuing a general public education program about HIV disease and expanding programs directed at current and projected high-risk persons, including teenagers, intravenous drug users, closed and "fast lane" gay and bisexual men, minorities, homeless youth, high risk heterosexuals, persons having other sexually transmitted diseases, correctional facility inmates, and public safety and emergency response personnel. Every incarcerated person should receive HIV disease prevention education and have the opportunity to be tested for HIV infection. Similarly, all schools should have an age-appropriate HIV disease prevention program beginning no later than the fifth grade.

RECOMMENDATION 3: CDHS should adopt, as practice, the CALC statement on, "Explicitness of AIDS Prevention Material," July 1987.

RECOMMENDATION 4: CDHS should give funding priority to education and prevention projects that target homosexual/bisexual men especially closeted populations; IVDUs especially those not in treatment; sexual partners of IV drug users and bisexual men; persons working in sex industries; incarcerated populations; adolescents especially homeless adolescents; the adult homeless population; at risk women of childbearing age; minority populations; and hemophiliacs, and transfusion recipients.

RECOMMENDATION 5A: The State of California should mandate all public schools to provide age appropriate HIV disease education beginning no later than the fifth grade unless the parent or guardian requests that the pupil not attend this instruction. It should encourage private and parochial schools to adopt a similar policy.

RECOMMENDATION 8: Age appropriate HIV prevention education should be provided to detained youth in detention centers, juvenile halls, youth shelters, residential care settings, and group homes in languages which youth use in daily parlance.

RECOMMENDATION 9: The state should continue to support education, for persons at no or minimal risk of HIV infection, through the California AIDS Education Campaign, secular and religious institutions, educational institutions, and worksites to reduce misconceptions and fears about HIV transmission.

RECOMMENDATION 48A: HIV disease prevention education should be mandatory for all levels of public safety workers including law enforcement, fire service, ambulance, custodial staff (jail, prison, juvenile hall, and probation) and other appropriate public safety workers.

5. Anti-discrimination legislation should be enacted so as to remove fears, real or perceived, that prevent persons from seeking HIV testing and education or treatment.

RECOMMENDATION 15: Legislation designed to prevent discrimination on the basis of HIV infection or AIDS in both the public and private sectors should be enacted.

6. Insofar as the long term prognosis of HIV disease in California depends on the course of intravenous drug use-related transmission of the virus, comprehensive and aggressive steps should be taken to stop transmission of HIV related to drug use.

RECOMMENDATION 27B: Voluntary partner notification of sex and needle sharing partners should be implemented and evaluated among IVDUs.

RECOMMENDATION 28A: Methadone treatment should be available to anyone who needs it. Increase availability of treatment by: 1) lowering the threshold of entry into programs to increase the absolute number of drug abusers receiving methadone treatment and 2) consider nontraditional modifications of treatment to expand the treatment system's capacity, e.g., brief maintenance or extended detoxification, prescription methadone for selected patients, and outreach to encourage drug users to get into treatment.

RECOMMENDATION 29B: AIDS educators should emphasize sexual transmission and prevention of HIV as well as the disinhibiting effects of substance use and its relationship to unsafe sex when working with substance using target populations.

RECOMMENDATION 30: Alcohol treatment programs should be targeted and encouraged to implement HIV disease prevention activities into their treatment protocols.

7. Continue and expand, where needed, HIV testing programs, both anonymous and confidential, coupled with appropriate education and having state oversight for quality assurance purposes.

RECOMMENDATION 13: All patients who present to sexually transmitted disease (STD) clinics, drug treatment facilities, hemophilia treatment centers, prenatal and family planning clinics, primary care clinics, emergency rooms, mental health facilities, physician offices, and jail or prison facilities should routinely be provided information about HIV transmission and prevention, assessed for risk of HIV infection, and offered counseling and testing if they are at risk.

RECOMMENDATION 16A: Establish testing standards including consistent interpretive and reporting guidelines for use with confirmatory tests.

RECOMMENDATION 20: Blood bank and plasma center procedures related to HIV disease should be updated by: 1) eliminating the 60 day waiting period before notifying blood donors of HIV antibody positive test results; 2) referring specimens with indeterminate test results to public health departments or their private physician for further laboratory evaluation; and 3) notification and referral of screened positives by plasma centers for confirmation and counseling after a single donation.

RECOMMENDATION 21: Availability of HIV testing should be made more readily available to minority populations in conjunction with culturally appropriate counselling, education, and culturally appropriate language.

RECOMMENDATION 50: Incarcerated individuals should be encouraged to partake of voluntary informed HIV antibody testing which include pre- and post-test counseling.

8. **Develop a comprehensive network of community-based and culturally sensitive HIV disease prevention programs among ethnic minority communities.**

RECOMMENDATION 42: The public and private sectors should assist racial/ethnic minorities to take the lead in planning the development, implementation, and evaluation of preventive education, HIV testing, delivery of care, and research activities which are necessary to the formation of a comprehensive network of community based and culturally sensitive HIV disease programs in racial/ethnic minority communities.

RECOMMENDATION 44: Cross-cultural training should be integrated into programs for health care workers, HIV test counselors, and others providing AIDS related services.

RECOMMENDATION 47: Civil Surgeons and others performing HIV antibody testing as part of the INS amnesty application should follow California standards for confirming screened positives and handling of indeterminate test results and inform applicants of their appeal rights.

9. **Implement a comprehensive program to prevent further neonatal HIV infection and to address the needs of HIV infected infants and children.**

RECOMMENDATION 32C: Reproductive counseling should be provided to all HIV infected pregnant women as part of their prenatal care.

RECOMMENDATION 33A: HIV antibody positive women should not breast feed their infants and women in high risk groups who wish to breast feed their infants should be educated about the possible risk of HIV transmission through breast feeding and tested in the postnatal period.

RECOMMENDATION 39A: California Department of Social Services (CDSS) should ensure that a coordinated effort is pursued between county, state, federal, and private agencies to educate and train foster and adoptive families willing to take care of HIV infected children.

RECOMMENDATION 39B: CDSS should provide foster and adoptive parents of children with HIV infection special incentives such as access to day care and respite care. Additionally, the foster care stipend should be increased for parents caring for HIV infected children.

RECOMMENDATION 39C: The development of living arrangements other than foster or adoptive care for children with HIV disease should be pursued.

10. Continue and expand the state's capacity for endeavors in HIV related research, including epidemiologic investigation, vaccine development, basic and applied clinical work, and health care services delivery and financing.

RECOMMENDATION 12: A sample of OA Education and Prevention programs should be rigorously evaluated over the next two years and results should be disseminated to all OA contractors and the California AIDS Clearinghouse.

RECOMMENDATION 24: The state should assess the current epidemiologic knowledge of HIV among IVDUs in California and identify areas where data are incomplete. Once an assessment has been completed, the state should allocate adequate resources to determine incidence and prevalence of HIV infection among drug abusing populations in representative areas of the state. Qualified researchers from indigenous racial/ethnic minority communities should be involved in the design and implementation of these studies.

RECOMMENDATION 31A: Examine existing Paraphernalia Exchange (PE) programs in the United States and Europe closely for effectiveness, acceptance, etc.

RECOMMENDATION 31B: The OA should establish pilot PE programs in California, funded as research projects, which will be answerable to an oversight committee composed of knowledgeable experts.

RECOMMENDATION 49B: A longitudinal follow-up study in selected sites to determine the risk of HIV transmission in various confinement settings should be conducted.

RECOMMENDATION 56B: California Department of Mental Health should conduct non-linked HIV testing in state hospitals to determine the extent of HIV disease.

RECOMMENDATION 62A: Study older adult services modes such as day care for their applicability to persons with HIV disease and make recommendations for implementation of services using this model as warranted.

RECOMMENDATION 62A: Study older adult services modes such as day care for their applicability to persons with HIV disease and make recommendations for implementation of services using this model as warranted.

RECOMMENDATION 62B: Examine the need to license hospice programs, hospice facilities, and residential facilities in order to promote optimal care and flexible reimbursement policies.

RECOMMENDATION 64: The Office of Statewide Health Planning and Development and CDHS should study whether the HIV epidemic will require more acute and non-acute care hospital beds during the next ten years.

To ensure that the recommendations in this document are acted upon and the dynamic nature of this epidemic taken into consideration, the CHDS with they assistance of the CALC will review the progress made upon implementation of the recommendation and the need to modify them on an annual basis.

DRAFT

## INTRODUCTION

## HIV DISEASE EPIDEMIOLOGY IN CALIFORNIA

In March 1983, California became one of the first states in the nation to make AIDS a reportable condition. Since then, California has consistently accounted for about one-fifth of all cases of AIDS reported in the United States. As of December 31, 1988, a cumulative total of 17,164 AIDS cases and 10,068 (59%) AIDS deaths have been reported to the California Department of Health Services (CDHS). It is expected that AIDS will become the seventh leading cause of death in California by 1990.<sup>1</sup>

Seventy percent of AIDS cases in California have been reported from Los Angeles (39%) and San Francisco (31%) counties, with San Diego (7%), Alameda (5%), and Orange (4%) counties also reporting a high incidence of cases. As in many other states, AIDS cases are now being reported from previously unaffected areas. As of December 31, 1988, 53 of California's 58 counties have reported one or more AIDS cases, increasing from 40 counties reporting cases at the end of 1986.

The distribution of reported AIDS cases in California, has remained essentially stable for the past 6 years, with approximately 90% of cases occurring in homosexual or bisexual men, 4% of cases in intravenous drug users, 2% in recipients of blood or blood products, 1% among hemophiliacs, and 1% in heterosexual contacts of individuals at increased risk. No risk factor has been identified in about 2% of cases, however many of these persons died before definitive risk information could be obtained.

While 4% of AIDS cases in California have been attributed to intravenous drug use (IVDU), this risk group accounts for 19% of cases nationwide. Although the number of AIDS cases among intravenous drug users (IVDUs) in California is low in comparison to the nation, since 1987, AIDS among IVDUs has been increasing at a higher rate than for any other risk group.

Heterosexual transmission is another area in which California differs from the nation. Approximately 1% of AIDS cases in California are due to heterosexual transmission, whereas this mode accounts for about 4% of cases nationally.

Ninety-seven percent of AIDS cases in California have been among men, with the majority (90%) being among homosexual or bisexual men. The mode of transmission of human immunodeficiency virus (HIV) among women is fairly equally divided; about one-third acquired HIV infection through IVDU, one-third through heterosexual contact, and about one-third through transfusion with blood or blood products. Nationally, 91% of AIDS cases have been among men.

Among pediatric AIDS cases transfusion with blood or blood products accounts for 42% AIDS cases in California, while 47% of cases are attributed to perinatal transmission. In comparison, nationally, over three quarters of pediatric AIDS cases are due to perinatal transmission. It is expected that California's statistics will become more like national statistics in this area over the next several years as AIDS cases increase among women

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of child bearing age and since screening of blood and other related measures were implemented in 1985 and has essentially decreased this mode of transmission.

In California, AIDS is a disease which has predominately affected young and middle-aged adults. Persons aged 20 to 49 account for 87% of AIDS cases, with 45% of cases being reported among those age 30 to 39. In contrast, only 1 percent of AIDS cases have been reported in children under 13 years of age. Nationally, 2 percent of cases have been in children under age 13, and 88% among those 20 to 49 years of age.

Whites account for approximately 59% of California's population, yet 76% of all AIDS cases in California, to date, have been among this group. However, there is evidence that HIV disease is a rapidly growing problem among California's ethnic/racial minorities. In the past year, the incidence of AIDS rose 77% among blacks, 53% among Hispanics, and 18% among Asian/Pacific Islanders.

### HIV Seroprevalence in California

AIDS case data is obviously a historical reflection of viral transmission and infection two to five years earlier, thus the CDHS conducts seroprevalence studies and monitors seroprevalence data collected by others in order to track the changing course of this disease.

In mid-1987, blood specimens and behavioral risk information were collected from 4,683 volunteers attending primary care clinics, drug treatment programs, and jails to assess HIV seroprevalence in populations other than Los Angeles and San Francisco. Of the 2.3% (108) persons found to be seropositive, all but 12 were homosexual or bisexual males, or IVDUs. Eleven of the remaining 12 seropositives reported sex with a high risk person or had a history of multiple sexual partners. Only one seropositive person denied any known risk for HIV infection.

This study found HIV seropositivity among gay and bisexual males to be 20.4%. Male IVDUs had a seroprevalence of 2.5% and female IVDUs had a seroprevalence of 1.6%. Among non-IV drug using heterosexual males, the seropositivity rate was 0.6% and among non-IV drug using females the rate was 0.3%.

### HIV Antibody Seroprevalence in California Blood and Plasma Donors

Except for specifically exempted donations such as autologous donations, California blood banks and plasma centers are required to test all blood and blood products for HIV antibodies and to discard those units which are repeatedly reactive on enzyme-linked immunosorbent assay (EIA) testing. Additional confirmatory testing with immunoblot or immunofluorescence assay (IFA) is not required by law but is recommended by CDHS.

During the third quarter of 1988, 507,259 units of blood or blood products were tested for the HIV antibody. Of these, 0.09% were reactive in initial and repeat testing. This rate reflects a decline from 1 year ago when the repeat HIV seropositivity rate was 0.15%. Of those facilities performing confirmatory testing on repeat EIA reactive tests, the positivity rate was 0.013%. This reflects a decline from 0.021% in 1987.

Comparison of HIV seropositivity by region indicates that the highest risk for confirmed positive blood or blood products has shifted from San Francisco County to Los Angeles, Orange, and San Diego counties. Data from the third quarter continue to indicate that blood and blood products donated by men are more likely to be confirmed HIV antibody positive than blood donated by women.

#### Alternative Test Site Seroprevalence Data

Anonymous HIV antibody testing through Alternative Test Sites (ATS) began in May 1985. Although the anonymity of those tested for antibody status is protected by law, non-identifying data are collected on a voluntary basis. Individuals attending ATS are a self-selected group and represent those who consider themselves to be at risk and choose to be tested on an anonymous basis.

Of the 286,351 individuals tested between June 1985 through December 1988, 24,151 tested HIV antibody positive for an overall seropositivity rate of 8.48%. The approximate seropositivity rates for risk groups were as follows: homosexual men 27%, bisexual men 13%, male IVDUs 5%, female IVDUs 2.5%, homosexual IVDU 29%, heterosexual male with multiple partners 1.4%, female heterosexual with multiple partners 0.42%, hemophiliacs 22%, recipients of blood or blood products 1.5%, male sex partners of the above high risk groups 2.6%, and female sexual partners of the above high risk groups 1%.

While this data cannot be generalized to the entire population it provides a means to track changing demographics and to determine areas of the state which are most heavily being impacted by HIV disease.

#### AIDS Case Projections for California 1988-1992

Predicting the future course of the HIV epidemic is critical to planning health care needs in California. Presented here are estimates of annual AIDS case incidence and prevalence for Los Angeles, San Francisco, the areas surrounded by Los Angeles, San Francisco, and the entire state through 1992. Projection curves were developed for the least severe scenario and the most severe scenario. Best estimates reflect those values lying midway between the least severe and worst scenarios.

Figure 1 depicts the best estimate of the projected annual incidence of AIDS in California through 1992 by region. It is estimated that both Los Angeles and San Francisco counties will reach their highest levels of annual incidence during calendar year 1990. Annual incidence in the Bay Area, outside of San Francisco, continues to increase throughout the projection period, reaching a probable maximum by the end of 1992. The projections of annual incidence for the remaining 2 regions show very little evidence of deceleration through 1992.

#### TABLE I

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Tables I and II present projected incidence and cumulative AIDS cases through 1992 for the 5 regions and the state as a whole. AIDS incidence is projected to increase in California each year through 1992. Projected cumulative cases for California are displayed in Figure 2. It is estimated that there will be a total of nearly 57,000 cases diagnosed in California by that time.

TABLES I & II

The projections of incidence described above provide the number of new cases expected to be diagnosed during a given time interval. The number of cases alive during a given time interval (prevalence) is another aspect of the epidemic that needs to be estimated since these are the cases still requiring health care, education, and counseling.

Survival curves were estimated for 12 groups with cases assigned according to their diagnostic category and region of residence at time of diagnosis (San Francisco, Los Angeles, or the rest of the state). The 4 diagnosed disease categories were: Kaposi sarcoma (KS) Group, Just Pneumocystis carinii pneumonia (PCP), PCP+ opportunistic infections (OI), and Just OI. Estimates of the cumulative 1 year survival rates for the 12 groups are presented in Table III. The KS group had the most favorable rate within each region and those diagnosed with Just OI had the least favorable survival.

TABLE III

The variation in survival curves by diagnostic category is illustrated in Figure 3 for Los Angeles. These curves show the cumulative probability of surviving past a given month as a function of month since diagnosis. Los Angeles cases diagnosed with an OI did not survive as long, with the OI & PCP group having the least favorable survival from 2 years on. Figure 4 displays differences in survival among the three regions for the KS group. KS group cases reported in San Francisco had the most favorable survival through 4 years.

FIGURES 3 and 4

Annual prevalence and mortality projections by region are presented in Table IV. Statewide, it is projected that 14,267 AIDS cases will be alive at some time during 1989. It is also projected that there will be 4,482 AIDS deaths during 1989. Annual prevalence is projected to increase in each of the 5 regions of the state, with the largest increases occurring outside of San Francisco and Los Angeles (Figure 5). By 1992 annual prevalence in the rural, San Francisco Bay Area (excluding San Francisco), and southern urban regions combined is projected to exceed that of San Francisco and Los Angeles.

TABLE IV

An analyses of the data reported here suggest that the future burden of AIDS in California may shift away from the initial epicenters of Los Angeles and San Francisco toward other portions of the state. The estimates developed are broadly consistent with other short-term projections, both statewide and for San Francisco and Los Angeles counties. Whether and to what degree incidence in these two counties actually begins to decline over the next few years remains to be seen. As for the remaining areas of the state where accelerating incidence is predicted, it should be recognized that the epidemic is "younger" in these areas, providing a weaker basis for projections.

The estimates presented in this report are influenced by a number of assumptions that are more fully discussed in the January/February 1989 issue of The California AIDS Update.<sup>2</sup>

#### Knowledge, Attitudes, and Beliefs Related to HIV Disease

Another area of assessment which is critical to planning and evaluation of California's HIV Disease prevention strategy is assessment of knowledge, attitudes, and behaviors (KAB) among Californians. CDHS conducted a household telephone survey to assess KAB related to AIDS among approximately 2,000 adult Californians during the fall of 1987.

Survey results were analyzed according to three groups of risk behaviors: multiple/high-risk partner heterosexuals, recreational drug users, and multiple/high-risk partner heterosexuals who are also recreational drug users. In-depth analysis of data regarding homosexual or bisexual behavior was not possible because the number of respondents admitting to this type of behavior was too small. While surveyors were better able to capture data regarding drug use, data regarding IVUDs could not be analyzed separately because the small sample size was inadequate. The inability to capture data regarding homosexual/bisexual behavior and IVUD is indicative of the highly sensitive nature of survey questions.

Multiple/high-risk partner heterosexuals were defined as men or women reporting 2 or more sexual partners of the opposite gender in the 12 months prior to the interview or one or more partners falling into high-risk groups since 1977. High risk groups were men who have had sex with other men, IVUDs, or someone with AIDS or who is antibody positive. Recreational drug users were defined as persons engaging in the non-medical use of prescription drugs, or non-indicated use of over-the-counter drugs, or use of drugs which are illegal.

Overall, the survey found that younger adults, males, students, and employed individuals were more likely to fall into one or more of the three risk groups analyzed. This survey did not find that racial/ethnic minorities were more likely to fall into any of the three risk groups analyzed.

Regarding levels of AIDS knowledge, this survey found that Californians are fairly knowledgeable about those methods which transmit HIV and risk reduction measures; however, misinformation about non-routes of transmission such as blood donation, food

handling, and sharing of toothbrushes and razors exists. Respondents indicated that they were most likely to obtain information about AIDS from television, newspapers, and magazines respectively.

In response to inquiries about behaviors, this survey indicated that 16% of men and 7% of women qualified as multiple high risk partner heterosexuals. Of all women responders, 1.2% reported having a gay or bisexual partner since 1977 and 2% reported IV drug using male partner since 1977. Among women who qualified as high risk, 19% had an IV drug using partner since 1977. Of all male responders, 2.5% identified themselves as gay or bisexual or reported having had sex with another man. Eleven percent of survey responders reported use of recreational drugs and 1.7% stated they had used IV drugs at some point in their lives. Five percent of recreational drug users were also multiple high risk heterosexuals.

Data from this survey indicate that the majority of Californians did not believe themselves to be at high risk of getting AIDS and few had altered their lifestyles or behavior in response to the HIV epidemic. Of those who had altered their lifestyle, the least restrictive measures and thus the least helpful measures were mostly implemented; 37% stated they had reduced the number of sexual partners; 26% were using greater caution in partner selection; and 19% reported using condoms or other safer sex techniques. At risk respondents were more likely to have used condoms with primary partners at least some of the time. Of coupled respondents, 95% reported being in a monogamous relationship.

A more thorough analysis of the data and recommendations for future research is presented in Planning for the AIDS Epidemic in California: A Population Based Assessment of Knowledge, Attitudes, and Behaviors.<sup>3</sup>

## SECTION I

FEDERAL/STATE/LOCAL LEVELS  
ROLES, RESPONSIBILITIES, AND COORDINATION

## Introduction

At the federal level, AIDS information and research is coordinated by the United States Public Health Service. Specific activities are conducted by the Centers for Disease Control (CDC), the National Institutes for Health (NIH), and the Food and Drug Administration (FDA).

CDC has primary responsibility for the public health aspects of HIV disease. They are involved in tracking the spread of AIDS and HIV disease as well as providing laboratory research, and developing guidelines and strategies to prevent further spread of HIV. CDC provides funding both to the CDHS and directly to San Francisco and Los Angeles counties.

Basic research regarding the nature of HIV and its effect on the body is carried out by the NIH. Additionally, this agency has been involved in vaccine development. The FDA regulates the safety of blood and blood products, approves tests used to detect the presence of infection with HIV, and medications used to combat infection with HIV.

In California, HIV disease control activities are coordinated by CDHS. The Office of AIDS (OA) is the primary unit involved in directing prevention, HIV antibody testing, surveillance, research, and case management programs.

The primary responsibility of CDHS, in consultation with the California AIDS Leadership Committee (CALC) and others, is to help establish general state policy, overall state goals, and program guidelines for the prevention and treatment of HIV disease. Further, the role of CDHS is to guide, consult with, and support local health jurisdictions to ensure that the most advanced and effective HIV disease prevention and treatment programs are functioning throughout California.

OA has responsibility for implementing, operating, and monitoring various statewide programs and activities. Such activities include the California AIDS Reporting System (ARS), the Alternative Test Site (ATS) program, Confidential Testing program, HIV counselor training program, Azidothymidine (AZT) program, blood bank surveillance, conducting HIV disease related studies, education and training programs, case management projects, Residential AIDS Shelters (RAS), Medi-Cal AIDS Waiver, AIDS Prevention Follow-up Centers (APFC), and allocation of state and federal funding. Funding is allocated through a variety of means including a competitive contracting system, block grants to local health jurisdictions for epidemiologic surveillance and planning purposes, and categorical subvention funding to the local level. This latter mechanism encourages collaboration between agencies at the local level by disbursing funding to the local public health department which in turns disburses funding to community agencies to perform specific activities related to prevention education, HIV testing, and epidemiologic surveillance.

The role and responsibilities of local public health agencies include collecting and interpreting local AIDS and HIV disease prevalence data; working with the community to plan and implement programs to prevent the spread of HIV as well as care for those who are infected; provide for the availability of treatment services for those who cannot pay or lack access to the health care system; and evaluate the effectiveness of their efforts.

#### Recommendations

1. PROBLEM STATEMENT: Coordination between private foundations and federal, state, and local governments is inadequate.

ANALYSIS: Funding and implementation of HIV disease related activities is occurring through a number of public and private agencies. Many of these areas overlap. For example, both the federal and state government directly fund prevention education, health care worker training, and testing programs at the local level. In many communities, local governments have directed county or city resources toward HIV related activities while private foundations are also directing funding towards assessment, education, and care related activities. Between state agencies there is some overlap too, especially in the areas of IVDU related activities and education directed at incarcerated populations.

RECOMMENDATION 1A: The OA should continue to serve as the center of expertise and the main resource for local and state authorities implementing HIV disease prevention and treatment programs.

RECOMMENDATION 1B: The OA should be aware of all federal, state, local, and private sector funding sources and distribute that information to those who need it.

2. PROBLEM STATEMENT: Many local health jurisdictions have not planned for community needs related to: epidemiologic surveillance, preventive education, provision of medical treatment and support services, research, coordination of programs, evaluation, and continuous planning.

ANALYSIS: Local health jurisdictions face many challenges in addressing the needs of their community as they relate to HIV disease. Although there are no current statutory requirements for state review and approval of local HIV disease response plans, it is believed that the best allocation of and the most effective use of state AIDS funds can be made by ensuring that each local jurisdiction has a locally appropriate HIV disease prevention and treatment plan. These plans should address regional problems when necessary. To encourage local planning efforts, CDHS allows local health jurisdictions to direct block grant funding toward community health planning and support of AIDS advisory boards. Additionally, a framework for local planning was distributed by CDHS in June 1988. <sup>4</sup> This document provides guidelines for the development of HIV disease prevention and treatment plans.

RECOMMENDATION 2: CDHS should make disbursement of county block grant funds dependent upon submission of HIV disease prevention and treatment plans to

*Linda*

*We should make sure our new plan  
can double for this, too.*

the OA. When it is appropriate to do so, these plans should reflect regional issues.

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## SECTION II

### EDUCATION AND PREVENTION

#### Introduction

California's strategy to prevent the spread of HIV disease includes prevention and education programs targeted at knowledge, attitudes, and behavior change; skill development; HIV antibody testing and counseling programs; partner notification; and APFC. CDHS funds approximately 158 contractors statewide to implement community prevention education programs. These programs are supported by English and Spanish speaking hotlines, an educational materials clearinghouse, a media campaign, and a multicultural resource center.

HIV antibody testing and counseling services are available through anonymous and confidential testing sites. Currently 34 local health jurisdictions operate ATS while confidential testing is available through public health departments, family planning clinics, and rural and community health clinics.

The CDHS advocates voluntary partner notification of sex and needle/syringe sharing partners of persons infected with HIV. In 1988, guidelines were published and distributed to public health authorities at the local level to assist them with their efforts related to partner notification.<sup>5</sup>

The APFC program is a relatively new component in California's prevention strategy. The goals of the program are to prevent HIV transmission by individuals who know they are seropositive, to detect early signs of clinical disease, and to prevent the onset of opportunistic infections or immunosuppression for as long as possible. Program goals are implemented through eight centers in the state.

#### Recommendations

##### The Educational Message

3. PROBLEM STATEMENT: AIDS educators need to be allowed to develop educational materials which are appropriate for their communities.

ANALYSIS: In order to be effective in communicating their message, AIDS educators need the flexibility to develop educational materials which are understandable and relevant to the target populations with which they work. However, those who develop educational materials should be sensitive to the opinions of others and, while trying to improve their products, they should also try to minimize any unnecessarily explicit depictions of sexual or drug using practices, which will not put into jeopardy the essential messages to be transmitted.

RECOMMENDATION 3: CDHS should adopt, as practice, the CALC statement on, "Explicitness of AIDS Prevention Material," July 1987. That statement advised the following:

- 1) Candor, frankness, and explicit representations are essential if communication of AIDS prevention messages are to be effective.
- 2) It must be assumed, because of the nature of AIDS virus transmission, that some AIDS education/prevention materials will offend some people.
- 3) It is the opinion of CALC that the social and economic benefits of the prevention of HIV transmission clearly outweigh the offensiveness to some people of explicit AIDS prevention materials. Local education and prevention contractors should be responsible for weighing the benefits against the drawbacks of using explicit materials.

#### Priority Target Populations

4. PROBLEM STATEMENT: HIV prevention and education needs to target those individuals whose behavior places them or their unborn offspring at risk of HIV infection and those at increased risk due to earlier medical treatments such as blood transfusions.

ANALYSIS: To prevent the continuation of the HIV epidemic, intensive efforts must be made to identify and target those individuals at highest risk. Priority populations targeted in the past have been homosexual/bisexual men, IVDUs, high risk heterosexuals, hemophiliacs, transfusion recipients, and racial/ethnic minority populations. In addition to these groups, additional attention should be focused upon: closeted homosexual and bisexual men, especially those in rural areas; out-of-treatment IV drug users; sexual partners of IVDUs and bisexual men; at risk women of childbearing age; persons working in sex industries; incarcerated populations; adolescents; homeless adolescents and adults. These groups are frequently difficult to identify and reach. AIDS educators need to engage in careful analysis of their communities to locate those to be educated, identify their educational needs, and examine the norms and values of the community which may sanction unsafe sex and drug using behavior.

RECOMMENDATION 4: CDHS should give funding priority to education and prevention projects that target homosexual/bisexual men especially closeted populations; IVDUs especially those not in treatment; sexual partners of IV drug users and bisexual men; persons working in sex industries; incarcerated populations; adolescents especially homeless adolescents; the adult homeless population; at risk women of childbearing age; minority populations; and hemophiliacs, and transfusion recipients.

5. PROBLEM STATEMENT: Many California schools have not adopted HIV disease educational curricula.

ANALYSIS: Schools, as the prime educational institutions, have an opportunity and an obligation to provide education about HIV infection and its prevention to students, principals, teachers, school personnel, and parents. Education about HIV

disease in schools is most appropriate when carried out within a more comprehensive health education program that establishes the relationship between personal decision making, self-esteem, behavior, and health. These types of skill learning opportunities must be combined with basic health information. While health instruction is mandated in California, specific time for instruction, standardized testing, and specific health courses are not required.

RECOMMENDATION 5A: The State of California should mandate all public schools to provide age appropriate HIV disease education beginning no later than the fifth grade unless the parent or guardian requests that the pupil not attend this instruction. It should encourage private and parochial schools to adopt a similar policy.

RECOMMENDATION 5B: The California Department of Education (CDOE) should add age-appropriate HIV-related items to standardized tests in the California Assessment Program. Additionally, HIV-related health criteria should be added to the Quality Review Process.

6. PROBLEM STATEMENT: There continues to be unjustified fear and confusion regarding the safety of allowing HIV infected children to participate in educational programs.

ANALYSIS: All medical evidence continues to support the notion that HIV infection is not spread by casual contact; there is no evidence that it can be spread by the type of contact that occurs in the schoolroom. Furthermore, it is clear that a significant number of infected children are attending regular school; asymptomatic children who do not know that they are infected and hemophiliacs are but two examples. The CDC has made recommendations that children do best in the regular educational setting. For these reasons, the majority of infected children of school age should attend the regular classroom. There may be a few exceptions by reasons of the children's own immune status or aberrant behavior which may pose a threat to themselves or others.

RECOMMENDATION 6: CDOE should recommend statewide model pupil placement guidelines to assist local districts in their deliberations regarding placement of HIV infected students.

7. PROBLEM STATEMENT: Out-of-school youth and homeless teens are at increased risk for HIV infection because of greater opportunity for sexual and drug using activity.

ANALYSIS: An important group of adolescents to be reached are out-of-school youth and homeless teens. Conventional school based HIV education and behavioral change programs will not reach these groups. To educate and achieve behavioral change in this target group, community based centers must be established and effectively utilized. Peer educators taught and coordinated by neighborhood community centers or public health resources may be the best way to reach out of school teens.

RECOMMENDATION 7: A model peer education program should be developed, piloted, and evaluated, using counties with a known high incidence of HIV infection and homeless teens.

8. PROBLEM STATEMENT: Detained youth are frequently at high risk of HIV infection due to sexual activity and/or substance abuse.

ANALYSIS: There are a significant number of adolescents who are present in detention centers, juvenile halls, youth shelters, residential care settings, and group homes, who by their very residence offer the opportunity to receive vital education and at least some attempt at behavioral change.

RECOMMENDATION 8: Age appropriate HIV prevention education should be provided to detained youth in detention centers, juvenile halls, youth shelters, residential care settings, and group homes in languages which youth use in daily parlance.

9. PROBLEM STATEMENT: Misconceptions regarding HIV transmission via mosquitos, food handling, blood donation, and casual contact persist.

ANALYSIS: Most Californians are at no or minimal risk of HIV infection. The major thrust of the educational message for these people must convey ways that HIV is NOT transmitted. Telephone survey data gathered by both the OA and the National Center for Health Statistics revealed that although people know that HIV is transmitted sexually and through sharing needles, misconceptions still persist regarding blood donation, mosquitos, food handling, and casual contact. Education to reduce these misconceptions is necessary so that undue fears of infection do not lead to public hysteria or calls for unwarranted and ineffectual containment programs. Media affords the advantage that it reaches both at risk and not at risk people who are unlikely to attend presentations.

RECOMMENDATION 9: The state should continue to support education, for persons at no or minimal risk of HIV infection, through the California AIDS Education Campaign, secular and religious institutions, educational institutions, and worksites to reduce misconceptions and fears about HIV transmission.

#### HIV Disease Prevention Education Program Design

10. PROBLEM STATEMENT: Individuals who are knowledgeable about HIV transmission and prevention continue to engage in high risk behaviors.

ANALYSIS: Simply providing information about HIV transmission and prevention methods is not enough to achieve sustained behavior change among persons who engage in high risk activities. Many people who can correctly answer questions about the sexual transmission of HIV and sharing needles, are not modifying their behavior accordingly. AIDS programs need to be multidimensional. They need to address: denial, perceived susceptibility, self-esteem, motivation, self-efficacy,

*at all times*

social support, reinforcement for risk reduction, skill development, and the physical, economical, and psychological barriers that affect the practice of risk reduction measures.

RECOMMENDATION 10: Information programs need to be complimented by interventions which target attitudes, beliefs, and teach skills. They must also seek to change community social norms which sanction unsafe sexual behavior and drug use.

11. PROBLEM STATEMENT: Individuals and agencies providing HIV education need access to education materials and information.

ANALYSIS: CDHS currently funds the California AIDS Clearinghouse (CAC) to maintain a computerized database of AIDS educational materials and AIDS organizations for OA contractors and other health care providers in California. A need for expanded clearinghouse capabilities has been identified by a variety of sources including health care workers, mental health providers, public safety personnel, and employers. The expanded need is for educational materials, curricula, infection control guidelines, personnel policies, and information regarding the availability of training. Only one AIDS education materials clearinghouse should be maintained in the state. First, the administrative costs of establishing and maintaining several specialized clearinghouses would not be cost-effective. Secondly, more than one clearinghouse operating in the state would greatly dilute the clout of each when negotiating discounts for bulk purchase, and thirdly, it would cause confusion to clients as to which clearinghouse to contact if there were more than one available.

RECOMMENDATION 11: Clearinghouse capabilities should be expanded in the state, however, only one AIDS clearinghouse should be funded and maintained by the state.

#### Evaluation of Educational Programs

12. PROBLEM STATEMENT: HIV education and intervention strategies are not being adequately evaluated.

ANALYSIS: Quality assurance and evaluation are critical elements of HIV disease prevention programs. While providing a framework for program improvement and justifying continuing funding support, the primary purpose is to develop effective educational models which can be used by others. To be effective, HIV disease prevention projects must have a means to: determine whether they reached their target audience; assess the quantity and quality of achievement; and determine if the program is resulting in changes in knowledge, attitudes, and behaviors. Those directing HIV disease projects need to review their program and educational strategies on a regular basis to identify the need for change and how to proceed. When possible, projects should attempt to follow a cohort of participants in their program over time to determine the program's effectiveness at achieving sustained changes in knowledge, attitudes, and behavior. Similar evaluation designs have been utilized in smoking cessation and weight loss programs and should be used to

evaluate HIV disease prevention programs.

Additionally, rigorous evaluation research regarding the effectiveness of educational strategies and their generalization to other populations is necessary. The 1988 Urban and Rural Systems Associates (URSA) Institute evaluation noted that educational strategies which appeared effective in urban areas, such as IVDU outreach and the STOP AIDS models, often failed to work in rural communities.

RECOMMENDATION 12: A sample of OA Education and Prevention programs should be rigorously evaluated over the next two years and results should be disseminated to all OA contractors and the CAC.

#### Other Prevention Methodologies

13. PROBLEM STATEMENT: Those at highest risk of becoming infected with HIV and subsequently developing the disease should be targeted for HIV antibody testing and counseling.

ANALYSIS: Counseling and testing are important components to California's AIDS prevention strategy. Individuals who are at risk of HIV infection should have the opportunity to learn if they are infected so that they can receive assistance with behavior modification; be referred to early intervention HIV treatment programs if they are infected; and in the case of women, be counseled so that they can make an informed decision regarding future pregnancies. Offering counseling and testing should become the standard of practice in health care facilities.

RECOMMENDATION 13: All patients who present to sexually transmitted disease (STD) clinics, drug treatment facilities, hemophilia treatment centers, prenatal and family planning clinics, primary care clinics, emergency rooms, mental health facilities, physician offices, and jail or prison facilities should routinely be provided information about HIV transmission and prevention, assessed for risk of HIV infection, and offered counseling and testing if they are at risk.

14. PROBLEM STATEMENT: Asymptomatic HIV infected persons need education and support regarding ways to delay or minimize onset of symptomatic HIV disease and to achieve sustained behavior change.

ANALYSIS: As many as 300,000 Californians may already be infected with HIV. Since there is no curative treatment for HIV infection at this time, control can only be achieved through prevention of infection. For those individuals already infected, prevention programs to detect early signs of clinical disease and to minimize the onset of opportunistic infection or immunosuppression should be established. These programs should incorporate education and support for sustained behavior change.

RECOMMENDATION 14: CDHS together with the medical community should ensure that all HIV seropositive persons have access to programs which provide evaluation and intervention for medical, behavioral, and psychosocial conditions together with

case management.

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## SECTION III

## HIV TESTING AND REPORTING ISSUES

## Introduction

HIV testing has expanded considerably since 1985 when the FDA licensed the first HIV antibody screening test kit. With the increased availability of testing, a number of concerns have risen including: the quality of test kits, laboratory certification to perform HIV testing, legitimate uses of test results, and involuntary testing. Many of these issues cut across federal, state, and local jurisdictions. Developing a consensus is essential to maintaining quality test results and high ethical standards. An example of successful consensus-building between the public and private sectors is in the area of home HIV test kits. Representatives and experts from consumer groups, the testing industry, health professionals, and others met in July 1988 to discuss the appropriateness of consumers testing themselves for the presence of HIV and other health conditions. (A summary of their findings is presented in Appendix H.)

## Recommendations

15. PROBLEM STATEMENT: HIV-related discrimination is impairing California's ability to limit the spread of the HIV epidemic.

ANALYSIS: Crucial to the control of the HIV epidemic are epidemiological studies to track the epidemic as well as early identification of infected individuals so that they can receive assistance with behavior modification and prompt care to prevent the early onset of immunosuppression. Public health measures which are necessary to prevent the spread of HIV depend on voluntary cooperation; for that to occur people must believe that they will be protected from discrimination. Public health officials are not able to gain this cooperation as infected individuals and those at high risk fear they will be discriminated against in employment, housing, and in terms of obtaining necessary health care and support services. In general it is not appropriate to maintain in law a list of those disabilities or diseases which are to be protected against discrimination. To do so risks declaring certain conditions unacceptable by their mere omission. However, HIV disease is different from other diseases because it is highly fatal and it is communicable. Controlling this disease requires extraordinary measures.

RECOMMENDATION 15: Legislation designed to prevent discrimination on the basis of HIV infection or AIDS in both the public and private sectors should be enacted.

16. PROBLEM STATEMENT: Accurate HIV testing and reporting of positive results is critical to California's HIV testing programs.

ANALYSIS: Screening enzyme immunoassay (EIA) test methods for HIV antibody are intrinsically very reliable. The false-positive rate for the EIA screening test, i.e., the number of reactive tests seen in a completely uninfected population, remains at about 2/1,000. Confirmatory testing is required to distinguish false positive from

true positive results. Confirmatory procedures, their interpretation, and reporting are in a state of disorder. Even in good laboratories using licensed methods, as many as 3 or 4 specimens which are truly negative will be called indeterminate.

RECOMMENDATION 16A: Establish testing standards including consistent interpretive and reporting guidelines for use with confirmatory tests.

RECOMMENDATION 16B: Require that all "reactive", "positive", and "indeterminate" sera be sent the CDHS laboratory (or their designee) for confirmation.

17. PROBLEM STATEMENT: Soon to be implemented HIV testing for life insurance applicants may not conform to the standard of practice for confirmation in California.

ANALYSIS: Tests performed for California insurance applicants may be performed in out-of-state laboratories which do not have to meet California's approval requirements applied to all in-state laboratories. Unless properly confirmed, truly negative individuals will be considered indeterminate and be denied insurance. These individuals will outnumber true positives by a factor of three or more.

RECOMMENDATION 17: Testing for the purpose of determining insurability should be limited to licensed methods and follow new confirmatory standards of CDHS as recommended above including referral of presumed positive and indeterminate specimens to a State of California approved laboratory for final confirmation and resolution.

18. PROBLEM STATEMENT: Surrogate testing is used for the purpose of denying health insurance.

ANALYSIS: HIV antibody testing for health insurance is prohibited in California; however, health insurance carriers frequently require a surrogate test (T Cell or Beta 2 macroglobulin) for determining health insurance eligibility. The sensitivity, specificity, and predictive value of non-HIV antibody tests have not been established and approved by the FDA. Those who test positive on these surrogate tests are frequently denied health insurance coverage.

RECOMMENDATION 18: Tests for markers to HIV other than antibody should be restricted to the evaluation of known infected individuals in research studies until licensed for diagnostic use by the FDA.

19. PROBLEM STATEMENT: Screening tests for infectious diseases are not required for the evaluation of tissues (organs, semen, or bone) from living donors.

ANALYSIS: HIV and other disease agents can be readily transmitted by any organ or tissue such as kidneys, bone, and semen. Current law only requires testing of cadaver donors, blood, and plasma.

RECOMMENDATION 19: Legislative action is needed to require screening of all

tissue donors (living or dead) for transmissible diseases. Such legislation should establish and provide for a fee-supported program for the licensure of tissue banks.

20. PROBLEM STATEMENT: Blood bank procedures and regulations for HIV testing are out dated.

ANALYSIS: Current law requires a 60 day waiting period for blood donors and 3 donations from plasma donors prior to notification of a positive HIV antibody test result. In some cases individuals with indeterminate HIV results are not informed and the true nature of their status is not defined in a timely manner. ATS programs are fully implemented and the reason for these rules no longer exists.

RECOMMENDATION 20: Blood bank and plasma center procedures related to HIV disease should be updated by: 1) eliminating the 60 day waiting period before notifying blood donors of HIV antibody positive test results; 2) referring specimens with indeterminate test results to public health departments or their private physician for further laboratory evaluation; and 3) notification and referral of screened positives by plasma centers for confirmation and counseling after a single donation.

21. PROBLEM STATEMENT: The impact of HIV disease in racial/ethnic minority communities is growing without an associated increase in availability of testing and education resources.

ANALYSIS: The current distribution of testing and education resources matches the demographics of the epidemic in its earliest phases. As the epidemic spreads, minority groups are more heavily represented in new infections and testing resources should be distributed to reflect this change in epidemiology.

RECOMMENDATION 21: Availability of HIV testing should be made more readily available to minority populations in conjunction with culturally appropriate counselling, education, and culturally appropriate language.

22. PROBLEM STATEMENT: On rare occasions, public health officials are confronted with individuals who knowingly and willfully continue to engage in high risk activities which are likely to expose others to HIV.

ANALYSIS: The primary focus for controlling the HIV epidemic should rely on voluntary public health measures; however, voluntary measures are unsuccessful in persuading a small number of individuals to alter their behavior. In these instances, public health officials should utilize a range of compulsory measures in order to restrict the activities of individuals who knowingly and willfully continue to engage in activities which are likely to infect others with HIV. Such measures should first seek to deal with the individual in terms of his/her illness, i.e. provide drug rehabilitation treatment and/or psychiatric treatment. If this fails, the full extent of laws available to public health officers should be pursued. Policy guidelines have been developed by the California Conference of Local Health Officers (CCLHO) for the management of recalcitrant patients with AIDS or ARC.<sup>6</sup> Additionally the

Presidential Commission's report on the HIV epidemic and the Institute of Medicine, National Academy of Science have made recommendations in this area.<sup>7,8</sup>

RECOMMENDATION 22: Public health officials should modify CCLHO's policy guidelines for the management of recalcitrant patients with AIDS or ARC to additionally address the asymptomatic HIV infected individuals who knowingly and willfully continues to engage in high risk behaviors. Such guidelines should provide for a full range of control measures that first deal with the individual as an ill person and incorporate recommendations made by the Presidential Commission of the HIV Epidemic and the Institute of Medicine, National Academy of Sciences.

23. PROBLEM STATEMENT: A shortage of certified public health microbiologists exists in California.

ANALYSIS: Laboratory staffing throughout California is not adequate to meet the rapidly growing HIV testing volume and the current level support for training of candidates will not fill this widening gap.

RECOMMENDATION 23: Increased state training funds should be made available to expand the pool of certified microbiologists and thereby help fill the large number of vacant positions which can only be filled by trained individuals.

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## SECTION IV

### INTRAVENOUS DRUG AND SUBSTANCE USE

#### Introduction

Intravenous drug users (IVDUs) are the second largest risk group for AIDS in California and are expected to be the main source of infection for heterosexual partners and future pediatric AIDS cases. The California Department of Alcohol and Drug Programs (CDADP), conservatively estimates that there are 440,000 IVDUs in the state. Heroin, cocaine, and methamphetamine are the most frequently injected drugs.

Although data are sketchy, HIV infectious among IVDUs in California appear to be approximately doubling in the number of infected drug users every 12 to 36 months depending upon locality. Representative rates of infection include Sacramento at 3% to 5%, Los Angeles at 2% to 10%, and San Francisco at 15% to 20%. Unless prevention efforts are successful, between 50% to 70% of IVDUs in California may eventually acquire the virus thus increasing the spread sexually to non-IV drug using partners, and to their children perinatally.

IVDUs have an addiction and a subculture that make risk reduction difficult. For example, sharing needles involves personal relationships. IVDUs carrying clean "works" (needle, syringe, spoon, "cooker", etc.) risk arrest. Furthermore, the IVDU population in California is not homogeneous. It includes all types of people including: young and old, gay and straight, minorities and whites, men and women, educated and uneducated. This diversity requires California to develop a multifaceted approach if it is to control the rising incidence of AIDS in this group. The control of spread of HIV among IVDUs, their sexual partners, and their offspring requires intensive, coordinated efforts at the local and state levels.

#### Recommendations

##### Research Needs

24. PROBLEM STATEMENT: The distribution and determinants of HIV infection among intravenous drug and substance abusing populations in California are poorly understood. The of lack complete data is impeding the development of successful, cost-effective HIV prevention strategies in California.

ANALYSIS: There is an incomplete picture of the scope of HIV infection among IVDUs in California. The limited studies which have been completed, and preliminary results from ongoing studies, have all underscored the need for more comprehensive data on the spread of the epidemic. Three broadly defined categories where additional investigation are: basic demographic descriptions of IVDUs; epidemiologic data quantifying the levels and trends of HIV infection in California; and quantitative and qualitative assessment of education and prevention strategies (including the behavioral and cultural factors which limit or enhance their effectiveness).

RECOMMENDATION 24: The state should assess the current epidemiologic knowledge of HIV among IVDUs in California and identify areas where data are incomplete. Once an assessment has been completed, the state should allocate adequate resources to determine incidence and prevalence of HIV infection among drug abusing populations in representative areas of the state. Qualified researchers from indigenous racial/ethnic minority communities should be involved in the design and implementation of these studies.

#### Behavior Change

25. PROBLEM STATEMENT: There is a need for education programs that encourage behavior change/modification among IVDUs which are not detrimental to the development of trust between IVDUs and the educator.

ANALYSIS: Multiple strategies are necessary to effect behavior change among IVDUs. Skill development, attitudes, and social support for behavior change should be addressed by educational interventions directed at IVDUs. Skill development includes targeting needle cleaning, condom use, communication skills, and coping with peer pressure. Training in needle cleaning should focus on methods which are quick and require a minimum of effort. Providing risk reduction equipment at the time of the educational intervention should be done to increase the likelihood that needle use behavior change will occur. Denial, perceived susceptibility, responsibility for one's health, risk taking behavior versus delayed gratification, and self-esteem development are attitudes that should be addressed by behavior change programs targeted at IVDUs.

RECOMMENDATION 25A: CDADP should mandate HIV disease education standards for clients and staff of drug treatment programs which address knowledge, attitudes, behavior change, and social support development.

RECOMMENDATION 25B: Effective treatment for substance abuse should involve significant others, i.e., sexual partners and enablers.

26. PROBLEM STATEMENT: Of approximately 200,000 chronic IVDUs, only 11.4% of IVDUs are in treatment at any given time.

ANALYSIS: The IVDU population not in treatment represents a significant proportion of the IVDU population in California. Because of the illegality of their activities, the reluctance of IVDUs to enter treatment programs, or the lack of treatment program accessibility, outreach is needed to the many drug users who will not enter treatment and to their sexual partners.

RECOMMENDATION 26: Appropriate agencies should conduct outreach to addicts not in treatment so that they can be educated about HIV transmission and prevention.

#### Sexually Transmitted Diseases

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27. PROBLEM STATEMENT: Recent research findings indicate the single most important factor in heterosexual and perinatal transmission of HIV may be the relationship between STD and IVDUs.

ANALYSIS: In addition to the obvious risk of direct HIV transmission through the sharing of needles/syringes by IVDUs and the fact that IVDUs are responsible for nearly 80% of HIV transmission to heterosexuals and newborns, other risks of HIV transmission exist for IVDUs.

- Heroin addicts often resort to prostitution to support their drug habit. Similar behavior appears to exist among those using cocaine.
- Hypersexual activity due to stimulation from cocaine and methamphetamine has been observed.
- There is a lack of culturally sensitive, ethnically targeted prevention/education efforts for reducing STD in the state.

RECOMMENDATION 27A: All IVDUs in treatment should be screened and treated for STD. Protocols for cross-referral and patient follow-up should be established.

RECOMMENDATION 27B: Voluntary partner notification of sex and needle sharing partners should be implemented and evaluated among IVDUs.

## Methadone

28. PROBLEM STATEMENT: Methadone treatment programs have an important role in prevention of HIV disease among IVDUs.

ANALYSIS: Methadone treatment yields beneficial effects on IVDU and the criminality of opiate addicts. It has an excellent retention rate for outpatient treatment and it is low-cost compared with residential care. Methadone treatment programs have waiting lists. If the availability of methadone treatment could be expanded, IVDU use would decrease and (by implication) so would HIV disease risk. Preferential admission of seropositive addicts would slow the spread of HIV to those not yet infected. But methadone treatment is not a complete solution. It treats only opiate addiction (not alcohol or cocaine abuse), it is an addicting medication (and, therefore, controversial), and traditional health care programs do not adequately understand it. Further, the treatment was designed for drug problems rather than for AIDS prevention, and application to HIV disease containment may require changes in approach.

RECOMMENDATION 28A: Methadone treatment should be available to anyone who needs it. Increase availability of treatment by: 1) lowering the threshold of entry into programs to increase the absolute number of drug abusers receiving methadone treatment and 2) consider nontraditional modifications of treatment to expand the treatment system's capacity, e.g., brief maintenance or extended detoxification,

prescription methadone for selected patients, and outreach to encourage drug users to get into treatment.

RECOMMENDATION 28B: Modify methadone treatment program goals to promote disease prevention. Program goals may need reexamination, as well as the program regulations that were promulgated in the era before AIDS. For example, the aim of eventual detoxification from methadone may not be realistic for the drug abuser with AIDS.

#### Polydrug and Alcohol Abuse

29. PROBLEM STATEMENT: Polydrug use and unsafe sexual activity compound the difficulty of controlling the spread of HIV among IV drug users.

ANALYSIS: Education and concomitant behavior change remain the cornerstone for preventing new infection with HIV. For the IVDU, this means getting off of drugs, not sharing needles, or cleaning needles with a disinfectant, and following safer sex guidelines especially the use of condoms. To achieve these types of behavior change AIDS educators must not only address drugs injected intravenously but any substance abuse that alters behavior and facilitates high risk behavior. Amphetamine and methamphetamine are in particular a problem because users who inject these drugs, frequently do so numerous times in a day thus increasing their risk of exposure to HIV.

RECOMMENDATION 29A: Programs and agencies which certify substance abuse counselors such as Chemical Dependency Counselor Training programs and the California Association of Drug and Alcoholism Counselors should encourage HIV disease education as a requirement of certification.

RECOMMENDATION 29B: AIDS educators should emphasize sexual transmission and prevention of HIV as well as the disinhibiting effects of substance use and its relationship to unsafe sex when working with substance using target populations.

30. PROBLEM STATEMENT: Alcoholism treatment programs have not been targeted to encourage on-going-AIDS prevention education as part of the treatment protocol.

ANALYSIS: For some communities the only treatment programs available for substance abuse are alcoholism treatment programs. Many clients report IVDU in association with primary alcohol abuse. Therefore, it is extremely important that alcoholism treatment facilities be viewed as an essential element in targeting information and education regarding HIV disease prevention to IVDUs.

RECOMMENDATION 30: Alcohol treatment programs should be targeted and encouraged to implement HIV disease prevention activities into their treatment protocols.

#### Paraphernalia Exchange (PE)

31. PROBLEM STATEMENT: IVDUs share drug paraphernalia which has led to an alarming rise of HIV infection among IVDUs.

ANALYSIS: IVDU negatively impacts society; however, a large population of infected IVDUs would have even greater negative consequences. Data about the effectiveness of PE programs in the United States is not clear at this point but there are indications from Holland and Britain which suggest PE programs may decrease the spread of HIV among IVDUs. While opponents of PE programs believe these programs condone and promote drug use, there is no evidence from Europe to indicate that drug use has risen as the result of PE programs.

RECOMMENDATION 31A: Examine existing PE programs in the United States and Europe closely for effectiveness, acceptance, etc.

RECOMMENDATION 31B: The OA should establish pilot PE programs in California, funded as research projects, which will be answerable to an oversight committee composed of knowledgeable experts.

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## SECTION V

## PERINATAL AND PEDIATRIC ISSUES

## Introduction

AIDS case data indicate that as of December 31, 1988, 468 cases of AIDS have been diagnosed and reported to the California AIDS Case Registry among women. Adult women account for nearly 3% of total AIDS cases in California. The proportion of adult females among total AIDS cases has grown from less than 1% of cases in 1983 to 3% in 1988. Currently, the number of adult female AIDS cases is doubling every 14 months.

Among AIDS cases in adult females, approximately one-third are attributed to each of the following risk factors: heterosexual contact, transfusion related, and IVDUs. White women account for the majority of reported cases in each risk category, but are under represented relative to the percent of the total adult female population. White adult females account for nearly 68% of the adult female population while representing approximately 56% of female AIDS cases. Black women are disproportionately represented among female AIDS cases, accounting for 25% of total female AIDS cases and only 7.2% of California's adult female population. Hispanic women account for approximately 15% of female AIDS cases and nearly 17% of California adult females. Asians account for 3% of adult female AIDS cases and 7% of California adult females.

The total number of AIDS cases diagnosed and reported as of December 31, 1988, in children under age 13 is 108. Of these, 42% of cases were due to transfusion with infected blood, 47% to perinatal transmission, 8% to hemophilia, and 3% were reported as none of the above or other.

## Recommendations

32. PROBLEM STATEMENT: HIV is transmitted perinatally.

ANALYSIS: Infants born to mothers with a positive test for antibodies to HIV are at increased risk for developing AIDS. Between 30% to 50% of infants born to infected mothers will be infected with HIV. It is unknown what percentage of those infants who test HIV positive will go on to develop AIDS, but the consensus is that most will. AIDS progresses much more rapidly in infants than in adults because of their immature immune system. The average age of AIDS diagnosis in infants is 9 months.

Preliminary results from a study conducted by CDHS using newborn blood samples to assess the rate of HIV infection in California women indicates a rate of 8.3/10,000. In comparison, the rate of infection among pregnant women in Massachusetts is 21/10,000 and in New York, 74/10,000. This data is based upon 43,301 specimens from all live births in California during a 1 month period in 1988. An additional 2 months worth of specimens are slated to undergo testing which will generate additional information on the groups of women who are at greatest risk and high seroprevalent areas geographically in the state.

RECOMMENDATION 32A: HIV risk assessment and culturally relevant prevention education should routinely be provided to all women of childbearing age.

RECOMMENDATION 32B: HIV antibody testing and counseling should routinely be offered to pregnant women who are considered high risk for seropositivity based on a full appropriate medical history. This may include routine screening in high seroprevalent areas.

RECOMMENDATION 32C: Reproductive counseling should be provided to all HIV infected pregnant women as part of their prenatal care.

RECOMMENDATION 32D: Providers should be recruited at the local or regional level to provide diagnostic and follow-up services to HIV infected women by appropriate CDHS administered programs such as Maternal and Child Health (M&CH) and professional organizations.

33. PROBLEM STATEMENT: Breast feeding can transmit HIV.

ANALYSIS: Human breast milk is the optimal diet for infants under one year of age. However, there is circumstantial evidence that postnatal transmission of HIV occurs through breast feeding although the risk is low. As adequate replacement formulas for infant feeding exist in California, elimination of breast feeding would not threaten the nutritional status of infants whose mothers are HIV positive. Breast milk banking is another issue to be considered. Breast milk banking involves the use of breast milk from donors. The recipients are usually low birth weight infants. While it is unlikely that breast milk obtained through a breast milk banking service would be contaminated by HIV, it seems prudent to take precautions.

RECOMMENDATION 33A: HIV antibody positive women should not breast feed their infants and women in high risk groups who wish to breast feed their infants should be educated about the possible risk of HIV transmission through breast feeding and tested in the postnatal period.

RECOMMENDATION 33B: CDHS should work with breast milk banks to develop standards for pasteurization of donated breast milk and determine to what extent donors should be screened before their milk is deemed acceptable for processing.

34. PROBLEM STATEMENT: There is a reluctance of some physicians to provide medical care to children with HIV infections.

ANALYSIS: Some physicians continue to refuse to care for children with known HIV infections. Because of this reluctance, there are areas in the state in which it is difficult to locate adequate medical care. The reason for this reluctance appears to be lack of information on the routes of infection and inadequate education on how to test, how to follow such children, and how to counsel family, school, and the community. In addition, uninformed physicians provide inaccurate information

which compromises care of these children and results in unnecessary fear in the community.

RECOMMENDATION 34: There should be active outreach, education, and recruitment of physicians willing to care for HIV infected children in the local community.

35. PROBLEM STATEMENT: Case management and support services for infants and children are not sufficient to meet the growing AIDS caseload in this population.

ANALYSIS: Families who have a child with AIDS may need emotional support and assistance with arranging medical appointments, hospitalizations, transportation, housing, and adequate nutrition for their child. Most infants born with HIV infection are born to women who are IVDUs or partners of IVDUs. These women are often ill themselves and require assistance to deal with the physical and emotional needs of their child. Limited case management services are presently available for HIV infected children through CDHS California Children Services (CCS), OA Pilot Care program, and the AIDS Medi-Cal Waiver. With the projected increases in pediatric AIDS cases there is a need to also increase the availability of case management services.

RECOMMENDATION 35A: There should be adequate support of the CCS program to provide psychosocial and other services such as supplemental nursing in the home for those children for whom other resources are unavailable to provide those services.

RECOMMENDATION 35B: As the incidence of pediatric AIDS cases increases, the availability of OA case management services for infants and children with AIDS/ARC should be increased and expansion of Medi-Cal waiver services to children considered.

36. PROBLEM STATEMENT: Federal funding often does not fully reimburse the cost of investigational studies.

ANALYSIS: The CCS program has had a policy for many years of not funding services for children in investigation or research studies. The reasons for this restriction include unavailable funding for research and the inability to adequately evaluate and monitor such activities. HIV infection is a unique disease in that it is generally fatal, is relatively widespread, and has rapidly changing treatment modalities. While the federal government is providing significant funds for research and investigation studies, often the funding is inadequate to pay for baseline evaluations and all required services. The centers caring for such children find themselves in the dilemma of being able to provide the proposed treatment once the child is evaluated but not having adequate funds for the total study.

RECOMMENDATION 36: There should be greater flexibility on the use of CDHS funds for patients in investigational studies and protocols that have been approved and funded by CCS and NIH for the diagnosis and treatment of HIV infection in

children.

37. PROBLEM STATEMENT: Access to day care for children with HIV disease is inadequate.

ANALYSIS: In areas of high incidence of HIV infection, there is a shortage of regular day care settings as well as foster homes in which providers are able to provide for the complex needs of children with ARC/AIDS. Such settings should be home-like in character and staffed with trained personnel.

RECOMMENDATION 37A: HIV infected children should be admitted to day care if their health, neurologic development, behavior, and immune status are appropriate based upon standardized admission guidelines and as determined by a team of qualified person's including the child's physician.

RECOMMENDATION 37B: The California Department of Social Services (CDSS) should recruit and provide for licensing of additional day care and special day health care facilities for technology dependent children and chronically ill children, including those with HIV infections.

38. PROBLEM STATEMENT: The current procedure for obtaining and informing prospective adoptive and foster parents regarding HIV status is cumbersome.

ANALYSIS: CDC has recommended that foster care and adoption placement agencies consider adding HIV screening to routine medical evaluations of children at increased risk of infection before placement since these parents must make decisions regarding the medical care of the child and must consider the possible social and psychological effects on their families. CDSS concurs with CDC's recommendation when the child's physician determines that HIV screening is medically appropriate. Laws are in place which allow agencies to obtain a court order for HIV screening of minors who are wards of the court and to disclose results to prospective foster and adoptive parents prior to placement. If specific standards for HIV testing of high risk children who are wards of the court were developed, the process of obtaining a court order could possibly be eliminated. This would improve access of infants and children to appropriate medical care.

RECOMMENDATION 38: CDSS should adopt and monitor standards in regards to testing and disclosure of medical information to prospective foster and adoptive parents.

39. PROBLEM STATEMENT: There is a growing problem of HIV infected children ending up in hospitals when it is no longer medically necessary for them to be there.

ANALYSIS: As with all children, children infected with HIV are in need of a loving, caring, supportive home environment and from a fiscal standpoint, it is less costly to provide alternatives to institutionalized care. Currently, CDSS is implementing a one county pilot project to recruit, train, and provide supportive

services to foster parents for children two years and under who are HIV seropositive. Additionally, some counties have implemented foster parent training and recruitment programs on their own. While CDSS has committed itself to recruiting sufficient numbers of foster and adoptive homes for special needs children, including those with HIV disease, it may not be possible to place all of these children in foster homes.

RECOMMENDATION 39A: CDSS should ensure that a coordinated effort is pursued between county, state, federal, and private agencies to educate and train foster and adoptive families willing to take care of HIV infected children.

RECOMMENDATION 39B: CDSS should provide foster and adoptive parents of children with HIV infection special incentives such as access to day care and respite care. Additionally, the foster care stipend should be increased for parents caring for HIV infected children.

RECOMMENDATION 39C: The development of living arrangements other than foster or adoptive care for children with HIV disease should be pursued.

40. PROBLEM STATEMENT: HIV can cause mental retardation and brain damage in affected children.

ANALYSIS: Central nervous system involvement is a prominent clinical finding in infants and children with congenital AIDS/ARC. While the type of neurological disfunction may vary, it is estimated that 78% to 93% of children with symptomatic HIV infection will present with developmental disabilities or cognitive defects. Based on current projections, HIV infection may become the largest infectious cause of mental retardation and brain damage in children in the next 5 years. Most of these children will be eligible for services through CCS and regional centers.

RECOMMENDATION 40: CCS and California Department of Developmental Services (CDDS) should jointly develop mechanisms for accessing state and federal funds allocated for AIDS to assure services for children with HIV infection.

41. PROBLEM STATEMENT: Homeless adolescents with AIDS have special housing needs.

ANALYSIS: Nationally several hundred teens and young adults through the age of 21 have been diagnosed with AIDS. Many of these adolescents and young adults are living a high risk life style that often detaches them from their core families. The diagnosis of AIDS or HIV infection further polarizes them away from any semblance of a family unit which might provide emotional support and residential care. Adolescents are developmentally different from adults and thus have needs which differ from adults.

RECOMMENDATION 41: A pilot RAS program for HIV infected homeless youth with AIDS needs to be developed. Such a facility will be most successful by utilizing medical resources and experts who are knowledgeable about health care delivery to

adolescents.

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## SECTION VI PEOPLE OF COLOR AND HIV DISEASE

### Introduction

As of December 31, 1988, 17,164 AIDS cases had been reported to the California AIDS Case Registry. Whites continue to account for the greater percentage of AIDS cases in California, however, data indicates a rapidly growing problem among racial/ethnic minority populations, especially among blacks, Hispanics, and Asians.

Blacks, account for 7.5% of the state's population while representing 11% of all AIDS cases. In 1988, blacks accounted for the highest proportion of new AIDS cases with a rate of 36.67/100,000. Hispanics account for 19.2% of California's population and 12% of AIDS cases. Hispanics accounted for the third highest proportion of new AIDS cases in 1988 with a rate of 11.7/100,000. Asians account for 5.7% of the state population and 1% of all AIDS cases. While the total number of AIDS cases reported among Asians is small, this population has experienced a dramatic increase in AIDS cases. The number of new cases approximately doubled from 1.9/100,000 in 1986 to 3.76/100,000 in 1988. Native Americans account for less than 1% of California's population and less than 1% of total AIDS cases. As of December 31, 1988 there had been 21 cases of AIDS reported among Native Americans.

Males have been disproportionately affected by AIDS in all racial/ethnic populations. Adult males account for 95% of cases among Hispanics, 92% of cases among blacks, 96% of cases among Native Americans, and 93% among Asians. Regardless of ethnicity, homosexual and bisexual men account for the majority of AIDS cases in every racial/ethnic group.

Among pediatric AIDS cases, 44% have been among whites, 23% among blacks, 31% among Hispanics, and 2% among Asians. No pediatric AIDS cases have been reported among Native Americans in California. Among blacks and Hispanics, perinatal transmission is the primary risk factor for pediatric AIDS.

California's Asian community is comprised of over 30 ethnic groups. Filipinos, Chinese, Japanese, Koreans, and Vietnamese constitute the largest Asians populations in the state. While national differences are very important to the design and implementation of effective community programs, Asians in general share some common characteristics. For example, within the Asian community, educators have to address the common myth that Asians are immune to AIDS. This must be done in a cultural context which has taboos against discussing sex, homosexuality, illness, and death. Within the Asian community conformity to group norms and tradition are highly valued. Homosexuality and IV drug use are not accepted and rarely acknowledged. There is a profound denial of these activities and a belief that if they are ignored they don't exist; therefore, there is no problem.<sup>9</sup>

California's black population is perceived to be more homogenous in terms of ancestry and language than the Asian or Hispanic community, but they are diverse in terms of socioeconomic factors, religion, rural-urban background, and geographic background in

terms of North versus South and East versus West. As a collective community they have strong cultural ties, extended family networks, and strong religious beliefs which influence the manner in which AIDS activities should be delivered. Paramount to addressing AIDS in the black community is the involvement of churches, social organizations, and community leaders.<sup>10,11</sup>

California's Hispanic/Latino population is a diverse group of individuals comprised primarily of Mexican descent, but also from Central and South America. While origin of descent is an important influence modified by degree of assimilation into California's mainstream; cultural and language similarities exist. Family and the church are important values within the Hispanic/Latino community. Women play key roles in the family for health promotion and are cultural gate keepers. Physicians and medical personnel are generally held in high esteem and looked to as authority figures by the community yet traditional folk medicine is also valued and practiced by many. Another factor influencing HIV prevention strategies within the Hispanic/Latino community is a tradition of combining visual images and the spoken language to teach versus a reliance upon the written word. As in many racial/ethnic minority communities, homosexuality is not readily accepted. However, sex between men is acceptable when it occurs between men who perceive themselves as heterosexuals.<sup>12</sup>

In proportion to other racial/ethnic groups in California, Native Americans are the smallest group but they represent the largest Native American population in the U.S. According to the 1980 U.S. Census estimates, there are 230,000 American Indians living in California. There are 94 tribes indigenous to California and over 400 nationally.

Of California's American Indian population, approximately 180,000 live in large urban centers. Most of these individuals maintain strong family and cultural ties to their tribe and families in rural and reservation communities. This phenomena results in a high rate of circular migration between urban and rural/reservation Indian communities and has serious implications for the spread of communicable diseases.

American Indian tribes maintain a unique social, legal, and political relationship as sovereign nations with the federal government. This relationship is defined in treaties which ideally provide for health and educational services in return for parts of the Northern American continent. However, health services in California for American Indians were virtually non-existent until 1972 and now are in the initial stages of development. In general, the health status of American Indians in California is less than that of the general population. Rates of alcohol and drug abuse, adolescent pregnancy, and STD are disproportionately high among Native Americans.<sup>13</sup>

#### Recommendations

42. PROBLEM STATEMENT: HIV disease is a rapidly escalating problem in many of California's racial/ethnic minority communities.

ANALYSIS: Implementation of culturally sensitive comprehensive prevention education programs in racial/ethnic minority communities is critical to the control of HIV disease. Development of a comprehensive community based HIV prevention

network targeted at racial/ethnic minorities requires improving public and private support for funding, technical assistance, and involvement in state and local planning bodies. Successful efforts will be dependent upon involving racial/ethnic communities in developing and implementing the solutions.

RECOMMENDATION 42: The public and private sectors should assist racial/ethnic minorities to take the lead in planning the development, implementation, and evaluation of preventive education, HIV testing, delivery of care, and research activities which are necessary to the formation of a comprehensive network of community based and culturally sensitive HIV disease programs in racial/ethnic minority communities.

43. PROBLEM STATEMENT: It is difficult for many AIDS service agencies to develop and translate educational materials in a variety of languages.

ANALYSIS: AIDS agencies have a need for culturally relevant educational materials in several languages. The development of these materials and/or translation of English materials is a time intensive task. Frequently agencies do not have in-house capabilities to develop multi-language specific and culturally relevant materials or modify and translate English materials nor do they have adequate budgets to purchase these services. The 1988 URSA Institute evaluation of FY 1987-88 OA Education and Prevention contractors noted that much of the Spanish language materials available were fraught with misspellings and grammatical errors. It is likely the same is true for other foreign languages. While education materials should be developed by organizations with knowledge and sensitivity to the target audience, providing quality translation services through one centralized or several sites may facilitate the development of culturally appropriate materials in a variety of languages.

RECOMMENDATION 43: CDHS should study the feasibility of providing centralized translation services to facilitate development of multi-language, culturally relevant educational materials.

44. PROBLEM STATEMENT: Health care workers frequently are inadequately educated about cultural factors related to racial/ethnic minority populations. This has implications for the provision of prevention and treatment services.

ANALYSIS: Controlling HIV disease among California's racial/ethnic minority populations requires an understanding and sensitivity to the cultural, socioeconomic, and political influences within these communities. Ethnic populations differ regarding the openness about which they discuss sexuality, drug use, illness, and death. Family and the church play different roles in various populations. Additionally, some cultures have traditional and homeopathic health practices and beliefs which are very important to them.

RECOMMENDATION 44: Cross-cultural training should be integrated into programs for health care workers, HIV test counselors, and others providing AIDS related services.

45. PROBLEM STATEMENT: The present method of reporting AIDS case and HIV infection prevalence and incidence data among Asian/Pacific Islander communities makes it difficult to plan and deliver prevention and treatment services to this population.

ANALYSIS: It is common practice for epidemiologists to categorize persons of Asian ancestry or descent into one group. However, there is really no substantive reason to do so. Asian/Pacific Islanders are a heterogenous group, comprised of 32 distinct ethnic groups with different languages, attitudes, traditions, and behaviors. There is no single Asian community, rather there are Chinese, Japanese, Koreans, Filipinos, Vietnamese, Samoans, Laotians, Cambodians, Hawaiians, etc. Because there are major differences in the various ethnic Asian/Pacific Islander subgroups, it would be beneficial to have an understanding of HIV disease prevalence and incidence in the major groups in order to effectively target programs.

RECOMMENDATION 45: The state should improve its HIV disease surveillance and reporting practices to include a breakdown of Asian/Pacific Islander subgroup populations.

46. PROBLEM STATEMENT: AIDS case data and HIV incidence data on Native American Indians are inaccurate.

ANALYSIS: Native Americans come from a variety of tribal backgrounds and are not easily identifiable by means of physical characteristics. Additionally, many Native Californian Tribal members have Hispanic surnames as a result of historical Spanish influence in this state. Accurate identification of Native Americans is critical in planning and evaluating AIDS services for this population. There have been local situations in California where the number of reported AIDS cases for Native Americans were determined to be grossly misrepresentative after multi-agency/government case validation studies were completed.

RECOMMENDATION 46: CDHS should provide training at the local and state level to ensure valid reporting of Native American AIDS cases.

47. PROBLEM STATEMENT: Mandatory HIV antibody test requirements for applicants to the Immigration and Naturalization Services (INS) has created confusion among applicants and Civil Surgeons.

ANALYSIS: Since December 1987, testing for HIV antibodies has been required as part of the medical examination submitted to the INS by persons 15 years and older who are applying for legalization under amnesty provisions of the Immigration Reform and Control Act (IRCA). HIV seropositive applicants are denied amnesty unless they apply for and are granted a waiver of exclusion by the INS. However, seropositive applicants cannot be deported based upon HIV antibody test results. Some individuals who discover they are HIV antibody positive will not complete their amnesty application but will continue to live in this country illegally. These individuals will go further "underground" thereby exasperating the public health

problem. They may not receive the health care and information they need to remain as healthy as possible and avoid infecting others.

RECOMMENDATION 47: Civil Surgeons and others performing HIV antibody testing as part of the INS amnesty application should follow California standards for confirming screened positives and handling of indeterminate test results and inform applicants of the following:

1. What the HIV antibody test does and does not reveal;
2. California law governing confidentiality and reporting of test results;
3. the method by which exam results are transmitted to the INS;
4. that they can have a photocopy of the form submitted to the INS which states their HIV antibody status;
5. that they can ask to be re-tested;
6. that the INS will not deport them on the basis of a positive finding;
7. that they can file for a waiver with the INS to complete their amnesty application if they test positive for HIV antibody; and
8. if they are seropositive, they should seek medical and psychological follow-up.

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## SECTION VII

## PUBLIC SAFETY WORKER AND CUSTODY ISSUES

## Introduction

Public safety workers are on the front line protecting the public from health and safety hazards. Through the discharge of their duties, public safety workers may knowingly or unknowingly have contact with persons infected with HIV. It is not uncommon for public safety workers to have contact with blood or body fluids during the course of their work in prisons and jails, at crime scenes, motor vehicle accidents, fires, etc. For these reasons, public safety workers should be trained to prevent occupational exposure to HIV and their work environment should be made as safe as possible.

This section also discusses incarcerated populations. In 1987, the National Institute of Justice established a Drug Use Forecasting (DUF) System to track trends in arrestees. Data from DUF have documented that an important avenue for reaching IV drug users is through the criminal justice system.

## Recommendations

48. PROBLEM STATEMENT: Public safety workers are at risk of HIV infection through the discharge of their duties.

ANALYSIS: All public safety worker staff should have a clear understanding of their occupational risk and the appropriate actions to take in order to decrease their risk. By understanding the proper precautions to follow, the fear and anxiety of personnel can be diminished. This position is taken with a clear understanding that the cost for such a policy is not insignificant. Education is not only important to reduce infections, but is also important to reduce the liability and costs of the involved agencies. Management and labor must be actively involved in the development of educational programs and appropriate policies and procedures.

RECOMMENDATION 48A: HIV disease prevention education should be mandatory for all levels of public safety workers including law enforcement, fire service, ambulance, custodial staff (jail, prison, juvenile hall, and probation) and other appropriate public safety workers.

RECOMMENDATION 48B: The Emergency Medical Services Authority (EMSA) should pursue legislation to amend the Health and Safety Code (H&SC) regarding training standards for Emergency Medical Technicians (EMT) I, EMT II, and EMT-P classifications to include communicable disease education with an emphasis on HIV disease. These training standards should be adopted by the California High Patrol, the Department Forestry, and other public safety agency personnel as appropriate. Training standards should be based upon models and guidelines available from the Occupational Safety and Health Administration (OSHA), California Occupational Safety and Health Administration (Cal-OSHA), National Institute for Occupational Safety and Health, and the American Red Cross' Public Safety Worker AIDS

Education Project.

RECOMMENDATION 48C: Policy and procedures regarding infection control should be developed for all public safety employees using universal infection precautions as developed by CDC.

49. PROBLEM STATEMENT: Detainees in custody settings are frequently at high risk for HIV infection.

ANALYSIS: The men, women, and juveniles who comprise incarcerated populations reflect a concentration of individuals at risk of HIV infection. They are younger, sexually active, often less educated than the general populations, and may have histories of intravenous drug use. During their confinement, inmates or wards may engage in needle sharing, sharing of tattoo devises, and sexual activity. Providing education and HIV testing in correctional facilities represents an efficient means of reaching large numbers of high-risk individuals at relatively low cost, in that the clientele is readily identifiable and expensive community outreach is not required. Chapter 1301, Statutes of 1988 (SB 2854, Watson) of the H&SC recognized the need to provide prevention education and counseling and testing services to inmates and wards in county jails, state prisons, and youth facilities; however, funding was not provided to implement the provisions of this bill.

RECOMMENDATION 49A: State funding should be provided to implement SB 2854 (Watson) which requires that the HIV prevention education and HIV testing information and services be provided to all inmates and wards in county jails, state prisons, and youth facilities.

RECOMMENDATION 49B: A longitudinal follow-up study in selected sites to determine the risk of HIV transmission in various confinement settings should be conducted.

50. PROBLEM STATEMENT: Due to recent changes in legislation and the initiative process many correctional institutions have discontinued voluntary HIV antibody testing.

ANALYSIS: Anonymous testing is the best incentive for encouraging inmates to take an HIV test. However, since anonymous testing in the prison and jail setting is not possible under current California statute, voluntary, informed testing should be encouraged. Voluntary testing, which includes pre- and post-test counseling, will provide an opportunity to offer one-on-one information and education about HIV disease. It will also provide the inmate with information about his/her risk factors, HIV antibody status, and prevention methods. It will provide the system with epidemiological information about HIV disease within the prison setting which will assist in planning for the health, education, and social services needs of this population while incarcerated and upon release.

RECOMMENDATION 50: Incarcerated individuals should be encouraged to partake of voluntary informed HIV antibody testing which include pre- and post-test

counseling.

51. PROBLEM STATEMENT: Housing of HIV infected inmates is an issue for correctional settings.

ANALYSIS: Separate housing of HIV antibody positive of AIDS prisoners is not necessary but may be appropriate in some institutions to protect a specific individual(s) from assault or harassment, to separate an individual whose conduct might lead to infection of other inmates, or if medical conditions require special medical care. The institution can then concentrate AIDS medical/education services in a particular area.

RECOMMENDATION 51: If separate housing is used, the following recommendations are made:

- . Equal access to programs and devices.
- . Staff and inmates in non-segregated areas must be made aware that the risk of infection is not eliminated and that universal precaution must be observed at all times.
- . Confidentiality of medical conditions within the inmate population must be protected.

52. PROBLEM STATEMENT: Methods are needed to eliminate and/or decrease HIV transmission within the correctional setting.

ANALYSIS: Nationwide, men account for 90% of AIDS cases in correctional settings. On average, these systems attribute two-thirds of their males cases to IVDU, and 43% to homosexual activity. Ninety-two percent of the female cases were related to IVDU. In general, intravenous drug abuse is a much more important transmission category in correctional AIDS cases than in the population at large.

RECOMMENDATION 52: The state should fund pilot projects to study distribution of condoms and needle disinfection solutions within correctional facilities to determine the efficacy of these measures in preventing HIV transmission within correctional facilities. Such a study should provide for appropriate safety and security measures.

## SECTION VIII THE WORKPLACE AND HIV DISEASE

### Introduction

HIV disease in the workplace has caused problems for some employers, not because this disease is spread by usual workplace activities, but due to fear, dissension and ignorance among employees and employers. Adequate personnel policies and training are necessary to prevent difficulties such as an absent work force, refusal to provide services, and even litigation.

Common concerns in the workplace center around the following issues:

- o Employees with HIV disease are concerned about their lives and their jobs.
- o Employees without HIV disease are concerned about contracting AIDS from co-workers, customers or others.
- o Employees are concerned about friends or relatives who have or who are dying from AIDS.

### Recommendations

53. PROBLEM STATEMENT: Many employers and workers in California lack sufficient knowledge about HIV disease including transmission, rights of employees, and responsibilities of employers.

ANALYSIS: The HIV epidemic in the United States affects everyone in the country and reaches into the workplace where most individuals spend a substantial amount of their time. While HIV disease is commonly discussed and feared, there is inadequate knowledge of the disease and modes of transmission as well as the rights of employees and the responsibilities of the employer. This ignorance can affect the workplace adversely as manifested by lost productivity.

RECOMMENDATION 53A: The California Department of Fair Employment and Housing (CDFEH) should be provided funding to implement an information campaign to educate employers about their responsibilities related to employees infected with HIV and distribute model policies and procedures including information regarding the process for filing a discrimination complaint.

RECOMMENDATION 53B: Employers should implement training and adopt policies and procedures which enable them to effectively deal with issues related to AIDS. As prescribed by the work environment, these policies should provide guidance for reasonable accommodation, compassion for individuals with HIV disease, education and training, infection control precautions, medical surveillance, and record keeping regarding training.

RECOMMENDATION 53C: Employers, boards of directors, and management should be targeted with educational programs regarding HIV disease and work related issues.

RECOMMENDATION 53D: Professional groups and community based organizations must take the lead to provide HIV disease training to those businesses too small for other options.

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## SECTION IX

## NEUROPSYCHIATRIC AND MENTAL HEALTH ISSUES

## Introduction

HIV disease impacts California's mental health system in two important ways. First are the mental health and medical needs of the individual with HIV disease and second are the demands generated indirectly by those whose loved ones, friends, or patients are afflicted with HIV disease.

## Recommendations

54. PROBLEM STATEMENT: The diagnosis of an HIV infection causes considerable emotional distress for the infected individual and significant others.

ANALYSIS: The psychosocial aspects of HIV disease must be addressed as well as the medical. For the newly diagnosed HIV infected/AIDS person, assistance with dealing with the emotional trauma that follows such a diagnosis is critical. Trained counselors and support groups experienced in AIDS-related grief counseling are best qualified to meet the needs of the individual, family, and loved ones.

RECOMMENDATION 54A: Adequate counseling services for persons with HIV disease, families, and significant others should be available in hospital and outpatient settings. Services provided should ensure that the unique needs of minority persons are met.

RECOMMENDATION 54B: California Department of Mental Health (CDMH) should conduct a statewide needs assessment and make recommendations regarding the need for additional emotional support services, the threshold level at which it is feasible to institute emotional support services, recommend standards for the provision of emotional support services and methods to improve coordination and linkages between emotional support and other support services.

55. PROBLEM STATEMENT: Access, delivery, and coordination of mental health and medical services to persons with sever HIV dementia are inadequate.

ANALYSIS: CDMH estimates that in 1989 25,000 Californians will suffer from some degree of HIV dementia. To meet the needs of this population a mix of different treatment resources including public health, medical, and mental health systems may be needed. In modeling services that feature this joint treatment responsibility, models that bring resources to the person are preferred to those that relocate the person from one system to another.

RECOMMENDATION 55: An assessment to determine California's needs related to caring for persons severely afflicted with HIV dementia should be conducted. It is assumed that inpatient (state hospital, local day care, and local locked facilities) will be required.

56. PROBLEM STATEMENT: HIV antibody testing among the mentally disabled is area of concern.

ANALYSIS: Parent groups interested in HIV disease issues related to patient care in state hospitals have expressed concern about the limited ability of CDMH to perform HIV testing. The Department is interested in factors supporting or negating any consideration of broadening current authority to perform HIV testing.

RECOMMENDATION 56A: CDMH should initiate information and education for conservators of hospital patients in the area of HIV testing.

RECOMMENDATION 56B: CDMH should conduct non-linked HIV testing in state hospitals to determine the extent of HIV disease.

57. PROBLEM STATEMENT: There has been concern that HIV infection presents a safety risk in terms of driving and flying.

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ANALYSIS: The National Institutes of Mental Health recently called a meeting to discuss a similar issue. Data were presented from the Multi-Center AIDS Cohort Study (MACS) with over 1,500 gay men (one-half of whom were HIV antibody positive and one-half of whom were HIV antibody negative). The results showed that in a cross-sectional comparison of neuropsychological functions using state of the art, sensitive neuropsychological tests, no increased incidence of neuropsychological impairment in asymptomatic seropositives versus seronegatives were found. These findings are in contrast with another study (Grant et al., 1987) which noted neuropsychological abnormalities in asymptomatic seropositives; however, this study had less than 15 subjects per group. In light of the MACS data with over 1,500 subjects, it would seem that asymptomatic seropositives do not show a different neuropsychological profile from a matched control group. Rather, it appears that the dementia syndrome usually appears in the presence of greatest immunocompromise--i.e., about two-thirds of patients show subtle or more obvious neuropsychological dysfunction, characterized by slowness, difficulty concentrating, and difficulty on more complex speeded cognitive tasks.

RECOMMENDATION 57: There is no empirical justification for discriminating against asymptomatic seropositive for the above licenses.

## SECTION X

## HEALTH CARE SERVICES AND FINANCING ISSUES

## Introduction

The HIV disease epidemic in California, even under the most optimistic assumptions, will create demands for health care services that are beyond the capability of the existing health care system. Therapeutic intervention for the near future will be both expensive and, possibly, will prolong life but not cure the disease. As a consequence, such intervention will increase, perhaps dramatically, the overall cost of this disease. It is unrealistic to expect the general availability of therapeutic interventions which are curative or a vaccine, at any time within the next five years.

In creating a more coordinated efficient continuum of care for HIV disease, the focus should be a model which delivers comprehensive primary care in outpatient settings so as to minimize expensive acute hospital services. In order for this to be accomplished successfully, extensive networks of support services are essential. Such a model would ensure medically appropriate primary care in an atmosphere that is sensitive to psychosocial support, cultural, linguistic, and sexual preferences. Ideally, primary care should be available to individuals from the time that HIV infection is diagnosed and continue throughout the course of the disease.

## Recommendations

## Health Care Financing

58. PROBLEM STATEMENT: Health care costs related to HIV disease must be financed through a rational system which distributes the burden equitably.

ANALYSIS: There must be universal recognition that all of us will pay for the system necessary to provide care and treatment to persons with HIV disease. Considering the magnitude of this epidemic it is reasonable to request that the public and private sectors share this responsibility. In the private sector responsibility must be extended to group insurers, those offering individual coverage, self-insurers, charities, churches, private foundations, and volunteers. For example, health insurers should not be allowed to use HIV testing to determine health insurance eligibility until such time as there is a satisfactory means to provide adequate health insurance coverage for persons with HIV infection. To do otherwise would further shift health care costs associated with HIV disease onto the public sector. Meanwhile, foundations and volunteer efforts should be directed toward improving community capacity to provide support services. In the public sector Medicare, Medi-Cal, and public health programs must assume their share of the financial burden. Methods to do this include promoting those services which keep HIV infected persons out of hospitals and developing more cost effective health financing mechanisms.

RECOMMENDATION 58A: The Directors of the California Department of Insurance

(CDOI) and CDHS should convene a working group with the insurance industry to develop and implement a solution that will provide adequate health insurance coverage for persons with HIV infection. Until this issue is resolved, HIV testing for the purpose of determine eligibility for health insurance should be prohibited.

RECOMMENDATION 58B: The state should continue to take advantage of Medicaid waivers; assess and support cost-effective methods of outpatient care such as case management, and RAS; develop and support foster care for HIV infected children; subsidize day care for infected children and adults; and promote innovative programs such as the Health Insurance Premium Payment Program.

RECOMMENDATION 58C: Provide assistance to agencies using volunteers to expand their capacity to recruit, train, and retain volunteers.

RECOMMENDATION 58D: Private insurers and foundations should be encouraged to reimburse for case management services for Persons With AIDS (PWA)/Persons With AIDS Related Conditions (PWARC).

59. PROBLEM STATEMENT: Some employers or insurers have tried to avoid the costs associated with HIV related illnesses by excluding those illnesses from self-insured employee health plans or insurance policies.

ANALYSIS: About 90% of Californians with health insurance have group health insurance or group provided self-insurance. Unions are another important sources of group health coverage, especially in industries dominated by small employers. Other group plans are provided through churches, fraternal or professional organizations, or other groups.

California and other states typically require that certain benefits are included in health insurance policies. Some employer provided health plans avoid state control by using Multiple Employer Trusts to insure California workers. If delivery of the group master policy occurs outside of California, California does not apply most of its insurance regulations, thus allowing the employer to look for a state with lax regulations.

California requires that group master insurance policies delivered in California provide "take over or replacement" coverage on group policies. If an insured group changes insurance carriers, the new carrier is required to insure every member covered under the old carrier's group without a new underwriting or "pre-existing condition" exclusion. If small employers use Multiple Employer Trusts based in states that do not require "take over" coverage, the new insurer can underwrite the existing group members and refuse to insure those with pre-existing illnesses. If an employee of a small employer who insures its employees through a Multiple Employer Trust contracts an expensive and long term illness, the premium increases to the employer can be enormous. As a result, the employer may feel forced either to change insurers or to discontinue health insurance for all its employees.

Employers can also avoid most state regulation through self-insurance as a result

of the Federal Employee Retirement Security Act of 1974 (ERISA) which preempts the application of much state law. The federal government currently exercises almost no regulatory power over the provisions of these self-insured health plans.

Many employers who provide self-insured health plans limit their own risk through "stop loss" or "excess coverage." States are allowed to regulate insurers who provide "stop loss" or "excess coverage" to self-insuring employers.

RECOMMENDATION 59A: The policy of the CDOI to require general insurance plans regulated by the state to cover HIV related illnesses, should be reinforced by legislation.

RECOMMENDATION 59B: Legislation should be adopted to require health care service plans regulated by the California Department of Corporations to cover HIV related illnesses.

RECOMMENDATION 59C: California should amend its health insurance statutes to prevent out-of-state Multiple Employer Trusts from evading state regulation with respect to covered employees in California.

RECOMMENDATION 59D: California should not automatically apply its "takeover" requirements to out-of state Multiple Employer Trusts. This problem requires careful study to avoid substantially reducing the prevalence of employer provided health insurance in small businesses.

RECOMMENDATION 59E: The Attorney General should study possible legal action against employers who use Multiple Employer Trusts or self-insurance to discriminate against employees with HIV disease.

60. PROBLEM STATEMENT: Some employees are not eligible for continuation of insurance coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

ANALYSIS: The federal COBRA requires employers with more than 20 employees who provide employee health plans to offer 18 months of "continuation coverage" for almost all employees who have lost their jobs. Under COBRA, the former employees can continue their earlier health coverage for a monthly payment of not more than 102% of the total cost (including both the employer's and the employee's contributions) for similar employees. Employees working for companies which employ fewer than 20 people are not covered by COBRA.

RECOMMENDATION 60: California should adopt its own "mini-COBRA" to require employers with fewer than 20 employees to provide continuation coverage on the same terms as COBRA.

#### The Continuum of Care

61. PROBLEM STATEMENT: More primary care physicians must be involved in

managing the care of patients with HIV disease.

ANALYSIS: The magnitude of the HIV epidemic necessitates that primary care physicians such as general internists, obstetrician/gynecologists, and pediatricians become involved in the ongoing management of persons infected with HIV. The number of primary care physicians, their geographic distribution, and experience in primary care management make them well suited to take on the care of persons infected with HIV. Recruiting primary care physicians to take on the care of persons with HIV disease will require more sophisticated training than has generally been available and there must be an assurance that primary care physicians will have accessibility to specialists when needed. Additionally, there will need to be recognition by third party payers that the typical AIDS patient visit is more complex than most office visits and the patient requires close medical management as well as social and psychological support.

RECOMMENDATION 61: Develop strategies to expand the number of primary care providers at the local level willing to provide diagnostic and follow-up services to persons with HIV disease.

62. PROBLEM STATEMENT: A comprehensive continuum of care meeting the needs of persons who are asymptomatic to those in the terminal stages of AIDS is not adequately available in many regions of California.

ANALYSIS: Persons infected with HIV need access to a variety of health, psychosocial, and practical support services that vary as the individual progresses through the spectrum of disease. Local communities and regional centers of care need to develop: prevention follow-up centers, out-patient care, mental health services, pharmaceutical services, ancillary therapies (occupational therapy, physical therapy, respiratory therapy, etc.) nutritional services, community-based care, substance abuse treatment services, residential living options, transportation, day care, respite care, skilled nursing facilities, intermediate care facilities, acute in-patient care, hospice, and pastoral care.

Three guiding principles for the development of a comprehensive continuum of care are:

1. To the greatest extent possible deliver care in the community and out-patient basis rather than in hospitals to make it as humane and cost-effective as possible.
2. Provide treatment and support services utilizing a multidisciplinary team approach.
3. Perform planning on a county and regional basis to ensure the availability of optimal care and equitable distribution of AIDS cases among medical facilities and providers.

RECOMMENDATION 62A: Study older adult services modes such as day care for

their applicability to persons with HIV disease and make recommendations for implementation of services using this model as warranted.

RECOMMENDATION 62B: Examine the need to license hospice programs, hospice facilities, and residential facilities in order to promote optimal care and flexible reimbursement policies.

RECOMMENDATION 62C: For HIV infected individuals with little or no income, promote access to existing housing, the development of new housing, and stabilize support for existing emergency housing services.

RECOMMENDATION 62D: Facilitate the development of services, especially in long term care, by the development of an incentive program to facilities initiating or expanding services to persons with AIDS.

RECOMMENDATION 62E: The public and private sectors should develop community capacity to provide health insurance/financial counseling, money management, and protective services to persons with HIV disease.

#### Drug Therapy

63. PROBLEM STATEMENT: There should be available funding for appropriate drug treatment.

ANALYSIS: Many of the promising treatments for HIV infection are new and frequently very expensive. Often these expensive treatments offer some of the only current hope for prolonging and improving the lives of persons with HIV disease. Many Californians covered by private health insurance or employer self-insured plans have very limited drug coverage or none at all.

A variety of pharmaceutical interventions and experimental therapies are currently undergoing investigational trials. Until these drugs are approved by the FDA, the cost of these drugs is borne by private pharmaceutical companies. Hospitalizations associated with the administration of experimental medications or therapies to monitor for complications are not reimbursed by the drug company or third party payers.

RECOMMENDATION 63A: Encourage private insurers and self-insuring employers to cover the cost of medications used in the treatment of AIDS even if their programs do not usually reimburse for the cost of medications.

RECOMMENDATION 63B: Study mechanisms to finance the administration of investigational or experimental therapies to HIV infected children and adults.

64. PROBLEM STATEMENT: California may need more health care facilities and/or beds availability to meet the long term needs of non-acute care of HIV infected persons.

ANALYSIS: California, like most of the country, has an overall surplus of acute care hospital beds. It is not yet clear whether the HIV epidemic will require any additional acute care beds. Most likely, additional acute care beds will be necessary in some areas but not in most. The HIV epidemic necessitates additional beds in skilled nursing facilities, intermediate care facilities, and hospices, particularly as the incidence of HIV related illness spreads to people with limited support structures, such as intravenous drug users.

RECOMMENDATION 64: The Office of Statewide Health Planning and Development and CDHS should study whether the HIV epidemic will require more acute and non-acute care hospital beds during the next ten years.

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## SECTION XI

## Health Care Workers

## Introduction

There is a need to train a broad range of health care workers to respond to the AIDS epidemic. Nursing assistants, homemakers, nurses, social workers, mental health providers, health educators, physicians, and dentists, are just a few of the health care workers who need more training in order to effectively respond to the HIV epidemic. Many health care workers are afraid of caring for people with AIDS because they are not sufficiently educated. Others are overwhelmed with caring for seriously ill and dying people. Training needs encompass a wide scope and include: infection control, the management of persons infected with HIV disease, the psychological burden of caring for these patients, and legal issues.

While professional organizations, colleges, universities, vocational programs, and employers have an obligation to incorporate HIV disease specific training in their programs; the state should for a short period of time, facilitate health care worker training regarding HIV disease to assist with the immediate education, training, recruitment and retention issues facing health care workers in the AIDS field.

## Recommendations

65. PROBLEM STATEMENT: There has been inadequate education and training of health care workers who may be exposed to potentially infectious body fluids on the job.

ANALYSIS: Health care workers, including non-professional job classifications and housekeeping staff, continue to need training regarding universal infection control practices. This is true for personnel who work in acute care hospitals, skilled nursing facilities, private medical and dental offices, clinical laboratories, ambulance personnel and fire department first responders. Training should take into consideration regulations drafted by OSHA and Cal-OSHA regarding prevention of blood borne pathogens in the workplace. These draft regulations define performance standards for protective clothing and equipment, medical surveillance, training, and record keeping. Employees should receive training prior to their beginning work in an area in which they may be exposed to body fluids and it should be offered on a periodic basis.

RECOMMENDATION 65A: Agencies employing health care workers should adopt and implement policies, procedures, and training to protect workers on the job. CDC guidelines and regulations promulgated by OSHA and Cal-OSHA should be used as guides in the development of these.

66. PROBLEM STATEMENT: Many health care providers have inadequate knowledge and clinical expertise to sufficiently care and treat patients with AIDS and HIV disease.

## NOT FOR REPRODUCTION OR DISTRIBUTION

ANALYSIS: Health care providers need specific HIV disease related training to enable them to effectively treat and care for persons infected with HIV. Health care providers should be capable of taking medical histories that include relevant information about drug use and sexual behavior. They should be able to recognize the signs and symptoms of HIV disease so that it can be diagnosed as early as possible. They also need to be able to counsel patients about risk reduction and be knowledgeable of community resources.

RECOMMENDATION 66A: A clinical hotline which has the capability of providing consultation regarding medical and mental health treatment of HIV infected patients as well as the availability of clinical trials should be developed

RECOMMENDATION 66B: A physician mentor program should be developed in rural areas to facilitate the training of physicians.

67. PROBLEM STATEMENT: There are not enough health care providers trained to deal with the special emotional and physical needs of those with HIV disease.

ANALYSIS: Professional and non-professional classifications of health care workers need to be encouraged to work with persons with AIDS and HIV related conditions. Increasing the pool of workers to provide care to people with HIV disease requires a multi-dimensional strategy. While the creation of financial incentives will be reliant upon employers, the state can assist recruitment efforts through promoting training and funding the development of educational materials for health care workers.

RECOMMENDATION 67A: Basic curricula in all medical and health profession education programs should be modified to ensure adequate HIV disease training regarding prevention, diagnosis, treatment, psycho-social issues, and infection control practices.

RECOMMENDATION 67B: The state professional licensure exams for health care workers should incorporate questions about AIDS and HIV infection.

RECOMMENDATION 67C: All state health care worker licensure boards should require licensed health care professionals to obtain a minimum of three continuing education units in the area of HIV disease as a condition of re-licensure. These units should not be interpreted to be additional continuing education units beyond that which is already required. This condition of renewal for licensure should automatically relinquish three years from implementation.

RECOMMENDATION 67D: The state should work with professional organizations and schools which train health care workers to provide low cost or no cost training to health care workers to address prevention strategies, infection control, care of HIV infected individuals, psychosocial issues, legal issues, etc.

RECOMMENDATION 67E: Educational materials, curricula, and training programs

specifically targeted at non-professional health care workers such as nursing assistants and In-Home-Supportive Service Workers should be developed.

68. PROBLEM STATEMENT: Health care workers in the AIDS field are experiencing burnout.

ANALYSIS: As the HIV epidemic progresses, health care workers in the field are experiencing psychological trauma. Dealing with seriously ill and dying people on a daily basis, and an extremely intense work load allows no opportunity for recovery and increasing disenchantment with their work. To prevent these highly skilled and valuable health care workers from leaving the field, measures must be instituted at the workplace and with educational institutions training health care workers.

RECOMMENDATION 68: Employers should institute programs to prevent burnout among their staff who are working in the field of HIV on a proactive and continuing basis.

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## SECTION XII

## HEALTH AND WELFARE AGENCY

## A. DEPARTMENT OF HEALTH SERVICES

## 1. OFFICE OF AIDS

In response to the public health crisis created by the AIDS epidemic, CDHS established California's AIDS program in July 1985. Initially the program was administered within the Infectious Disease Branch but in March 1987 the program was organizationally designated as an Office, reflecting the rapid growth and high profile of the program.

The primary goal of OA is to develop strategies and implement programs for epidemiologic surveillance, education and prevention, testing and counseling, supportive care and treatment, and research as public health measures designed to control the spread of HIV. State funding for OA activities has grown from \$15.5 million allocated in FY 1985-86 to \$79.6 million in FY 1988-89. Federal funds appropriated in FY 1988-89 total approximately \$18.4 million.

Programmatic activities within OA are conducted by the following sections and units: Education and Prevention Unit, Preventive Services Section, Epidemiologic and Research Section, Pilot Care Unit, Medi-Cal Waiver Unit, and the Training Unit. Each of these is described in more detail below.

## Education and Prevention Unit

## Goals and Objectives

The Education and Prevention Unit is charged with developing programs and strategies which will: 1) change attitudes and modify behavior in order to decrease transmission of HIV; 2) train those who may have contact with HIV infected persons to protect themselves from an occupational exposure and to deal with HIV infected persons in a compassionate manner; 3) decrease anxiety about HIV disease and misconceptions about transmission; 4) create a network among state, county, community based organizations, and others to facilitate dissemination of successful education interventions; and 5) provide training to OA education and prevention contractors regarding educational strategies directed toward knowledge, attitude and behavior change, community organization, and evaluation methodology.

## Progress

Funding for AIDS education and prevention activities has increased dramatically in California from \$432,000 in FY 1983-84 to \$16,328,000 in FY 1988-89. AIDS education activities are conducted through a statewide AIDS education and prevention contracting program with county health departments, community-based organizations, and state agencies. Contractors develop and implement a variety of

educational interventions which are conducted at the local level. The number of OA education and prevention contractors has leaped from 15 to 158 over the past 5 years. Approximately 73% of contractors are community based organizations, 24% are county or city health departments, and the remaining 3% are state agencies or universities.

In addition to local programing, the state provides funding for telephone hotlines in Northern and Southern California, a two year statewide AIDS education media campaign, a educational materials clearinghouse, a Minority AIDS Resource Development and Prevention Center (MARDPC), and an evaluation of the effectiveness of AIDS education and prevention programs conducted by OA contractors.

The media campaign runs from March 1988 to January 1990. It includes the production of television, radio, and print materials which are distributed through local AIDS education coalitions at the community level. The media campaign targets sexually active men and women, teenagers and their parents, and such special populations as migrants, runaways, prostitutes, IVDUs, and the homeless. Campaign materials are targeted for release in three waves: October 1988, Spring 1989, and October 1989. To enhance the effectiveness of the campaign, media events are being provided in conjunction with local educational activities conducted by OA contractors.

The clearinghouse serves as a materials resource center for OA contractors and health care providers in California. It publishes a quarterly newsletter describing educational materials, develops new materials, and publishes a biannual newsletter providing a synopsis of AIDS experimental drug trials.

The MARDPC is charged with developing leadership among ethnic minority communities and agencies. MARDPC provides training for community leaders, is involved in building coalitions, and provides technical assistance and support to community based minority projects.

The URSA Institute has conducted a yearly statewide evaluation of AIDS education and prevention contractors since 1986. The evaluation is used to identify areas in need of improvement as well as identifying those components which are successful and which should be expanded.

#### Preventive Services Section

The Preventive Services Section is comprised of three units. These are the HIV Testing Unit, Preventive Field Operations Unit, and Prevention and Follow-up Unit. Programmatic activities are directed towards epidemiologic surveillance, oversight of local assistance Block Grant funded activities, anonymous and confidential HIV antibody testing, education and information related to testing, support for asymptomatic HIV infected individuals, and distribution of AZT.

##### HIV Testing Unit

The ATS program, Confidential Testing program, HIV Counselor Training program, AZT Drug program, and the Alcohol and Drug Counselor program are all administered by the HIV Testing Unit.

#### ATS Program

The ATS program was established by the Legislature shortly after March of 1985 out of concern for the integrity of the state's blood supply. It was believed that many people would donate blood as a means of ascertaining their antibody status. To safe guard against this, the ATS program was implemented to provide voluntary anonymous testing and education services at no charge.

Through the ATS, individuals participate in a pre-test education session that provides basic information about HIV disease. Those who decide to take the test return in approximately two weeks for their test results and a post-test education session. In this session the goal is to explain the individuals test result in terms of his/her health, future behavior, and to refer the person to appropriate medical or psychosocial support resources.

To ensure that persons who engage in high risk activities are aware of the ATS program, an ATS Education and Outreach Campaign was initiated in 1986. The goal of the campaign is to provide information about the ATS program services to high risk populations without encouraging low risk populations to become concerned and seek services at the ATS. An evaluation of the ATS system is also currently underway. The evaluation seeks to assess the quality of services provided and administrative/management performance.

#### Confidential Testing Program

The Confidential Testing program provides HIV risk assessment, education, and HIV antibody testing through facilities providing health care services such as family planning clinics, maternal and child health clinics, rural health primary care clinics, drug and alcohol rehabilitation programs, STD clinics, and other county and community based organization programs. The testing component of the program differs from anonymous testing in that testing requires written consent so the test result can be linked to an individual through their name.

#### Alcohol and Drug Counselor Program

In 1988, OA was funded by CDC to place HIV counselors in county alcohol and drug treatment programs. Nine counties are to receive funding to hire counselors to provide HIV disease education including pre-counseling, referral for the HIV test, and post-test counseling. The program is anticipated to facilitate HIV antibody testing of high risk individuals.

#### HIV Counselor Training Program

The training component of the HIV Testing Program began as a response to the need to prepare counselors to provide education and information to persons seeking anonymous testing. All ATS and confidential testing program counselors are required to be certified. This measure was adopted to achieve standardization and to maintain quality assurance. As of December 1988, approximately 800 individuals have been certified as HIV Test Counselors. To maintain the availability of high quality HIV counseling, a refresher course and on-site evaluation of counselors is being implemented.

#### AZT Drug Program

In August 1987, the federal government awarded funding to California on a one-time-only basis to provide AZT to low income persons with AIDS and ARC. Funds are disbursed to eligible persons through county and city health departments. Persons eligible for the program must meet income eligibility guidelines and cannot receive benefits from Medi-Cal, third party payers, or other local assistance programs. However, persons enrolled in health insurance plans which do not include medications as a benefit and who meet other eligibility criteria may enroll in the program. AZT funds may also be used to cover insurance co-payments.

#### Preventive Field Operations Unit

The Preventive Field Operations Unit was designed to meet the AIDS field surveillance needs of the state. Field staff are assigned to six surveillance areas in the state where they act as program contacts to the health care community.

Local health jurisdictions are allocated Block Grant funding based upon population and reported AIDS cases. Forty-nine counties receive funding to conduct epidemiologic surveillance, test linked education, and other AIDS related activities. Contract counties receive assistance through a Memorandum of Agreement with the R&CH Division. Additionally, the cities of Berkeley, Long Beach, and Pasadena are funded.

Local health jurisdictions are required to submit yearly plans specifying how funds will be directed towards active case surveillance, HIV testing and test linked information programs, and local AIDS service needs. This latter category allows local health jurisdictions to direct funding toward community planning and other local priorities.

Field staff also help local health jurisdictions to: implement criteria based testing programs within targeted specialty clinics, jails, and drug treatment facilities; provide HIV counselor training; and assist in the establishment of voluntary partner notification programs. A final area in which field staff are responsible is the establishment of HIV disease prevention education and confidential HIV testing in all county STD clinics.

#### AIDS Prevention and Follow-Up Center Unit

The APFC was developed to address the long recognized need for additional

support and intervention for HIV infected asymptomatic individuals. The goals of the program are to prevent HIV transmission by persons who know they are seropositive, to detect early signs of clinical disease, and to prevent the onset of opportunistic infections or immunosuppression for as long as possible.

APFC provide medical screening, evaluation, referral, intensive risk reduction and behavior change education, and social/emotional support to asymptomatic seropositive individuals. The education component of the APFC is designed to influence risk causing drug use and sexual behaviors of HIV positive individuals.

In FY 1988-89, two APFC were funded on a pilot basis in the local health jurisdictions of the City of Long Beach and Santa Clara County. The pilot projects were established to develop protocols, determine the feasibility of such centers, and to examine the cost effectiveness of the program. During 1989 an additional six APFCs will be funded.

### Epidemiologic Research and Statistics Section

#### Goals and Objectives

The goals of the Epidemiologic Research and Statistics Section are to achieve an improved understanding of the factors influencing HIV transmission; to have up-to-date information on the levels and progress of HIV infection in the state's affected populations; and to track, analyze and project morbidity and mortality data for purposes of resource allocation, planning, and evaluation. Programmatic activities within the unit are conducted through the AIDS Case Registry, the Epidemiologic Studies Program, and the Policy and Development Unit.

#### AIDS Case Registry

The AIDS Case Registry has primary responsibility for maintaining a confidential record of all AIDS cases reported in California. The Registry maintains a complete, accurate, and up-to-date database of AIDS case information; conducts detailed analyses of case data; and disseminates information through a monthly newsletter.

#### Epidemiologic Studies

Through a multidisciplinary approach that incorporates behavioral and applied epidemiologic methodologies, the Research and Statistics Unit in collaboration with others is actively involved in studies to determine HIV disease prevalence, incidence, and trends.

#### Institution Based HIV Seroprevalence Studies

In the spring of 1988 OA collaborated with the California Department of Corrections (CDC) to test sera for HIV infection from persons entering the correctional system. Overall seroprevalence among this population was

approximately 3%. Further discussion of this study is discussed in the report, HIV Seroprevalence Among Prisoners Entering the California Correctional System. 14

A similar study to the corrections study is being coordinated with the CDMH. Additionally, a study of hospital emergency room and trauma center admissions is planned for FY 1988-89.

#### Clinic Based Seroprevalence Studies

In FY 1988-89, OA funded 12 counties to conduct clinic based seroprevalence studies outside of Los Angeles and the Bay Area. This study will provide invaluable information regarding the incidence and prevalence of HIV infection by age, race/ethnicity, geographic region and sex. The study is anticipated to span a 5 year period.

#### Population Based HIV Seroprevalence Studies

Population based studies provide epidemiologic data on the incidence and prevalence of HIV infection in specific populations. Two such studies were funded by the OA in FY 1987-88. In one study, serologic and risk factor data were collected from IV drug users in treatment. The other study is ongoing and is examining risk factors among multiple-partner heterosexual females.

Studies currently underway, include a population based study of HIV seroprevalence among women of child bearing age through a large scale blinded testing of neonatal blood specimens routinely collected for genetic disease screening. Data generated through this study will be used to identify high risk geographic areas as well as high risk groups.

#### Knowledge, Attitude and Behavior Assessment

A household telephone survey to assess knowledge, attitudes, and behaviors related to AIDS among approximately California adults was conducted during the fall of 1987. A follow-up telephone survey was conducted in October 1988 to obtain information specifically from recreational drug users. Obtaining a greater number of drug using survey respondents will allow additional analysis of IVDUs and assist the development of a profile of the knowledge, attitudes, and behaviors of the IV drug using and needle sharing population.

#### Pilot Care Project Unit.

##### Goals and Objectives

The goal of the Pilot Care Project Unit is to assure a continuum of home and community based care for PWAs and PWARCs in California that is comprehensive, cost effective, humane, and of high quality.

##### Case Management/Pilot Care Projects

The Pilot Care Project Unit was established in 1986 to fund pilot projects to demonstrate the value of non-institutional health care services such as home health care, attendant care, and hospice care in controlling costs and providing humane care to PWAs/PWARCs. An evaluation of the pilot care projects suggests that by maintaining PWAs at home with comprehensive case managed health and social support systems, the utilization of acute care hospital days can be reduced. Through the Pilot Care program, community based case management services are provided to approximately 1,400 PWA/PWARCs through 26 projects in 31 counties. There are no age or financial eligibility criteria for participation in Pilot Care projects.

#### Residential AIDS Shelters

With the passage of AB 4448 Chapter 1526, Statutes of 1988, H&S Code, CDHS was authorized to contract with up to 20 pilot projects statewide to provide housing and food for homeless PWA/PWARCs through RAS. The RAS will provide PWA/PWARCs with temporary or long-term housing, basic services such as kitchen and laundry facilities, and are staffed with a 24 hour house manager. They will provide a clean, safe, and healthy environment in which residents may receive in home medical, social, or mental health services. An evaluation process is to be conducted concurrent to the pilot projects to analyze specific shelter needs of PWAs/PWARCs and develop a profile of individuals utilizing this type of facility. Additionally data will be collected which will assist CDHS to determine whether licensing or regulation of these facilities is necessary.

#### Medi-Cal Waiver Program

The Medi-Cal AIDS Waiver program is a three-year pilot authorized by the Federal Health Care Financing Administration (HCFA) under Section 1915 (c) of the Social Security Act and, therefore, provides financing for one-half of the waiver program costs. The program authority provides some discretion to states to select the specific services to be provided under a waiver, as long as such services are cost effective.

The waiver will serve a maximum of 788 unduplicated recipients the first year (1989), 963 the second year (1990), and 1,138 the third year (1991). The program will provide home and community based services (HCBS) to Medi-Cal eligible PWA or PWARC who meet specific eligibility criteria. The services provided under this program will be provided in lieu of institutionalization and are provided in addition to any other home health services already available under the regular Medi-Cal program. Waiver services to be provided by contract waiver agencies are: case management, skilled nursing, psychosocial counseling, attendant care, homemaker services, minor home adaptations, and a foster child supplemental payment.

#### Training Unit

The Training Unit was recently established within OA. The goal of the unit is to develop and implement training programs for a variety of audiences. The Training Unit will provide both technical assistance and direct service to public and private organizations and will target state, county, and city government agencies as well as the private sector. Standardized training models and evaluation guidelines will be developed by the unit.

## 2. FAMILY HEALTH DIVISION

### California Children Services Program

CCS is a joint state-county program which provides diagnostic, medical treatment, and rehabilitation services to children with physically handicapping conditions ages birth to 21 who meet medical, financial, and residential eligibility requirements. Services are provided through county health departments, hospitals, special centers, physicians, and other health care disciplines.

As a disease of the immune system, AIDS has been covered by the CCS program since it was identified; however, asymptomatic HIV infections have only recently become a covered condition. The CCS program received a \$1.1 million augmentation from the Legislature in FY 1987-88 to implement the HIV Children Program. Through this new program component CCS provides diagnostic testing and follow-up services to children who are either at risk of HIV infection and/or who are HIV antibody positive.

In the area of professional education, CCS is working with the American Academy of Pediatrics to develop guidelines for physicians directed at determining medical indications for HIV testing in children and information guidelines to be imparted to parents or adolescents when HIV antibody testing is indicated or requested. Additionally, approximately 80 county and state CCS professional staff will be trained during FY 1988-89. The training program will concentrate on pediatric HIV infections, management, and support systems for pediatric patients and their families, confidentiality issues, and provide orientation to the CCS HIV Children Program.

### Office of Family Planning

The Office of Family Planning (OFP) provides funding for clinical services relating to contraception, sterilization, infertility, and education by contracting with 157 public and non-profit agencies serving low income sexually active men and women. OFP services are provided to 472,000 individuals annually, over 98% are women aged 15 to 44 years old.

In January 1988, OA provided funding to the OFP to implement HIV antibody testing and counseling through 10 of its 157 family planning service contractors on a pilot basis. As of January 31, 1989, results of 5,347 tests were reported. Of these, 123 (2.3%) were HIV antibody positive. Of the positive test results, 108 were among males. In FY 1988-89, funding for HIV antibody testing and

counseling through OFP was increased and currently 156 sites provide confidential testing.

### Maternal and Child Health Branch

MCH develops, implements and maintains programs which reduce and prevent maternal, infant and childhood morbidity and mortality. Economically disadvantaged women aged 15 to 44 years old and children under age 21 year are the primary targets for MCH program activities. Through a system of 200 contractors, MCH administers programs which provide comprehensive perinatal care for low-income women, case management services for pregnant and parenting adolescents, high risk infants follow-up, perinatal service coordination, and local MCH program coordination.

During FY 1988-89 approximately 300 maternal and child health providers throughout the state will be trained regarding perinatal AIDS. It is anticipated that this comprehensive training project will assist MCH providers to implement effective perinatal AIDS programs at the local level. Confidential HIV antibody testing is widely available to MCH contractors who receive testing funds through OFP, R&CH or county health departments.

### 3. RURAL AND COMMUNITY HEALTH DIVISION PRIMARY HEALTH CARE SYSTEMS BRANCH

The Primary Health Care Systems Branch is one of three major program areas within the Rural and Community Health Division. Through the provision of financial assistance, technical assistance, and consultation, public health services are provided in rural areas which would otherwise have little or no access to such services. Rural and county hospitals, medical providers, primary care clinics, Native American clinics, farmworker clinics, and counties with populations of 40,000 or less are targeted by the Primary Health Care Systems Branch.

#### Local Health Services Section

Public health needs in the rural underpopulated counties of Modoc, Lassen, Trinity, Glenn, Amador, Calaveras, Mariposa, Sierra, Alpine, Mono, and San Benito are coordinated through the Local Health Services Section (LHSS). In FY 1988-89, funding was provided to LHSS \$40,000 to conduct a needs and resource assessment among contract counties and to provide them with technical assistance related to HIV disease program planning. Major deficits were found in funding, personnel, and the availability of services. Five of the 11 contract counties are served by one public health nurse whose priority is to provide mandated public health programs for the entire county. Allied services, such as mental health and drug and alcohol programs have limited staff and funding, and there is a scarcity of physicians. Health officers in most of these counties serve on a part-time basis.

Based on identified needs, contract counties are being assisted to develop a local AIDS task force and a county HIV disease plan. Key activities to be included in

local HIV disease plans are coordination of HIV disease education and prevention services, strengthening the linkages between existing resources, establishment of an AIDS case reporting system, and the implementation of confidential HIV antibody test programs.

#### Primary Care Clinics and Indian Health Program

The clinic programs within the Primary Health Care Systems Branch are involved in a number of HIV disease prevention activities. Funding has been allocated to the Rural and Community Health Division to fund pilot confidential HIV antibody testing programs in primary health clinics. As of February 1989, 37 Rural and Community Health Clinics had been approved as testing sites. These clinics include rural, urban, migrant farmworker, and Native American clinics.

#### 4. PREVENTIVE MEDICAL SERVICES DIVISION

The Preventive Medical Services Division targets the control of infectious diseases, chronic diseases, and environmental health hazards. The division is comprised of three branches with specific programmatic responsibility in each of the above areas. The Infectious Disease Branch has been involved with AIDS activities through the Immunization Unit and the STD Section.

##### Immunization Unit

The Immunization Unit promotes the control of vaccine preventable disease through surveillance activities, investigation of outbreaks, education, and the provision of vaccine to local health jurisdictions. Through its weekly newsletter, California Morbidity, the Infectious Disease Branch has notified local health jurisdictions and medical providers about national recommendations for the immunization of persons infected with HIV. Recommendations were first published in December 1986 and revised recommendations regarding measles/mumps/rubella were published in April 1988.

##### Sexually Transmitted Disease Section

Control of sexually transmitted diseases in California is conducted cooperatively by federal, state, and local governments in concert with private medical providers. At the state level, sexually transmitted disease control is promoted through surveillance activities, provision of technical consultation and training to local programs, assignment of STD case management staff to high incident areas for partner notification and patient counseling.

The STD Control Section integrated HIV disease education activities into their patient counseling activities beginning in 1985. To further facilitate HIV disease education activities among STD clinic populations, local health jurisdictions were funded by OA to provide education and HIV antibody testing services in STD clinics. This is being aided by the provision of HIV Test Counselor training to approximately 130 state STD program staff and 60 local STD clinicians.

Through a cooperative arrangement with OA, the STD Section is performing partner notification of sexual partners and needle sharing partners of HIV infected persons. Duplication of effort and expense are avoided by this collaboration as STD program staff perform partner notification activities for HIV disease as well as other sexually transmitted diseases.

## 5. LABORATORY SERVICES DIVISION

State laboratories involved in HIV disease related activities are the Viral and Rickettsial Disease Laboratory, Microbial Disease Laboratory and, Laboratory Field Services.

### Viral and Rickettsial Disease Laboratory

The Viral and Rickettsial Disease Laboratory (VRDL) has played a major role in California's response to the HIV epidemic through the provision of reference testing, training, quality control activities, disease surveillance, research, and policy development. Reference testing is provided to public health laboratories performing HIV screening but which do not have the capability to perform the confirmatory tests. Through the provision of confirmatory testing tremendous support has been provided to anonymous and confidential testing programs conducted at the local level.

Due to federal cutbacks in training, the VRDL undertook training of public health microbiologists regarding HIV, viral techniques, and test interpretation. Their training provides the necessary link for quality assurance, uniform testing, and consistent test result interpretation throughout the state.

Maintaining the availability of quality HIV testing and test interpretation is critical to California's testing programs, epidemiologic surveillance, early intervention programs, and for treatment purposes. One means by which this is achieved is through the evaluation of commercial test kits. In 1986, an extensive evaluation of commercial HIV antibody test kits was conducted by the VRDL. Due to this study and work with manufacturers, the quality of testing was improved not only in California, but throughout the United States. Another means by which testing standards are maintained is through collaboration with CDC and other researchers regarding policy development related to licensing of HIV test kits, development of interpretation standards for Western Blots, and the development of laboratory testing profiles to monitor the health status of individuals with HIV infections. Through these collaborative efforts, California continues to lead the way toward development of national standards for uniform and quality testing.

### Microbial Diseases Laboratory

The Microbial Disease Laboratory (MDL) performs reference testing, drug susceptibility testing, training and consultation, quality control activities, evaluation of testing techniques, development of clinical standards, and research as related to bacteria, fungi, and parasites. Their involvement in AIDS centers around

those infectious organisms which particularly affect persons with AIDS or ARC due to their immunosuppression. Frequently these organisms present with atypical growth and biochemical properties or are organisms not commonly found in humans. Culturing techniques may be labor intensive and require specialized techniques not available in most laboratories. As a central reference laboratory in the state, MDL is able to track trends and disseminate findings throughout their network of public and private laboratories.

MDL is also involved in the evaluation and development of testing techniques. They are currently evaluating a fluorescent antibody test for the identification of the causative agent of Pneumocystis carinii pneumonia and are involved in evaluating new test kits to screen for Treponema pallidum. The latter involves utilization of sera from PWAs.

### Laboratory Field Services

Laboratory Field Services (LFS) provides for quality and consistent laboratory testing statewide through licensure of clinical laboratories, their technical personnel, and on-site monitoring of quality assurance activities. These activities are particularly important as they relate to HIV antibody testing where inaccurate test results can have detrimental ramifications for the public as well as the individual tested.

LFS is responsible for approving the performance of some laboratory services such as HIV antibody testing. Licensure to perform this test involves completion of an application process and a site visit by LFS to determine laboratory proficiency. In addition to laboratories, LFS licenses and monitors blood banks, plasmapheresis centers, blood collection stations, and approves those facilities which receive and store tissue and organs from deceased donors. HIV antibody screening procedures are one of the factors reviewed during inspections.

### 6. FOOD AND DRUG BRANCH

The Food and Drug Branch (FDB) implements, directs, and coordinates prevention, detection, and control activities to protect the public against: improperly manufactured, adulterated, misbranded, unsafe, or falsely advertised foods, drugs, medical devices, hazardous household products, cosmetics, and ineffective drugs and medical devices.

California law prohibits the sale and distribution of any new drug unless a new drug application (NDA) has been approved by the U.S. Food and Drug Administration (FDA) or FDB. The NDA must demonstrate that the new drug is safe and effective when used as directed and that it is properly manufactured and labeled. Investigational New Drug (IND) studies are conducted by product manufacturers or other sponsors to develop data which will support the approval of an NDA. The purpose of these laws is to protect the public from exposure to drugs which may cause unacceptable adverse effects or are simply ineffective.

In the spring of 1987, in the face of mounting criticism that FDA was slow to approve new AIDS drugs, funding was appropriated to CDHS for new staff to process and monitor AIDS related INDs and NDAs. As of December 31, 1988, nine IND applications and one NDA for AIDS related drugs and medical devices had been reviewed by FDB. Of these, four IND applications were approved and these studies are currently underway.

To date, no AIDS related medical devices have been approved by FDB. Two applications have been received for Home Human Immunodeficiency Virus Test Kits. If approved, these kits would be available without a prescription and consist of home specimen collection equipment and a package for mailing the specimen to a central laboratory for analysis. Test results and counseling would be provided to the customer over the telephone. The sponsors of these test kits have been requested to provide data regarding the adequacy and safety of providing counseling and test results over the telephone.

## 7. MEDI-CAL PROGRAM

Medi-Cal is a state and federally supported welfare program that pays for health care for needy and low income California residents who do not have the means to pay for their medical care. The program is administered at the state level by CDHS. Eligibility is established locally by county welfare departments for AFDC and other medically needy persons, and by Social Security District Offices for the aged, blind, and disabled. A broad range of services are covered by Medi-Cal including inpatient and outpatient services. To become a Medi-Cal beneficiary, individuals must meet income and other eligibility requirements.

Medi-Cal beneficiaries receive services either from private providers who are reimbursed on a fee-for-service basis, or through pre-paid health plans. Inpatient services are only available from contract hospitals, except in emergency situations. Hospitals receive a flat per diem rate for inpatient care regardless of the patient's acuity. While most of Medi-Cal's benefits (acute care, long term care, outpatient care) are very important to PWA/PWARCs, of particular interest are prescription drugs, Health Insurance Premium Payment (HIPP) program, and hospice.

### Prescription Drugs

The Medi-Cal drug formulary is comprised of a wide range of prescription medications. These medications can be prescribed to Medi-Cal beneficiaries who are seen in outpatient settings or skilled nursing facilities without prior authorization. Approximately five percent of the drugs listed in the formulary have Code One Restrictions. These specify the circumstances under which the medication can be prescribed. Prior authorization is required from Medi-Cal in order for pharmacies to be reimbursed for medications which are ordered for uses other than those specified in the Code One Restriction or for medications not listed in the formulary.

Medications listed in the Medi-Cal drug formulary are updated several times a year.

New drugs which are petitioned to be added to the formulary must be FDA approved and are subject to a review process. Reviewers analyze the medical justification for adding the drug, comparing the benefits of the new drug to the medications currently available through the formulary. Additionally, the financial impact of adding the new drug is taken into consideration. While investigational new drugs are not added to the formulary, these drugs are usually provided by the manufacturer at no cost to patients participating in clinical drug trials.

California was the first state in the nation to add AZT to its drug formulary. Additionally, Medi-Cal is required to immediately add to the formulary, any drug approved by the Food and Drug Administration for use in the treatment of AIDS or ARC. (Welfare and Institution Code, section 14105.3)

There are almost no restrictions on the medications that Medi-Cal beneficiaries hospitalized for acute care may receive. This places the responsibility for cost containment in the purview of the hospital as it is reimbursed based on a negotiated per diem rate.

#### Health Insurance Premium Payment Program

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The HIPP program was established by AB 3328, Chapter, 940, Statutes of 1986. Under this law, CDHS is permitted to pay or continue to pay the private health insurance premiums for Medi-Cal eligibles whenever it is cost effective to do so.

Through HIPP, Medi-Cal may pay private health insurance premiums for Medi-Cal eligibles who require high cost medical care and 1) may be losing their insurance due to loss of employment, 2) may be dropping their insurance coverage because of high premium cost, or 3) may have entitlement to continue group health insurance through their former employer.

This program is expected to be of benefit to Medi-Cal eligibles with high medical costs who prefer to maintain their private health insurance coverage, continue with the same medical providers, and who have a specific high cost medical regime. PWAs are expected to be candidates for HIPP because of the cost of their medical care and because PWAs who require Medi-Cal assistance, may have recently lost or may be losing medical insurance because of employment loss.

#### Hospice

Hospice care became a Medi-Cal benefit January 1, 1988. Benefits are provided in the same amount, scope, and duration as provided by the Medicare hospice program and payment rates are tied to the Medicare program.

Hospice care utilizes a multidisciplinary approach to meet the unique needs of terminally ill individuals. Care is focused on treating the symptoms of a terminal illness rather than on curative services. Palliative and supportive items and services directed toward the physical, psychological, social, and spiritual needs of the patient/family are provided. Medical and nursing services are designed to

maximize the patient's comfort, alertness, and independence in order to allow the patient to reside in his/her own home as long as possible. Any Medi-Cal eligible beneficiary certified by a physician as having a life expectancy of six months or less may elect to receive hospice care in lieu of normal Medi-Cal coverage for services related to the terminal condition.

#### Medi-Cal AIDS Treatment Costs

Medi-Cal estimates that their total cost for treatment of patients with AIDS between August 1982 through March 1988 were \$74 million. In FY 1987-88 costs were approximately \$28 million. While Medi-Cal payments for patients with AIDS has risen each year, the rate of increase has declined. Per person per month costs have declined roughly one-third in the past three years. The decline can be attributed to a number of factors including the fact that the average length of hospital stay for PWAs has steadily decreased in the past several years due to the movement away from acute hospital care towards community based care. However, Medi-Cal AIDS treatment costs are expected to more than double in the next two years. FY 1989-90 Medi-Cal costs are projected to be approximately \$60 million.

As the AIDS epidemic progresses, it appears that Medi-Cal will be paying a greater proportion of AIDS related health care costs. In 1987, approximately 31% of PWAs were on Medi-Cal at the time of death. By 1992, it is projected that 42% of PWAs will be on Medi-Cal at the time of death.

#### B. ALCOHOL AND DRUG PROGRAMS

CDADP directs and coordinates the state's effort to prevent and minimize the adverse effects of alcohol and drug use in California. Through a partnership with California's 58 counties, CDADP provides services in the areas of alcohol and drug prevention, identification, early intervention, treatment, and rehabilitation. During FY 1987-88, 141,800 individuals received alcohol recovery services and 120,958 individuals received drug treatment services.

In response to HIV disease, CDADP trained its 180 employees and provided HIV disease training and educational materials to staff of local alcohol and drug treatment programs. Additionally, CDADP funded four pilot AIDS/IVDU projects in FY 1987-88 to investigate innovative approaches to outreach and treatment for IVDUs. These projects include treatment for IV drug using prostitutes, pregnant women, and others. Local funding for HIV disease prevention and drug treatment activities totals \$9.45 million in FY 1988-89.

CDADP has also increased availability and accessibility to methadone treatment slots. In addition to increasing the number of slots, CDADP revised methadone licensing regulations to allow for emergency increases in capacity and reduced admission criteria. Since 1986, the methadone program has grown by approximately 3,000 slots.

AIDS related activities regarding alcohol and drug using individuals are

coordinated with CDHS through a Memorandum of Understanding. Areas of mutual activity include: drug abuse rehabilitation, HIV antibody testing, training for professionals, treatment linked education, street outreach worker training, IVDU street AIDS education, educational material development, media campaigns, and Request for Proposal (RFP) development. Through this cooperative effort, CDADP and CDHS are seeking to coordinate services to individuals who are infected with HIV, or are at substantial risk of becoming infected with HIV as a direct or indirect outcome of intravenous drug use. An example of this cooperative effort is the coordination of a \$900,000 HIV testing project in nine counties. The purpose of the project is to contain the spread of HIV by encouraging drug users to be tested and by providing pre- and post-test counseling and AIDS prevention to drug users.

### C. DEPARTMENT OF MENTAL HEALTH

CDMH provides for the care and treatment of the mentally ill through a system of five state mental hospitals and by funding a spectrum of inpatient and outpatient services at the local level through county mental health departments.

In 1986 the CDMH conducted a needs assessment of mental health providers, acute care hospitals, colleges and universities, and persons with AIDS or ARC or their significant others to determine the mental health needs of individuals affected by AIDS in California. This study identified several common issues across the state. These were: 1) the need to provide services to PWA/PWARCs, asymptomatic HIV infected individuals, and significant others; 2) lack of coordination between state, county, and public sector programs; 3) lack of training for mental health providers; 4) lack of skilled nursing facilities, residential treatment programs, and acute care psychiatric facilities which would accept individuals with HIV infection.

In 1986, the state mental hospitals began providing HIV antibody testing on a voluntary informed consent basis to patients who had engaged in high risk activities. Of the 392 tests performed in 1986, 24 (6.6%) were positive. In 1987, 997 were performed and 32 (3.3%) were positive. The decrease in the percent of positive tests is believed to reflect testing of a broader group of patients. Cumulative data on HIV infections within the state mental hospital system are collected on a weekly basis.

AIDS education and training policies were implemented in state mental hospitals in 1986. All employees received training which included basic AIDS information, infection control, and the care of HIV infected patients. HIV disease training was also incorporated into the new employee orientation program. Medical staff have additionally received advanced training in the diagnosis and treatment of HIV infected patients. Through their community mental health program, CDMH sponsored six regional workshops for mental health professionals in late 1986 and early 1987. Updates of these workshops were held in the spring of 1988.

The state mental hospitals implemented a system wide three-tier approach to educating patients about HIV transmission and prevention in 1987. In the first

level, all patients receive basic HIV information at the time of admission. This information is provided both in writing and verbally. The second level of education involves the presentation of information either in a group or individually utilizing a video and/or discussion format. The third level of education is targeted at patients with sufficient comprehension ability for more indepth education and may involve intensive group therapy around HIV issues.

In community based mental health programs, the scope of patient and provider prevention education is at the discretion of local mental health providers. To assist AIDS educators and mental health providers at the local level to educate the general public and specific target populations about the emotional impact of HIV infection upon those affected and their significant others, CDMH commissioned the production of three videos. Presented in a documentary format, these videos focus on individuals, couples, and families successfully coping with the diagnosis of HIV and upon health care providers who provide services to HIV infected persons.

In the state mental hospital system each facility has designated a physician to coordinate the care of patients with an HIV infection. Comprehensive medical care services including AZT are available to patients either at the state mental hospital or through community based acute care hospitals. Upon discharge patients with an HIV infection are referred back to their local mental health program to coordinate referral to community based AIDS treatment and support services.

At the community level, the treatment and support of persons with HIV infections includes one-on-one counseling, support groups and case management services. CDMH funds projects throughout the state to provide these services.

#### D. DEPARTMENT OF SOCIAL SERVICES

CDSS administers a broad range of social and welfare service programs aimed at protecting, assisting, and enabling Californians to live with dignity and independence. Those program areas which have been most greatly impacted by the HIV epidemic are: Adult Services, Family and Children Services, Foster Care, Adoptions, and Community Care Licensing. Counties are kept up-to-date about HIV disease program policy implications through All County Information Notices directed to County Welfare Department Directors and others. Issues such as education and training, HIV antibody testing, and confidentiality have been discussed through these notices.

##### Adult Services

Adult Services administers the In-Home Supportive Services (IHSS) program. The purpose of the program is to provide supportive services to eligible elderly, blind or disabled persons who cannot perform these services for themselves and who cannot safely remain in their own homes unless support services are provided. Services provided through this program include: homemaker services, personal attendant care, protective supervision, transportation to medical appointments, and respite care.

While IHSS has not been greatly impacted to-date by PWAs and PWARCs it is anticipated that the need for these services will grow as this population increases. CDSS is working closely with the OA to assure a continuity of care for PWA/PWARCs between the IHSS program and the AIDS Medi-Cal Waiver program.

### **Family and Children Services Bureau**

Family and Children Services are provided to abused, neglected, and exploited children and their families. Support services are available to HIV infected children and their families or caregivers who are otherwise eligible for these services as defined by Dependency Statutes.

Additionally, the Family and Children Services Branch is working with the Foster Care Bureau to implement SB 2076, Chapter 1236, Statutes of 1988. This legislation mandates the establishment of a one-county three year pilot project to recruit foster parents for children two years of age and under who have AIDS or who have tested positive for the AIDS virus and to develop education, training, and support services for foster parents.

### **Foster Care and Adoptions Program**

CDSS has informed county welfare departments, adoptions agencies, and others that they concur with the CDC guidelines distributed in August 1985 regarding HIV infection in children and foster care. These guidelines recommended that foster care placement agencies consider adding HIV screening to routine medical evaluations of children at increased risk of being infected with HIV prior to placing them in foster homes.

Adoption agencies have also been advised to discuss HIV antibody testing with birth parents and prospective adoptive parents if the child is at high risk for HIV infection. CDSS recommends that the need for testing be discussed with the child's physician and it be done if the physician indicates it is appropriate. Dependent children, referred by the court for adoption or foster placement, may be tested at the direction of the court. Once tested, prospective foster and adoptive parents must be informed of the test result.

### **Community Care Licensing**

CDSS licenses non-medical facilities which provide care and supervision to children and adults. Among the types of facilities licensed are: foster homes, group homes for minors, child day care centers, family day care, adult residential facilities, adult day care facilities, rehabilitation facilities, and small family homes for the mentally, developmentally, or physically disabled. The types of activities provided in community care facilities include assistance with dressing, personal hygiene, supervision, assistance taking medications, arranging for medical or dental care, monitoring food intake, and maintenance and/or supervision of client cash resources or property.

Homes that provide care and supervision of PWA/PWARCs have been established in a number of communities. Due to gaps in licensing regulations within CDSS and CDHS, many of these facilities have not been regulated. The situation came to the attention of CDSS and CDHS when it became apparent that some of these homes provided less than optimal living conditions. While it is recognized that these homes are meeting a need along the HIV disease continuum of care, it is also acknowledged that PWAs and PWARCs deserve a caring, protective, and safe environment. To address this issue, the need for regulation of these homes is being monitored.

#### E. DEPARTMENT OF DEVELOPMENTAL SERVICES

CDSS serves 84,500 clients who have mental retardation, cerebral palsy, epilepsy, autism or other severe and long term neurologic handicaps. Also served are 5,600 infants and toddlers who are at risk of developing developmental disabilities.

Clients are served through 21 regional centers and through seven developmental centers. The majority of CDSS clients are served in the community either in their own home or in community licensed facilities. The regional centers are entry points into the developmental services system. They provide intake, assessment, diagnostic and counseling services, and coordinate a spectrum of services for clients including vocational training, housing, medical care and other support services. The developmental centers are state operated inpatient facilities. Only a small proportion of CDSS clients reside in developmental centers. In general, residents of developmental centers have severe medical or behavior problems, handicapping conditions, or other traits which make community living difficult.

The presence of HIV infection among CDSS clients has been small to date. Of patients in the developmental centers, fewer than 10 patients have been identified as HIV infected. A seroprevalence study among developmental center patients is planned for the near future. The number of clients served by the regional centers who have either AIDS or some other form of HIV disease has also been small. A few children became infected from blood transfusions received prior to 1985; however, the majority of CDSS clients with HIV infection are infants and toddlers who became infected perinatally. The number of adult DDS clients with HIV disease has also been very small and resulted primarily from blood transfusion or high risk behaviors.

Regional centers are responsible for training their staff and for assuring that providers giving services to CDSS clients have adequate HIV disease training. Regional centers have by and large accessed local training programs provided by community based organizations, public health departments, and others. The Association of Regional Centers Agencies (ARCA) was awarded an education and prevention contract by CDHS/OA in FY 1988-89. ARCA is piloting two training programs based on the unique needs of their staff and providers. The developmental centers have all implemented employee AIDS training programs. Generally, these are being integrated into other communicable disease control

education and training inservice programs.

#### F. DEPARTMENT OF AGING

The California Department of Aging (CDA) administers a number of health and social service programs for the elderly and other impaired adults. Programs are implemented at the local level through 33 area agencies on aging and by community based long term care providers. Adult day health care, case management, home nursing care, respite care, nutrition programs, legal assistance, transportation, and ombudsman assistance are among the program activities directed by CDA. Services are primarily provided to the elderly, age 60 or older; however, functionally impaired adults 18 years of age or older are served by Adult Day Health Care (ADHC) centers and the case management Linkages program.

The CDA is involved with the HIV epidemic from two perspectives. The Department is working with the senior network to provide information and education on HIV disease. In addition, CDA providers are beginning to provide health care and support services to persons with AIDS. Through the Linkages sites, case management services have been provided to a small number of PWAs and a very small number of PWAs have enrolled in existing ADHC centers. Presently CDA is working with several organizations interested in establishing ADHC centers targeted exclusively towards PWAs.

Training and coordinating the senior labor pool to provide support services to PWAs is another area under consideration by the CDA. Older adults have a track record in providing support services for clients in their homes. Programs such as Senior Companion and Friendly Visitor represent a low cost labor pool that potentially could be utilized to help maintain PWAs in the home setting.

#### G. DEPARTMENT OF REHABILITATION

The California Department of Rehabilitation (CDR) provides services to individuals with medical or psychological disabilities. The goal of the program is to provide training and services which will enable clients to return to the mainstream of society and to work. Services are provided at no charge to the client.

Clients are referred to CDR from a variety of sources including other government agencies, private physicians or self-referral. Eligibility requirements for the program include the diagnosis of a substantial medical or mental disability which interferes with employment and a reasonable expectation that the individual will be able to complete the program and return to work. Individuals with a rapidly progressive disease are not eligible for the program as the individual's expected longevity must justify their involvement in the program.

Individuals with HIV infections may receive training and services from CDR provided they meet the eligibility requirements. Medical staff and vocational rehabilitation counselors at CDR have received training regarding HIV disease and are prepared to provide assistance to clients with HIV infections. As treatment

of HIV infections improves and length of life is extended, CDR anticipates that their role in providing services to this population will increase.

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## SECTION XIII

## DEPARTMENT OF EDUCATION

The CDOE serves in an advisory capacity to county and district superintendents of schools regarding AIDS issues by providing technical assistance and training which are coordinated by the Critical Health Initiatives Unit. Expertise on AIDS issues is provided to CDOE by an AIDS Advisory Committee comprised of experts from a variety of disciplines.

AIDS guidelines regarding infection control practices, age appropriate education, and policy development have been formulated by CDOE. These were distributed to county and district superintendents of schools in May 1986 and May 1988. Guidelines emphasize that planning and curriculum adoption should occur at the local level and that state and federal guidelines should be tailored to individual community needs. Information guidelines for school employees on HIV disease and hepatitis B are under development.

In FY 1987-88, CDOE implemented a train the trainer program funded by CDC and CDHS for teachers and school personnel. The two day training program provides participants with the knowledge and skill to train their colleagues to provide classroom instruction. It focuses on age appropriate teaching strategies for regular and alternative school settings. More than 400 individuals were trained during FY 1987-88 including 58 educators from each County Office of Education. These latter individuals form a network of AIDS Coordinators who assist CDOE to facilitate training within each county. CDOE has recently implemented a teacher training project. The project, "Healthy School-AIDS Prevention and Health Promotion through Education" is a statewide project to further facilitate teacher training. Classroom HIV education is supported by the Comprehensive Resource Center in Vallejo which loans age-appropriate education materials to teachers.

A baseline knowledge, attitude, and behavior survey of 8,000 high school students throughout California was conducted by CDOE in cooperation with CDC in May 1988. The survey found that California's high school students are knowledgeable about the routes of HIV transmission. More than 90% of survey respondents were aware that having sexual intercourse and sharing drug injection equipment are ways that a person can get AIDS. Approximately 50% of respondents reported that they are sexually active. While the majority (87.8%) knew that condoms reduce the risk of exposure to HIV, only 27.2% reported using them all of the time. Sharing of drug injection equipment was reported by less than 2% of respondents. Further discussion of these survey results are presented in the November 1988 issues of CAHPERD Journal/Times.<sup>15</sup> A follow-up student study is planned for FY 1988-89.

CDOE and the San Diego County Office of Education jointly produced a two-part AIDS Prevention Education Guide during the past year. The Administrator's Guide targets curriculum planners and will assist them to develop, implement, and evaluate AIDS education programs while the Teacher's Guide is a progressive and sequential curriculum with age appropriate lessons for grades 6 through 12. Student handouts, pre/post tests, detailed lesson plans and a resource section are provided. Student worksheets are

available in Spanish.

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## SECTION XIV

## CALIFORNIA DEPARTMENT OF CORRECTIONS

The California Department of Corrections (CDC) has an inmate population of approximately 75,000 men and women who have primarily been committed by the courts for crimes of violence, crimes against property or drug related offenses. The population is predominately composed of young men. The average inmate age is 29 years old. Males represent 94% of the population while females account for 6% of the population. The racial/ethnic make-up of the inmate population is as follows: white 32%, black 36%, Hispanic 28%, and Other 4%.

The program goals of the CDC as they relate to HIV are: 1) to provide a safe environment for staff and inmates; 2) to prevent HIV transmission within their facilities; and 3) to provide quality medical treatment, support, and education to inmates. Dealing with HIV disease related issues in the prison setting is complicated by logistical and procedural problems which are required to ensure the safety of staff and inmates.

Since September 1984, the CDC estimates they have identified an approximate cumulative total of 500 inmates with HIV disease within the state prison system. Inmates identified as HIV antibody positive are separated from the general prison population. This decision was made in order to protect these inmates from aggressive acts by other inmates, to help stem transmission within the facilities, and to more closely monitor the health status of those infected by the virus.

The CDC houses identified HIV infected inmates at one of the three following facilities:

1. The California Medical Facility (CMF) at Vacaville which can house approximately 140 HIV infected male inmates in special housing units.
2. The California Institution for Men (CIM) in Chino which can accommodate approximately 170 HIV infected male inmates.
3. The California Institution for Women (CIW) at Frontera which can house a small number of HIV infected female inmates in its infirmary. During FY 1988-89 a Special Housing Unit, similar to the ones at CMF and CIM, will be completed to provide for the anticipated future increase of HIV infected female inmates.

Both CMF and CIM offer the availability of acute hospital services. Female inmates in need of such health services are transferred to Riverside General Hospital.

The risk profile of the incarcerated AIDS patient indicates that the typical patient is heterosexual with a history of intravenous drug use. The Department of Corrections has issued two reports on AIDS. These are: An Overview of AIDS within the California Department of Corrections and A Demographic Profile of AIDS, ARC, HIV Cases and AIDS Mortalities within the California Department of Corrections.<sup>16,17</sup>

The CDC and CDHS conducted a blinded HIV seroprevalence study of inmates during a

two month period in 1988. All newly committed inmates and returnees-to-custody processed through CDOC reception centers were tested. Overall seroprevalence was approximately 3%. Further discussion of this study is presented in the report, HIV Seroprevalence Among Prisoners Entering the California Correctional System.<sup>14</sup>

In addition to participating in seroprevalence studies, the CDOC makes HIV antibody testing available to inmates on a voluntary informed, written consent basis. Inmates are provided pre/post counseling by the appropriate medical staff with respect to the implications and ramifications of a positive HIV antibody test.

HIV disease training is provided to CDOC staff through a variety of means. HIV disease education has been incorporated into the infectious disease curriculum presented at the Richard A. McGee Corrections Academy. Parole agents also receive this training at the Modesto Training Center/Criminal Justice Training Center. All new peace officers receive a 2 hour HIV disease training unit. Additionally, the Department mandated that all employees receive at least 30 minutes of HIV disease related training annually. A network of 120 AIDS trainers created within the Department in 1988 provides, assists in the provision of, and performs in the capacity of resource personnel within their respective facilities and parole regions.

Inmates receive up-to-date information on the transmission and nature of HIV disease upon reception into the prison system, while incarcerated, and again upon release. Parolees also receive pamphlets from their parole officers. Some institutions have developed broader educational programs and utilize such mechanisms as prison orientation sessions, closed circuit television, and articles in inmate newspapers. County health departments and community based organizations have also been invited into prison facilities to conduct education presentations and support groups.

Additionally, videos, posters, and pamphlets are distributed system wide on an ongoing basis. During FY 1987-88, over 30 educational pieces for inmates were purchased, written and distributed. Whenever possible, materials are in both English and Spanish and are at a low literacy level. During 1988 the CDOC developed an inmate specific comic book on AIDS for men and a pamphlet for women.

Comprehensive medical services including AZT are available to inmates with HIV infection. Medical needs of inmates are generally met by the Department's medical staff and facilities. When medical problems require tertiary care, arrangements have been made with nearby medical centers to provide care. Prior to release from prison HIV infected inmates are assisted to obtain medical coverage, placement in the community and referral to the appropriate community resources.

## SECTION XV

## CALIFORNIA YOUTH AUTHORITY

The California Youth Authority (CYA) has a population of 9,000 youth aged 14 to 23 years old who have been committed by the courts for offenses similar to those committed by adult offenders. Approximately half of the wards in the CYA are under 18 years of age, 96% are male and 4% are female.

The first AIDS case diagnosed in the Youth Authority system occurred in October 1984. To date, the presence of HIV infections including AIDS within the CYA system has been small and manageable. No more than seven wards have been identified as infected with HIV at any one time. Youth who are identified as infected with the virus are not separated from the general population based upon their HIV status, rather wards are separated when their behavior or symptoms indicate the need for closer observation or medical care.

In 1987, the CYA conducted a 6 month prevalence study of Hepatitis B and HIV among new arrivals at CYA reception centers. Risk behavior data was collected on 1,200 youth. Of these, 700 indicated some degree of involvement in high risk behavior. Voluntary informed consent was obtained from this group and Hepatitis B/HIV antibody testing was performed. Of the 700 youth tested, 4 individuals were HIV antibody positive (.03%) and 84 were positive for Hepatitis B (7%). All of the individuals who were HIV antibody positive were 18 years of age or older.

A voluntary confidential HIV seroprevalence study was conducted among youth entering CYA reception centers in the spring of 1988. No risk behavior data was collected. Of the 400 tests performed, there were no positive test results. The CYA anticipates conducting epidemiological surveillance on new admissions on a periodic basis.

Staff education for CYA personnel began in 1985 on a voluntary basis. Medical personnel, administrators, school staff, parole officers, and others participated in these early training sessions. Beginning in FY 1987-88, CYA designed and implemented a mandatory AIDS training program for staff which was made possible by a \$50,000 grant from OA. Through this program, 72 trainers were trained in an intensive three-day course. In turn, these trainers educated 4,600 employees in a number of 2 hour presentations. HIV disease education has also been incorporated into the CYA Academy to ensure that all new employees are trained.

Recognizing that the population served by CYA is at high risk for HIV infection, a preventive education program was implemented for wards. Thirty teachers were trained during FY 1987-88 in the use of a curriculum targeted at the youth within their system. The six hour curriculum, implemented in July 1988, is written at sixth grade reading level and is required for all wards through their school program and for all youth living on substance abuse wards.

Comprehensive medical services are available to wards with HIV infections. Specialists follow wards identified as HIV antibody positive through periodic T-cell counts and other

assessment measures. Upon release or parole from the CYA, youth are given assistance to arrange for the appropriate medical benefits and are referred to community resources.

DRAFT

## SECTION XVI

## DEPARTMENT OF INSURANCE

CDOI is a regulatory agency whose role it is to regulate insurers' solvency, sales, claims practices, and the quality of products offered to consumers. All insurers operating in California are required to be licensed by CDOI.

The jurisdiction of CDOI includes life and health insurance companies. Excluded from their authority are health care service plans (regulated by Department of Cooperation) and self-insured plans. Individual, group, and supplemental health insurance plans are submitted for review and approval by CDOI prior to offering them to the public. Group health insurance plans covering Californians under master policies held by employers or trusts in other states need not be approved by CDOI, but their insurers' claims practices are subject to CDOI jurisdiction.

To assist the insurance industry to understand California laws and regulations as they relate to AIDS issues, CDOI issued two health bulletins dealing with HIV antibody testing, discrimination, and AZT coverage. The first bulletin, issued in October 1986, dealt with testing issues and discrimination on account of sex and/or marital status. The California H&SC Section 199.21 (f) prohibits the use of HIV antibody testing to determine insurability except in the case of life or disability insurance, effective January 1, 1989. HIV antibody test results cannot be used as a means to determine insurability even if the information is voluntarily provided. Inquiries as to whether an applicant has had the test, as well as questions concerning whether applicants have been told not to donate blood, are considered improper; however, blood tests which do not detect HIV antibodies but measure immune system function are currently allowable. Discrimination against insurance applicants based upon sex, marital status, or sexual orientation is expressly prohibited by CDOI regulations (Title 10 California Administrative Code 2560.3). Thus establishing special underwriting standards for single males thought to be homosexual or refusing to insure persons in certain geographical areas or occupations which are identified with the homosexual community are prohibited.

CDOI issued its second AIDS related information bulletin in April 1987. In this bulletin the insurance industry was informed that they were expected to cover AZT if prescription drugs were a provision of the insurance policy.

Several bills were introduced to the Legislature during FY 1987-88 to address the concerns of the insurance industry. Effective January 1, 1989, life or disability income insurers may request an applicant to take an HIV antibody test for the purpose of determining insurability. This law requires the insurer to bear the cost of the test and to provide the applicant with written education material and a list of counseling resources.

## SECTION XVII

## EMERGENCY MEDICAL SERVICES AUTHORITY

The Emergency Medical Services Authority (EMSA) is responsible for the coordination and integration of an effective efficient emergency medical care system throughout the state's 58 counties. These responsibilities include the development of training and certification standards for prehospital emergency medical care and public safety personnel. EMSA regulations apply to both paid and volunteer prehospital care providers.

EMSA requires the course curricula for all prehospital emergency medical care personnel, including public safety personnel, to include a section on communicable diseases. EMSA distributed a resource list, the guidebook, "Public Safety Workers and the AIDS Epidemic", and reference materials to EMT training program instructors to facilitate the incorporation of information about AIDS in course curricula.

## References

1. California Department of Health Services. An Updated Quantitative Analysis of AIDS in California, by KW Kizer, JR Rodriquez, and GF McHolland. Sacramento, CA, 1987.
2. "AIDS Case Projections for California: 1988-1992," California AIDS Update, 2 (January-February 1989):1.
3. Planning for the AIDS Epidemic in California: A Population-Based Assessment of Knowledge, Attitudes, and Beliefs. San Francisco, CA: Communication Technologies, 1988.
4. California Department of Health Services. AIDS Prevention and Treatment: A Framework for Local Planning, by KW Kizer, MA Conant, DP Francis, et.al. Sacramento, CA, 1988.
5. California Department of Health Services. Guidelines for the Voluntary Notification of Sex and Needle/Syringe Sharing Partners of Persons with Human Immunodeficiency Virus Infection, ed. by KW Kizer and T Frazier. Sacramento, CA, 1988.
6. Smith CL and Wolfe G. California Local Health Jurisdictions and the Management of Recalcitrant Patients with AIDS or AIDS Related Conditions. Sacramento, CA: California Conference of Local Health Officers, 1987.
7. Presidential Commission on the Human Immunodeficiency Virus Epidemic. Report of the Presidential Commission of the Human Immunodeficiency Virus Epidemic, Washington, D.C.: U.S. Government Printing Office, 1988.
8. Institute of Medicine, National Academy of Sciences. Confronting AIDS: Update 1988. Washington, D.C.: National Academy Press, 1988.
9. Eya E. "AIDS in the Asian Community," Presentation Area IV HIV Surveillance Meeting, Berkeley, CA, February 29, 1988.
10. Paskick, RJ. Health Promotion for Minorities in California. Berkeley, CA: Western Consortium for Public Health, 1988.
11. Jang M, et. al. Second Year Evaluation of California's AIDS Community Education Program. San Francisco, CA: URSA Institute, 1988.
12. California Legislature Senate Committee on Health and Human Services, Senator Diane Watson, Chair. Hearing on AIDS in Minority Communities. Los Angeles, CA: December 1987.

13. Wilburn S. California Urban Indian Health Council, Inc., Sacramento, CA. Personal Communication, January 19, 1989.
14. California Department of Health Services. HIV Seroprevalence Among Prisoners Entering the California Correctional System, by JA Singleton, CI Perkins, AI Trachtenberg, M Hughes, and KW Kizer. Sacramento, CA, 1989.
15. Bradley BJ. "Influencing AIDS-Related Choices of High School Students with Instruction." CAHPERD Journal/Times. 51 (November 1988): 16-19.
16. California Department of Corrections. An Overview of AIDS within the California Department of Corrections. Sacramento, CA, 1987.
17. California Department of Corrections. A Demographic Profile of AIDS, ARC, HIV Cases, and AIDS Mortalities with the California Department of Corrections 1984-86. Sacramento, CA, 1987.

## AIDS Surveillance Report

January 1, 1989  
AIDS Reporting System

1. Disease Category	Adult/Adolescent		Pediatric		Total	
	Reported Cases ( %)	Reported Deaths ( %)	Reported Cases ( %)	Reported Deaths ( %)	Reported Cases ( %)	Reported Deaths ( %)
PCP	10471 ( 61)	6268 ( 60)	46 ( 43)	32 ( 70)	10517 ( 61)	6300 ( 60)
Other Disease w/o PCP	4187 ( 25)	2533 ( 60)	61 ( 56)	34 ( 56)	4248 ( 25)	2567 ( 60)
KS Alone	2398 ( 14)	1200 ( 50)	1 ( 1)	1 (100)	2399 ( 14)	1201 ( 50)
No Diseases Listed	0 ( 0)	0 ( .)	0 ( 0)	0 ( .)	0 ( 0)	0 ( .)
Total	17056 (100)	10001 ( 59)	108 (100)	67 ( 62)	17164 (100)	10068 ( 59)

2. Age		3. Race/Ethnicity	Adult/Adolescent	Pediatric	Total
Reported Cases ( %)			Reported Cases ( %)	Reported Cases ( %)	Reported Cases ( %)
Under 13	108 ( 1)	White, Not Hispanic	12927 ( 76)	48 ( 44)	12975 ( 76)
13-19	30 ( 0)	Black, Not Hispanic	1839 ( 11)	24 ( 22)	1863 ( 11)
20-29	2943 ( 17)	Hispanic	1992 ( 12)	34 ( 31)	2026 ( 12)
30-39	7741 ( 45)	Asian	228 ( 1)	2 ( 2)	230 ( 1)
40-49	4233 ( 25)	Native American	21 ( 0)	0 ( 0)	21 ( 0)
Over 49	2109 ( 12)	Unknown	49 ( 0)	0 ( 0)	49 ( 0)
Unknown	0 ( 0)				
Total	17164 (100)	Total	17056 (100)	108 (100)	17164 (100)

4. Patient Groups	Adult/Adolescent		Total ( %)
	Males ( %)	Females ( %)	
Homosexual or bisexual Men	13620 ( 82)	0 ( 0)	13620 ( 80)
Intravenous (IV) drug User	492 ( 3)	130 ( 28)	622 ( 4)
Homo/Bi IV drug User	1717 ( 10)	0 ( 0)	1717 ( 10)
Hemophiliac	105 ( 1)	8 ( 2)	113 ( 1)
Heterosexual contact	92 ( 1)	142 ( 31)	234 ( 1)
Transfusion with blood/products	265 ( 2)	136 ( 29)	401 ( 2)
None of the above/Other	302 ( 2)	47 ( 10)	349 ( 2)
Total	16593 (100)	463 (100)	17056 (100)

	Pediatric		Total ( %)
	Males ( %)	Females ( %)	
Hemophiliac	8 ( 12)	0 ( 0)	8 ( 7)
Parent at risk/has AIDS/HIV	23 ( 34)	26 ( 63)	49 ( 45)
Transfusion with blood/products	33 ( 49)	13 ( 32)	46 ( 43)
None of the above/Other	3 ( 4)	2 ( 5)	5 ( 5)
Total	67 (100)	41 (100)	108 (100)

Appendix B

CHRONOLOGY OF CALIFORNIA'S AIDS FUNDING\*

Agency	1983-84	1984-85	1985-86	1986-87	1987-88	1988-89
Department of Health Services	\$ 500	\$1,040	\$7,323	\$21,329	\$47,068	\$ 76,587
University of California	2,900	3,094	7,597	9,597	9,597	9,857
Department of Mental Health	0	0	600	0	700	1,500
Department of Drug and Alcohol Programs	0	0	0	0	5,000	10,003
Department of Corrections	0	0	0	589	1,279	2,800
Youth Authority	0	0	0	0	200	200
Department of Social Services	0	0	0	0	0	63
TOTAL**	\$3,400	\$4,134	\$15,520	\$31,515	\$63,844	\$101,010

\* Dollars in thousands.

\*\* General Fund and Federal Funds.

1/18/89

Appendix C

STATE OF CALIFORNIA  
ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) FUNDING  
FISCAL YEAR 1988-89

(\$ in Thousands)

<u>FUNDING - BY STATE ORGANIZATION</u>	<u>GENERAL FUND</u>	<u>FEDERAL FUND</u>	<u>TOTAL</u>
Department of Health Services	\$61,157	\$15,430	\$76,587
University of California	9,857		9,857
Department of Alcohol and Drug Programs	1,300	8,703	10,003
Department of Corrections	2,800		2,800
Department of Mental Health	1,500		1,500
Department of Youth Authority	200		200
Department of Social Services	<u>63</u>	<u>          </u>	<u>63</u>
<u>TOTAL FUNDING - STATE OF CALIFORNIA</u>	<u>\$76,877</u>	<u>\$24,133</u>	<u>\$101,010</u>

1/18/89

Appendix D

STATE OF CALIFORNIA  
AIDS FUNDING PROGRAM DETAIL  
FISCAL YEAR 1988-89

FUNDING - DEPARTMENT OF HEALTH SERVICES (DHS)

(\$ In Thousands)

	<u>GENERAL FUND</u>	<u>FEDERAL FUND</u>	<u>TOTAL</u>
Office of AIDS	\$59,235	\$15,430	\$74,665
Division of Laboratories	1,493		1,493
Environmental Health	429		429
	<hr/>	<hr/>	<hr/>
TOTAL FUNDING - DHS	\$61,157	\$15,430	\$76,587

1/18/89

## Appendix E

STATE OF CALIFORNIA  
 OFFICE OF AIDS, DEPARTMENT OF HEALTH SERVICES  
 AIDS FUNDING  
 FISCAL YEAR 1988-89

(\$ in Thousands)

<u>FUNDING - OFFICE OF AIDS</u>	<u>GENERAL FUND</u>	<u>FEDERAL FUND</u>	<u>TOTAL</u>
STATE OPERATIONS (SUPPORT):			
Medi-Cal Waiver	\$195	\$229	\$424
All Other Support	<u>5,595</u>		<u>5,595</u>
	5,790	229	6,019
Human Clinical Trials for AIDS and Vaccine Research	<u>2,000</u>		<u>2,000</u>
 TOTAL SUPPORT	 <u>7,790</u>	 <u>229</u>	 <u>8,019</u>
LOCAL ASSISTANCE:			
Education and Prevention Contracts	16,328		16,328
Pilot Care Contracts (Including \$225,000 for Barlow Hospice)	8,549		8,549
San Francisco General Hospital	5,700		5,700
County Block Grants	5,488		5,488
Alternative Test Sites	5,412		5,412
Confidential Testing	2,821		2,821
Azidothymidine Treatment	2,500		2,500
Prevention and Follow-Up Centers	1,500		1,500
Epidemiology Study Grants	1,199		1,199
California Children Services HIV Program	1,100		1,100
Homeless Shelter Contracts	621		621
Medi-Cal Waiver Contracts	227	227	454
 TOTAL LOCAL ASSISTANCE	 <u>51,445</u>	 <u>227</u>	 <u>51,672</u>
 TOTAL SUPPORT AND LOCAL ASSISTANCE	 <u>59,235</u>	 <u>456</u>	 <u>59,691</u>
 FEDERALLY FUNDED SPECIAL PROJECTS:			
Alternative Treatment Projects			
Counseling/Testing		4,108	4,108
Surveillance/Seroprevalence		6,036	6,036
Information and Education		4,830	4,830
 TOTAL FEDERALLY FUNDED SPECIAL PROJECTS		 <u>14,974</u>	 <u>14,974</u>
 TOTAL FUNDING OFFICE OF AIDS	 <u>\$59,235</u>	 <u>\$15,430</u>	 <u>\$74,665</u>

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STATE OF CALIFORNIA  
AIDS FUNDING ALLOCATIONS BY LOCAL HEALTH JURISDICTION  
FISCAL YEAR 1987-88

Appendix F

LOCAL HEALTH JURISDICTION	DEPARTMENT OF HEALTH SERVICES								DEPARTMENT OF		
	EDUCATION AND PREVENTION	BLOCK GRANT	ALTERNATIVE TEST SITE	CONFIDENTIAL TESTING	PILOT <sup>2</sup> CARE	CALIFORNIA <sup>3</sup> CHILDREN SERVICES	ADULTHOOD- MIDLINE (A2T) TREATMENT	TOTAL	MENTAL HEALTH	ALCOHOL AND DRUG PROGRAMS	GRAND TOTAL
Alameda County	\$414,000	\$211,285	\$681,300	\$43,750	\$225,636	\$22,500	\$309,198	\$1,907,669		\$255,352	\$2,163,021
Alpine County										2,000	2,000
Anaador County										2,000	2,000
Berkeley, City of	55,000	24,859					34,353	114,212	\$28,000		142,212
Butte County	50,000	24,944	65,548					140,492		2,000	142,492
Calaveras County										2,000	2,000
Colusa County										2,000	2,000
Contra Costa County	175,250	123,690	314,346	126,750	128,100	16,250	68,986	953,372		46,319	999,691
Del Norte County							2,802	2,802		2,000	4,802
El Dorado County	43,000	20,000					4,472	67,472		2,000	69,472
Fresno County	184,000	87,778	145,345	40,490	28,944	13,125	20,694	522,376		232,876	755,252
Glenn County										2,000	2,000
Humboldt County	45,000	20,000	61,000				10,625	136,625		2,000	138,625
Imperial County	47,000	20,000	40,000					107,000		2,000	109,000
Inyo County										2,000	2,000
Kern County	101,000	74,850	165,148	61,930	23,004	11,875	1,988	439,795		2,000	441,795
Kings County	20,000	20,000						40,000		2,000	42,000
Lake County		20,000						20,000		2,000	22,000
Lassen County										2,000	2,000
Long Beach, City of	140,000	103,419	698,946		175,000		105,778	1,223,143			1,223,143
Los Angeles County	2,229,608	1,250,000	753,240	273,700	1,227,403	112,500	1,663,959	7,510,410	181,000	1,918,441	9,609,851
Madera County		20,000						20,000		2,000	22,000
Marin County	86,000	44,635	156,128	10,125	93,500	11,250	6,622	400,260		34,118	442,378
Mariposa County										2,000	2,000
Mendocino County	25,000	20,000			18,392		4,866	68,258		2,000	70,258
Merced County	37,000	24,800	9,880					71,680		2,000	73,680
Modoc County										2,000	2,000
Mono County										2,000	2,000
Monterey County	118,000	54,534	82,340			15,000	11,956	281,830		33,552	315,382
Napa County		20,000				11,250	1,123	32,373		2,000	34,373
Nevada County	15,000	20,000					2,102	37,102		2,000	39,102
Orange County	354,000	366,275	691,420	107,824	211,664	27,500	226,275	1,984,958	50,000	473,662	2,508,620
Pasadena, City of	20,000	25,437					11,038	56,525			56,525
Placer County	26,000	21,854						47,854		2,000	49,854
Plumas County	13,000							13,000		2,000	15,000
Riverside County	185,000	147,778	167,640		170,000	14,375	77,265	762,058	20,000	168,289	930,347
Sacramento County	523,000	147,913	277,016	60,025	198,057	16,250	86,922	1,309,183	200,000	139,628	1,648,811
San Benito County										2,000	2,000
San Bernardino County	95,000	179,433	227,448			21,250	44,151	567,282		124,187	691,469
San Diego County	555,000	400,178	874,776	512,550	250,586	30,625	343,554	2,967,269	50,000	426,965	3,444,234
San Francisco, City / County	1,401,236	620,712	889,361	141,700	636,952	37,500	2,051,664	5,779,125	96,000	660,531	6,535,656
San Joaquin County	93,000	67,507	123,730		38,917	10,625	26,214	359,993	20,000	68,336	448,329
San Luis Obispo County	45,000	30,820	64,841			11,875		152,536		2,000	154,536
San Mateo County	115,000	110,233	184,700	91,000	134,848	15,625	96,579	747,985	35,000	77,386	860,371

STATE OF CALIFORNIA  
AIDS FUNDING ALLOCATIONS BY LOCAL HEALTH JURISDICTION  
FISCAL YEAR 1987-88

LOCAL HEALTH JURISDICTION	DEPARTMENT OF HEALTH SERVICES								DEPARTMENT OF		GRAND TOTAL
	EDUCATION AND PREVENTION	BLOCK GRANT	ALTERNATIVE TEST SITE	CONFIDENTIAL TESTING	PILOT CARE	CALIFORNIA CHILDREN SERVICES	AIDDOHY- MIDLINE (AZT) TREATMENT	TOTAL	MENTAL HEALTH	ALCOHOL AND DRUG PROGRAMS	
Santa Barbara County	120,000	56,213	194,412	38,625	53,061	11,250	45,531	519,092	20,000	47,481	588,573
Santa Clara County	160,000	229,506	405,569	33,625	127,500	19,375	136,593	1,112,168		79,621	1,191,789
Santa Cruz County	110,000	35,804	121,320	19,750	28,013	11,250	18,217	344,354		30,931	375,285
Shasta County	40,000	20,000	61,427					121,507		2,000	123,507
Sierra County							702	702		2,000	2,702
Siskiyou County										2,000	2,000
Solano County	80,000	45,715	76,724			12,500	184	215,123		7,350	222,473
Sonoma County	114,000	68,053	199,340	59,400	132,136	11,250	35,097	620,091		31,498	651,589
Stanislaus County	73,800	47,656	71,580			11,250		204,286		2,000	206,286
Sutter County		20,000						20,000		4,000	24,000
Tehama County										2,000	2,000
Trinity County										2,000	2,000
Tulare County		42,568	63,700			11,250	4,732	122,250		2,000	124,250
Tuolumne County										2,000	2,000
Ventura County		94,089	94,320		28,030	11,875	9,199	237,512		65,477	302,989
Yolo County	5,700	20,000						25,700		2,000	27,700
Yuba County		20,000						20,000			20,000
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	\$7,913,594	\$5,024,693	\$7,762,545	\$1,621,244	\$3,929,743	\$510,000	\$5,453,615	\$32,415,434	\$700,000	\$5,000,000	\$38,115,434
	=====	=====	=====	=====	=====	=====	=====	=====	=====	=====	=====

- 1 Allocation may serve a multiple county area. An additional \$3,629,498 allocated to statewide projects.
- 2 Allocation may serve a multiple county area.
- 3 Additional \$90,000 to dependent CCS programs with populations under \$200,000.

Appendix G  
LEADING CAUSES OF DEATH IN CALIFORNIA  
AND PUBLIC HEALTH PREVENTION EXPENDITURES

Cause of Death	Number of Deaths 1986*	Average Number of Deaths Per Day - 1986 No. (%)	Mortality Rate Per 100,000 Inhabitants	Percent Change in Mortality Rate Since 1980	FY 86-87 Prevention Expenditures**	Percent of PH Prevention Expenditures
Heart Disease and Arteriosclerosis	70,345	193 (35)	260.7	-10.2	\$2,405,279 <sup>1,2</sup>	11.6
Malignant Neoplasms (Cancer)	46,412	127 (23)	172.0	1.8	562,000 <sup>3</sup>	2.7
Cerebrovascular Disease (Stroke)	15,075	41 (7)	55.9	-20.4	515,514 <sup>1,2</sup>	2.5
Accidents (Unintentional Injuries)	10,817	30 (5)	40.1	-11.1	100,000 <sup>4</sup>	0.5
Chronic Lung Disease	8,477	23 (4)	31.4	21.7	0	0.0
Pneumonia and Influenza	7,602	21 (4)	28.2	20.5	907,000 <sup>5</sup>	4.4
Cirrhosis	3,968	11 (2)	14.7	21.8	0	0.0
Suicide	3,960	11 (2)	14.7	2.1	0	0.0
Homicide	3,089	8 (2)	11.4	-21.4	0	0.0
Diabetes Mellitus	3,028	8 (2)	11.2	61.0	234,438	1.1
AIDS	1,850	5 (2)	6.9	1,850.0	15,940,000 <sup>6</sup>	77.2

- \* Total number of deaths in California in 1986 was 202,826. This is the latest year for which complete statistics are available.  
 \*\* Does not include diagnostic tests, etc., through Medi-Cal, California Children's Services, or other benefit programs.

- 1 These figures reflect a percentage from each of the Hypertension and Health Education Risk Reduction (HERR) programs.  
 2 The difference between the \$3,426,000 from FY 85/86 and the \$2,920,793 in FY 86/87 reflects the "Impact Study" that had been completed and for which the funds were discontinued.  
 3 This figure reflects a percentage of HERR and Nutrition and Cancer programs.  
 4 This figure is from a contract with North County Health Services.  
 5 This figure reflects \$752,000 for influenza vaccine and \$155,000 for pneumococcal vaccine.  
 6 This figure includes Information and Education Programs, Alternative Test Sites, and Confidential Testing.

Projected Pediatric AIDS Cases in California  
Through 1993 (and lower and upper bounds)

	INCIDENT CASES			CUMULATIVE CASES		
	Estimate	(low, high)		Estimate	(low, high)	
1988	54	( 46,	65)	156	(147,	167)
1989	81	( 57,	114)	237	(205,	281)
1990	119	( 81,	173)	355	(286,	454)
1991	174	(115,	263)	529	(401,	718)
1992	255	(163,	400)	784	(563,	1118)
1993	374	(182,	608)	1158	(745,	1725)

Source: California Department of Health Services,  
Office of AIDS, Research and Statistics Section

## Appendix I

### HOME TEST KIT

#### SUMMARY

The CDHS held a conference on home test kits on July 7, 1988 in Sacramento. The objective of the conference was to have a panel of representatives and experts from consumer interest groups, the testing industry, health professionals, and others familiar with home testing issues discuss specific questions regarding the appropriateness of consumers testing themselves for the presence of various health conditions. Discussion included home test kits in general, and the use of these kits for testing for the presence of HIV infection, in particular.

HIV Antibody Home Testing: Participants generally agreed that:

- . counseling is a mandatory element of HIV antibody testing;
- . face-to-face counseling and notification of test results is the accepted standard of practice; and
- . indeterminate (i.e., non-confirmed) test results should not be reported to test subjects.

Some participants expressed the opinion that alternatives to face-to-face counseling and notification of test results (e.g., via telephone) may be acceptable, but they also acknowledged that, at this time, there is insufficient scientific data to fully evaluate the risks and benefits of these alternatives. Well-controlled clinical studies are needed to produce such data. Copies of the report are available from California Department of Health Services, Food and Drug Branch, 714 P Street, Room 400, Sacramento, CA 95814, (916) 445-2263.