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AIDS IN SAN FRANCISCO:
STATUS REPORT AND PLAN FOR 1987-88

REVISED*

February 1987

San Francisco Department of Public Health

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*A revision/expansion of the preliminary plan submitted to the San Francisco Health Commission in December 1986.

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I. EXECUTIVE SUMMARY

AIDS IN SAN FRANCISCO: STATUS REPORT AND PLAN FOR FISCAL YEAR 1987-8 (REVISED FEBRUARY 1987) is the second major document in a series which will result in a firm plan and budget for AIDS programs and services for the new fiscal year. In December 1986, a STATUS REPORT AND PRELIMINARY PLAN was presented to the San Francisco Health Commission. This February edition includes some corrections, some additional information about existing service configurations, more detailed recommendations about directions for 1987-8, and an analysis of the potential impact on the Department of Public Health's budget.

The document begins with a description of the purpose and scope of the work done, and the process undertaken in developing the report/plan. This is followed by a report of the number of cases of AIDS on record in San Francisco and the number anticipated by June 1988, and subsequently by a discussion of demographic trends and their implications for prevention and health care services. Particular concerns of women and people of color are addressed in separate chapters. The balance of the report/plan is organized around eight categories of programs and support services:

- Surveillance, epidemiology and related research
- Public education
- Provider education
- Clinical screening and acute medical care
- Chronic care and related support services
- Mental health services
- Substance abuse services
- Administrative support and coordination

Most sections include a discussion of the nature of services/programs covered in the section, an identification of goals, a brief description of current service configurations, a summary of factors and constraints which have or will probably have a particular impact on services, reaffirmation of relevant departmental policy, an indication of the general direction in which program development is expected to move, and a discussion of funding needed to make such development possible. Since the categories around which the document is organized are not mutually exclusive, there are frequent references to other parts of the document.

It is hoped that readers will appreciate the comprehensiveness of San Francisco's response to AIDS as well as the complexity of the problems being addressed.

II. INTRODUCTION

The current epidemics of acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV) infection are the most serious health crises ever faced by the City and County of San Francisco. This document provides an overview of the current situation and identifies the general direction of programs planned by the San Francisco Department of Public Health (DPH) for the short-term future. It reflects several needs:

- to meet the crises*
1. The need for an overview of the problems associated with managing the epidemic that have emerged to date and what has been done to address these problems.
 2. The need for broadly based community-oriented educational and prevention programs to limit the transmission of HIV.
 3. The need to continuously assess. . .
 - nature and scope of the who has been affected, who is likely to be affected*
 - how the epidemic *(is growing)*, what the impact of educational and prevention programs have been, and what the demand for services related to it will be;
 - *risk behaviors and those at risk of HIV infection and its clinical manifestations*
 - what existing services will need to be expanded or modified and what new services will need to be developed; *particularly ARC and AIDS;*
 - how to distribute the financial burden of the epidemic reasonably among private and public (local, state, national) agencies to maintain and expand these services;
 - how to insure that planning and management related to the epidemic are well coordinated with governmental agencies and community organizations;
 - what progress has been made toward the development of a vaccine and what progress has been made toward the development of effective therapy both for symptomatic and asymptomatic HIV-infected patients;
 - the need for a clearer understanding of the constraints on the long range planning of responses to the epidemic.

This is a very limited perspective

This document has been organized around services currently in place and funded entirely or in part by DPH. Services of other providers are noted but discussed in less detail. It contains descriptions of current services and identifies unmet or emerging needs.

The recommendations contained in this report have been shaped by a variety of intramural and extramural committees, groups and reports. They include::

- DPH's Executive Committee and the DPH's AIDS Committee
- Hearings conducted by the San Francisco Health Commission
- Reports on AIDS from the National Academy of Sciences and the Surgeon General of the United States Public Health Service
- Recently enacted state and federal legislation regarding support for AIDS services
- Observations about established and anticipated patterns of contracting with state and federal agencies
- Written descriptions of current AIDS services from San Francisco service providers
- Written descriptions of reported gaps in AIDS services and written proposals for expanded and new AIDS services from current service providers, advocacy groups, and community-based organizations
- The Mayor's AIDS Task Force
- The Director of Health's Medical Advisory Committee on AIDS, AIDS Advisory Committee, and Minority Advisory Task Force on AIDS

The AIDS status report and plan should be viewed as a flexible working document which will change as the character of the epidemic changes. It should also be viewed as a reference document which can be used for planning the variety of services needed to deal with the epidemic. Finally, it should help place current and planned services in the context of managing the epidemic as a whole.

Unlike the December 1986 edition of the report/plan, which outlined general directions of programmatic development but did not include fiscal information, the report/plan in its February 1987 draft does include information about specific dollar amounts needed and sources from which they are likely to come.

The written descriptions of current AIDS services from San Francisco providers, from which most of the "current services" material is gleaned, have been edited for uniformity of format and some gaps in the information provided have been filled. A similar process was conducted with the written descriptions of perceived AIDS service gaps and proposals for expanded and new services. These submissions influenced the planning of services as it became more specific. They are being made available to the Health Commission under separate cover for reference.

III. DIMENSIONS OF THE EPIDEMIC IN SAN FRANCISCO

A. CURRENT EPIDEMIOLOGY OF AIDS AND AIDS-RELATED COMPLEX

1. AIDS

By January 31, 1987, 2853 cases of AIDS and 1,707 deaths from AIDS had been reported to the Department of Public Health. This corresponded to an incidence of 420.2 cases per 100,000 population. The number of cases of AIDS diagnosed per month in San Francisco is continuing to rise (Figure 1).

The demographics of AIDS in San Francisco are shown in Tables 1-4. These include:

- 2,408 (84.6%) homosexual and bisexual men, 358 (12.6%) homosexual and bisexual men with histories of intravenous drug use, and 34 (1.2%) heterosexual intravenous drug users
- 2,823 (98.9%) adult and adolescent men, 23 (0.9%) adult and adolescent women, and 7 (0.2%) children
- 1,432 (50.2%) 30 to 39 years old, 726 (25.4%) 40 to 49 years old, and 407 (14.3%) 20 to 29 years old
- 2,461 (86.3%) whites, 188 (6.6%) Latinos, 164 (5.7%) Blacks, and 38 (1.3%) Asians and Pacific Islanders.

The proportion of gay and bisexual men with AIDS was lower among nonwhites [344/392 (87.8%)] than among whites [2422/2461 (98.4%), Table 5].

2. Other HIV-related diseases

Using estimates of the ratio between AIDS and ARC patients in cohort studies, we can estimate a range of the number of ARC cases in San Francisco:

- 4,246 to 22,824 total ARC cases (including lymphadenopathy syndrome)
- 2,389 to 19,908 cases of lymphadenopathy syndrome

The ratio of 8.6 cases of ARC per case of AIDS are from a cohort study conducted in 1984, and the ratio of 1.6 cases of ARC per case of AIDS are from a subset of the same cohort infected for an average of 70 months examined in 1986. The proportion of ARC to AIDS cases appears to decrease with increasing length of infection. The true number of ARC cases currently is, because of the relatively short duration of HIV infection among gay men in San Francisco, probably closer to the higher estimate than the lower.

3. Numbers of HIV-infected patients using inpatient health care facilities

Approximately 7-10% of all living AIDS patients are hospitalized in acute-care facilities and up to 10% are probably in need of subacute, intermediate, or chronic care services at any given point in time. Additionally, there is about one ARC patient hospitalized for every 10 hospitalized AIDS patient in both acute and chronic care settings.

4. Numbers using publicly subsidized health care services

Between January 1985 and June 1986, 32% of all AIDS hospitalizations in San Francisco were at San Francisco General Hospital (Table 6). During this same period 37% of all AIDS hospitalizations in San Francisco were reimbursed by public third party payors (MediCal, Medicare, etc.).

- Of 435 public-third-party-reimbursed hospitalizations, 278 (64%) were at San Francisco General Hospital

- Of the 70 self-pay hospitalizations, 48 (69%) were at San Francisco General Hospital

B. PROJECTED EPIDEMIOLOGY OF AIDS IN SAN FRANCISCO

1. AIDS

Using mathematical modelling to project total AIDS cases, total living AIDS cases, AIDS cases by race, and AIDS cases by major transmission categories (homosexual and bisexual men, homosexual and bisexual men with histories of intravenous drug use, and heterosexual intravenous drug users), we predict:

By June 30, 1987, there will be:

- 3,297 cumulative AIDS cases (Table 7 ~~7~~ TABLE 8)
- 1,226 living AIDS cases (Table 7)
- 2,763 (83.8%) cases among homosexual and bisexual men, 422 (12.8%) cases among homosexual and bisexual men with histories of intravenous drug use, and 46 (1.4%) cases among heterosexual intravenous drug users (Table 8) 23 Transfusion, 11 heterosexual, 3 hemophiliac, 20 no ident. risk
- 2,822 (85.6%) cases among whites, 207 (6.3%) cases among Blacks, 219 (6.6%) cases among Latinos, and 46 (1.4%) cases among Asians (Table 9). 1mm children

By June 30, 1988, there will be

- 4,485 cumulative AIDS cases (Table 7).
- 1,449 living AIDS cases
- 3,756 (83.7%) cases among homosexual and bisexual men, 571 (12.7%) cases among homosexual and bisexual men with histories of intravenous drug use, and 66 (1.5%) cases among heterosexual intravenous drug users (Table 8)
- 3,827 (85.3%) cases among whites, 291 (6.5%) among Blacks, 296 (6.6%) among Latinos, and 66 (1.5%) cases among Asians (Table 9).

Significant changes in the length of survival of AIDS patients (for instance, from antiviral therapy) will increase the number of living AIDS patients.

2. Other HIV-related diseases

Using the same ratios between AIDS and ARC patients as above, we can estimate a range of the number of ARC cases in San Francisco to be:

- 5,143 to 25,354 total ARC cases with 2,963 to 24,728 cases of lymphadenopathy syndrome by June 30, 1987
- 7,176 to 38,571 total ARC cases with 4,037 to 33,638 cases of lymphadenopathy syndrome by June 30, 1988.

As these patients will likely have been infected longer than ARC patients in 1986 (i.e., there will be relatively few new cases of HIV infection) the true number of ARC cases will be more likely be closer to the lower estimate than the higher.

3. Projected numbers of HIV-infected patients using inpatient facilities and publicly subsidized health care services.

Needs for hospitalization may increase as effective antiviral therapy becomes available leading to a higher percentage of living AIDS patients hospitalized because of more aggressive management of the disease and treatment of drug side effects. Additionally, as AIDS becomes more prevalent among intravenous drug users, there will be increased utilization of public-third-party reimbursement, potentially placing further demands on San Francisco General Hospital.

note → what about demand for blood transfusion for AIDS patients treated with AZT. What has been number of transfusions per AIDS patient by AZT per month? What is the total number of transfusions per patient among survivors (how many months), among those who have been treated with AZT and died?

Projections should be for inpatient care (admissions, aver. length of stay, days per admission, total number of admissions, total days hospital and visit, physician office visit, SNF (admissions, length of stay, # days), Subacute hosp (same), hospice, in home service 0533a 2/13/87 (home health, nurse, -8-), community source service

C. EPIDEMIOLOGY OF HIV INFECTION

1. Seroprevalence

Studies of cohorts of homosexual and bisexual men in San Francisco have found the prevalence of HIV infection to be between 33% and 73%. In a large population-based study conducted in San Francisco census tracts with relatively high concentrations of unmarried male residents, the current prevalence is 52%. Studies of methadone clinic patients in San Francisco found that the prevalence of infection was 10% in 1985. More recent estimates suggest this prevalence may have doubled in 1986. Population-based data are not available for other populations in San Francisco, such as heterosexuals with multiple partners, blood transfusion recipients, and haemophiliacs.

What
do these
figures
suggest
in terms
of number
of HIV
infectious
individuals
50,000?

Prevalence data from anonymous test sites are not population-based and do not accurately reflect the true prevalence of HIV infection either in the general population or in at risk groups. The prevalence of HIV infection among blood donors in San Francisco is currently 0.05% with the prevalence among male donors 0.06% and the prevalence among female donors 0.04%. These data are also from a non-random population but have some utility as a reflection of the overall seroprevalence of HIV infection in the general population. Other data on the seroprevalence of HIV infection in San Francisco are available from military recruit HIV screening programs. During the first three quarters of the screening programs, the seroprevalence among recruits from San Francisco was:

- Overall, 0.75%.
- 0.76% for men and 0.60% for women.
- 1.67% for whites, 0.60% for Blacks, 0% for Latinos, 0% for Asians and Pacific Islanders, and 0% for American Indians.

2. Seroconversion (Incidence)

Data from the homosexual and bisexual male cohorts suggest recent seroconversion rates of between 3% and 5% of uninfected men per year. No data are available for other at risk groups or the general population.

What was
seroconversion
rate in 1984-
1985-
1986-

Further population-based cross-sectional and cohort studies will be needed to ascertain more fully the true seroprevalence and incidence of HIV infection in the general population and selected at risk groups.

3. Attack Rate (Number of AIDS cases / 100 HIV infectious indiv.)

SAN FRANCISCO AIDS CASES BY MONTH OF DIAGNOSIS (FORECASTS THROUGH 1988)

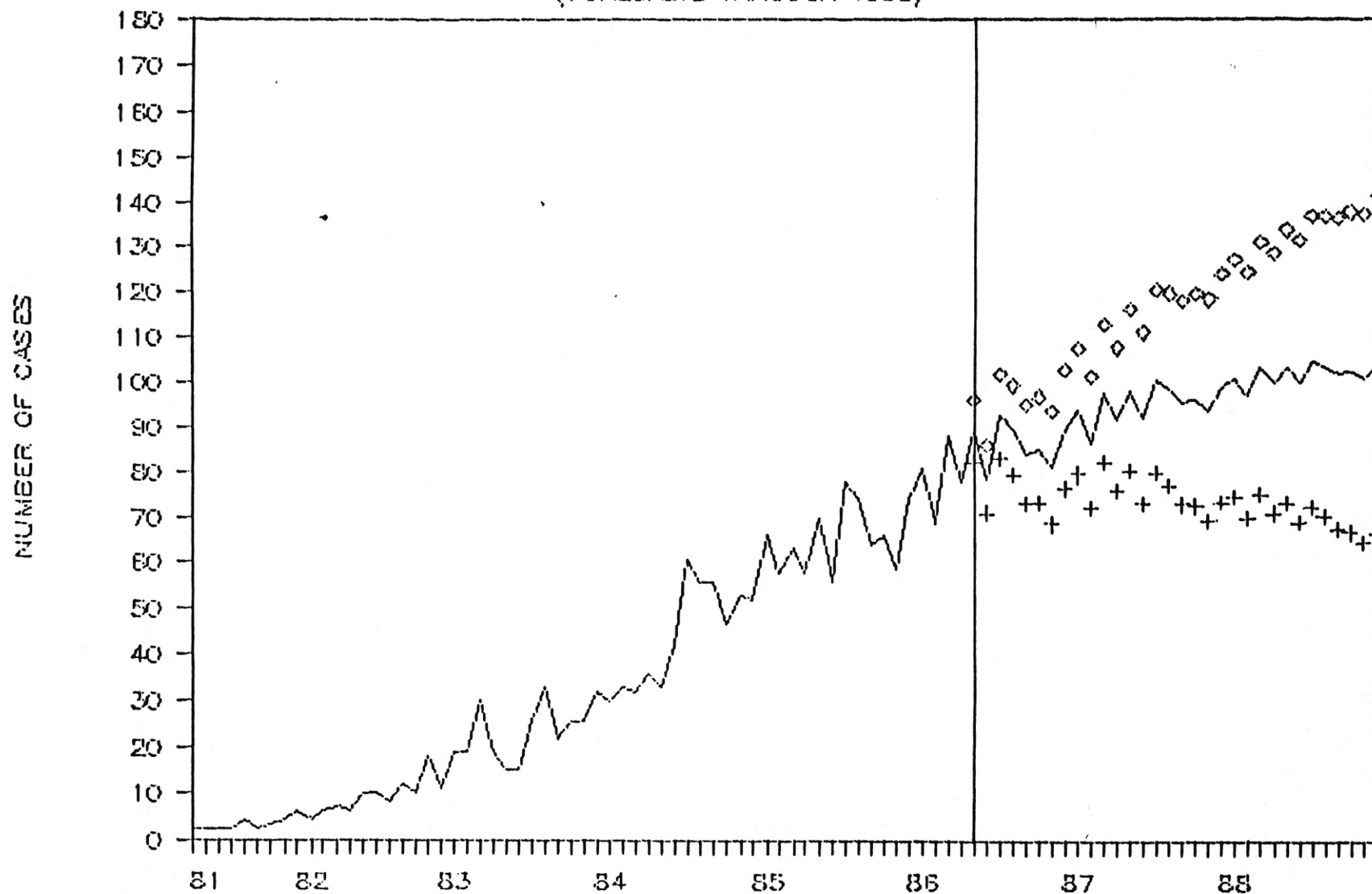


FIGURE 1

— ACTUAL AND FORECAST

+ LOWER 67% CI

◇ UPPER 67% CI

TABLE 1

AIDS CASES BY TRANSMISSION CATEGORY AND SEX

SAN FRANCISCO, 1981-1987*

<u>TRANSMISSION CATEGORY</u>	<u>MALE</u>	<u>FEMALE</u>	<u>TOTAL</u>	<u>PERCENT OF TOTAL</u>
<u>ADULTS/ADOLESCENTS</u>				
HOMOSEXUAL/BISEXUAL MALE	2,408	0	2408	84.6
HOMOSEXUAL/BISEXUAL MALE AND IVDU	358	0	358	12.6
IV DRUG USER	25	9	34	1.2
TRANSFUSION RECIPIENT	14	7	21	0.7
HETEROSEXUAL CONTACT	6	5	11	0.4
HEMOPHILIA	3	0	3	0.1
NONE OF THE ABOVE/OTHER	<u>9</u>	<u>2</u>	<u>11</u>	<u>0.4</u>
SUBTOTAL:	2,823	23	2,846	100.0
<u>CHILDREN (0-12 yrs.)</u>				
CHILD OF HIGH-RISK/ AIDS PARENT	1	3	4	57.1
TRANSFUSION RECIPIENT	3	0	3	42.9
HEMOPHILIA	0	0	0	0.0
NONE OF THE ABOVE/OTHER	<u>0</u>	<u>0</u>	<u>0</u>	<u>0.0</u>
SUBTOTAL:	2,827	26	2,853	100.0

*Cases reported through January 31, 1987

TABLE 2

AIDS CASES BY TRANSMISSION CATEGORY AND YEAR OF DIAGNOSIS

SAN FRANCISCO, 1981-1987*

Transmission Category	YEAR OF DIAGNOSIS													
	1981		1982		1983		1984		1985		1986		1987	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
<u>ADULTS/ADOLESCENTS</u>														
HOMOSEXUAL/BISEXUAL MALE	23	85.2	97	95.1	241	85.2	445	83.3	674	84.5	886	83.3	42	91.3
HOMOSEXUAL/BISEXUAL MALE and IVDU	2	7.4	3	2.9	36	12.7	82	15.4	98	12.3	134	12.6	3	6.5
IV DRUG USER	0	0.0	0	0.0	2	0.7	4	0.7	8	1.0	19	1.8	1	2.2
TRANSFUSION RECIPIENT	0	0.0	0	0.0	0	0.0	0	0.0	11	1.4	10	0.9	0	0.0
HETEROSEXUAL CONTACT	0	0.0	0	0.0	2	0.7	2	0.4	0	0.0	7	0.7	0	0.0
HEMOPHILIA	0	0.0	0	0.0	0	0.0	0	0.0	2	0.3	1	0.1	0	0.0
NONE OF THE ABOVE/OTHER	1	3.7	0	0.0	1	0.4	1	0.2	4	0.5	4	0.4	0	0.0
<u>CHILDREN (0-12 yrs.)</u>														
CHILD OF HIGH-RISK/ AIDS PARENT	1	3.7	2	2.0	0	0.0	0	0.0	0	0.0	1	0.1	0	0.0
TRANSFUSION RECIPIENT	0	0.0	0	0.0	1	0.4	0	0.0	1	0.1	1	0.1	0	0.0
HEMOPHILIA	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
NONE OF THE ABOVE/OTHER	<u>0</u>	0.0	<u>0</u>	0.0	<u>0</u>	0.0	<u>0</u>	0.0	<u>0</u>	0.0	<u>0</u>	0.0	<u>0</u>	0.0
TOTAL	27		102		283		534		798		1,063		46	

*Cases reported through January 31, 1987

TABLE 3
AIDS CASES BY AGE GROUP
SAN FRANCISCO, 1981-1987*

<u>AGE GROUP</u>	<u>CASES</u>	<u>PERCENT OF TOTAL</u>
0 - 4	6	0.2
5 - 12	1	0.0
13 - 19	5	0.2
20 - 29	407	14.3
30 - 39	1432	50.2
40 - 49	726	25.4
50 - 59	226	7.9
<u>60+</u>	<u>50</u>	<u>1.8</u>
Total	2853	100.0

*Cases reported through January 31, 1987

TABLE 4
AIDS CASES BY RACE AND ETHNIC GROUP
San Francisco, 1981-1987*

<u>RACE/ETHNICITY</u>	<u>CASES</u>	<u>%</u>	<u>SF POPULATION</u> <u>#</u> <u>%</u>
WHITE	2,461		
BLACK	164		
LATINO	188		
ASIAN/PACIFIC ISLANDER	38		
<u>OTHER</u>	<u>2</u>		
TOTAL	2,853		

(on page 37 it states that 20/34 are gay Filipino men :. 14 cases are all other Asian groups)

*Cases reported through January 31, 1987

TABLE 5

AIDS CASES BY RACE AND ETHNIC GROUP AND TRANSMISSION CATEGORY

SAN FRANCISCO, 1981-1987*

Transmission Category	Race/Ethnic Group									
	WHITE		BLACK		LATINO		ASIAN/PACIFIC ISLANDER		OTHER	
	N	%	N	%	N	%	N	%	N	%
<u>ADULTS/ADOLESCENTS</u>										
HOMOSEXUAL/BISEXUAL MALE	2097	85.2	(110)	67.1	(167)	88.8	(32)	84.2	2	100.0
HOMOSEXUAL/BISEXUAL MALE AND IVDU	325	13.2	(22)	13.4	(9)	4.8	(2)	5.3	0	0.0
IV DRUG USER	(11)	0.4	(15)	9.1	(6)	3.2	(2)	5.3	0	0.0
TRANSFUSION RECIPIENT	15	0.6	3	1.8	1	0.5	2	5.3	0	0.0
HETEROSEXUAL CONTACT	4	0.2	6	3.7	1	0.5	0	0.0	0	0.0
HEMOPHILIA	2	0.1	0	0.0	1	0.5	0	0.0	0	0.0
NONE OF THE ABOVE/OTHER	4	0.2	5	3.0	2	1.1	0	0.0	0	0.0
<u>CHILDREN (0-12 yrs.)</u>										
CHILD OF HIGH-RISK/ AIDS PARENT	0	0.0	3	1.8	1	0.5	0	0.0	0	0.0
TRANSFUSION RECIPIENT	3	0.1	0	0.0	0	0.0	0	0.0	0	0.0
HEMOPHILIA	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
NONE OF THE ABOVE/OTHER	<u>0</u>	0.0	<u>0</u>	0.0	<u>0</u>	0.0	<u>0</u>	0.0	<u>0</u>	0.0
TOTAL	2,461		164		188		38		2	

*Cases reported through January 31, 1987

TABLE 6

AIDS PATIENT DISCHARGES BY ANTICIPATED PRINCIPAL PAY
SOURCE AND TYPE OF HOSPITAL, SAN FRANCISCO, 1985 - JUNE, 1986

<u>HOSPITAL</u>	<u>Private Third Party</u>				<u>Public Third Party</u>						<u>Self-Pay</u>		<u>Total</u>	
	<u>Insurance</u>		<u>Other</u> <u>(HMO,PPO)</u>		<u>Medi-Cal</u>		<u>Medicare</u>		<u>Other</u>		<u>N</u>	<u>(%)</u>	<u>N</u>	<u>(%)</u>
	<u>N</u>	<u>(%)</u> *	<u>N</u>	<u>(%)</u>	<u>N</u>	<u>(%)</u>	<u>N</u>	<u>(%)</u>	<u>N</u>	<u>(%)</u>				
SFGH	53	(14)	2	(1)	256	(67)	8	(2)	14	(4)	48	(13)	381	(100)
KAISER, SF	0	(0)	155	(100)	0	(0)	0	(0)	0	(0)	0	(0)	155	(100)
ALL OTHER	350	(54)	122	(19)	119	(18)	29	(4)	9	(1)	22	(3)	651	(100)
TOTAL	403	(34)	279	(24)	375	(32)	37	(3)	23	(2)	70	(6)	1187	(100)

Source: West Bay Hospital Conference

*Percentage of row total

TABLE 7

SAN FRANCISCO AIDS PROJECTIONS BY FISCAL YEAR

<u>FISCAL YEAR ENDING:</u>	<u>Cumulative No. of Cases (95% C.I.)</u>	<u>Cumulative No. of DEATHS (95% C.I.)</u>	<u>Number Alive (95% C.I.)</u>	<u>Percentage Alive (%)</u>
June 1986	2230	1234	996	44.7
June 1987	3297 (2932-3660)	2071 (1891-2188)	1226 (1041-1472)	37.2
June 1988	4485 (3492-5475)	3036 (2577-3467)	1449 (915-2008)	32.3

TABLE 8

PROJECTED AIDS CASES BY TRANSMISSION CATEGORY AND VITAL STATUS

SAN FRANCISCO, 1981-1988*

<u>Transmission Category</u>	<u>1987*</u>		<u>NUMBER ALIVE</u>		<u>1988#</u>		<u>NUMBER ALIVE</u>	
	<u>CUMULATIVE CASES</u>				<u>CUMULATIVE CASES</u>			
<u>ADULTS/ADOLESCENTS</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>
HOMOSEXUAL/BISEXUAL MALE	2763	83.8	1028	83.8	3756	83.7	1213	83.7
HOMOSEXUAL/BISEXUAL MALE AND IVDU	422	12.8	157	12.8	571	12.7	184	12.7
IV DRUG USER	46	1.4	17	1.4	66	1.5	22	1.5
TRANSFUSION RECIPIENT	23	0.7	9	0.7	31	0.7	10	0.7
HETEROSEXUAL CONTACT	11	0.3	4	0.3	15	0.3	5	0.3
HEMOPHILIA	3	0.1	1	0.1	5	0.1	1	0.1
NONE OF THE ABOVE/OTHER	20	0.6	7	0.6	27	0.6	9	0.6
<u>CHILDREN (0-12 yrs.)</u>								
CHILD OF HIGH-RISK/ AIDS PARENT	6	0.2	2	0.2	9	0.2	3	0.2
TRANSFUSION RECIPIENT	3	0.1	1	0.1	5	0.1	2	0.1
HEMOPHILIA	0	0.0	0	0.0	0	0.0	0	0.0
NONE OF THE ABOVE/OTHER	<u>0</u>	0.0	<u>0</u>	0.0	<u>0</u>	0.0	<u>0</u>	0.0
TOTAL	3,297		1,226		4,485		1,449	

*Diagnosed as of June 30, 1987

#Diagnosed as of June 30, 1988

TABLE 9

PROJECTED AIDS CASES BY RACE/ETHNIC GROUP AND VITAL STATUS

SAN FRANCISCO, 1981-1988*

RACE/ETHNIC GROUP	1987*		NUMBER ALIVE		1988#		NUMBER ALIVE	
	CUMULATIVE CASES				CUMULATIVE CASES			
	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>
WHITE	2822	85.6	1050	85.6	3827	85.3	1236	85.3
BLACK	207	6.3	77	6.3	291	6.5	94	6.5
HISPANIC	219	6.6	81	6.6	296	6.6	96	6.6
ASIAN/PACIFIC ISLANDER	46	1.4	17	1.4	66	1.5	22	1.5
OTHER	<u>3</u>	0.1	<u>1</u>	0.1	<u>5</u>	0.1	<u>1</u>	0.1
TOTAL	3,297		1,226		4,485		1,449	

*Diagnosed as of June 30, 1987

#Diagnosed as of June 30, 1988

IV. SURVEILLANCE, EPIDEMIOLOGY, AND RELATED RESEARCH

A. GOALS

The overall purpose of these activities is to help us understand better how HIV infection manifests itself, how it is transmitted, where it is moving in our community and how fast, and what kinds of education and interventions are likely to be or have been successful in curtailing its movement. These activities focus on the collection of numerical data and the analysis of significant patterns evident in the numbers.

The surveillance data set is used extensively for predicting future numbers of cases, AIDS-associated morbidity and mortality, and the changing nature of the epidemic.

San Francisco provides a unique setting for such activities. In one relatively compact geographic area, there is a high concentration of cases, a community commitment to an aggressive education and prevention support program, and a large pool of talented and experienced researchers to draw on.

B. ACTIVITIES

In California, clinical AIDS as defined by the US Public Health Service's Centers for Disease Control (CDC) is a reportable disease. San Francisco has an "active" surveillance program, which works closely with private and public providers of medical care to insure that data critical to our understanding of the nature and dimensions of the epidemic are captured without compromising the confidentiality of patients.

Tracking patterns of seroconversion and manifestations of HIV infection that do not meet the criteria established in the "surveillance definition" of clinical AIDS is often accomplished through following carefully selected cohorts of volunteers who are representative of population groups known to be at risk for AIDS. Individuals who volunteer to be subjects in such studies are contacted, tested for HIV infection, and interviewed at regular intervals over long periods of time. Testing is often very important in such studies, since it provides hard data about transmission. Since AIDS is transmitted almost exclusively through sexual contact or needle sharing, interviews often focus on behavior, attempts to change behavior and the usefulness of education efforts. Those following each cohort provide education and counseling to subjects in addition to tracking their responses.

Tracking knowledge of AIDS, its transmission, and the impact of prevention education efforts is also undertaken in situations where no testing for HIV infection is done. A representative sample of a targeted population group is identified and interviewed to establish what the group targeted already knows about AIDS, how they have responded to what they know, what needs to be addressed next, and what further interventions would be appropriate. Interviews are conducted in person or by telephone. These kinds of population-based surveys are repeated from time to time to measure the nature and extent of responses by the group targeted to prevention education efforts.

Contact tracing and related individual education are feasible in situations where the trail of transmission is relatively clear and the number of contacts small.

Surrogate markers of behavior patterns provide useful information as well. Where a sexually transmitted virus such as HIV is concerned, for example, data confirming a reduction in the incidence of rectal gonorrhoea among men can be taken as an indirect indicator of a reduction in unprotected anal intercourse among gay/bisexual men.

C. CURRENT ACTIVITIES OF DPH

1. Case reporting of CDC-defined AIDS in San Francisco is managed by DPH's AIDS Office and depends almost entirely on Federal funding for its operations.
2. The AIDS Office (AO) conducts Federally-funded epidemiologic research projects in the areas of the natural history, biology and epidemiology of HIV infection in gay and bisexual men and of transmission-associated HIV infection. The AO also cooperates with research groups from the University of California and the Centers for Disease Control in studies of HIV transmission to female sexual partners of bisexual men, the psychosocial ramifications of HIV antibody testing, the transmission of HIV infection in households, and the epidemiology of AIDS in patients surviving more than three years. Additionally, data from other San Francisco-based longitudinal studies of HIV infection in at risk populations are available to DPH. These include two separate cohort studies of gay and bisexual men being conducted by the University of California San Francisco and the University of California Berkeley and studies of women at risk of infection and prostitutes being conducted by the University of California San Francisco. . . . (continue) When is it continued.
3. Substance abuse treatment programs administered by DPH's Community Substance Abuse Services (CSAS) and mental health services cooperate with several concurrent research efforts being conducted under the aegis of the University of California San Francisco's SAMHA Center. The Substance Abuse and Mental Health in AIDS (SAMHA) Center, supported by a grant from the National Institute of Mental Health (NIMH) and the National Institute of Drug Abuse (NIDA), creates a working environment in which academic researchers at University of California - San Francisco and University of California - Berkeley, county health officials at DPH, and minority health professionals associated with Bayview/Hunter's Point Foundation can benefit from a pooling of knowledge, skills and community activities. The focus of the center is on developing and testing preventive interventions and on formulating and disseminating health policy guidelines.

4. Through its contract with the San Francisco AIDS Foundation, DPH has underwritten base-line and tracking surveys of gay/bisexual men and heterosexuals at risk for AIDS.
 5. DPH recently announced the award of contracts to Black- and Latino-identified research teams to conduct population based surveys of their respective communities regarding knowledge of and attitudes toward AIDS and its prevention. These surveys are scheduled for completion in July 1987. DPH also recently identified funding to initiate a process for assessing needs in San Francisco's Asian communities regarding AIDS education. The short term task is to ascertain how DPH can best proceed to secure comparable information about Asians' awareness of AIDS, perception of risk, level of risk behavior, etc., with so many different languages and cultures to deal with.
 6. Contact tracing of heterosexual partners of persons with AIDS is conducted by DPH's Bureau of Communicable Disease Control (BCDC). In conjunction with Irwin Memorial Blood Bank, the Bureau also provides counseling, education and testing of recipients of HIV-infected blood.
 7. Surrogate markers such as gonorrhoea, hepatitis, and syphilis rates are reported to and analyzed by the Bureau.
- D. FACTORS INFLUENCING SURVEILLANCE, EPIDEMIOLOGIC STUDIES RELATED RESEARCH, AND EDUCATION ASSOCIATED WITH THEM
1. The usually long period between infection with HIV and the development of symptoms which can be traced to HIV infection has complicated the problem of tracking this disease.
 2. The surveillance definition of AIDS only identifies very advanced clinical manifestations of HIV infection. This is the only manifestation of the disease that is reportable at this point. This hampers efforts to gauge the size and scope of the overall problem of HIV-associated disease.
 3. The US Public Health Service's Centers for Disease Control (CDC) is in the final process of expanding the definition of reportable AIDS cases to include the more severe forms of what to date are often referred to as AIDS-related conditions. This new definition is expected to be official by June 1987. This mid-course change in definition will generate an awkward "blip" in the tabulations of cases reported, but in the long run it should contribute to a better understanding of the epidemiology of the disease. For some who are very ill an side effect of this definition change may be easier access to entitlement programs for the disabled.

4. Questions about insuring confidentiality have emerged around AIDS making it necessary to limit use of the antibody test to situations in which subjects' identity can be particularly well protected.
5. Prospective studies (i. e. studies built around a representative cohort to be followed over a long period of time) are extremely expensive and traditionally have depended on Federal funding for support.
6. Population based surveys of risk group knowledge, attitudes and behavior among the particular groups at risk for AIDS (e. g. gay/bisexual men, IV drug users) are extremely useful in the development of effective educational programs. However, to date state and federal funding for such surveys has been limited.

What are DPH goals with respect to HIV inf?
 " are other national policies,
 " " state goals? Policies?

E. POLICY REAFFIRMATION

1. DPH reaffirms its policy that antibody testing should be conducted only in a manner consistent with the provisions of AB403 and which maximizes the protection of information identifying any subject participating in the studies.
2. DPH reaffirms its commitment to careful behavioral and serologic assessments of populations targeted for education and prevention support programs to maximize the effectiveness of prevention and education programs.

F. PRIORITIES FOR FY 87-88

- Maintenance of surveillance in proportion to the number of reportable cases.
- Expansion of serologic surveys and studies of knowledge, attitudes and behavior of specific risk groups.

G. BUDGET ISSUES

(Note: An asterisk identifies issues for which new ad valorem are being sought)

1. Active surveillance of cases of CDC-defined AIDS will be maintained with Federal funding provided through cooperative agreements with the Centers for Disease Control.
2. CDC's revision of the definition of AIDS which will broaden the definition to include those with severe ARC is expected to become official in May or June 1987. This will increase surveillance activity. New Federal/State funding will be sought to cover the increased costs involved.

What is
 exact language
 of AB 403 -
 that is state
 policy.

3. Prospective studies built around representative cohorts will continue to depend on Federal grants. The AIDS/Hepatitis B Cohort Study, for which DPH receives direct funding, will be maintained with CDC funding. Other studies of gay/bisexual men, women, and substance abusers are supported by grants to the University of California (San Francisco and Berkeley).
4. Tracking surveys of risk group knowledge, attitudes and behavior will be underwritten with a combination of funds from the AIDS Office's ad valorem base budget (\$80,000) and a State block grant anticipated for AIDS epidemiology and education (\$83,190). These funds will cover four tracking surveys of knowledge, attitudes and behavior changes among the following target populations: (a) gay/bisexual men, (b) heterosexuals with multiple or high risk partners, (c) the Black community, and (c) the Latino community. In all cases the tracking surveys will follow up on baseline surveys conducted in 1986-7 or earlier.
- * 5. In the last half of 1986-7, block grant funding will be used to initiate a process for assessing AIDS education needs in San Francisco's Asian communities regarding perception of risk, level of risk behavior, and adequacy of existing knowledge about risk reduction. DPH is requesting \$75,000 in new ad valorem funds to cover the costs of baseline surveys in these communities, surveys

missing from
AIDS
packet

SURVEILLANCE, EPIDEMIOLOGY AND RELATED RESEARCH

<u>Goals</u>	<u>Program components</u>	<u>Factors influencing program development</u>
Better understanding of HIV infection	Active surveillance of cases which meet CDC criteria for clinical AIDS	Long period between infection and development of symptoms
- How it manifests itself		
- How it is transmitted	Research on natural history, biology and epidemiology of HIV infection	Number of cases requiring active surveillance is growing
- What kinds of education is successful in curtailing its transmission	Cooperation with research in substance abuse treatment programs	Clinical definition of AIDS is limited
In conjunction with studies educate subjects on preventing transmission and controlling the development of clinical disease	Population-based knowledge and attitudinal surveys which assess community need for and response to AIDS prevention programs	Protection of human subjects participating in surveys and cohort studies is a complicated process and is critical to their success
	Contact tracing of heterosexual partners	Cohort studies are expensive and have had to depend on limited Federal funding
	Following surrogate markers as indicators of particular behavior patterns	Knowledge/attitudinal surveys are difficult

Shouldn't the goal
be prevention of HIV
infection

V. CONCERNS OF PEOPLE OF COLOR

A. GOALS

Outside of San Francisco, there is a disproportionate number of AIDS cases among people of color. Although rates among people of color in San Francisco are lower, the numbers of reported cases have increased and serologic studies in San Francisco suggest that the rate of seroconversion in racial and ethnic minority communities, particularly among substance abusers, is rising. The picture of what has happened in other communities, most notably on the East Coast, is a stark reminder of what could happen here if adequate measures are not taken to prevent further spread of HIV within these communities. There is a need to expand and make more effective prevention programs that people of color in San Francisco can identify with and respond to.

Achieving DPH's general goal of providing high quality health care and other support services for people infected by HIV also requires services which are culturally specific and linguistically appropriate for people of color.

B. BACKGROUND INFORMATION

The racial and ethnic breakdown of total cases has indicated a trend of increasing numbers of people of color being diagnosed with AIDS each year in San Francisco, although the overall distribution by race and ethnicity has remained relatively stable over the last three years and is expected to maintain this pattern over the next eighteen months. The table below reflects San Francisco data:

		1984	1985	1986	1987	See Table 5 (page 15)	
White	Total	473	680	901	40	94.8	In (table)
	%	88.6	85.2	84.8	87.0		
Black	Total	23	45	70	2	110	37 (15)
	%	4.3	5.6	6.6	4.3		
Latino	Total	34	59	73	3	167	15 (6)
	%	6.4	7.4	6.9	6.5		
Asian-Pacific Islander	Total	4	14	17	1	32	4 (2)
	%	0.7	1.8	1.6	2.2		

There has been a 160% increase in the number of AIDS cases among nonwhites from 61 cases in 1984 to 160 cases in 1986. The estimated projections for racial and ethnic minorities in 1987 are 207 new cases among Blacks, 219 among Latinos and 46 among Asians and Pacific Islanders. This represents an almost eight-fold increase since 1984. In each community, the majority of new cases are expected to be men who have sex with other men: 80.7% of the new Black cases, 94.4% of the new Latino cases, and 85.3% of the new Asian and Pacific Islander cases.

These counts of reported cases should be kept in mind, but the important numbers are those which indicate seroconversion. Since clinical AIDS usually takes a very long time to manifest itself (often in excess of five years from the time of infection), one- and two-year projections for reported cases are not a particularly graphic indicator of the challenge presented to education and prevention programs. In the absence of extensive data about seroconversion in San Francisco outside of San Francisco's gay and bisexual male community, we need to look at national patterns for some indication of what could occur.

Nationally, the statistics are quite different from the above San Francisco data. The table below reflects figures provided by the US Public Health Service Centers for Disease Control on January 26, 1987:

<u>Racial/Ethnic Group</u>	<u>Cases</u>	<u>Percent</u>
White	17,688	60
Black	7,383	25
Latino	4,238	14
Other	273	1

From this table, it is clear that nationally there is a disproportionate number of people of color with AIDS: 38% of the AIDS population in the adult and adolescent group and 80% of the children with AIDS are from racial and ethnic minority communities. These disproportionate numbers have not been seen in San Francisco, as indicated in the first table. Therefore, San Francisco seems to have a unique opportunity to demonstrate that education and prevention programs, which are far less costly than treatment programs, can be effective in addressing the threat of AIDS among people of color.

C. FACTORS INFLUENCING AIDS EDUCATION AND SERVICES TO PEOPLE OF COLOR

All of the factors listed in the remaining sections of this document will influence the development of programs and provision of services to these target populations. The key factor, however, is the fact that people of color have (a) come to appreciate the threat of AIDS and the fact that it can be avoided by behavior change and (b) perceived that the necessary education and prevention support services are not adequately in place to significantly reduce high risk behavior in their communities.

D. CURRENT SERVICES

Many of the programs described in the following pages interact regularly with people of color but do not routinely document these as distinct services. Services targeted to gay and bisexual men, for example, often include members of racial and ethnic minority groups. AIDS education for youth in San Francisco schools, for employee groups, for patients of prenatal and perinatal clinics, and for substance abusers are additional examples of circumstances under which people of color are reached but not documented separately. Some of what is done, therefore, is not counted because it is not specific to people of color.

Is this
true in
Asian communities
Pacific
Islander
communities?

In 1986-7 State Department of Health Services funding has been provided directly to two community based organizations in San Francisco who have specifically targeted the Black and Latino communities for AIDS education. DPH is complementing these efforts with funding for the two baseline surveys of awareness, attitudes and risk behavior discussed in the section of this report on SURVEILLANCE, EPIDEMIOLOGY AND RELATED RESEARCH. Some of the programs described in the section on SUBSTANCE ABUSE SERVICES are also racially/ethnically specific.

E. POLICY REAFFIRMATION

1. DPH should ensure that prevention education programs and intervention strategies are developed in San Francisco which will meet the unique needs of people of color risk for AIDS in a timely fashion.
HIV infection
2. The design and content of AIDS education and intervention efforts among people of color should be shaped by information from epidemiologic research as well as careful assessments of what targeted audiences already understand about AIDS and its transmission and of what stands in the way of their adopting or maintaining new behaviors.
3. The organizational bases from which AIDS education efforts in San Francisco are launched should be diversified. There should be a wide range of community settings and community-based organizations who educate the general and at risk public about AIDS and its prevention. Particular attention needs to be paid to programs which will communicate effectively with people of color.
4. AIDS provider education must address directly attitudes that may distort the way in which information about AIDS is received by those participating in training. Of particular concern where AIDS is an issue are attitudes about racial and ethnic minority groups.
5. DPH should insure that services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, culture and language should be evident in all service settings.
6. DPH should make every effort to ensure that staff in contract services and DPH settings in which services are planned or provided are culturally sensitive and, where monolingual clients are involved, language specific. Staffing patterns should reflect the populations targeted and served.
7. DPH should ensure that each AIDS service contractor includes in their annual program proposal a plan for addressing the special needs of people of color as they relate to the services concerned.
8. DPH should ensure that people of color participate in the Department's periodic monitoring of contract services.

VI. CONCERNS OF WOMEN

A. GOALS

Nationally, the proportion of AIDS cases among women is much higher than in San Francisco, and the majority are women of color. Needle sharing by IV drug users plays a large role in the transmission of HIV to women outside of San Francisco: the majority are infected by sharing needles themselves or from sexual contact with an infected IV drug user. The chances of a pregnant woman passing HIV infection on to her fetus are very high. Here again is a unique opportunity to avoid some dimensions of the East Coast's experience with AIDS. There is a need to insure effective education and prevention program that women can identify with and respond to.

- New York City
- Newark
- Jersey City
- Miami

Achieving DPH's general goal of providing high quality health care and other support services for people infected by HIV also requires services which are responsive to the special concerns of women.

B. BACKGROUND INFORMATION

The reported AIDS cases among women show a five-fold increase over the same period, although the raw numbers are too small to make this statistically significant. The following table indicates San Francisco cases by gender:

		<u>1984</u>	<u>1985</u>	<u>1986</u>	<u>1987</u>
Males	Total	532	791	1051	46
	%	99.6	99.1	98.7	
Females	Total	(2)	(7)	(12)	0
	%	0.4	0.9	1.3	0.0

These counts of reported cases should be kept in mind, but the important numbers are those which indicate seroconversion. Since clinical AIDS usually takes a very long time to manifest itself (often in excess of five years from the time of infection), one- and two-year projections for reported cases are not a particularly graphic indicator of the challenge presented to education and prevention programs. In the absence of extensive data about seroconversion in San Francisco outside of San Francisco's gay and bisexual male community, we need to look at national patterns for some indication of what could occur. Nationally, the statistics are quite different from the above San Francisco data. The table below reflects figures provided by the US Public Health Service Centers for Disease Control at January 26, 1987:

<u>Gender</u>	<u>Cases</u>	<u>Percent</u>
Males	27,398	93
Females	2,184	7

Data on AIDS among women in San Francisco juxtaposed to the national figures shown above supports the argument that we have an opportunity no longer available to many urban centers on the East Coast to prevent the spread of AIDS among women.

C. FACTORS INFLUENCING AIDS EDUCATION AND SERVICES TO WOMEN

All of the factors listed in the remaining sections of this document will influence the development of programs and provision of services to women. The key factor, however, is the fact that women have come to appreciate the threat of AIDS and perceived that the necessary education and prevention support services are not in place for women in San Francisco.

What data supports this statement?

D. CURRENT SERVICES

Some of the programs described in the following pages provide services to women but do not routinely document these as distinct services to women. Women's concerns are addressed to some extent under a variety of labels: services to "heterosexuals", "substance abusers", "people of color", "youth", "employee groups", for example. However, it has only been in special clinical settings (e. g. pregnancy testing clinics), in a limited number of special studies (e. g. UCSF's Project AWARE), and in some of the educational outreach to women organized by agencies such as the San Francisco AIDS Foundation, that the AIDS concerns specific to women as a discrete target population have been addressed.

E. POLICY REAFFIRMATION:

1. DPH should ensure that prevention education programs and intervention strategies are developed in San Francisco which will meet the unique needs of women at risk for AIDS in a timely fashion.
2. The design and content of AIDS education and intervention efforts among women should be shaped by information from epidemiologic research as well as careful assessments of what targeted audiences already understand about AIDS and its transmission and of what stands in the way of their adopting or maintaining new behaviors.
3. The organizational bases from which AIDS education efforts in San Francisco are launched should be diversified. There should be a wide range of community settings and community-based organizations who educate the general and at risk public about AIDS and its prevention. Particular attention needs to be paid to programs which will communicate effectively with women.
4. AIDS provider education must address directly attitudes that may distort the way in which information about AIDS is received by those participating in training. Of particular concern where AIDS is an issue are attitudes about women.

What does this mean? →

5. DPH should insure that services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to gender-related differences in lifestyle and culture should be evident in all service settings.
6. DPH should make every effort to ensure that staff in contract services and DPH settings in which services are planned or provided are sensitive to women. Staffing patterns should reflect the populations targeted and served.
7. DPH should ensure that each AIDS service contractor includes in their annual program proposal a plan for addressing the special needs of women as they relate to the services concerned.
8. DPH should ensure that women participate in the Department's periodic monitoring of contract services.

VII. PUBLIC EDUCATION

A. GOALS

1. Goals of education to the general public

- HIV infection
- To educate the public about the transmission of AIDS and how they can protect themselves and others from infection.
 - To help the public understand the dimensions of the problem, its complexity, and the potential costs (in terms of lives, emotions, and dollars) so support for constructive and cost-effect services will be forthcoming
 - To demystify AIDS and in consequence reduce hysteria about casual transmission

2. Goals of education targeted to risk groups

Has this been tested with IV Drug users?

In developing its AIDS prevention program, DPH has used as its basic reference a model articulated several years ago by San Francisco psychologist Steven Morin, PhD. The model is built on the premise that preventing the spread of AIDS requires that individuals infected and at risk of becoming infected must alter behaviors which are known to transmit the infection. In order for individuals to successfully manage new behaviors, Morin argues, the following beliefs need to be incorporated incrementally into individual belief systems. The issues are similar for people who are at risk and for those who have already been infected.

Fatal

- AIDS is a dreadful disease and I am at risk for it or may threaten others with it.
- AIDS is avoidable. Certain actions will lessen the threat of my getting AIDS or giving it to someone else.
- I can manage new, low-risk behaviors which will lessen the threat of my getting AIDS or transmit it, and I can still lead a satisfactory life.
- I am willing and able to talk to potential sex partners or fellow needle users about low-risk behaviors which will lessen the threat of my getting or transmitting AIDS.
- My peers and community will support these new behaviors.

information
↓
attitude
(responsibility)
(for self & others)
↓
Behavior

Fear of Death
can change Behavior
Also lead to denial.
Large number
of deaths has been
a major factor in
behavior change.

Education

Community
Institutions - [workplace
school
Individual
peers - [counseling
group
physicians
office
hospital

San Francisco's AIDS prevention-through-education program has the goal of moving individuals at risk from (a) to (e) on the health beliefs scale. For convenience, this will be referred to as the Morin belief scale.

It is perhaps important to emphasize at this point in the discussion that the Morin model does not claim to show how one helps move a particular target population through the steps indicated on the scale. It simply defines the general direction of movement. Other educational models and research about specific cultures must be engaged to make it all happen. The variables are discussed further in the sections on "Educational Vehicles" and "Message Content" in the pages immediately following.

B. EDUCATIONAL VEHICLES

A wide variety of communication vehicles are used for general education as well as promoting behavior changes. Where general education ends and prevention support begins depends on the individual's perception of risk. The vehicles are listed here in an order which reflects increasing individual involvement and confrontation. The order also reflects degrees of exposure that would lead some to progress through the Morin belief scale.

The vehicles listed below should be reviewed with the clear understanding that the usefulness of particular vehicles will undoubtedly vary among groups with different cultural heritages. Some, for example, may value the distance and anonymity provided by a telephone information service; others may be suspicious of the reliability of any information not secured in a face-to-face encounter. It is suggested, however, that with appropriate sensitivity to the issues of who delivers the messages and how they are framed and communicated, one or more of the vehicles listed below will probably be used in any successful education program..

1. Media advertising: Brief messages designed to reach large numbers of people. Advertisements are placed in general circulation newspapers and magazines and in specialized outlets (e. g. community newspapers). Transit ads, billboards, and TV and radio spots are also used.
2. News and feature coverage: Stories which enhance audiences' general awareness and understanding of the health concerns associated with the AIDS epidemic are promoted.
3. Pamphlets and collateral materials: These include all materials developed for distribution via mail and street intercepts, at public forums and health care facilities. Specific messages and target populations vary. Most are printed and can be carried away; some are video presentations.
4. Telephone information and referral services: An information clearinghouse to respond to questions stimulated by other elements of the prevention program and referrals for persons wishing to participate

- Churches
- Schools
- Workplace
- Street corner
- Stores
- Doctors
- Clinics
- Other

How many people simply do not believe that government can help public health officials. I discount info. and curb their beliefs (as usual spread)

in other aspects of the program. The hallmarks are easy access to information, comprehensive and accurate information, and caller anonymity.

5. Forums, workshops and classes: One session group training events which reinforce the basic messages of other education efforts and include panel discussions, lectures, video presentations and opportunities for getting brief answers to questions. The specific subject matter and focus of these events varies depending on the audience. Some of these events are initiated by the provider; some are offered in response to requests from participant groups.
6. Individual health education and counseling: One-on-one and face-to-face discussion of issues related to AIDS prevention. The most obvious example of education at this level is the interaction that occurs when clients of the anonymous antibody testing program receive their test results. Since the testing in this setting is not done in the context of a more general medical examination, it is valued more as an opportunity for education than clinical screening. The "line" between health education and mental health support (therapy) in such situations is not necessarily a distinct one, although it is sometimes convenient to discuss the distinction as a function of time and number of sessions.
7. Peer support groups: Group interactions whose principal agenda is to provide mutual support for behavioral change
8. Volunteer participation in AIDS organizations/services: Opportunities for self actualization in the fight against AIDS which go beyond opportunities to discuss personal concerns and behavioral changes.

C. TARGET POPULATIONS

General education is targeted at everyone, including groups at risk. Prevention education is targeted to groups at risk. Target populations are described in a variety of ways which do not result in mutually exclusive groups. They include:

1. The general public
2. Groups defined by behavior: men who have sex with other men, IV drug users/needle sharers, people whose sexual behavior is disinhibited by substance use, people with multiple sexual partners, sexual partners of the aforementioned groups, sexual partners of people infected through blood transfusion/blood products, etc.
3. Groups defined by community: people whose primary "community" is defined by their race or ethnicity, gender, sexuality or sexual orientation, etc.

4. Groups defined by the place they are available to be educated: jail inmates, youth in school, patients of health care clinics, employees, members of a church, community group or social organization..

D. TARGET POPULATION ASSESSMENTS

San Francisco's AIDS education programs are, whenever possible, built on the foundation of quantitative and qualitative assessments of populations targeted. Quantitative assessments (population based surveys) help to determine where people are on the Morin's five-step belief scale discussed earlier, how they have responded to what they already know, and what communication vehicles they are likely to respond to. They may also include seroprevalence and incidence studies of the target population. Qualitative assessments (usually using focus groups representative of target populations) help to shape quantitative surveys as well as determine the likely impact of draft materials and approaches to particular target populations.

E. MESSAGE CONTENT

DPH-associated educational programs follow the general principals that (1) all messages should be consistent with the latest developments in epidemiological and medical knowledge of AIDS and its transmission and (2) messages should be conveyed through mediums (print, pictures, oral/aural) and in language (visual, verbal) which the audience targeted will understand and respond to. Specific messages, however, will be varied. Important determinants of message content include:

1. Who is targeted: the "identity" of the audience targeted and the social and cultural value systems associated with that identity.
2. What they already know/believe: where the audience is on the Morin scale of incremental beliefs described above
3. Who is delivering the message: status in the community, relationship to audience, etc.
4. What resources are available: what is feasible given the setting and funding constraints; what are others doing
5. What literacy/education levels can be assumed: the level of education, literacy and language capability of the audience addressed
6. What medium(s) are used: print, pictures, oral/aural
7. What levels of formality the audience will respond to

See
Temoshom's
study
communities
- SF
- NY
- London

F. FACTORS INFLUENCING DEMANDS FOR GENERAL AND PREVENTION EDUCATION

1. The size and complexity of the epidemic and its impact on institutions and the public psyche are expanding dramatically when general education efforts have worked reasonably well. The pressure of circumstances encourages demagoguery and hype. Education needs to be provided on an ongoing basis, even in areas such as San Francisco, where overall community response is responsive.
2. Advocacy groups have emerged representing communities and (a) recognize the threat of AIDS and the fact that it causes behavior change and (b) perceive that the necessary education and prevention support services are not in place to make a difference in high risk behavior in their communities/settings. They primarily represent people of color and substance abuse education and treatment settings.
3. Serologic studies of IV drug users in treatment programs show seroconversion among IV drug users is growing and, by providing education and prevention support services to this population, distinct subgroups have not yet shown an impact.
4. Population based serologic studies of self-identified gay and bisexual men in San Francisco indicate that 55% of the community has been infected with HIV and the annual seroconversion rate is 8%. This reduction in seroconversion in community where the number of infected individuals is already so large suggests that the prevention education effort in this community has had an impact.

Other population-based surveys of knowledge and attitudes among gay and bisexual men also indicate that (a) the immune response in the community is high (an average of 8% per year over the last five years), (b) occasional "slippage" from safe sex practices is widespread, and (c) particular subgroups of the community (those involved with substance abuse) have not responded to prevention education efforts.

Data from DPH's sexually-transmitted diseases (STD) surveillance indicate that (a) rectal gonorrhea rates among men (evidence of condom use among gay/bisexual men) have "leveled off" after a pattern of fewer cases each month (suggesting that a ceiling has been reached by existing programs).

5. A population based survey of multiple/high-risk partner adults indicates that risk group members are very active and aware of the AIDS epidemic, moderately informed about prevention, have done little to accommodate behavior changes other than somewhat (a) the number of partners they have and (b) the use of recreational drugs.

Actually last info provided commission indicated a continuing decline with new cases among prev. uninfected men. Some respondents inf. 1-

6. Population based surveys specifically targeted to San Francisco's Black and Latino communities will be completed by July 1987. Data from these surveys should indicate where these communities are on the Morin "belief scale", their understanding of risk reduction, the extent of the adaptation of risk reduction behaviors, and the communication vehicles they have confidence in. Some initial, largely qualitative assessments of San Francisco's Asian communities should also be completed by July. These studies should help focus prevention education efforts in these communities.

Data from DPH's STD clinic indicates that STD rates among adolescents and young adults, particularly those from racial/ethnic minority communities, are still high.

7. While the numbers of documented AIDS cases among Asians/Pacific Islanders in San Francisco remains small, the fact that 59% of these (20 out of 34) have been among gay/bisexual Filipino men will focus attention on this community as well.
8. Federal (CDC) and State (DHS) funding offices are particularly anxious that educational materials be "inoffensive" to the community at large. Since sexual behavior and substance abuse information is a significant factor in AIDS education materials, it can be difficult to meet Federal and State requirements and still provide messages that will really reach groups targeted. CDC has dealt with the issue by requiring the appointment of a local panel to review CDC-funded materials. DHS policy calls for review of all materials by DHS staff in Sacramento and prohibits the use of "slang". (In one of the more interesting paradoxes of AIDS contracting, DHS has prohibited the distribution of "Can We Talk?" because it includes slang. This is a brochure which San Francisco's CDC-endorsed review panel singled out as one of the "best" they had seen precisely because it used terminology that the audience targeted was likely to respond to.)

In sharp contrast to the bureaucratic cautiousness reflected in these policies, the recently released report on AIDS of the National Academy of Sciences' Institute of Medicine calls for educational programs that are "willing to use whatever vernacular is required for the message to be understood". The US Surgeon General has also taken the position that "we can no longer afford to sidestep frank, open discussion about sexual practices--homosexual and heterosexual".

G. CURRENT SERVICES

Since current service budgets are generally organized around cost centers defined by educational vehicle, the following discussion is organized around educational vehicles. Services whose principal target population is substance abusers and whose principal link to DPH is through CSAS are discussed in the section on Substance Abuse Services.

1. Media advertising

The San Francisco AIDS Foundation develops advertisements primarily for display on public transportation vehicles, on billboards and in community newspapers. Messages and placement vary and are generally coordinated with the themes being promoted in community forums and literature being distributed. Since most of the advertisements (no matter what the theme) are designed to encourage people ultimately to get more information, the impact of certain campaigns can be measured by the increase in calls to San Francisco's AIDS Hotline on the topic the campaign promotes awareness of (e. g. the risk of sharing needles, the risk to heterosexuals). The Foundation reports that over half of their media advertising budget in 1986-87 will be used for campaigns targeted to women, people of color or needle users.

2. News and feature coverage:

Both the Department of Public Health and the San Francisco AIDS Foundation employ liaisons to work with print and electronic media to promote accurate and constructive coverage of the AIDS epidemic in news stories as well as printed feature stories, panel discussions, talk shows and documentaries. The Foundation estimates that over 40% of media liaison work in 1986-87 will focus on issues related to women, people of color, heterosexual transmission and needle users.

3. Pamphlets and collateral materials:

The AIDS Foundation develops and distributes a wide variety of materials for different target populations in different settings. In some instances, a particular piece for a targeted population will stand on its own; in others it is part of a comprehensive package which may include a video, brochures, posters designed for a sustained and comprehensive educational effort in a particular setting (e. g. a large corporation). Materials are sometimes developed in collaboration with specific independent groups (e. g. Forensic Services AIDS Project, the Women's AIDS Network). Materials are available in Spanish, Chinese and Tagalog as well as English. They are distributed on request, at Foundation-sponsored forums and workshops, and through a network of distribution sites as well as street intercepts.

Where have
the advertisements
been placed by
the budget.
What is total
adv. budget?
How much?
DPH

See by the
Tombstone
paper in
analysis of
SF newspapers.
NOTEWORTHY
HAVE BEEN
KPIX
SFChron.

SF AIDS FID
Manual on
Prevention

Final
by DPH?
other?
who
else
provides
material

Other
Providers
• Hospice - Manual
• Shanti.
• STOP AIDS
PROJECT

PM. Educ
• SFGH/UCSF Med.
• UCSF School
of Med., Dentistry
Nursing,
• UCSF School
Public Health
• SFMS, CMA,
• BMTA, AHA
ANA

Prevention
SF DPH
Unified School Dist
Employers?
USPHS
DHS

In FY 86-7, San Francisco's Instituto Familiar de la Raza and the Bayview Hunter's Point Foundation received funding directly from California DHS to provide AIDS education targeted to people of color. Some of this funding will be used for materials development and distribution.

4. Telephone Information and Referral:

The AIDS Foundation recruits, trains and supports volunteer counselors who operate the AIDS Hotline approximately 70 hours a week. It is a resource for people who are ill with AIDS/ARC as well as for those seeking information about AIDS risk, transmission, prevention and AIDS antibody testing. The service is anonymous, non-judgmental, and easily accessed. Spanish-speaking counselors are available during a limited number of shifts per week. Spanish and Cantonese recorded messages are available at all other times. Their equipment includes a TDD hookup for the deaf. The service currently accommodates approximately 32,000 calls a year.

All AIDS service organizations receive and handle calls for general information about AIDS and referral to AIDS services.

5. Forums, workshops and classes

- a. The AIDS Foundation's Educational Events Program is a centralized resource which provides speakers and coordinates AIDS educational events for a wide variety of groups. Speakers provide easy-to-understand, specific, detailed information about AIDS to specialized groups ranging from San Francisco dentists to employees at the Levi Strauss Company. The program also provides informational booths at diverse community events such as the Martin Luther King Day Parade and the Japantown Fair. Programs are tailored to fit their audiences; some provide basic or more advanced medical information about AIDS, while others focus on issues of casual contagion, infection control, and the emotional issues which surround working with someone who has AIDS.

Program staff recruit, train and supervise volunteer speakers, many of whom are health care professionals, and coordinate the speaking requests received. Staff also produce educational events, where a need for such an event is determined by research surveys.

The program provides sign language interpretation upon request, and can provide speakers in a variety of languages. Special effort is made to integrate AIDS educational events into other occasions which draw audiences at high risk or with a specific need for AIDS information, such as neighborhood street fairs. During 86-7 290 events will be organized through this program.

The Foundation anticipates that well over half of their staff time in this program will focus on the concerns of racial and ethnic minorities, women and substance abuse.

- ETR in
San Cruz -
an SF school
using this
material?
- b. DPH's Bureau of Family Health (BFH) is working in cooperation with the San Francisco Unified School District (SFUSD) to develop and implement a comprehensive AIDS education curriculum for San Francisco Schools. The curriculum will be piloted in several classes during 86-7 but the main focus this year will be the development, delivery and evaluation of a training program for middle and high school teachers, which is discussed at greater length under Provider Education.
 - c. In FY 86-7, San Francisco's Instituto Familiar de la Raza and the Bayview Hunter's Point Foundation received funding directly from California DHS to provide AIDS education targeted to people of color. Some of this funding will support forums and workshops.
 - d. The Women's AIDS Network (WAN) and the California Prostitutes Education Project (CAL-PEP) are two all-volunteer groups who also sponsor and provide speakers for forums and workshops on AIDS.

6. Individual health education and counseling:

San Francisco's program for anonymous HIV antibody testing were initially called "the alternate test site program" (alternatives to blood banks). They are now generally referred to as "anonymous test sites". This program is a comprehensive effort that brings together media advertising, pamphlets and collateral materials, small group education and individual health education and counseling. The focus, however, is on the opportunity for dialogue and counseling for which the test serves as a catalyst. Since the testing is not done in the context of a more general medical examination, it is valued more as an opportunity for education than clinical screening. The DPH policy to offer this testing without assembling personal identifying information on any participants is supported by State law. At current rates, approximately 10,500 individuals will be tested and counseled through this program in 86-7. Of those tested, approximately 11% are expected to be women and 15% people of color.

• How many
tested in
anonymous
test sites?
• Blood Bank?
• Doctors
• Miss?
• Hospitals?

The basic safeguards of anonymous testing are: (a) no personal identifying information on program participants is sought or recorded; and (b) staff of the testing program have no job-related responsibilities which are likely to put them in contact with those tested outside the testing program. The purpose of (b) is to provide reasonable assurance that staff members will not be able to identify a person tested because of knowledge gleaned from job-related intereactions outside of the testing program itself.

DPH has contemplated offering antibody testing with a prevention education focus to clients of substance abuse and STD treatment programs at substance abuse and STD treatment settings. This program was to be different from anonymous testing to the extent that at least one staff member from the treatment program would, as the on-site educator/counselor for antibody testing, have personal knowledge of which clients were tested and what the results were. The proposal was based on the assumption that procedures could be developed which would adequately protect individuals participating in the program and the record of their test results. In the absence of a general consensus that sufficiently rigorous safeguards could be designed for such a program, the proposal has been tabled. Instead, substance abuse and STD treatment programs will provide some general education about antibody testing and refer those who are interested to an anonymous testing site. A similar scenario of individual education and referral to an anonymous testing site will be developed for women who are patients of family planning, pregnancy testing and prenatal clinics.

The University of California San Francisco (UCSF) AIDS Health Project and Pacific Mental Health Services (PMHS') Operation Concern also provide individual health education and counseling as part of assessing potential participants in the peer support groups described below. As was noted in Section IV, epidemiologic research projects provide participants with opportunities for education and counseling as well.

DPH's Forensics AIDS Project staff offer individual education and counseling to inmates, in addition to circulating materials, rotating posters and training jail staff about AIDS.

7. Peer support groups

The Stop AIDS Project is an interpersonal communications campaign which seeks to organize a community-at-risk (primarily self-identified gay and bisexual men) in San Francisco to achieve the goal of ending transmission of the AIDS virus. The major strategy of the campaign is to shift prevailing community norms about sexual behavior, to make "safe sex" and the social interactions which support safe sex the norm. The Project's main focus is not the individual, but the group. It is viewed as a movement for social change with major health-promotion goals.

Street intercepts, door-to-door canvassing, and outreach to strategically placed opinion leaders are used to attract participants to volunteer-facilitated small group meets of 10-15 per single session group. Participants are encouraged and empowered to communicate with their sex partners and friends about the campaign to end transmission of the AIDS virus. Stop AIDS meetings are held nearly every day of the week, including weekends, in the homes of volunteer hosts throughout the City.

The single-session group efforts of the Stop AIDS Project, as presently constituted, have been scheduled since July 1986 to "wind down" by June 1987. The program was designed to provide a particular kind of educational "push" at a specific point in the history of the gay community's response to the epidemic. The designers of the program and DPH staff agree that the need for such a program will have been largely met by June 1987. By that date, approximately 8,000 San Franciscans will have participated in a Stop AIDS group, 3,500 in 86-7 alone. In light of experience to date, approximately 20% will have been from people of color. Three percent will have been women.

The UCSF/AIDS Health Project and PMHS/Operation Concern work together in providing one-time individual health consultations and closed, eight-week group support services. The target population for the services are people who are apprehensive about their prospects of acquiring AIDS and want to identify and find support for new behaviors likely to reduce their risk. Additionally, the project offers both drop-in and closed groups specifically for people with ARC in an attempt to help these individuals deal with their illness and reduce behaviors that may put others or themselves at greater risk. The majority of clients served in this program to date have been gay-identified males; 15% of clients served have been from racial and ethnic minority communities. Groups for special populations (e.g. people of color and women) are also organized: two groups exclusively for people of color have been conducted to date; women who have felt at risk have been seen predominantly for health consultations only. Taken together 3,500 San Franciscans are expected to participate in individual assessments and group sessions in 86-7.

Male and female?

The all-volunteer California Prostitutes Education Project (CAL-PEP) offers a monthly support group for prostitutes and other sex workers with an AIDS prevention focus.

8. Volunteer participation in AIDS organizations/services:

To varying degrees, all of DPH's AIDS service contractors provide opportunities for meaningful volunteer participation. There are, in addition, a number of community organizations who depend entirely on volunteers (e. g. WAN and CAL-PEP).

H. POLICY REAFFIRMATION

1. The focal point of coordination of AIDS education (both public education and prevention support) in San Francisco should be the San Francisco Department of Public Health.
2. The design and content of AIDS education and intervention efforts should be based on epidemiologic research as well as careful assessments of targeted audiences' understanding about AIDS and its transmission and of the obstacles which prevent adoption or maintenance of new behaviors.

What is the goal of the transmission of HIV?

Culture language

3. Educational materials should utilize language and visuals which the audience(s) targeted are most likely to understand and respond to. Judgments about the propriety of materials produced and distributed with public funds should be made by local public health authorities and should be based on careful assessments of the needs of local audiences. *in consultation with affected community*
4. The organizational bases from which AIDS education efforts in San Francisco are launched should be diversified. There should be a wide range of community settings and community-based organizations whose goal is to educate the general and at risk public about AIDS and its prevention. Particular attention needs to be paid to programs which will communicate effectively with groups not yet well addressed by established programs (i. e. programs targeted to hard-to-reach gay men, substance abusers, people of color, youth, and heterosexuals with multiple or at risk partners).
5. Anonymous antibody testing should be available to anyone fourteen years of age or older in the community who wishes to know his/her antibody status and is willing to participate in a pre- and post-test education and counseling program.
6. Confidential antibody testing should be promoted as a health education tool only if and when there is substantial community sentiment that procedures have been developed which adequately protect individuals participating in the program and the record of their test results.

I. PRIORITIES FOR FY 87-8

[NOTE: Prevention support that specifically related to substance abusers and treatment settings is discussed in a separate chapter.]

- Maintenance of support of media liaison which promotes broad and frequent coverage of AIDS issues in news and feature stories and of other broad-impact efforts such as "AIDS in the workplace."
- Maintenance of prevention education among gay/bisexual men sufficient to insure that the momentum towards new norms of safe sexual expression in the community is maintained.
- Expansion of education targeted to people of color.
- Expansion of education targeted to youth, both in school and out of school.
- Expansion of education targeted to jail inmates.
- Expansion of education targeted to heterosexually active men and women with multiple partners and single partners who are bisexual men or IV drug users

Goal -
Stop transmission
of HIV

• Workplace
• Churches
(family
context)

See Perinatal
Guideline
already
approved.

- Expansion of education regarding risk of AIDS to fetuses of infected mothers, education targeted particularly to women who are pregnant or contemplating pregnancy.
- Expansion of education targeted to clients of sexually transmitted disease clinics.

J. BUDGET ISSUES

(Note: An asterisk identifies issues for which new ad valorem funds are being sought)

1. The ad valorem base budget, supplemented with State (DHS) information/education funding, is expected to cover maintenance of general media liaison at current levels.
2. The ad valorem base budget includes funding to support broad impact general population outreach such as workshops for employee groups.
3. Planning for 1987-88 anticipates a different mix of contractors providing AIDS education to gay/bisexual men and men who have sex with other men but do not identify themselves as gay/bisexual. Some new contracts will be with organizations working with target populations defined by sexuality as well as other demographic tags: for example, organizations working with men of color who have sex with other men and those serving male substance abusers who have sex with other men. Overall, therefore, prevention education targeted to gay/bisexual men is expected to shift focus somewhat to more discretely defined subgroups. It is our expectation that the momentum that has developed for prevention among gay/bisexual men will be enhanced rather than compromised by these shifts. Total funding for the combined efforts is expected to be about the same. Appropriations from the ad valorem base budget will be complemented by funding anticipated from Federal (CDC and HRSA) and State (DHS I&E) grants.
4. The ad valorem base budget calls for funding of education programs specifically targeted to people of color. Additional funding anticipated from Federal (CDC and HRSA) and State (DHS/I&E) grants is expected to augment ad valorem funds in contracts with community based organizations closely identified with people of color. Taken together, contracts totalling at least \$541,149 are anticipated for education to groups defined by their race/ethnicity. Funding for the tracking surveys in the Black, Latino, and Asian communities discussed above (\$83,190 expected from the DHS block grant and \$75,000 requested in new ad valorem) is not included in this total; funding for expanded outreach to media outlets serving minority communities is. Education efforts targeted to substance abusers, women, youth, and people in the workplace will also serve people of color, although their funding is classified under different headings.

When is
the Budget??

What is the
ad valorem base?

*** →

very
high

5. In 1986-7 AIDS education in San Francisco schools has been supported by a general CDC grant to DPH, under which the San Francisco Unified School District is a subcontractor. CDC has identified a special block of funds for school curriculum development in 1987-8. It is anticipated that the program initiated in 1986-7 will be expanded in 1987-8 with a grant from this special block.

How much in budget? →

* 6. DPH is requesting \$101,829 in new ad valorem funding to support prevention education efforts which target youth out of school: street youth and those seen by a wide range of youth service providers in the city.

7. AIDS education for jail inmates is currently supported by a Federal (CDC) grant. Expansion of this effort is being requested in the grant renewal application and will be proposed in DPH's application for State (DHS I&E) funding as well.

8. Heterosexually active men and women with multiple partners or single partners who are bisexual men or IV drug users will be addressed specifically by programs supported by a combination of ad valorem base budget and Federal/State grants mentioned above, as well as by programs discussed under the heading of Substance Abuse Services.

- What materials are available currently from our services??*
- * 9. DPH is requesting \$40,000 in new ad valorem funding to underwrite the development of a video and printed materials needed to support the prevention education and counseling at pregnancy testing, prenatal and perinatal clinics called for by San Francisco's Perinatal AIDS Guidelines. Additional activities in this arena are addressed in the section on CLINICAL SCREENING AND MEDICAL CARE.

- Can we do testing (HIV) at STD clinics?* →
- *10. DPH is requesting \$101,829 in new ad valorem funding to expand AIDS prevention education and counseling for clients of sexually transmitted disease clinics.

PAGE FOR CHART SUMMARIZING ISSUES RELATED TO PUBLIC EDUCATION

PUBLIC EDUCATION

<u>Goals</u>	<u>Vehicles</u>	<u>Populations targeted</u>	<u>Factors influencing program development</u>
General education:	Media advertising	General public	General pressure of a growing and complex epidemic
-To move those at risk to risk reduction ^a	News and feature stories	Populations defined by behavior:	Emergence of special interest groups
-To demystify AIDS and reduce hysteria	Pamphlets and collateral materials	- Men who have sex with other men	Patterns of sero-conversion among risk groups
-To help public understand dimensions and dynamics of the epidemic	Telephone I&R services	- IV drug users/needle sharers	Responses to community surveys
Risk reduction support:	Forums/workshops/classes	- People whose sexual activity is disinhibited by substance use	Patterns evident in surrogate markers of risk behavior
-To move those at risk along Morin scale and promote behavior change necessary to prevent HIV transmission	Individual health education and counseling	- People with multiple sexual partners	Necessary redundancy between programs for different target populations
	Peer support groups	- Sexual partners of all the behavior groups	Politically motivated restrictions on language/messages used in educational programs
	Volunteer participation	- Sexual partners of hemophiliacs and other recipients of infected blood or blood products	
		Populations identified by community:	
		- Race/ethnicity	
		- Gender	
		- Sexuality/sexual orientation	
		Populations identified by place:	
		- Jail	
		- School	
		- Workplace	
		- Clinic/treatment setting	
		- Community group	

What
wider
of hysteria?

VIII. PROVIDER EDUCATION

A. GOALS

The programs which DPH includes under the general heading of "Provider Education" serve two kinds of providers: (1) those who routinely provide services to people who are sick or concerned about their health (health care professionals and hospital workers, mental health and substance abuse treatment professionals, emergency service workers, etc.) and (2) those who, because of their work, are uniquely placed to educate others about the problem, reduce hysteria and promote risk reduction (teachers, detention facility staff, etc.)

In the case of those who routinely provide services to people who are sick or concerned about their health, the goal of provider education is to help them understand and respond appropriately around issues of symptoms and treatment, transmission and infection control, patient/client rights, psychosocial pressures generated by the epidemic, risk reduction, and the availability of related support services. In the case of those in a position to serve as an educational vector, the issues are similar but the emphasis is more on risk reduction and the special psychosocial dynamics of the epidemic than on the technical aspects of transmission, symptoms and treatment.

Provider education is particularly complicated when AIDS is at issue because service providers sometimes bring bias to such training. The vast majority of those in San Francisco who have been infected with HIV and have developed AIDS are members of behavioral minorities (gay men and IV drug users) whose behavior is, in the minds of many, considered reprehensible: people with AIDS/ARC and those at risk are frequently "blamed" for their circumstances. Insensitivity to the special concerns of racial and ethnic minority groups is often part of the bias as well. Provider education, therefore, must address these prejudices along with issues that are specific to HIV infection.

B. FACTORS INFLUENCING SERVICE CONFIGURATIONS

1. As AIDS cases become more numerous and health care for AIDS becomes more decentralized, the number of professionals whose jobs involve them with the epidemic will expand.
2. Staff turnover must be anticipated in training programs
3. New trends in opportunistic infections associated with HIV infection, new drugs, new treatment regimens, greater experience in the development and management of psychosocial support services, new tactics of the peddlers of AIDS hysteria, the pressure of dealing with an expanding epidemic --- any one or any combination of these may require new or expanded training efforts.

still
burnt

C. CURRENT ACTIVITIES

1. General

Professional associations and university-based training programs are expanding their role in educating their constituencies about AIDS. There are, in addition, periodic regional, national, and international conferences organized to inform and educate professional service providers about AIDS. Interest in AIDS is also increasingly reflected in professional journals and newsletters. San Francisco-based providers are frequently high-profile participants in these forums.

In San Francisco, an annual "AIDS/ARC Update" is co-sponsored by an array of local service providers and constitutes the most general effort to provide new information and renewed support to San Franciscans working on AIDS-related issues.

2. Training for medical professionals and other health care workers

San Francisco General Hospital's AIDS Outpatient Clinic (SFGH/Ward 86) offers clinicians a variety of opportunities to benefit from the expertise being developed at Ward 86 regarding the diagnosis, treatment and support of AIDS and ARC patients:

- Drs. Volberding, Abrams and Wofsy each give between 50 and 100 lectures per year in the form of hospital grand rounds, lectures, workshops etc.
- A course entitled "Comprehensive Care of the AIDS Patient: A Workshop" is presented annually by faculty and staff of the University of California and SFGH to help hospitals cope with the major dilemmas encountered in providing effective care. The course is designed to cover a wide range of topics including issues related to financing, AIDS care, the hospital/community interface, as well as legal/ethical issues.
- Dr. Abrams and other physicians based at SFGH/Ward 86, in cooperation with UCSF, the San Francisco Medical Society and members of Bay Area Physicians for Human Rights, sponsor a monthly meeting of the San Francisco Community Physicians Consortium. At this meeting, physicians in private practice from San Francisco and the surrounding counties who are providing clinical services to people with AIDS, or ARC gather to review interesting or problematic cases and to keep up to speed with respect to clinical drug trials. Patients of those participating in the consortium have access, through their physicians, to clinical drug trials managed by SFGH.
- A proposal is being negotiated with a donor to provide seed money for the first dedicated AIDS training program for physicians. The program will include a combination of classroom teaching as well as practical clinical experience, including structured interactions

*Impatient
Service
• Residents
in training
• medical
Students
• Physicians
Physicians
• Visiting
From Minister
of Health
Nursing Services
Administrators*

with community service agencies. A primary goal of this program will be to include those physicians particularly involved with the care of patients from racial and ethnic minorities as well as of women and children with AIDS. This program will include 5-10 practicing physicians rotating in a series of one-month blocks.

Hospice Manual
Shanti: volunteer training

The California Nurses Association (CNA), working in cooperation with the San Francisco AIDS Foundation and AIDS Project Los Angeles and with special assistance from DPH's AIDS Office, has developed and is piloting state-wide program to train 750 hospital- and agency-based trainers of hospital and home health agency staff; 70 of these will be from San Francisco.

DPH's AIDS Office supports with State grant funds a half-time health educator who develops and implements training programs for local health care workers, in cooperation with the San Francisco AIDS Foundation. The program is particularly concerned with occupational categories that tend to be unaddressed in established training and professional development programs: e. g. hospital orderlies, laundry and food service personnel; assistants and technicians in private clinics. The program is geared to changing levels of awareness, knowledge, and attitudinal sensitivity. 1200 health care personnel are targeted for FY 86-7.

San Francisco General Hospital and a number of private hospitals in San Francisco (e. g. Kaiser, Pacific-Presbyterian, Mount Zion, St. Mary's) have also developed AIDS-specific training programs for in-house staff members. Staff of the social service advocacy program of the San Francisco AIDS Foundation contribute to these training programs.

3. Training for mental health professionals

The UCSF AIDS Health Project has provided educational services to mental health professionals from its inception, taking the skills and experiences of the project staff and making them available to psychotherapists, social workers, and health educators at all levels of training and licensure. AHP also offers trainings about the psychosocial issues in AIDS to other health care providers. There are multiple and complex issues raised by this disease: most notably the need to discuss sexuality and sexual practices, issues of death and dying, the related issue of suicide and the ethical issues raised in the care and treatment of persons with a terminal illness. In 86-7 the project's Mental Health Training Coordinator will organize and conduct workshops, forums and smaller trainings for 8,000 professionals in San Francisco. She also maintains an active liaison with Community Mental Health Services and other mental health agencies in the Bay Area. PMHS' Operation Concern cooperates with the UCSF/AIDS Health Project in the training of mental health professionals.

The AIDS Health Project also publishes a monthly newsletter, FOCUS, which summarizes developments in the areas of epidemiological, medical and psychosocial research which may have implications for psychosocial support services related to the AIDS epidemic.

SAMHA Center

The National Institute of Mental Health has provided the UCSF Department of Psychiatry with a grant to introduce coverage of all areas of psychosocial concern about AIDS in both continuing education and professional training programs of the UCSF Schools of Medicine and Nursing. The project includes special components for concerns of people of color and community based continuing education. The UCSF AIDS Clinical Research Center has received a State grant to organize in 86-7 three regional conferences entitled "AIDS and Mental Health: Clinic, Social and Administrative Issues" and to publish reports of the proceedings.

The State-funded AIDS education program at Bayview/Hunters Point Foundation also offers training for mental health professionals on concerns specific to AIDS in people of color.

4. Training for substance abuse professionals

The AIDS and Substance Abuse Education Program (ASAP) of the UCSF AIDS Health Project provides consultation and training about the intimate and complex interaction between AIDS and substance abuse. ASAP assists substance abuse agencies in dealing with AIDS and AIDS agencies in dealing with substance abuse. Services include formal trainings on topics such as substance abuse assessment, counseling strategies for substance abuse clients with AIDS concerns, and basic AIDS information. Consultation services center upon treatment planning for individual clients and programmatic or agency needs concerning substance abuse and AIDS training. All drug and alcoholism treatment programs in San Francisco have been contacted and have had inservice training or consultation for staff members. The particular needs of gay men and Latino clients who are substance abusers have been included in training and consultations. Some direct education to clients in substance abuse treatment settings is also provided. An estimated 4,900 service providers will receive training or consultation from this program in FY 86-7.

In conjunction with a State-funded demonstration project described in Section XI, DPH contracts with the Multicultural Prevention Resource Center (MPRC) through the Bayview/Hunter's Point Foundation to develop and implement training for Community Substance Abuse Services (CSAS) agencies that is specific to the concerns of their Black, Latino and Asian clients at risk for AIDS.

5. Training for emergency service personnel

At some point in the past few years, San Francisco's police department, fire department, sheriff's office, and emergency medical services have all

offered information and education about AIDS to their line managers and staff. The San Francisco AIDS Foundation will organize seminars and workshops for emergency service personnel on request from the department or the labor association concerned.

The American Red Cross and the California Firefighter Foundation recently received a grant from the California Department of Health Services to develop a training program on AIDS education for public safety department trainers.

6. Training for jail staff

Education concerning AIDS risk and risk reduction is given to all staff working within the three county jails, Ward 7D (SFGH) and Youth Guidance Center by the CDC-funded Forensic Services AIDS Project. Training concerning effective ways of working with people with AIDS and ARC is offered for those providing medical, correctional and social services to inmates and youth. Approximately 500 staff are employed at these facilities.

7. Training for SFUSD teachers

DPH's Bureau of Family Health (BFH) is working in cooperation with the San Francisco Unified School District (SFUSD) to develop and implement a comprehensive AIDS education curriculum for San Francisco Schools. The curriculum will be piloted in several classes during 86-7, but the main thrust this year will be the development, delivery and evaluation of a training program for middle and high school teachers. Project staff have compiled a Teacher's Guide designed specifically for use in middle and high schools. A total of 120 teachers will be trained as part of this pilot project. From this total, six teachers (three middle school and three high school) will be selected to pilot the curriculum in middle and high school classes in a monitored study.

C. POLICY REAFFIRMATION

1. DPH should encourage the development of comprehensive and constructive AIDS education components in a broad spectrum of (a) professional degree training programs, (b) university-affiliated continuing education and in-service training programs, (c) training opportunities organized by professional associations and labor organizations, and (d) in-house training offered by local service providers. Experienced providers based at DPH should cooperate by making their experience available to those who are planning and implementing such training.
2. DPH should assist as much as possible in training efforts that will ultimately enhance the capacity of private sector providers to accommodate needs generated by the AIDS epidemic.

3. DPH recognizes that, to be constructive, AIDS provider education must address directly prejudices that may distort the way in which information about AIDS is received by those participating in training. Of particular concern where AIDS is at issue are attitudes about homosexuality, racial and ethnic minority groups, women, people with substance abuse and mental health problems, and death and dying.
4. DPH recognizes that AIDS provider education programs have a special responsibility to address concerns of stress and burnout among providers.

D. PRIORITIES FOR FY 87-8

- Maintenance at least at current levels of all provider education efforts.
- Augmentation of training for health care providers to help broaden the base from which comprehensive health care for persons with AIDS/ARC can be provided.
- Insurance that all AIDS service provider training programs include activities designed to sensitize providers to the unique dynamics of working with clients or patients who may be (a) gay or bisexual men, (b) women, (c) people of color, and/or (d) people with substance abuse and mental health problems.

E. BUDGET ISSUES

(Note: An asterisk identifies issues for which new ad valorem funds are being sought)

1. The capacity of SFGH/Ward 86 to service as a general resource for training health care providers has been enhanced by a three-year Federal (HRSA) grant which underwrites the salaries of 1.5 FTE physicians/clinical instructors, part of whose time is to be made available for such training.
- * 2. DPH proposes to expand this effort further with \$53,000 in new ad valorem funding to support the equivalent of one additional FTE physician/clinical instructor for such medical training.
3. Maintenance of the California Nurses' Association training program for trainers of nurses in San Francisco is expected with State (DHS/I&E) funding which has been earmarked for such training in San Francisco city/county.
4. Guidelines for 1987-8 State (DHS/I&E) funds seem to preclude continuation of State support for an effort initiated in 1985-6 to

• RWS A in
position in
coordination

provide training for health care workers such as hospital orderlies, laundry and food service personnel, assistants and technicians in private clinics. DPH will address these needs through ad valorem base budget funding for outreach to employee groups.

Why not
Charge for
These services
Many programs
in continuing
education
have never

5. Guidelines for 1987-8 State (DHS/I&E) funds seem to preclude continuation of State support for the kind of direct training of mental health and substance abuse service providers in San Francisco which, in 1986-7, were supported by a combination of State and ad valorem funds. These programs also work with health care providers regarding the special dynamics of providing care to patients with substance abuse and mental health concerns. The AIDS Office's ad valorem base budget covers maintenance of this provider education effort (\$150,061 for mental health providers and \$115,754 for substance abuse service providers).

4. Guidelines for 1987-8 State (DHS/I&E) grants indicate that a specific level of their funding will be assigned to training of trainers for emergency service personnel (firefighters, police and emergency medical technicians) in San Francisco.

5. Federal (CDC) funding is expected to maintain current training of jail staff.

6. New Federal (CDC) funding is expected to expand AIDS curriculum development and teacher training for AIDS education in San Francisco schools.

* 7. DPH requests \$102,465 in new ad valorem funds for technical assistance to all other DPH-affiliated provider education programs which will help each program develop components to sensitize providers to the unique dynamics of working with clients/patients of color.

8. Sensitivity to the particular concerns of women and gay/bisexual men will be specifically addressed in all programs.

PROVIDER EDUCATION

<u>Goals</u>	<u>Provider groups</u>	<u>Factors influencing program development</u>
Training for providers to help them respond appropriately to issues around symptoms and treatment, transmission and infection control, patient/client rights, etc.	Generally those whose job responsibilities bring them in contact with the epidemic	Number of professionals whose jobs involve them with the epidemic is expanding
Training for educational vectors emphasizing similar issues but with more emphasis on risk reduction and the psychosocial dynamics of the epidemic	Medical professionals and other health care workers	Staff turnover
Training which helps providers come to terms with their own potentially biased attitudes about "at risk" patient/client groups	Mental health professionals	New developments in understanding and treatment
	Substance abuse service professionals	Professional associations assuming a large role in this education
	Emergency service personnel	State funding promoting state-wide and regional training
	Jail staff	
	School personnel	

IX. CLINICAL SCREENING AND MEDICAL CARE

A. GOALS AND ACTIVITIES

A general goal of San Francisco's response to the AIDS epidemic is to provide care for patients in a manner which is medically appropriate, psycho-socially supportive and culturally sensitive, as well as cost-effective. This goal is not unique to AIDS. However, the rapid development and complex dynamics of the AIDS epidemic have presented the Department with problems whose solutions have required dramatic departures from patterns of service delivery considered typical in other situations.

*Hospitals
Public SFGH
Private UCSF
Federal*

*Physicians
Private - 14 to 15
CMMC based
Private -
Veterans - 50mm
Medians 1mm*

*UCSF
SFGH
VA*

The clinical screening and medical care features of DPH's response include clinical screening clinics and primary care services in community centers, a dedicated inpatient unit at San Francisco General Hospital, and a highly specialized AIDS outpatient clinic. These are backed up by a comprehensive array of home support services which are discussed in Section IX. The overall purpose of these dedicated services is to concentrate the expertise of a wide variety of medical disciplines (e. g. oncology, infectious diseases, neurology, pathology, dermatology, oral medicine, virology, epidemiology, gastroenterology, parasitology, immunology, and pulmonary medicine) to provide the care required by HIV-associated diseases. The concentration minimizes the logistical complications of "moving" patients from one specialist to another and in doing so makes high quality care more accessible to them. It also makes it possible to minimize the number admissions for inpatient care and keeps the length of stay as short as possible for those admitted. Therefore, a recurring theme behind the continuum of care developed by DPH for AIDS may be stated as a slogan: "Maximize the potential of patients' maintaining themselves well at home or in residential facilities".

An equally important feature of DPH's response has been encouragement of private sector participation in the medical care of patients with HIV-associated illnesses.

B. CURRENT SERVICES

The San Francisco AIDS Foundation's AIDS Hotline is the most widely advertised source of information and referral about clinical screening and sensitive outpatient care. However, a wide range of other organizations are now sufficiently involved and knowledgeable to provide such information to people they come in contact with.

Most preliminary screening for AIDS is done by physicians in private practice, at University of California San Francisco clinics, and in community clinics. A number of epidemiologic research projects also provide screening. There are, in addition, three DPH-funded programs which offer AIDS-specific screening to low- and no-income individuals: one at the Haight Ashbury Free Medical Clinic, another at Health Center #1, and a third for pregnant women at SFGH's Women's Health Center.

The first two sites will screen approximately 320 patients during FY 86-7 and will provide referrals to appropriate care resources when indicated. The Women's Health Center will screen between 50 and 100 pregnant women this year who are at high risk for acquiring AIDS.

The AIDS Outpatient Clinic at San Francisco General Hospital (SFGH/Ward 86) specializes in care for the person with AIDS and AIDS related conditions (ARC). Clinics are organized to provide the following:

- screening and referral services for AIDS and ARC
- comprehensive medical care, including evaluation, diagnosis, treatment and follow-up care, to people with AIDS and ARC
- comprehensive and coordinated psycho-social support services for people with AIDS and ARC
- active participation in AIDS related clinical research
- various outpatient procedures that might otherwise require a hospital admission, such as transfusions, hydration, and chemotherapy administration
- on-site phlebotomy
- on-site MediCal registration and SFGH patient registration

What does this mean 1986 - 1987 - or July 1, 1986 - June 30, 1987 (FY 1987) Is it visits? or does "patient registration" mean?

What is this on Dx AIDS - ARC - what is the relationship between these two?

Patient registrations at Ward 86 are expected to total 24,000 in 86-7. In October 1986, 1,700 different patients were being followed. This includes patients with AIDS-related complex as well as clinical AIDS. Of this number, approximately 80% look to Ward 86 as their primary care provider.

How many patients?

Mount Zion Hospital and UCSF's Moffitt Hospital have also organized dedicated outpatient clinics for the treatment of HIV-associated illnesses.

Comprehensive health maintenance and infirmity care services are currently provided to approximately 70 AIDS/ARC patients by satellite clinics of SFGH: Family Health Center, Adult Medical Center, Southeast Health Center, South of Market Health Center, and Potrero Hill Health Center. Health Centers #1 and #2 are expected to provide primary care to 450 ARC patients in 86-7, in addition to the screening services mentioned above. The Bureau of Communicable Disease Control's Division of Tuberculosis Control will provide clinical services to 30 patients with AIDS and TB in 86-7 and Jail Medical Services report that approximately 15 inmates at the county jail at any given time identify themselves or have been diagnosed as having AIDS or ARC.

SFGH's Department of Hospital Dentistry currently sees approximately 15-20 AIDS/ARC patients per month in the hospital-based Dental Unit and 25-30 in satellite units.

Fourteen hospitals in San Francisco now provide inpatient care to persons with AIDS/ARC. San Francisco General Hospital (SFGH) accounts for 33% of the total patient days. Most SFGH patients are accommodated in a 20-bed unit dedicated to the acute care of persons with AIDS/ARC (Unit 5A). When the dedicated unit is full, patients are assigned to other medical-surgical units on a space-available basis. SFGH has accommodated an average of 33 patients per day over the past four months. The centerpiece of the budget for 5A is nursing services. There are, however, an array of other subdivisions of the hospital which contribute to the care provided at 5A. They include medical

services such as radiology, anatomic pathology, surgery, gastrointestinal , psychiatry, neuropsychiatry, family practice, general medicine, medicine, endocrinology, pulmonary, neurology, and nephrology. They also include laboratory and other support services such as medical social services, physical therapy, respiratory therapy and pharmacy. There are, in addition, a number of administrative support operations which contribute as well: infection control, medical records, housekeeping, employee health services, and the medical library.

Kaiser/San Francisco, an HMO hospital which accounts for approximately 15% of inpatient care for persons with AIDS/ARC, has recently opened a 10-bed dedicated unit in the near future.

B. FACTORS INFLUENCING SERVICE CONFIGURATIONS

1. There is a steady increase in the number of people who develop clinical complications from HIV infection.
2. The population groups requiring treatment are expected to change. The preponderance of current cases of both AIDS and ARC are among white gay and bisexual men. The vast majority of reported cases with a history of IV drug use are also white gay/bisexual men. While DPH anticipates that in the next eighteen months most new cases of CDC-defined AIDS will be from the groups mentioned, we will probably see the beginning of an increase in the proportion of ARC cases who are (a) from people of color (both gay/bisexual and non-gay/bisexual), (b) women, (c) infants, (d) substance abusers (both gay/bisexual and non-gay/bisexual), and (e) jail inmates. These populations may be better served in different settings.
3. The California Department of Health Services (DHS) has commissioned a study of the need for special health care and psychosocial support in racial and ethnic minority communities. It is scheduled for completion by March 1988. This may have implications for planning future clinical screening and medical care in San Francisco.
4. There are new patterns in the clinical manifestations of AIDS. The marked increase in the incidence of neurological impairment is the most dramatic example. These new patterns will require different treatment and different support services.
5. New treatments are being developed. New drugs will prolong life expectancy and therefore expand demands for health care services. New treatment regimens will create demands for different staffing, space and equipment, primarily in outpatient service settings.
6. DPH also anticipates an increase in dependence on public sector support. Patients will live longer and more will "spend down" to eligibility for greater public assistance. Some may live long enough

How many
private physc
provide care
to AIDS/
ARC
20? 30?
none?
what is number
of MDs in SF?

will
open?
or
has
opened?

see
your
own
table
cite
there

Special
problems
in care

Transfusions

COST OF
DRUGS - who
will pay?

What does ART
do?

to qualify for Medicare. Patients with certain forms of ARC often require as much care and support as patients with AIDS, yet they are not presumptively eligible for MediCal, SSI, etc., which tends to make them more dependent on local public resources.

C. POLICY REAFFIRMATION

- Continuum of coordinated services - inpatient, SFGH, outpatient, SFGH, residential, HMC, hospice*
1. DPH should maintain its general focus on comprehensive outpatient care and maximize the potential of patients' maintaining themselves well at home or in residential facilities.
 2. DPH should insure that services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, culture and language should be evident in all service settings. The special needs of women with AIDS/ARC and dependent children should be taken into account.
 3. Private providers should participate as fully as possible in the screening and care of persons with clinical manifestations of HIV infection.
 4. At this point in the history of the epidemic, testing for the antibody to HIV is clinically indicated in relatively few circumstances. Any physician who accommodates the provisions of AB 403 can order the test with the informed consent of his/her patient. DPH's Microbiology Laboratory should do the necessary laboratory work free of charge for any physician who agrees to certain guidelines regarding pre- and post-test education and counseling. The sera sent to the Lab for such testing should continue to be identified by code number alone; only the physician concerned should have a record of the patient associated with the code number.

D. PRIORITIES FOR FY 87-88

- Should clinic be relocated to more suitable site?*
- SFGH should remodel Ward 84/86 to accommodate new outpatient treatment regimens and an increased patient load.
 - While maintaining a dedicated and comprehensive outpatient clinic for those with AIDS and ARC at SFGH, DPH should develop the capacity of satellite programs to serve patients equally well at other sites. The satellite programs may be designed to provide primary care to more discrete population groups (e.g. women, children with AIDS/ARC, etc.) or to particular neighborhoods with a high prevalence of HIV infection. Initially, DPH should expand support for clinical screening, outpatient and primary care services at Health Center #1, Health Center #2, Southeast Health Center. Clinical services to children with AIDS/ARC and women at risk who are pregnant or contemplating pregnancy should be covered in this expansion.
 - SFGH should expand the capacity of the inpatient unit dedicated to AIDS care from 20 to 28 beds.

- DPH should encourage private sector participation in clinical screening and medical care of persons with HIV-related disease by (a) providing training and technical assistance as discussed in Section VI, (b) facilitating the access of their patients to clinical trials; and (c) advocating changes in insurance and MediCal/Medicare regulations which will give an adequate return to all providers for their services to persons with AIDS/ARC.
- DPH should monitor services to insure that they are accessible to populations targeted. Special language and cultural concerns of patients should be taken into account.

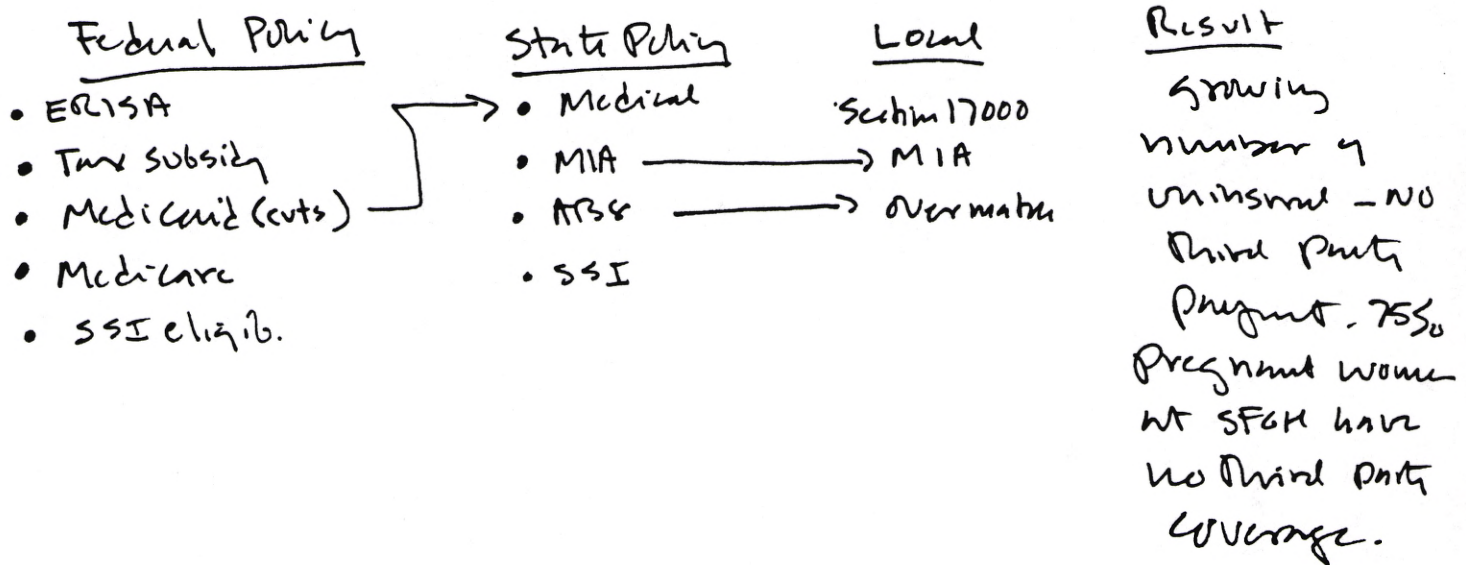
E. BUDGET ISSUES

(Note: An asterisk identifies issues for which new ad valorem funds are being sought)

- * 1. SFGH's capital request 1987-8 includes approximately \$1,000,000 for remodeling Wards 84/86 to accommodate an increase in the number of patients served and demands imposed by new treatment regimens. (NOTE: Since this is a capital request, the amount is not reflected in the \$3,288,713 total shown for operating budget issues.)
- * 2. DPH requests \$1,199,607 in new ad valorem funds to expand inpatient, outpatient and support services for persons with AIDS/ARC at SFGH. This covers the development of AIDS-dedicated outpatient services at Southeast Health Center, South of Market Health Center, Children's Health Center, and Women's Health Center; it also covers the expansion of the dedicated inpatient unit at SFGH/5A from 20 to 28 beds. The overall costs total \$4,293,213. SFGH indicates that \$169,246 is covered in their ad valorem base budget, 89,000 is addressed in other sections of this document (i. e. in PROVIDER EDUCATION and in SUBSTANCE ABUSE SERVICES), and \$2,835,360 is anticipated from MediCal, private insurance and private pay revenues generated by the service expansion.
- * 3. DPH requests \$223,774 in new ad valorem funds to expand AIDS screening and AIDS/ARC primary care services at Health Centers 1 and 2.
- * 4. DPH requests \$81,602 in new ad valorem funds to support the clinical implementation of San Francisco's Perinatal AIDS Guidelines at sites not associated with the SFGH proposals mentioned above. The cost of developing some materials to be used in this and SFGH's effort are discussed in PUBLIC EDUCATION issues.
5. The expansion of health care provider training discussed under the heading of PROVIDER EDUCATION is expected to encourage private sector participation in health care for persons with AIDS/ARC. Facilitation of private patients' access to clinical trials is closely associated with the physician training based at SFGH.

What will
the \$1.99M
cover — is this
to cover "bad
debt and charity
care" for AIDS
patients? If so,
how does this
diff from
others (including
pregnant
women without
third party
coverage)

6. A Federal (HRSA) grant supports a position whose primary focus will be collecting data and developing cogent arguments for more reasonable reimbursement by MediCal and private insurance of care provided persons with AIDS/ARC (acute inpatient and ambulatory care, subacute institutional care, home care).
7. The team offering technical assistance to all DPH-affiliated provider education programs regarding the unique dynamics of working with clients or patients of color will be asked to monitor the accessibility of direct services to these clients/patients.



CLINICAL SCREENING AND MEDICAL CARE

<u>Goals</u>	<u>Services</u>	<u>Populations requiring special services</u>	<u>Factors influencing service development</u>
Provision of patient care which is medically appropriate, psycho-socially supportive and culturally sensitive	Information and referral	Persons with AIDS/ARC	Growing numbers of new cases and corresponding increase in numbers living
	Specialized screening clinics	Persons with AIDS/ARC and concurrent substance abuse problems	Anticipated shift in population groups requiring care
	Primary care clinics	Women with AIDS/ARC	New patterns in clinical manifestations of HIV infection
Encourage the development and use of services outside of acute care settings when clinically indicated and cost effective	Specialized, comprehensive outpatient care	Adults with AIDS/ARC and dependent children	New treatment protocols
	Dedicated inpatient care	Adult psychiatric patients with AIDS/ARC	Increase in dependence on public sector services and MediCal
Encourage the development of settings in which the full range of outpatient services can be provided in a single setting		People with AIDS/ARC who speak little no English	New information on special health care and psycho-social support needed by racial and ethnic minorities
		People in jail with AIDS/ARC	
		Hemophiliacs with AIDS/ARC	
		Children with AIDS/ARC	

X. CHRONIC CARE AND RELATED SUPPORT SERVICES

A. GOAL

The general goal of San Francisco's chronic care and related support services for AIDS and ARC patients is identical to the goal of primary and acute care services: to provide care for patients in a manner which is medically appropriate, psycho-socially supportive and culturally sensitive, as well as cost-effective. The focus of medical care on outpatient services necessitates an extensive network of complementary services designed to maximize the potential of patients' maintaining themselves well outside of acute care settings.

B. ELEMENTS OF SERVICE

1. "Subacute care", "intermediate care" and "skilled nursing care" are variations on the theme of licensed health care in a setting that provides close 24-hour monitoring by a nursing staff when patients' conditions are relatively stable and not likely to require heroic interventions. In certain circumstances, the terms are used to identify different categories of licensure, different levels of patient acuity and staffing requirements, and different reimbursement rates. Since persons with AIDS and disabling ARC who require such care are often subject to sudden and dramatic changes in status, a high level of staff support is generally required for persons with AIDS/ARC in such settings.
2. Where HIV-related infections are concerned, home health care and in-home hospice care often go hand in hand. In some instances, for example, the care is provided to a patient recovering from an episode of pneumonia, and the care consists largely of intermittent monitoring of improvement in health status. In most instances, however, the care at home is for patients who are in the terminal phases of the disease, extremely debilitated, and focused on the dying process. Effective care under these circumstances usually requires that the patient have a viable personal support system with which the in-home hospice provider can work.
3. In-home assessments are generally conducted by public health nurses for patients who are home-bound and who may require some assistance in understanding their need for medical care or support services and in securing such services once the need is identified. In 86-7 DPH will experiment with in-home assessments by physicians and psychiatrists in certain circumstances.
4. Housing for persons with AIDS/ARC falls into three general categories:
(a) short-term, emergency housing for those still in fairly good health and able to function independently while looking for more permanent arrangements; (b) long term housing for those capable of living

cooperatively with others without 24-hour staff supervision and monitoring of behavior; and (c) long term housing for people who are unlikely to manage well in a living situation which depends on cooperation with others.

5. "Practical support" is a catch-all term which encompasses a wide range of services which assist people who are very ill in activities of daily living so they can maintain themselves at home for as long as possible. It includes help with grocery shopping, laundry, cleaning, meal preparation, transportation to medical and social service appointments.
6. Emotional support for someone confronted by a life-threatening illness is particularly complex. San Francisco's response to the need for such support includes crisis intervention, psychotherapy, support groups, peer counseling for the person with AIDS/ARC and the same range of support services for members of their personal support systems.
7. Social service/entitlement program advocacy is an integral part of many organized health care services: acute care hospitals, subacute care facilities and home health care agencies all provide advocacy for their patients/clients while they are patients/clients. San Francisco also funds a "generalist" program which provides client advocacy and assistance for those not yet or not currently connected to an organized health care service.
8. Legal education, referral and advocacy is often associated with social service and entitlement programs. Where AIDS is concerned, there are special dynamics which require a more focused program: AIDS-related discrimination in employment and housing occurs in San Francisco in spite of an extensive public education program. In addition, there are special problems that arise from situations involving terminal illness, e.g. conflicts between lovers and relatives of gay men who have died from AIDS/ARC.
9. Accurate information about and referral to appropriate services is essential if the system is to work as it has been designed.

C. FACTORS INFLUENCING SERVICES

1. There is a steady increase in the number of people who develop clinical complications from HIV infection.
2. The population groups requiring treatment are expected to change. The preponderance of current cases of both AIDS and ARC are among white gay and bisexual men. The vast majority of reported cases with a history of IV drug use are also white gay/bisexual men. While DPH anticipates that in the next eighteen months most new cases of CDC-defined AIDS will be from the groups mentioned, we will probably see the beginning of an increase in the proportion of ARC cases who are (a) from people

of color (both gay/bisexual and non-gay/bisexual), (b) women, (c) infants, (d) substance abusers (both gay/bisexual and non-gay/bisexual), and (e) jail inmates. These populations may be better served in different settings. } cite data

3. The California Department of Health Services (DHS) has commissioned a study of the need for special health care and psychosocial support in racial and ethnic minority communities. It is scheduled for completion by March 1988. This may have implications for planning future clinical screening and medical care in San Francisco.

4. There are new patterns in the clinical manifestations of AIDS. The marked increase in the incidence of neurological impairment is the most dramatic example. These new patterns will require different treatment and different support services.

5. New treatments are being developed. New drugs will prolong life expectancy and therefore expand demands for health care services. New treatment regimens will create demands for different staffing, space and equipment, primarily in outpatient service settings.

6. DPH also anticipates an increase in dependence on public sector support. Patients will live longer and more will "spend down" to eligibility for greater public assistance. Some may live long enough to qualify for Medicare. Patients with certain forms of ARC often require as much care and support as patients with AIDS, yet they are not presumptively eligible for MediCal, SSI, etc., which tends to make them more dependent on local public resources.

7. Planning for out-of-hospital support services has been facilitated by a grant from California DHS to DPH to underwrite the costs of a study of service utilization and demand. The preliminary report for the study should be released by June 1987.

8. Subacute beds for persons with AIDS/ARC are currently quite limited. A year ago, MediCal suspended reimbursements for this level of care and reimbursements for the promised substitute level of care have not yet been authorized.

9. The California Department of Health Services (DHS) has identified funding for a direct contract to a skilled nursing facility (SNF) in the San Francisco area to cover SNF care for ten persons with AIDS/ARC. Negotiations with St. Mary's Hospital regarding this demonstration project are in progress and should be completed before July 1987.

10. DPH has received a demonstration project grant from the US Public Health Service which provides funding to underwrite a variety of chronic care and other support services over a 27-month period beginning July 1987: intermediate care (6 beds/day), home care

(5 patients/day), in-home medical assessments (physician and psychiatrist time), and residential substance abuse treatment for persons with AIDS/ARC (21 beds/day).

11. The vast majority of those who develop AIDS or severe ARC are members of behavioral minorities (gay men and IV drug users) whose behavior is in the minds of many presumed to be reprehensible. People with AIDS/ARC are often blamed for their condition. Patients often buy into this sense of guilt.
12. Gay men and IV drug users are minorities who often choose not to share information about their lifestyle. When AIDS or ARC is diagnosed, many are obliged to admit to family, friends and colleagues for the first time that they are members of one of these risk groups. In such situations, patients and those who comprise their personal network must often deal simultaneously with the news of a terminal illness as well as a hidden lifestyle.
13. AIDS is an infectious disease and, unlike most chronic illnesses, can be transmitted from one person to another. Even though epidemiologists are in general agreement that the virus is very difficult to transmit, many fear contagion from casual contact. Their reaction to people with AIDS/ARC often amounts to hysteria. This hysteria has created particular problems in health care and employment settings, as well as with families, friends and living situations.
14. AIDS is currently evident in population groups whose home support systems are (a) in some instances strong but non-traditional and therefore awkward for some to deal with, (b) in some cases weak (e. g. roommates who may not be willing or able to take on the role of primary care provider when in-home hospice services are called for), and (c) in many cases non-existent (e. g. some have never had a home support system; others have been abandoned).
15. As more adults with dependent children are diagnosed, the problem of care for the children concerned will grow.
16. As more children are diagnosed with AIDS or develop HIV related infections, special support services for parents and foster parents may need to be developed.

C. CURRENT SERVICES

Garden Sullivan Hospital provides continuing hospital care for San Franciscans with AIDS and severe ARC within its ten-bed Garden Unit, which is licensed to provide acute-rehabilitation services. Common causes for placement at GSH are acute diarrhea, dementia, dehydration, and other sudden losses of function that require 24-hour care. The Unit averages 6 patients with AIDS/ARC per day; some are covered by private insurance.

xx
Hospice of San Francisco provides a full range of home health services for persons with AIDS and severe ARC. A multidisciplinary team provides an individualized program of organized, skilled and compassionate care utilizing pain control, comfort care, and relief of the symptoms of terminal illness, whether physical, emotional, psychological or spiritual. An average daily census of 63 persons with AIDS and ARC has been contracted for in 1986-7. During the year about 403 patients will be served. Length of stay in the program averages about 57 days. Over 80% of terminations in the program are due to death, about 15% to remission, and the rest because people move.

In February 1987, Hospice of San Francisco opened a board and care facility (Coming Home Hospice) at which home health care is provided residents by the AIDS home care teams described above. It is estimated that 10 of the 63 patients per day contracted for will be cared for in this environment.

Public health nurses maintain liaison with those who are AIDS care providers and will provide in-home health and social assessments of 130 AIDS/ARC patients in 86-7, followed by appropriate referrals.

The San Francisco AIDS Foundation's Emergency Housing Program provides persons with AIDS or ARC housing in a program-managed facility for up to two weeks, limited hotel accommodations for up to one week, help in obtaining public assistance and in developing alternative permanent housing resources. At this time the program is unable to serve the needs of children, people whose mobility is grossly impaired, or clients with major medical and/or psychological disorders which prohibit their utilization of independent living skills. A significant portion of the clients are chronic substance abusers and are therefore not eligible for many existing housing and support programs. The program typically houses 8 people per month (4 individuals at a time) and facilitates the placement of an average of 17 per month in hotels and through roommate referrals.

Shanti Project secures and manages low-cost, long-term housing for single men, women, and emancipated minors with AIDS (or ARC with a prognosis of six months or less) who have been displaced. Each resident is provided with a separate room; kitchen, living room, and bathrooms are shared. The aim of the program is to provide a home for persons with AIDS/ARC facing debilitation and death, not simply a shelter. The program promotes cooperative interaction, emotional stability, and the residents' independence and control over their environment. Program staff screen prospective residents, determine eligibility, help with moving, facilitate house meetings, provide advocacy for residents needing related support services services, and generally maintain the premises. Staff do not live in or provide meals. While Shanti itself does not provide licensed home health care services, these residences are settings in which licensed home health care can be provided in a responsive and supportive environment. Volunteers from Shanti's Practical Support Program and Emotional Support Program also work with residents from a separate administrative base.

* A typical Shanti residence houses four people. The program's current capacity is 44. It is estimated that 120 different individuals will be housed by this program in 1986-87. Length of stay ranges from a few weeks to more than a year, and averages 120 days. 90% of terminations are due to client deaths, 9% are at the initiative of clients, 1% are at the initiative of program staff.

* Some people with AIDS or ARC have been excluded from the housing programs described above due to active substance abuse or severe psychiatric problems. Community Substance Abuse Services (CSAS) recently received funding to organize a 21-bed residential treatment program for persons with AIDS/ARC (scheduled to open July 1987) and DPH's Medically Indigent Adult Program is now working with CCSF's Department of Social Services and community based agencies on the development of a program would provide a supportive living environment for other homeless people with AIDS or ARC who are ineligible for other housing programs or residential treatment. The CSAS program is discussed further in the section on substance abuse services.

In addition to housing specifically for people with AIDS or ARC, there are several agencies providing shelter for the homeless that occasionally house people with AIDS/ARC. They include the Episcopal Sanctuary (accommodates 200 each night; primarily seniors, women and disabled), Hospitality House (shelters 80 men per night), Ozanam Reception Center (shelters 85 men per night, many of whom have substance abuse problems), the Salvation Army Shelter (accommodates 55 men per night), and San Francisco Support Services (which administers three hotel-based programs, primarily for people with mental health problems). It is important to be clear that the numbers given above reflect total program capacity, not the numbers of persons with AIDS/ARC. the number of people with AIDS/ARC diagnoses staying in shelters for the homeless may vary greatly from one point in time to another, and their presence is not always known to shelter staff.

Shanti Project's Practical Support Volunteer Program recruits, trains and supervises volunteers to assist people with AIDS and severe ARC in the execution of their basic everyday needs: shopping, laundry, cooking. Volunteers from this program are also utilized by the Residence Program and San Francisco General Hospital Program on an as-needed basis when such support is necessary. Currently, individual volunteers are provided to each person requesting such support. In addition, a van driver is employed to transport persons to non-emergency medical, psychiatric and social service appointments. Shanti estimates that 530 persons with AIDS/ARC and 30 significant others will benefit directly from this service in 86-7.

The Food Bank Program of the San Francisco AIDS Foundation is a community-supported program which assists indigent people with AIDS or ARC through grocery supplementation. The average income for a person with AIDS is using the Food Bank is \$533 per month; the average income for a person with ARC is \$301 per month plus \$20 in food stamps. The Food Bank provides up to one bag per week of groceries to each client and expects to distribute 6,000 bags in 86-7

Reimbursements from the Department of Social Services for in-home supportive services are generally handled through Hospice of San Francisco's AIDS Home Care program. There are several community-based meal delivery programs which also serve persons with AIDS/ARC.

Emotional support services are an integral part of the continuum needed to maintain people with AIDS/ARC outside of acute care settings. They are discussed in more detail in Section X (Mental Health Services) and in Section XI (Substance Abuse Services). Mental health programs include a peer counseling program managed by Shanti Project, a professional counseling and advocacy program at SFGH also managed by Shanti Project, mental health assessments and educational support groups offered by the UCSF AIDS Health Project and PMHS' Operation Concern, as well as individual and group counseling offered by Community Mental Health Services. Substance abuse contract programs administered by Community Substance Abuse Services include a variety of group and individual counseling services.

Social service/entitlement program advocacy is an integral part of many organized health care services: acute care hospitals, subacute care facilities and home health care agencies all provide advocacy for their patients/clients while they are patients/clients. DPH also funds a "generalist" program at the San Francisco AIDS Foundation which provides client advocacy and assistance for those not yet or not currently connected to an organized health care services. Services include (1) information and referral on entitlements and eligibility; (2) orientation to, scheduling and trouble shooting for General Assistance, Food Stamps, MediCal, Social Security and other entitlement programs; (3) case management of clients with multiple service needs; (4) liaison with hospitals and community agencies to reach target populations; (5) technical assistance for and training of other direct service providers; and (6) limited development of employment and other resources for clients. The staff of this program is bilingual (Spanish) and multicultural. In 86-7 this program is expected to serve 800 persons with AIDS/ARC in San Francisco.

In San Francisco there are two community organizations who provide legal education on AIDS-related issues and free or reduced-cost legal services to persons with AIDS/ARC and their significant others: the Bay Area Lawyers for Individual Freedom and National Gay Rights Advocates. Their education efforts focus on wills, testing, confidentiality, employment, insurance and housing discrimination. Their legal services address similar issues as well as probate, bankruptcy, etc. NGRA is also active in promoting legislative and administrative policy initiatives to protect and better serve people with HIV-related concerns.

The San Francisco Human Rights Commission is the administrative agency primarily responsible for the enforcement of Article 38 of the Municipal (Police) Code, the AIDS/ARC Discrimination Ordinance. Under this ordinance the Commission has conducted an public outreach campaign, and the investigation, mediation and resolution of complaints of AIDS/ARC based

discrimination. In FY 85-6, the Commission investigated 65 AIDS/ARC complaints, an increase from 20 investigated complaints over the previous year. In addition to assistance to individuals, the Commission provides technical assistance to City agencies, other governmental bodies, community groups, the private sector, and the media. The Commission has played a role in the development of services for underserved populations, specifically women and ethnic minorities. As the population of people with AIDS/ARC continues to shift toward these populations, the Commission has assumed an increasingly active role in the area of housing.

Information and referral about the continuum of support services for persons with AIDS/ARC is provided to some degree by all agencies working with the epidemic. However, there is a special information and referral focus at the San Francisco AIDS Foundation and Shanti Project. The Foundation's AIDS Hotline is complemented by a special contact number which is answered exclusively by volunteers who themselves have AIDS; the information and referral functions of the Foundation's Social Service Department is discussed above. Shanti Project also handles a large number of requests for information and referral.

D. POLICY REAFFIRMATION

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specifically
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p 63*
1. DPH should maintain its general focus on comprehensive outpatient care to maximize the potential of patients' maintaining themselves at home or in residential facilities.
 2. DPH should insure that services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, race/ethnicity, culture, language, and gender should be evident in all service configurations.
 3. Service utilization assessments and cost analyses of various service configurations should be ongoing to insure that in the long run services provided are indeed the most appropriate from the perspective of both health care and cost.
 4. Since Laguna Honda Hospital has a significant waiting list of persons without AIDS/ARC needing chronic care and since there are a number of private facilities in San Francisco with large numbers of unused beds, the development of San Francisco's subacute and skilled nursing care for persons with AIDS/ARC should focus initially on underutilized private facilities.

D. PRIORITIES FOR FY 87-88

- Expansion of subacute/SNF services for those who cannot be effectively cared for at home.
- Expansion of housing and specialized support services for persons with AIDS/ARC, particularly those with concurrent substance abuse or other mental health problems.

- Expansion of advocacy services for persons with AIDS/ARC who do not speak English or whose support systems do not speak English coupled with an assessment of the capacity of current chronic care and support service configurations to accommodate such patients/clients.
- An assessment of special needs of pregnant women with AIDS/ARC and adult AIDS/ARC patients with dependent children regarding housing and related support services and a plan for addressing these needs as the demand grows.
- An assessment of the special chronic care needs of children with AIDS/ARC and a plan for addressing these needs as the number of cases expands.

E. BUDGET ISSUES

(Note: An asterisk identifies issues for which new ad valorem funds are being sought)

1. The AIDS Office's ad valorem base budget provides for maintenance of all services except subacute/SNF care at current or expanded capacities. Ad valorem support for subacute/SNF care has been reduced from \$710,786 to \$417,000 in the base budget. This reduction has been projected in anticipation of two developments having an impact by July 1987. The first development is that revised MediCal rates for subacute/SNF care have been approved by the State (DHS), although contracts have not been issued to San Francisco providers for reimbursement under the new rate schedule. Issuance of these contracts is anticipated by July 1987. The second development is that the State (DHS) has expressed an interest in contracting directly with St. Mary's Hospital for a dedicated 10-bed SNF facility for AIDS/ARC patients. This facility would be one of several demonstration projects throughout the State. The purpose of the project is to study the demand for and costs of providing care at this level for persons with AIDS/ARC. It is expected that the contracting process will be completed by July 1987.

2. Federal (HRSA) funding has been secured which will underwrite part of the costs of a six-bed SNF demonstration project in 1987-8. The project anticipates a certain level of MediCal reimbursement to complement the effort.

3. Federal (HRSA) funding for a 21-bed residential treatment program for substance abusers with AIDS/ARC has been secured.

* 4. The AIDS Office's ad valorem base budget provides \$220,595 for a joint effort with DSS to provide long term housing for 40 persons with AIDS/ARC (a) who cannot or will not effectively participate in residential substance abuse treatment, (b) whose clinical status has remained relatively good and does not justify subacute or skilled nursing care, and (c) whose behavior patterns require housing where

What is the project budget?

staff are available 24-hours to monitor and support the cooperative living of residents. This level of funding covers an array of support services (money management, case management, and home health services) eight hours a day, five days a week. DPH is requesting \$86,789 in new ad valorem funding to extend support services to twenty four hours a day, seven days a week. The population of this housing program is expected to have a high incidence of significant behavioral problems and this all-hours coverage is considered essential to the successful management of the program.

new A →

* 5 DPH is requesting \$50,050 in new ad valorem funding to expand the Shanti independent residence concept by one 4-person residence.

* 6 DPH is requesting \$33,052 in new ad valorem funding to expand the capacity of Shanti Project's practical support program to recruit, train and support volunteers who will provide 13,500 contact hours to and additional 175 persons with AIDS/ARC.

* 7 Federal (HRSA) funding has been secured to cover the expansion of home health care and in-home hospice services by five patients per day. DPH is requesting \$108,000 in new ad valorem funding to expand these services further to an additional five patients per day.

8. The AIDS Office's ad valorem base budget covers the addition of one full time social worker for the San Francisco AIDS Foundation's social services advocacy program. This position will be used to expand the program's capacity to provide effective advocacy to monolingual Spanish speakers.

9. Federal (HRSA) funding has been secured to support the position of a fulltime coordinator of chronic care and related contract services to be based at the AIDS Office. Part of this position's responsibility will be to conduct the assessments and develop the plans called for in the priorities.

10. The team offering technical assistance to all DPH-affiliated provider education programs regarding the unique dynamics of working with clients or patients of color will be asked to monitor the accessibility of direct services to these clients/patients.

Must relate
to numbers
4 AIDS/ARC
patients

CHRONIC CARE AND RELATED SUPPORT SERVICES

<u>Goal</u>	<u>Services</u>	<u>Populations requiring special services</u>	<u>Factors influencing service development</u>
Minimize unnecessary use of acute care facilities	Subacute, intermediate and skilled nursing care	Persons with AIDS/ARC	Numbers of new cases and corresponding increase in numbers living
Maximize possibility of maintenance at home or in residential facilities	Home health and in-home hospice	Persons with AIDS/ARC and concurrent substance abuse problems	Some shift in population groups requiring care
	In-home assessments	Women with AIDS/ARC	New patterns in clinical manifestation of HIV infection
	Housing	Adults with AIDS/ARC and dependent children	New treatment protocols
	Practical support	Adult psychiatric patients with AIDS/ARC	Increase in dependence on public sector support
	Emotional support	People with AIDS/ARC who speak little or no English	No presumptive eligibility for MediCal or other entitlement program for persons with disabling ARC
	Entitlement program advocacy	People with AIDS/ARC released from jail	Factors influencing service development
	Legal education and advocacy	Hemophiliacs with AIDS/ARC	Study of current service utilization and demand will be available in June 1987
	Information and referral	Children with AIDS/ARC	Potential availability of state funding for a skilled nursing facility
			Demonstration grant funds available to underwrite startup of some chronic care and support services
			Impact of biased attitudes toward patient populations
			Psychosocial issues raised as a result of disclosure of hidden lifestyles by patients
			Fear of infection by all levels of care givers
			Non-traditional, weak or non-existent home support systems
			Care for children of adult patients

XI. MENTAL HEALTH SERVICES

A. GOAL AND ELEMENTS OF SERVICE

A general goal of mental health services is to help clients manage more effectively the ordinary stresses of daily living as well as cope with extraordinary pressures associated with personal and community crises. These services are, in large measure, educational.

Where AIDS is concerned, the stresses will vary depending on the individual's relationship to the epidemic. In general terms, the populations that might call on mental health services because of AIDS fall into one or more of the following categories:

- (1) people who have developed clinical manifestations of advanced HIV-infection and are faced with the prospect of chronic illness or death;
- (2) people who know they have been infected with HIV but remain asymptomatic and who are concerned about the prospect of developing clinical disease or transmitting the infection to others;
- (3) people in groups at high risk who are concerned about being or becoming infected;
- (4) people who have friends, lovers, or relatives diagnosed with or at risk for AIDS and who must share the burden and consequences of that diagnosis;
- (5) people who are anticipating or grieving the death of a loved one from AIDS;
- (6) people whose work brings them in contact with any of the above.

The elements of service include information and referral, crisis intervention services, individual and group psychotherapy, mental health assessments, and psychotropic medication. Because HIV infection sometimes precipitates neurological complications, assessments must be able to distinguish between such complications and other kinds of responses.

B. FACTORS INFLUENCING THE MENTAL HEALTH CARE SYSTEM

1. Most publicly subsidized crisis intervention services, as well as opportunities for individual and group therapy, are provided through Community Mental Health Services (CMHS) programs and contract services. Few programs or contractors are specifically funded to work with AIDS issues. Underfunded even before the AIDS epidemic became recognized as such, most publicly funded mental health programs have not been expanded in view of increased demands on the

mental health service delivery system related to the AIDS epidemic.
They have borne whatever share of the burden they have borne by cutting back in other areas.

2. More cases of HIV-related disease are being diagnosed; more people are involved in providing care and support.
3. More people with knowledge of their HIV antibody status and attendant concerns (staying well, if positive; staying negative, if negative)
4. As was mentioned in conjunction with the discussion of primary and acute care, chronic care and related support services, the population groups requiring treatment are expected to change. The preponderance of current cases of both AIDS and ARC are among white gay and bisexual men. The vast majority of reported cases with a history of IV drug use are also white gay and bisexual men. While DPH anticipates that in the next eighteen months most new cases of CDC-defined AIDS will be from the groups mentioned, we will probably see the beginning of an increase in the proportion of ARC cases who are (a) from people of color (both gay/bisexual and non-gay/bisexual), (b) women, (c) infants, (d) substance abusers (both gay/bisexual and non-gay/bisexual), and (e) jail inmates. It should be anticipated that the demand for mental health services will shift in proportion. These populations may be better served in settings other than those in which current services are provided..
5. The State DHS study of the need for special health care and psychosocial support in racial and ethnic minority communities is, as noted above, scheduled for completion by March 1988. This may have implications for planning future mental health services as well. Of particular concern will be the availability of services for those who do not speak English.
6. The results of SAMHA Center research (see Section IV) may also have implications for planning future mental health services.
7. There are instances in which mental health issues related to AIDS seem to overlap with issues being addressed by other interests of the service continuum. In particular. . .
 - (a) neurological impairment associated with HIV infection are sometimes difficult to distinguish from mental health problems;
 - (b) problems of mental health often coincide with those of substance abuse;
 - (c) while "educational support programs" often address mental health concerns, people with severe mental health problems may be particularly unresponsive or inappropriately responsive to the messages of AIDS prevention

8. While we have sometimes dealt with these mental health concerns through settings and procedures labeled "education", "substance abuse", and "medical care" (because those are the labels funding was available to support), planning efforts need to keep in mind there may be an appropriately larger role for "mental health" per se in the continuum.
9. The incidence of neurological complications among persons with AIDS and ARC is increasing.
10. The US Public Health Service's three-year demonstration project grant to DPH includes provides for psychiatric outreach to home-bound AIDS/ARC patients to support the care of neurologically impaired patients in their home settings.
11. Therapists in private practice have expressed a willingness to provide therapy on a free or very low cost basis for a limited number of hours per week for people with AIDS/ARC and others with AIDS-related concerns. The PHS grant mentioned above provides the UCSF AIDS Health Project with a half time staff member to (a) recruit and coordinate these volunteer services, (b) facilitate the development of a support system for them (e. g. regular inservice training opportunities), and (c) screen and refer prospective clients as appropriate.

C. CURRENT SERVICES

The UCSF AIDS Health Project (AHP) currently provides a range of mental health services on Ward 86, the AIDS outpatient clinic at San Francisco General Hospital. The AHP worker has an established consultative role within the clinic and functions as a member of the treatment team. Clients are seen as a result of either self- or staff-generated referral for assessment and evaluation because of acute psychological or emotional distress, behavioral disturbance, or interest in the group work (for stress reduction, women with AIDS, or couples) offered by AHP. These groups are geared toward helping individuals deal more effectively with this disease. Thus, the services offered in this setting are: crisis intervention, psychiatric assessments, patient-centered consultation with medical staff and personnel, group interventions, short-term psychotherapy services (not to exceed 12 weekly sessions for no more than six clients at any time), and referral to other resources. Approximately 600 clients are expected to benefit from these services in 86-7.

The Emotional Support Program of Shanti Project trains community volunteers to provide free counseling services to people with AIDS/severe ARC and their significant others, and both their biological and extended families. Currently, individual counselors are provided to each person requesting such support and services are provided for as long as the client and counselor feel it is useful. Group counseling is available for those who prefer group support. Shanti estimates that 850 people with AIDS/ARC and 800 others will be served in 86-7.

Shanti Project also provides professional counselors to meet the psychosocial needs of patients and their visitors on Unit 5A. These counselors are available to AIDS patients, visitors and hospital staff in other areas of the hospital as well as on an as-needed basis. They provide crisis counseling in situations such as death, a patient's removal from life-support systems, potential suicide, worsening of patient's condition necessitating transfer to a Critical Care Unit, etc. They also provide patient advocacy services to optimize patient input regarding care and management. On Ward 86 a Shanti counselor is available for 26 hours per week for the newly diagnosed person with AIDS and their loved ones to provide emotional support services similar to those offered by the Shanti Unit 5A staff as well as liaison to other Shanti services. In 86-7 Shanti clients on 5A are expected to number 750; those on Ward 86, 440.

Shanti Project's support for individuals who are grieving is described above. As an extension of its in-home hospice services, Hospice of San Francisco also provides bereavement counseling to the survivors of patients served at home.

Publicly-funded mental health services outside of SFGH are concentrated in the Adult Outpatient Programs of Community Mental Health Services (CMHS). The services provided range from crisis intervention to individual or group therapy consisting of one or two weekly sessions. Clients with AIDS or severe ARC are seen in longer-term treatment up to and beyond a year, with no specific time limits set. Those with less severe ARC are transitioned to non-psychiatric support groups after stabilization. Direct clinical services are also provided to persons who are in acute distress secondary to HIV antibody testing or who would be considered among the "worried well". These are seen for immediate brief treatment, then referred back to non-psychiatric supports. In a typical month CMHS programs see 60 persons with AIDS or ARC and 25 persons in acute distress secondary to HIV antibody testing.

D. POLICY REAFFIRMATION

1. DPH should maintain mental health support services to maximize the potential of patients' maintaining themselves at home or in residential facilities. This includes direct care to persons with AIDS and ARC as well as to significant others whose participation in providing care at home is essential to its success.
2. DPH should insure that mental health services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, race/ethnicity culture and language should be evident in all service settings.
3. Private providers should be encouraged to participate as fully as possible in the provision of mental health services related to AIDS with clinical manifestations of HIV infection.

D. PRIORITIES FOR FY 87-88

- Expansion of mental health services related to AIDS should parallel the development of satellite programs for primary care and specialized outpatient clinics. In other words, a satellite program designed to provide primary care to more discrete population groups (e. g. women, children with AIDS/ARC, etc.) or to particular neighborhoods with a high prevalence of HIV infection should be complemented with an expansion of mental health services to the same population and its support systems. Of particular concern is the availability of psychiatric assessments in instances where dementia and other forms of neurological disorder are associated with HIV infection.
- The development of additional antibody testing sites should be complemented by an expansion of mental health services associated with the new sites.
- Provisions should be made to accommodate AIDS/ARC patients with severe neurological impairment in facilities in addition to SFGH.
- Private sector involvement in providing mental health services related to AIDS should be encouraged.

E. BUDGET ISSUES

(Note: An asterisk identifies issues for which new ad valorem funds are being sought)

1. Mental health support services at SFGH/Ward 86 provided by the UCSF AIDS Health Project are maintained at existing levels by the AIDS Office's ad valorem base budget.
- * 2. DPH requests \$92,000 in new ad valorem funding to expand mental health counseling services at AIDS screening and primary care clinics and at sites accepting referrals from the antibody testing program. Assignment of staff to particular clinic sites will reflect relative demand at participating clinics.
- * 3. DPH requests \$37,804 in new ad valorem funding to increase Shanti Project's capacity to recruit, train, and support volunteer peer counselors for 18,000 contact hours with an additional 330 persons with AIDS, ARC or their significant others.
- * 4. DPH requests \$32,928 in new ad valorem funding to expand Shanti Project's program of counseling and advocacy for inpatients with AIDS/ARC at SFGH. This request parallels the SFGH request to expand the capacity of Unit 5A from 20 to 28 patients.

5. Federal (HRSA) funding has been secured to support ten hours per week of psychiatrist time to conduct psychiatric assessments for patients outside of SFGH. It is anticipated that most of these patients will be home bound and consultations will be provided home support service providers as well.
6. Included in the SFGH request discussed under CLINICAL SCREENING AND MEDICAL CARE are provisions for expanding assessments of neurological impairment further. The demand for such services may be sufficient to justify a regular rotation at satellite clinics.
- * 7. DPH requests \$152,000 in new ad valorem funding to cover the cost of acute psychiatric beds in a community hospital setting in situations where lower level care is not appropriate.
8. Federal (HRSA) funding has been secured to support a coordinator of volunteer therapists in private practice who are willing to provide psychotherapy for free or at reduced cost to people with AIDS/ARC.

MENTAL HEALTH SERVICES

<u>Goals</u>	<u>Services</u>	<u>Populations requiring special services</u>	<u>Factors influencing service development</u>
Utilize mental health services to support AIDS prevention among those at risk	Information and referral Crisis intervention	Persons with AIDS/ARC Persons who are neurologically impaired as a result of HIV infection	Numbers developing clinical disease growing Numbers indicating neurological complications growing
Address the extra-ordinary pressures associated with the epidemic on the community's mental health	Mental health assessments including those which identify neurological complications associated with HIV infection Group and individual psychotherapy Psychotropic medication	Asymptomatic seropositives Other worried well Bereaved Care providers	Numbers with knowledge of HIV antibody status growing Shift in population groups requiring care Increase in dependence on public sector support Current mental health services are underfunded and full New information about psychosocial support needs of racial and ethnic minority communities Overlap with other program areas Potential larger role for mental health services New psychiatric evaluation services planned for homebound Free therapy services by volunteer therapists in private practice

XII. SUBSTANCE ABUSE SERVICES

A. GOALS:

The relationship of AIDS and substance abuse is exceptionally intimate and complex. Substance abusers are at particularly high risk for exposure to or transmission of HIV as a consequence of (a) sharing contaminated needles or (b) engaging in unsafe sexual activity when disinhibited by substance use. Once infected, the progress to clinical disease is accelerated by a health status already compromised by substance use. Their treatment is often complicated and the availability of personal and community support services also limited by their substance abuse.

As far as AIDS prevention is concerned, the goals of DPH's program may be best described as incremental and pragmatic. The initial goal is to end the sharing of contaminated needles and the unsafe sexual activity associated with substance use. The larger goal is to end the substance use which encourages needle sharing and unsafe sexual activity. Where providing health care to persons with AIDS/ARC and a concurrent substance abuse problem at issue, the initial goal is to end substance use which undermines attempts to stem or reverse the progress of the disease. Since the prognosis for anyone with AIDS is quite grim, in many cases the joint goal of AIDS care and substance abuse services shifts at some point to controlling the substance abuse sufficiently to insure that the balance of the individual's life is lived with as much dignity and comfort as possible without compromising the well-being of others.

B. FACTORS INFLUENCING SUBSTANCE ABUSE SERVICES

1. The State funding used to initiate many of these AIDS-specific programs in San Francisco is expected to run out on March 31, 1986. Renewal of AIDS/substance abuse demonstration project funding was not covered by Administration in the 86-7 State budget and legislative action to put funds into the budget was vetoed by the governor. Maintenance of the existing levels of service is an immediate issue.
2. Given the circumstances under which HIV is communicable, all elements of substance abuse prevention, detoxification and treatment services are ipso facto AIDS prevention services. By extension,, all shortcomings of existing substance abuse services are shortcomings in AIDS prevention services. The only circumstances under which AIDS prevention education among substance abusers is not also substance abuse intervention are when the focus of the education is limited to particular patterns of substance use (e. g. needle sharing or getting high before sex) and does not encompass the substance use itself.
3. Established substance abuse treatment programs typically focus on the future benefits of a clean and substance-free lifestyle. Even methadone maintenance programs, which begin by substituting one substance use for another, are promoted as stepping stones to a drug-free lifestyle. For someone with AIDS/ARC, prospects of a future are often very limited. The paradox is not lost on patients

4. Many of the assumptions about what PWAs/ARC want and need which underlie most of the services on the current health care/support services continuum are not valid if substance abuse is a factor. For example, a home health care/in-home hospice program which assumes that each client/ patient has a personal support system that can be galvanized and constructively integrated into the home health care plan does not work well in situations where the personal support system is nonexistent or not particularly responsible. The behavior of substance abusers is often characterized as non-compliant, anti-social and self-destructive. This characterization does not match the premises on which many current services are built.
5. Substance abuse compromises further an already-compromised immune system, tends to accelerate the progress of clinical disease, and often precludes certain treatment protocols. The resulting drain on acute care resources is intensified.
6. Ninety-two percent of AIDS cases reported in San Francisco with a history of IV drug use are gay/bisexual men; 90.5% of these are White, 6.5% Black, 2.7% Latino, and 0.3% Asian/Pacific Islander. Of the 21 heterosexual men with a history of IV drug use, more than half (12) are Black and one fifth (4) are Latino. To date nine women in San Francisco with a history of IV drug use have been diagnosed with AIDS.
7. Seroconversion rates among women and men (gay/bisexual men, men who have sex with other men but do not consider themselves to be gay/bisexual, and heterosexual men) who abuse substances (particularly those who share needles) are higher than among gay/bisexual men who are not substance abusers. Consequently the incidence of AIDS/ARC among all substance abusers is expected in the long run to rise at a faster rate than among gay/bisexual men who are not substance abusers. This will be reflected directly or indirectly in increases in the proportion of cases who are women and indirectly in the proportion who are children.
8. The results of SAMHA Center research (see Section IV) may have implications for planning future AIDS prevention/substance abuse services.

C. CURRENT SERVICES

It has been argued above that all 16,000 clients of Community Substance Abuse Services as well as the participants in voluntary community support services such as Alcoholics Anonymous are involved in AIDS prevention programs. Stopping the spread of AIDS cannot be contemplated without an appreciation of this argument. The programs singled out in the following paragraphs have received funding labeled "AIDS-specific", but they constitute only a fraction of the overall effort and potential of San Francisco's continuum of services.

Methadone maintenance and related counseling are provided by three programs to approximately 35 persons who have AIDS/ARC or who are seropositive are provided: UCSF's Substance Abuse Services at San Francisco General Hospital's Ward 92, Bayview/Hunter's Point Foundation, and Westside Community Mental Health Center. Clients receive a daily dose of methadone and are seen weekly or more often by a counselor. UCSF Substance Abuse Services, a hospital-based program, deals with medically more complicated cases. UCSF's AIDS Health Project (AHP) has staff based at Ward 92 who provide assessment and consultation services to AIDS/ARC patients at Unit 5A and Ward 86 who indicate substance abuse problems. Consultations regarding 1,650 clients are anticipated by AHP during 86-7.

The Alcohol Evaluation and Treatment Center (AETC) at San Francisco General Hospital provides residential detoxification services to limited numbers of substance abusers with AIDS/ARC.

Bay Area Addiction Research and Treatment (BAART) and the California Detoxification Program (CDP) have provided counseling and followup care to 22 patients who are seropositive or diagnosed with AIDS/ARC and their significant others.

The Multicultural Prevention Resource Center, Asian-American Residential Services and Horizons Unlimited (Projecto Ayuda) cooperate in providing AIDS prevention education to a variety of programs serving people of color.

Seven outreach workers provide outreach education and health promotion to IV drug users and social services providers in the Tenderloin, Polk Street, South of Market, the Haight, and the Mission districts under the aegis of the Midcity Consortium to Combat AIDS (MCtCA). Many of those contacted are adolescent runaways. This outreach includes, for example, distributing comic strips which illustrate the most effective methods for decontaminating hypodermic syringes and distributing one-ounce bottles of household bleach. The MCtCA expects to provide 2,400 formal and informal counseling sessions, 8,000 safe sex and safe needle-using practice education contacts, 960 agency referrals, and 120 poster presentations during the fiscal year.

18th Street Services is an outpatient substance abuse counseling center for gay men in San Francisco which provides (1) all clients with comprehensive education about their risk for AIDS and what they can do about it and (2) substance abuse treatment for men with AIDS and ARC. Services include community education as well as individual, group and couples counseling to address these concerns. The goal of the program is to empower clients to participate actively and positively in mainstream society, to achieve higher self-esteem and to find satisfaction in their lives while remaining clean and sober. Clients are required to abstain from drug and alcohol use while in counseling, and it is strongly suggested that they utilize 12-step programs. The agency is currently treating over 90 active clients, of whom approximately 80% are HIV positive or have AIDS or ARC.

PMHS' Operation Concern/Operation Recovery provides individual and group counseling to gay IV stimulant users who are diagnosed with AIDS/ARC or who test antibody positive. Their partners and significant others are also encouraged to participate in counseling as co-dependents in order to assist clients providing a supportive system for their recovery from IV stimulant substance abuse and adoption of safe sexual practices. Approximately 90 clients will be served in the course of the fiscal year.

The Drug Detoxification, Rehabilitation, and Aftercare Project of the Haight Ashbury Free Medical Clinic provides outpatient detoxification treatment services to San Francisco residents with drug abuse problems. These services are designed around a 21-day detoxification period, during which withdrawal symptoms are ameliorated by a carefully prescribed regimen of medications; this is followed by a "drug free" aftercare period of unlimited duration. Supportive, one-on-one counseling is the principal intervention during both the detoxification and aftercare phases. All persons are examined by a physician at admission, and treatment is given for chronic or acute medical problems. Group and family counseling is also available, as is vocational rehabilitation counseling. All entering clients are provided with brochures, comic strips, and other written materials relevant to AIDS risk reduction. AIDS-related posters are placed prominently around the Detox facility. During the most recent year, 2,200 different individuals were treated, with an average of just less than ten treatment sessions each. Of these persons, about 65% were primary abusers of heroin, 13% of cocaine, 10% of methamphetamine, 3% of opiates other than heroin, and 9% of other drugs. Nearly 90% of these clients had a recent history of needle use, and about 90% of that group admitted to recent sharing of needles.

By July 1987, Community Substance Abuse Services will contract for a residential treatment program specifically for substance abusers with AIDS/ARC. The program will provide the following under one roof: (a) basic 24-hour staffing appropriate to a substance abuse treatment program; (b) treatment for a range of substance abuse (including amphetamines, opiates, and alcohol); (c) rules which call for abstinence but which identify sanctions other than a long exile from the program if this rule is broken; (d) on-site detoxification to insure program continuity and a "short loop" back into the program if needed; (e) access to AIDS-specific outpatient care when needed; (f) rooms and bathroom facilities which make home health care for those who are very sick feasible; (g) AIDS-specific home care on an as-needed basis. A capacity of 21 beds has been targeted. Residents entering the terminal stage of AIDS will in most cases be transferred to a subacute care facility.

The University of California San Francisco's Substance Abuse and Mental Health in AIDS (SAMHA) Center is supported by a grant from the National Institute of Mental Health (NIMH) and the National Institute of Drug Abuse (NIDA). It creates a working environment in which academic researchers at UCSF and UCB, county health officials at DPH, and minority health professionals at Bayview Hunter's Point Foundation can benefit from a pooling of knowledge, skills and community activities. The focus of the center is on

developing and testing preventive interventions and on formulating and disseminating health policy guidelines. Investigations specific to AIDS and substance abuse include studies of (a) the impact of residential treatment on AIDS prevention, (b) the impact of methadone maintenance on sexual behavior and needle use, and (c) the impact of HIV antibody testing and notification on IV drug users.

D. POLICY REAFFIRMATION

1. DPH recognizes that all current substance abuse services are in some measure AIDS prevention programs. The "AIDS agenda" should be a specific item in all program descriptions developed for FY 1987-88.
2. DPH recognizes that preventing the transmission of AIDS may require extraordinary measures, such as educating IV drug users about how to decontaminate their syringes, which may create paradoxes for programs whose goals include stopping substance abuse.
3. DPH recognizes that substance abusers with AIDS/ARC present special problems for providers of health care and other support services. Support services specific to the needs of substance abusers should be developed and maintained.
3. DPH should insure that substance abuse services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, culture and language should be evident in all service settings.

E. PRIORITIES FOR FY 87-8

- Addressing the "AIDS agenda" in all program descriptions developed for FY 1987-88. DPH recognizes that all current substance abuse services are in some measure AIDS prevention programs and they should not depend entirely on AIDS-specific funding for implementation of this agenda.
- Maintenance of AIDS-specific services currently in place.
- Expansion of service categories should take into account that certain types of service "feed" others (for example, outreach education is designed in many instances to channel clients to treatment programs). Expansion of community education and outreach to substance users should be complemented by funding to shorten waiting lists in treatment programs (detoxification, methadone maintenance, residential and outpatient counseling services).

BUDGET ISSUES

(Note: An asterisk identifies issues for which new ad valorem funds are being sought)

1. No special direct funding is required to develop contract language in each substance abuse service provider's contract which mandates an element of AIDS prevention in every substance abuse education and treatment program. This will have to be supported by specialized training for provider staff, however, and by making appropriate materials available to all providers for use with program clients.
2. Training for substance abuse service providers and limited consultations is addressed in the AIDS Office ad valorem base budget. The \$142,885 identified maintains this service at 1986-7 levels and is the principal support for addressing the first priority listed above.
- * 3. Continuation of State (DHS) funding for an AIDS-specific substance abuse service program initiated in 1986 has not been provided for in the Governor's initial budget for 1987-8. DPH has requested that the renewal be covered by the State. In the absence of any assurance that the necessary funding will be forthcoming, DPH requests \$630,000 in new ad valorem funding to maintain this effort for the full twelve months of 1987-8.
4. Federal (HRSA) funding for a 21-bed residential treatment program for substance abusers with AIDS/ARC has been secured. This funding is mentioned in the section on CHRONIC CARE AND RELATED SUPPORT SERVICES; it is not additional funding.
5. Some new Federal funding for substance abuse treatment services is anticipated under the Omnibus Drug Act. These funds will come to CSAS through the State and will probably be allocated by a formula which does not take into account the prevalence of HIV cases or infection.
6. Guidelines for State (DHS I&E) and Federal (HRSA) funding not specific to substance abuse services permit use of some of these funds for prevention education programs targeted to substance abusers. Together these funds total 34% of the amount being deducted by the State (DHS) from support for AIDS prevention in San Francisco, so they do not represent a net gain for substance abuse prevention. Whatever outside funding sources allow DPH to invest in AIDS-related substance abuse prevention will be invested accordingly.

AIDS/SUBSTANCE ABUSE SERVICES

<u>Goals</u>	<u>Services</u>	<u>Populations requiring special services</u>	<u>Factors influencing service development</u>
End the sharing of contaminated needles and unsafe sexual activity associated with substance use	Outpatient and inpatient detoxification	IV drug users	Continuance of current programs at issue due to lack of State funding
End the substance use which encourages needle sharing and unsafe sexual activity	Outpatient and inpatient treatment and rehabilitation	People whose sexual behavior is disinhibited by substance abuse	Substance abuse prevention services are considered AIDS prevention services
End substance use which undermines attempts to stem or reverse the progress of the disease	Recruitment to treatment programs	PWAs/ARC with concurrent substance abuse problems who are able to participate in substance abuse treatment	The potential limited life span of someone with AIDS/ARC is a disincentive to changing substance abuse patterns
Control the substance abuse sufficiently to insure highest possible quality of remaining life without compromising well-being of others	Prevention education to substance abusers not in treatment	PWAs/ARC with concurrent substance abuse problems who are not able to participate in substance abuse treatment	Care of PWA/ARC presents a new set of problems for service providers
	AIDS health care and support services specifically designed to accommodate needs of persons who are also substance abusers	Subsets of the above who have special concerns (e. g. adults with dependent children)	Compound problems of clinical disease and substance abuse
			Seroconversion rate in this population growing

XIII. ADMINISTRATIVE SUPPORT AND COORDINATION

A. GOALS

The goal of the administrative services supporting AIDS programs in San Francisco is to insure that the community's response to the epidemic is equal to the task and cost-effectively managed. These services are also concerned that the financial burden of meeting the demands of the epidemic are distributed reasonably between the public and private sector and, within the public sector, distributed fairly among local, state, and national resources.

B. ORGANIZATIONAL STRUCTURE AND DIVISION OF RESPONSIBILITIES

Except where noted, all of the publically funded services described in this document are provided directly by the Department of Public Health or by community-based contractors of the Department.

The Department is governed by a seven-member Health Commission appointed by the Mayor for staggered four-year terms. The Director of Health is the chief administrative officer of the Department appointed by the Commission.

Under the Director of Health, there are four major subdivisions of the Department, each of which provides AIDS-related services. Community Public Health Programs includes (a) Health Centers involved in anonymous antibody testing, clinical screening, and primary care for persons with ARC; (b) the Bureau of Family Health, which provides liaison to the San Francisco Unified School District's AIDS education efforts as well as managing pregnancy testing, prenatal and perinatal clinics at the Health Centers; and (c) the Bureau of Communicable Disease Control, which manages the City's sexually transmitted disease clinic and tuberculosis clinic, in addition to serving as liaison to community blood banks and providing some contact tracing/recipient education.

Community Mental Health Programs is the umbrella for Community Mental Health Services, Community Substance Abuse Services and Forensic Services.

San Francisco General Hospital is the County's general acute care facility. SFGH's specialized AIDS services include a dedicated inpatient unit (5A) and comprehensive outpatient services at Ward 86. People with AIDS/ARC are also seen by SFGH-based dental services and a variety of satellite clinics. Laguna Honda Hospital is the County's long term care facility. The vast majority of patients are elderly. Laguna Honda Hospital's provision of services to AIDS patients has been limited to date.

As a special arm of his office, the Director has established and recently reorganized the AIDS Office. This Office assists him generally with the coordination and integration of departmental and contract services provided by the Department for AIDS. The Office is also responsible for AIDS surveillance and DPH's participation in epidemiologic studies, as well as the administration of specific grants involving inter-divisional cooperation and a variety of contracts for education programs, chronic care and related support services.

The Office of Planning and Program Support provides the Director with general assistance in planning and liaison to the California legislature and San Francisco's congressional delegation in Washington, D. C.

C. ADVISORY GROUPS

There are a number of groups who contribute in one way or another to the Department's policies and planning for AIDS services. The concerns of some are general, some specific to a particular subdivision of the Department, others have developed in response to community-based concerns. Some are more active than others; some have been active in the past and have become inactive. The most active include the following:

1. The Mayor's AIDS Task Force:

Dr. Werdegar and other senior staff of DPH, Dr. Sande and UCSF's AIDS specialists at SFGH, Commissioners Lee and Foster, and others. Their main function has been to keep the Mayor apprised of emerging epidemiological trends, diagnosis and treatment issues, and prevention strategies.

2. The Director's AIDS Medical Advisory Group:

Physicians from DPH, SFGH, UCSF, the San Francisco Medical Society, Bay Area Physicians for Human Rights, and others from private practice. Their main function has been to help keep the Director's communication lines to the medical community open.

3. The Departmental AIDS Committee:

Representatives of all the major subdivisions of DPH providing AIDS-related services. Their main function is to advise the Director on the development of departmental AIDS policy and program, coordination of programs between subdivisions of the department, and discussion of program strategy.

4. The Director's AIDS Advisory Committee:

Convened initially as the AIDS Health Care Services Advisory Committee and chaired by the Director of Health, this committee includes members from AIDS contract services agencies, subdivisions of DPH providing AIDS services, private sector providers (e. g. physicians in private practice, Kaiser-Permanente HMO) and community interest groups (e. g. people with AIDS/ARC, ethnic minority groups, gay-identified organizations). The group replaces the AIDS Coordinating Committee and advises the Director of Health on the development and coordination of AIDS programs for which the Department is responsible. It was recently expanded to provide greater representation from racial/ethnic minorities and community groups; its scope was also broadened to include education as well as health care services.

5. The Advisory Committee on AIDS Services in Ethnic Minority Communities:

The Director of Health convened this group to provide a direct avenue of input from San Francisco's ethnic minority communities regarding their concerns about AIDS. There is substantial overlap between this group's membership and that of the AIDS Advisory Committee.

There are also several population-specific task forces organized by DPH. These include the AIDS Substance Abuse Task Force, the AIDS Forensics Task Force, and the Perinatal and Pediatric AIDS Advisory Committee

The San Francisco Unified School District AIDS Task Force focuses on the development of AIDS education guidelines and curriculum for school-age youth and teacher training. The AIDS Research Council is composed of representatives of both DPH and UCSF. Its function is information sharing, coordination, and identification of funding for AIDS research.

Community-based organizations or individuals have convened coalitions, committees and task forces whose principal concerns are the impact of AIDS on their respective constituencies. They include The Latino Coalition for AIDS/SIDA Education and Action, The Black Coalition on AIDS, The Third World AIDS Advisory Task Force, The Women's AIDS Network, The Tenderloin AIDS Network, The Homeless Service Providers Coalition AIDS Subcommittee, The California Prostitutes' Education Project, People with AIDS/San Francisco, The AIDS/ARC Vigil, Mobilization Against AIDS, and the California Hemophilia Association.

The Kaiser Community Council on AIDS Health Care, initiated by the administration of Kaiser Permanente Medical Center in 1985, includes representatives from Kaiser and designated community agencies. Its function is to facilitate the provision of health care for Kaiser Health Plan members who are persons with AIDS/ARC, through cooperation and coordination with community AIDS service providers.

There are, additionally, professional associations with an interest in AIDS with which DPH personnel have contact: the San Francisco Medical Society, Bay Area Physicians for Human Rights, and Bay Area Lawyers for Individual Freedom.

D. FACTORS WHICH HAVE A SPECIAL IMPACT ON ADMINISTRATIVE SUPPORT SERVICES, BUDGETING, ETC.

1. The rapid and ongoing expansion of demand for services discussed above provides enormous pressure all by itself.
2. In the early period of the epidemic, the climate in which local providers operated was cooperative. As the epidemic progresses and vested interests in various "pieces of the action" are refined, a shift to more open competition for scarce resources seems inevitable.

3. Because AIDS has such a direct and visible impact on so many features of public health and health care, AIDS is sometimes "blamed" for shortcomings in services which existed before AIDS began to take its toll.
4. With one exception in the case of State funding, State and Federal support for AIDS-related services in San Francisco has been in the form of contracts/cooperative agreements issued after a competitive application process. It is clear that DPH has been at a disadvantage in many instances in which we have used local funding to initiate services prior to the availability of State/Federal funding for them. Since the RFPs often preclude using State or Federal grants to underwrite activities for which local funding has already been allocated and since DPH has initiated such a comprehensive range of activities with local funding, our applications are often limited to proposals to round out an already functioning operation. We will continue to operate with this handicap except when (a) block grants are provided, (b) local matching funds are required, or (c) we delay initiating particular types of services until State or Federal funding is available.
5. State and Federal grant and cooperative agreement funding is frequently provided on fiscal cycles that do not coincide with DPH's fiscal year.
6. Contracts with the State Department of Health Service are a particularly heavy administrative burden for DPH: contract terms are very narrowly defined and inflexible; contract processing typically requires more than five months (up to nine in some instances) after the initial proposal has been approved; DHS staff are frequently obliged to renege on verbal commitments made in contract negotiations; prospects of contract renewal are usually quite unclear. Cooperative agreements with the Centers for Disease Control and the Health Resources and Services Administration are, in contrast, reasonably flexible and quickly processed.
7. State Department of Health Services is increasingly inclined to bypass local departments of health when contracting for local services. In the past six months there have been three instances in which DHS elected to contract directly with (a) community-based organizations for AIDS prevention education, (b) community-based organizations for a study of health care needs specific to people of color, and (c) skilled nursing facilities.

8.

DPH's own contracting procedures have become much more complex in light of (a) Health Commission review of all contracts and (b) MBE/WBE/LBE interests. Civil Service review of all intentions to contract has been part of the process from the beginning, but it nonetheless contributes to the administrative complexity of contract management.

9. Filling grant-funded positions is an enormously complex and time-consuming administrative process. Where State-funding is involved (with 5-9 month delays in processing contract documents) the problems are magnified.
10. There are two areas of bureaucratic turf in the City/County of San Francisco that are particularly difficult to negotiate in the midst of a rapidly expanding epidemic: (1) the requirements for bringing new personnel on board and (2) the restrictions on the acquisition and deployment of computer hardware.
11. Beginning in FY 1986-87, there has been a general understanding at DPH that new and expanded AIDS services should depend as little as possible on ad valorem funding. This is not an anti-AIDS position. It simply reflects the reality that other needed services have been neglected in order to make funding available for AIDS, and the pinch is being felt everywhere.
12. Until recently San Francisco has been able to manage services for PWAs/ARC regardless of the limitations on State/Federal funding and programs and private insurance. San Francisco is reaching its limit, thus making us increasingly dependent on these other financing systems. For the first time in San Francisco there is a shortage of those services not otherwise reimbursed: most notably for the chronic care components of the system. The epidemic now requires that other finance systems change their policies to permit the development of these badly needed services. If there is no change in this regard, the burden on the acute care system will simply outstrip these resources.
13. The wide variety of interest groups that have emerged in conjunction with the epidemic demand that their various interests be appreciated and addressed in plans for AIDS services. An adequate "hearing" for these interests and the development and implementation of programs require lead time and staff support which is not currently available to the AIDS Office.

E. POLICY REAFFIRMATION

1. The Department of Public Health reaffirms its commitment to insuring that San Francisco's response to the AIDS epidemic is equal to the task and cost-effectively managed.
2. DPH also reaffirms that the financial burden of meeting the demands of the epidemic should be distributed reasonably between the public and private sector and, within the public sector, distributed fairly among local, state, and national resources.

3. DPH recognizes that the interests of community advocacy groups and community based organizations must be appreciated and addressed in plans for AIDS services.
4. DPH maintains that, in situations where the local department of health has an established and credible track record in AIDS prevention and health care services, State and Federal agencies should be encouraged to support these services through block grants to the local department. Competitive application procedures in these situations create an administrative burden on all parties that does not serve the epidemic well. Guidelines for block grant use may well confine the use of block grant funds to certain areas of endeavor (e. g. prevention education or out-of-hospital support services which MediCal does not subsidize) and may well set some expectations about the utilization of appropriate community-based organizations (e. g. "the services supported by this grant must reflect a substantial level of cooperation with and involvement of appropriate community-based organizations")
5. In situations where there are opportunities for direct funding of community-based organizations, the funding agency involved should encourage close cooperation with related programs in the continuum.
6. DPH expects that the California Department of Health Services streamline its contract procedures to (a) provide much faster processing of contracts and (b) give contractors more flexibility to respond quickly and constructively to emerging needs in the area of service for which the funds are earmarked. DPH recognizes that the greater utilization of block grants mentioned above would accomplish this goal as well.
7. DPH requests that State and Federal funding be offered local jurisdictions in a manner which encourages joint utilization of State/Federal and local dollars. State and Federal funding restrictions which arbitrarily penalize local jurisdictions who have taken the initiative to respond to needs created by the epidemic, simply because they have taken the initiative, should be withdrawn.
8. DPH encourages the City and County of San Francisco to recognize that an epidemic is in progress and it is necessary to waive personnel classification, testing, and requisition processing requirements that contribute to delays of more than two months in filling critical positions. CCSF should also waive requirements that all computer equipment (even equipment which is leased or purchased with grant funds) be part of a plan developed long before needs raised by the epidemic could possibly be anticipated.
9. The performance of DPH-affiliated AIDS services should be assessed on a regular basis.

D. PRIORITIES FOR FY 87-88

- Expansion of the AIDS Office to include a Medical Director to supervise epidemiologic research and planning for chronic care services and to assist with the oversight of subacute and home care contract services.
- Expansion of the AIDS Office to include an Associate Medical Director with special responsibilities for racial/ethnic minority programs and maternal and child health services.
- Expansion of DPH Accounting and Personnel Offices to handle the greatly increased workload associated with new ad valorem and grant-funded operations.
- As planning and administrative responsibilities of DPH are expanded further, staff support for these responsibilities should expand.

E. BUDGET ISSUES

(Note: An asterisk identifies issues for which new ad valorem funds are being sought)

1. The Medical Director has been identified. He is currently on salary with CDC and on loan to DPH from CDC. Direct CDC support will end in June 1987. DPH has built the salary for this position into its ad valorem base budget for 1987-8. The position, however, is a new position.
2. A combination of State (DHS) block grant and Federal (HRSA) funding is anticipated to cover the salary of the Associate Medical Director.
- * 3. DPH requests \$84,984 in new ad valorem funding for two new administrative support positions for DPH Fiscal Division.

ADMINISTRATIVE SUPPORT AND COORDINATION

<u>Goals</u>	<u>Features</u>	<u>Participants</u>	<u>Factors influencing program development</u>
Insure that planning and management of responses to the epidemic are appropriate, coordinated, and responsive to local dynamics	Ad valorem budget development and management	Mayor/Board of Supervisors	General pressure of an epidemic growing in size and complexity
	Departmental services	Health Commission	Emergence of special interest groups, potential for competition
	Grant applications	DPH-Central Office	
	Contract service management	DPH-Community Health Programs	Perception that AIDS expenditures cause reductions in other health programs
Distribute the financial burden of the epidemic reasonably among private and public sector; in public sector, distribute fairly among local, state and national sources	Advocacy for State/Federal funding support	DPH-Community Mental Health Programs	
	Advocacy for State/Federal policy support	DPH-SFGH	Most State/Federal support through a competitive allocation process and favors situations in which no services have been developed with local funding
		DPH-PPS	
		DPH-Contract services	State and Federal grants on fiscal cycles different from DPH
		DPH-Accounting	
		DPH-Personnel	Contracting with State DHS is particularly difficult
		Private hospitals	
		Other private sector providers	State DHS inclined to bypass local departments in contracting for local services
		UCSF	
		Advisory groups	Local contract processing and personnel recruitment procedure very complex
		Advocacy groups	Development of new or expanded programs will depend on new state and federal funding and changes in insurance reimbursement policies
			Additional staff needed to respond to emerging demands of community interest groups and to insure effective program planning and implementation

APPENDICES

AIDS in San Francisco: A Status Report and Plan for FY 1987-88

	Pages
A. Statistics and projections	97-106
B. Summary of ad valorem budget issues	107-109

APPENDIX A - AIDS CASES BY VARIOUS DEMOGRAPHIC CATEGORIES, SAN FRANCISCO
1981-86: CASES REPORTED THROUGH JANUARY 31, 1987.

TOTAL CASES:

Cases N = 2,853

Living N = 1,135

	<u>No. of cases</u>	<u>Percent</u>	<u>No. living</u>	<u>Percent</u>
IVDU	392	13.7	153	13.5
Non-IVDU	2,461	86.3	982	86.5
White	2,461	86.3	972	85.6
Black	164	5.7	67	5.9
Latino	188	6.6	77	6.8
Asian	38	1.3	18	1.6
Other	2	1	1	.1
Gay/bisexual	2,766	97.0	1,108	97.6
Non-gay/bisexual	87	3.0	27	2.4
Male	2,827	99.1	1,128	99.4
Female	26	.9	7	.6
0 - 4 years of age	6	.2	2	.2
5 - 19 years of age	6	.2	2	.2
20 - 49 years of age	2,565	89.9	1,052	92.6
50 - Over	276	9.7	79	7.0

IVDU SUBTOTAL:

Cases N = 392

	<u>Male</u>		<u>Female</u>	
	<u>Gay</u>	<u>Non-Gay</u>	<u>Gay</u>	<u>Non-Gay</u>
White	325	5	0	6
Black	22	14	0	1
Latino	9	6	0	0
Asian	2	0	0	2
Other	0	0	0	0

APPENDIX A - AIDS CASES BY VARIOUS DEMOGRAPHIC CATEGORIES, SAN FRANCISCO
1981-86: CASES REPORTED THROUGH JANUARY 31, 1987.

WHITE SUBTOTAL:	Cases N = 2,461		Living N = 972	
	<u>No. of cases</u>	<u>Percent</u>	<u>No. living</u>	<u>Percent</u>
IVDU	336	13.7	137	14.1
Non-IVDU	2,125	86.3	835	85.9
Gay/bisexual	2,422	98.4	964	99.2
Non-gay/bisexual	39	1.6	8	0.8
Male	2,447	99.4	970	99.8
Female	14	.6	2	.2
0 - 4 years of age	2	.1	1	.1
5 - 19 years of age	3	.1	1	.1
20 - 49 years of age	2,214	90.0	900	92.6
50 - Over	242	9.8	70	7.2

BLACK SUBTOTAL:	Cases N = 164		Living N = 67	
	<u>Percent</u>	<u>No. of cases</u>	<u>Percent</u>	<u>No.</u>
living				
IVDU	37	22.6	8	11.9
Non-IVDU	127	77.4	59	88.1
Gay/bisexual	132	80.5	55	82.1
Non-gay/bisexual	32	19.5	12	17.9
Male	155	94.5	64	95.5
Female	9	5.5	3	4.5
0 - 4 years of age	3	1.8	1	1.5
5 - 19 years of age	1	.6	0	0
20 - 49 years of age	146	89.0	64	95.5
50 - Over	14	8.5	2	3.0

APPENDIX A - AIDS CASES BY VARIOUS DEMOGRAPHIC CATEGORIES, SAN FRANCISCO
1981-86: CASES REPORTED THROUGH JANUARY 31, 1987.

LATINO SUBTOTAL:		Cases N = 188		Living N = 77	
		<u>No. of cases</u>	<u>Percent</u>	<u>No. living</u>	<u>Percent</u>
IVDU		15	8.0	6	7.8
Non-IVDU		173	92.0	71	92.2
Gay/bisexual		176	93.6	71	92.2
Non-gay/bisexual		12	6.4	6	7.8
Male		187	99.5	76	98.7
Female		1	.5	1	1.3
0 - 4 years of age		1	.5	0	0
5 - 19 years of age		2	1.1	1	1.3
20 - 49 years of age		168	89.4	70	90.9
50 - Over		17	9.0	6	7.8

ASIAN SUBTOTAL:		Cases N = 38		Living N = 18	
		<u>No. of cases</u>	<u>Percent</u>	<u>No. living</u>	<u>Percent</u>
IVDU		4	10.5	2	11.1
Non-IVDU		34	89.5	16	88.9
Gay/bisexual		34	89.5	17	94.4
Non-gay/bisexual		4	10.5	1	5.6
Male		36	94.7	17	94.4
Female		2	5.3	1	5.6
0 - 4 years of age		0	0	0	0
5 - 19 years of age		0	0	0	0
20 - 49 years of age		35	92.1	17	94.4
50 - Over		3	7.9	1	5.6

APPENDIX A - AIDS CASES BY VARIOUS DEMOGRAPHIC CATEGORIES, SAN FRANCISCO
1981-86: CASES REPORTED THROUGH JANUARY 31, 1987.

OTHER SUBTOTAL:	Cases N = 2		Living N = 1	
	<u>No. of cases</u>	<u>Percent</u>	<u>No. living</u>	<u>Percent</u>
IVDU	0	0	0	0
Non-IVDU	2	100	1	100
Gay/bisexual	2	100	1	100
Non-gay/bisexual	0	0	0	0
Male	2	100	1	100
Female	0	0	0	0
0 - 4 years of age	0	0	0	0
5 - 19 years of age	0	0	0	0
20 - 49 years of age	2	100	1	100
50 - Over	0	0	0	0

APPENDIX A - AIDS CASES BY VARIOUS DEMOGRAPHIC CATEGORIES, SAN FRANCISCO
1981-86: PROJECTIONS TO JUNE 30, 1987

TOTAL CASES:

Cases N = 3,297

Living N = 1,226

	<u>No. of cases</u>	<u>Percent</u>	<u>No. living</u>	<u>Percent</u>
IVDU	468	14.2	164	13.4
Non-IVDU	2,829	85.8	1,062	86.6
White	2,822	85.6	1,050	85.6
Black	207	6.3	77	6.3
Latino	219	6.6	81	6.6
Asian	46	1.4	17	1.4
Other	3	0.1	1	0.1
Gay/bisexual	3,185	96.6	1,190	97.1
Non-gay/bisexual	112	3.4	36	2.9
Male	3,264	99.0	1,212	98.9
Female	33	1.0	14	1.1
0 - 4 years of age	7	.2	2	.2
5 - 19 years of age	6	.2	1	.1
20 - 49 years of age	2,964	89.9	1,127	91.9
50 - Over	320	9.7	96	7.8

IVDU SUBTOTAL:

Cases N = 468

	<u>Male</u>		<u>Female</u>	
	<u>Gay</u>	<u>Non-Gay</u>	<u>Gay</u>	<u>Non-Gay</u>
White	385	7	0	8
Black	30	16	0	1
Latino	10	5	0	1
Asian	1	1	0	3
Other	0	0	0	0

APPENDIX A - AIDS CASES BY VARIOUS DEMOGRAPHIC CATEGORIES, SAN FRANCISCO
1981-86: PROJECTIONS TO JUNE 30, 1987

PROJECTIONS TO JUNE 30, 1987

WHITE SUBTOTAL: Cases N = 2,822 Living N = 1,050

	<u>No. of cases</u>	<u>Percent</u>	<u>No. living</u>	<u>Percent</u>
IVDU	400	14.2	144	13.7
Non-IVDU	2,422	85.8	906	86.3
Gay/bisexual	2,774	98.3	1,036	98.7
Non-gay/bisexual	48	1.7	14	1.3
Male	2,802	99.3	1,043	99.3
Female	20	.7	7	.7
0 - 4 years of age	3	.1	1	.1
5 - 19 years of age	3	.1	0	0
20 - 49 years of age	2,540	90.0	968	92.2
50 - Over	276	9.8	81	7.7

BLACK SUBTOTAL:	Cases N = 207	Living N = 77		
	<u>No. of cases</u>	<u>Percent</u>	<u>No. living</u>	<u>Percent</u>
IVDU	47	22.7	14	18.6
Non-IVDU	160	77.3	63	81.4
Gay/bisexual	165	79.6	64	83.1
Non-gay/bisexual	42	20.4	13	16.9
Male	195	94.2	72	93.2
Female	12	5.8	5	6.8
0 - 4 years of age	5	2.2	1	1.7
5 - 19 years of age	1	.7	0	0
20 - 49 years of age	181	87.6	71	91.5
50 - Over	20	9.5	5	6.8

APPENDIX A - AIDS CASES BY VARIOUS DEMOGRAPHIC CATEGORIES, SAN FRANCISCO
1981-86: PROJECTIONS TO JUNE 30, 1987

LATINO SUBTOTAL:	Cases N = 219		Living N = 81	
	<u>No. of cases</u>	<u>Percent</u>	<u>No. living</u>	<u>Percent</u>
IVDU	16	7.1	5	6.6
Non-IVDU	203	92.9	76	93.4
Gay/bisexual	208	94.8	76	93.4
Non-gay/bisexual	11	5.2	5	6.6
Male	218	99.4	80	98.7
Female	1	.6	1	1.3
0 - 4 years of age	0	0	0	0
5 - 19 years of age	1	.6	0	0
20 - 49 years of age	198	90.3	74	90.8
50 - Over	20	9.0	7	9.2

ASIAN SUBTOTAL:	Cases N = 46		Living N = 17	
	<u>No. of cases</u>	<u>Percent</u>	<u>No. living</u>	<u>Percent</u>
IVDU	5	10	2	10.5
Non-IVDU	41	90	15	89.5
Gay/bisexual	38	83.3	14	84.2
Non-gay/bisexual	8	16.7	3	15.8
Male	43	93.3	16	94.7
Female	3	6.7	1	5.3
0 - 4 years of age	0	0	0	0
5 - 19 years of age	0	0	0	0
20 - 49 years of age	41	90	15	89.5
50 - Over	5	10	2	10.5

APPENDIX A - AIDS CASES BY VARIOUS DEMOGRAPHIC CATEGORIES, SAN FRANCISCO
1981-86: PROJECTIONS TO JUNE 30, 1988

TOTAL CASES:

Cases N = 4,485

Living N = 1,449

	<u>No. of cases</u>	<u>Percent</u>	<u>No. living</u>	<u>Percent</u>
IVDU	637	14.2	194	13.4
Non-IVDU	3,848	85.8	1,255	86.6
White	3,827	85.3	1,236	85.3
Black	291	6.5	94	6.5
Latino	296	6.6	96	6.6
Asian	66	1.5	22	1.5
Other	5	0.1	1	0.1
Gay/bisexual	4,327	96.5	1,407	97.1
Non-gay/bisexual	158	3.5	42	2.9
Male	4,440	99.0	1,433	98.9
Female	45	1.0	16	1.1
0 - 4 years of age	9	.2	3	.2
5 - 19 years of age	9	.2	0	0
20 - 49 years of age	4,032	89.9	1,333	92.0
50 - Over	435	9.7	113	7.8

IVDU SUBTOTAL:

Cases N = 637

	<u>Male</u>		<u>Female</u>	
	<u>Gay</u>	<u>Non-Gay</u>	<u>Gay</u>	<u>Non-Gay</u>
White	525	9	0	11
Black	41	22	0	2
Latino	14	7	0	0
Asian	1	1	0	4
Other	0	0	0	0

APPENDIX A - AIDS CASES BY VARIOUS DEMOGRAPHIC CATEGORIES, SAN FRANCISCO
1981-86: PROJECTIONS TO JUNE 30, 1988

WHITE SUBTOTAL: Cases N = 3,827 Living N = 1,236

	<u>No. of cases</u>	<u>Percent</u>	<u>No. living</u>	<u>Percent</u>
IVDU	545	14.2	169	13.7
Non-IVDU	3,282	85.8	1,067	86.3
Gay/bisexual	3,761	98.3	1,220	98.7
Non-gay/bisexual	65	1.7	16	1.3
Male	3,799	99.3	1,227	99.3
Female	27	.7	9	.7
0 - 4 years of age	4	.1	1	.1
5 - 19 years of age	4	.1	0	0
20 - 49 years of age	3,443	90.0	1,140	92.2
50 - Over	375	9.8	95	7.7

BLACK SUBTOTAL: Cases N = 291 Living N = 94

	<u>No. of cases</u>	<u>Percent</u>	<u>No. living</u>	<u>Percent</u>
IVDU	65	22.3	17	18.6
Non-IVDU	226	77.7	77	81.4
Gay/bisexual	232	79.6	78	83.1
Non-gay/bisexual	59	20.4	16	16.9
Male	274	94.2	88	93.2
Female	17	5.8	6	6.8
0 - 4 years of age	6	2.2	2	1.7
5 - 19 years of age	2	.7	0	0
20 - 49 years of age	255	87.6	86	91.5
50 - Over	28	9.5	6	6.8

APPENDIX A - AIDS CASES BY VARIOUS DEMOGRAPHIC CATEGORIES, SAN FRANCISCO
1981-86: PROJECTIONS TO JUNE 30, 1988

LATINO SUBTOTAL:	Cases N = 296		Living N = 96	
	<u>No. of cases</u>	<u>Percent</u>	<u>No. living</u>	<u>Percent</u>
IVDU	21	7.1	6	6.6
Non-IVDU	275	92.9	90	93.4
Gay/bisexual	281	94.8	90	93.4
Non-gay/bisexual	15	5.2	6	6.6
Male	294	99.4	95	98.7
Female	2	.6	1	1.3
0 - 4 years of age	0	0	0	0
5 - 19 years of age	2	.6	0	0
20 - 49 years of age	267	90.3	87	90.8
50 - Over	27	9.0	9	9.2

ASIAN SUBTOTAL:	Cases N = 66		Living N = 22	
	<u>No. of cases</u>	<u>Percent</u>	<u>No. living</u>	<u>Percent</u>
IVDU	6	9.1	2	10.5
Non-IVDU	60	90.9	20	89.5
Gay/bisexual	55	83.3	19	84.2
Non-gay/bisexual	11	16.7	3	15.8
Male	61	92.4	21	94.7
Female	5	7.6	1	5.3
0 - 4 years of age	0	0	0	0
5 - 19 years of age	0	0	0	0
20 - 49 years of age	59	88.4	20	89.5
50 - Over	7	10.6	2	10.5

<u>CATEGORY</u>	<u>87-8 AD VALOREM BUDGET ISSUE</u>	<u>AM'T REQUEST</u>	<u>COMMENTS</u>
SURVEILLANCE, EPIDEMIOLOGY, AND RELATED RESEARCH	Baseline survey of knowledge, attitudes, behaviors re: AIDS in Asian communities	75,000	Contract service
PUBLIC EDUCATION	Outreach education and AIDS counseling to youth <u>out of school</u>	101,829	Contract service 2.5 FTEs
	Materials development to support imple- mentation of perinatal AIDS guidelines	40,000	Contract service ..includes 1 video
	AIDS prevention education and counseling for clients of STD clinics	101,829	Contract service 2.5 FTEs
PROVIDER EDUCATION	Physician training based at SFGH	53,000	UCSF Contract 1.0 FTE
	Technical assistance for all provider training programs and health care service planning re: language/cultural concerns of people of color	102,465	Contract service 2.5 FTEs
CLINICAL SCREENING AND MEDICAL CARE	Expansion of screening and primary care at Health Centers 1 and 2	223,774	2.0 City FTEs/As Needed 2.0 City FTEs/Permanent
	Clinical implementation of perinatal AIDS guidelines (See PE above for educational material to support this effort)	81,602	Contract service 1.5 FTEs
	Expansion of services at SF General (See separate breakdown, which provides units of service and revenues expected. Expansion of primary care at Children's HC, Southeast HC and South of Market HC are addressed in SFGH budget breakdown.)	NET 1,199,607	New City and UC contract positions
CHRONIC CARE AND RELATED SUPPORT	Expansion of support services for DSS hotel housing people with AIDS/ARC to 24-hour coverage	86,789	Contract service 3.5 FTEs
	Expansion of independent residence program (Shanti): 4 residents x 365 days	50,050	Contract service
	Expansion of practical support program (Shanti): 13,500 contact hours for 175 persons with AIDS/ARC	33,052	Contract service 1.0 FTE

<u>CATEGORY</u>	<u>87-8 AD VALOREM BUDGET ISSUE</u>	<u>AM'T REQUEST</u>	<u>COMMENTS</u>
CHRONIC CARE AND RELATED SUPPORT (continued)	Expansion of home health care and in- home hospice services: 5 patients per day x 365 days.	108,000	Contract service
MENTAL HEALTH	Expansion of mental health counseling services at AIDS screening and primary care clinics and sites providing antibody testing.	92,000	Contract service 2.0 FTEs
	Acute psychiatric beds in a community hospital setting: 385 pat. days @ \$400	154,000	Contract service
	Expansion of counseling/emotional support at SFGH/5A (Shanti): 1,650 contact hours for 43 patients	32,928	Contract service 1.0 FTE
	Expansion of peer counseling/emotional support program (Shanti): 18,000 contact hours for 330 persons with AIDS, ARC, or their significant others	37,804	Contract service 1.0 FTE
SUBSTANCE ABUSE	Maintenance of AIDS/minority community education: 20,000 contacts in 2,000 contact hours	58,000	Contract service
	Maintenance of AIDS/prevention outreach to IV drug users (generic): 30,000 contacts in 3,000 contact hours	104,000	Contract service
	Maintenance of AIDS/counseling inter- ventions: 18 sessions each for 250 persons	162,000	Contract service
	Maintenance of AIDS/short term methadone maintenance: 7,870 doses for 100 persons	76,000	Contract service
	Maintenance of detox./counseling for people with AIDS/ARC: 9,125 hours for 375 persons	230,000	Contract service
ADMINISTRATIVE SUPPORT	Creation of position for Medical Director, AIDS Office	-0-	1.0 City FTE, covered in base budget
	Support for DPH Fiscal Division	84,984	2.0 City FTEs
	TOTAL 87-8 AIDS AD VALOREM ISSUES	3,288,713	

ISSUE	UNITS OF	FTEs		SALARY COST		CONTRACTS	SUPPLIES	COVERED IN BASE	DPH REVENUE	NET	ALLOCATION OF COSTS		NET INCRS/ DECREASE	COMMENTS
	SERVICE	CITY	UC	CITY	UC			BUDGET	TRANSFER*	REVENUE	SFGH	UC CONTRACT	AD VALOREM	
1. 5A**	2,920	14.60		627,042			30,000			1,228,590	657,042		(571,548)	Assumes all M-C pts. with 33% decert.days. 8 additional beds.
2. Physcl Thrpy**	3,000	1.00		36,812			2,500			23,625	39,312		15,687	Assumes 6 inpts/day, 6 outpts/day, 250 working days Assume all M-C, \$45/outpt, 35% collectible
3. Med Soc Svc	40,000	4.00		131,715		60,000	2,500				194,215		194,215	Assumes phase in of services. Addresses perinatal, and community issues. 60K for CBO contracts. Satellite pgs at Southeast & So of Mkt.
4. Pharmacy	45,000	3.00		124,642			760,000 (Drugs) 450,000 (AZT)			650,000	1,334,642		684,642	16,000 outpt visits. Assumes AZT FDA appvd drug, full reimbursement for M-C pts. 4 scripts/clin visit
5. Radiology	3,100	1.00		25,968			5,000			37,333	30,968		(6,366)	1600 outpatient, 1500 inpatient
6. Clinical Labs			1.50		100,826		200,000	100,826		280,000	200,000	100,826	(80,000)	Includes 100K for blood. 20% of AIDS pts will be transfusion dependent.
7. Anatomic Path			1.00		20,736		11,000				11,000	20,736	31,736	
8. Psychiatry**	365	1.80	1.00	78,566	69,300		3,500				82,066	69,300	151,366	To increase nursing hrs/pt day for 4 existing pts to address more intensive acuity needs. Psych consult svcs - Depts of Psych & Neuro.
9. Neurology			1.50		103,950							103,950	103,950	Neuropsych svcs (consult & clinic)
10. Nephrology							12,000 ***					12,000	12,000	***Equipment - dedicated Dialysis delivery system
11. GI			1.17		68,420			68,420				68,420	0	
12. Men's Hlth Ctr	1,000		0.75		26,649					21,000		26,649	5,649	Screening & educn - complement to State funded pgs
13. Dental Clinic**	1,200	1.50		66,232			10,000			32,812	76,232		43,420	400 pts, 3 visits/pt. .5 dentist, 1.0 hygienist
14. Clinic**									53,000	550,000	186,759	684,918	268,677	
Primary Care Clinic	7,500		2.00		138,600									One FTE physician for Southeast, .5 FTE physician for Children's Hlth Ctr, & So of Mkt.
Nursing		2.00		85,896										One RN each to Southeast & So of Mkt.
Med Rec		2.00		50,863										Screening education & dvlpt of protocols.
Ward 86	8,658		17.00		546,318		50,000							Two med rec tech to support incrs outpt utiliz.
15. Ophthalmology			1.00		30,000							30,000	30,000	
16. Methadone		2.00		101,966			500		36,000	12,000	102,466		54,466	36 clients/month @ \$150/client
17. Administration											157,106		157,106	Accred.issue.Charge capture guidelines to be dvlpd 2119 Health Care Analyst - UR analysis
Infec Cntrl**		1.00		53,216			11,000							
Admin Supp		1.00		36,240										
Pl Fin Svcs**		2.00		56,650										Two 2908 Elig Workers for hosp & satellites.
18. Housekeeping		5.00		99,607			5,000				104,607		104,607	
		42.40	26.92	1,575,414	1,104,799	60,000	1,553,000	169,246	89,000	2,835,360	3,176,414	1,116,799	1,199,607	

* Issues to be discussed in other DPH Division issue papers.

**City positions budgeted for 12 months - requested on basis of existing critical need.

2/11/87 Rev.

Highest concentration of AIDS cases is in S.F.

By Josh Meyer

STATES NEWS SERVICE

WASHINGTON — With nearly 5,000 AIDS cases already reported — or one for every 150 people — San Francisco has the world's highest concentration of victims of the disease, a public health official told a Senate panel Monday.

"The impact of AIDS on San Francisco has been enormous. ... This is the highest concentration of AIDS cases in the world," said Jeffery Amory, director of the Public Health Department's AIDS office.

Even more alarming, Amory said, is that the number of reported people with AIDS in San Francisco is expected to soar by 1993 to 17,000 — or one in every 42 residents. Almost all will come "from the ranks of the 28,000 who were probably infected before 1985," he told a Senate Governmental Affairs subcommittee that is hearing two days of testimony on how to handle the costs of fighting the acquired immune deficiency syndrome.

Currently, there are about 1,900 people with AIDS in San Francisco. By June 1993, it is projected that number will quadruple, Amory said, as will the number of those "with AIDS-related conditions that are not reportable."

The president's AIDS commission last week predicted that 450,000 people nationwide would have AIDS by 1993, that nearly all of those who had been infected with the human immunodeficiency virus, or HIV, which causes AIDS, would die as a result, and that a vaccine was nowhere in sight. So far, about 64,000 cases have been

reported in the United States.

Amory and other witnesses testified that the cost of treating people with AIDS was severely depleting hospital and community resources. They said health-care providers could soon be broke and overwhelmed unless comprehensive federal help came quickly.

That recommendation echoed the findings of a prestigious panel of scientists that warned last week that the federal response to the AIDS epidemic had been "woefully inadequate."

Sen. John Glenn, D-Ohio, the subcommittee chairman, said the facts painted a grim picture for health care in the 1990s.

"We don't have a solution," Glenn said.

Dr. David N. Sundwall, administrator of the U.S. Health Resources and Services Administration (HRSA), which funds long-term care programs for people with AIDS, said an emphasis on cheaper, nonhospital care was necessary.

"In order to cope with the inevitable, increasing burden of caring for persons with AIDS, we are going to have to have facilities to which they can be discharged from hospitals," Sundwall said. "Some of these people have no place to go."

Amory said 90 percent of the people with AIDS in San Francisco were able to live at home, and that San Francisco had model community health-care programs.

"Our biggest problems are acute care for indigent AIDS patients and long-term custodial care," Katherine Wright, a care coordinator at the AIDS Arms Network in Dallas, told a Senate committee.

SF Examiner 6/7/88 p.18

FUNDING DISTRIBUTION: SAN FRANCISCO 1986-7

SURVEILLANCE, EPIDEMIOLOGY AND RELATED RESEARCH

	<u>FUNDING SOURCE</u>					
	<u>CITY AD VALOREM</u>	<u>DHS I&E GRANTS</u>	<u>DHS BLOCK GRANT</u>	<u>CDC Surveill.</u>	<u>CDC/Hep.B AIDS Cohort</u>	<u>TOTALS</u>
TOTALS	44,455	56,840	109,458	309,634	804,811	1,325,198
<u>BY PROVIDER</u>						
DPH/AIDS OFFICE	44,455	6,251	17,838	309,634	804,811	1,182,989
SF AIDS FOUNDATION						
OTHER CBOs ^a		50,000	91,620			141,620
CCSF CONTROLLER		589				589

^a "Other CBOs" here are CBOs identified with racial/ethnic minority communities

FUNDING DISTRIBUTION: SAN FRANCISCO 1986-7

PUBLIC EDUCATION: [Does not include DHS support for HIV antibody testing, which is reimbursed at a fixed rate per person tested.]

	FUNDING SOURCE					
	CITY AD VALOREM	DHS I&E GRANTS	DHS BLOCK GRANT	CDC ^a 253	CDC ^{a,b} 249	TOTALS
TOTALS	693,633	573,188	117,128	514,658	237,129	2,135,736
<u>BY PROVIDER</u>						
DPH/AIDS OFFICE		32,960	57,128	43,852	26,183	160,123
DPH/ FORENSICS				67,083		67,083
DPH/FAMILY HEALTH				67,960 ^c	63,434	131,394
DPH/HEALTH CENTERS-CC					13,442 ^d	13,442
DPH/MICRO. LAB					45,423	45,423
SF AIDS FOUNDATION	422,329	177,392		122,392 ^e		722,113
UCSF/AIDS HEALTH PROJ	136,360			154,814	11,234	302,408
OPERATION CONCERN	35,644					35,644
STOP AIDS INC.	92,800	79,730				172,530
OTHER CBOs ^f		280,000 ^g	60,000	35,347	57,755	433,102
CCSF CONTROLLER	6,500	3,106		23,210	19,658	52,474

^a Funding for a fiscal period other than 7/86-6/87 but renewal at same level anticipated

^b This is funding originally earmarked for "provider based testing"; specifics being renegotiated

^c Includes \$50,000 for SFUSD

^d For City Clinic

^e Includes \$6,000 for Forensics materials

^f "Other CBOs" here are CBOs identified with racial/ethnic minority communities

^g Funding from DHS direct to CBOs: \$150,000 to Bayview-Hunter's Point Foundation and \$130,000 to Instituto Familiar de la Raza

FUNDING DISTRIBUTION: SAN FRANCISCO 1986-7

PROVIDER EDUCATION

	<u>FUNDING SOURCE</u>			
	<u>CITY AD</u> <u>VALOREM</u>	<u>DHS I&E</u> <u>GRANTS</u>	<u>PHS/HRSA</u> <u>GRANT</u>	<u>TOTALS</u>
TOTALS	156,238	155,972	74,141	386,351
<u>PROVIDER</u>				
DPH/AIDS OFFICE		17,616		17,616
DPH/ FORENSICS		[JAIL STAFF TRAINING COVERED UNDER GRANT FOR INMATE EDUCATION]		
DPH/FAMILY HEALTH		[TEACHER TRAINING COVERED UNDER GRANT FOR CURRICULUM DEVELOPMENT]		
UCSF/AIDS HEALTH PROJECT (MENTAL HEALTH)	86,306	85,334		171,640
OPERATION CONCERN (MENTAL HEALTH)	8,911			8,911
UCSF/AIDS HEALTH PROJECT (SUBSTANCE ABUSE)	61,021	51,362		112,383
UCSF/SFGH (PHYSICIAN TRAIN.)			72,687	72,687
CCSF CONTROLLER		1,660	1,454	3,114

FUNDING DISTRIBUTION: SAN FRANCISCO 1986-7CHRONIC CARE AND RELATED SUPPORT SERVICES:

	FUNDING SOURCE			
	CITY AD VALOREM	DHS DEMO GRANT	PHS/HRSA ^a GRANT	TOTALS
TOTALS	2,574,304	369,904	117,645	3,061,853
<u>BY PROVIDER</u>				
DPH/AIDS OFFICE			24,548	24,548
DPH/ PLANNING		118,065	5,258	123,323
DPH/MIA HOMELESS	75,000			75,000
SHANTI PROJECT (RESIDENCE)	467,374			467,374
SHANT PROJECT (PRACTICAL SUPPORT)	109,113	30,049		139,162
SFAF/SOCIAL SERVICES	291,750			291,750
HOSPICE OF SF	876,717	210,900		1,087,617
PMC/GARDEN SULLIVAN HOSP.	754,350			754,350
OTHER CONTRACTORS				
OUT OF COUNTY (ALAMEDA)			86,559	86,559
CCSF CONTROLLER		10,890	1,280	12,170

^a Figures extrapolated. Grant provided for three years, 10/86-9/89.

FUNDING DISTRIBUTION: SAN FRANCISCO 1986-7

AIDS-SPECIFIC MENTAL HEALTH SERVICES:

[Does not include funding for SAMHA Center program
whose focus is as much on assessment as client
services]

	<u>FUNDING SOURCE</u>			
	<u>CITY AD</u> <u>VALOREM</u>	<u>DHS</u> <u>GRANTS</u>	<u>PHS/HRSA</u> <u>GRANT</u>	<u>TOTALS</u>
TOTALS	480,194	145,430	22,417	648,041 ^a
<u>BY PROVIDER</u>				
UCSF/AIDS HEALTH PROJECT (SFGH/Ward 86)	78,899		22,417	101,316
UCSF/AIDS HEALTH PROJECT (PROVIDER EDUC)	86,306	85,334		171,640
OPERATION CONCERN (PROVIDER EDUC)	8,911			8,911
SHANTI PROJECT (SFGH/INPATIENT)	183,598			183,598
SHANTI PROJECT (PEER COUNSEL.)	122,480	60,096		182,576
CCSF CONTROLLER				

^a Only \$467,490 is exclusive to this category since PROVIDER EDUCATION
is repeated (\$648,041 - 180,511 = 467,490).

FUNDING DISTRIBUTION: SAN FRANCISCO 1986-7

AIDS-SPECIFIC SUBSTANCE ABUSE SERVICES:

[Does not include funding for SAMHA Center program whose focus is as much on assessment as client services]

	FUNDING SOURCE						
	<u>CITY AD</u> <u>VALOREM</u>	<u>DHS</u> <u>GRANTS</u>	<u>DHS BLOCK</u> <u>GRANT</u>	<u>PHS/HRSA</u> <u>GRANT</u>	<u>PHS/HRSA</u> <u>AUGMENT.</u>	<u>CDC</u> <u>249</u>	<u>TOTALS</u>
TOTALS	187,362	351,362	57,000			110,519	706,243 ^a
<u>BY PROVIDER</u>							
UCSF/AIDS HEALTH PROJECT (PROVIDER EDUC)	61,021	51,362					112,383
DPH/CSAS and CONTRACTORS	100,000	300,000 ^b	57,000			110,519	567,519
UCSF/AIDS HEALTH PROJECT (CONSULTATION)	26,341						26,341
OTHER CBOs							
CCSF CONTROLLER							

^a Only \$593,860 is exclusive to this category since PROVIDER EDUCATION is repeated (\$706,243 - 112,383 = 593,860).

^b Prorated funding for April 86-March 87. DHS did not budget renewal for 87-8.

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PROPOSED FUNDING DISTRIBUTION: SAN FRANCISCO 1987-8

SUMMARY .. 2/17/87: BUDGET DISCUSSION

	<u>86-87</u>	<u>87-88</u>	CHANGES				
			<u>Net</u>	<u>Ad Valorem Base</u>	<u>Ad Valorem Issues</u>	<u>State</u>	<u>Federal</u>
Surveillance, Epidemiology & Related Research	1,325,198	1,440,434	115,236	80,000	75,000	[39,764]	-0-
Public Education	2,135,736	2,673,812	538,076	[66,866]	243,658	[136,160]	497,444
Provider Education	386,351	620,000	233,649	109,577	155,465	[74,032]	42,639
Chronic Care & Related Support	3,061,853	3,825,726	763,873	[73,595]	277,891	-0-	559,577
Mental Health	648,041	961,914	313,873	66,393	316,732	[85,334]	16,082
Substance Abuse	706,243	1,629,284	923,041	[44,477]	630,000	[310,362]	647,880
TOTALS	8,263,422	11,151,170	2,887,748	71,032	1,698,746	[645,652]	1,763,622

HSRA \$10 million added
 \$5 " to San Francisco - \$900-1,000,000 to SF (27mo)
 \$5 " to other jurisdiction