

EXECUTIVE SUMMARY

The Centers For Disease Control and Prevention (CDC) reports that as of June 30, 1993 there were more than 61,700 diagnosed cases of AIDS among gay and bisexual men of color, including those identified as injecting drug users (IDUs). Prevention efforts to stop the spread of HIV and slow the progression of the disease among infected individuals have not had an impact on gay and bisexual men of color to the degree that they have on white gay and bisexual men, and therefore newly diagnosed cases of AIDS among gay and bisexual men of color are increasing as a percentage of all newly diagnosed cases of AIDS among men who have sex with men, regardless of race. Cumulatively, since the beginning of the epidemic, men of color account for 32% of all AIDS cases diagnosed among men who have sex with men, including IDUs. Among cases reported to the Centers for Disease Control and Prevention in the twelve months previous to June 1993, men of color account for nearly 35% of all AIDS cases diagnosed among men who have sex with men.

It is essential that we begin to understand the impact of HIV on gay and bisexual men of color, determine the availability and accessibility of services, and how to respond to the epidemic within these populations. A better understanding of these issues will make it possible to design, fund and implement programs which may help prevent HIV infection in these populations.

IMPACT OF HIV/AIDS

AIDS has had a devastating impact on gay and bisexual men of color. Gay and bisexual men of color represent the largest proportion of diagnosed AIDS cases in specific racial/ethnic categories in most of the cities assessed¹. Specifically:

- In Chicago, about 69% of AIDS among African American men are among men who have sex with men (including IDUs), and 71% of cases among Latino/Hispanic men are among men who have sex with men (including IDUs);
- In Los Angeles, 76% of AIDS cases among African American men, 80% of cases among Latino men, 86% among Asian and Pacific Islander men and 80% among Native American men involve sexual contact between men;
- In New York City, 37% of AIDS cases among African American men, 38% among Latinos, 75% among Asian and Pacific Islander men, and 41% among Native Americans are among men who have sex with men, including those who inject drugs;

¹Surveillance data gathered from quarterly and/or monthly reports issued by the respective local, or state, health department.

- In Oklahoma City, it is estimated that of the 104 officially reported cases among Native American males, 75% occurred among men who have sex with men. Throughout the State of Oklahoma, 67% of cumulative AIDS cases involve men who have sex with men;²
- In the San Juan Metropolitan Statistical Area (MSA), 30% of cumulative AIDS cases are among men who have sex with men, including those who inject drugs.

In Chicago, Los Angeles and New York, high rates of STDs are also widespread in communities of color. The rates per 100,000 men for syphilis and gonorrhea are particularly high among African American men, including those who have sex with men, and among those in the 13-19 year old bracket.

Of the 285 men interviewed for this study in five cities:

- About 75% have been tested for HIV, and of these 20% said they had been diagnosed as seropositive. Twenty-four percent of those diagnosed as seropositive said they were living with AIDS.
- More than 80% were very knowledgeable about HIV transmission. Despite this high knowledge of risk of HIV, however, more than 26% had engaged in unprotected anal intercourse and 65% had engaged in unprotected oral intercourse during the previous six months.
- Over 10% had engaged in vaginal intercourse and of these almost 70% did not use a condom.

PROGRAM AVAILABILITY AND FUNDING PATTERNS

In the five cities surveyed, primary HIV prevention programs do not adequately meet the needs of gay and bisexual men of color. This is particularly true in cities in which gay men of color communities lack infrastructure, such as identifiable gay minority organizations, networks, support groups, and outreach activities. In cities where local health authorities have weak linkages with gay and bisexual men of color, few prevention services specifically for gay and bisexual men of color are available. With approximately one-third of total cumulative AIDS cases among men who have sex with men, including IDUs, occurring among men of color in the five cities, funding for prevention programs specifically targeting

²The City-County Health Department of Oklahoma County does not collect HIV/AIDS surveillance data. All surveillance data is gathered by the Oklahoma State Health Department.

this population usually ranged from 1.0% to 13% of total available city or county prevention funds. Specifically:

- In Chicago, the first grant awarded by the local health department to a gay-identified, gay-operated minority organization for HIV prevention activities exclusively targeting gay and bisexual men of color was not made until March 1993 and totaled only \$50,000;
- In Los Angeles, only 13% of total county prevention funds expended from 1990-92 was specifically for gay and bisexual men of color;
- In New York City, only 8% of total city prevention funds between 1990 and 1992 was expended for gay and bisexual men of color;
- The local health department in Oklahoma City/County does not provide grants or contracts to community organizations. The Oklahoma State Health Department reported that \$45,000, or 3% of the total, was expended in 1992 for HIV prevention services targeting gay and bisexual men of color;
- In Puerto Rico, of the total island-wide funds distributed in 1992 by the Central Office on AIDS and Communicable Diseases, 11.6% was awarded to three organizations with specific programs targeting gay and bisexual populations and men who have sex with men. Two of these organizations are located within the San Juan metropolitan area.

Specific prevention programs for gay and bisexual men of color are frequently small in terms of staff and funding levels, although there are notable exceptions where there are programs run by and for gay men of color. In larger metropolitan cities such as Los Angeles and New York, these programs are part of a network or consortium sharing resources and information and thereby providing a kind of infrastructure.

The majority of well-funded programs specifically for gay and bisexual men of color are, nevertheless, provided by large, established organizations or agencies which are not located or based within the communities of gay and bisexual men of color. They are mostly based within the white gay or ethnic non-gay communities and, for a variety of reasons, including weak linkages to the target community and a lack of culturally-sensitive staff, are not often well received by gay and bisexual men of color.

While all the gay and bisexual men of color communities receive inadequate prevention services, the Asian/Pacific Islander and Native American communities generally receive the least. Providing services for Asian and Pacific Islander communities is complicated by the wide range of language and cultural diversity, issues of acculturation, assimilation and the general lack of established gay Asian/Pacific Islander groups that provide HIV-related

services. Prevention efforts among "two-spirited"³ Native Americans are frequently relegated to the Indian Health Service (IHS) with totally inadequate results since IHS has no HIV prevention program for gay and bisexual men.

Primary HIV prevention programs for adolescent males of color who have sex with other adolescent or older males are virtually non-existent in most cities even though almost 20% of cumulative AIDS cases among men are among those between the ages of 13 and 29, and it is likely that the older men in this group (those between 20 and 29 years of age) are infected with the AIDS virus in their adolescence. This is particularly worrisome because recent evidence suggests that for a variety of developmental reasons, adolescents fail to hear or heed warnings about high-risk sexual behavior. Without adequate prevention programs for this population, the rate of HIV infection among young gay and bisexual men of color is bound to rise quickly.

PRIMARY PREVENTION PROGRAM ACCESSIBILITY

A variety of factors, including foreign language capabilities, staffing patterns and program location, influence accessibility of primary prevention programs to the various communities of gay and bisexual men of color.

- Primary HIV prevention programs for non-English speaking gays are frequently not available, particularly for people who speak Asian languages. These men generally do not seek services or, if they do, they seek services from Asian and Pacific Islander agencies which are not identified as gay or whose mission is not HIV-related. In addition, there is a lack of education materials printed in Asian and Pacific Islander languages.
- Programs generally considered to be the most helpful for HIV prevention among gay and bisexual men of color are those programs run by and for gay men of color. However, as previously mentioned, these programs are frequently small and poorly funded. When they are not available, services are generally provided by gay organizations with few men of color on staff or in positions of leadership, or by ethnic agencies which often have no openly-gay or bisexual men on staff. Gay and bisexual men of color see these programs as much less accessible.
- Cities with gay enclaves frequently have a number of prevention services within those areas. But gay and bisexual men of color in these cities generally live within ethnic

³ Two-spirited is a term which originated in the Native American community where it is used to define people who have both masculine and feminine traits. It is often used elsewhere as shorthand for bisexual. (verify this definition)

communities as opposed to the area where the gay community is centered. Therefore many gay and bisexual men of color fail to receive these services.

LOCAL CAPACITY

The HIV primary prevention services provided in the cities surveyed are generally inadequate to meet the needs of their diverse communities of gay and bisexual men of color.

- Gay and bisexual men of color are frequently not targeted for such prevention services as health education, outreach, and testing/counseling. When they are targeted it is generally by small, poorly-funded gay minority programs or larger, white gay established organizations with which gay and bisexual men of color do not identify.
- Local health departments, except for New York, still do not have a specific component addressing the needs of gay and bisexual men of color who comprise a large portion of their cumulative AIDS cases. It is important to note that local health department involvement is pivotal to any effort that aims to improve current levels of HIV prevention activity specifically targeting gay and bisexual men of color.
- Except in San Juan, in cities where there are strategic plans for HIV prevention, the needs of gay and bisexual men of color, and especially the gaps in and barriers to services, are but barely touched upon.

RECOMMENDATIONS

- Federal, state and local resources for prevention which target gay and bisexual men of color need to be substantially increased. These funds should be provided specifically to programs developed by and for gay and bisexual men of color. In cities where there is no established infrastructure for gay men of color, seed money and technical assistance in grants writing and program development should be provided to organizations of gay men of color to enable them to start primary HIV prevention programs.
- Funding is needed for the design, testing and evaluation of HIV prevention interventions that incorporate the cultural and behavioral realities of gay and bisexual Puerto Rican men (including men who have sex with men but do not identify as gay), as well as for gay and bisexual men of color in other cities.
- Primary HIV prevention programs operated by established organizations or agencies need gay men of color on staff and in positions of leadership to ensure the use of culturally-appropriate mechanisms of support and outreach.

- HIV prevention materials need to be developed for gay and bisexual men who do not speak English, particularly for those who speak only Asian languages.
- Programs for adolescent and young adult men (i.e., 13-21 years old) of color who have sex with other young or older men need urgently to be developed, with input from adolescent and young adult men of color.
- Men of color are generally knowledgeable about HIV transmission and prevention, but many, nonetheless, have negative attitudes towards safer sexual practices. Prevention programs should be highly interactive and engaging, confronting negative attitudes and demonstrating that there are pleasurable safer alternatives to high risk sexual behavior. All HIV prevention efforts must also address the role drugs and alcohol play in HIV transmission.
- Services need to be provided in the neighborhoods where gay and bisexual men of color live. In smaller cities, services may have to be based within ethnic agencies, where safe space could be created for gay and bisexual men of color.
- Local health departments should collaborate with organizations representing gay and bisexual men of color in the design and development of strategies for reaching men who have sex with men but who do not identify as gay or bisexual.

o Add surveillance demographics

SAN FRANCISCO HIV CONTRACTORS ASSOCIATION

1010 Gough Street, San Francisco, California 94109
(415) 474-7310 ext. 437

Member
Organizations
(as of 12/10/93)

AIDS
Indigent
Direct
Services

American
Indian AIDS
Institute

Baker Places

Bay View
Hunter's Point
Foundation
AIDS Services

Black
Coalition on
AIDS

Continuum
HIV
Day Services

El Instituto
Familiar
De La Raza

Family
Services
Agency
San Francisco

Haight
Ashbury Free
Medical Clinic

National
Association
for Visually
Handicapped

Operation
Concern

ANNOUNCING THE NATURAL BIRTH OF THE SAN FRANCISCO HIV CONTRACTORS ASSOCIATION

WHO: We are a group of Community-Based Organizations who have formed this association to address mutual concerns in matters related to the delivery of HIV services contracted by the County.

GOALS: To strive to improve and upgrade the provision of HIV services to clients by increasing coordination and cooperation among HIV contractors and the AIDS Office.

ELECTED EXECUTIVE COMMITTEE:

President: Gail McBride, Family Service Agency of San Francisco

Vice President: Pat Tibbs, Project Open Hand

Secretary: Ted Knapp-Duncan, San Francisco Community Clinic Consortium

Treasurer: Chris Sayer, Walden House

Member-at-Large: Jonathon Vernick, Baker Places

DEVELOPMENTAL STAGE: We have a foundation. We encourage your participation in building on it.

ACTION: DPH AIDS Office non-profit contractors are invited to join us on the first Fridays of the month*) from 9:00-10:30 am at 1010 Gough Street, Family Services Agency-San Francisco.
Refreshments will be served.

* 2/4, 3/5, 4/2/94, etc.

Project Open
Hand

Rose Resnick
Lighthouse

Salvation Army
Harbor Light
Center

San Francisco
Community
Clinic
Consortium

San Francisco
AIDS
Foundation

San Francisco
Food Bank

San Francisco
Suicide
Prevention
AIDS/HIV
Nightline

Tenderloin
AIDS Resource
Center

The Bridge for
Kids/Un
Punto Para Niños

UCSF
AIDS Health
Project

Walden House

Westside
Community
Mental Health
Center



February 16, 1994

Reggie Williams, Executive Director
National Task Force on AIDS Prevention
631 O'Farrell Street
San Francisco, CA 94109

RE: Preparation for Contract Negotiations
Ryan White Comprehensive AIDS Resources Emergency (CARE) Act
Title I Grant Award 1994

Dear Mr. Williams:

This letter concerns the preparation of a contract for CARE-supported services your agency plans to provide in 1994-95. Attached is a summary of recommendations based on: (1) recommendations from the CARE evaluation team which monitored your 1993-94 program(s); and (2) if your agency has been awarded additional funds for 1994-95, recommendations from the review team which recommended your proposal(s) for funding. If your agency is contracting for more than one service, a separate set of recommendations is attached for each service.

In an effort to ease reporting requirements for those service providers operating programs which currently have different funding cycles, the AIDS Office is combining contract exhibits for some programs. This process will usually result in a change in the term of your contract, the dollar amount and, for some exhibits, the funding cycle. If the contract exhibits for any of your programs are being combined, the instructions about how this will be accomplished will be included on the attached recommendations summary.

Our office will be contacting you soon to schedule a contract negotiation meeting. In order to expedite the contracting process, please submit **two copies** of the following information for each service program **five working days** prior to the date of the contract negotiation meeting:

- **Contact Person(s)**
The name and telephone number of the contact person(s) from your agency relative to program and budget issues for this service.
- **Program Narrative**
A revised program narrative (labeled Exhibit A-1) which addresses:
(1) statement of need; (2) goal statement; (3) target population; (4) units of service and unduplicated clients; (5) objectives; (6) methodology; (7) project timeline; (8) evaluation; (9) program organization; and (10) quality assurance.

The attached recommendations concerning your program(s) must also be addressed in the narrative. If applicable, clearly describe the role of each collaborating agency in the program(s). In cases where an organization is receiving funding for multiple programs, each program should be represented by a separate distinct program narrative (Exhibit A-1, A-2, A-3, etc.).

You will need to carefully review the enclosed instructions (entitled Program Narrative Instructions dated July 20, 1993), and develop your program narrative to address these requirements. Follow the format provided to ensure inclusion of all areas. Program Narratives which do not follow these instructions will be returned immediately, and your contract negotiation will be postponed.

- **Budget**

Budget forms as enclosed. Budget forms should bear the appropriate page number in the upper right hand corner. Each program narrative should be accompanied by a separate distinct set of budget forms (Exhibit B-1, B-2, B-3, etc.) and a budget justification. Please note that only one budget summary page will be required for all budget form sets provided. This form is entitled D.P.H. Budget Summary by Program.

Should you desire to prepare your budget on a computer, the AIDS Office can transfer the current budget forms (including calculation formulas) to your computer discs. Please call James Alexander in the Fiscal Services Branch at 554-9333 to obtain assistance.

- **Budget Justification**

A budget justification which briefly explains the formula or rationale for allocating money to each line item. In the case of personnel positions, be sure to include a description of the responsibilities of the position and to identify the percentage of program time (FTE) to be supported by the CARE. Information provided in the budget justification should be consistent with the budget and the program narrative. Provide one budget justification per program.

You will need to carefully review and follow the budget and budget justification instructions which are also enclosed (entitled D.P.H. Contract Services Budget Instructions dated January 19, 1994) in completing the budget and budget justification for this program.

- **Subcontracts**

Subcontracts which define any CARE supported services delivered by another provider, or any relationship with a collaborating agency or fiscal agency. Whenever another agency is: (1) providing direct service as part of your program; (2) collaborating with your agency to provide services; or (3) functioning as a fiscal agent, responsible for contract compliance and cash flow to your agency, a subcontract in the form of a Memorandum of Understanding (MOU) is required to document this relationship. MOUs define relative responsibilities, fiscal obligations, and agreements for interactions with other service providers and with fiscal agents. All signed MOUs should be submitted with contract documents.

In addition, please submit **one copy** of the following information **five working days** prior to the date of the contract negotiation meeting:

- Contract Compliance Documents

Insurance and all other contract compliance documents, including: a certificate of insurance (including workers compensation); updated demographic information sheet (enclosed); and affirmative action requirements (enclosed).

Your program is expected to deliver, at a minimum, units of service and unduplicated clients equivalent to your current CARE contract. Any exception needs to be justified in writing, in a separate submission to the AIDS Office. Please use the Units of Service/Unduplicated Clients Change Request Form (enclosed) to explain your request. Be advised that submission of a request for change in contracted units of service does not assure approval. Each request will be evaluated on individual merit. If your program has been performing at a higher than anticipated level, you may be asked to increase its contracted performance.

During your contract negotiation meeting, please be prepared to discuss: (1) any budget or program changes from the preceding contract; (2) any increase or decrease in units of service, unduplicated clients, cost per unit of service, or cost per unduplicated client of 10% or more; (3) any change in revenue sources by 10% or more; and (4) the gender, ethnicity and sexual orientation balance of your organization's board and staff.

It is the expectation of the AIDS Office that all collaborating agencies and/or a fiscal agency will participate in contract development and contract negotiations.

If we do not receive the above documents **five working days** prior to the scheduled contract negotiation meeting, your agency's meeting will be rescheduled. Any delays in contract development will result in a delay in your contract certification and may jeopardize the flow of funds to your agency. If you have any questions, please call your program manager in the AIDS Office.

Please be advised that a short time frame is being used to prepare contracts due to requirements by the Federal government. The AIDS Office will work with you to develop your contract in as timely a manner as possible.

Sincerely,



Valerie Dorr

Assistant Chief, Health Services Branch

Bill Haskell

Assistant Chief, Health Services Branch

Attachments (7):

- Program Narrative Instructions
- D.P.H. Contract Services Budget Instructions
- D.P. H. Contract Budget Forms
- Demographic Information Sheet
- Affirmative Action Requirements
- Units of Service/Unduplicated Clients Change Request Form
- Recommendations Summary

Recommendations Summary

Agency: National Task Force on AIDS Prevention
Program: Brothers Support Services
93-94 Contract Number: 83-27108
94-95 Contract Amount: \$101,757
94-95 Contract Exhibit Amount: \$101,757

Contract Term: 5/1/94-4/30/95

Service: This program provides emotional support groups, peer counseling and transportation services within the context of the Brothers Network.

Due to the significant increase in the number of programs funded under CARE, the Health Services Branch has had to redistribute the workload in an equitable manner among the Program Managers. For some agencies, this means that your Program Manager will be changing effective with the date of this letter to the individual listed below. We appreciate the magnitude of this change, both for the agencies involved and the Program Managers, and are committed to working with you to assure a smooth contract negotiation process. We are planning on adding additional Program Managers during the year, so there may be further changes that affect your agency. Our Program Managers are dedicated to working together and providing high quality service. We are committed to smoothing any transitions and ameliorating any disruptions to your agency that these changes generate.

NOTE: Michelle Long Dixon will be your AIDS Office contact for contract negotiation and contract development, and may be reached at 554-9043.

DEPARTMENT OF PUBLIC HEALTH

Contract Services Budget Instructions

I. GENERAL GUIDELINES

A. Number and type of budget pages.

There are 8 pages in the budget set, as follows:

1. Department of Public Health Contract Budget Summary
By Program - DPH #1
2. Summary of Client Services By Program - DPH #1A
(Mental Health and Substance Abuse, AIDS Optional)
3. Department of Public Health Contract Budget
By Funding Source - DPH #1B (AIDS Office Only)
4. Salaries and Benefits Detail - DPH #2
5. Operating Expense Detail - DPH #3
6. Capital Expenditure Detail - DPH #4
(Equipment and Remodeling)
7. Indirect Cost Detail - DPH #5
8. CRDC - Cost Reporting/Data Collection (Mental Health only)

B. Format for budget pages

1. Complete only those pages which are applicable to the contract funding. If salaries are being paid under the contract, then the Salaries and Benefits Detail must be completed. However, if no salaries are being paid under the contract then the Salaries and Benefits Detail should not be completed or submitted. This rule applies to all the budget detail pages (Salaries and Benefits, Operating Expense, Capital Expenditure and Indirect Cost). The Contract Budget Summary must always be completed and submitted.

2. Do not enter zeroes in any column for which there is no dollar amount, simply leave the column blank.
3. Round all figures to THE NEAREST DOLLAR. Do not use decimal points or zeroes. Example: \$100.45 should be shown as \$100
4. Use cents only in the Cost Per Unit of Service, Line #37 of DPH #1. Example: If the Cost Per Unit of Service is \$20.34, it should be shown as \$20.34
5. Make sure all dollar amounts and units of service that appear on the budget pages are consistent with the dollar amounts and units of service in the Narrative and any other documentation completed regarding the contract
6. If the contract includes more than one Program, there has to be a set of detail budget pages for each Program.
7. Start-Up cost should be on a separate set of detail budget pages and shown as a separate Program.
8. Exhibits

Fill in the space in the right hand corner labeled "Exhibit" as follows:

Contract Budget Summary by Program, Exhibit B, corresponding to Exhibit A (Summary). Program Budget Detail Pages should be labeled Exhibit B-1, corresponding to Exhibit A-1 (Narrative). If there is an Exhibit A-2 (Narrative) there will be a corresponding Budget labeled Exhibit B-2.

9. Numbering Pages

Each Program Budget Detail begins with Pg. 1, then for a second Program Budget Detail, the numbering begins at 1 again. Example:

Exhibit B-1
Pg. 1

Exhibit B-2
Pg. 1

II. DETAILED INSTRUCTIONS

A. Department of Public Health Budget Summary - DPH #1

The Contract Budget Summary worksheet is to provide a summary of the Budget by Program(s)

This page should be completed after completing the Salaries & Benefits Detail-DPH #2, Operating Expense Detail-DPH #3, Capital Expenditure Detail-DPH #4, and Indirect Cost Detail-DPH #5.

Line 1 Exhibit and Page Number

Fill in Exhibit and Page Number according to instructions given in 8 & 9 of the format instructions.

Line 2 Document Date

Fill in date document prepared. This date should be consistent with date on other detail worksheets submitted.

Line 6 Contractor's Name

Fill in complete and legal name of Contractor. This is the organization providing the actual service, not the Fiscal Agent or Parent Organization.

Line 6 Contract Term

Fill in the date of Contract Term using mo/day/year to mo/day/year. This is the period of time in which the contract will cover.

Line 7 Check One

Check the appropriate box to indicate if this contract is new, Contractor's first time doing business with DPH or if this is a new program with an existing Contractor; a renewal, Contractor is continuing to provide existing contractual services; or a modification, adjustments need to be made to existing contract.

Line 8 Modification Line

Enter the effective date of this modification mo/day/year and the number of the modification. Example: Effective Date of Mod. 10/15/91, No. of Mod. 2,

Line 9 Program

Fill in the name(s) of the Program(s) under this contract.

Line 10 Budget Reference Page No.(s)

Enter the Budget page number where the budget narrative can be found.
Example: Exhibit A; Pg. 2.

Line 11 Program Term

Fill in the Program term only if it differs from the contract term. This is the period of time in which the program services will be provided.

Line 12 Expenditures

Enter total from each detail page onto the appropriate expenditure line. This total will be for the Proposed Transaction Budget only.

Line 13 Salaries and Benefits

Enter total Salaries and Benefits, for proposed transaction budget by program(s).

Line 14 Operating Expense

Enter total Operating Expense, for proposed transaction budget by program(s).

Line 15 Capital Expenditure

Enter total Capital Expenditure, for proposed transaction budget by program(s).

Line 16 Direct Cost

Enter the Direct Cost by program(s). The direct cost is the sum of expenditures (Salaries & Benefits + Operating Expense + Capital Expenditures = Direct Cost).

Line 17 Indirect Cost

Enter Indirect Cost, for proposed transaction budget by program(s).

Line 18 Indirect Cost Percent

Enter the Indirect Cost as a percent of the direct cost. The indirect cost as a percent is the indirect cost divided by the direct cost (indirect cost ÷ direct cost = indirect cost percent).

Line 19 Total Expenditures

Enter the Total Expenditures by program(s). The total expenditure is the sum of direct cost and indirect cost (direct cost + indirect cost = total expenditures).

Line 20 DPH Revenues

Enter the name(s) of the fund source(s) and the amounts awarded under this contract. This may consist of any fund received through DPH grant funds for program services.

Line 28 Total DPH Revenues

Enter the total of all DPH Revenues by program(s). Add lines 21 through 27 = total DPH revenues

Line 29 Other Revenues

Enter the name(s) and amount(s) of non-DPH revenues by program(s). This may consist of client fees collected for program services, insurance reimbursement for program services, fundraising, contributions, in-kind contributions, etc.

Line 35 Total Revenues

Enter the amount of Total Revenues by program(s). This amount should equal the sum of DPH Revenues and Other Revenues.

Line 36 Total Units of Service.

Enter the total number of units of service by program(s). If there are different Cost Centers within the program, do not complete this line, complete DPH #1A.

Line 37 Cost Per Unit of Service

Enter the amount of cost per unit of service by program(s). This is calculated by dividing the total program costs by the number of units provided (total program costs ÷ number of units provided = cost per unit of service). If there are different Cost Centers within the program, do not complete this line, complete DPH #1A.

Line 38 Full Time Equivalent (FTE)

Enter number of FTE's provided by program(s). FTE reflects actual time worked. If a position is listed as 1.0 FTE, it will be assumed that the position is a full-time position for forty hours per week for the entire contract period. If the position is full-time, but for a shorter period of time than the entire contract period, it should be explained in the Budget Narrative.

Line 40 Prepared By

Enter the name of person budget prepared by.

Telephone Number

Enter the telephone number of person budget prepared by.

Date

Enter the date budget is submitted to the Department of Public Health.

Line 41 DPH-CO Review Signature

Signature of Department of Public Health Contracts Officer.

**B. Summary of Client Services By Program Detail - DPH #1A
(Mental Health and Substance Abuse, AIDS Optional)**

The purpose of the Summary Client Services By Program worksheet is to show program(s) cost by elements of service or modalities of service. **NOTE: This detail is to be completed only if there are different Cost Centers within the Program.**

Line 1 Exhibit and Page Number

Fill in the Exhibit and Page Number according to instructions given in 8 & 9 of the format instructions.

Line 2 Document Date

Fill in date document prepared. This date should be consistent with date on other detail worksheets submitted.

Line 7 Program Name

Fill in the name of program mode and service function will be provided under.

Term

Show the fiscal period the services will be provided.

Line 11 **Mode and Service Function**

Describe the mode and service function being provided. (Mode of service identifies the different kind of service(s) provided within each program. Service function identifies the specific level of service(s) within a mode of service.)

Total Cost

Enter the total cost for the mode and service function.

No. of Clients

Enter the number of clients that will be served.

No. of Units

Enter the number of units provided under the mode and service function.

Cost Per Unit

Enter the amount of cost per unit of service.

**C. Department of Public Health Contract Budget
By Funding Source - DPH #1B (AIDS Office Only)**

The Contract Budget by Funding Source worksheet is to provide a summary of the Budget by Funding Source(s).

Line 1 **Exhibit and Page Number**

Fill in Exhibit and Page Number according to instructions given in 8 & 9 of the format instructions.

Line 2 **Document Date**

Fill in date document prepared. This date should be consistent with date on other detail worksheets submitted.

Line 5 **Contractor's Name**

Fill in complete and legal name of Contractor. This is the organization providing the actual service, not the Fiscal Agent or Parent Organization.

Term of Contract

Fill in the date of Contract Term using mo/day/year to mo/day/year. This is the period in which the contract will cover.

Line 7 Check One

Check the appropriate box to indicate if this contract is new, Contractor's first time doing business with DPH or if this is a new program with an existing Contractor; a renewal, Contractor is continuing to provide existing contractual services; or a modification, adjustments need to be made to the existing contract.

Line 8 Effective Date of Modification

Enter the effective date of this modification mo/day/year and the number of the modification. Example: Effective Date of Mod. 10/15/91, No. of Mod. 2

Line 9 Funding Source

List the sources of funding for the Contract. This should include the different sources of DPH funding for the contract.

Line 10 Terms of Funds

Indicate the term of each funding source. Different funding sources may have different terms. For instance, Federal grant funds administered through DPH may have a different term than General Fund money.

Line 11 Exhibit Name

Fill in the name of the specific Exhibit. This should match the name of the exhibit in your program narrative.

Line 12 Cost Center Name

If your exhibit is divided into cost centers, fill in the name of each cost center.

Line 14 Salaries and Benefits

Enter total Salaries and Benefits from Line 36 of DPH #2.

Line 15 Operating Expense

- Enter total Operating Expense from line 35 of DPH #3.
- Line 16** Capital Expenditure'
- Enter total Capital Expenditure from line 31 of DPH #4
- Line 17** Direct Cost
- Enter the Direct Cost for the Exhibit or Cost Center. The direct cost is the sum of expenditures (Salaries & Benefits + Operating Expense + Capital Expenditures = Direct Cost).
- Line 18** Indirect Cost
- Enter Indirect Cost from line 37 of DPH #5.
- Line 19** Indirect Percentage of Direct Cost
- Enter the Indirect Cost as a percent of the direct cost. The indirect cost as a percent is the indirect cost divided by the direct cost (indirect cost/direct cost = indirect cost percent)
- Line 20** Total Expenditures
- Enter total expenditures. The total expenditure is the sum of the direct cost and indirect cost (direct cost + indirect cost = total Contract cost).
- Line 21** Units of Service
- Enter the total number of units of service for the Exhibit or Cost Center.
- Line 22** Cost per Unit of Service
- Enter the amount of cost per unit of service. This is calculated by dividing the total program costs by the number of units provided (total program costs/number of units provided = cost per unit of service).
- Line 23** Full Time Equivalent (FTE)
- Enter the number of FTE's provided. FTE reflects actual time worked. If a position is listed as 1.0 FTE, it will be assumed that the position is a full-time position for forty hours per week for the entire contract period. If the position is full-time, but for a shorter period of time than the entire contract period, it should be explained in the Budget Narrative.
- Line 24** Prepared By

Enter the name of person budget prepared by.

Date

Enter the date budget is submitted to the Department of Public Health.

Line 25 DPH-CO Review Signature

Signature of Department of Public Health Contracts Officer.

D. Salaries and Benefits Detail - DPH #2

The purpose of the Salaries and Benefits Detail worksheet is to show personnel costs associated with the provision of program services.

This worksheet is designed to present both the previous as well as the proposed transaction budget information. The previous transaction's budget is the latest approved budget, i.e., certified by the City, on file with DPH contracts. The proposed transaction's budget refers to the new budget being presented for approval. Refer to your copy of the previous transaction's budget at DPH to complete previous transaction's budget, if contract is a renewal or modification.

Line 1 Exhibit and Page Number

Fill in the Exhibit and Page Number according to instructions given in 8 & 9 of the format instructions.

Line 2 Document Date

Fill in date document prepared. This date should be consistent with date on other detail worksheets submitted.

Line 4 Program Name

Fill in the name of program salaries and benefits will be paid under.

Line 11 Term

Previous Transaction

Show the fiscal period in which the previous transaction services were provided. This should be the same as that in the latest approved budget on file with DPH

Proposed Transaction

Show the fiscal period the proposed transaction services will be provided.

Line 12

Position Title

Show all position titles for previous transaction and proposed transaction budget. Enter position titles that correspond to position titles referenced in the narrative. For example, do not refer to a Project Director in the narrative, and then list the title as an Executive Director in the budget.

Full Time Equivalent (FTE)

Previous Transaction

Enter number of FTE's for all position titles listed. This should be the same as that in the latest approved budget on file with DPH.

Proposed Transaction

Enter number of FTE's for all position titles listed. If contract is a renewal and a position title has been deleted show 0 FTE.

Salaries

Previous Transaction

Enter salary for all position titles listed. This should be the same as that in the latest approved budget on file with DPH.

Proposed Transaction

Enter salary for all position titles listed. If contract is a renewal and a position title has been deleted leave salary line blank.

Increase/(Decrease)

Enter amount of difference between the previous transaction salary and the proposed transaction salary for the position title. Show decrease salary amount in parenthesis (\$).

Line 30

Totals

Previous Transaction

Add the salaries for the previous transaction budget column and show the sum as the total salaries for the previous transaction's budget. This should be the same as that in the latest approved budget on file with DPH.

Proposed Transaction

Add the salaries for the proposed transaction budget column and show the sum as the total salaries for the proposed transaction's budget.

Line 33 Employee Fringe Benefits

Previous Transaction

Fill in the percent by which benefits were calculated and the actual dollar amount of benefits for the previous transaction's budget. This should be the same as that in the latest approved budget on file with DPH.

Proposed Transaction

Fill in the percent by which benefits are calculated and the actual dollar amount of benefits for the proposed transaction's budget. Specify each benefit, the average applicable rate and the amount being incorporated within the contract, in the budget narrative.

Line 36 Total Salaries and Benefits

Add the total salaries and total fringe benefits for total. Then show difference between the previous and proposed transaction total amount. Show decrease dollar amounts in parenthesis (\$).

E. Operating Expense Detail - DPH #3

The purpose of the Operating Expense Detail worksheet is to budget for operating costs by line items, which are associated with the provisions of program services.

This worksheet is designed to present both the previous as well as the proposed transaction budget information. The previous transaction's budget is the latest approved budget, i.e., certified by the City, on file with DPH contracts. The proposed transaction's budget refers to the new budget being presented for approval. Refer to your copy of the previous transaction's budget at DPH to complete previous transaction's budget, if contract is a renewal or modification.

Line 1 Exhibit and Page Number

Fill in Exhibit and page number according to instructions given in number 8 & 9 of the format instructions.

Line 2 Document Date

Fill in date document prepared. This date should be consistent with date on other detail worksheets submitted.

Line 4 Program Name

Fill in name of program operating expense will be paid under.

Line 12 Expenditure Category

Enter dollar amounts for new contracts in the column titled "Proposed Transaction". For renewal contracts do the same, but also enter the dollar amounts of the previous contract in the column titled "Previous Transaction". Enter the difference between the previous transaction and the proposed transaction in the column titled "Increase/(Decrease)". If this is a new contract the Increase/Decrease column will remain blank.

Term

Previous Transaction

Show the fiscal period in which the previous transaction services were provided. This should be the same as that in the latest approved budget on file with DPH.

Proposed Transaction

Show the fiscal period the proposed transaction services will be provided.

Line 13 Rental of Property

Enter total amount paid for rental of property.

Line 14 Utilities

Enter total amount paid for utilities, this includes electricity, water, gas, telephone and scavenger.

Line 15 Office Supplies

Enter total amount paid for office supplies, including postage expenses.

Line 16 Building Maintenance

Enter total amount paid for building maintenance supplies and repair.

Line 17 Printing and Reproduction

Enter total amount paid for printing and reproduction.

Line 18 Insurance

Enter total amount paid for insurance.

Line 19 Staff Training

Enter total amount paid for staff training. This includes reimbursement of registration and travel.

Line 20 Staff Travel

Enter total amount paid for staff travel. This includes local work related mileage.

Line 21 Rental and/or Purchase of Equipment

Enter total amount paid for rental and/or purchase of equipment.

Line 22 Consultant/Subcontractor Descriptive Title

Identify consultant or subcontractor descriptive title. Specify previous transaction's total fees, if any, and proposed transaction's total fees paid to consultant or subcontractor Explain all consultant services in budget narrative.

Line 28 Other

Enter description(s) and total amount(s) paid under this contract for expenditures that cannot be accommodated in standard line items listed. This may include items specific to your program such as; Client Related Needs, Medical Supplies, etc.

Line 35 Total Operating Expense

Previous Transaction

Add the expenditure categories for the previous transaction budget column and show the sum as the total operating expense for the previous transaction's budget. This should be the same as that in the latest approved budget on file with DPH.

Proposed Transaction

Add the expenditure categories for the proposed transaction budget column and show the sum as the total operating expense for the proposed transaction's budget.

Increase/(Decrease)

Add the increase/decrease column and show the total increase/decrease between the previous transaction and the proposed transaction's budgeted operating expense. Show decrease dollar amounts in parenthesis (\$). This figure should be the same as the difference between the total previous transaction budgeted operating expense and the proposed transaction budgeted operating expense.

F. Equipment and Remodeling Detail - DPH #4

The purpose of the Capital Expenditure Detail worksheet is to show costs of purchased equipment and to show any remodeling costs for the proposed transaction budget.

Line 1 Exhibit and Page Number

Fill in Exhibit and Page Number in accordance with instructions given in 8 & 9 of the format instructions.

Line 2 Document Date

Fill in date document prepared. This date should be consistent with date on other detail worksheets submitted.

Line 4 Program Name

Fill in name of program capital expenditure will be paid under.

Line 10 Equipment

Equipment shall be defined as:

a. Non expendable property which has useful life expectancy of three years or more.

b. A unit valued at \$400 or more.

Line 11 No.

Enter the number of items to be purchased.

Item/Description

Give a brief description of the piece of equipment that will be purchased, include serial number if it is available.

Purchase Cost Each

Enter cost per unit of equipment purchased.

Total Purchase Cost

Enter total cost of equipment purchased (quantity x cost per unit = total purchase cost) of the line item.

Line 20 Total Equipment Cost

Enter the total amount paid for total purchase cost of equipment.

Line 23 Description - Remodeling

Briefly describe remodeling that will be done and the name of company that will be performing work, in the space provided.

Line 29 Total Remodeling Cost

Show the proposed transaction remodeling cost being charged to the contract.

Line 31 Total Capital Expenditures

Enter total amount paid for total capital expenditures, (total equipment cost + total remodeling cost = total capital expenditures)

G. Indirect Cost Detail - DPH #5

The purpose of the Indirect Cost Detail worksheet is to show costs indirectly associated with each individual program.

This worksheet is designed to present both the previous as well as the proposed transaction budget information. The previous transaction's budget is the latest approved budget, i.e., certified by the City, on file with DPH contracts. The proposed transaction's budget refers to the new budget being presented for approval. Refer to your copy of the previous transaction's budget at DPH to complete previous transaction's budget, if contract is a renewal or modification.

Line 1 Exhibit and Page Number

Fill in the Exhibit and Page Number according to instructions given in 8 & 9 of the format instructions.

Line 2 Document Date

Fill in date document prepared. This date should be consistent with date on other detail worksheets submitted.

Line 4 Program Name

Fill in the name of program indirect cost will be paid under.

Line 12 Term

Previous Transaction

Show the fiscal period in which the previous transaction services were provided. This should be the same as that in the latest approved budget on file with DPH

Proposed Transaction

Show the fiscal period the proposed transaction services will be provided.

Line 13 Position Title

Show all position titles for previous transaction and proposed transaction budget. Enter position titles that correspond to position titles referenced in the narrative. For example, do not refer to a Project Director in the narrative, and then list the title as an Executive Director in the budget.

Full Time Equivalent (FTE)

Previous Transaction

Enter number of FTE's for all position titles listed. This should be the same as that in the latest approved budget on file with DPH.

Proposed Transaction

Enter number of FTE's for all position titles listed. If contract is a renewal and a position title has been deleted show 0 FTE.

Salaries

Previous Transaction

Enter salary for all position titles listed. This should be the same as that in the latest approved budget on file with DPH.

Proposed Transaction

Enter salary for all position titles listed. If contract is a renewal and a position title has been deleted leave salary line blank.

Increase/(Decrease)

Enter amount of difference between the previous transaction salary and the proposed transaction salary for the position title. Show decrease salary amount in parenthesis (\$).

Line 22 Employee Fringe Benefits

Previous Transaction

Fill in the percent by which benefits were calculated and the actual dollar amount of benefits for the previous transaction's budget. This should be the same as that in the latest approved budget on file with DPH.

Proposed Transaction

Fill in the percent by which benefits are calculated and the actual dollar amount of benefits for the proposed transaction's budget. Specify each benefit, the average applicable rate and the amount being incorporated within the contract, in the budget narrative.

Line 23 Total Salaries and Benefits

Add the total salaries and total fringe benefits for total. Then show difference between the previous and proposed transaction total amount. Show decrease dollar amounts in parenthesis (\$).

Line 26 Expenditure Category

Enter description(s) and total amount(s) paid under this contract for expenditures that cannot be accommodated as direct cost expenditures. This may include loan expenses taken out to cover operational expenses or to meet payroll; Specify as "Cost of Loan Administration".

Line 35 Total Operating Cost

Previous Transaction

Add the operating cost for the previous transaction budget column and show the sum as the total operating cost for the previous transaction's budget. This should be the same as that in the latest approved budget on file with DPH.

Proposed Transaction

Add the operating cost for the proposed transaction budget column and show the sum as the total operating cost for the proposed transaction's budget.

Increase/(Decrease)

Add the increase/decrease column and show the total increase/decrease between the previous transaction and the proposed transaction's budgeted operating cost. This figure should be the same as the difference between the total previous transaction budgeted operating cost and the proposed transaction budgeted operating cost.

Line 37 Total Indirect Cost

Add the total salaries and benefits and total operating cost for total indirect cost. Then show difference between the previous and proposed transaction total amount. Show decrease dollar amounts in parenthesis (\$). This figure should be the same if you add the figure shown in the increase/decrease column for salaries and benefits and operating cost.

BUDGET JUSTIFICATION FOR AIDS OFFICE CONTRACTS

The Budget Justification provides the detailed information and calculations supporting the budgetary figures. It provides an explanation of budgetary figures and calculations for each budget line item. There is no form provided for the Budget Justification. The standard format is as follows:

1. Each Budget set must have its own Budget Justification.
2. The Budget Justification becomes part of the Budget set(s), and is labeled accordingly: Exhibit B-1, or Exhibit B-2, or Exhibit B-3. The beginning page number follows the last page number of the corresponding Budget.

For example, if the last page of the Budget (Exhibit B-1) was page 3, the Budget Justification for Exhibit B-1 would begin on Page 4.

3. The Budget Justification should exactly follow the order of the Budget pages by line item. For example, the first item in the Budget Justification should be the first Position Title listed in the Salaries and Benefits Detail page.
4. Show all mathematical computations for each line item that is listed in the Budget. Show how the total dollar amount was derived, e.g., the annual salary for each position multiplied by the FTE, the number of square feet of office space to be utilized multiplied by the rate per square foot, the cost per month for insurance multiplied by the number of months in the contract term, etc.
5. For the Salaries and Benefits section, **do not** include **detailed** descriptions of position responsibilities. List the position, a general overview of the position's responsibilities, the full-time equivalent (FTE), the salary per month, the salary per annum, and the mathematical computation used to arrive at the total dollar amount.

For example:

Health Educator: Will be responsible for developing outreach activities, informational materials, and staff trainings on HIV and other sexually transmitted diseases. 0.5 FTE at \$30,000 per year for twelve (12) months = \$15,000; **Alternative Explanation**: 0.75 FTE at \$28,000 per year for six (6) months = \$10,500.

6. For the Operating Expense section, provide a brief explanation of costs for each expenditure category utilized. Each description should end with the expenditure category amount that is listed in the Operating Expense Detail form (DPH #3). Examples include:

Rental of Property: Rental of drop-in center space at \$1.50 per sq. ft. per month at 600 sq. ft. for 12 months = \$10,800. [*Please note: factors that determine how reasonable the expense is include total square footage, FTEs, the monthly rate per square foot, and what is included in the rent (for example, scavenger service).*]

Utilities (electricity, water, gas, telephone, and scavenger service): Based on last year's experience, plus 4% for inflation, plus \$200 for the new service, utility costs for telephone, gas, electricity, water, and scavenger service = \$1,080.

Office Supplies, Postage: Desk supplies for program staff and materials for Health Educator for group sessions and presentations = \$300; postage for flyers/publicity = \$100; total = \$400.

Building Maintenance Supplies and Repair: Building maintenance supplies and monthly janitorial service = \$300; exceptional plumbing repairs = \$500; total = \$800.

Printing and Reproduction: Printing costs for 3,000 brochures = \$750; reproduction costs = \$1,000; total = \$1,750.

Insurance: Based on agency's costs for required coverage (\$12,000) multiplied by health education program's share of entire agency's costs (1.5 contract FTEs/10 agency FTEs = 15%) = \$1,800; Alternative Explanation: Based on last year's experience, plus 4% for inflation, = \$500.

Staff Training: Two all-staff training sessions at \$375 per session = \$750.

Staff Travel (Local and Out of Town): Local travel, 2 adult Muni Fast Passes at \$35 each for 12 months = \$840; Alternative Explanation: Local travel at \$0.25 per mile, based on last year's experience of 1,440 miles = \$360 [*Please note: 1) if mileage is charged, the agency must have auto insurance coverage; and 2) out of town travel is negotiable.*]

Rental of Equipment: Copier lease for one year = \$1,440; typewriter lease for one year = \$300; total = \$1,740.

Other:

Advertisement and Promotion: Three (3) one-week advertisements in the *Sentinel*, *Bay Guardian*, and *The Advocate* at \$150 each = \$450.

Supplies: Condoms and Hygiene: Condoms, dental dams and hygiene (first aid) supplies to be distributed by drop-in program staff. \$5.00 per person for 250 persons = \$1,250. [*Please note: Prevention and Education supplies cannot be purchased with CARE funds but first aid or medical supplies can be.*]

Educational Materials: Development of posters and brochures, including layout, design, and production. \$60.00 per hour for 4 hours = \$240.

7. Use figures to the nearest cent, for example: \$2,859.55. If the contract is for new services and the figures are estimated, please round to the nearest dollar, for example: \$2,860.
8. (If applicable) Attach a separate detailed Subcontracting budget if there is a Subcontractor arrangement made under the terms of the contract. On this page, provide a brief explanation of the subcontracting arrangement, as well as a budget breakdown.
Note: All Subcontracting arrangement requests must be submitted in writing and approved by the AIDS Office and the DPH Office of Contract Management.
9. Indirect costs should be broken out and listed on the Invoice Cost Detail form, DPH #5. If this is not possible, a detailed explanation of what is included needs to be provided.

These Guidelines provide general information. if further clarification or technical assistance is required, consult an AIDS Office Contract Specialist at 554-9020.

DEPARTMENT OF PUBLIC HEALTH - AIDS OFFICE

PROGRAM NARRATIVE INSTRUCTIONS

July 20, 1993

(NOTE: INFORMATION IN *ITALICS* APPLIES TO HEALTH SERVICE CONTRACTS)

I. OVERVIEW:

The program narrative section (entitled Exhibit A-1, A-2, A-3, etc.) of the contract is the description of contract services to be provided. It is not a proposal to provide services, which is a more lengthy and persuasive piece. The narrative section should consist of brief and concise statements that include the most pertinent information about the contract activities and interventions. However, sufficient detail is required to clearly delineate how services will be provided under the terms of the contract. It is composed of ten sections as follows:

1. STATEMENT OF NEED
2. GOAL STATEMENT
3. TARGET POPULATION
4. UNIT OF SERVICE AND *UNDULPLICATED CLIENTS*
5. OBJECTIVES
6. METHODOLOGY
7. PROJECT TIMELINE
8. EVALUATION
9. PROGRAM ORGANIZATION
10. QUALITY ASSURANCE

If your agency's program is receiving funding from more than one funding source, (i.e. General Fund and CDC) a separate program narrative exhibit is required for each funding source. If your agency is receiving funding for multiple activities or interventions under a single contract, a separate program narrative exhibit is required for each distinct activity or intervention. A program is defined by the type of service (activity or intervention) to be provided. (The Program Manager and Contract Specialist working with your agency will discuss with you during contract negotiations the manner to best structure your contract narrative exhibits prior to contract development.)

II. COVER LETTER

Please attach a cover letter to the contract narrative document identifying your agency, fiscal agent (if applicable), and subcontractors (if applicable). Please indicate the appropriate program and fiscal contact person(s).

III. PAGE HEADINGS

The following headings should appear, as shown below, on each page of the program narrative. The Fiscal Agent's name should be used if the service provider has a Fiscal Agent. The Fiscal Agent relationship should be identified in the cover letter that accompanies contract documents submitted to the AIDS Office. (See above.)

Agency Name
Funding Source
Term of Contract

Exhibit
Page

The start-up narrative must include all the applicable program narrative components (as referenced in the Overview Section). In addition, the following information should be provided:

- An explanation of why a start-up period is needed.
- Length of start-up period.

VI. NARRATIVE EXHIBIT BREAKDOWN

1. STATEMENT OF NEED

This section should summarize the extent of the problem or need that the program will address. Describe the need for services in the community. Will services provided fill an existing gap in the continuum of HIV services in the community? Cite current statistics concerning the service needs of the target population.

AVOID:

- National Statistics
- Describing problem in terms of the agency's needs.

2. GOAL STATEMENT

The goal statement is a general statement that describes what the program will accomplish through this contract.

3. TARGET POPULATION

Describe the target population to be served by the program. Who will your program reach? For example: women of child-bearing age; youth between the ages of thirteen and nineteen years; Asian/Pacific Islander gay and bisexual men; African American males residing in the Tenderloin.

4. UNIT OF SERVICE AND UNDUPLICATED CLIENTS

Units of Service:

This section should define the unit(s) of service (UOS) and state the total number of units of service to be provided during the contract period. For direct services, the unit of service must be defined as an hour of client contact or client service. For residential or institutional services, a unit of service is defined as a bed-day, resident-day or overnight stay. The UOS definition should describe what is included in an hour of client service or a resident day. If your program provides more than one type of service, a distinct unit of service should be defined for each service type.

If appropriate, the unit of service, an hour of direct client service for example, can be further broken down into component parts such as: the number of face to face contacts, telephone contacts, and services/activities performed on behalf of clients. Individual and group service units must also be designated separately in the contract language (e.g. "x" hours of group counseling and "y" hours of individual counseling).

Other unit of service definitions may be required depending on the type of services delivered, (e.g. number of meals delivered, number of phone calls/drop-in visits. All unit of service definitions will be reviewed by your AIDS Office Program Manager.

The start-up narrative must include all the applicable program narrative components (as referenced in the Overview Section). In addition, the following information should be provided:

- An explanation of why a start-up period is needed.
- Length of start-up period.

VI. NARRATIVE EXHIBIT BREAKDOWN

1. STATEMENT OF NEED

This section should summarize the extent of the problem or need that the program will address. Describe the need for services in the community. Will services provided fill an existing gap in the continuum of HIV services in the community? Cite current statistics concerning the service needs of the target population.

AVOID:

- National Statistics
- Describing problem in terms of the agency's needs.

2. GOAL STATEMENT

The goal statement is a general statement that describes what the program will accomplish through this contract.

3. TARGET POPULATION

Describe the target population to be served by the program. Who will your program reach? For example: women of child-bearing age; youth between the ages of thirteen and nineteen years; Asian/Pacific Islander gay and bisexual men; African American males residing in the Tenderloin.

4. UNIT OF SERVICE AND UNDUPLICATED CLIENTS

Units of Service:

This section should define the unit(s) of service (UOS) and state the total number of units of service to be provided during the contract period. For direct services, the unit of service must be defined as an hour of client contact or client service. For residential or institutional services, a unit of service is defined as a bed-day, resident-day or overnight stay. The UOS definition should describe what is included in an hour of client service or a resident day. If your program provides more than one type of service, a distinct unit of service should be defined for each service type.

If appropriate, the unit of service, an hour of direct client service for example, can be further broken down into component parts such as: the number of face to face contacts, telephone contacts, and services/activities performed on behalf of clients. Individual and group service units must also be designated separately in the contract language (e.g. "x" hours of group counseling and "y" hours of individual counseling).

Other unit of service definitions may be required depending on the type of services delivered, (e.g. number of meals delivered, number of phone calls/drop-in visits. All unit of service definitions will be reviewed by your AIDS Office Program Manager.

To reduce substance use in 60% of program clients to once a week or less by the end of the contract period, as assessed by the program counselor through an interview with the client after three months of outpatient treatment, using a standardized assessment form.

To improve patient function by the end of the contract period in 30% of the institutionalized patients receiving rehabilitative treatment for dementia as determined by the Project Coordinator, measured by discharge to a lower level of care (residential facility or home) in the community.

6. METHODOLOGY

The methodology section describes how program activities are structured to achieve the objectives described in the previous section. Each objective should have a related methodology statement. Describe how services will be provided and include the following in your description:

- What strategies will be utilized to reach the target population?
- Where will program activities be conducted? Indicate the site(s) where services will be provided to clients.
- Which staff will be involved in the development and the delivery of services including staff positions both funded and not-funded by the contract.
- How will coordination with other agencies occur?
- How will participants/clients be recruited?
- How will program activities/services be promoted/advertised?
- Describe the program content. Explain how a client receives service beginning with outreach/initial contact through the delivery of service to discharge. Describe individual service components in the order in which they are encountered by a client. For example: Intake/assessment includes: collection of identifying demographic information, verification of HIV status, a client interview regarding perceived needs, review of client rights and grievance procedure including obtaining client signature and providing a copy of the signed form to the client, and obtaining consent for treatment and providing a copy of the signed form to the client.
- How will program activities/services/clients be documented?

This section should clearly state and provide the address location(s) where all services will be provided. If contract services will be provided in more than one location, list all locations. Outreach programs should indicate target areas, days and times. For residential programs with confidential site locations, a separate confidential list will be maintained on file with the AIDS Office and will not be disclosed in the contract document.

7. PROJECT TIMELINE

The project timeline is a work plan for the program implementation and service delivery during the contract period. Ideally, the timeline should indicate all activities and the date on which they will commence or be completed. At a minimum, the project timeline should be broken down into quarters. The types of activities could include the following: hiring of staff; development of outreach materials; staff training; start of service; program evaluation activities; completion of quarterly reports for the AIDS Office; development, administration, and analysis of a client survey etc. **DO NOT INCLUDE ACHIEVEMENT OF UNITS OF SERVICE AND UNDUPLICATED CLIENTS IN THIS SECTION.**

8. EVALUATION

Evaluation is an ongoing process. Activities related to evaluation should occur throughout the contract period. In this section, describe how you will conduct the following forms of evaluation:

narrative instructions (Con't)

10. QUALITY ASSURANCE

Quality assurance (QA) procedures are necessary to assure that all services are provided by a program in the manner intended, following professional and agency standards. Quality assurance should focus primarily on the methodology of your program. This section should focus on the routine reviews conducted within your program or agency to assure that services provided are of high quality. These procedures should include, but are not limited to:

- Board Review of Quality Assurance Plan
- Review of Policies and Procedures
- Infection Control/*TB control*
Universal Precautions
- Review of Staff Training Plan
- Peer Review of Client Records
- Monitoring of TB Screening Procedures**
- Review of Cultural Competency Plan
- Medical Protocol

**Primarily for housing programs, however all agencies are being encouraged to develop TB screening policies and procedures that are appropriate for their programs.

t:narinstr

	A	B	C	D	E
1	Exhibit ____ Page ____				
2	Document Date _____				
3	DEPARTMENT OF PUBLIC HEALTH CONTRACT BUDGET SUMMARY				
4	BY PROGRAM				
5	Contractor's Name			Contract Term	
6					
7	(Check One) New ☐ Renewal ☐ Modification ☐				
8	If modification, Effective Date of Mod.		No. of Mod.		
9	Program				Total
10	Narrative Page No.(s)				
11	Program Term				
12	Expenditures				
13	Salaries & Benefits				
14	Operating Expense				
15	Capital Expenditure				
16	Direct Cost				
17	Indirect Cost				
18	Indirect Percentage (%) of direct cost (Line 16)				%
19	Total Expenditures				
20	DPH Revenues				
21	General Fund				
22					
23					
24					
25					
26					
27					
28	TOTAL DPH REVENUES				
29	Other Revenues				
30					
31					
32					
33					
34					
35	Total Revenues				
36	Total Units of Service				
37	Cost Per Unit of Service				
38	Full Time Equivalent (FTE)				
40	Prepared by:		Telephone No.:		Date
41	DPH-CO Review Signature: _____				
42	DPH #1				

	A	B	C	D	E	F
1						Exhibit ____ Page ____
2						Document Date _____
3						
4	SUMMARY OF CLIENT SERVICES					
5	BY PROGRAM					
6						
7	Program Name _____			TERM _____		
8	(Same as Line 9 on DPH #1)					
9						
10			Total	No. of	No. of	Cost Per
11	Mode and Service Function		Cost	Clients	Units	Unit
12						
13						
14						
15						
16						
17						
18	Program Name _____			TERM _____		
19	(Same as Line 9 on DPH #1)					
20						
21			Total	No. of	No. of	Cost Per
22	Mode and Service Function		Cost	Clients	Units	Unit
23						
24						
25						
26						
27						
28						
29	Program Name _____			TERM _____		
30	(Same as Line 9 on DPH #1)					
31						
32			Total	No. of	No. of	Cost Per
33	Mode and Service Function		Cost	Clients	Units	Unit
34						
35						
36						
37						
38						
39	DPH #1A					2/08/93 IBM disk

	A	B	C	D	E	F	G	H	I	J	K
1	Exhibit ____ Page ____										
2	Document Date _____										
3											
4	Program Name _____										
5	(Same as Line 9 on DPH #1)										
6											
7	Salaries & Benefits Detail										
8											
9											
10											
11											
12	POSITION TITLE		PREVIOUS TRANSACTION TERM _____		PROPOSED TRANSACTION TERM _____		INCREASE (DECREASE)				
13		FTE	SALARIES	FTE	SALARIES						
14											
15											
16											
17											
18											
19											
20											
21											
22											
23											
24											
25											
26											
27											
28											
29											
30	TOTALS										
31											
32											
33	EMPLOYEE FRINGE BENEFIT % _____ % _____										
34											
35											
36	TOTAL SALARIES & BENEFITS _____										
37	DPH #2										

	A	B	C	D	E
1	Exhibit ____ Page ____				
2	Document Date _____				
3	DEPARTMENT OF PUBLIC HEALTH CONTRACT BUDGET BY FUNDING SOURCE				
4					
5	Contractor's Name			Contract Term	
6					
7	(Check One) New ☐ Renewal ☐ Modification ☐				
8	If Modification, Effective Date of Mod.			No. of Mod.	
9	Funding Source:				
10	Term of Funds:				
11	Exhibit Name:				
12	Cost Center Name:				
13	Expenditures				Totals
14	Salaries & Benefits				
15	Operating Expense				
16	Capital Expenditure				
17	Direct Cost				
18	Indirect Cost				
19	<i>Indirect Percentage (%) of direct cost (Line 17)</i>				
20	Total Expenditures				
21	Units of Service				
22	Cost Per Unit of Service				
23	Full Time Equivalent (FTE)				
24	Prepared by:			Telephone No.: Date	
25	DPH-CO Review Signature: _____				
26	DPH #1B				

	A	B	C	D	E	F	G	H	I
1							Exhibit ____ Page ____		
2							Document Date _____		
3									
4	Program Name _____								
5	(Same as Line 9 on DPH #1)								
6									
7	Operating Expense Detail								
8									
9									
10					PREVIOUS	PROPOSED			
11					TRANSACTION	TRANSACTION		INCREASE	
12	Expenditure Category	TERM			_____	_____		(DECREASE)	
13	Rental of Property				_____	_____		_____	
14	Utilities(Elec, Water, Gas, Phone, Scavenger)				_____	_____		_____	
15	Office Supplies, Postage				_____	_____		_____	
16	Building Maintenance Supplies and Repair				_____	_____		_____	
17	Printing and Reproduction				_____	_____		_____	
18	Insurance				_____	_____		_____	
19	Staff Training				_____	_____		_____	
20	Staff Travel-(Local & Out of Town)				_____	_____		_____	
21	Rental of Equipment				_____	_____		_____	
22	CONSULTANT/SUBCONTRACTOR DESCRIPTIVE TITLE								
23	_____				_____	_____		_____	
24	_____				_____	_____		_____	
25	_____				_____	_____		_____	
26	_____				_____	_____		_____	
27	_____				_____	_____		_____	
28	OTHER								
29	_____				_____	_____		_____	
30	_____				_____	_____		_____	
31	_____				_____	_____		_____	
32	_____				_____	_____		_____	
33	_____				_____	_____		_____	
34									
35	TOTAL OPERATING EXPENSE				_____	_____		_____	
36									
37	DPH #3								

	A	B	C	D	E	F	G	H	I
1						Exhibit _____ Page _____			
2						Document Date _____			
3									
4	Program Name _____								
5	(Same as line 9 on DPH #1)								
6									
7	Indirect Cost Detail								
8									
9	1. Salaries and Benefits								
10					PREVIOUS			PROPOSED	
11					TRANSACTION			TRANSACTION	
12					TERM _____	TERM _____		INCREASE	
13	Position Title				FTE	SALARIES	FTE	SALARIES	(DECREASE)
14									
15									
16									
17									
18									
19									
20									
21									
22	EMPLOYEE FRINGE BENEFITS				%		%		
23	TOTAL SALARIES & BENEFITS								
24									
25	2. Operating Cost								
26	Expenditure Category								
27									
28									
29									
30									
31									
32									
33									
34									
35	TOTAL OPERATING COST								
36									
37	TOTAL INDIRECT COST								
38	(Salaries & Benefits + Operating Cost)								
39	DPH # 5								

	A	B	C	D	E
1					Exhibit _____ Page _____
2					Document Date _____
3					
4	Program Name _____				
5	(Same as line 9 on DPH #9)				
6					
7	Capital Expenditure Detail				
8	(Equipment and Remodeling Cost)				
9					
10	EQUIPMENT				
11	No.	ITEM/DESCRIPTION		PURCHASE COST EACH	TOTAL COST
12					
13					
14					
15					
16					
17					
18					
19					
20	TOTAL EQUIPMENT COST				\$ _____
21					
22	REMODELING				
23	Description:				
24					
25					
26					
27					
28					
29	TOTAL REMODELING COST				\$ _____
30					
31	TOTAL CAPITAL EXPENDITURE				\$ _____
32	(Equipment and Remodeling Cost)				
33	DPH#4				

AFFIRMATIVE ACTION REQUIREMENTS
FOR CITY CONTRACTORS

The Human Rights Commission of San Francisco is responsible for contract compliance relative to affirmative action. The City and County of San Francisco Administrative Code, Chapter 12B, requires businesses and agencies contracting with the City and County to comply with certain obligations.

Suppliers of goods and services for the City and County of San Francisco are required by Chapter 12B to take affirmative action to ensure equal opportunity in employment without regard to race, color, religion, ancestry, national origin, age, sex, sexual orientation or disability.

The Human Rights Commission, as representative of the City and County, is mandated to monitor the recruitment, hiring, promotional and training practices of all City suppliers.

City suppliers are urged to hire and promote qualified applicants so that the workforce breakdown reflects San Francisco City and County population parity. For example, if minorities make up 50% of the City's population, the HRC will urge the supplier to recruit and hire in such a way that their overall workforce is 50% minority. This same standard will apply to women and each class of minority [American Indian, Asian, Black, Filipino, and Hispanic].

The HRC will especially encourage the training and promotion of minorities to achieve population parity at all levels of employment. The contractor must utilize an equal employment program designed to facilitate the achievement of ethnic balance throughout all levels of its staff.

Goals and timetables covering affirmative action employment programs will be established as part of an overall affirmative action agreement between the suppliers and the City and County. The procedure for drafting an agreement of this type is negotiation between the supplier and the HRC on behalf of the City and County.

The HRC recognizes that it has a joint responsibility to cooperate and participate with the supplier to achieve the goals set forth. However, the supplier retains the responsibility for showing evidence of compliance. If the goals set forth are not reached, the supplier must show, to the satisfaction of the Human Rights Commission, the good faith efforts made in attempting to reach the goals. Use of non-traditional techniques in recruitment and hiring, e.g. community resource groups, women's organizations, and local ethnic minority news media, will prove to be useful tools in the achievement of these goals.

Employment Expectations

Emphasis will be placed on commitments according to HRC's priorities in affirmative action for employment:

1. Full-time employment of minorities and women as officials and managers in decision-making positions.
2. Full-time employment of minorities and women in sales and professional positions.
3. Full-time employment of minorities and women in the crafts [skilled] positions.
4. Part-time/summer employment for minorities and women.
5. Training and upgrading of minorities and women from semi-skilled and clerical positions.

Pursuant to enforcement of Chapter 12B, the HRC requires the completion of the attached Questionnaire on Recruitment, Hiring, and Training Practices.

If there are any questions, please feel free to call the Human Rights Commission at 252-2500.

For all proposals over \$50,000, please provide the information requested on the Questionnaire, complete the attached charts, and return with your proposal.

DEPARTMENT OF PUBLIC HEALTH
Office of Contract Management and Compliance

* NOT APPLICABLE TO CONTRACTS UNDER \$50,000 *

HRC FORM 6A

EMPLOYMENT AFFIRMATIVE ACTION REQUIREMENTS AND NON-DISCRIMINATION PROVISIONS

To be completed by the proposer and returned with the proposal. If the form is not returned with the proposal, the proposal may be determined non-responsive and rejected.

1. Indicate key personnel designated to work on this project for the entire project team (prime consultant, joint venture partners, subconsultants).

The employees listed should include all those listed in descriptions of key personnel in other sections of the proposal, if this form is submitted in response to an RFP.

<u>Name of Firm</u>	<u>Name of Employee</u>	<u>Project Role</u>	<u>Race & Sex</u>

2. Indicate disabled personnel who will be working on this project in any capacity for any member of the project team (prime consultant, joint venture partners, subconsultants).

<u>Name of Firm</u>	<u>Name of Employee</u>	<u>Project Role</u>	<u>Nature of Disability</u>

Owner/Authorized Representative
(Signature)

Name & Title (please print)

Date

* NOT APPLICABLE TO CONTRACTS UNDER \$50,000 *

HRC Form 6B

EMPLOYMENT AFFIRMATIVE ACTION REQUIREMENTS AND NON-DISCRIMINATION PROVISIONS

To be completed by the proposer or contractor (including a separate form for each joint venture partner) and each subconsultant with a subcontract of \$50,000 or more. The forms should be returned with the proposal. If the forms are not returned with the proposal, the proposal may be determined non-responsive and rejected.

Section 1 General Information (Please answer all questions, writing responses on a separate sheet of paper)

1. Name, title and telephone number of Company officials at the establishment who are responsible for recruitment and hiring and who will provide information concerning this matter.
2. Name, title and telephone number of senior managing official at the establishment, if he/she is not the person in 1.
3. Describe briefly the basic business activity at the establishment (i.e., identify the product supplied or the service performed).
4. Describe briefly how employees at various levels are hired.
5. Describe in full any affirmative action programs in the past two years which serve to increase the number of under-represented minorities and/or women. Attach any written programs.
6. Has your firm entered into a conciliation agreement, consent decree, or court order which provides for short and long range affirmative action goals? If so, please attach a copy of the document.
7. Have you previously submitted to the HRC your company's affirmative action plan, consent decree or conciliation agreement? If so, when?
- 8A. Indicate disabled employees on your staff: (Information should be submitted only for the branch office that will perform the project work).

<u>Name of Employee</u>	<u>Job Title</u>	<u>Nature of Disability</u>
_____	_____	_____
_____	_____	_____

- 8B. Will you use outreach programs during the project with the goal of hiring a disabled person? Yes ___ No ___

Owner/Authorized Representative (Signature)

Name & Title (please print)

Date

Section II
Workforce Breakdown

	MALE EMPLOYEES								FEMALE EMPLOYEES								
COMPANY NAME						<u>Total</u>	<u>Total</u>							<u>Total</u>	<u>Total</u>		Total Male
						<u>Minority</u>	<u>White</u>	<u>Total</u>						<u>Minority</u>	<u>White</u>	<u>Total</u>	and
	(1)	(2)	(3)	(4)	(5)	Male	Male	Male	(1)	(2)	(3)	(4)	(5)	Female	Female	Female	Female
Employee Status by Job Categories																	
Officials and Managers																	
Professionals																	
Technicians																	
Sales																	
Office & Clerical																	

White-(not of Latino origin): All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East

(1) Black-(not of Latino origin): All persons having origins in any of the Black racial groups of Africa

(2) Latino-All persons of Mexican, Puerto Rican, Cuban, Central or South America, or other Spanish culture or origin

(3) Asian or Pacific Islander - All persons having origins in any of the original peoples of the Far East, Southeast Asia the Indian Subcontinent or the Pacific Islands.

(4) Filipino - All persons having origins in any of the original peoples of the Philippine Islands.

(5) American Indian or Alaskan Native - All persons having origins in any of the original peoples of North America and who maintain cultural identification through tribal affiliation or community recognition.

When completing the Workforce Breakdown, please include only those employees working or based in the San Francisco Bay Area.

**DEPARTMENT OF PUBLIC HEALTH
CONTRACT PROVIDERS**

**THIS INFORMATION MUST BE COMPLETED
FOR THE CONTRACTORS PARENT ORGANIZATION AND
FOR THIS PROGRAM FUNDED BY DPH.**

TYPE OF BUSINESS OR ORGANIZATION:
 ___an individual ___a partnership ___a non-profit org.
 ___a private corporation ___a public corporation
 ___other, explain _____

CONTRACTOR: _____

ADDRESS: _____

PARENT ORGANIZATION: _____

DATE: _____

DPH DIVISION: _____

**DEMOGRAPHIC INFORMATION
STAFF, CLIENTS SERVED, BOARD OF DIRECTORS**

Description	PROGRAM NAME:						PARENT ORGANIZATION:					
	STAFF		UNDUPLICATED CLIENTS SERVED		BOARD OF DIRECTORS		STAFF		UNDUPLICATED CLIENTS SERVED		BOARD OF DIRECTORS	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
American Indian/ Alaskan Native												
Asian/Pacific Islands												
Black												
Filipino												
Latino/a												
Other												
TOTAL MINORITY												
TOTAL WHITE												
TOTAL												
Total Women												
Total Men												
Transgender*												
Gay*												
Lesbian*												
Bisexual*												

For those programs whose target population serves gays, lesbians or bisexuals, give the number of persons on your staff and board of directors who openly identify their sexual orientation. An estimate of unduplicated clients will suffice if precise information is not available.

ETHNIC DESIGNATIONS

- (1) American Indian or Alaskan Native: Persons having origins in any of the original peoples of North America who maintain cultural identification through tribal affiliation or community recognition.
- (2) Asian or Pacific Islanders (except Filipino): Persons having origins in any of the original peoples of the Far East, Southeast Asia, the India subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, and Samoa.
- (3) Black (not of Hispanic origin): Persons having origins in any of the Black racial groups of Africa.
- (4) Filipino: Persons having origins in any of the original peoples of the Philippine Islands.
- (5) Latino/a: Persons of Mexican, Puerto Rican, Cuban, Central or South America, or other Spanish culture or origin, regardless of race.
- (6) White (not of Hispanic origin): Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

UNITS OF SERVICE/UNDUPLICATED CLIENTS CHANGE REQUEST FORM

AGENCY NAME: _____

PROGRAM/COST CENTER NAME: _____

FUNDING SOURCE & AMOUNT: _____

DATE: _____

A) SERVICE DESCRIPTION (one sentence):

B) DEFINITION OF UNIT OF SERVICE (UOS):

C) Contract UOS: _____

Actual UOS through _____ : _____

Proposed Contract UOS: _____

D) Contract unduplicated clients (UDC): _____

Actual UDC through: _____

Proposed Contract UDC: _____

E) Contract Cost/UOS: _____

Proposed Cost/UOS: _____

F) Contract Cost/UDC: _____

Proposed Cost/UDC: _____

**G) REASON FOR CHANGE: PLEASE ATTACH A COVER LETTER
DETAILING THE REQUESTED UOS/UDC REVISION.**

H) IMPACT ON SERVICE PROVISION (Staffing changes, mode of service provision, etc.):

Request Approved _____ Denied _____

Program Manager _____ Date _____

Branch Chief _____ Date _____

Fiscal Services _____ Date _____



STEVE HODGE DESIGN

1451 TENTH AVENUE
SAN FRANCISCO, CALIFORNIA 94122
TEL: 415.731.6956 FAX: 415.731.8445

Carl Yoshimoto
Project Director
EACH Program
944 Market Street
Suite 210
San Francisco, California 94102

November 10, 1993

Project: AIDS Is About Living Posters (Contract 10.5.93)

Specifications:

Art Direction, Design, Photography and Final Mechanical Art
for Four (4) Bus Posters (size: 11x28"/ live area: 9x28")
and Four (4) General Usage Posters (size: 11x17"). These
posters will be designed for reproduction in black + 1 PMS.

Direction:

The four posters will target each of 4 communities: Black,
Asian, Hispanic, and White. The bus posters will contain
3 photographic images each and the general posters will
contain 6 photographic images each. The images will pre-
dominately focus on the ethnic community being portrayed,
with other ethnic mixes blended in. I would like to see
the language of the people on the poster where applicable:
i.e.: Spanish, Chinese, English. The photographic images will
be positive, diverse in activity and in some cases challenging.



STEVE HODGE DESIGN

1451 TENTH AVENUE
SAN FRANCISCO, CALIFORNIA 94122
TEL: 415.731.6956 FAX: 415.731.8445

Schedule:

Photography Shooting Schedule:

Nov 15-21	Poster #1	Black Orientation
Nov 22-28	Poster #2	Asian Orientation
Nov 29-Dec 5	Poster #3	Hispanic Orientation
Dec 6-12	Poster #4	White Orientation

Photographic Print Schedule:

Dec 13-19

Final Mechanical Art Schedule:

Dec 13-22

Delivery of Final Mechanical Art:

Dec 22

Submission of Remaining Billings:

Installment Payment #2	Dec 1
Installment Payment #3 (Final)	Dec 22



Steve Hodge
Steve Hodge Design



STEVE HODGE DESIGN

1451 TENTH AVENUE
SAN FRANCISCO, CALIFORNIA 94122
TEL: 415.731.6956 FAX: 415.731.8445

Carl Yoshimoto
Project Director
EACH Program
944 Market Street
Suite 210
San Francisco, California 94102

November 10, 1993

Billing for Services

Project: AIDS Is About Living Posters (Contract 10.5.93)

Installment Payment #1 \$3,333.00

Payment for professional consultant services

Total Amount Due: \$3,333.00



Steve Hodge

Steve Hodge Design

Agreement as of the 5 day of October 1993, between the **Early Advocacy and Care for HIV (EACH) Program** (a program of the National Task Force on AIDS Prevention, hereinafter referred to as the "Client"), located at 944 Market Street, Suite 210, San Francisco, CA and **Steve Hodge Design** (hereinafter referred to as the "Consultant"), located at 1451 Tenth Avenue, San Francisco, CA, with respect to the creation of certain photographic poster work (hereinafter referred to as the "Work").

WHEREAS, Consultant is a professional photographer and graphic designer of good standing;

WHEREAS, Client wishes the Consultant to create certain Work described more fully herein; and

WHEREAS, Consultant wishes to create such Work;

NOW, THEREFORE, in consideration of the foregoing premises and the mutual covenants hereinafter set forth and other valuable considerations, the parties hereto agree as follows:

1. Description. The Consultant agrees to create the Work in accordance with the following specifications:

Title: AIDS is About Living (Early Intervention and Treatment for HIV to Support a Healthy Life)

Subject Matter: A series of photographs depicting a gay male couple of mixed ethnicity, in various activities of positive living. Text accompanying each photograph shall be life positive. Photographs and text shall promote positive images of living with HIV.

Finished deliverable product: Photographs and text shall be produced into several posters of different sizes and formats. These posters shall be placed in City Muni buses, bars and restaurants, and other appropriate settings. In addition to posters, the Work shall be incorporated into an Early Intervention Guide and Early Intervention flyer.

2. Due Date. The Consultant agrees to deliver the Work within 90 days after the signing of this Agreement.

3. Grant of Rights. Upon receipt of full payment, the Consultant grants to the Client the following rights in the Work:

For use in the Client's advertising campaign in the entire Bay Area.

With respect to the usage shown above, the Client shall have exclusive rights.

4. Reservation of Rights. All rights not expressly granted hereunder are reserved to the Consultant, including but not limited to all rights in preliminary materials. If client wishes to make any additional uses of the Work, Client agrees to seek permission from the Consultant.

5. Fees and Payment. Consultant's *professional photographic and graphic design services shall be provided pro bono* to the Work. Client agrees to pay Consultant for:

- 1) professional consultant services (i.e., convening focus groups, conceptualization of the Work, recruitment, screening and selection of models, coordination and set-up of the shoots, obtaining of Permission and Privacy Release Forms from models);
- 2) expenses for supplies and materials (i.e., film, paper, film processing);
- 3) expenses related to other services (i.e., copying, printing).

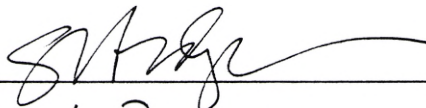
All of consultant's services and expenses shall be reimbursed through payments made in three monthly installments in the amount of \$3333.00, inclusive of all taxes, and the total payment to the Consultant shall not exceed \$10,000. Consultant shall submit an invoice to the Client on a monthly basis, detailing expenses incurred and progress of work.

6. Delivery of product: Consultant shall deliver the final product to the Client consisting of camera-ready art suitable for production of posters and flyers.

7. Miscellany. This Agreement shall be binding upon the parties hereto, their heirs, successors, assigns, and personal representatives. This Agreement constitutes the entire understanding between the parties. Its terms can be modified only by an instrument in writing signed by both parties, except that the Client may authorize expenses or revisions orally. A waiver of a breach of any of the provisions of this Agreement shall not be construed as a continuing waiver of other breaches of the same or other provision hereof. This Agreement shall be governed by the laws of the State of California.

IN WITNESS WHEREOF, the parties hereto have signed this Agreement as of the date first set forth above.

Consultant



Client

EACH Program

By

Carl K. Yslwinski, Prog. Director

Authorized Signatory, Title

February 22, 1994

Randy Miller
Director, Local Programs
National Task Force on AIDS Prevention
844 Market Street
San Francisco, California 94102

Dear Mr. Miller:

Ron Vanduyne and I spoke with Allen Piniol last Thursday, February 17, about the request for carry-over and redirection submitted as a draft for our review and feedback. We were able to clarify some issues and Allen is working on necessary revisions. The program principally affected by the carry-over will be the Latino risk reduction program, *Nuestras Voces/Nuestras Vidas*. With the revisions in staffing, 3.6 full-time equivalents (FTEs) would potentially be funded directly by CDC under Announcement #202. This would include Jesse Johnson, Latino Program Director at .60 FTE, Juan Rodriguez at 1.0 FTE (Deputy Director), Coordinator of Program Activities, Hector Leon at 1.0 FTE, and Latino Health Educator, Ricardo Bracho at 1.0 FTE.

To evaluate the request for carry over and redirection, it will be necessary to review a summary of each person's role in carrying out the program goals and objectives. For instance, it is my understanding that Ricardo is very involved in developing and planning Colegio ContraSIDA, the educational and cultural classes which promote discussion of HIV related issues and encourage further participation in the educational programs. Please provide, with the final request for carry over and redirection a summary of each person's roles and responsibilities in carrying out the risk reduction program.

As we explained to Allen last week, the request to fill the position titled "Outreach Coordinator" would not be granted, primarily because this award did not fund street outreach activities. We would, however, consider funding an additional .45 FTE of Hector Leon's salary as the Coordinator of Program Activities. This would bring him to full-time status (100%) on this project. His responsibilities, however, should NOT include any involvement in developing a new street outreach program which is not supported by this award. As defined in the year two application, he is primarily responsible for the retreats. Again, it will be important for us to have a better understanding of each person's role in carrying out the activities of the Latino risk reduction program.

Additionally, we requested that Allen submit an overview of other funding supporting Latino programs and the people/positions funded under each. We did express to Allen our concern about Jesse's involvement at the proposed .60 FTE

In the program development and implementation of this program when he is overseeing the development of many new grants and contracts. Even of greater concern was Juan's role as "Deputy Director," proposed to be funded by this award at 100%. What will their roles be in the development and delivery of this program? How many other programs will Jesse be overseeing? These are areas which require further explanation in the final request.

In regard to the other expenses proposed for carry over funds, we asked for further explanation of the formula used to determine the requested amounts.

I also suggested that Jesse Johnson submit with the request for redirection a final version of the project goals and objectives. In light of the proposed staffing plan at 3.6 FTEs, I would ask that the following changes be made to these objectives and program plan:

Program Objective 1: Street outreach should be eliminated; it is not funded under this award. We will, however, fund the cultural events and media work both which will promote participation in the other program components funded under this award.

Program Objective 2: In-Bring Activities: (Colegio ContraSIDA) The objectives should specify 100 unduplicated gay Latinos will attend. The objectives should also specify the length of each of the nine classes.

Program Objective 3: The Nuestras Vidas Campaign: A focus group of 7 men should review the completed prototypes for campaign. If major problems are identified, another focus group should review the campaign after revisions are made and before it is implemented. Also, I am assuming that this campaign will take the form of the posters for which funding is requested in the carry over budget. Is this a correct assumption?

Program Objective 4: Gay Latino Leadership Retreats: Please provide further information about the number of volunteer facilitators to be recruited to conduct the retreats; how they will be trained (e.g.: an eight hour facilitators training which addresses listening skills, HIV transmission, the retreat curriculum, etc.); how the curriculum for the retreat is developed; and the number of facilitators working at each retreat. It is also important that during the retreats the importance of these "leaders" modeling healthy sexual behavior for their community is addressed. It is critical that through these retreats you discuss how Latino gay men can redefine healthy cultural norms around safer sex.

Program Objective 5: HIV Primary Prevention Workshop: A minimum of 250 men should be reached through the 18 workshops. Specify the length of the workshop; specify the length and content of the training for 14 facilitators; specify how quality will be assured by the project staff; specify whether a curriculum for the workshop will be available for the facilitators. It is important that these workshops address more than education about transmission and safer sex methods. It is important that the

workshops provide an opportunity for participants to discuss barriers to using condoms and methods to overcome those barriers.

Program Objective 6: Establish a community advisory board. (I have no recommendations about this objective.)

We are not funding you to carry out outcome objectives. It is unclear to me how you will measure the outcome objectives stated in the program plan. It may be more beneficial, at this point in the program, for Jesse to develop a sound process evaluation plan.

It also may be more helpful to construct these objectives as a "work plan." For instance, for Program Objective #4:

Gay Latino Retreats: (Nuestras Voces)

Activities:

1. Develop a draft of retreat activities based on results of the formative evaluation study completed by Rafael Diaz.
2. Community Advisory Committee reviews the draft activities.
3. Develop a training curriculum for volunteer facilitators.
4. Recruit 8 volunteer trainers. (I am using 8 only as an example.)
5. Conduct training for volunteer facilitators.
6. Develop evaluation tools for the retreats.
7. Schedule 4 retreats.
8. Solicit participation for the retreats.
9. Hold pilot retreat and revise accordingly for remaining three.

It is helpful to include dates in the workplan so that all staff are clear on the time lines for carrying out the program. The program objectives developed and submitted are a great start to a more detailed work plan.

I would suggest the following process evaluation plan for Jesse to consider. These correspond to the appropriate program objectives.

Process Evaluation Plan:

Objective 2: Colegio ContraSIDA:

1. Demographics and numbers of men attending the classes.
2. Dates and theme of each class. (What was the primary HIV message imparted?)
3. Length (in time) of each class.
4. Successful referrals of participants to other program activities should be tracked.
5. Satisfaction surveys from class participants should be completed to provide facilitator feedback.

Objective 3: Nuestras Vidas Campaign:

1. Demographics and numbers of men participating in think tanks.
2. Summary and date of each think tank.
3. Results of focus group to display prototypes including the number and demographics of participants.
4. End result (campaign).

Objective 4: Retreats:

1. Demographics and numbers of men participating.
2. Demographics and numbers of trainers.
3. Curriculum for trainers.
4. Curriculum for the retreat.
5. Satisfaction surveys from participants.
6. Attrition rates for the two day training.

Objective 5: HIV Prevention Workshop:

1. Demographics and numbers of trainers.
2. Curriculum for training facilitators.
3. Curriculum for the workshop.
4. Quality Assurance Plan for volunteer facilitators.
5. Demographics and numbers of workshop participants.
6. Referral Mechanism.
7. Satisfaction surveys from workshop participants.
8. Satisfaction surveys from facilitator training.

Objective 6: Advisory Board

1. Roles and responsibilities for board defined and written.
2. Minutes from meetings maintained.

These are the sorts of evaluation measures which will be important for Jesse to maintain and submit to CDC with your regular quarterly reports. The summary of your progress in meeting these objectives provided in the first quarter report was very good. The suggestions in the evaluation plan above will also provide a construct for measuring and documenting your quarterly progress.

In regard to the Community-Level Intervention being implemented by GCHP, their progress reported in the first quarter report is also very good. The media conference was well planned and although fewer attended than what they hoped, it was a very commendable first attempt. I support their decision to reconsider expanding their "think tank" efforts to new communities this year. I would encourage them to consider broadening their work with current think tank members, exploring how these individuals can take a larger role in continuing to affect the social norms in their own communities. I will anticipate receiving the revised objectives later this month from Steve Lew. I also look forward to the opportunity to review the speakers handbook on sexual diversity which is under final review.

Steve
Lew

Ernest

For the Prevention Case Management program, I continue to have concerns about the small number of clients the program is able to maintain on a longer term basis. Notwithstanding the small case load of longer-term clients currently carried by each case manager (a total of 23 clients), it seems that what is in place is a risk reduction program providing referral and a one-time counseling intervention. If this approach is preferred by the clients and the community is not responding to a prevention case management program, then I think we should discuss a formal change in the program. This is something to keep in mind as you continue to employ new strategies to increase recruitment such as placing case managers on-site at the anonymous testing sites. With the majority of the prevention case managers working on a half-time basis, the objective to carry a caseload of 20 clients (on a longer term basis) seems manageable. If this objective is not being met by the end of the third quarter, then I would like to discuss in more depth with you and Ernest Andrews the future direction for the program.

1. I would also like to request at this time, that formal program objectives be drafted and submitted for the prevention case management component (for year two) similar to the objectives submitted by the Latino Risk Reduction effort. It is difficult for me to assess the progress of this program without these objectives in place. These objectives should clearly state the number of clients to be enrolled. A distinction between short-term and long-term clients should be made and definitions for both these terms provided. Also, objectives addressing the outreach for the program, the referral network, staff training, and case management protocol should be included. A corresponding process evaluation plan should be included. In subsequent quarterly reports, each objective should be listed and the progress in meeting that objective described. Demographics and numbers of clients should be recorded in each report. 3 *

3. In a letter dated October 6, 1993, I had requested that a training plan for the two new prevention case managers be developed and submitted with the first quarter report. This was not included. In the same letter I also requested that a plan for ensuring effective referral between street outreach efforts and the prevention case management program be developed and submitted with the first quarter report. This was also not included. Please ask that Mr. Andrews follow up on these requests, including providing final program objectives, by March 15th, 1994.

4. I am glad to hear that Mr. Brown is representing the consortium at the community PCM meetings. I encourage the PCM staff to express their priorities for that group at the regular meetings.

FEB 23 '94 04:27PM EACH PROGRAM 4046391459- 31415403P.7/7

I would also like to congratulate and wish you well in your new position as Executive Director. I am looking forward to working with you in the future. Thank you for your attention in seeing that the requests noted above are responded to by the appropriate program staff. I would like to also thank Jesse and Juan for all their efforts to ensure that a well thought out risk reduction program for Latino gay men is implemented.

Sincerely,



Amy DeGroff
Project Officer
Division of STD/HIV Prevention
National Center for Prevention Services

cc: Tim Quinn
Ron Vanduyne
Criss Crisaman
Allen Piniol

CENTERS FOR DISEASE CONTROL AND
PREVENTION

FACSIMILE TRANSMISSION

ADDRESSEE: Name <i>Allen Piniol/Randy Miller</i> <i>NTFAP</i>	National Center for Prevention Services Program Operations Branch Division of STD/HIV Prevention Corporate Square (Mallstop E27) Atlanta, Georgia 30333 FAX # (404) 639-6623 & (404) 639-6607 PHONE # (404) 639-6315
ADDRESSEE FACSIMILE # ADDRESSEE TELEPHONE NO. <i>415-403-3809</i>	FROM: <i>Amy DeBorja</i> Name <i>CDC</i> Organization Telephone: (404) 639-6315
DATE:	Number of pages: <i>6</i> (Do not count this form) Please Call if Retransmission is Necessary
COMMENTS: <i>Allen - You'll get this letter formally in the mail - it's a follow up to our conversation last week + also in response to ^{the} 1st Qtr. report. Please share the info on the Latino price w/ Jesse so that they can make make appropriate revisions - Ask him to call me if he has any questions. Thanks. Amy</i>	



Design Industries Foundation for AIDS

BOARD OF TRUSTEES

Chair

Michael Sorrentino
Donghia Furniture & Textiles

Chair-Elect

Daniel Baldinger
Baldinger Architectural Lighting

Vice Chairs

Patricia Green
Groundworks/Lee Jofa

Fern Mallis

Council of Fashion Designers of America

Secretary

Dorothy Kalins
Meigher Communications

Treasurer

Simon Trimble
Lehman Brothers

Founders

Patricia Green

Larry Pond

(1950-1992)

Chair Emeritus

George W. Slowik, Jr.
OUT Magazine

Philip R. Beuth

Capital Cities / ABC, Inc.

Michael Dale, ASID

Michael Dale Interiors

Louis Fabrizio

The New York Times

Annie Flanders

Amy Gross

ELLE

John C. Jay

Weiden Kennedy

Ayse Manyas Kenmore

Equivest Partners, Inc.

William Maguire

Interior Space International

John D. Mason

R. M. Flanagan & Associates, Ltd.

Michael S. Perlis

Playboy Enterprises, Inc.

David Sheppard

NCAP / Heart Strings

Rosemary L. Kuropat

Executive Director

CHAPTERS

Boston • Chicago • Dallas
Phoenix • Seattle • Houston
Kansas City • Los Angeles
Minnesota • Cleveland
Northern California
Orange County • Oklahoma City
San Diego • Washington, D.C.
Western Massachusetts

150 West 26th Street, Suite 602
New York, NY 10001-6813
Telephone: 212-727-3100
Facsimile: 212-727-2574

January 31, 1994

Mr. Randy Miller
Program Coordinator
Early Advocacy & Care for HIV (EACH)
944 Market Street, Suite 210
San Francisco, California 94102

Dear Mr. Miller:

It is a pleasure to enclose our check #15822 in the amount of \$5,000 toward DIFFA/Northern California's grant of \$20,000. The balance is \$5,000. The schedule for payments is: 9/30/93 \$5,000 11/30/93 \$5,000 1/31/94 \$5,000 3/31/94 \$5,000.

The terms of this grant require you to inform DIFFA in writing of any changes in the program or agency staff, budget or management. Failure to so inform the Foundation office may result in withheld payments or cancellation of the grants. Please telephone should you have any questions.

Thank you.

Very truly yours,

Thomas G. Dunlap
Director of Grantmaking

Enclosure as Cited
cc: Northern California Grants Chair

Fund Raising for Small Nonprofits

Instructor: Kim Klein

Kim Klein is a nationally known fundraising trainer, consultant, and writer. She is best known for adapting traditional fundraising techniques — particularly major gift campaigns — for successful use by grass-roots organizations.

Klein specializes in training nonprofits who are working for social change and addressing social concerns, and she works primarily with low budget (under \$500,000) organizations. She has conducted training in 45 states and 11 foreign countries.

She is the publisher of *Grass-roots Fundraising Journal*, and *Fundraising for Social Change*, and has contributed to a number of books and periodicals on fund raising.

If you're faced with raising money without an adequate staff or budget, this course is for you. It provides a brief overview of the fund raising process and deals especially with having to do it all yourself.

Whether you're a newcomer or an old hand, you'll benefit from this specially-designed course presented by an instructor with personal experience in meeting the challenges of small organizations. Plus, you'll be able to network with others in small nonprofits who may be facing problems similar to yours.

During two full days of intensive study, you'll learn how to:

- ✓ Write a mission statement and build your case for support
- ✓ Focus on donors and markets best suited to you
- ✓ Choose the right fund raising vehicles for your organization
- ✓ Research and develop large-gift donors
- ✓ Solicit major gifts

NOTE: Fund Raising for Small Nonprofits is recommended for 501(c)(3) organizations with total annual operating budgets no greater than \$300,000. When sending your enrollment form, please enclose a copy of your current year's operating budget. This course is not recommended for people who have already taken Course 101.

LOGISTICS

Date: Wednesday & Thursday,
March 16-17, 1994

Registration begins at 8:00 a.m. on Wednesday. Class will be held from 8:30 a.m. to 5:00 p.m. each day.

Location: Wells Fargo
Conference Center
1560 Van Ness Avenue
San Francisco, CA 94109
415/396-5816

Recommended Accommodations:
Holiday Inn Golden Gateway
1500 Van Ness Avenue
415/441-4000
800/465-4329

TUITION:

\$195

1.4 CEUS

**CLASS SIZE
LIMIT: 45**

The Fund Raising School

INDIANA UNIVERSITY CENTER ON PHILANTHROPY



ENROLLMENT FORM

To register, please fill out the information below and return it with your check or money order for full payment of \$195 or a \$100 deposit. You may also FAX your MasterCard or VISA payment to The Fund Raising School at (317) 684-8900.

Course 105 "Fund Raising for Small Nonprofits" — San Francisco, March 16-17, 1994

Name _____ Nickname _____ Job Title _____

Organization _____

Address _____

City _____ ST _____ Zip _____

Daytime Telephone: (____) _____

Please bill my full tuition to my: ☐ MasterCard ☐ VISA

Amount _____ Card Number _____

Expiration Date _____ Signature _____

FRS0131 7050 94109MLMS631
REGGIE WILLIAMS
EXEC DIRECTOR
NATL TAKS FORCE ON AIDS PREV
631 OFARRELL ST
SAN FRANCISCO CA 94109-7489

Non-Profit Org.
U.S. Postage
PAID
Indianapolis, IN
Permit No. 4245

The Fund Raising School
Indiana University Center on Philanthropy
IUPUI
550 W. North St., Suite 301
Indianapolis, Indiana 46202-3162
(800) 962-6692

**Course 105 -
Fund Raising for
Small Nonprofits**

The Fund Raising School

INDIANA UNIVERSITY CENTER ON PHILANTHROPY



The San Francisco
PLUS
(Positive Living for US)
Seminar

Weekend Schedule

Friday, February 4, 1994

6:00 - 6:30	Friday Registration (Coffee, Tea, Snacks)
6:30 - 7:00	Welcome and Introduction <i>Alfredo Armendáriz, PLUS Coordinator</i>
7:00 - 7:15	"Who Am I" Exercise
7:15 - 8:35	Medical Overview <i>Mark Katz, MD</i>
8:35 - 8:45	Break
8:45 - 9:40	Support Groups
9:40 - 10:00	Nurturing Process <i>Alfredo Armendáriz</i>
10:00	Closing Circle

241-5134

Saturday, February 5, 1994

9:00 - 9:30 Saturday Registration

**** Concurrent Presentation ****

9:30 - 10:15 Empowerment Presentation (Main Room)
Gregg Cassin, The SF Center for Living

(or)

Working the System (Room B)
Ed Miller, Castro Village Pharmacy

10:15 - 11:15 Living with HIV Panel
Alfredo Armendáriz, Moderator
Pat Griffin
Ben Collins
Enrique Massa
Fernando Peraza

11:15 - 11:20 Energizing Exercise

11:20 - 11:30 Break

**** Concurrent Presentation ****

11:30 - 12:20 Insurance Options and Public Benefits (Main Room)
John Yarling, AIDS Benefits Counselors

(or)

Health Care Provider Group Meeting (Room B)
Carl Yoshimoto, MPH, MPA

12:20 - 12:30 Break

12:30 - 1:30 Lunch with your Support Group

**** Concurrent Presentation ****

1:35 - 3:20 Drug Treatment Options for HIV Infection (Main Room)
Mark Katz, MD

(or)

Significant Others Group Meeting (Room B)
Jeff Beane, MFCC

3:20 - 3:40 Break

3:40 - 4:30 Nutrition and HIV
Lynda E. Bell, RD, CNSD

4:30 - 5:40 Coping with Emotions
Jeff Beane, MFCC

5:40 - 6:40 Support Groups

6:45 - 7:15 Sufi Process
Rich Starr

7:15 Saturday Closing Circle

Sunday, February 6, 1994

- 8:45 - 9:15 Sunday Registration
- 8:45 - 9:15 The Doctor's In (Optional)
 Mark Katz, MD
- 9:15 - 10:15 Natural, Alternative, Traditional and Complementary
 (NATC) Therapies Presentation
 Mark Katz, MD
- 10:15 - 11:15 NATC Therapies Panel
 John Brisbane, Brothers Network/ACT-UP
 Bernard Depa, D.C.
 Howard Moffet, ACTCM
- 11:15 - 11:25 Break
- ** Concurrent Presentation ****
- 11:25 - 1:15 Men's Sexuality and HIV (Main Room)
 Buzz Bense, EROS
- (or)
- Women Issues and HIV (Room B)
 Rebecca Denison, WORLD
- 1:15 - 1:25 Break
- 1:25 - 2:25 Lunch with Support Groups
- ** Concurrent Presentation ****
- 2:30 - 3:15 Clinical Trials for HIV (Main Room)
 Nicolé Mandel, Community Consortium
- (or)
- HIV and the Law (Room B)
 Marina Sarmiento, ALRP
- ** Concurrent Presentation ****
- 3:20 - 4:05 Stress Management (Main Room)
 Robert Hopke, MFCC, Operation Concern
- (or)
- HIV and Substance Use/Misuse (Room B)
 Muneer Hassan, AIDS Health Project
- 4:05 - 4:15 Break
- 4:15 - 5:15 Support Groups
- 5:20 - 6:15 Where do we go from Here?/Evaluations
 Jerry Wolfe
- 6:20 - 6:50 Nurturing Process
 Alfredo Armendáriz
- 6:50 Final Closing Circle

February '94 PLUS Seminar

LIST OF CONCURRENT PRESENTATIONS FOR SATURDAY AND SUNDAY

NOTE: Please read the following description of concurrent presentations, then choose ahead of time which one you'd like to attend.

Saturday, February 5, 1994 at 9:30 am

Empowerment Presentation: Gregg Cassin, The SF Center for Living

This presentation will focus on the concept of personal power and one's ability to take action in spite of being HIV+. During this session, Gregg, through his own personal experience, offers to help participants move from feeling powerless to feeling powerful.

Working the System: Ed Miller, Castro Village Pharmacy

Based on his experience with the HIV care bureaucracy, Ed will help participants navigate the HIV health care system and will show the participants how to make the system work for them.

Saturday, February 5, 1994 at 11:30 am

Insurance Options and Public Benefits: John Yarling, AIDS Benefits Counselors

John will provide basic but essential information on obtaining health and life insurance, and how to maximize one's insurance coverage without jeopardizing benefits. He will also provide information on State and Federal government benefit programs available to an HIV+ person.

Health Care Provider Group Meeting: Carl Yoshimoto, MPH, MPA

This special group meeting affords the professional and volunteer caregivers an opportunity to identify and begin to address feelings and issues relating to their care-giving relationships.

Saturday, February 5, 1994 at 1:35 pm

Drug Treatment Options: Mark Katz, MD

This presentation will provide an in-depth introduction to the subject of Western drug treatment options. Antivirals, prophylaxis, immune boosters, nutritional therapies, and vaccines will be among the topics covered by Dr. Katz.

Significant Others Group Meeting: Jeff Beane, MFCC

Jeff leads a special group experience for individuals who provide love and support to HIV+ persons on a non-volunteer, non-professional basis (i.e. lovers, family, friends).

Sunday, February 6, 1994 at 11:25 am

Men's Sexuality and HIV: Buzz Bense, EROS Center for Safer Sex

This presentation will focus on issues around Men's sexuality. Safer sex practices, negotiation techniques, disclosure of one's HIV status, intimacy, HIV and dating, sex and drugs and sexual addiction will be some of the topics covered by Buzz.

Women Issues and HIV: Rebecca Denison, WORLD

Rebecca will lead a presentation focussing on similar issues for women, with the inclusion of specific topics as physical symptoms in women with HIV, pregnancy, child custody and more.

NOTE: Everyone is welcome to each of this presentation regardless of gender. Both presentations will be inclusive of all sexual orientations.

Sunday, February 6, 1994 at 2:30 pm

Clinical Trials for HIV: Nicolé Mandel, Community Consortium

Nicolé will present on the protocols around clinical trials and those trials available to the HIV+ asymptomatic and symptomatic person in the Bay Area.

HIV and the Law: Marina Sarmiento, ESQ, AIDS Legal Referral Panel

Marina will share important information on legal issues around confidentiality, discrimination and advance planning (wills, durable power of attorney, guardianships for children, etc.).

Sunday, February 6, 1994 at 3:20

Stress Management: Robert Hopke, MFCC, Operation Concern

This session will offer very practical methods of handling the stress that often comes when dealing with HIV.

HIV and Substance Use/Misuse: Muner Hassan, AIDS Health Project

Munner will lead a non-judgmental session for those in recovery of questioning their use or possible misuse of substances.

20th Anniversary
NATIONAL
NGLTF
GAY & LESBIAN
TASK FORCE

Policy Institute

*leading the fight
for freedom*

February, 1994

Dear Friend,

The National Gay &
the President's health
bisexual community

Post-it® routing request pad 7664
BRAND

ROUTING - REQUEST

Please

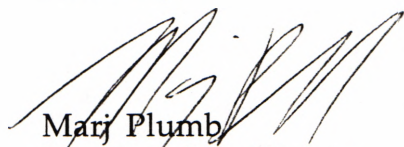
☒ READ	To	RM
☐ HANDLE		AA
☐ APPROVE		AP
and		MF
☒ FORWARD		CM
☐ RETURN		
☐ KEEP OR DISCARD		
☐ REVIEW WITH ME		
Date	2/22/94	From DCS

is of
n and

We have enclosed a copy of the President's health care reform efforts you undertake on health care reform. Please feel free to duplicate the materials for further distribution.

Also enclosed are materials sent to national and local media and an Action Alert for you to copy and distribute in your area. Please feel free to call if we can provide any assistance to your community's efforts on behalf of national health care reform.

Sincerely,


Mary Plumb
Health Policy Director
(202)332-6483 Ext. 3310

20th Anniversary

NATIONAL

NGLTF

GAY & LESBIAN
TASK FORCE

Policy Institute

*leading the fight
for freedom*

February, 1994

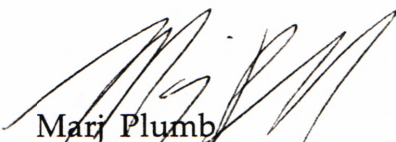
Dear Friend,

The National Gay and Lesbian Task Force has just completed an analysis of the President's health reform proposal and its impact on the gay, lesbian and bisexual communities.

We have enclosed a copy for you to use in any public education efforts you undertake on health care reform. Please feel free to duplicate the materials for further distribution.

Also enclosed are materials sent to national and local media and an Action Alert for you to copy and distribute in your area. Please feel free to call if we can provide any assistance to your community's efforts on behalf of national health care reform.

Sincerely,



Mari Plumb
Health Policy Director
(202)332-6483 Ext. 3310

For Immediate Release

Contact: David M. Smith
(202) 332-6483 ext. 3309
pager (800) 757-7736 or
Robin Kane, (202) 332-6483 ext. 3311

NGLTF CALLS FOR UNIFORM NON-DISCRIMINATION LANGUAGE IN CLINTON HEALTH SECURITY ACT

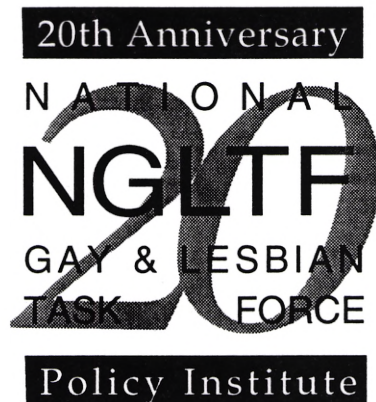
Washington, D.C. -- (November 18, 1993) -- The National Gay and Lesbian Task Force (NGLTF) today released its analysis of the Clinton Health Security Act and how it will affect lesbians, gay men and bisexuals. The report, released at a briefing conducted by NGLTF at the National Press Club, commends the Clinton Administration for its commitment to universal coverage. However, the analysis revealed little protection against bias and suggests uniform non-discrimination language that guards against prejudice in both giving and receiving health care.

The analysis commends the Administration's proposal for including the single payer option for states, the employer mandate to provide health insurance, a standard benefits package and insurance reform. There are, however, several areas of the plan that may leave lesbians, gay men and bisexuals a little less covered than everyone else. There is currently no provision in the plan that would bar discrimination against lesbians, gay men and bisexuals, either as patients or physicians attempting to contract with a health plan, and the family provision excludes lesbians and gay men and their children. Additionally, community health clinics, experts at providing culturally sensitive primary care and HIV services, are not as well protected as they should be.

"We applaud the Administration's efforts to enact universal health reform," said Marj Plumb, Health Policy Director at the National Gay and Lesbian Task Force. "But health care reform must include the enactment of protections against anti-gay bias in the delivery of services. Lesbian, gay, and bisexual people must have access to providers who are sensitive to their health care needs."

The briefing today also marks the beginning of a lobbying effort on Capitol Hill to urge lawmakers to include uniform non-discrimination language that protects people from bias based **on race, ethnicity, gender, age, disability, and sexual orientation**. Groups participating in today's briefing include the American Civil Liberties Union, and the Human Rights Campaign Fund.

- 30 -



HEALTH CARE REFORM ACTION ALERT!

Your action is needed to ensure health reform that reflects the principles of universality, accessibility, equality, diversity and social responsibility. This year Congress is expected to begin deliberations on health care reform. The Lesbian, gay and bisexual communities must weigh in with our voices. We urge you to get informed and get involved.

It is important that you contact your Members of Congress. If you need to find out who your representative is and the location and phone number of the appropriate offices please call the U.S. Capitol Switchboard at (202) 224-3121.

Here are some talking points for your meetings, letters and phone calls:

- ▼ Congress must pass national health reform that covers everyone and offers a broad range of benefits.
- ▼ Public and community health programs must be maintained and enhanced as a part of a reformed health care system. These services are vital safety net providers for our communities.

- more -

- ▼ A single-payer system offers choice of physician, does not discriminate against gay and lesbian families, is financed progressively to ensure access for the poor and low-income, and stops the insurance industry's control of health care in this country. **Indicate your support for the Wellstone/McDermott/Conyers legislation (S. 49/H.R. 1200).**
- ▼ President Clinton's Health Security Act provides access to health insurance, community rating and subsidies. It must be strengthened, however, as it moves through the legislative process. Tell your Senator **and Representative** that Sexual Orientation must be added to the non-discrimination language and the definition of family must include domestic partners and their children. **Indicate your support for the President Clinton's Health Security Act (S. 1757/H.R. 3600).** (For a more detailed analysis of this bill please call NGLTF's Public Information Project at 202-332-6483 x3327).
- ▼ **State in no uncertain terms your opposition to alternative health reform proposals.** The following legislative proposals do not provide universal, comprehensive approaches to health care reform: Cooper/Breaux, Chafee/Thomas, Lott/Michel, Nickles/Stearns, and Gramm/Armey. Except for the Chafee/Thomas bill none of these bills require that all individuals have health coverage. The Chafee bill establishes an individual mandate (kind of like car insurance) but no employer mandate.

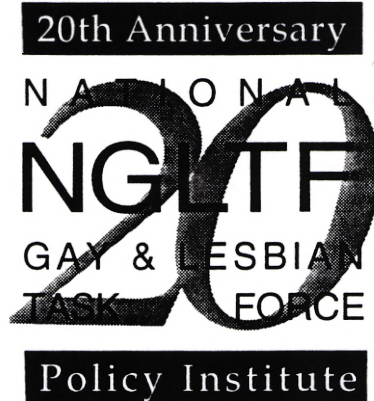
It is important that legislators hear from our community. Many of the bills listed above have a substantial number of co-sponsors and the political negotiations are going to be fierce. Make sure your legislators know what is important to you. Call now!

PLEASE WRITE AND CALL YOUR SENATORS AND REPRESENTATIVES TODAY!

To phone, call the U.S. Capitol Switchboard at (202) 224-3121 and ask for your Senators and Representative. To write, please address your Members of Congress as:

SENATORS
The Honorable _____
U.S. Senate
Washington, DC 20510

REPRESENTATIVE
The Honorable _____
U.S. House of Representatives
Washington, DC 20515



THE CLINTON HEALTH SECURITY ACT:

**How will Lesbians, Gay Men, and
Bisexuals be affected ?**

**AN ANALYSIS BY THE
NATIONAL GAY AND LESBIAN TASK FORCE**

The National Gay and Lesbian Task Force Policy Institute
Health Policy Project
1734 14th St. NW
Washington, D.C. 20009
(202)332-6483, ext. 3310

Peri Jude Radecic, NGLTF Executive Director
Marj Plumb, Health Policy Director

TABLE OF CONTENTS

	<i>Page</i>
Principles Of Universal Health Care	1
Review of the Health Security Act	2
Anti-Discrimination	5
Youth	6
Families	6
Red-Lining	7
Non-Profit Community Clinics	8
Women's Health Care	10
National Health Board	11
Regional Alliance Boards	12
Provider Advisory Boards	12
Religious Clause	13
Home And Community-Based Services	13
Medical Provider Training	14
Medically Underserved Populations	14
Summary Of Suggestions	16
Chart of Family Definition Affect	20

NATIONAL GAY & LESBIAN TASK FORCE

PRINCIPLES OF UNIVERSAL HEALTH CARE

The National Gay and Lesbian Task Force reflects the interests of a broad cross-section of the U.S. population. Because lesbian, gay, bisexual and transgender communities are a part of every town, city, county and state in this nation, our constituents cross every demographic category invented by human beings. We truly are everywhere. NGLTF supports the following principles of health care reform as providing the most effective and fair means to ensure the best health care system for all people.

- **Universality:** Health care must be a basic right for all persons residing in the U.S, including immigrants, prisoners, the homeless, the poor and the under/unemployed.
- **Accessibility:** Health care must be broadened to mean not just the provision of medical care but must include outreach and education that will ensure that all people know how to maintain and improve their health and know how to obtain care.
- **Equality:** Benefits should be standard and broad, offering the same quality of care to all. Poorer people should not experience barriers (such as co-payments) which serve to limit access.
- **Diversity:** People should be able to choose culturally and linguistically appropriate care, non-western and non-traditional methods of treatment and community-based providers including gay-identified and gay-sensitive providers.
- **Social Responsibility:** Health is not just an individual's concern but is also the responsibility of the community and of the government. The government must ensure that health care is delivered fairly to all members of our society.

NGLTF will assess all proposals for health care reform by these principles.

NATIONAL GAY & LESBIAN TASK FORCE

REVIEW OF THE HEALTH SECURITY ACT SB 1757/ HR 3600

The Health Security Act as presented to Congress by President Clinton relies on a system known as Managed Competition. Managed Competition is based on the belief that if consumers have a choice of health plans, the health plans will want to offer the best service for the lowest premiums to attract new consumers and retain current consumers. The Health Security Act is intended to ensure consumers the choice between at least one "lower-cost sharing" plan and one "higher-cost sharing" plan. Consumers have a choice of providers within the plan they choose. All plans will have a monthly premium and annual limits on how much each consumer pays out of his/her own pocket. The "lower-cost sharing" plan will include payments of between \$10 and \$25 per visit and at least 20% of the visit charge if you go to a provider out of your plan. The "higher-cost sharing" plan will include a deductible and payments for service of between 20% - 50% of the service charge.

A new structure called Health Alliances will represent consumers in negotiating for health insurance rates and service. Sparsely populated states such as Montana might have one alliance, while California and New York might have eight or ten.¹ The Health Alliances will tell consumers what plans are available in their area, what the premiums are for each plan, register consumers for the health plan of their choice and collect the monthly premiums. A new National Health Board will oversee the benefits and costs.

NGLTF is encouraged by several elements of the President's proposal for health care reform:

- o Single payer option for states
- o Employer mandate to provide health insurance
- o Standard comprehensive health benefits package
- o Mental health and substance abuse benefits (although limited)

¹ Congressional Quarterly, *Health Care's Hour*, Volume 51, P. 27

- o Global cost containment
- o Consumer involvement and a grievance system
- o Insurance reform to remove pre-existing conditions exclusions, lifetime caps and experience ratings
- o Subsidies for low-income individuals (although limited)
- o Equalizing provider reimbursement for low-income people
- o A uniform and non-contingent phase-in
- o Protections for essential community providers

Since we do not currently have effective methods of ensuring quality medical care throughout the country we are also optimistic about the attempts as developed in the plan to institutionalize consumer protection. The concept of risk-sharing that was the basis for our modern insurance system has been reduced to risk-reduction and service rationing. The President's plans for performance-based quality assurance systems are a good step towards protecting consumers from health plans intent on leveraging profit by reducing quality and access.

The principles of health care reform NGLTF supports - universality, accessibility, equality, diversity and social responsibility - are met to a great extent by this bill. Additional work by Congress must be waged to further protect:

- The poor and lower middle class (especially those persons above income limits for federal subsidies and too poor for any co-payment)
- Rural populations (where health plans and medical providers will still be limited)
- People with serious health problems (needing access to services that are limited or not covered)
- Non-legally recognized families (many lesbian and gay families could be forced into separate health plans)
- Immigrants and prisoners (who are not covered by this bill at all)

- People of color, women, lesbians, gay men and bisexuals (who have had historical access barriers because of racism, sexism and homophobia)

Single-payer and Clinton Proposal offer the best health care reform solutions: Both plans guarantee coverage for citizens and legal residents, both plans guarantee the broadest coverage of specific services, and both plans guarantee greater access to more doctors. It is NGLTF's belief that these are the only two plans currently before congress that even come close to the kind of system reform that our community so desperately needs.

THE HEALTH SECURITY ACT

SB 1757/ HR 3600

SUGGESTIONS FOR IMPROVEMENT

NGLTF offers the following list of suggestions (indicated by a ▼) to improve the Health Security Act .

ANTI-DISCRIMINATION: "While health alliances would be under federal mandates that would bar discrimination, there are no provisions in those mandates including sexual orientation."² The bill specifically states that Health Plans cannot discriminate in the selection of providers of health services based on the "race, national origin, sex, language, age, or disability of the provider"³ but does not include sexual orientation. This is a serious flaw when the discrimination against lesbian, gay and bisexual medical providers is a very real threat. A Survey of San Diego physicians found that 40% would not refer patients to fellow physicians whom they know are gay, lesbian or bisexual.⁴ We believe these attitudes could limit lesbian, gay and bisexual physicians from being accepted into health plans as well.

▼ Anti-discrimination provisions related to providers need to include "sexual orientation" to protect lesbian, gay and bisexual medical providers from discrimination when attempting to join health plans.

Lesbian, gay and bisexual patients have experienced homophobia from medical providers. In the San Diego survey cited above 40% of those surveyed stated they were sometimes or often uncomfortable providing care to Gay or Lesbian patients.⁵ In a survey of third year New York medical students, those surveyed felt that more than one-fourth of their peers and half of their faculty had negative attitudes

² ACLU, Washington Office. *The American Health Security Act and Civil Rights*. p. 4

³ Health Security Act, Section 1402 (c) (2) (A)

⁴ Mathews et al., Physicians' Attitudes Toward Homosexuals. *West J Med* 144:106, 1986

⁵ Mathews et al., Physicians' Attitudes Toward Homosexuals. *West J Med* 144:106, 1986

toward Gay and Lesbian patients.⁶ These surveys reflect the kind of homophobia, and sometimes hostility, that lesbian, gay and bisexual patients confront throughout this country. This bill does not make the healthcare system safer for lesbians, gay men or bisexuals.

▼ Anti-discrimination provisions related to consumers need to include "sexual orientation" to protect lesbian, gay and bisexual patients from discrimination when enrolling in a health plan or seeking services from a medical provider.

YOUTH: NGLTF believes that family coverage, as it is currently written, could limit the ability of youth to access services without parental consent or knowledge; this is a concern specifically for lesbian, gay and bisexual youth seeking STD, HIV, pregnancy-related services, mental health, and substance abuse services. Under this bill's structure, parents would receive information about what health services their children are using because all services used by any family member would need to be recorded and reported for the purpose of determining whether deductibles and the out-of-pocket limit has been met.

▼ Congress needs to ensure full funding of the Public Health Service (Title III) section of this bill that will continue to fund free anonymous services and expand the school based services provision in the bill to include out of school youth.

FAMILIES: Family coverage, as written in the bill, includes only single parents with children or married couples (as determined under applicable State Law) with or without children and therefore does not include gay and lesbian couples or their families.⁷ This definition might limit corporations, universities and state and local governments that wish to extend health insurance to domestic partners (as many already do).⁸ The primary benefit of providing family coverage is to ensure that all members of the family are enrolled in the same health plan.⁹ This is an important benefit and can impact the quality of care members of a family receive.

The current definition of family would also limit the ability of lesbian and gay couples to receive family counseling for mental

⁶ McGrory, Survey of Third Year New York Medical Students. Psychosom 31:426, 1990

⁷ Health Security Act, Section 1011.

⁸ NGLTF, *Domestic Partnership Organizing Manual*, 1992.

⁹ Health Security Act, Section 1323 (e)

health or substance abuse services.¹⁰ And, finally, this provision also discriminates financially against non-traditional families. A married couple with one child would have an annual out-of-pocket expense cap of \$3000 aggregate; a non-married couple with one child would pay \$1500 more for out-of-pocket expenses to a combined \$4500 limit (\$1500 aggregate for an individual plan plus \$3000 aggregate for a single parent family plan).

▼ The bill should allow for a broader definition of family to include the people in our lives who actually participate in our healthcare decisions. At the very least, the bill must allow for other definitions of family including domestic partners that would allow corporations, universities and state and local governments the ability to provide benefits for lesbian and gay employees and their families.

RED-LINING/DEFACTO DISCRIMINATION: The Health Security Act restricts health plans from attracting or limiting enrollees "on the basis of personal characteristics" but does not specifically list race, sexual orientation or gender.¹¹ This is especially important because health plans will be permitted to limit enrollment "because of the plan's capacity to deliver services or to maintain financial stability."¹²

▼ Sexual orientation, gender, race and age language need to be added to every section of the bill where discrimination is discussed.

▼ Strong protections need to be added to forbid geographic red-lining and enrollment limitations that function as discrimination against people with HIV/AIDS, other disabilities and poor people.

The bill outlines a means to "randomly" enroll individuals in health plans that are oversubscribed. This will leave some individuals without coverage or without appropriate coverage.¹³ For instance, if the lower-cost sharing plan is full, low-income individuals could be forced into the higher-cost sharing plan and if the higher-cost sharing plan is full it could leave all individuals with limited choice of medical providers through the lower-cost sharing plan.

¹⁰ Health Security Act, Section 1115 (b) (4)

¹¹ Health Security Act, Section 1402 (a) (1)

¹² Health Security Act, Section 1402 (b) (2)

¹³ Health Security Act, Section 1323 (f) (2) (B)

▼ Assurances need to be added guaranteeing that all individuals seeking to enroll in either a lower-cost sharing plan or a higher-cost sharing plan are able to do so within a reasonable period of time.

Each State will designate geographic areas that will be called "alliance areas." Each of these geographic areas will have its own community rating to determine premium rates. People living in areas with high rates of poverty and/or disease rates (San Francisco, New York, Washington, D.C.) could have higher premium rates and fewer health plans willing to operate in that area.

▼ There must be a cap on premiums or a provision added that ties the rates of premiums to within a certain percentage of bordering alliance areas or alliance areas within a state to avoid some areas being charged much higher premiums.

NON-PROFIT COMMUNITY CLINICS AND SERVICES: Non-profit community clinics have the longest history of providing culturally sensitive services to underserved communities in this country. Their expertise and accessibility is essential to the long-range success of national health reform. There are several areas where the bill's language needs to be strengthened to better reflect a national commitment to these institutions.

In the bill there are two methods for determining whether existing community clinics can be categorized as "essential community providers" for the purpose of participation in health reform. Community clinics funded by one or more of eleven federal funding programs are automatically considered an "essential community provider"; or the Secretary of Health will certify non-federally funded providers if the community clinics are functioning in a designated "health professional shortage area" or serving officially designated "medically underserved persons".¹⁴ Many health providers who serve the lesbian, gay, bisexual or other communities (women's clinics, clinics in projects, mental health and substance abuse providers) are not federally funded and are not in "health professional shortage areas." Lesbians, gay men and bisexuals are also not currently designated as "medically underserved populations."

¹⁴ Health Security Act, Section 1581 (a) (1) and (2)

▼ Lesbian/gay and women's community clinics should be automatically certified as essential community providers; and, broader language needs to be added to allow the Secretary of the Department of Health and Human Services to certify other community clinics who do not fit the first two criteria but are providing essential service to underserved communities.

The first criteria for being automatically considered an essential community provider is being funded by one or more of eleven federal funding programs. Therefore, if a community clinic receives Family Planning Title X funds or Ryan White funding for HIV services, it would automatically be part of the new health system. However, the bill does not specifically state that Essential Community Providers must be contracted with by Health Plans for all the services they provide, not just those for which they receive federal funding. This may lead to Health Plans contracting with Ryan White funded community clinics only for the HIV services they provide. The clinic would not be reimbursed for the primary care it provided to non-HIV+ people.

▼ The bill should specifically state that certified Essential Community Providers must be considered eligible for all the health plan services they provide, not just those that are federally funded.

In the bill, health plans have the option to include essential community providers in their system or simply make payments to those providers for services rendered.¹⁵ Community clinics have been essential providers for underserved communities for over thirty years and should have the ability to decide whether they join health plans operating in their area.

▼ Language needs to be added to the bill to allow each essential community provider the ability to elect participation in health plans.

The bill states that, in the development of participation agreements, health plans must treat essential community providers at least as favorable as other providers participating in the health plan.¹⁶ Because health plans will have a wide latitude in the agreements

¹⁵ Health Security Act, Section 1431 (c) (1)

¹⁶ Health Security Act, Section 1431 (b)

they make with providers this statement does not ensure fair treatment to the essential community providers.

▼ Language needs to be added to the bill to ensure that health plans contract with essential community providers at least as favorably as the best treatment given any other provider in their health plan.

Essential community providers without a participation agreement by a health plan can decide to be paid by a state established fee schedule or under federal Medicare rates. Either of these options may still be 40-60% below the actual costs of service.

▼ Essential community providers must be assured an accurate rate for the essential services they provide. This could include the use of a Federal Reinsurance Fund to compensate essential community providers for the difference between what the health plan pays and what the true cost of service is. Additional funding should be made available to expand and improve community clinics.

The participation of essential community providers in this new health system is only secure for five years; at that time the Secretary of Health must prepare recommendations to the Congress with recommendations concerning whether and to what extent, essential community providers should continue to be included in the health system.¹⁷ This is unacceptable.

▼ Remove the Sunset Requirement that could limit the participation of community clinics in the health plan to five years.

WOMEN'S HEALTH CARE: The bill legislates dangerously restrictive benefits for pap smears and mammograms. Pap smears are provided for females who have reached "childbearing age." Annual pap smears, chlamydia and gonorrhea tests are available for women at risk of "fertility-related infectious illnesses." If a woman is not at risk for a fertility-related infectious illness or has had three consecutive negative smears she can then only get pap smears every three years. Coverage for mammograms does not begin until age 50 and then are only allowed every two years.¹⁸

¹⁷ Health Security Act, Section 1432

¹⁸ Health Security Act, Section 1114

▼ The American Cancer Society recommendations should be used. ACS states that a baseline mammogram be taken at 40 years of age and every two years afterward until the age of 50 when a mammogram should be done annually. The ACS also recommends that pap smears should begin with sexual activity or at least by 18 years of age, occur annually, and *at the discretion of the patient and her medical provider*, less frequently after three consecutive negative smears.

The use of the terms "childbearing age" and "fertility related infectious illnesses" are heterosexist and inaccurate. Pap smears are needed when a woman becomes sexually active, which may be prior to menstruation. "Fertility related infectious illnesses" refers only to sexually transmitted diseases that could cause infertility in women. There are many gynecological conditions and diseases that are serious to a woman's health, yet do not cause infertility, for which annual pap smears are recommended. We question the overemphasis in this section on fertility concerns.

▼ Throughout the section of the bill describing pap smear benefits the language "for females who have reached childbearing age" should be changed to "for females who are sexually active, menstruating or at least by 18 years of age" and "fertility related infectious illnesses" should be changed to "sexually transmitted diseases".

NATIONAL HEALTH BOARD: A new National Health Board would regulate standard benefits packages (as approved by Congress) and their costs. The seven board members would be appointed by the President and confirmed by the Senate. The boards' regulatory powers are not as well established as they should be. The bill grants states unlimited discretion to set quality standards, allowing for tremendous variations in service from state to state and allows each health plan unlimited discretion to establish a list of drugs that they will pay for. This could result in wide variances of care between health plans.

▼ The National Health Board should be given the authority to establish prescription formularies and to regulate - and roll back drug prices.

▼ The National Health Board should be given the authority to set minimum quality and access standards for health plans.

REGIONAL ALLIANCE BOARDS: The bill creates Regional Alliance Boards, possibly over 200 nationwide, which will have a great deal of power and control in the new health care system. The bill states that regional alliances must be governed by a Board of Directors who are appointed, presumably by the state governor. The bill calls for equal representation of employers and consumers on these boards and no conflict of interest (i.e. no health providers)¹⁹ but there is no assurance that the regional alliance boards will be representative of the communities they serve.

- ▼ The Regional Alliances should be mandated to ensure diversity by race, age, gender, sexual orientation, and socioeconomic status.

Health plans have a strong incentive to reduce access to their services to increase their profits. Complicated or lengthy grievance procedures are disincentives for consumers to get the treatments they request but are denied. Differences in treatment protocols between health plans in the same area will be confusing for consumers and will make discrimination harder to determine. In this system, regulation is the only method to ensure fair and equitable treatment for all consumers.

- ▼ The Regional Alliances should handle all disputes and appeals for denied treatment. Disputes that cannot be resolved by a health plan within a limited time period -- perhaps 15 days or so for non-urgent matters - should be handled by the alliance.

- ▼ The Regional Alliances should establish treatment protocols, including policies toward experimental treatments, that all health plans operating in the alliance area be required to operate by.

PROVIDER ADVISORY BOARDS: The bill also establishes Provider Advisory Boards to advise the Regional Alliances on provider concerns and leaves the establishment of such boards to the Regional Alliances.²⁰ There is no language ensuring that these board must include participation from medical providers and community clinics experienced in serving underserved communities.

¹⁹ Health Security Act, Section 1302 (b)

²⁰ Health Security Act, Section 1303

▼ The Provider Advisory Board should be mandated to have designated seats for Essential Community Providers operating within the alliance area.

RELIGIOUS CLAUSE: The bill states that "A health professional or a health facility may not be required to provide an item or service in the comprehensive benefit package if the professional or facility objects to doing so on the basis of a religious belief or moral conviction."²¹ While the purpose of this clause is to allow health professionals the right to not perform abortions, the language is so vague the possibilities for abuses are great.

▼ The National Health Board should be required to review all requests of the use of this clause by health professionals and facility directors to ensure accurate interpretation.

▼ A health facility must be controlled by a religious institution in order to refuse to provide an item or service but only based on religious belief not moral convictions (facilities cannot have moral convictions).

▼ Entire health plans cannot refuse to provide an item or service based on religious belief or moral convictions. This provision should be applicable solely to individual providers and facilities.

▼ Non-discrimination language must be developed to restrict a provider or facility from raising religious objections to providing services to people based on personal characteristics (such as lesbians, gay men and bisexuals).

▼ Clear efforts must be made to ensure that consumers have access to a provider in their plan or area who provide all covered services and that consumers are fully informed about which providers in their area have invoked this section.

HOME AND COMMUNITY-BASED SERVICES: The bill defines a disabled person, for the purposes of benefits, as an individual who "requires hands-on or standby assistance, supervision, or cueing to perform three or more activities of daily living."²² We believe that this is too restrictive and is an example of service rationing to control

²¹ Health Security Act, Section 1162

²² Health Security Act, Section 2103 (a) (1) (A)

costs; it is not based on a principled analysis of service needs. Individuals with diseases such as HIV infection and cancer should not have to fight the bureaucracy for home- and community-based services.

▼ Home- and community-based services should be available for anyone who is unable to perform one or more activities of daily living.

▼ Home and community-based services should be provided to anyone who has received a diagnosis of a terminal illness.

MEDICAL PROVIDER TRAINING: Lesbians, gay men and bisexuals have historically suffered from the homophobic attitudes of medical providers. Both general/family practice physicians and obstetric/gynecology physicians were rated among the highest in negative attitudes towards lesbian/gay clients in a survey of homophobic attitudes reported in the *Western Journal of Medicine*.²³ A survey of third year New York medical students found that they believed "more than one-fourth of their peers and half of their faculty had negative attitudes toward Gay and Lesbian patients and to AIDS patients."²⁴ Other surveys have found that lesbians fear receiving inferior care if they are open about their sexual orientation.²⁵

▼ Medical schools should be encouraged through financial incentives to include human sexuality and diversity training as part of their basic curriculum for medical students. Health plans (such as Health Maintenance Organizations and Preferred Provider Organizations) and the new Health Alliances should be encouraged, again through financial incentives, to train all their staff annually in human sexuality and diversity.

MEDICALLY UNDERSERVED POPULATIONS: Many surveys have reported a higher degree of medical access problems for lesbians and the consequent concern that this may lead to poorer health status for

²³ Mathews et al, Physicians' Attitudes Toward Homosexuals. *West J Med* 144:106, 1986

²⁴ McGrory, *Psychosom* 31:426, 1990

²⁵ Stevens & Hall, *J Nursing Scholarship* 20:5, 1988

this population.²⁶ Lesbians also obtain fewer screening exams and use the medical system less often than heterosexual women.²⁷

▼ Lesbians should be designated a Medically Underserved Population under section 330 of the Public Health Service Act. This will encourage health plans to enroll and serve lesbians.

Special Thanks To: the following organizations whose framing of health reform issues for their constituencies were useful in the development of this document: AIDS Action Council, American Civil Liberties Union Washington Office, Boston Women's Health Care Coalition, Consumers Union, Health Policy Advisory Center, Human Rights Campaign Fund, National Association of Community Health Clinics, National Black Women's Health Foundation, National Center for Lesbian Rights, Universal Health Care Action Network, Whitman-Walker Clinic Lesbian Services

²⁶ NGLTF, Lesbian Health Issues and Recommendations, July 1993

²⁷ O'Hanlan, Katherine A., Lesbian Health Perspective, address to the American Medical Women's Association national meeting, San Francisco, CA, November 16, 1992.

NATIONAL GAY & LESBIAN TASK FORCE

SUMMARY OF SUGGESTIONS TO IMPROVE THE HEALTH SECURITY ACT FOR LESBIANS, GAY MEN AND BISEXUALS

1. Anti-discrimination provisions related to providers need to include "sexual orientation" to protect lesbian, gay and bisexual medical providers from discrimination when attempting to join health plans.
2. Anti-discrimination provisions related to consumers need to include "sexual orientation" to protect lesbian, gay and bisexual patients from discrimination when enrolling in a health plan or seeking services from a medical provider.
3. Congress needs to ensure full funding of the Public Health Service (Title III) section of this bill that will continue to fund free anonymous services and expand the school based services provision in the bill to include out of school youth.
4. The bill should allow for a broader definition of family to include the people in our lives who actually participate in our healthcare decisions. At the very least, the bill must allow for other definitions of family including domestic partners that would allow corporations, universities and state and local governments the ability to provide benefits for lesbian and gay employees and their families.
5. Sexual orientation, gender, race and age language need to be added to every section of the bill where discrimination is discussed.
6. Strong protections need to be added to forbid geographic red-lining and enrollment limitations that function as discrimination against people with HIV/AIDS, other disabilities and poor people.
7. Assurances need to be added guaranteeing that all individuals seeking to enroll in either a lower-cost sharing plan or a higher-

cost sharing plan are able to do so within a reasonable period of time.

8. There must be a cap on premiums or a provision added that ties the rates of premiums to within a certain percentage of bordering alliance areas or alliance areas within a state to avoid some areas being charged much higher premiums.

9. Lesbian/gay and women's community clinics should be automatically certified as essential community providers; and, broader language needs to be added to allow the Secretary of the Department of Health and Human Services to certify other community clinics who do not fit the first two criteria but are providing essential service to underserved communities.

10. The bill should specifically state that certified Essential Community Providers must be considered eligible for all the health plan services they provide, not just those that are federally funded.

11. Language needs to be added to the bill to allow each essential community provider the ability to elect participation in health plans.

12. Language needs to be added to the bill to ensure that health plans contract with essential community providers at least as favorably as the best treatment given any other provider in their health plan.

13. Essential community providers must be assured an accurate rate for the essential services they provide. This could include the use of a Federal Reinsurance Fund to compensate essential community providers for the difference between what the health plan pays and what the true cost of service is. Additional funding should be made available to expand and improve community clinics.

14. Remove the Sunset Requirement that could limit the participation of community clinics in the health plan to five years.

15. The American Cancer Society recommendations should be used. ACS states that a baseline mammogram be taken at 40 years of age and every two years afterward until the age of 50

when a mammogram should be done annually. The ACS also recommends that pap smears should begin with sexual activity or at least by 18 years of age, occur annually, and *at the discretion of the patient and her medical provider*, less frequently after three consecutive negative smears.

16. Throughout the section of the bill describing pap smear benefits the language "for females who have reached childbearing age" should be changed to "for females who are sexually active, menstruating or at least by 18 years of age" and "fertility related infectious illnesses" should be changed to "sexually transmitted diseases".

17. The National Health Board should be given the authority to establish prescription formularies and to regulate - and roll back drug prices.

18. The National Health Board should be given the authority to set minimum quality and access standards for health plans.

19. The Regional Alliances should be mandated to ensure diversity by race, age, gender, sexual orientation, and socioeconomic status.

20. The Regional Alliances should handle all disputes and appeals for denied treatment. Disputes that cannot be resolved by a health plan within a limited time period -- perhaps 15 days or so for non-urgent matters - should be handled by the alliance.

21. The Regional Alliances should establish treatment protocols, including policies toward experimental treatments, that all health plans operating in the alliance area be required to operate by.

22. The Provider Advisory Board should be mandated to have designated seats for Essential Community Providers operating within the alliance area.

23. The National Health Board should be required to review all requests of the use of this clause by health professionals and facility directors to ensure accurate interpretation.

24. A health facility must be controlled by a religious institution in order to refuse to provide an item or service but only based on

religious belief not moral convictions (facilities cannot have moral convictions).

25. Entire health plans cannot refuse to provide an item or service based on religious belief or moral convictions. This provision should be applicable solely to individual providers and facilities.

26. Non-discrimination language must be developed to restrict a provider or facility from raising religious objections to providing services to people based on personal characteristics (such as lesbians, gay men and bisexuals).

27. Clear efforts must be made to ensure that consumers have access to a provider in their plan or area who provide all covered services and that consumers are fully informed about which providers in their area have invoked this section.

28. Home- and community-based services should be available for anyone who is unable to perform one or more activities of daily living.

29. Home- and community-based services should be provided to anyone who has received a diagnosis of a terminal illness.

30. Medical schools should be encouraged through financial incentives to include human sexuality and diversity training as part of their basic curriculum for medical students. Health plans (such as Health Maintenance Organizations and Preferred Provider Organizations) and the new Health Alliances should be encouraged, again through financial incentives, to train all their staff annually in human sexuality and diversity.

31. Lesbians should be designated a Medically Underserved Population under section 330 of the Public Health Service Act. This will encourage health plans to enroll and serve lesbians.

AFFECT OF CURRENT FAMILY DEFINITION	FAMILY MARRIED (1 ADULT & CHILD + 1 ADULT & CHILD)	FAMILY UNMARRIED (1 ADULT & CHILD + 1 ADULT & CHILD)
MONTHLY PREMIUM	1 FAMILY PREMIUM	2 FAMILY PREMIUM
ANNUAL DEDUCTIBLE	\$400	\$800
ANNUAL OUT OF POCKET	\$3000	\$6000
MENTAL HEALTH COLLATERAL SERVICES	YES	NO
SAME HEALTH PLAN & PHYSICIAN	SECURED	NOT SECURED



THE UNITED STATES CONFERENCE OF MAYORS

FUNDING ALERT

Public Health Conference Support Cooperative Agreement Program for Human Immunodeficiency Virus (HIV) Prevention Announcement Number 412

PURPOSE:

The U.S. Centers for Disease Control and Prevention (CDC) has announced the availability of FY1994 funds to provide partial support for non-Federal conferences to stimulate efforts to prevent the transmission of HIV. CDC will collaborate with grantees in the development and approval of those portions of the agenda supported with CDC funds.

FUNDING PRIORITIES:

The following topics have been identified as funding priorities by CDC: community planning for HIV prevention, including the linkages between prevention and care services; prevention of HIV infection among underserved populations, high risk populations in special settings (e.g., racial and ethnic minorities, out-of-school youth, incarcerated persons, men who have sex with men, migrant workers, injecting drug users, and populations, such as gay men of color, affiliated with multiple groups); HIV prevention in women of reproductive age and in children; management and prevention of coexisting medical conditions (e.g., tuberculosis, STDs, hemophilia, and mycobacterial infections) in persons with HIV and their families and partners; prevention of HIV infection in health-care settings; development of HIV prevention strategies with a broad range of community partners including those who have not traditionally been involved with public health programs (e.g., business, religious leaders); and development of HIV prevention strategies including various behavior modification messages related to sexual practices (e.g., abstinence, condom use, etc.).

ELIGIBLE APPLICANTS:

Eligible applicants include nonprofit and for-profit organizations. These include: universities, colleges, research institutions, hospitals, other public and private (e.g., community-based, national, and regional) organizations, State and local governments or their bona fide agents, federally-recognized Indian tribal governments, Indian tribes or Indian tribal organizations, and small, minority-and/or women-owned businesses.

AVAILABILITY OF FUNDS

Approximately \$300,000 is available in FY 1994 to fund approximately 10 to 15 awards. The awards will average \$22,000 and will be funded with a 12-month budget and project period.

TO APPLY:

Applicants must submit a one-page Letter of Intent (LOI) and two copies by the following deadline dates to be considered. Cycle 1 LOI is due January 13, 1994 (Cycle 1 application is due March 14, 1994). Cycle 2 LOI is due April 18, 1994 (Cycle 2 application is due June 20, 1994).

The LOI should include the following: title, location, and purpose of the meeting, its relationship to CDC Funding Priorities, the date of the proposed conference, the intended audience, and the estimated cost of the conference.

Following submission of an LOI, applications may be submitted only after CDC staff have reviewed the LOI and the applicant has received a written invitation to submit an application for funding.

TO OBTAIN ADDITIONAL INFORMATION:

To receive additional written information, call (404) 332-4561. You will be asked to leave your name, address, and phone number, and will need to refer to Announcement Number 412. You will receive a complete program description, information on application procedures, a list of the relevant Healthy People 2000 HIV objectives, and an application package containing the addresses and phone numbers of contact personnel.



NATIONAL TASK FORCE ON AIDS PREVENTION

631 O'Farrell Street • San Francisco • California • 94109
415/749-6700 • FAX 415/749-6706

From: Randy Miller, NTFAP

To: National Program Staff & Local Program Directors

Date: 2-22-94

re: Staff Meeting

I would like to hold a staff meeting with all National Program staff and local Program Directors next Tuesday, March 1, 1994 from 2:00 PM - 4:30 PM. Please note that this is a mandatory meeting. I would greatly appreciate it if everyone could arrange their schedules to be at the meeting on time. If this is not possible, please give me a call. We have a number of important issues to discuss including working with the new ED, the move, the current financial situation, the new job openings, the new travel policies, etc.

The meeting will take place at the NTFAP Offices on O'Farrell.. As you have probably figured out by now, having people show up on time for staff meetings is important to me because I believe that it shows a basic level of respect for the agency and for each other. Please be on time for the staff meeting. Bring your calendars and come ready as always to give your input

CENTERS FOR DISEASE CONTROL AND
PREVENTION

FACSIMILE TRANSMISSION

ADDRESSEE:

Name

Allen Piniol/Randy Miller
NTFAPNational Center for Prevention Services
Program Operations Branch
Division of STD/HIV Prevention
Corporate Square (Mailstop E27)
Atlanta, Georgia 30333FAX # (404) 639-8623 & (404) 639-8607
PHONE # (404) 639-8315

ADDRESSEE

FACSIMILE #

ADDRESSEE TELEPHONE NO.

415-403-3809

FROM:

Name

Amy DeBorja

Organization

CDC

Telephone: (404) 639-8315

DATE:

Number of pages:

6

(Do not count this form)

Please Call if Retransmission is Necessary

COMMENTS: Allen- You'll get this letter formally in the mail - it's a follow up to our conversation last week + also in response to ^{the} 1st Qtr. report. Please share the info on the Latino piece w/ Jesse so that they can ~~say~~ make appropriate revisions - Ask him to call me if he has any questions. Thanks. Amy

February 22, 1994

Randy Miller
Director, Local Programs
National Task Force on AIDS Prevention
844 Market Street
San Francisco, California 94102

Dear Mr. Miller:

Ron Vanduyne and I spoke with Allen Piniol last Thursday, February 17, about the request for carry-over and redirection submitted as a draft for our review and feedback. We were able to clarify some issues and Allen is working on necessary revisions. The program principally affected by the carry-over will be the Latino risk reduction program, Nuestras Voces/Nuestras Vidas. With the revisions in staffing, 3.6 full-time equivalents (FTEs) would potentially be funded directly by CDC under Announcement #202. This would include Jesse Johnson, Latino Program Director at .60 FTE, Juan Rodriguez at 1.0 FTE (Deputy Director), Coordinator of Program Activities, Hector Leon at 1.0 FTE, and Latino Health Educator, Ricardo Bracho at 1.0 FTE.

To evaluate the request for carry over and redirection, it will be necessary to review a summary of each person's role in carrying out the program goals and objectives. For instance, it is my understanding that Ricardo is very involved in developing and planning Colegio ContraSIDA, the educational and cultural classes which promote discussion of HIV related issues and encourage further participation in the educational programs. **Please provide, with the final request for carry over and redirection a summary of each person's roles and responsibilities in carrying out the risk reduction program.**

As we explained to Allen last week, the request to fill the position titled "Outreach Coordinator" would not be granted, primarily because this award did not fund street outreach activities. We would, however, consider funding an additional .45 FTE of Hector Leon's salary as the Coordinator of Program Activities. This would bring him to full-time status (100%) on this project. His responsibilities, however, should NOT include any involvement in developing a new street outreach program which is not supported by this award. As defined in the year two application, he is primarily responsible for the retreats. **Again, it will be important for us to have a better understanding of each person's role in carrying out the activities of the Latino risk reduction program.**

Additionally, we requested that Allen submit an overview of other funding supporting Latino programs and the people/positions funded under each. We did express to Allen our concern about Jesse's involvement at the proposed .60 FTE

In the program development and implementation of this program when he is overseeing the development of many new grants and contracts. Even of greater concern was Juan's role as "Deputy Director," proposed to be funded by this award at 100%. What will their roles be in the development and delivery of this program? How many other programs will Jesse be overseeing? These are areas which require further explanation in the final request.

In regard to the other expenses proposed for carry over funds, we asked for further explanation of the formula used to determine the requested amounts.

I also suggested that Jesse Johnson submit with the request for redirection a final version of the project goals and objectives. In light of the proposed staffing plan at 3.6 FTEs, I would ask that the following changes be made to these objectives and program plan:

Program Objective 1: **Street outreach should be eliminated**; it is not funded under this award. We will, however, fund the cultural events and media work both which will promote participation in the other program components funded under this award.

Program Objective 2: In-Bring Activities: (Colegio ContraSIDA) The objectives should specify 100 **unduplicated** gay Latinos will attend. The objectives should also **specify the length of each of the nine classes**.

Program Objective 3: The Nuestras Vidas Campaign: **A focus group of 7 men should review the completed prototypes for campaign**. If major problems are identified, another focus group should review the campaign after revisions are made and before it is implemented. Also, I am assuming that this campaign will take the form of the posters for which funding is requested in the carry over budget. Is this a correct assumption?

Program Objective 4: Gay Latino Leadership Retreats: **Please provide further information about the number of volunteer facilitators to be recruited to conduct the retreats; how they will be trained (e.g.: an eight hour facilitators training which addresses listening skills, HIV transmission, the retreat curriculum, etc.); how the curriculum for the retreat is developed; and the number of facilitators working at each retreat**. It is also important that during the retreats the importance of these "leaders" modeling healthy sexual behavior for their community is addressed. It is critical that through these retreats you discuss how Latino gay men can redefine healthy cultural norms around safer sex.

Program Objective 5: HIV Primary Prevention Workshop: **A minimum of 250 men should be reached through the 18 workshops**. Specify the length of the workshop; specify the length and content of the training for 14 facilitators; specify how quality will be assured by the project staff; specify whether a curriculum for the workshop will be available for the facilitators. It is important that these workshops address more than education about transmission and safer sex methods. It is important that the

workshops provide an opportunity for participants to discuss barriers to using condoms and methods to overcome those barriers.

Program Objective 6: Establish a community advisory board. (I have no recommendations about this objective.)

We are not funding you to carry out outcome objectives. It is unclear to me how you will measure the outcome objectives stated in the program plan. It may be more beneficial, at this point in the program, for Jesse to develop a sound process evaluation plan.

It also may be more helpful to construct these objectives as a "work plan." For instance, for Program Objective #4:

Gay Latino Retreats: (Nuestras Voces)

Activities:

1. Develop a draft of retreat activities based on results of the formative evaluation study completed by Rafael Diaz.
2. Community Advisory Committee reviews the draft activities.
3. Develop a training curriculum for volunteer facilitators.
4. Recruit 8 volunteer trainers. (I am using 8 only as an example.)
5. Conduct training for volunteer facilitators.
6. Develop evaluation tools for the retreats.
7. Schedule 4 retreats.
8. Solicit participation for the retreats.
9. Hold pilot retreat and revise accordingly for remaining three.

It is helpful to include dates in the workplan so that all staff are clear on the time lines for carrying out the program. The program objectives developed and submitted are a great start to a more detailed work plan.

I would suggest the following process evaluation plan for Jesse to consider. These correspond to the appropriate program objectives.

Process Evaluation Plan:

Objective 2: Colegio ContraSIDA:

1. Demographics and numbers of men attending the classes.
2. Dates and theme of each class. (What was the primary HIV message imparted?)
3. Length (in time) of each class.
4. Successful referrals of participants to other program activities should be tracked.
5. Satisfaction surveys from class participants should be completed to provide facilitator feedback.

Objective 3: Nuestras Vidas Campaign:

1. Demographics and numbers of men participating in think tanks.
2. Summary and date of each think tank.
3. Results of focus group to display prototypes including the number and demographics of participants.
4. End result (campaign).

Objective 4: Retreats:

1. Demographics and numbers of men participating.
2. Demographics and numbers of trainers.
3. Curriculum for trainers.
4. Curriculum for the retreat.
5. Satisfaction surveys from participants.
6. Attrition rates for the two day training.

Objective 5: HIV Prevention Workshop:

1. Demographics and numbers of trainers.
2. Curriculum for training facilitators.
3. Curriculum for the workshop.
4. Quality Assurance Plan for volunteer facilitators.
5. Demographics and numbers of workshop participants.
6. Referral Mechanism.
7. Satisfaction surveys from workshop participants.
8. Satisfaction surveys from facilitator training.

Objective 6: Advisory Board

1. Roles and responsibilities for board defined and written.
2. Minutes from meetings maintained.

These are the sorts of evaluation measures which will be important for Jesse to maintain and submit to CDC with your regular quarterly reports. The summary of your progress in meeting these objectives provided in the first quarter report was very good. The suggestions in the evaluation plan above will also provide a construct for measuring and documenting your quarterly progress.

In regard to the Community-Level Intervention being implemented by GCHP, their progress reported in the first quarter report is also very good. The media conference was well planned and although fewer attended than what they hoped, it was a very commendable first attempt. I support their decision to reconsider expanding their "think tank" efforts to new communities this year. I would encourage them to consider broadening their work with current think tank members, exploring how these individuals can take a larger role in continuing to affect the social norms in their own communities. I will anticipate receiving the revised objectives later this month from Steve Lew. I also look forward to the opportunity to review the speakers handbook on sexual diversity which is under final review.

Steve
Lew

Ernest

For the Prevention Case Management program, I continue to have concerns about the small number of clients the program is able to maintain on a longer term basis. Notwithstanding the small case load of longer-term clients currently carried by each case manager (a total of 23 clients), it seems that what is in place is a risk reduction program providing referral and a one-time counseling intervention. If this approach is preferred by the clients and the community is not responding to a prevention case management program, then I think we should discuss a formal change in the program. This is something to keep in mind as you continue to employ new strategies to increase recruitment such as placing case managers on-site at the anonymous testing sites. With the majority of the prevention case managers working on a half-time basis, the objective to carry a caseload of 20 clients (on a longer term basis) seems manageable. If this objective is not being met by the end of the third quarter, then I would like to discuss in more depth with you and Ernest Andrews the future direction for the program.

1. I would also like to request at this time, that formal program objectives be drafted and submitted for the prevention case management component (for year two) similar to the objectives submitted by the Latino Risk Reduction effort. It is difficult for me to assess the progress of this program without these objectives in place. These objectives should clearly state the number of clients to be enrolled. A distinction between short-term and long-term clients should be made and definitions for both these terms provided. Also, objectives addressing the outreach for the program, the referral network, staff training, and case management protocol should be included. **A corresponding process evaluation plan should be included.** In subsequent quarterly reports, each objective should be listed and the progress in meeting that objective described. Demographics and numbers of clients should be recorded in each report. }
2. }
3. In a letter dated October 6, 1993, I had requested that a training plan for the two new prevention case managers be developed and submitted with the first quarter report. This was not included. In the same letter I also requested that a plan for ensuring effective referral between street outreach efforts and the prevention case management program be developed and submitted with the first quarter report. This was also not included. **Please ask that Mr. Andrews follow up on these requests, including providing final program objectives, by March 15th, 1994.**
4. }

I am glad to hear that Mr. Brown is representing the consortium at the community PCM meetings. I encourage the PCM staff to express their priorities for that group at the regular meetings.

I would also like to congratulate and wish you well in your new position as Executive Director. I am looking forward to working with you in the future. Thank you for your attention in seeing that the requests noted above are responded to by the appropriate program staff. I would like to also thank Jesse and Juan for all their efforts to ensure that a well thought out risk reduction program for Latino gay men is implemented.

Sincerely,



Amy DeGroff
Project Officer
Division of STD/HIV Prevention
National Center for Prevention Services

cc: Tim Quinn
Ron Vanduyne
Criss Crissman
Allen Piniol

EMC2 EVALUATION PLAN

family,
FYI

There are three aspects of the evaluation of EMC2. The first part is a retrospective assessment of the community and the impact of EMC2 on the target population during Program Years 1 and 2, where was the community at and how did EMC2 change the capacity of the community to address issues of HIV. The second aspect is project monitoring for Program Year 3, is EMC2 fulfilling the contractual obligations and objectives established by the program staff and the Office of Minority Health. The third part is case studies, to describe the models, and define cultural appropriateness. A fourth aspect which we are investigating is the feasibility of implementing a cost benefit analysis, what is the cost benefit of the consortium as compared to individual agency and does the consortium model actually help people.

Part One: Retrospective Assessment

The main goal of the assessment is to arrive at baseline services before EMC2 program implementation, as well as a sense of the impact after Program Years 1 and 2. This will be accomplished by in-depth interviews with program staff and clients.

Step One: Identify program staff and clients to be interviewed.

Step Two: Design and pilot and assessment tool.

Step Three: Conduct in-depth interviews.

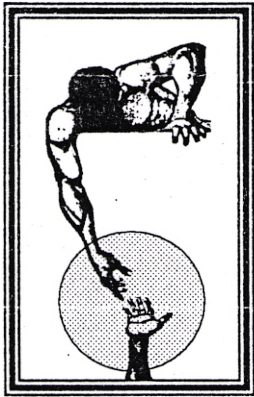
Step Four: Write up results.

Part Two: Project Monitoring

In this section, records of project monitoring will be maintained for each component. A binder will be available for each EMC2 component which contains information on how are dollars being spent and is it doing any good. Projected numbers as compared to actuals, as well as cost per unit of service where available will also be provided.

Part Three: Case Studies

This component will consist of Case Studies of each of the five EMC2 components. The case studies will describe what about the program is culturally appropriate. Quantitative and qualitative research methods will be used to collect data. Minimally the case studies will provide general information about the communities, demographic information about the target populations reached, the program's effectiveness/success and difficulties encountered.



The Brothers Network

625 O' Farrell Street • San Francisco • CA • 94109

Phone: 415-749-6714 • Fax: 415-749-6706

MEMORANDUM

The Brothers Network

Tony Glover
Program Director

Shurland H. Aird
Workshop Coordinator

John Brisbane
Treatment Advocate/Educator

Jonathan William Brown
Prevention Advocate/Educator

Albert Cromedy
Office Manager

Jelousy Jiggerts
Special Programs Assistant
& Volunteer Coordinator

Dwone Jones
Physique Trainer/Nutritionist

Demetres Munford
Risk Reduction Coordinator

Reggie Pulliam
Administrative Assistant

Ama R. Saran
Staff Self-Care Consultant

J.D. Scott-Hoffman
Program Coordinator
Support Services

Rica Madame Turner
Transgender Services
Coordinator

TO: Allen Piniol, NTFAP Operations Manager
cc: Randy Miller, NTFAP Local Programs Director
Albert Cromedy, Office Manager
Shurland H. Aird, Workshop Coordinator

FROM: Tony Glover, Director, Brothers Network

RE: January Deliverables for CDC Prevention Grants

DATE: February 23, 1994

Dear Allen:

Attached is deliverables information to be reported to the AIDS Office regarding the extended CDC Prevention Grant.

Since the Relapse Grant was not extended, there is no activity to report.

Due to the continued leave of Shurland Aird I was not able to get these numbers to you sooner. Shurland should be back on March 1, 1994.

Thanks in advance for reporting these numbers as soon as you are able.

Reggie's Dinner

- Reggie	Paul Kawata
- Valerie	Diana Johnson
- Wolfgang	John Conway
- Didi	Matthew Rutherford
- Vain	Thomas Rutherford

M & M Subcontract - Units of Service Reporting Form
General Funds Contract #83-20322
7/1/93 - 12/30/93 extended through April 1994

Month: January 1994

**Units of Service Breakdown for Black Gay Men,
Bisexual Men or Transgenders:**

Workshop Participants: 51 Black Gay/Bisexual Men (about 50% duplicated)

Special Events Participants: 15 Event Participants at Kwanzaa

Information Table Contacts: 66 Black Gay/Bisexual Men

Bar Zap Contacts: 85

Total Black Gay/Bisexual Men 217

**BESIDES BLACK GAY OR BISEXUAL MALES, THE FOLLOWING CONTACTS WERE ALSO MADE
DURING DECEMBER**

Other Workshop Participants: 109 (about 50% duplicated)

4 Asian/Pacific Islander (4 gay male)
72 African American (66 hetero male, 1 Lesbian, 5 Hetero female)
6 Latino gay/bisexual males)
27 European American/White (16 gay male, 9 hetero male, 2 hetero female)

Other Special Educational Events Participants 9

1 Latino Gay Male,
8 European American/White Gay men

Other Information Table Contacts: 146

18 Asian/Pacific Islanders (14 Gay men, 4 Lesbians)
29 African Americans (13 Heterosexual Male, 14 Lesbian, 1 Hetero Female, 1 Transsexual)
7 Latinos(as) (6 Gay Male, 1 Lesbian)
92 European Americans/Whites (56 Gay Male, 4 Hetero male, 30 Lesbians, 2 Transvestites)

Total "Other" Contacts: 264

Total Black/African-American Contacts= 318 (217 Gay/Bi Men, 79 Hetero Men, 6 Hetero Women, 15 Lesbian, 1 Transsexual)

Total White/Euro American Contacts= 127 (80 Gay/Bi Men, 13 Hetero Men, 2 Hetero Women, 30 Lesbians, 2 Transvestites)

Total Latino(a) Contacts= 14 (13 Gay/Bi Men, 1 Lesbian)

Total Asian/Pacific Islander Contacts= 22 (18 Gay Men, 4 Lesbians)

Total Native American Contacts= 0

Total Contacts (All Races & Sexual Orientations): 481

75
125

14

Randy's

Randy

Glenn

Alan

Don

Patrick

~~Debra Kent~~

Debra Kent

Andy Ilves

+ 4

Ruby Miller

DRAFT

MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding is entered into as of the _____ day of February, 1994 by and between the Proyecto Contra Sida Por Vida (hereinafter referred to as PCPV) and the National Task Force on Aids Prevention (hereinafter referred to as NTFAP).

RECITALS

WHEREAS, the Advisory Board of PCPV recognizes PCPV as a program of the NTFAP and acknowledges NTFAP efforts and commitment to providing HIV Prevention, Education and Support services to Latino gay men and,

WHEREAS, the NTFAP recognizes and supports PCPV and its Advisory Board's wish to become an independent agency,

NOW, THEREFORE, the parties agree as follows:

AGREEMENT

The Community Planning Board of PCPV and PCPV Project Director will:

- 1) Submit a written "Transition Plan" to NTFAP Executive Director and Board no later than _____. Such plan will delineate a process for obtaining a 501C(3) status for PCPV, a Fundraising Plan, a Strategic Plan and plans for Board Development and Fiscal Policies and Procedures.
- 2) Provide 7% to the NTFAP of all monies collected through fundraising efforts.
- 3) Be responsible for program development and planning in accordance with NTFAP policies.
- 4) Have responsibility for hiring of PCPV staff in accordance with NTFAP Personnel Policies and Procedures. Have Responsibility for dismissal of staff in consultation with the NTFAP Executive Director and in accordance with NTFAP policies and procedures.
- 5) Manage program budgets in accordance with NTFAP policies and procedures.

The NTFAP will:

- 1) Open an account for the PCPV project with the understanding that any fundraising conducted by the Community Planning Board Board and program staff is to be used to support the existing project and for efforts in becoming an independent

ROUTING - REQUEST

Please

☒

READ

☐

HANDLE

☐

APPROVE

and

☒

FORWARD

☐

RETURN

☐

KEEP OR DISCARD

☐

REVIEW WITH ME

To

RM

EM

AP

AA

MF

Date _____

From _____