

g) neither administration nor evaluation expenses may exceed 5% of the grant.

Distribution formula:

- o Each state, the District of Columbia and Puerto Rico will receive the greater amount of \$100,000 or the amount appropriated for this Title allocated by a formula incorporating the proportion of total AIDS cases in the state weighted by a relative per capita income factor.
- o The territories of the U.S. will receive an allocation proportional to their caseload over the most recent 2 fiscal years, without a minimum dollar amount.

Requirements:

- o States are required to match (in dollars or in kind contributions) federal funds according to the following schedule if the State has more than 1% of all AIDS cases:
 - 1991--\$5 Federal for every \$1 State
 - 1992--\$4 Federal for every \$1 State
 - 1993--\$3 Federal for every \$1 State
 - 1994 and 1995--\$2 Federal for every \$1 State
- o States must develop a fee for services schedule that limits the imposition of charges in the following manner:
 - no charge for those under 100% of the federal poverty line
 - a cap of 5% of gross income for those under 200% of poverty
 - a cap of 7% of gross income for those under 300% of poverty
 - a cap of 10% of gross income for those over 300% of poverty

Authorization of Appropriations

\$275 million for FY 1991 and FY 1992 and such sums as necessary for FY 1993 through FY 1995.

TITLE III -- AIDS EARLY INTERVENTION SERVICES GRANTS TO STATES AND CLINICS

Purpose:

To develop comprehensive early intervention services for individuals that seek testing and require diagnostics, monitoring and therapeutics provided on an outpatient basis.

Eligible areas:

50 states, the District of Columbia, Puerto Rico, and U.S. territories

Grantees/Administration:

Eligible grantees are divided in two categories:

a) State health departments receive grants administered by the Centers for Disease Control (CDC). The state may provide services through existing sites as well as TB, STD, drug abuse, and other high-incidence clinics. The state may also provide services through high-incidence hospitals that are defined in the bill as those that have 250 or more AIDS admissions each year or a total of 20% of more of all admissions per year.

b) Public and Private nonprofit clinics receive grants administered by HRSA. These clinics include: community health centers, migrant health centers, homeless health clinics, hemophilia centers, family planning clinics, and others providing comprehensive outpatient AIDS services.

Use of funds:

- o The following services are required to be provided by all grantees, although this may be done directly or through financial contract with others:
 - a) pre-test counseling

- b) ELISA, Western blot, and T-Cell diagnostics (and technologies that may succeed these)
- c) post test counseling for sero-positive and sero-negative patients
- d) preventive health services for people testing sero-positive including:
 - outpatient diagnostics
 - outpatient prescription drugs
 - referral for inpatient services
- o States are not permitted to spend more than 5% of the grant on inpatient services.
- o States must provide the following assurances before money can be provided under this Title:
 - informed consent be required for all testing
 - no making receipt of health services conditional upon testing
 - maintenance of confidentiality in accordance with state law
 - provision of substantial opportunity for anonymous and pseudonym testing in accordance with applicable state law

Requirements:

- o The following restrictions apply only to the funds given to the States. Prior to the receipt of funds, a State must assure the Secretary of HHS that:
 - a) it will report statistical and epidemiological data on HIV antibody tests
 - b) the State public health officer has made a determination regarding partner notification and will carry out such program as he/she deems necessary
 - c) that adequate state laws exist to prosecute anyone who knowingly transmits the HIV virus through the donation of blood, semen or organs, through sexual activity or needle use.
 - d) matching payments will be made by the State (in dollars or in kind contributions) in accordance with the following formula for States that have greater than 1% of all AIDS cases.
 - 1991--\$5 Federal for every \$1 State
 - 1992--\$4 Federal for every \$1 State
 - 1993--\$3 Federal for every \$1 State
 - 1994 and 1995--\$2 Federal for every \$1 State
 - e) States may spend no less than 35% of their grant on counseling, testing, diagnosis, and referral; and may spend no less than 35% on treatment.
- o The following requirements apply to all grantees -- the States and the public and private nonprofit clinics:
 - a) grantees must be Medicaid providers unless they accept no fees or reimbursements except voluntary donations
 - b) funds will be used to supplement not supplant existing services
 - c) recipients must develop a fee for services schedule that limits the imposition of charges in the following manner:
 - no charge for those under 100% of the federal poverty line
 - a cap of 5% of gross income for those under 200% of poverty
 - a cap of 7% of gross income for those under 300% of poverty
 - a cap of 10% of gross income for those over 300% of poverty

Distribution:

- o The grants to state health departments will be the greater of \$100,000 (\$50,000 for territories) or an amount allocated by a formula based upon the proportion of all AIDS cases in the U.S. reported in that state. The States are assured no less in FY 1991 than they were awarded in FY 1990 for counseling and testing.
- o The grants to clinics will be allocated by application with a preference to areas with increasing incidence of HIV with equitable distribution among urban and rural areas.
- o Additional grants to States for prison programs--A state health officer may determine that a particular prison has a high incidence of infection and mandate testing, diagnostics and the provision of intervention treatment. Implementation of such a program is contingent upon the appropriation of funds for this program. Such sums as may be necessary were authorized.

Authorization of Appropriation:

A total of \$305 million in FY 1991 and such sums as may be necessary in FY 1992-1995.

Of this, \$230 million is allocated to State health departments through grants from CDC.

\$75 million will go to HRSA for categorical grants to clinics.

**TITLE IV -- PEDIATRIC AIDS RESEARCH DEMONSTRATION PROGRAM AND
GENERAL PROVISIONS, REPORTS AND EVALUATIONS**

PEDIATRIC AIDS RESEARCH DEMONSTRATION PROGRAM

Purpose:

To establish a joint NIH-HRSA demonstration grant program to develop experimental drugs for pediatric AIDS patients and to provide the necessary primary health care that is necessary for participation in such drug trials.

Grantees:

Community health centers and other providers of outpatient care to pregnant women and children. Priority is given to those grantees that demonstrate experience in the design of research protocols.

Requirements:

Grantees are required to provide ancillary health and social services to pediatric AIDS patients and their families.

Authorization of Appropriations

\$20 million for FY 1991 and such sums as necessary thereafter.

STUDY OF AIDS IN RURAL AREAS

HHS acting through the Office of Rural Health Policy is to conduct a study to estimate the incidence and prevalence of AIDS in rural areas and to determine the adequacy of services in such areas.

PROVISIONS RELATING TO BLOOD BANKS

\$1.5 million is authorized for the Department of Human Services to develop and make available information regarding the safety of the blood supply to organizations and industry that are involved in the donation of blood and the production of blood products.

Distribution:

- o The grants to state health departments will be the greater of \$100,000 (\$50,000 for territories) or an amount allocated by a formula based upon the proportion of all AIDS cases in the U.S. reported in that state. The States are assured no less in FY 1991 than they were awarded in FY 1990 for counseling and testing.
- o The grants to clinics will be allocated by application with a preference to areas with increasing incidence of HIV with equitable distribution among urban and rural areas.
- o Additional grants to States for prison programs--A state health officer may determine that a particular prison has a high incidence of infection and mandate testing, diagnostics and the provision of intervention treatment. Implementation of such a program is contingent upon the appropriation of funds for this program. Such sums as may be necessary were authorized.

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IDENTIFIED
NEED/PRIORITY

Gay and Lesbian
People of Color
Report

AIDS Dementia Complex
Study

Exec. Summary DPH
Task Force on
Combined Care
Med/Psych

Substance Abuse & HIV
Spectrum Disease

HIV and Homeless
Youth

SUBSTANCE ABUSE
TREATMENT

*Out-pt. treatment
*Early Intervention
*Detox
*Methadone Maint.
*Aftercare

Drug Abuse Treatment

CASE MANAGEMENT

Case Management for
survival-related
concerns for poor and
homeless LGBPOC

Case Management

Case Management for
dual diagnosis

Extended Case
Management

VOLUNTEER RECRUITMENT

Within LGBPOC
Community

FINANCIAL COUNSELING

PRACTICAL/EMOTIONAL
SUPPORT

Peer Counselor
Intervention Programs

*Peer Outreach &
Counseling
*Self-Help Programs

Support Groups
Psychosocial Support

RESIDENTIAL CARE

Special facility for
moderately to severely
impaired ADC

Acute psychiatric
care with SNF medical

*Clean & Sober
housing units
*Residential
treatment programs

Long-term housing;
24-hour support

HOME HEALTH CARE

As respite

ADULT DAY CARE

Adult day with
respite

SKILLED NURSING CARE

SNF level medical and
Psych. care

SUBACUTE CARE

HOSPICE CARE

FOOD SERVICES

SPECIAL NEEDS

Culturally- and
sexuality-sensitive
services for LGBPOC

AIDS-Dementia Complex
population living
alone or without
assistance or
homeless

*AIDS Patients with
dementia or
pre-existing
psychiatric disorders

*Conservatorship
issue

*IVDU population
*Women-specific
programs
*Dual diagnosis
services
*High-risk youth
*Pregnant addicts
*Multi-cultural
*Homeless

*Adolescent, homeless
IVDU population
*Gay Youth

IDENTIFIED NEED/PRIORITY	AIDS Plan (89-90) Community Mental Health Services	West Bay Hospital Conference Survey 1989	AIDS Office 1988-89
SUBSTANCE ABUSE TREATMENT			Constant Demand
CASE MANAGEMENT	Case Management		Constant Demand Social Service Advocacy
VOLUNTEER RECRUITMENT			
FINANCIAL COUNSELING	Financial Management and benefits advocacy		
PRACTICAL/EMOTIONAL SUPPORT	Individual and Group Counseling	for AIDS Dementia	
RESIDENTIAL CARE	Community Placement for mild dementia. Long-term for dual or triple dx.	Long-term for indigents. Med/psych facilities for dementia	Indep. Living 24-hour care
HOME HEALTH CARE		Home Care	Home Health
ADULT DAY CARE	Day Activities	Adult day	Adult Day
SKILLED NURSING CARE		Medical and Psych-bed needs	SNF
SUBACUTE CARE	Sub-acute, locked for severe dementia		Intermediate Care
HOSPICE CARE		*24-hour (pre-SNF) *More hospice beds	Home Hospice
FOOD SERVICES			Food Service Food Bank
SPECIAL NEEDS	*Linguistically & Culturally relevant services *High-risk youth (Incarcerated, homeless, ethnic minority) *Triple dx. (Mental illness substance abuse, HIV +)	*Out-patient, primary care *Early Intervention *Dementia patients: housing, attendant care *Transportation Needs	AZT

IDENTIFIED NEED/PRIORITY	Mayor's HIV Task Force	CBO Response to Mayor's HIV Task Force	Latino Needs Assessment	AIDS/ARC Housing	Blum Committee
SUBSTANCE ABUSE TREATMENT	Drug Rx, Needle X-change	Needle X-change	Substance Abuse Programs		Substance Abuse Residential Programs
CASE MANAGEMENT		Case Management	Case Management/ Community Casework		
VOLUNTEER RECRUITMENT	Home Health and Support	Practical/Emotional Support	Within Latino Community		
FINANCIAL COUNSELING	Financial Counseling			Money Management	
PRACTICAL/EMOTIONAL SUPPORT	Through Volunteers		For Latino PWA's in residential setting		
RESIDENTIAL CARE	Residential Care	Residential Care for dual diagnosis	Residential Care with Practical Support	Permanent, Temporary, & SRO's	Dependent, independent with 24-hour support & emergency
HOME HEALTH CARE					Home Care
ADULT DAY CARE					Adult day with respite
SKILLED NURSING CARE					SNF
SUBACUTE CARE					Subacute
HOSPICE CARE					Hospice Facility
FOOD SERVICES					
SPECIAL NEEDS	IVDU Population	Adolescents	Bicultural/Bilingual Providers	Homeless	Facility

MAYOR'S HIV HEALTH SERVICE PLANNING COUNCIL

Co-Chairs: Sandra R. Hernandez, M.D.
Pierre Ludington

Staff: Sophia Chang, M.D. *Carol Piccione*

1. Michael Baxter
2. Pat Christen
3. Moher Downing
4. Marcy A. Fraser
5. Yvonne Frazier
6. David M. French, M.D.
7. Estela Garcia. Ph.D.
8. Jaime Geaga, PA-C
9. Lydia Gorrez, Ph.D.
10. Karen F. Hembry, Ph.D.
11. Gerald LeNoir
12. Gifford S. Leoung, M.D.
13. Steve Lew
14. J.B. Molaghan, RN, NP
15. Bob Nelson
16. Veneita L. Porter
17. Eric E. Rofes (Ellen Hartke)
18. Wayne E. Sauseda (Peggy Falknor)
19. Mike Shriver
20. Patricia Underwood, DS.RN.
21. Reggie Williams
22. Mary Jane Wood

* CU to Carol

~~except from~~

Health Service

Title I - emergency relief SF \$5441,912.

- formula grant - set sum Feb 1
 - ~~competitive~~ grant - April 15 5.5 mil
- = 10.8 mil

Title II 90% community + Home based program
- to states

- Federal AIDS Drug Program
JAN - sept base funds
G.F. 2.8 mil

- HIV CARE Consortium

Home + Community Care

8 mil / 10% discretionary funds (HHS)
Sullivan

Title III Early Intervention 173 mil

- prevention - CDC HRSA
- Education
- counselling
- testing
- medical care

Title 4 not funded

November 15, 1990

To: All HIV Planning Council Members

Because of a need to be in Atlanta, I am unable to greet you personally. But I did want to welcome you and address some issues relating to your current challenge.

As you know, planning and executing the CARE money is an extremely important juncture in the history of AIDS and, indeed, the history of this country. The process in front of you addresses the question: Can we as a society work together for the betterment of fellow men and women?

The history of AIDS nationally is a history of failed opportunities, of failed decision making, of people not being able to work together to better the whole. San Francisco has been somewhat different. But not perfect. The world looks to us for examples. Let's give them a good one.

It is within the context of social evolution that your efforts in the coming weeks should be viewed. You are not a body dedicated to represent some constituency. Exactly the opposite. You are a group of broad-ranging experts who must use your personal and professional expertise to make the best decisions FOR THE WHOLE of San Francisco.

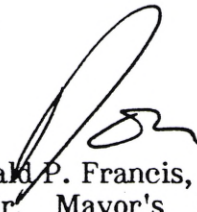
In the process of making those decisions, I urge you not to lose sight of the recipient of the services for whom CARE monies are intended. It is not some special program, some political agenda, some organization that is to benefit from these monies, but the HIV-infected person - specifically the impoverised HIV-infected person.

In making decisions to target CARE monies, you are going to have to move fast, after all this is for disaster relief. But in that process, you will need to keep the long term perspective in mind. Everyone would like to minimize the constraints of government contracting. Ultimately we need to have a system that is driven by the consumer not the RFP process. You will need to plan for a time when HIV-infected persons, in consultation with their care team, makes the decision as to the service provider who is best for them. Through a voucher, charge account or the like, the provider would then be able to bill the city for services provided (Sophia Chang and Pat Franks are good sources of help on this issue).

To make such a system work, the Mayor's HIV Task Force has recommended that all HIV-infected persons have access to a counselor-advisor who, as part of the care and prevention team, assists the the person obtain necessary services and advice. This concept is pushed hard in the CARE bill in the name of case management. This is a very important concept. Not just as a logical way to provide better services DOWN to the HIV-infected person, but, equally important, is the need to have all counselor-advisor-case managers report UP the system all of the unmet needs of each client at regular intervals. Those reports will form the foundation of planning, fund raising and fund allocation for the future.

Finally, during your deliberations, I request you remain conscious of the requirement to spread the costs of HIV across all segments of our society. It would be very easy, and I might say logical, to say that the government will take financial responsibility for the care of all HIV-infected persons. But we do not have such logic in this country. We have made decisions that the private sector pays for those who have private benefits and the government is supposed to pay for those who don't. With this system, the government does not have the money to pay for services that are available through the private sector. If we attempt to do everything for everyone, those in desperate need, the poor, will not get services. Your planning must, therefore, target the poor.

I wish you the best in your endeavors. If I or others on the Task Force can be of any help, please call me at 540-2522.



Donald P. Francis, M.D., D.Sc.
Chair, Mayor's HIV Task Force

CARE

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET

P.O. BOX 942732

SACRAMENTO, CA 94234-7320



(916) 323-3740

Requestor:

Enclosed is the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Title II Grant Application. We have not included copies of the Attachments (A-J) as these were background materials that were requested by the Health Resources and Services Administration. The final page of this document is the HIV Care Consortia Funding Formula. Please note, base allocation amounts are estimates and may change based on new data and number of consortia applications. Further questions should be addressed to:

**Office of AIDS
Ryan White CARE Act of 1990
P.O. Box 942732
Sacramento, CA 94234-7320**

**Att: Lura Franzella
(916) 323-3740**

NOTICE OF PUBLIC HEARINGS
Ryan White CARE Act of 1990, Title II

This is to announce State of California, Office of AIDS statewide public hearings for the implementation of Title II of the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990. The Act authorizes federal funds for health and support services for persons with HIV infection and AIDS. Copies of the plan may be obtained by contacting and specifically asking for the CARE Act Plan:

California AIDS Clearinghouse
P.O. Box 1830
Santa Cruz, CA
(800) 258-9090 (ext. 227)

Hearings will be held at the following locations:

REDDING

April 2, 1991
10:00 a.m. - 1:00 p.m.
Hilltop Inn-Best Western
2300 Hilltop Drive
Redding, CA 96002
(916) 221-6100

BERKELEY

April 3, 1991
10:00 a.m. - 1:00 p.m.
Marina Marriott
200 Marina Boulevard
Berkeley, CA 94710
(415) 548-7920

SAN DIEGO

April 3, 1991
10:00 a.m. - 1:00 p.m.
Ramada Inn-Old Town
2435 Jefferson Street
San Diego, CA 92110-3012
(619) 260-8500

FRESNO

April 3, 1991
10:00 a.m. - 1:00 p.m.
Holiday Inn Center Plaza
2233 Ventura Street
Fresno, CA 93721
(209) 268-1000

SACRAMENTO

April 3, 1991
10:00 a.m. - 1:00 p.m.
Beverly Garland Hotel
1780 Tribute Road
Sacramento, CA 95815
(916) 929-7900

LOS ANGELES

April 3, 1991
10:00 a.m. - 1:00 p.m.
Marriott-LAX
5855 West Century Blvd.
Los Angeles, CA 90045
(213) 641-5700

Written testimony will be accepted at each of the public hearing or can be submitted directly to the Office of AIDS. All written comments must be received by 5:00 p.m. on April 3, 1991.

Please return the bottom portion of this form indicating which location you will be attending. Requests will also be accepted at the registration table on the day of the hearing. Each speaker will be limited to 5 minutes.

Mailing Address: Office of AIDS
Ryan White CARE Act of 1990
P. O. Box 942732
Sacramento, CA 94234-7320

Express Mail: Office of AIDS
Ryan White CARE Act of 1990
830 S Street
Sacramento, CA 95814

Name: _____

Organization: _____

Address: _____

Telephone Number: () _____

Location: _____

**RYAN WHITE COMPREHENSIVE AIDS RESOURCES
EMERGENCY ACT OF 1990**

DEPARTMENT OF HEALTH SERVICES

**Kenneth W. Kizer, M.D., M.P.H.
Director**

**Wayne E. Sauseda, Chief
Office of AIDS**

**Greg Weber, Chief
Policy and Program Development Unit**

**Lura Franzella
Executive Officer
AIDS Leadership Committee**

**Peggy Falknor, R.N., Chief
Pilot Care Project Unit**

**Anna Ramirez, M.P.H., Chief
Preventive Services Section**

**Barbara Thomas
Administrative Support Staff**

THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES WISHES TO THANK THE FOLLOWING INDIVIDUALS WHO HAVE CONTRIBUTED TO THIS PLAN.

HIV COMPREHENSIVE CARE WORKING GROUP, ADVISORS, AND PARTICIPANTS

ABEYTIA, RICK
AIELLO, ANDREA
ALVAREZ, DELIA
AMORY, JEFF*
ANCHORDOGUY, ROSALIE
ARMOGIDA, KATHLEEN
BARFIELD, JOHN
BLAIR, DONALD (MONTI)
CALKINS, CATHERINE
CARON, MICHAEL
CARPENTER, PETER
CASTILLON, FRANCISCO
COWEN, GENI*
COX, J. WILLIAM, M.D.
DAW, JOHN
DEBOW, MAGGIE
DEMARTINI, ROD
DUNN-MORTIMER, JOHN*
ELDRED, STEVE
FERMAZIN, MARY, M.D.
FINKELSTINE, RUTH
FRANCIS, DONALD, M.D.
FRANGENBERG, ROBERT
FRANKS, PAT*
GELLERT, GEORGE, M.D.
GILBERT, BRAD, M.D.*
GOLDBERG, DEBORAH
GUTIERREZ, MARIO
HARRIS, ALAN
HERNANDEZ, SANDRA, M.D.
HINTON, BETTE M.D.
JOHNSON, ALAN
JOHNSON, CAROL
KROETCH, LORRAINE
LIDOT, TOM
LOBDELL, GEORGE
MAISONET, GERMAN, M.D.
MALDANADO, YVONNE, M.D.
MCBRIDE, LAURIE*
MESHAR, HELYNE*
MOORE, BRANDY
NANCE, DAROL
NGUYEN, BANG
NODORA, JESSE
RODRIGUEZ, SUZI
ROMANO, MARGRET
SANDOVAL, CHRIS*
SAUSEDA, WAYNE*
SELF, NANCY
SHAW, RUGMINI
SWARTZ, MARJORIE*
TAPLIN, GERALDINE, M.D.
TORRES, ARNOLD
VILLARREAL, SYLVIA, M.D.
WARREN, NANCY
WEISMULLER, PENNY
WILSON, GEORGE, M.D.
WILSON, PHILL
YARANON, DOUGLAS

*CARE Planning Task Force Member

PROJECT NARRATIVE

A. CURRENT HIV SERVICES

The California Department of Health Services (CDHS), Office of AIDS (OA) is the lead State agency responsible for a wide range of programs related to the Human Immunodeficiency Virus (HIV) in California. The OA has been designated as the lead agency for Title II of the Comprehensive AIDS Resources Emergency (CARE) Act. In an attempt to prevent new HIV transmission and to provide for the needs of Californians already infected with HIV, a number of statewide and local initiatives have been implemented, including:

- Education and prevention programs
- Anonymous and confidential HIV antibody counseling and testing
- HIV counselor training and certification
- AIDS Drug Program (zidovudine and aerosolized pentamidine)
- Nurse managed home/community-based pilot care programs
- Residential AIDS shelters for homeless persons with AIDS
- Epidemiologic research, monitoring and evaluation
- HIV vaccine research and development
- HIV vaccine clinical trials support

There are several attachments which describe the programs and services that the OA administers as well as the overall budget for all AIDS related expenditures in California. Attachment "A" entitled "Office of AIDS Program Elements" is a detailed description of all of the programs within the OA. Attachment "B" entitled "State of California AIDS Funding Program Detail" displays all funding allocations for AIDS programs for a period of four years. Actual expenditures are shown for Fiscal Years (FY) 1988-89 and 1989-90. Current year budget allocations are displayed in the column labeled "1990-91" and represent the spending plans for AIDS programs through June 30, 1991. The figures shown for FY 1991-92 represent the anticipated spending levels proposed in the 1991 Governor's Budget released on January 10, 1991. Until the State Budget Act is approved by the Legislature and signed by the Governor, the FY 1991-92 numbers represent the Administration's plan and may not necessarily be the actual amounts budgeted on July 1, 1991. The State fiscal year runs from July 1 of one year through June 30 of the next year. Attachment "C" is a comparison of current OA programs that correspond to the four Title II service categories. This document shows that the Governor's Budget proposes over \$13 million in State categorical funding for programs which are consistent with those designated in Title II of the CARE Act.

B. PLANNING PROCESS

Listed below are three plans which have been developed over the years to address many issues surrounding the HIV/AIDS epidemic. Portions of each plan contain HIV care related recommendations which impact Title II services and funding. Staff has reviewed and taken these recommendations into consideration in the development of the Title II - Comprehensive CARE Act Plan.

California's Continuing Response to HIV Disease: A Strategic Plan. This plan is the product of the California AIDS Leadership Committee and many individuals working with the Committee between the summer of 1988 and spring of 1989. The plan focuses primarily on the next three years and is designed principally as a long range policy plan, providing 12 major strategic recommendations and numerous more specific programmatic recommendations. Importantly, the plan is intended to provide policy guidance for all HIV programs in California, not just those programs operated by the State.

AIDS Prevention and Treatment: A Framework for Local Planning. This document was prepared in June 1988 to assist local health jurisdictions in planning AIDS prevention and treatment programs. It outlines a five-point approach to the AIDS epidemic entailing the following components: 1) epidemiologic surveillance; 2) preventive education; 3) provision of medical treatment and supportive services; 4) research; and 5) continuous planning, evaluation, and coordination of programs.

Acquired Immune Deficiency Syndrome in California: A Prescription for Meeting the Needs of 1990. This comprehensive plan was developed in FY 1985-86 to address the information and education, testing, mental health, research, and treatment needs relating to AIDS and to address the identified needs in the FY 1986-87 budget.

These planning documents have identified the importance of collaborative and participatory community planning in the development of programs, especially for those which require implementation by local health departments, community-based organizations, ethnic minority organizations, mental health providers, hospitals, and other human service agencies.

Epidemiology of AIDS in California

California ranks second in the nation for total number of cumulative AIDS Cases. As of December 31, 1990, 31,644 cumulative cases of AIDS had been diagnosed and reported in California, or about 20% of all cases reported in the United States. Sixty six percent of these cases are known to have died as compared to 62.5% of cases nationwide.

The reported mode of transmission among diagnosed AIDS cases in California is predominately by men

having sex with men. When homosexual-bisexual men who use injection drugs (9%) are included, over 88% of all reported cases involve men having sex with men. Outside California, only about 60.1% of cases involve sex between men with even smaller percentages reported for this mode in recent years. On the other hand, California reports only 5% of its cases as heterosexual injection drug users while the rest of the country reports that 26% of their cases are due to this mode of transmission. California also reports 1% of its cases are hemophiliacs and another 2% transfusion related cases, primarily due to tainted blood transfusions received early in the epidemic. Also 2% of the cases are due to heterosexual transmission and the another 2% have no identified risk and are still being investigated for a mode of transmission.

The racial/ethnic makeup of California's AIDS caseload is also different from the rest of the United States. Whites constitute 72.7% of California's cumulative cases followed by Hispanics with 13.1% and Blacks with 12.1% of reported cases. Asians make up about 1.5% and others about 0.5%. In other states, whites make up 50.5%, blacks 32.2%, Hispanics 16.5%, Asians 0.4% and others, including Native Americans, about 0.4%, of reported cases.

Women account for 4.5% of AIDS cases, while children under the age of 18 represent less than 1% of the cases. Attachment "D" is a statistical summary of AIDS cases in California through 12/31/90.

California's Planning Process

California convened an HIV Care Working Group of 41 people empowered to plan for the organization and delivery of HIV-related health and support services to be funded under Title II of the CARE Act. The key issues included funding allocations and priority setting for services to be funded. The members of the working group represented a diverse and balanced cross-section of California's population, cultures, providers, and affected communities. Specifically, the group represented the perspectives of persons with HIV disease, community-based organizations, local health jurisdictions, State government, county government, Title I cities, advocacy groups, ethnic groups, women, and at-risk populations.

The HIV Care Working Group was formed by a smaller planning committee consisting of community members and State government which developed and made recommendations to the State as to the agendas and issues to be discussed by the working group. The OA made final selections of individuals to serve on the working group from recommended composition and representation criteria of the planning committee. The planning committee also recommended a facilitator to manage the working group meetings. The planning committee met 8 times for approximately 3 hours each session to plan and organize the working group meetings. Attachment "E" is the list of participants in the planning committee, working group, and technical advisors. The proportional representation of the working group is shown in Attachment "F" and the graph marked Attachment "G". The OA was represented on the working group by the Division Chief. Other OA staff functioned both as resource persons and support persons to the group. In addition, several advisors were available to the working group to provide technical assistance and guidance. Attachment "H" includes the agendas for each of the working group meetings.

The working group met three times over a total of four days. The meetings were held in the geographic regions of San Diego, San Francisco and Los Angeles. An opportunity was provided at each of these meetings for public input and comment to the working group. The meetings were facilitated by Pat Franks, a health policy analyst from the Institute for Health Policy Studies, University of California, San Francisco. Ms. Franks is an experienced planner in relation to community-based models of care. The group processes and techniques used to develop the plan included brainstorming on issues related to the implementation of the CARE Act in California, problem identification, consensus building, and problem solving. Small group discussions were held on the key implementation issues related to Title II. The small groups presented their recommendations to the working group as a whole for final resolution. The working group as a whole tried to reach consensus on as many issues as possible. Majority rule was used where consensus could not be reached. It identified unresolved issues which required further discussion or decisions. The State reserved the right to make final decisions where none could be reached by the group.

As mentioned earlier, the public had an opportunity at each meeting to provide input and comment. In April, the State intends to have 6 public hearings at various sites throughout California to receive final comments both in writing and orally. Attachment "I" is the proposed announcement and schedule for public hearings. The month of March will be used to publicize the public hearings and receive written comments on the comprehensive care plan. The hearings will be advertised in the general circulation newspaper of the city where the hearings occur. Also in March, written comment will be accepted from those who cannot appear at one of the public hearings. The deadline for receipt of written comments submitted by mail is April 3, 1991. However, written testimony will be accepted at each of the public hearings.

The comprehensive HIV Care Plan which follows is the result of the working group's efforts with consideration of informal public input received at the meetings. The State reserves the right to revise the HIV Care Plan submitted herein after formal public comment has been received and reviewed in April.

In addition to the working group and planning committee, which included Title I city representatives, the State has consulted with and been a member of the HIV Health Services Planning Councils in Title I cities. Two staff members have been assigned as liaisons to each of the three Title I HIV Health Services Planning Councils in California. The State has also received a number of unsolicited comments and ideas from various agencies and organizations regarding the formulation of an HIV Care Plan. Organizations which have developed community care plans using HRSA planning grants have provided the State with copies of their documents.

C. TITLE II - COMPREHENSIVE HIV CARE PLAN

California will use its Title II allocation to provide a comprehensive integrated continuum of care for individuals and families affected by HIV disease through a locally determined system of case management and service delivery. The State HIV Care Plan will provide a framework for the planning, organization, and delivery of HIV related care services according to locally determined needs and priorities. This framework will consist of requirements for HIV Care Consortia, service delivery, reporting, and evaluation. The first year of the plan concentrates on funding HIV Care Consortia, while maintaining the existing AIDS Drug Program, and the Home and Community-based Care Program. Statewide planning will occur during this year for the second year of operations. Determinations will be made regarding the efficacy of including various Title II service components in the consortia concept. Feedback and comments will be solicited from the working group as to the progress of the comprehensive plan and its impact on the delivery of services at the local level. A pilot program of insurance continuation will be initiated to determine the viability and cost-effectiveness of such a program. State administrative and planning funds will be used to survey and assess statewide HIV care services and to assist in providing better statewide and local coordination of services. The State will provide technical assistance to consortia and will strive to improve its collection of HIV incidence and prevalence data for underserved and under reported communities and populations such as women and persons of color. The intent of this plan is to use a portion of Title II funds to maximize the delivery of services to individuals by efficiently using all sources of funding at the State, local, and federal level, and to provide for unmet community needs.

Title II service components will be funded according to the following table for the first year of program implementation:

<u>Program Component</u>	<u>Other \$</u>	<u>Title II \$</u>
50% to HIV Care Consortia		\$6,476,877
10% to State for Administration, Planning and Evaluation		1,295,375
Continue AIDS Drug Program	4,100,000*	5,181,501
*Current State Funded Allocations		
Continue Home and Community-based Care	2,639,980**	-0-
**Existing federal funds through 06/30/92)		
Pilot Insurance Continuation Program		-0-
Included as an option under AIDS Drug Program		
Total Amount Requested		12,953,753

Minimum 15% for Women, Infants, Children, and Families

While the number and rate of new AIDS cases reported in women and children is increasing in California, the total number of reported cases in women and children are, 1123 and 273, respectively. These two categories combined represent approximately 4.4% of the 31,644 cumulative AIDS cases in California. In order to expend 15% of the Title II funds for women, infants, children, and families, consortia and other Title II programs will have to target services to these groups heavily. Assuming that the California AIDS Drug Program serves all individuals in need of AZT and pentamidine in the same proportion as those represented by AIDS Case data, then the number of women and children served by these funds is about 4.4% of the annual \$12,000,000 expended in California, or \$528,000. If we attribute this \$528,000 to the federal Title II drug allocation of \$5,181,501 then the percent expended for Women and Children represents a little over 10% of the Title II AIDS Drug Program. This means that HIV Care Consortia and other programs will have to expend greater than 15% in order to meet the overall expenditure requirement. Local HIV Care Consortia will have to expend approximately \$1,220,000 for women and children in order for California to meet the 15% minimum requirements. This represents over 19% of the HIV Care Consortia allocation of \$6.4 million. HIV Care Consortia will have to sign assurances that they will expend over 19% of their funds for women, infants, children and families. They will also need to assure that adequate documentation is maintained on the amounts expended and services provided by sex and age.

The formula described below under HIV Care Consortia contains factors which balance the allocations to local consortia between both large urban, high incidence areas and small, rural communities. The State has consulted with Title I cities to assure the continuation of HRSA Demonstration Grants either through Title I supplemental applications or through Title II formulas. The formula should permit non-Title I areas to continue HRSA Adult Demonstration Projects through March 30, 1992 through their HIV Care Consortia allocations.

1. Establishment of HIV Care Consortia

Of the Title II allocation to California, \$6,476,877 (50%) will be committed to local HIV Care Consortia.

California defines an HIV Care Consortia to be an association or partnership of public and private non-profit HIV health and support service providers, persons with HIV, and affected communities in a given geographic area. In order to receive funds from the State the consortia must be legally incorporated or designate one of its constituent agencies, which is incorporated, to act as its fiscal agent. Since it is more expeditious for the State to contract with other governmental agencies, local health departments are encouraged but not required to act as the fiscal agent. Except in very unusual circumstances there will only be one consortia funded in any one geographic area. A geographic area may be a city, county, part of a city or county, or a combination of counties. The exact service area will be determined by the consortia. The primary purpose of Title II funding for HIV Care Consortia is to deliver comprehensive outpatient health

and support services to individuals and families with HIV disease. The HIV Care Consortium may provide services directly or through contractual arrangements with other entities. The consortia may use a minimal portion of these funds for planning, development of services, coordination and administration of the consortia.

California envisions HIV Care Consortia funded under Title II to be guided by the assessments, planning and priorities developed by an inclusive, broadly based community planning process. The membership of the HIV Care Consortia will be self appointed by the affected communities and service providers. The State will only accept applications from consortia which are properly constituted and contain the requisite participation of the local health department and representatives from the interests and perspectives listed below. In effect, the formation of a consortium and the application for funding requires concurrence of all members of the HIV Care Consortia, including the local health department, but is not dependent solely upon the initiative of local governmental officials.

The interests and perspectives which are required or recommended to be represented in an HIV Care Consortia are listed below. The list is broader and more detailed than the Title I HIV Health Services Planning Council; however, it is consistent with the legislative intent of the CARE Act. An individual member may represent more than one interest or perspective for the purposes of Title II implementation in California. The general intent of this provision is to promote participatory community planning without requiring a group of unmanageable size. The State may waive specific representation required of a consortium if the consortium can demonstrate that it either: (a) made a good-faith effort to solicit and obtain the required representatives from the community but was unsuccessful; or (b) has unique local conditions or circumstances that prevent such inclusive representation. The consortium must request the waiver from the State in writing and include sufficient justification to allow the Chief of the Office of AIDS to make a determination as to the granting of such a waiver. A waiver will be granted if the justification demonstrates the following: 1) a good-faith effort was made; 2) reasonable attempts were made to notify and recruit required representatives; and, 3) consortia membership reflects local demographic and seroprevalence data.

Required Membership:

1. individuals with HIV and their advocates
2. non-profit community-based organizations
3. local health departments
4. mental health provider
5. social service provider
6. health care provider
7. substance abuse provider
8. affected communities: may be representatives or advocates
 - disabled - physically, visually or hearing impaired, mentally ill or retarded
 - gays and lesbians
 - homeless

hemophiliacs
incarcerated (representatives)
women
pediatric services: includes adolescents
gay men of color
substance abusers
ethnic groups including
 Latino, African Americans, Asians, Pacific Islanders, Native Americans, and others
advocates for new immigrants and undocumented persons

9. Others

agencies receiving HIV testing and early intervention funds
community health care clinics
non-elected community leaders
cities or other jurisdictions or special districts providing HIV services

Recommended Membership:

1. Hospitals
2. For-Profit Health Care Providers
3. Volunteer Groups
4. AFDC and WIC representatives

Jurisdictions which operate under subventions are encouraged to use existing advisory bodies.

The specific responsibilities of each HIV Care Consortia funded under Title II include: (a) conducting or updating an assessment of service needs in the area to be served, (b) establishing a service delivery plan and establishing priorities for the allocation of Title II funds, (c) coordinating and integrating the delivery of services, contracting with other providers when necessary, and (d) evaluating the success and cost-effectiveness of the response to identified needs. Consortia must develop a grievance process to resolve conflicts over membership and operation of the consortia.

Populations to be served by consortia

The specific geographic area to be planned for and served by a consortium will be determined by the consortium itself. Due to the diverse geographic and demographic characteristics of California, the working group felt that consortia should be allowed flexibility in determining the service area. The State expects that the service area will, in most cases, correspond to the geographic boundaries of a single public health jurisdiction: in California, 58 public health jurisdictions are coterminous with county boundaries and 3 with city boundaries. In some instances, however, public health authorities, community-based providers, and affected communities in contiguous jurisdictions may agree to aggregate their HIV service resources under a multi-jurisdiction consortium. In other instances, a case may be made for a large county with

geographically distant loci of persons with HIV to establish a separate consortium (i.e., a separate planning process and service delivery network) for each geographic subdivision. In these last instances, however, all HIV Care Consortia funded under Title II in a single county will be expected to coalesce as a joint planning body at least for the purpose of establishing how much of the aggregate Title II funding assigned to the public health jurisdiction will be subdivided among the geographic centers. In all instances where the consortium's service area does not coincide with the boundaries of a single or multiple public health jurisdiction, the consortium's application must provide a persuasive rationale for such a boundary or region.

The scope of services planned for by each consortium will address the needs of persons with HIV disease regardless of where they fall in the spectrum of HIV disease. Although no maximum income eligibility standard is recommended for a consortium *per se*, individual providers operating under its umbrella may make a case for such a standard for certain services. In general, low-income, uninsured and/or underinsured persons with HIV disease should be targeted by services funded under Title II, with a special emphasis on previously neglected or unrepresented populations. All consortia providers must be willing and able to accept referrals for previously incarcerated individuals. The State also acknowledges the legislation's requirement that consortium-affiliated providers charge fees on a sliding scale in situations where fees are charged for other HIV-related services.

Consortia will be required to provide services to low income and minority populations inclusive of specific ethnic, racial, gay, lesbian, and transsexual groups identified as requiring services in the needs assessment prepared by the Consortia.

Services to be provided by consortia

The HIV Care Working Group reached consensus on expanding and modifying the list of essential services as described in the CARE Act. It believes the list should be as inclusive as possible to cover the continuum of care required by HIV positive individuals. Only three of the services were determined to be mandatory for HIV Care Consortia: (1) case management; (2) benefits counseling, assistance and management; and (3) reporting of unmet client needs. Case management means each client has one and only one person (a case manager) who serves as that person's contact, advisor, advocate and service organizer to assist the HIV client through the entire continuum of care system. The case manager must at a minimum provide the client with: (1) a comprehensive health and support service plan; (2) benefits counseling and (3) assistance and advocacy in finding needed services. These mandatory services must be provided by the HIV Care Consortia but do not necessarily have to be funded directly by Title II funds. These three services were determined to be essential for the care of individuals and families as well as to maximize and efficiently utilize all resources available. The theme for the provision of services by HIV Care Consortia is to allow as much flexibility as possible for local determination of service needs and priorities to be met by these funds. Health care and support services provided by the HIV Care Consortia should reflect the specific needs of HIV

affected individuals and subpopulations in a given geographic area. Services to be provided by HIV Care Consortia are comprehensive outpatient and support services which may include, but are not limited to, the following:

Health Care Services include: case management services; medical, nursing, and dental care; diagnostic services; medical, psychological, and social needs monitoring; medical follow-up services; mental health services (including psychological and social counseling); developmental and rehabilitation services; home health services; hospice care; obstetrical and gynecological care; pediatric care; drug therapies; substance abuse treatment; and, health insurance premium continuation.

Support Services include: benefits counseling, assistance and management; transportation services; attendant care; homemaker services; day or respite care; advocacy services; nutritional counseling and food subsidies; housing and shelter support; child welfare and family services (including foster care, adoption services, and family and partner counseling); provision of information and counseling on living with HIV; reporting of unmet needs; development of volunteer services; and translation services for visual and hearing impaired, and non-English speaking populations.

The services listed allow for all components of Title II to be provided through an HIV Care Consortia if desired, including Home and Community-based Care, Drug Therapies, or Health Insurance Premium Continuation. This allows flexibility and continuity of service delivery if funding through other mechanisms is inadequate or less efficient than through HIV Care Consortia. It is recommended that HIV Care Consortia perform a needs assessment to determine service gaps and unmet needs in the community, if such an assessment has not already been conducted. From this assessment, a plan for service delivery and priorities for services to be funded should be developed. The plan should include a mechanism for documenting services delivered and unmet needs identified at the service delivery site. This mechanism should allow for the data to be reported to the HIV Care Consortia and the State.

Criteria for funding consortia

HIV Care Consortia seeking funding under Title II will be required to submit applications to the State. The evaluation of each application will focus on the extent to which it reflects; (a) membership that meets the guidelines mentioned above, (b) planning which is consistent with the requirements for an inclusive, community-based and comprehensive process, (c) realistic expectations of the service delivery system planned by the consortium and supported by Title II funding, (d) a mechanism for evaluating the success and cost-effectiveness of consortium services, and (e) signing of required assurances. Assurances that Title II funds will not be used to supplant local government funding for similar services will be required in addition to assurances specifically required by the CARE Act.

The amount of Title II funding awarded to each eligible consortium will be determined by a formula which weighs various relative needs indicators. The relative need will be measured by specific AIDS incidence and

prevalence factors, socio-economic factors, and demographic factors. The working group reached a majority opinion that the formula should be used and that it should be based on the following factors by county using the indicated percentage weights: 25% on recent AIDS cases, 10% on recent AIDS incidence, 10% on population below poverty, 20% on non-white population, 20% on percent of county population in rural areas, 5% on combined STD and TB rates, 5% on maternal HIV+ results from neonatal surveillance data and 5% on medically underserved or health manpower shortage areas. The overall goal of using a formula is to expedite the contracting process by eliminating a competitive bidding process and to provide an equitable distribution of funds based on relative need.

Having agreed in principle to funding "by formula" all HIV Care Consortia which qualify for Title II funding in California, some of the working group members acknowledged the formula should not disrupt current services and that there may be a need for the following caveats if the formula does not adequately provide for the following:

- (1) Areas in which an HIV Care Consortium may not have been fully developed may be awarded a planning and capacity building grant entitled a "Consortium Development Grant" from the funds earmarked for Title II HIV Care Consortia. Such grants may be for a maximum of one year with the expectation that a fully qualified consortium will be in place by the end of that grant period. The grant may not exceed a total of \$10,000 per consortia or the amount of their formula allocation, whichever is less. Any funds remaining, after initial formula allocations have been made, will be redistributed by formula to rest of the qualifying consortia.
- (2) For the Fiscal Year (FY) 1991-92 (July 1, 1991 - June 30, 1992), it is expected that no jurisdiction with a qualified full service consortium will receive an aggregate of State and Federal discretionary HIV care service funding that is less than the total assigned to HIV care services in the jurisdiction for FY 1990-91.
- (3) Although no funding will be taken off the top of the formula for existing HRSA Demonstration Projects, the State has coordinated with Title I Cities to assure that adequate funding is available for the continuation of these projects through March 30, 1992. The formula allocations should provide adequate funding for the continuation of non-Title I HRSA Demonstration Projects through March 30, 1992.

It should be noted that, while formula funding assures each jurisdiction that qualifies for full consortium funding under Title II of aggregate Federal/State funding for HIV services equal to the level established for FY 1990-91, the State will not mandate that Title II funding be used first to maintain established programs. However, for the first year of operation, consortia must provide adequate funds through some funding source to continue the HRSA Demonstration Grants at least through March 30, 1992. After that date, each consortium will decide the relative need and priority for funding the continuation of these programs.

Funding mechanisms to be used

The specific mechanism used by the State to distribute Title II funding to the consortium will depend on the fiscal agent named. Certain options are available to local public health departments that are not available to private organizations, i.e. grants or subventions versus contracts. HIV Care Consortia will be encouraged by the State to select a fiscal agent and funding mechanism that is both efficient and consistent with the State's and HRSA's interest in accountability.

Each HIV Care Consortium will designate one member agency to serve as fiscal agent for the consortium. In order to expedite contract processing and enhance accountability it is suggested but not mandatory that the local health department be the fiscal agent. Other agencies may be used if they are incorporated and have generally accepted accounting systems in place.

Only local government agencies and private not-for-profit entities with: (a) a track record in human service delivery and contracting for service delivery; (b) demonstrated experience with generally accepted accounting principles; (c) sufficient cash reserves; (d) legal entity status; and (e) program management experience; will be eligible to serve as fiscal agent for an HIV Care Consortium.

2. Home and Community-Based Care

California currently funds 33 projects statewide to provide nurse case management, home/community-based care (CHC) to persons with AIDs and ARC. Initiated in 1986 as a result of State legislation, the program has a base budget of \$6,859,000 and provides services to about 2,000 persons with AIDS (PWA) or AIDS related complex (ARC) each year. Through data provided by the projects, the OA maintains a statewide information system for the purpose of monitoring the long term care needs of PWA/ARC and determining the cost of home and community-based care. The projects use standardized protocols for case management, quality assurance and data collection.

On September 30, 1990, California received \$2,639,980 from HRSA in one-time only funds for home and community-based direct care services. A total of \$760,000 was allocated to the existing 33 CHC projects. The remainder of the appropriation (minus 5% for administration) was added to the State budget for Fiscal Year 1991-92. OA is just completing the request for proposal (RFP) process for next year, and 36 projects are being recommended for funding. This means no funds from Title II will be used for the first year to operate a separate Home and Community-based Care program. The State intends to continue these programs with existing HRSA funds through June 30, 1992.

The State recognizes the need for additional planning for year two of the CARE Act to deal with the issue of continuing these programs as separate contracts or folding them into consortia.

3. Continuum of Health Insurance Coverage

California will use federal and State funds provided for the AIDS Drug Program (ADP) to establish a separate program of financial assistance to help low-income individuals with HIV disease to maintain a continuity of health insurance which will provide drugs covered by the ADP. The intent of this program is to use ADP funds, as an option to enrollment in the ADP, for purchasing or continuing health insurance premiums for individuals at risk of losing insurance coverage due to declining income or who are unable to purchase health insurance. All areas will be eligible for this program.

Persons who meet the eligibility criteria of the ADP would be given the option of continuing or enrolling in ADP, or to use funds which would pay for drugs for the maintenance of health insurance premiums through COBRA. COBRA laws allow for the maintenance or continuation of health insurance policies after an individual has left their employment. Additionally, OA is exploring the feasibility of using ADP funds to purchase health insurance through various insurance programs. The ADP funds would be used to pay for an individual's premiums as a third party payor.

Purchasing or maintaining insurance coverage using the ADP funds will pay for drug therapies, including Food and Drug Administration (FDA) approved Treatment Investigational New Drugs, and outpatient medical services, hospital care, emergency care, durable medical equipment, home health care, and mental health visits. Participants will likely benefit by improving their access to health care, and alleviating the excess demand on the Medi-Cal and medically indigent programs that usually provide health care through local jurisdiction health care systems.

This program will benefit the participants as well as federal, State, and county government. Participants will benefit by being able to continue to be treated by their current health care providers, and they will have broader access to care. Health care cost shifts from the private sector to the public sector will be prevented, benefiting the Medi-Cal and county medically indigent programs. Preserving health insurance up to the time of Medi-Cal eligibility will maximize participation in the State's Health Insurance Premium Payment program, which provides for subsidies for health insurance for Medi-Cal recipients when it is cost-effective to do so. With average annual Medi-Cal costs for AIDS care at \$20,257 per patient, there is great potential for cost savings.

This program will also provide for cost-efficient use of Title II funds. Annual per person costs for AZT and aerosolized pentamidine average \$4,930 through the State ADP. This compares to an annual cost of \$4,100 to maintain a COBRA policy that has a \$175 monthly premium plus \$2,000 in additional costs for deductibles and co-payments, or \$4,415 average annual cost to purchase health insurance premiums, deductibles, and copayments for a 37 year old in Los Angeles. These programs will provide coverage for drug therapies and additional health services.

Eligibility for these programs will be limited to those persons who have HIV disease and meet the eligibility criteria of the ADP. Persons would have to meet additional specific requirements for the individual insurance programs. For any insurance coverage, persons must have incomes of no greater than 300% of the federal poverty level and assets not exceeding \$4,000 excluding a home and one car. The OA will develop a sliding fee scale for individuals with incomes or assets exceeding these levels. Individuals with a COBRA policy must have health insurance policy which provides coverage for drug treatments included in the ADP. The payment of premiums should be cost-effective when compared to annual cost of treatment of the individual.

4. Provision of Treatments

The OA has provided drugs determined to prolong or prevent the serious deterioration of health to eligible individuals with human immunodeficiency virus (HIV) disease through the AIDS Drug Program (ADP) since October 1987. The total amount being requested for ADP from Title II funds is \$ 5,181,501. This amount will be supplemented by an additional \$4.1 million from the State General Fund, for a total of \$9.3 million for the ADP. Additionally, these funds will be used to pay for or maintain health insurance for persons with HIV disease who opt to participate in the health insurance programs as described in 3. Continuation of Health Insurance of this application. This option will be limited to persons who would otherwise be eligible to receive drugs under the ADP. Additionally, as a condition of participating in a health insurance program, the insurance benefits must provide all treatments currently provided under ADP.

Number of Persons Served

The number of individuals served cannot be estimated because the OA does not compute this data on individuals. However, the number of prescriptions provided on a monthly basis is routinely collected. Actual numbers of prescriptions filled and paid by the program vary by month. For purposes of providing estimates for 1991, an average for the last three completed months of reported data has been computed. This number, 4952 average number of prescriptions per month, was multiplied by 12 months for a total of 59,420 prescriptions which are expected to be provided during 1991. It should be noted that these figures do not represent unduplicated counts of individuals served. In many cases, persons receive zidovudine (AZT) and pentamidine in the same month.

Treatments Covered

Currently only AZT and aerosolized pentamidine are covered by the ADP. Additionally, the ADP reimburses on a monthly basis a maximum of two Respigard II Nebulizer Systems per person who is receiving aerosolized pentamidine. Other drugs considered for coverage by the program are reviewed on a case by case basis. If a client opts to participate in the health insurance program described in this application, funds would be used to cover the premiums. The benefits provided by these insurance plans would at a minimum have to provide but not be limited to the same treatments provided under the ADP.

New drugs for the treatment of HIV disease are expected to be available and approved by the Food and Drug Administration (FDA) in the near future. If these drug therapies meet the inclusion parameters established by the Department, and it is determined that there are sufficient funds available to provide the drugs, they will be added to the ADP.

Financial Eligibility Criteria

The current financial eligibility criteria for the ADP were established by Assembly Bill (AB) 1724, Chapter 141 of the Health and Safety Code, Statutes of 1990. These income eligibility criteria are as follows:

1. Persons whose adjusted gross income does not exceed \$50,000 will be eligible for the program. Additionally, persons with incomes higher than \$50,000 will be eligible to receive the drug if the estimated cost of the drug(s) exceeds 20 percent of the person's adjusted gross income upon approval by OA.
2. A repayment requirement has been established. Persons whose adjusted gross income is more than 400 percent of the Federal Poverty Level shall be required to pay for a portion of the cost of the drug(s). Therefore, persons whose income is between approximately \$26,376 and \$50,000 will have to pay for a portion of the drugs.

An individual's repayment obligation will be the lesser of (a) two times the person's annual State income tax liability, less funds expended by the person for health insurance premiums; or, (b) the cost of the drug.

Reimbursement for Treatment

The ADP is administered through local health jurisdictions with prescriptions filled at county or city pharmacies, or through local pharmacies contracted for the purpose of providing the drug. The local health jurisdiction is responsible for verifying eligibility and providing the drug. The eligible individual does not receive any monetary compensation for the purchase of the drug. The State opted for a local health jurisdiction distribution methodology because of the geographic characteristics of the State. Centralization of the program would have made it more cumbersome for an individual to access the program.

Reimbursement for the drug is provided through intergovernmental agreements which allocate a maximum amount for a specific time period. Approximately 19 local health jurisdictions have formal agreements with the State. These jurisdictions invoice on a monthly basis for actual reimbursement of funds. For local health jurisdictions which spend relatively small amounts per month, they provide the drug, and OA reimburses on a monthly basis without formal agreements. This involves about 25 local health jurisdictions.

Reimbursement for insurance premiums under the proposed health insurance programs will occur in the same manner as reimbursement currently exists in the ADP. Local health jurisdictions will be required to pay for health insurance premiums for qualified persons under ADP. Reimbursement will be made upon receipt of invoices and data reporting requirements on a monthly basis.

D. COORDINATION

The Office of AIDS currently serves as the State agency responsible for coordination of HIV programs statewide. There is a Statewide Interagency AIDS Task Force consisting of all health and social service agencies having programs which serve HIV affected individuals. The task force has members from the Departments of Health, Education, Corrections, Mental Health, Developmental Services, Medi-Cal among others. The task force meets quarterly to plan and coordinate HIV-related programs in the areas of Prevention, Education, Testing and Treatment.

With Title II administrative funds, the OA will gain a better perspective on the funding streams coming into the State from various federal and private agencies. Before the CARE Act passed, most of the federal dollars coming into California bypassed the State to fund local categorical projects. The work begun to identify funds and services for the Title II plan will continue and be expanded to provide a comprehensive overview of services and unmet needs throughout California.

As mentioned earlier, the State will continue to serve on Title I HIV Health Services Planning Councils and will coordinate with HIV Care Consortia as they develop. The State will assist local HIV Care Consortia in identifying other sources of funding and programs providing HIV services to assure efficient and unduplicated service delivery at the local level. The State also meets regularly with the California Conference of Local Health Officers to enhance State-County cooperation and coordination.

E. STATE PLAN TO MEET FEDERAL REQUIREMENTS

1. Peer Review

Collaborative review and evaluation of progress reports and periodic site visits will be performed by State staff, local HIV affected individuals, local health department staff and providers which do not receive funds directly from Title II. Participants will be selected by the State from a list of recommended volunteers developed locally. The peer reviewers will be screened for possible conflicts of interest. Periodic client surveys will be performed to measure client satisfaction and quality of service delivery. The surveys will be used by the State and the local consortia to identify areas to be improved. If peer review cannot be adequately provided within a specific location, then the State may contract with individuals from other areas of the State to provide peer review. This will be paid for from the planning and evaluation funds allotted under Title II. The State will also perform statewide evaluation of program efforts and service delivery.

2. Limit on Charges for Services

Assurances will be required from providers of services paid for by Title II funds to not exceed the mandated sliding fee schedule in Title II. It is anticipated that the overwhelming majority of services will be provided at no cost to the patient. Therefore, a sliding scale will be required of a minimal number of providers. HIV Care Consortia will have to describe the services and providers which will charge a fee.

3. Distribution of Title II Funds by Sept 1, 1991

The formula funding of Title II programs will allow the State to fund contracts with local HIV Care Consortia in an expedited manner by eliminating the need for competitive bidding through a RFP process. By eliminating the RFP process a savings of two to three months is possible in a contract process which normally requires five to six months. HIV Care Consortia will be required to submit a comprehensive care plan to the State. However, the plan may not be required until after the allocation has been made. The State will make the allocation based on the formula, with HIV Care Consortia signing assurances for program requirements. The plan will be required to be submitted within three months of the date of the allocation. Expenditures incurred by the HIV Care Consortia will be limited in amount and payments will be held until the plan is submitted to and approved by the State. Those consortia which do not apply for funding or which fail to provide a plan within the specified time will have their allocation canceled, and the funds will be reallocated among the remaining qualified HIV Care Consortia. The State will announce the availability of funds in early April. Assurances from HIV Care Consortia will be required by the end of May 1991. Contracts based on formula allocations will be made by the end of July 1991. The AIDS Drug Program will have obligated all of its allocation by July 1991.

4. Maintenance of Effort

Baseline expenditures for State funded Title II HIV care related programs will not be lower in FY 1990-91 than expenditures for similar services in FY 1989-90. The amount budgeted in the Governor's Budget as submitted to the Legislature on January 10, 1991 for FY 1991-92 is not less than the FY 1989-90 expenditures for similar programs. None of the funds allocated under the CARE Act will be used to supplant existing program funds for HIV care related services. For the purposes of this requirement the State does not include one-time only appropriations nor funds which have been reappropriated or carried forward from previous budget periods.

5. Matching Funds

In 1991 the State will spend at least \$4.2 million on the AIDS Drug Program alone. This is sufficient to match in excess of \$20 million in federal Title II funds for the first year. Since the allocation to California is only \$12.9 million, the State easily exceeds the required 5 to 1 match required by the CARE Act.

6. Reporting Requirements

The State plans to collect service, cost and demographic data from each consortia by category of service on a quarterly basis. Data will be compiled and submitted to HRSA on each of the four categories of service, annually, within 90 days of the end of the budgeted period. The State will include assurances in any agreement with providers that they provide the required data. The data collection system will attempt to measure unmet needs as well as services delivered. The State and local representatives will participate with HRSA in any data collection standardization meetings.

California will provide a financial status report to HRSA by Sept 1, 1991 specifying the cumulative obligation of funds to providers under each of the four service categories. The percentage obligated will be computed and reported in order to determine if the State has complied with the 75% obligation factor. The report will also include a description of progress made toward implementing the program and a summary of issues or problems which may be impeding implementation.

HIV Care Consortia Funding Formula

CARE Act Formula		Scenario1 Allocation	
		Base	*Base
County		Formula	Amounts
=====			
1 Alameda		4.32%	279,998
2 Alpine		0.06%	3,712
3 Amador		0.47%	30,649
4 Butte		0.75%	48,866
5 Calaveras		0.42%	27,174
6 Colusa		0.36%	23,325
7 Contra Costa		2.03%	131,724
8 Del Norte		0.23%	14,623
9 El Dorado		0.82%	52,980
10 Fresno		2.47%	160,019
11 Glenn		0.61%	39,374
12 Humboldt		0.69%	45,003
13 Imperial		0.65%	42,391
14 Inyo		0.16%	10,577
15 Kern		1.64%	106,263
16 Kings		0.65%	42,408
17 Lake		0.64%	41,149
18 Lassen		0.30%	19,515
19 Los Angeles		25.42%	1,646,718
20 Madera		0.69%	44,511
21 Marin		1.09%	70,747
22 Mariposa		0.22%	14,071
23 Mendocino		0.78%	50,581
24 Merced		1.00%	64,763
25 Modoc		0.34%	21,848
26 Mono		0.11%	7,369
27 Monterey		1.42%	91,730
28 Napa		0.37%	23,990
29 Nevada		0.61%	39,702
30 Orange		3.88%	251,260
31 Placer		0.79%	51,087
32 Plumas		0.21%	13,841
33 Riverside		3.43%	222,193
34 Sacramento		2.10%	136,079
35 San Benito		0.42%	27,051
36 San Bernardino		3.42%	221,385
37 San Diego		6.91%	447,283
38 San Francisco		10.54%	682,909
39 San Joaquin		1.56%	101,331
40 San Luis Obispo		0.79%	50,966
41 San Mateo		1.44%	93,292
42 Santa Barbara		1.05%	67,867
43 Santa Clara		2.67%	173,089
44 Santa Cruz		0.77%	49,687
45 Shasta		0.71%	46,152
46 Sierra		0.68%	44,358
47 Siskiyou		0.33%	21,461
48 Solano		1.07%	69,203
49 Sonoma		1.94%	125,396
50 Stanislaus		1.23%	79,745
51 Sutter		0.28%	18,190
52 Tehama		0.44%	28,792
53 Trinity		0.21%	13,520
54 Tulare		1.37%	88,759
55 Tuolumne		0.48%	31,112
56 Ventura		1.10%	70,985
57 Yolo		0.48%	31,288
58 Yuba		0.35%	22,814
California		100.00%	6,476,877

Scenario 1 Weights

* Base Allocation Amounts are estimates and may change based on new data and number of consortia applications.

CARE Formula Awards
SFDPH Portions

CONFIDENTIAL

Division and Service

AMOUNT

AIDS Division	
Administration (5% of Formula Funds)	\$319,693
San Francisco Service Demonstration Project (support for October 1, 1991 to January 31, 1992)	\$382,040
Community Public Health Services	
Primary Medical Care Services	\$856,862
Special Programs for Youth - Outreach & Medical Care for Youth	\$184,027
Bureau of Family Health - Case Management for Women & Children	\$56,313
San Francisco General Hospital	
Ward 92, HIV-IDU Medical Clinic	\$203,809
Ward 86, AIDS Medical Clinic	\$167,346
Psychiatric Consultation & Liaison (Inpatient)	\$102,276
Early Intervention, General Medical Clinic	\$67,513
Mental Health, Substance Abuse & Forensic Services	
Forensics - Early Diagnosis & Treatment/Intervention for Inmates	\$111,339
Community Mental Health Services - Mental Health Case Management	\$92,907
Community Substance Abuse Services - Substance Abuse Treatment	\$72,996

Subtotals, SFDPH CARE Awards

AIDS Division (Admin. plus Service Demo. Project)	\$701,733
Community Public Health Services	\$1,097,202
San Francisco General Hospital	\$540,944
Forensics	\$111,339
Community Substance Abuse Services	\$72,996
Community Mental Health Services	\$92,907
TOTAL, SFDPH Portion of CARE Formula Awards:	<u>\$2,617,121</u>

CONFIDENTIAL

CARE Supplemental Application
SFDPH Portions

Division and Service

AMOUNT

AIDS Division	
Administration (5% of Supplemental Funds)	\$315,998
HIV Drugs	\$500,000
Systemwide Eligibility and Advocacy	\$250,009
Community Public Health Services	
Medical Care Outreach to Adults	\$57,548
Community Mental Health Services	
Mental Health Case Management	\$230,545
Acute Psychiatric Care	\$149,944
Laguna Honda Hospital	
Institutional Respite Care	\$100,016
TOTAL, SFDPH Portion of CARE Supplemental Application:	<u>\$1,604,060</u>

CARE Funding
for San Mateo & Marin Counties

CONFIDENTIAL

	<u>Formula</u>	<u>Supplemental</u>	<u>Total</u>
San Mateo	\$201,405	\$201,405	\$402,810
Marin	\$159,900	\$159,800	\$319,700
TOTAL:	\$361,305	\$361,205	\$722,510

MINUTES

MAYOR'S HIV HEALTH SERVICE PLANNING COUNCIL

JANUARY 5, 1991

9:00 am - 1:00 p.m.

Members present: Sandra Hernandez, Pierre Ludington, Michael Baxter, Marcy Fraser, Yvonne Frazier, David French, Estela Garcia, Jaime Geaga, Lydia Gorrez, Karen Hembry, Gerald LeNoir, Gifford Leoung, Steve Lew, J.B. Molaghan, Bob Nelson, Veneita Porter, Eric Rofes, Peggy Falknor, Anna Ramirez, Mike Shriver, Laura Thomas, Patricia Underwood, Claire Rappaport, Reggie Williams, Mary Jane Wood

Members absent: Pat Christen, Moher Downing, Bonnie Maldonado, Phil Tingley (absentee policy not in effect.)

Council Staff present: Sophia Chang, Bill Haskell, Miriam Stoll

Public present John Walmsley

I. Roll Call

Roll Call was taken, as above.

II. Review and Approval of Minutes

The Council approved minutes from the meeting of 1-3-91.

III. Potential Conflicts of Interest (Handout)

Arthur Greenburg, Deputy City Attorney, presented to the Council the Mayor's Proclamation that addresses conflict of interest issues concerning membership on the Planning Council. The Proclamation is designed to forestall potential conflicts of interest associated with the Council's decisions concerning funding priorities. The City Attorney's Office will continue to work with the Council to address conflict of interest issues concerning review committees and other problem areas.

IV. Continuation of Service Prioritization

The Council continued to prioritize service areas. A Table, which represents a working document of the Council's allocations, accompanies these minutes.

The following motions related to service prioritization were passed:

- 1) A portion of C.A.R.E. funds will be allocated for the development and implementation of a systematized eligibility, advocacy/ entitlements and case management program.

AIDS Office Staff agreed to develop a preliminary, tentative budget for the Program to the next Council meeting.

- 2) The Council tentatively allocates \$500,000 from the Formula grant and \$500,000 from the Supplemental funds for a systematized eligibility, advocacy/entitlements and case management program.
- 3) The Council allocates 60% of remaining CARE funds to the category of Primary Health Care Services, after allocations to the AIDS Drug Program, the systematized entitlements program and administrative costs.
- 4) The approximately \$3,000,000 allocated to Primary Health Care Services is tentatively allocated to the following service areas:

<u>Primary Medical Care Services:</u>	<u>\$1,800,000</u>
<u>Home Health Care</u>	<u>500,000</u>
<u>Substance Abuse Services</u>	<u>400,000</u>
<u>Mental Health Services</u>	<u>300,000.</u>
- 5) The Council allocates 5% of remaining CARE funds to the category of Food/Nutritional Services, after allocations to the AIDS Drug Program, the systematized entitlements program and administrative costs.
- 6) Priority service areas within Food/Nutritional services are (1) Food Banks, including dissemination of nutritional supplements and (2) Food Service Delivery.
- 7) The Council allocates 15% of remaining CARE funds to the category of Psycho-social Services and 20% to Housing Services, after allocations to the AIDS Drug Program, the systematized entitlements program and administrative costs.
- 8) Priority service areas within Psycho-social Services are: (1) Case Management (2) Emotional Support (3) Practical Support.
- 9) The Council agrees to allocate \$250,000 of the funds allocated to Psycho-social Services to augment the Systematized Entitlements/Case management system.

Specific services types and target populations tentatively determined to be funded in each of the above categories were defined and are presented on the accompanying chart.

In choosing these specific services and target populations the Council considered current service availability and future available funding streams.

As a homework assignment the Council was asked to prioritize specific service types within (1) Emotional Support (2) Practical Support and (3) Housing.

HIV HEALTH SERVICE PLANNING COUNCIL
25 Van Ness
3rd Floor Conference Room

January 7, 1991
4:00 - 8:00 pm
AGENDA

- I. Roll Call
- II. Review and Approval of Minutes
- III. Presentation of Seroprevalence Data
- IV. Eligibility, Advocacy/Case Management System Budget
- V. Finalization of Service Prioritization and % Funding
- VI. Decision regarding How to Allocate Funds to DPH Requests
- VII. Development of Criteria for Service Funding and Review of Letters of Application
- VIII. Approval of Draft Application Form and Advertisement
- IX. Public Comment



HIV HEALTH SERVICES PLANNING COUNCIL
25 Van Ness Avenue
Third Floor Conference Room

April 8, 1991
4:00 to 6:00 p.m.

AGENDA

- I. Roll Call
- II. Review and Approval of Minutes from March 11th meeting.
- III. Review and Discussion of Public Hearing
- IV. Update on CARE Titles II and III
- V. Update from Evaluation Subcommittee
- VI. Update from Intergovernmental Subcommittee
- VII. Review of Remaining Gaps in Services after Letter of Application Process
- VIII. Public Testimony



March 27, 1991

To: Interested Parties

From: Dr. Sophia Chang *SC*
HIV Health Services Planning Council Staff

Re: Minutes from Planning Council Meetings

The AIDS Office has received a blanket request from SFDPH Advisory Committees for inclusion on the mailing list for Planning Council minutes. In the interest of saving paper and postage, I am asking that individuals or organizations who are not currently receiving minutes, to request them. Please complete and fill in the form below if you would like to be added to the Planning Council Minutes mailing list.

Please return the form below to: AIDS Office, San Francisco
Dept. of Public Health, 25 Van Ness Avenue, Suite 500, San
Francisco, 94102, Attn: Planning Council Mailing List.

Thank you for your time and cooperation

Please add my name to the HIV Health Services Planning Council mailing list.

Name:

Agency:

Address:

PUBLIC HEARING

MAYOR'S HIV HEALTH SERVICES PLANNING COUNCIL March 18, 1991

I. Planning Council Presentation

The public hearing was co-chaired by Pierre Ludington and Venetia Porter, who directed the presentation of the Planning Council as follows:

.Overview of CARE legislation	Mike Shriver
.Process for establishing priorities	Lydia Gorrez Pat Christen
.Review teams	Gifford Leoung
.Review criteria	Estela Garcia
.Explanation/description of CARE allocations	Gerald LeNoir
.Ongoing role of Planning Council	Steve Lew
.Ongoing role/goals: process & program evaluation	Ann Guillory-Thom

II. Public Hearing - Speakers

1. Howard Moffitt - Quan Yin

Expressed opinion that all medicines including Chinese medicine and acupuncture be considered under the category of Primary Medical Care. Chinese medicine providers should be placed on panels to review future applications for funding.

2. Joe Gonzalez - CURAS

Expressed concern for the uninsured and underinsured, undocumented persons who speak only their language of origin. Also expressed concern for Latino gay men who have sex with men. Would like to see Latino men represented on the Planning Council.

3. Jan Barker - BAART/CAL DETOX

Addressed needs of IDUs. Sees 1,000 IDUs a day in clinic. Wants to identify uninsured and underinsured. Believes more funding is necessary to care for this population.

4. Sam Akinake - BAART /CAL DETOX

Addressed needs of IDUs. Especially those who will not go outside methadone clinic to access services. These persons need access to HIV services at substance abuse treatment sites. This would get IDUs into treatment earlier than is currently possible.

5. Orland Outland - Act Up, Golden Gate
Addressed AIDS Drug Program. Concerned about new income requirement resulting from AB 1724. Referred to AB 665 pending in Sacramento to lower copayment. Requested Planning Council to lobby to get AB 665 passed, and to get AB 1724 rescinded. Requested Council to use CARE funds to pay copayment for those unable to pay.
6. Jerry William - Act Up, Golden Gate
Inquired what the Planning Council is doing to assure non-supplantation of city funds with CARE funds.
7. James Freeman - Person with AIDS
Addressed the needs of PWAs like himself, whose needs are not being adequately met. Requested Planning Council to include PWAs who do not represent political organizations and without vested interests. Concerned about housing for low income PWAs, specifically that autonomy must be given up to live in such congregate settings. Stated that his best option is to remain in current housing, but does not have the resources. Expressed the need for more independent housing without long wait lists.
8. Michael Foo - Gay Asian Pacific HIV Project
Requested to have definition of underserved populations clarified. Current definition is too vague. Would like greater distinction in definition for people of color, and gay and bisexual men of color. Stated that people of color did not get adequate funding based on their percent of total population. Concerned that minority community-based agencies received little funding.
9. Valentin Aguirre - Latino Coalition on AIDS/SIDA
Expressed concern that people of color agencies, especially Latino agencies, are under funded. Planning Council should provide technical assistance in proposal development, and should consider categorical set-asides. Requested that information be distributed by Council in a timely manner to CBOs and coalitions. Desires more ongoing dialogue and input into Title II, III, and IV implementation.
10. Dorothy Wong - Asian AIDS Project
Expressed concern about the availability of services for people of color. Recommended that cultural competency be given greater emphasis in the selection of CBOs that will be providing HIV services. Proposed that review team members be selected for both expertise and cultural competency. Program monitoring and evaluation should include assessment of cultural competency, contractors should be responsible to document racial breakdown of clients served.

Recommended that the Council adopt a policy of inclusion in awarding contracts to organizations run by people of color. Board and staff composition should be taken into consideration. In order to consider a proposal as a collaborative effort, at least 50% of the funds should go to participating organizations in communities of color. Due to issues of cultural competency and empowerment, 30% of all CARE funds should go to organizations in communities of color. In collaborative proposals, only those funds going directly to organizations in communities of color should be counted as part of the 30%.

RFP process should include an initial letter of intent which would enable Council to ascertain if any gaps in services will result from proposals being considered for submission. Technical assistance and grant writing help should be made available by the Council for small CBOs. The Council should ensure the steady flow of accurate and timely information about its deliberations and decisions.

11. Greg Monardo - Davies Medical Center
Expressed disappointment that Davies was not funded to provide HIV services. Feels that his institution is not recognized by the Planning Council for its work with HIV disease. Believed that the process of allocation of funds is flawed, but will not pursue any legal action.
12. Shirley Gross - Bayview Hunters Point Foundation
Believed that the southeast section of San Francisco was not adequately funded, and that this was overlooked by the Planning Council. Requested that the Council consider parity to benefit all persons in the City, based on geography.

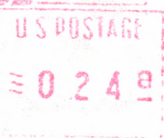
III. Ethnicity of Speakers

The twelve speakers consisted of five White males, two Latino males, two Asian males, one White female, one Asian female, and one Black female.



SFDPH AIDS Office
Health Reso. & Serv. Branch
25 Van Ness Ave. Suite 500
San Francisco CA 94102-6033

PALSBOROUGH
FIRST CLASS



PERMIT
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MINUTES

MAYOR'S HIV HEALTH SERVICE PLANNING COUNCIL

DECEMBER 17, 1990

4:00 - 8:00 pm.

Members present: Sandra Hernandez, Pierre Ludington, Michael Baxter, Pat Christen, Moher Downing, Marcy Fraser, Peggy Falknor, Yvonne Frazier, David French, Jaime Geaga, Karen Hembry, Gerald LeNoir, Gifford Leoung, Steve Lew, J.B. Molaghan, Bonnie Maldonado, Bob Nelson, Anna Ramirez, Eric Rofes, Mike Shriver, Laura Thomas, Patricia Underwood, Mary Jane Wood

Members absent: Lydia Gorrez (excused), Veneita Porter (unexcused), Claire Rappoport (unexcused), Phil Tingley (excused), Reggie Williams (excused)

Council Staff
present:

Sophia Chang, Bill Haskell, Carol Piccione

Public present: Adam Braver, David Gillen, Tom Calvanese

I. Roll Call

Roll Call was taken, as above.

II. Review and Approval of Minutes

The Council approved minutes from the meeting of 12-10-90.

III. Review and Approval of Motions to Date

All motions made to date were voted on and passed by the Council.

IV. Review and Approval of By-Laws

Sophia reviewed the changes reflected in the by-laws concerning open meetings, the posting of upcoming meetings for the public, and the inability to vote by proxy. The Council voted to adopt the revised by-laws.

The City Attorney's Office has been asked to investigate the issue of potential conflict of interest for Council members. Council members were asked to fill out a questionnaire with 4 questions submitted by the City Attorney's Office, who will evaluate this information.

V. Review of Priorities from the Public Hearing

Copies of all written public testimony received was distributed to Council members for review. The Council voted to issue a public notice that no more written testimony will be accepted after 5 pm. on December 26, 1990. Staff will prepare the notice.

Carol reviewed the matrix of information she prepared reflecting the oral public testimony at the hearing. It was suggested that the Council view those target populations where no public testimony was offered as potentially reflecting ongoing neglected, and poorly advocated for, populations.

Carol presented a process for prioritizing service needs and making decisions regarding allocation of CARE monies. She reviewed graphics that were prepared to depict the services in each of the basic human needs categories (primary health care, psycho-social, housing, food/nutritional services). Services that were included were taken from needs assessments, continuum of care models, and public testimony. Once the Council defines these services, the Council would then define the specific target populations. Graphics will then be made of each target population and their specific service needs, facilitating the Council's process in prioritizing those needs, and then allocating CARE monies to each.

The Council discussed each of the categories and the services presented. The following motions reflect changes that were adopted, and will be used to edit the graphics and bring them back to the Council:

Housing

1. Use the following terms to form a housing matrix/table: emergency (0-3 months), transitional (3-6 months), permanent (6 months or more); autonomous living, independent living, supervised living, and residential treatment.
2. Autonomous housing is defined as residential services where a requirement for occupancy is not based on the need for any HIV-related supervision or assistance.
3. Supervised housing is defined as residential services where the requirement for occupancy is based on needed HIV-related supervision or assistance on-site.

The Council requested that staff to the Council develop the definitions for Independent living and Residential treatment, and bring these back to the Council for discussion.

Sandra pointed out that the Council should keep in mind that HUD monies may also be available to support housing needs of the target populations.

The Council had a discussion regarding the inclusion of "clean and sober housing" on the graphics. It was suggested that if this was to be included that housing for active users should be a separate category. The Council decided to eliminate clean and sober housing as a housing category, and instead voted to adopt a target population definition:

4. Define as two separate target populations substance users who are actively using and substance users who are not actively using.

Food/Nutritional Services

1. Eliminate TPN from Food/Nutritional Services.
2. Change Home-Delivered Meals to Home-Delivered Food.

Psycho-Social Support Services

1. Add case-management as a service category.

The Council requested the staff bring 4 definitions of case-management back to the Council for review and assistance in defining this term.

2. Add family planning/counseling; change pastoral care to spiritual support, and separate this from grief and bereavement counseling; change individual and group psychotherapy to individual, group and family emotional support; separate adult day care and child care; add money management under practical support; and eliminate hospice, and respite services.

Primary Health Care

1. Add to the primary health care mission statement a sentence that includes use of an entitlement advocate.

The Council also voted to add entitlement advocacy to every service category, where reimbursements or other entitlements are potentially available, and include in each category's access statements.

2. Add health care maintenance, health education, and clinical trials advocacy under Early Intervention; add residential substance abuse treatment under substance abuse treatment; add Adult Day Health Care; add alternative HIV care; move hospice to a separate category; change Ophthalmology to specialty care on referral; add individual and group psychotherapy under mental health; add routine medical care, including Pediatrics under primary care medical services.

VI. Review of HRSA Demonstration Projects

Time did not permit the Council to discuss this item.

VII. Identification of Service Priorities by Target Population

Time did not permit the Council to discuss this item.

VIII. Public Comment

Tom Calvanese, manager of the Ambassador Hotel, addressed the Council on Item V. Review of Priorities from the Public Hearing. He also distributed written comments.

Sophia reminded the Council that the Formula Grant application, due to HRSA December 20, 1990, will be available at the AIDS Office for any Council member who would like to review it.

Carol reminded all Council members who have not done so, to submit their resumes to her.

The next meeting of the HIV Planning Council will be December 20, 1990, from 4:00 - 8:00 pm., at 25 Van Ness, on the 5th Floor* Conference Room.

* Please note room change.

Proposed Target Population Categories

1. People of Color

- * Gay/Bisexual Males
- * Lesbian
- * African-American
- * Latino
- * Native American
- * Asian/Pacific Islanders
- * Other

2. Homeless

- * Youth
- * IDUs
- * Women
- * Other

3. Indigent

- * IDUs
- * Other

4. Substance Users

- * Dual Diagnosis (Mentally Ill)
- * Actively Using
- * Not Actively Using
- * Other

5. Youth

- * IDUs
- * Gay/Bisexual Males
- * Other

6. Women

- * of Color
- * Other

7. Children

- * of Color
- * Other

8. Persons with AIDS Dementia

9. Gay, White Males

10. Deaf/Hearing Impaired

HIV HEALTH SERVICE PLANNING COUNCIL
25 Van Ness
5th Floor Conference Room

December 20, 1990
4:00 - 8:00 pm.

AGENDA

- I. Roll Call
- II. Review and Approval of Minutes
- III. Identification of Target Populations
- IV. Review of Comprehensive Services under each of the
Basic Human Needs Categories
- V. Presentation of Priorities of the AIDS Health Services
Advisory Committee
- VI. Review of HRSA Demonstration Projects
- VII. Public Comments

THE RYAN WHITE COMPREHENSIVE AIDS RESOURCES
EMERGENCY ACT OF 1990

Presentation to Representatives of Governors' Offices, and
State and Local Health Departments and Education Agencies
in Atlanta, Georgia on August 9, 1990

The House and Senate have both approved the "Ryan White Comprehensive AIDS Resources Emergency Act of 1990", also known as Title XXVI - HIV Health Care Services Program. This bill combines the House's "AIDS Prevention Act of 1990" and the Senate's Comprehensive AIDS Emergency Resources Act. The purpose of the bill is to amend the Public Health Service Act by creating a new authorization which provides grants to improve the quality and availability of care for individuals and families with HIV disease. Title XXVI contains five parts: (a) emergency relief for areas with substantial needs; (b) care grants; (c) early intervention services; (d) general provisions; and (e) emergency response employees.

For the remainder of my time, I will focus on Part C, dealing with early intervention services. Part C consists of three subparts: (1) Formula Grants for States; (2) Categorical Grants; and (3) General Provisions. First, we will look at the major provisions (found in Subparts I and II) that are common to both grant programs. Then we will examine aspects that are relevant only to the State formula allotments, followed by a look at provisions relevant only to categorical grants. Next, we will discuss additional provisions relevant to both grant programs (found in Subpart III), and finally, we will briefly discuss the prison testing program.

Subparts I & II - Major Provisions Relevant To Both Grants

Two types of grants are authorized for each fiscal year from 1991 through 1995: (1) allotments for States and (2) categorical grants for public and non-profit private entities. The allotment for States will be administered by CDC in consultation with HRSA while the categorical grants will be administered by HRSA.

These grants will provide for a continuum of HIV-related early intervention services. Each applicant must agree to provide five types of service:

1. pre- and post-test counseling;
2. testing which includes tests to:
 - determine the presence of HIV;
 - diagnose the extent of immune deficiency; and
 - provide information on appropriate therapeutic measures for preventing and treating both the deterioration of

the immune system and other conditions arising from the infection;

3. referrals to:

- other grantees funded under Part C; and
- universities, community-based organizations, or other entities providing experimental treatment;

4. other HIV-related clinical and diagnostic services and periodic medical evaluations of persons infected with HIV; and

5. provision of appropriate preventive and therapeutic measures.

The applicant must agree to provide these services either directly or through agreements with other public or nonprofit private entities. Although it appears as if these grants are intended to create a continuum of services, all services need not be provided at a single site.

In addition to the required services, grants may be used for the following optional services:

- outreach activities to publicize the availability of the grantee's early intervention services;
- case management for clients of the grantee (this includes coordination of service provision and review of service utilization);
- assistance in establishing client eligibility for other health, mental health, and social and support services; and
- in the case of grants to States, providing early intervention services for hospital inpatients if the hospital has admitted in the most recent fiscal year at least 250 people with AIDS or if at least 20% of its inpatients had AIDS.

Early intervention services supported under both grant programs must be delivered by providers that have entered into a participation agreement with the State Medicaid plan and are qualified to receive funds under that plan. This requirement can be waived if the provider does not impose fees or accept reimbursements for the provision of the required services.

Congress has authorized \$305 million under Part C of this legislation: \$230 million for the States' allotment and \$75 million for the categorical grants.

State-related Provisions of Subpart I

I will now discuss other major provisions of Subpart I that are relevant to States only.

Formula for Determining Allotment

In determining amounts to be awarded, there are five important points that need to be considered: (1) minimum allotments; (2) formula determination; (3) 10% reduction; (4)

transition rules; and (5) matching funds.

(1) The minimum allotment is:

- \$100,000 for States, the District of Columbia, and Puerto Rico; and
- \$50,000 for other United States territories.

(2) The formula used to determine an applicant's award is based on the State's proportion of AIDS cases with respect to the U.S. total, specifically: the number of AIDS cases reported by a State and confirmed by CDC for the most recent fiscal year that data are available, divided by the number of AIDS cases reported to and confirmed by CDC for the entire United States during the same time period. This proportion is multiplied by the total amount appropriated by Congress for this particular grant program to yield the proportion of the total grant to be allotted to the State.

(3) Next, all awards are reduced by 10%. The 10% residual funds will be distributed by CDC on a discretionary basis.

(4) Transition rules will apply during fiscal years 1991 through 1993. This means that applicants will receive the greater of either the minimum, the formula amount, or:

- in 1991, 100% of the amount received by the State from CDC for counseling and testing activities in 1990;
- in 1992, 85% of that amount; and
- in 1993, 70%.

In short, no State will receive less in 1991 than it received in 1990, unless the total amount appropriated decreases.

(5) Matching funds are required if a State reports more than 1% of the cases reported to CDC for the two-year period preceding the fiscal year for which a State is applying for funds. For the first year that the State meets these criteria, it must contribute, in cash or in kind, at least \$1 for each \$5 of Federal funds provided in the grant. In the second year this is \$1 for each \$4; in the third year, \$1 for each \$3; and by the fourth year the State match is up to \$1 for each \$2 in Federal funds. Please note that Puerto Rico is exempted from this provision.

There are a number of other fiscal considerations that you may be interested in. States must agree to spend:

- at least 35% of their grant on counseling, testing, and referral services;
- at least 35% on other clinical, diagnostic, and therapeutic services;
- not more than 5% on early intervention services for hospital inpatients (this 5% can be used to help meet either of the previously mentioned 35% expenditure levels); and

- not more than 5% on administrative expenses.

According to our calculations, the remaining 20% can be spent in either or both of the first two categories, namely, in counseling, testing, and referral services or in clinical, diagnostic, and therapeutic services. It can also be used for case management, outreach services, and providing eligibility assistance.

In addition, the authorization mandates that of the amount appropriated for State allotments in 1991, \$130 million must be used for three of the required services: counseling, testing, and referral. It appears that if no more than \$130 million is appropriated in 1991, then all of it must be spent on counseling, testing, and referral, and none would be available for other diagnostic, clinical, therapeutic, and optional services.

Under Subpart I, there are a number of other provisions that States must agree to in order to obtain funding. For example, offering and encouraging services, notification to transfusion recipients, HIV reporting, partner notification, State law protection against intentional transmission, and other miscellaneous provisions. I will briefly discuss each of them.

(1) Offering/encouraging Early Intervention Services

While providing other types of health care in STD, TB, intravenous drug use, and family planning clinics, providers must offer and encourage voluntary acceptance of early intervention services. These clinics will only have to offer, encourage, and provide these services to the extent that the grant funds are sufficient to pay for them.

(2) Notification to Transfusion Recipients

Through a public information campaign, persons who received transfusions of whole blood or a blood-clotting factor between January 1, 1978 and April 1, 1985, will be: (1) encouraged to consider using the early intervention services and (2) informed of any health care facilities in their area providing these services. This does not mean that persons who received blood products need to be identified and notified individually, but that States must publicize the appropriateness and availability of testing for such persons.

(3) HIV Reporting

All providers performing tests for HIV infection will report to the State public health officer enough information to:

- perform statistical and epidemiological analyses of the incidence of cases of HIV infection;
- perform statistical and epidemiological analyses of the demographic characteristics of the population with HIV infection; and
- assess the adequacy of early intervention services.

(4) Partner Notification

The State public health officer will conduct, to the extent he or she determines appropriate, a program of partner notification for cases of HIV infection. This provision neither requires nor prohibits the collection of identifying information. In addition, Only the State public health officer is required to make notifications under the State's partner notification program.

(5) State Law Protection Against Intentional Transmission

The State's chief executive officer must certify that the State's laws are adequate to prosecute any HIV-infected person who knows he or she is infected and knowingly exposes another to HIV through:

- donating blood, semen, or breast milk;
- engaging in sexual activity; and
- using a hypodermic needle and then sharing it with another.

The State laws need not apply when the individual who is exposed to the behavior involved knows that the other person is infected and provides consent prior to the activity. Additionally, the State laws do not need to be specific for HIV. You may ask, "What happens if my State is unable to certify compliance? Your State can still receive awards in 1991 and 1992 if it provides satisfactory assurances that it will establish or have the necessary prohibitions in place by October 1, 1992.

(6) Miscellaneous Provisions

In the grant application, States will submit a comprehensive plan for the organization and delivery of early intervention services and will conduct public hearings on the proposed use and distribution of their grants. To the maximum extent possible, services will be provided without regard to an individual's ability to pay or past health condition. Early intervention services will be provided in settings accessible to low-income persons with HIV infection who will receive, through outreach, information on available services.

Subpart II-Categorical Grants

Now let's look at some of the provisions specific to categorical grants: (1) minimum qualifications of grantees; (2) participation in a consortium; (3) preferences in making categorical grants; and (4) grants for individuals with hemophilia. As previously mentioned, these grants will be administered by HRSA.

(1) Minimum Qualifications

To be eligible for categorical grants, applicants must be public entities and nonprofit private entities that are either:

- migrant or community health centers (under sections 329 and 330);
- grantees providing health services for the homeless (under section 340);
- grantees, except for States, providing family planning services (under section 1001);
- comprehensive hemophilia diagnostic and treatment centers;
- federally-qualified health centers (under section 1905 of the Social Security act); or
- nonprofit private organizations providing comprehensive primary health care services to populations at risk of HIV infection.

(2) Participation in Consortium

In addition to providing the required and optional early intervention services mentioned previously, applicants must make reasonable efforts to participate in one of the consortiums established with grant funds under Part B of this bill, also known as the CARE GRANT PROGRAM.

(3) Preference

Preference will be given to qualified applicants experiencing an increase in the burden of providing HIV-related services during the two-year period prior to the year the grant is being applied for. The following will be used as indicators:

- the number and rate of increase in cases of AIDS, other sexually transmitted diseases, tuberculosis, and of drug abuse;
- the lack of availability of early intervention services;
- the lack of availability of primary health care services from providers other than the applicant; and
- the distance and time required to travel between the area served by the applicant and the nearest community that has accessible and appropriate HIV-related services.

(4) People with Hemophilia

All grants for early intervention services for people with hemophilia must be awarded through the network of comprehensive hemophilia diagnostic and treatment centers.

Subpart III-GENERAL PROVISIONS

(Additional provisions for both State and Categorical Grants)

Now I would like to discuss a number of general provisions applicable to both grant programs. In order to obtain funding, States and other entities must agree to comply with these provisions.

(1) Requirements Regarding Confidentiality

All information regarding receipt of early intervention services must be maintained confidentially.

(2) Requirements Regarding Informed Consent

An individual will be tested only after giving written

consent which indicates that the individual has received counseling and has voluntarily decided to be tested. Exceptions are permitted in only two instances: (1) when individuals want to undergo testing using a pseudonym, they can use the pseudonym when giving written consent; and (2) when individuals undergo testing anonymously, they can give their consent orally.

(3) Provision of HIV Counseling

Applicants must provide specified counseling messages during the pretest session and additional messages during the posttest session. Posttest messages will vary based on whether the client is positive or negative for HIV. When a grantee or individual determines that testing is not necessary, the grantee cannot withhold counseling from that individual.

(4) Applicability of Certain Requirements to Non-federal HIV Testing

The applicant must certify that all provisions regarding confidentiality, informed consent, and counseling services will also apply to any non-federally supported HIV testing conducted by the applicant.

(5) Reporting Requirements

All applicants must submit the following information in their applications:

- expenditures for early intervention services made in the preceding fiscal year; and
- the estimated number of individuals who received those services.

In addition, applicants will agree to submit the following information, when it becomes available:

- the number of individuals receiving early intervention services;
- epidemiological and demographic data on those individuals;
- the percentage of HIV-related health care costs paid by third-party payors;
- the average costs of providing each category of early intervention service; and
- the aggregate amounts expended for each such category.

(6) Provision of Opportunities for Anonymous Counseling and Testing.

The applicant must agree that to the extent permitted under State law they will offer substantial opportunities for people to undergo counseling and testing for HIV infection without having to provide any identifying information as well as through the use of a pseudonym.

(7) Prohibition Against Requiring Testing as a Condition of Receiving Other Health Services

Unless medically indicated, applicants cannot require any individual to undergo testing as a condition of receiving other health services.

(8) Maintenance of Support

The applicant will maintain the same level of expenditures for early intervention services that it spent in the year prior to the application.

(9) Charges for Services

For individuals with an income at or below the poverty level, the applicant will not impose a charge for early intervention services. In the case of individuals with an income greater than the poverty level, the applicant will impose a charge according to a schedule of charges that is made available to the public. In addition, there will be a limit to how much one individual can be asked to pay during one calendar year. For individuals with an income greater than 100% and not exceeding 200% of the poverty level, the applicant will not impose charges exceeding 5% of the individual's annual gross income; if greater than 200% and not exceeding 300%, charges are limited to 7%; and if greater than 300% and not exceeding 400%, charges are limited to 10%.

(10) Items and Services Under Other Programs

Applicants and their subcontractors will not expend grant funds to pay for any early intervention service that has been or might be paid:

- under any State compensation, an insurance policy, or any Federal or State health benefits program; or
- by an entity that provides services on a prepaid basis.

(11) Grant Application

All applications submitted must provide all necessary information, agreements, and assurances of compliance with program requirements.

(12) Supplies and Services in Lieu of Grant Funds

Grantees may request and receive from CDC supplies, equipment, and services to help it provide early intervention services. If requested, the Department of Health and Human Services may also detail its officers or employees for the same purpose. However, the grant award would be reduced by an amount equal to the cost of detailing personnel and the fair market value of supplies, equipment, and services.

Revision, Extension, and Transfer of Program of Prison Testing Act of 1988

Lastly, at the end of Part C we find a provision for prison testing which is actually an additional grant program. The Prison Testing Act of 1988 has been revised, extended to 1995, and transferred to Part C of TITLE XXVI. It authorizes

grant funds to assist States in providing early intervention services for inmates in certain prisons. The State public health officer, after consulting with the chief State correctional officer, will determine which prisons are appropriate sites to provide early intervention services. He or she will focus on the inmates' areas of residence prior to incarceration, and consider the severity of the HIV epidemic and the occurrence of high risk behaviors in those areas. There are provisions for matching funds, testing at specified times, and disclosure of test results to spouses, exposed employees, and victims of rape and assault. No specific dollar amount is specified.

In summary, this legislation will greatly change the way we provide HIV early intervention services. It focuses on some of the activities from our current grant programs: counseling, testing, referral, and partner notification. In addition, States will now be required to provide immunological monitoring, and HIV-related clinical, diagnostic, and therapeutic services. The State allotments will be administered by CDC with consultation from HRSA. Grant amounts will be determined by a formula based on the proportion of new AIDS cases reported by the State with respect to the U.S. total.

There is no doubt that we all face a great challenge in adapting our programs to this new legislation. However, our main problem is still HIV, and we at CDC will do our best to help you, the States, in your efforts to mount new programs under this legislation to confront HIV. Thank you.

DEFINITIONS OF CASE MANAGEMENT

Source

Definition

CARE Title I
Application
Guidelines
(HRSA)

Case management is a client-centered service that links clients with health care and psychosocial services in a manner that ensures timely, coordinated access to medically appropriate levels of care and support services, and continuity of care. Key activities include: assessment of the client's needs and personal support systems; development of a comprehensive, individualized service plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan; and periodic reevaluation and adaptation of the plan as necessary over the life of the client.

RFP for Case
Management, Home
and Community-
Based Care
Projects (DOHS
Office of AIDS)

Case management is a process through which a nurse case manager coordinates a core case management team to perform initial and on-going client assessment; develops, implements, and evaluates a service plan; and locates, coordinates and monitors the high-quality, cost-effective services provided to a client in accordance with client needs set forth in the service plan. Case management incorporates a collaborative, interdisciplinary team approach.

US Public Health
& Welfare Code
(used by
Medicaid)

The term "case management services" means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

Short-Doyle/
MediCal (Mental
Health)

Case management is the provision of various services which assist the eligible client to gain access to needed medical, mental health, social, educational, and other services. Case management services include evaluation, individual service plan development, emergency intervention, placement services, assistance in daily living, and linkage and consultation. Case management services may be either face-to-face or by telephone with the client, client's family, significant other, service provider, and may be provided anywhere in the community.

Blue Cross

(no written definition exists; working on developing one - main thrust is to prevent the exhaustion of benefits unnecessarily due to unnecessary or inappropriate hospitalizations, or due to lack of knowledge of other existing services)

Minority AIDS
Needs Assessment
(Comprehensive
Social Work
Model)

Comprehensive case management is the coordination of referrals to, and the facilitation of access to, providers for health care, housing, nutritional, translation, and psychosocial services for HIV infected individuals from diagnosis to death (and for family members 3 months after death). Facilitation of access to services includes benefit entitlement counseling and follow-up, and advocacy, by culturally competent and sensitive case managers.

DRAFT

1/7/91 2:00 p.m.

**Comprehensive AIDS Resources Emergency Act of 1990 (CARE)
Contractor Selection Process**

The federal legislation known as the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE) provides emergency disaster relief funds to support HIV services in localities hardest hit by the AIDS epidemic. The funds will be granted to San Francisco in two installments: the first installment of \$6.3 million is based on a formula allocation; the second installment, potentially of a like (but still unknown) amount, will be awarded through a competitive supplemental process. A primary condition set by the Ryan White CARE Act for receipt of these funds is that an HIV Health Services Planning Council be established to set the binding priorities for use of CARE funds. All funds support HIV care (not prevention or education) and there is a 5% cap on expenditure for administrative support. Since these are disaster relief funds, the federal government intends that localities encumber their funds within ninety days of their award. The formula award will be made to San Francisco on February 1, 1991; the supplemental grant award will be made on April 4, 1991.

The normal contracting process for the Department of Public Health requires a competitive request for proposal (RFP) process. At present, that process requires six months from the time of RFP development to contract encumbrance. Clearly this standard process would not allow the CCSF to meet the 90 day deadline for encumbering contracts.

Per federal legislation, the CARE HIV Planning Council formed in San Francisco is determining the priority service areas for funding, the target populations, and general service area funding percentages. The Council will also approve and oversee the process of selecting providers. Given their role, the Council did not feel comfortable with direct sole sourcing of the \$6 million or more to predetermined contractors. However, the standard RFP process used by the DPH Office of Contracts Management would not leave sufficient time for AIDS Office staff to negotiate, develop, and process contracts before the 90 day deadline and would require a lengthy proposal from bidders which is unreasonable to demand given the tight timeline. Therefore, the Council has developed a fast-track process to ensure that the largest possible number of qualified providers would apply, and that the best and most effective providers are chosen.

The Council, with assistance from Department of Public Health AIDS Office staff, has developed the following selection process.

DRAFT

1. A formal call for Letters of Application will be advertised in the Sunday Examiner/Chronicle on January 13. (The ad will be a quarter page in the "A" section, as opposed to the standard small classified ad in the Business section which is used for RFP's.) This formal call will also be mailed to the DPH, Health Commission, and AIDS Office mailing lists.
2. Guidelines for Letters of Application will be available at the AIDS Office on January 14, 1991.
3. Community Informational Meetings will be held on January 16 and 17 in order to answer questions about services and/or about the application format. One meeting will be scheduled per service area. (This serves essentially the same function as the RFP Bidders Conference.)
4. Letters of Application will be due to the AIDS Office by Noon on January 25, 1991. These applications will be a maximum of 5 pages, plus a budget and five required forms.* (This package is approximately a quarter of the size of our normal RFP proposals. The size will facilitate speedier completion and review.)
5. Between January 25 and February 4, review teams will read, discuss, and rank the applications submitted under each service area. Teams will be composed of members of the HIV Planning Council, community representatives, and non-voting DPH program staff. Potential conflicts of interest will be carefully screened and no person with a conflict of interest in a particular service area will be permitted to serve on that team.

Teams will rank the applications according to criteria published in the formal call and in the Letter of Application guidelines. The Council has developed the selection criteria to be used in reviewing the application. These criteria are similar to those used in the RFP process but are tailored to meet the needs of the CARE legislation and the Council's mission. The team members will rank all the applications in funding priority order. They may choose not to recommend all applications for funding.

* The five forms are:

1. Contracting History and references
2. Collaborative Effort Agreement (when necessary)
3. Financial Capability
4. Demographic Information
5. Agreement to Submit Supplemental Forms (necessary to ensure that agency will be eligible to enter into a contract with the Department of Public Health)

1/7/91 2:00 p.m.

6. Using the review team's rankings and the funding limits, AIDS Office staff will develop a list of providers and award amounts for the formula monies, as well as recommendations for the supplemental monies. The HIV Planning Council will review this list for its compliance with the Council's binding priorities.
7. Representatives of the Health Commission who are members of the Planning Council and DPH AIDS Office staff will present the plan for providers of services and the service/contract amounts. After the Commission's review and consent, the providers and amounts will be announced on February 19.
8. The list of providers, amounts, services, and contract terms will be forwarded to the Controller's Office. With this information contracts will be encumbered immediately, thus ensuring compliance with the 90-day CARE requirement. (Normally contracts are encumbered only after certification.)
9. Contracts will be negotiated, developed, and processed for certification.

The CARE legislation requires the City, and in particular DPH, to develop an enormous quantity of contracts between February and June. Since the AIDS Office already has one of the largest contract workloads in the department, it is essential to pace the development of these contracts so as not to overload either the AIDS Office or the Office of Contracts Management. By fast-tracking the selection process and not using the standard RFP we are ensuring the timely processing of contracts. Without these measures San Francisco would risk losing CARE funds. By using a competitive selection process the Council will be able to select the best possible providers given the constraints of the legislation.

CARE APPLICATION GENERAL REVIEW CRITERIA

Clarity of program description

Clear demonstration of program need

Realistic and achievable goals within implementation time frame

Reasonable budgetary requests based on proposed level of service and agency capability

Potential impact of program on specified target populations and the community at large

Efficient use of other agency resources

Demonstrated knowledge and experience with comparable programs in the community

Demonstration of cooperation with other providers*

Past agency performance

*Collaborative proposals are encouraged. A collaborative agency will be defined as one which would receive financial support from the proposed program budget.

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SAN FRANCISCO CHRONICLE/EXAMINER ADVERTISEMENT
FOR SUNDAY JANUARY 13, 1991

Ryan White Comprehensive AIDS Resources Emergency (CARE) Act

Funding Opportunities for HIV Services in San Francisco

Call For Letters of Application by January 25, 1991

The federal legislation known as the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 provides emergency disaster relief funds to support HIV services in cities hardest hit by the AIDS epidemic. The Act specifically allows the funds to be used for: (a) outpatient and ambulatory health and support services, including case management and comprehensive treatment services for persons with HIV disease; or (b) inpatient case management services that prevent unnecessary hospitalization or that expedite discharge. Funds cannot be used for prevention services.

The City and County of San Francisco has been awarded \$6.3 million dollars as a result of the CARE legislation, and will apply for a like amount to supplement this initial award. All funds will be used to address basic care needs for persons with HIV disease, specifically: primary health care, psycho-social support, food/nutrition services, and housing services. CARE funds will target low-income, uninsured, and/or under-insured persons with HIV infection, with a special emphasis on previously neglected or unrepresented populations.

The San Francisco HIV Health Services Planning Council, appointed by Mayor Agnos, has developed a comprehensive plan for HIV care and has identified priority service areas to be funded by CARE monies. On December 11, 1990, the Planning Council held a public hearing to listen to the needs and priorities for the care of persons with HIV disease in San Francisco. These needs and priorities have been incorporated into the Planning Council's comprehensive HIV plan.

Since the CARE Act provides funds for disaster relief, newly supported services should begin as soon as possible. The HIV Planning Council is seeking to identify and select HIV service providers through a CARE Letter of Application process.

Application Process:

Letters of Application are to propose direct service programs for persons with HIV infection in San Francisco. The schedule for their submission, review and selection is as follows:

<u>Date</u>	<u>Event</u>
January 14 to January 25, 1991	Letter of Application Guidelines available at the AIDS Office* between 8:00 a.m. and 5:00 p.m.
January 16 & 17, 1991	Community Informational Meetings to review application procedures and services solicited. Locations and times announced in the Guidelines.
January 25, 1991	Letters of Application due to the AIDS Office by 12:00 noon. There will be no exceptions to this deadline.
February 19, 1991	Awards announced for the initial \$6.3 million
April 23, 1991	Awards announced for supplemental funds

Instructions to Apply:

- 1) Eligible agencies must document:
 - a) 501(c)3 nonprofit status;
 - b) That CARE funds will comprise no more than 70% of the applicant organization's total budget.
- 2) Submit a complete Letter of Application package in the format described in the Guidelines by noon on January 25, 1991. The format will require a five page description of the agency and the proposed services, two page budget, budget justification, and five additional forms.
- 3) Agencies may apply in more than one service area by submitting a separate and distinct Letter of Application for each area in which services are proposed.
- 4) Collaborative proposals are encouraged. A collaborative agency is one which would receive financial support from the proposed program budget.

Funding Priorities and Amounts Available:

<u>SERVICE AREA</u>	<u>ESTIMATED MAXIMUM AMOUNT AVAILABLE**</u>	<u>MAXIMUM AMOUNT PER APPLICATION***</u>
1. <u>Primary Medical Care</u>	\$3,654,000	\$1,500,000
2. <u>Other Primary Health Care</u>	\$2,436,000	\$ 600,000
3. <u>Psycho-Social Support</u>	\$1,522,500	\$ 375,000
4. <u>Housing</u>	\$2,030,000	\$ 500,000
5. <u>Food and Nutrition</u>	\$ 507,500	\$ 250,000
6. <u>Eligibility Advocacy/ Case Management System</u>	\$1,250,000	\$ 500,000

Service Area Definitions:

Primary Medical Care: Routine Outpatient Medical Care; Early Intervention/Medical Follow-Up; Obstetrics/Gynecology; Dental Care; Neuropsychologic and Dementia Evaluation. Target Population: All low income, uninsured/underinsured, and indigent populations.

Other Primary Health Care: Home Health Care (attendant care); Substance Abuse Treatment (clinic/outpatient care); Mental Health/Psychiatric Care (crisis intervention and general therapy). Target Population: All low income, uninsured/underinsured, and indigent populations.

Psycho-Social Support: Emotional Support (peer counseling, grief/bereavement counseling, individual and group counseling); Practical Support (transportation, childcare, translation, volunteer recruitment). Target Population: All low income, uninsured/underinsured, and indigent populations.

Housing: Autonomous Living, Independent Living, and Supervised Living; Residential Treatment. Target Population: All low income, uninsured/underinsured, and indigent populations.

Food and Nutrition: Food Banks (including nutritional supplements); Home Delivered Food. Target Population: All low income, uninsured/underinsured, and indigent populations.

Eligibility Advocacy/Case Management System: Systematized Assessment Information System; Information Coordination, Training, and Organization; Insurance Reimbursement Ombudsperson; Entitlement, Needs Assessment, and Benefits Counseling; Money Management; Advocacy -- Nursing Case Management/Brokerage, Psycho-Social Support, Outreach (as indicated for ethnic, cultural, linguistic and spiritually distinct populations). Target Population: All persons with HIV disease receiving services.

Review Process:

Letters of Application will be reviewed by a team of: members of the HIV Health Services Planning Council, community representatives, and non-voting Department of Public Health technical advisors. No person with a potential conflict of interest in a given service area will be permitted to review applications in that area.

Review Criteria for Selection of Potential Contractors:

Program

- ^ Clarity of program description.
- ^ Clear demonstration of program need.
- ^ Potential impact of program on specified target populations, especially in geographic and service areas previously neglected, and the community at large.
- ^ Realistic and achievable goals within implementation time frame.

Organization

- ^ Demonstrated knowledge and experience with comparable programs in the community.
- ^ Past agency performance, especially history of HIV service provision.
- ^ Reasonable budgetary requests given proposed level of service and agency capability.
- ^ Efficient use of other agency resources.
- ^ Demonstration of cooperation with other providers (distinct from collaborative efforts).

* San Francisco Department of Public Health, AIDS Office, 25 Van Ness Avenue, Suite 500, San Francisco, California 94102

** Maximum funds available are estimated and depend upon the supplemental award to the City and County of San Francisco.

*** Maximum award amounts are set to allow a wide variety of service program applications. Greatest consideration will be given to reasonable budget requests.

PRIORITY	SERVICE	TARGET POPULATIONS	% FUNDING	APPROXIMATE FORMULA PORTION (BASED ON \$6 MILLION)	APPROXIMATE MAXIMUM FORMULA & SUPPLEMENTAL (BASED ON \$13 MILLION)
1	Eligibility/ Advocacy/Case Management System	All persons with HIV receiving services	"Off the top"	\$ 750,000	\$1,000,000 - 1,250,000
2	AIDS Drug Program	All low income	"Off the top"	\$ 500,000	\$1,000,000
	ADMINISTRATION		"Off the top 5%"	\$ 300,000	\$ 600,000
3	Primary Med Care Hlth Care Maint. EI Med. F/U OB GYN/Fam. Plng Psych/Demen. Eval Dental Care	.Women, esp. of child-bearing age .Youth, esp. People of Color .Gay & Bisexual Men, esp. People of Color	36%	\$1,710,000	\$3,654,000
4	Other Pr.HlthCare		24%	\$1,140,000	\$2,436,000
4a	Home Hlth Care Attendant Care	(Same as #3)		475,000	
4b	Substance Abuse Clin/OutPat. Trt.	.Women, esp. of child-bearing age; Youth, esp. of color		380,000	
4c	Mental Health Crisis Intervent. Dementia Care Services as medically indicated	(Same as #3)		285,000	

PRIORITY	SERVICE	TARGET POPULATIONS	% FUNDING	APPROXIMATE FORMULA PORTION (BASED ON \$6 MILLION)	APPROXIMATE MAXIMUM FORMULA & SUPPLEMENTAL (BASED ON \$12
5	HOUSING Autonomous living Independnt living Supervised living Resdntl treatment	?	20%	\$ 950,000	\$2,030,000
6	Psych-Soc Support 6a Case Management 6b Emotional Support Peer Counseling Grief/Berievemnt Indiv/Grp Tx 6c Practical Support 1. Transportation 2. Child Care 3. Translation 4. Recruitment of Volunteers	All, especially People of Color Currently underserved Women/families w/children Monolingual non-Engl. spkrs Especially to recruit People of Color	15%	\$ 712,500	\$1,522,500
7	Food/Nutrition 7a Food Banks (in- cluding Nutri- supplements) 7b Home-delivered food	All All who cannot pick up food themselves	5%	\$ 237,500	\$ 507,500
TOTAL			100%	\$6,350,000	\$13,000,000

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A I D S
A C T I O N
F O U N D A T I O N

RYAN WHITE
COMPREHENSIVE AIDS RESOURCES EMERGENCY
ACT
OF 1990

Summary
of
CONFERENCE REPORT
July 31, 1990

prepared by:
AIDS ACTION FOUNDATION

SUMMARY

CONFERENCE REPORT JULY 31, 1990

The Ryan White Comprehensive AIDS Resources Emergency Act of 1990 provides federal support for comprehensive health and social services for people living with AIDS and HIV disease. Title I provides "disaster relief" grants to meet the outpatient and case management needs identified by planning councils in localities disproportionately affected by the HIV epidemic. Title II provides grants to states for care consortia and other means to improve the existing organization and availability of services. Title III provides grants to states and to private organizations for counseling, HIV antibody testing, diagnostics, and early intervention treatments and referrals. The fourth Title includes a number of provisions, including a set-aside for pediatric AIDS research demonstration and services, several studies, evaluation, and requirements for notification of emergency personnel of potential exposures. Authorization of funds under this bill total almost \$900 million per year for five years.

TITLE I -- HIV EMERGENCY RELIEF GRANT PROGRAM

Purpose:

To provide emergency assistance to localities disproportionately affected by the HIV epidemic.

Eligible areas:

a) Those metropolitan areas (as defined in the CDC HIV Surveillance Report) reporting more than 2000 cases of AIDS as of June 30, 1990 for FY 1991 grants and March 31 for the four subsequent years. In FY 1991, which begins on October 1, 1990, the cities included are:

Atlanta GA
Boston MA
Chicago IL
Dallas TX
Ft. Lauderdale FL
Houston TX
Los Angeles CA
Miami FL
New York NY
Newark NJ
Philadelphia PA
San Diego CA
San Francisco CA
San Juan PR
Washington DC; and

b) Those metropolitan areas that have a per capita cumulative incidence of reported AIDS cases of 0.0025 or more. These cities include:
Jersey City NJ

Total: 16 cities in FY 1991

Grantees/Administration:

- o Funds made available under this Title will be administered by the Health Resources and Services Administration (HRSA) and directed to the chief elected official of the city or urban county that administers the public health agency that provides outpatient and ambulatory services to the greatest number of individuals with AIDS (as reported to CDC).

- o The chief elected official is required to have in place intergovernmental agreements with any political subdivision that provides HIV services to more than 10% of the total cases for the eligible area.
- o Planning Councils -- the chief elected official is required to appoint a planning council empowered to establish priorities for the allocation of funds under the grant and to develop a comprehensive plan for the organization and delivery of services. Required representation on the Council includes:
 - health care providers
 - community based and AIDS service organizations
 - social service providers
 - mental health providers
 - local public health agencies
 - hospital planning agencies and health care planning agencies
 - affected communities, including people with HIV disease
 - non-elected community leaders
 - State government
 - grantees of early intervention services (Title III)
 - the lead agency of any HRSA demonstration grant.
- o Grants may not be made to an eligible area unless the chief elected official assures that the plan established by the council will be specifically followed.
- o Agencies that may receive direct financial assistance include: public or nonprofit agencies (including hospitals), community-based organizations, hospices, ambulatory care facilities, community health centers, migrant health centers, and homeless health centers.
- o Priority is given to those agencies that are currently participating in HRSA HIV health care demonstration grant programs.

Use of Funds:

- a) outpatient and ambulatory health and support services, including case management and comprehensive treatment services for people with HIV.
- b) inpatient case management services that prevent unnecessary hospitalization or that expedite discharge.
- c) Inpatient hospital care reimbursement is capped at no more than 10% of the grant.
- d) Administration expenses may not exceed 5% of the grant.

Distribution:

- o Funds allocated under this Title will be distributed in two parts:
 - a) 50% of the funds to be distributed to eligible areas within 90 days of the appropriations for the bill in FY 1991 and 60 days for the fiscal years thereafter.

The chief elected official is required to submit an application within 45 days after funds are available that certifies that the intergovernmental agreements are in place and that the planning councils are established. There is a 60 day extension available from the Secretary if an eligible area cannot submit an application within 45 days despite a good faith effort.

Funds made available under this section will be distributed based upon a formula that takes account of both actual numbers of AIDS cases and incidence of AIDS cases per capita. The formula calculates the proportion of AIDS cases in all eligible areas that are in this area and the proportion of per capita incidence

in this area. 75% of the funds are based on reported cases and 25% is weighted for per capita incidence reported.

b) 50% of the funds allotted in Title I are to be held by the Secretary of Health and Human Services for competitive grants to eligible areas. The Secretary is required to disburse these grants within 150 days of appropriations being made available. Only the eligible cities (for FY 1991, the 16 named above) can apply for these funds.

Requirements:

- o Entities receiving funds under this Title must accept Medicaid if services are reimbursable under the state Medicaid program unless the entity does not charge for any services or accepts only voluntary contributions.
- o No funds may be used to improve land, purchase or construct or permanently repair any building (other than minor remodeling).
- o Recipients must assure that funds received under this provision will not supplant any existing programs or resources for HIV programs and services. This includes an assurance that the amount of money expended by the eligible area for HIV services not fall below what it was for the year preceding the first year of this grant.
- o Recipients must develop a fee for services schedule that limits the imposition of charges in the following manner:
 - no charge for those under 100% of the federal poverty line
 - a cap of 5% of gross income for those under 200% of poverty
 - a cap of 7% of gross income for those under 300% of poverty
 - a cap of 10% of gross income for those over 300% of poverty

Authorization of Appropriations

\$275 million in FY 1991 and FY 1992 and such sums as may be necessary for FY 1993 - 1995.

TITLE II -- HIV CARE GRANTS

Purpose:

Grants under this title will be made by HRSA to the states for the purpose of improving the quality, availability and organization of care for individuals with HIV by:

- a) establishing and operating HIV care consortia within areas of a state that are most affected by HIV so that a comprehensive system of services is established;
- b) providing home and community-based care services for people with HIV;
- c) providing assistance to assure the continuity of health insurance coverage for individuals with HIV;
- d) providing treatments to low income individuals with HIV, including outreach to such individuals.

Eligible areas:

50 states, District of Columbia, Commonwealth of Puerto Rico, U.S. territories

Administration/Grantees:

- o Any state that has more than 1% of the total U.S. AIDS cases is required to spend not less than 50% of the state allocation to establish and operate HIV care consortia. In FY 1991, this includes 28 states.

- o A consortium is defined as an association of one or more public, and one or more private nonprofit, health care and support service providers and community based organizations operating within areas determined by the State to be most affected by HIV disease.
- o The consortia will not duplicate existing services, but will develop and deliver a comprehensive spectrum of care, including:
 - a) health services such as case management; medical, nursing and dental care; diagnostics, monitoring and medical follow-up services; mental health, developmental and rehabilitation services; home health and hospice care;
 - b) support services such as transportation, attendant care, homemaker, day care and respite, benefits advocacy, nutrition services, housing referrals and child welfare and family services.
- o In order to fund a consortium, the State must assure that:
 - a) one consortium be in place within an area that addresses the needs of all affected populations (with a provision for separate consortia if necessary);
 - b) the consortia include organizations and agencies with a record of service to individuals with HIV;
 - c) each consortium has carried out a needs assessment and that service needs will be addressed through the coordination and expansion of existing programs before new programs are created.
- o Priority is given to care consortia that are receiving assistance from HRSA for adult and pediatric HIV-related care demonstration projects and other existing HIV care consortia (ie. Robert Wood Johnson Foundation grantees).

Use of the grants:

- a) to establish and operate HIV care consortia within areas of a state that are most affected by HIV so that a comprehensive system of services is established;
- b) to provide home and community-based care services for people with HIV, including skilled health services such as durable medical equipment, homemaker or home-health services, day treatment, home drug therapy, diagnostic testing, and mental and rehabilitation services;
- c) to provide assistance to assure the continuity of health insurance coverage for individuals with HIV;
- d) to provide treatments to low income individuals with HIV, including outreach to such individuals.
- e) Special Programs of a National Significance -- the Secretary of Health and Human Services may use up to 10% of the amount appropriated under this Title for grants that may be awarded to public and nonprofit entities, including community based organizations, to fund special programs for the care and treatment of individuals with HIV. Some of these special programs include: the delivery of drug abuse treatment and HIV health services at a single location; providing respite care and support for family based care networks; delivering comprehensive health care and support through hemophilia centers; delivering HIV care to Indians and their families; and improving the provision of HIV health care and support to those in rural areas, people who are homeless and those who are incarcerated.
- f) States must assure that not less than 15% of funds allocated under this Title provide health and social services to infants, children, women, and families with HIV disease.

g) neither administration nor evaluation expenses may exceed 5% of the grant.

Distribution formula:

- o Each state, the District of Columbia and Puerto Rico will receive the greater amount of \$100,000 or the amount appropriated for this Title allocated by a formula incorporating the proportion of total AIDS cases in the state weighted by a relative per capita income factor.
- o The territories of the U.S. will receive an allocation proportional to their caseload over the most recent 2 fiscal years, without a minimum dollar amount.

Requirements:

- o States are required to match (in dollars or in kind contributions) federal funds according to the following schedule if the State has more than 1% of all AIDS cases:
 - 1991--\$5 Federal for every \$1 State
 - 1992--\$4 Federal for every \$1 State
 - 1993--\$3 Federal for every \$1 State
 - 1994 and 1995--\$2 Federal for every \$1 State
- o States must develop a fee for services schedule that limits the imposition of charges in the following manner:
 - no charge for those under 100% of the federal poverty line
 - a cap of 5% of gross income for those under 200% of poverty
 - a cap of 7% of gross income for those under 300% of poverty
 - a cap of 10% of gross income for those over 300% of poverty

Authorization of Appropriations

\$275 million for FY 1991 and FY 1992 and such sums as necessary for FY 1993 through FY 1995.

TITLE III -- AIDS EARLY INTERVENTION SERVICES GRANTS TO STATES AND CLINICS

Purpose:

To develop comprehensive early intervention services for individuals that seek testing and require diagnostics, monitoring and therapeutics provided on an outpatient basis.

Eligible areas:

50 states, the District of Columbia, Puerto Rico, and U.S. territories

Grantees/Administration:

Eligible grantees are divided in two categories:

- a) State health departments receive grants administered by the Centers for Disease Control (CDC). The state may provide services through existing sites as well as TB, STD, drug abuse, and other high-incidence clinics. The state may also provide services through high-incidence hospitals that are defined in the bill as those that have 250 or more AIDS admissions each year or a total of 20% of more of all admissions per year.
- b) Public and Private nonprofit clinics receive grants administered by HRSA. These clinics include: community health centers, migrant health centers, homeless health clinics, hemophilia centers, family planning clinics, and others providing comprehensive outpatient AIDS services.

Use of funds:

- o The following services are required to be provided by all grantees, although this may be done directly or through financial contract with others:
 - a) pre-test counseling

- b) ELISA, Western blot, and T-Cell diagnostics (and technologies that may succeed these)
 - c) post test counseling for sero-positive and sero-negative patients
 - d) preventive health services for people testing sero-positive including:
 - outpatient diagnostics
 - outpatient prescription drugs
 - referral for inpatient services
- o States are not permitted to spend more than 5% of the grant on inpatient services.
- o States must provide the following assurances before money can be provided under this Title:
 - informed consent be required for all testing
 - no making receipt of health services conditional upon testing
 - maintenance of confidentiality in accordance with state law
 - provision of substantial opportunity for anonymous and pseudonym testing in accordance with applicable state law

Requirements:

- o The following restrictions apply only to the funds given to the States. Prior to the receipt of funds, a State must assure the Secretary of HHS that:
 - a) it will report statistical and epidemiological data on HIV antibody tests
 - b) the State public health officer has made a determination regarding partner notification and will carry out such program as he/she deems necessary
 - c) that adequate state laws exist to prosecute anyone who knowingly transmits the HIV virus through the donation of blood, semen or organs, through sexual activity or needle use.
 - d) matching payments will be made by the State (in dollars or in kind contributions) in accordance with the following formula for States that have greater than 1% of all AIDS cases.
 - 1991--\$5 Federal for every \$1 State
 - 1992--\$4 Federal for every \$1 State
 - 1993--\$3 Federal for every \$1 State
 - 1994 and 1995--\$2 Federal for every \$1 State
 - e) States may spend no less than 35% of their grant on counseling, testing, diagnosis, and referral; and may spend no less than 35% on treatment.
- o The following requirements apply to all grantees -- the States and the public and private nonprofit clinics:
 - a) grantees must be Medicaid providers unless they accept no fees or reimbursements except voluntary donations
 - b) funds will be used to supplement not supplant existing services
 - c) recipients must develop a fee for services schedule that limits the imposition of charges in the following manner:
 - no charge for those under 100% of the federal poverty line
 - a cap of 5% of gross income for those under 200% of poverty
 - a cap of 7% of gross income for those under 300% of poverty
 - a cap of 10% of gross income for those over 300% of poverty

Distribution:

- o The grants to state health departments will be the greater of \$100,000 (\$50,000 for territories) or an amount allocated by a formula based upon the proportion of all AIDS cases in the U.S. reported in that state. The States are assured no less in FY 1991 than they were awarded in FY 1990 for counseling and testing.
- o The grants to clinics will be allocated by application with a preference to areas with increasing incidence of HIV with equitable distribution among urban and rural areas.
- o Additional grants to States for prison programs--A state health officer may determine that a particular prison has a high incidence of infection and mandate testing, diagnostics and the provision of intervention treatment. Implementation of such a program is contingent upon the appropriation of funds for this program. Such sums as may be necessary were authorized.

Authorization of Appropriation:

A total of \$305 million in FY 1991 and such sums as may be necessary in FY 1992-1995.

Of this, \$230 million is allocated to State health departments through grants from CDC.

\$75 million will go to HRSA for categorical grants to clinics.

**TITLE IV -- PEDIATRIC AIDS RESEARCH DEMONSTRATION PROGRAM AND
GENERAL PROVISIONS, REPORTS AND EVALUATIONS****PEDIATRIC AIDS RESEARCH DEMONSTRATION PROGRAM****Purpose:**

To establish a joint NIH-HRSA demonstration grant program to develop experimental drugs for pediatric AIDS patients and to provide the necessary primary health care that is necessary for participation in such drug trials.

Grantees:

Community health centers and other providers of outpatient care to pregnant women and children. Priority is given to those grantees that demonstrate experience in the design of research protocols.

Requirements:

Grantees are required to provide ancillary health and social services to pediatric AIDS patients and their families.

Authorization of Appropriations

\$20 million for FY 1991 and such sums as necessary thereafter.

STUDY OF AIDS IN RURAL AREAS

HHS acting through the Office of Rural Health Policy is to conduct a study to estimate the incidence and prevalence of AIDS in rural areas and to determine the adequacy of services in such areas.

PROVISIONS RELATING TO BLOOD BANKS

\$1.5 million is authorized for the Department of Human Services to develop and make available information regarding the safety of the blood supply to organizations and industry that are involved in the donation of blood and the production of blood products.

RESEARCH, EVALUATION AND ASSESSMENT PROGRAM

The Agency for Health Care Policy and Research is directed to establish a program to enable independent research to be conducted on the following topics:

- a) Comparative assessment of the impact and cost-effectiveness of HIV health care, mental health care and early intervention.
- b) An assessment of strategies to maintain private health insurance benefits for people with HIV.
- c) An assessment of points of entry into the health care system and the related outcomes of care and treatment.
- d) Summary of major unmet needs regarding health and social services for people with HIV in urban and rural areas.

STUDY OF PARTNER NOTIFICATION

A study is authorized to determine the number of individuals that have been notified under such programs, the percentage of such individuals that undergo counseling and testing, those who subsequently test positive for the HIV virus, and the extent to which these programs are useful in changing behaviors and are cost effective.

COORDINATION

The Secretary of HHS will assure that HRSA and CDC will coordinate planning of the funding of programs authorized under the Titles of the bill. States receiving funds appropriated under the provisions of the CARE Act are required to integrate the programs funded under this act with all existing HIV related health and social services programs (including Medicaid).

PROVISIONS REGARDING EMERGENCY RESPONSE EMPLOYEES

- o Grants in the amount of \$5 million are authorized for the implementation of model curriculum and guidelines established by previous law and grant programs.
- o A system of notifying emergency response employees is established requiring the following:
 - a) a list be compiled by the Secretary of HHS of all potentially life-threatening infectious diseases that an emergency response employee may be exposed to, including guidelines describing the circumstances under which exposure may occur. This list will be transmitted to State public health officers and made available to the general public.
 - b) If a treating facility (ie. hospitals) makes a determination that the transported victim has an airborne infectious disease, the medical facility shall notify the designated officer of the employees who transported the victim within 48 hours that an exposure may have occurred. Should the victim die and subsequent medical determination indicates the presence of an infectious airborne disease then such notification will be made in the same way.
 - c) If an emergency response employee believes that he/she has been exposed to an infectious disease as the result of transporting and assisting a victim of an emergency, he/she may seek, through a designated officer, to document the exposure risk and then obtain any information that may be available and applicable. The designated officer will make an initial determination regarding the possible exposure to an infectious disease (from the list established by the Secretary of HHS). Once the designated officer makes the determination that exposure may have occurred the officer, on behalf of the employee, may request from the facility to which the victim was transported information relating to the victim's health status. The medical facility then reviews the facts presented by the designated officer to ensure that in fact exposure may have been possible (given the list established by the Secretary of HHS). A medical facility may not

designated officer. Information given by the facility to the designated officer will contain only the name of the infectious disease and the date on which the victim was transported to the medical facility involved. Nothing in this section of the law can be construed to authorize any mandatory testing, legal proceedings regarding damages or civil action, or the breach of any confidentiality standards applicable in any State or locality. Emergency response employees are specifically restricted from denying services or failing to respond to any victim of an emergency.

- o The notification provisions shall not apply in a State if the chief executive officer of the State certifies to the Secretary of HHS that the law of the State is in substantial compliance with this provision.

NEEDLE EXCLUSION

No funds authorized under this bill may be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs. (There is no prohibition on the use of bleach and educational materials targeted to IV drug users.)

CARE APPLICATION REQUESTS

SUBSTANCE ABUSE

<u>Organization</u>	<u>Amount Requested</u>
18th Street Services	\$145,192
Baker Place	208,787
BAART	296,156
Walden House	414,025

HOUSING

<u>Organization</u>	<u>Amount Requested</u>
HOPE House	\$ 44,852
Catholic Charities	62,000
Maitri AIDS Hospice	64,800
S.F. AIDS Foundation	96,348
PPMC/VNH	99,284
AIDS Emergency Fund	188,000
A.I.D.S.	314,469
Independent Housing Services	349,032
Shanti	491,317

PRIMARY MEDICAL CARE

<u>Organization</u>	<u>Amount Requested</u>
S.F. AIDS Foundation	\$ 136,531
Family Service Agency	174,172
University of the Pacific	300,000
UCSF AIDS Health Project	356,528
Bayview-Hunters Foundation--Minority Women w/HIV Primary Care Services	366,019(?)
S.F. Community Clinic Consortium	627,918
Davies Medical Center	1,329,200

CARE Application Requests
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PSYCHOSOCIAL SUPPORT/FOOD & NUTRITION

<u>Organization</u>	<u>Amount Requested</u>
The Rest Stop Support Center	\$ 30,000
S.F. Black Coalition on AIDS	40,976
Home Care Companions	41,500
Bridge for Kids	44,168
St. Benedict Deaf AIDS Info. Center	49,000(?)
Tenderloin Resource Center	54,620
S.F. Suicide Prevention	60,000
PPMC - Department of Pastoral Care	90,000
Black and White Men Together	104,476
S.F. Food Bank	112,721
Larkin Street Youth Center	118,088
Walden House, Inc.	151,745
Project Open Hand	250,000
S.F. AIDS Foundation	250,000
Instituto Familiar de la Raza, Inc.	307,194
S.F. Project Inform	308,857
Parent's Pediatric AIDS Coalition	333,886
Operation Concern	341,664
UCSF AIDS Health Project	351,789
Shanti Project/Women's Bldg./AIDS	374,750
KIDS Foundation	374,978
Bayview-Hunters Point Foundation	375,000

OTHER PRIMARY HEALTH CARE

<u>Organization</u>	<u>Amount Requested</u>
UCSF Center on Deafness	\$ 26,095
Immune Enhancement Program	100,053
Continuum	115,247
Quan Yin	151,455
UCSF AIDS Health Project	276,177
Operation Concern	294,460
Westside Community Mental Health Center	297,444
American Indian AIDS Institute	324,184
Mt. Zion/UCSF	443,587
Bayview-Hunters Point Foundation	566,686
PPMC/VNH	599,520

CARE Application Requests

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CASE MANAGEMENT

<u>Organization</u>	<u>Amount Requested</u>
Trials Search	\$ 39,632
Central City Hospitality House	42,655
Gay Asian Pacific Community HIV Project & Filipino Task Force	97,926
AIDS Legal Referral Panel	104,250
Income Rights Project, Inc.	114,405
Health Outreach Team	117,300
Operation Concern	207,658
AIDS Benefits Counseling	221,488
St. Luke's Hospital	266,450
Catholic Charities	330,000
UCSF/AHP	373,220
Community United in Response to AIDS/SIDA (CURAS)	675,150
Westside Community Mental Health Center	730,103

01251A

**Comprehensive AIDS Resources Emergency Act (CARE)
City and County of San Francisco
LETTER OF APPLICATION GUIDELINES**

I. INTRODUCTION

A. Background

Information on number of reported AIDS cases, living PWAs, and estimate of HIV-infected in San Francisco. Brief discussion of CARE legislation and its implications for San Francisco. Explanation of CARE limitations, the HIV Planning Council, and process.

[TO BE COMPLETED]

B. Goals

The CARE legislation is intended to provide disaster relief funds from the federal government in order to support a continuum of HIV services. The monies will be utilized to address four priority service areas: primary health care, housing, psychosocial support, and food/nutritional support. CARE monies cannot be used for education/prevention or for direct financial support. These funds will target low-income, uninsured, and/or underinsured persons with HIV infection, with a special emphasis on previously neglected or unrepresented populations.

C. Available Funding

The City and County of San Francisco will receive CARE funds in two installments: the first portion is an amount pre-determined by formula; the second, or supplemental funds, will be allocated based on a competitive proposal process. This call for letters of application is seeking to identify contractors to be funded first by the formula monies, and secondly by the supplemental monies. The amounts listed below represent the total formula monies available in each of the four priority service areas, since the amount of the supplemental monies is still unknown. San Francisco's formula award totals \$6,393,866, and San Francisco is eligible to apply competitively for a like amount of supplemental funds. Some agencies may therefore be funded through formula monies, and others by supplemental monies. Applicants should designate the service area to which they are applying.

<u>SERVICE AREA</u>	<u>ESTIMATED MAXIMUM FUNDS AVAILABLE</u>	<u>MAXIMUM REQUEST PER APPLICATION</u>
1. Primary Medical Care	\$3,654,000	\$1,500,000
2. Other Primary Health Care	\$2,436,000	\$ 600,000
2. Psychosocial Support Services	\$1,522,500	\$ 375,000
3. Housing	\$2,030,000	\$ 500,000
4. Food/Nutritional Support	\$ 507,500	\$ 250,000
5. Eligibility Advocacy/ Case Management System	\$1,250,000	\$ 500,000

D. Eligibility

1. Only 501(c)3 non-profit organizations are eligible to apply.
2. Eligible organizations will have demonstrated successful experience in HIV-related services, or services to populations at risk for HIV.
3. DPH CARE funding may account for no more than 70% of the organization's operating costs.

II. **CONTRACT SELECTION PROCESS**

A. Timetable

January 13	Official call for CARE letters of proposal
January 14	Guidelines available at AIDS Office, 25 Van Ness Avenue, Suite 500, San Francisco.
January 16 and 17	Community Informational Meeting to review application procedures and services solicited. To be held at the AIDS Office, 25 Van Ness Avenue....[time, service areas, etc. TBD]
January 25	Letters of Application due to AIDS Office by 12:00 noon. THERE WILL BE NO EXCEPTIONS TO THIS DEADLINE.
February 19	Awards announced for formula monies
March	Contract negotiations and development for formula awards
May 1	Contracting period begins for formula awards
April 23	Awards announced for supplemental monies
May	Contract negotiations and development for supplemental awards
July 1	Contracting period begins for supplemental awards

B. Letters of Application

The original plus 7 copies of the complete application package must be received by 12:00 p.m. on Friday, January 25th and must be delivered to:

AIDS Office
25 Van Ness, Suite 500

(A staff person will be present to record receipt of your package)
THERE WILL BE NO EXCEPTIONS TO THE 12:00 NOON DEADLINE

C. Technical Assistance

The AIDS Office will not provide any additional programmatic information except at the Community Information Meetings on January 16 and 17. For technical assistance in completing your application package, or for questions regarding procedures, you may contact Judith Weld, AIDS Office Operations Branch, at 554-9044.

D. Proposal Review

Proposal review and selection will be made by a team consisting of members of the HIV Health Services Planning Council, community representatives, and Department of Public Health staff. Proposals will be evaluated for:

Program

- Clarity of Program Description
- Clear Demonstration of Program Need
- Potential Impact of Program on Target Population & Community at Large
- Realistic & Achievable Goals Within Implementation Timeframe

Organization

- Demonstrated Knowledge and Experience with Comparable Programs in the Community
- Past Agency Performance
- Reasonable Budgetary Requests Given Proposed Level of Service and agency capability
- Efficient Use of Other Agency Resources
- Demonstrated Cooperation with...

E. Multiple Applications

Agencies may submit more than one application, but proposed services may not overlap. Only one application letter may be submitted under each of the four services areas by any one organization. In cases where more than one application is submitted, the applicant agency must clearly demonstrate the capacity to provide the specific services described in each application.

F. Unfunded Applications

After the issuance of award letters, any applicant may request an opportunity to a) discuss with the AIDS Office Director the reasons for not being selected and b) examine all applications and the list of awards in that service area. Such requests must be submitted in writing to the AIDS Office within five days of receipt of notification of award. Such requests are not considered appeals. Award decisions are final and may not be appealed.

Some applications which are not awarded funds at this time may be recommended for funding under the CARE supplemental monies.

G. Contractual Obligations

Agencies selected to provide the services will be required to comply with all normal Department of Public Health contract requirements. Contract terms will be of nine months duration: 5/1/91 to 1/31/92 for formula monies; 7/1/91 to 3/31/92 for supplemental monies. After awards are announced, those agencies selected will be required to submit the supplemental response forms listed in the application format. Those agencies will also be required to participate in a series of technical assistance meetings to begin the preparation of additional documentation which will be required in order to develop contracts. Special contractual requirements will include, but may not be limited to, the reporting of the number and demographic characteristics of clients served, as mandated by the CARE legislation.

**Comprehensive AIDS Resources Emergency Act (CARE)
City and County of San Francisco
LETTER OF APPLICATION FORMAT**

Contents of Letter of Application

1. Cover Page: Name and address of agency, C.A.R.E. service area, name of authorized official, signature of authorized official, date. No letters of application will be accepted without an original signature by an authorized representative.
2. Abstract: No more than 1/2 page
3. Organization Description and Experience: No more than one page. To include brief table of all organization funds by funding source and by service area. (??)
4. Description of Target Population: No more than 1/2 page
5. Program Description: No more than 3 pages. To include measurable, time-specific program objectives, activities needed to achieve each objective, milestones and methods for evaluating progress, and potential sources of funding beyond the first year.
6. Collaborative Effort Agreement: Standard forms are provided. Required only with collaborative applications. Collaborating agencies are defined as co-applicants who will receive or potentially receive a portion of the awarded funds.
7. Budget: Please use the format provided here.
8. Budget Justification: Briefly explain the formula or rationale for allocating money to each line item. In the case of personnel positions be sure to identify the individuals by name and the percentage of their time to be spent on these services.
9. Other HIV-related Funding: Please list all funding by source which supports HIV-related services.
10. Financial Capability: Please use the form provided here.
11. Demographic Information: Please provide staff and current client information on the form provided.
12. Supplemental Forms: Please review and sign the form listing supplemental documentation which will be required by the AIDS Office should your agency be awarded funds. This form is required of all applicants; letters of application lacking this form will not be accepted for review.
13. Documentation of 501c3 status

Additional Note: Head each page with: name of agency, CARE funding area, and date of submission.

SECTION 3B: ORGANIZATION EXPERIENCE

1. List all contracts (both public and private) relevant to services in this solicitation which have been completed during the last five years. Additionally, response must include all current contracts with the City and County of San Francisco, whether or not related to services being solicited.

Ref. No.	Year of Service	Type of Services	Amount	Contracting Agency
1			\$	
2				
3				
4				
5				
6				
7				
8				
9				
10				

2. Indicate those references that may be contacted to verify the services of the offeror

	Name	Telephone No.	Reference No.	
1			to Above	
2				
3				
4				
5				
6				

3. Describe any failure or refusal to complete a contract, including details and dates:

4. List any disciplinary or investigative action currently pending by any professional body or local, state or federal branch of government.

5. List all pending litigation to which you are a party that is related or similar to services being solicited

Collaborative Effort Participation Schedule

To be completed by the ^{applicant} proposer in a collaborative participation effort and returned with the ^{application} proposal. If the form is not returned with the ^{application} proposal, the ^{proposal} will be determined ineligible for any submission proposing collaborative efforts.

Section 1

1. Name of Project: _____

2. Names of all collaborative effort partners:

1. _____

2. _____

3. _____

4. _____

5. _____

3. Location of collaborative effort's partner's office(s).

4. Describe the collaborative effort's insurance.

5. Describe the management of the collaborative effort.

<u>Management Personnel</u>	<u>Collaborative Effort Partner</u>	<u>Management Role</u>

6. Detail all administrative costs to be paid throughout this project for each collaborative effort partner.

<u>Item</u>	<u>Cost</u>

6. Attach copy of Collaborative Effort Agreement.
(The appropriate legal agreement between the parties
controlling the management, administration and financial
aspects of the collaborative effort).

Owner/Authorized Representative
(Signature)

Owner/Authorized Representative
(Signature)

Name & Title (please print)

Name & Title (please print)

Date

Date

Name & Title (please print)

Name & Title (please print)

Date

Date

Name & Title (please print)

Name & Title (please print)

Date

Date

(All collaborative effort partners must sign this form)

CARE Letter of Application
Budget Format

BUDGET CATEGORY	REQUESTED IN APPLICATION	CURRENT TOTAL AGENCY BUDGET ***
A. <u>Personnel</u> (Please specify each : Position Title, Name, FTE, Biweekly rate, Number of biweekly periods)		
TOTAL PERSONNEL		
B. <u>Mandatory Fringe Benefits</u> Maximum is 26% of Personnel		
TOTAL PERSONNEL AND FRINGE		
C. <u>Travel</u> 1. Local Travel 2. Out of Jurisdiction Travel		
TOTAL TRAVEL		
D. <u>Equipment</u> (Please specify) TOTAL EQUIPMENT		
E. <u>Materials and Supplies</u> 1. Office Supplies 2. Clinical Supplies 3. Educational Materials and Supplies 4. Laboratory Supplies		
TOTAL MATERIALS AND SUPPLIES		
F. <u>Contractual Services</u> 1. Subcontracts (please specify)		

*** Please define fiscal year

BUDGET CATEGORY

REQUESTED
IN
APPLICATION

CURRENT TOTAL
AGENCY BUDGET

G. Other

1. Rent Support
2. Telephone/Communication
3. Postage
4. Delivery/Courier Services
5. Reproduction/Photocopying
6. Printing/Slide Production
7. Promotions/Advertising
8. Staff Training
9. Client Participation Incentive
10. Other (please specify)

TOTAL OTHER

TOTAL DIRECT COSTS

H. Indirect Costs

(Maximum of 10% of Total Direct Costs)

TOTAL BUDGET

BUDGET SUMMARY

PERSONNEL
FRINGE
TRAVEL
EQUIPMENT
MATERIALS AND SUPPLIES
CONTRACTUAL SERVICES
OTHER

TOTAL DIRECT COSTS

INDIRECT COSTS

TOTAL BUDGET

*** Please define fiscal year

SECTION 10: ~~Financial~~ Financial Capability

Prospective Contractor Name and Address				Service Location									
Section I - Balance Sheet/Profit and Loss Statement													
Part A - Latest Balance Sheet													
1. Date		2. Filed With		Section III - Credit Rating <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Most Recent Credit Rating</td> <td style="width: 30%;">Date</td> </tr> <tr> <td style="height: 40px;"></td> <td></td> </tr> </table> Section IV - Liens & Judgments <i>(List Outstanding items)</i> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Type</td> <td style="width: 30%;">Amount</td> </tr> <tr> <td style="height: 40px;"></td> <td></td> </tr> </table>		Most Recent Credit Rating	Date			Type	Amount		
Most Recent Credit Rating	Date												
Type	Amount												
3. Financial Position as of:													
a. Cash	\$												
b. Other current assets													
c. Working capital													
d. Current liabilities													
e. Net worth													
f. Total liabilities													
4. Ratios													
a. Current Assets to current liabilities	b. Acid Test <i>(Cash, temporary investments held in lieu of cash and current receivables to current liabilities)</i>		c. Total liabilities to Net Worth										
:	:		:										
Part B - Latest Profit and Loss Statement													
1. Current Period		2. Filed with		Section V - Sign Off Fiscal Year Ends <i>(Date)</i> Balance Sheets and Profit and Loss Statements have been Certified a. Through <i>(Date)</i> b. By <i>(Signature)</i>									
a. From	b. To												
3. Net Profits Before Taxes													
a. Current Period	\$												
b. First prior fiscal year													
c. Second prior fiscal year													

Section II: Demographic Information

CONTRACTOR NAME.

ADDRESS

CITY

STATE

PARENT ORGANIZATION
NAME:

DEPARTMENT OF PUBLIC HEALTH DIVISION

FOR DELIVERY OF _____

TYPE OF BUSINESS OR ORGANIZATION

- ☐ an individual
☐ a nonprofit organization
☐ a private corporation
☐ a public corporation
☐ a partnership
☐ other, explain _____

DATED _____

For Contract Program

For Entire Organization

DEMOGRAPHIC DATA	STAFF		UNDUPLICATED CLIENTS SERVED		STAFF	UNDUPLICATED CLIENTS SERVED	BOARD OF DIRECTORS	
	NUMBER	%	NUMBER	%	NUMBER	%	NUMBER	%
AMERICAN INDIAN/ ALASKAN NATIVE								
ASIAN/PACIFIC ISLANDS								
BLACK								
FILIPINO								
LATINO								
OTHER								
TOTAL MINORITY								
TOTAL WHITE								
GRAND TOTAL								
TOTAL MEN								
TOTAL WOMEN								
GAY*								
LESBIAN*								
BISEXUAL*								

*FOR THOSE PROGRAMS WHOSE TARGET POPULATION SERVES GAYS, LESBIANS OR BISEXUALS, GIVE THE NUMBER OF PERSONS ON YOUR STAFF WHO HAVE OPENLY IDENTIFIED THEIR SEXUAL ORIENTATION.

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 Indian 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: Persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture of 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

SECTION 12:

SUPPLEMENTAL RESPONSE FORMS

The following documentation will be required immediately after written notification of a tentative award. No contract will be awarded to any applicant unable to sign and submit these documents.

1. Certificate of Insurance: Certificate demonstrates that the potential contractor has met all the standard City requirements, including \$1,000,000 General Liability.
2. Declaration of Business Tax Certification Form: Declares compliance with the Business Tax Ordinance.
3. Human Rights Commission Form #2: Provides information for MBE/WBE/LBE bid or ratings preference.
4. Human Rights Commission Form #3: Affidavit declares compliance with Chapters 12B and 12D of the San Francisco Administrative Code (Nondiscrimination in Contracts; Minority/Women/Local Business Enterprise Ordinance).
5. Human Rights Commission Forms #6A and #6B: Employment Affirmative Action Requirements and non-discrimination provisions.
6. Affidavit of Compliance with South Africa Divestment Ordinance

By the affixed signature, the applicant agrees to provide the above documentation within five days of the AIDS Office request.

Authorized Representative Signature

Authorized Representative Name and Title

Applicant

C.A.R.E. Service Area

Date

*With a Great Sense of Accomplishment and
Deep, Satisfying Relief
You Are Cordially Invited To:*

A CELEBRATION OF (Tentative) COMPLETION

*To recognize the achievements of members of the
San Francisco HIV Health Services Planning Council
in surviving the distribution process of
Ryan White Care Funding over the last three months.*

*February 25, 1991
Monday evening
6:00-8:00pm*

*San Francisco AIDS Foundation
25 Van Ness, 3rd Floor
San Francisco*

*Significant Others Welcome
Appreciation Program at 6:45pm*

*Each council member is expected to provide one big tasty dish
(serving 6-10 people). We'll provide beverages, decorations,
paper products and festive music.*

SHANTI PROJECT
525 Howard Street
San Francisco, CA 94105

Admin. Dept.



CONFIDENTIAL

2/12/91 memo to SRH
page 2

CARE Formula Awards

<u>APPLICANT</u>	<u>SERVICE AREA</u>	<u>AMOUNT</u>
AIDS Benefits Counseling Eligibility counseling and advocacy; production and distribution of informational materials	<u>Eligibility/Advocacy/ Case Management</u>	\$ 221,450
AIDS Legal Referral Panel Free and low-cost legal services to assist in Social Security eligibility hearings	" "	\$ 75,000
Health Outreach Team Client-oriented, in-the-field case management for homeless individuals		\$ 117,300
AIDS Health Project Case management and self-advocacy training for women	" "	\$ 60,790
Community Clinic Consortium Early intervention medical services at seven community- based clinic sites	<u>Primary Medical Care</u>	\$ 200,000
18th Street Services Outpatient substance abuse counseling	<u>Other Primary Care</u>	\$ 145,190
UCSF Center on Deafness Outreach and mental health services to deaf clients. Education and clinical consultations to providers caring for deaf clients with HIV	" "	\$ 26,100
Operation Concern Outpatient mental health and substance abuse services to HIV+ clients in the Tenderloin who have psychiatric and substance abuse impairments	" "	\$ 170,000

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2/12/91 Memo to SRH

Page 3

Catholic Charities	<u>Other Primary Care</u>	\$ 95,550
Attendant care services in AIDS residential settings		
AIDS Health Project	" "	\$ 114,700
Outpatient psychiatric consultation and counseling for HIV-infected patients on Ward 86		
PPMC/VNH with Shanti	" "	\$ 270,000
24 hour home/hospice care in residential hotels and congregate sites.		
American Indian AIDS Institute	" "	\$ 70,000
Case management for Native Americans with HIV. Practical support program.		
Walden House	<u>Housing</u>	\$ 200,000
Long-term residential drug and alcohol treatment for HIV+ substance abusers		
AIDS Emergency Fund	" "	\$ 188,000
Assistance to HIV+ individuals in maintaining or gaining housing		
SF AIDS Foundation	" "	\$ 96,350
Emergency housing vouchers		
AIDS Indigent Direct Services with A.B.C.	" "	\$ 250,000
Stabilized housing at SRO, on-site case management benefits counseling and advocacy, and emotional and practical support		
Catholic Charities	" "	\$ 52,000
Expand residential counselor coverage and provide emergency child care at residential program for women and families with AIDS/HIV		
Shanti Project	" "	\$ 100,000
2 additional congregate houses, one four bedroom unit targeting Latinos, one two bedroom unit targeting youth		

2/12/91 Memo to SRH

Page 4

Shanti Project with Women's Building and A.I.D.S. Peer counseling and practical support for Tenderloin, Mission and South of Market areas	<u>Psychosocial Support</u>	\$ 200,000
Tenderloin AIDS Resource Center Emotional support to HIV+ gay/bisexual men and transgender persons with a history of substance abuse	" "	\$ 54,260
The Bridge for Kids Child care services to HIV infected families of color	" "	\$ 44,170
Home Care Companions Training of friends and family in basic home-care skills	" "	\$ 41,500
BAHSES - BWMT/MACT Emotional group peer support	" "	\$ 75,000
SF Suicide Prevention Emotional support, crisis intervention and suicide prevention through AIDS/HIV nightline	" "	\$ 60,000
Gay Men of Color/EACH with Project Inform Early intervention and HIV treatment advocacy to HIV infected, targeting: gay/bisexual people of color who have sex with men; hard to reach indigent gay/bisexual white men	" "	\$ 150,000
Instituto Familiar de la Raza Psychosocial support to Latinos with AIDS/ARC	" "	\$ 100,000
Project Open Hand Bulk food purchases for home delivered food for persons with AIDS/disabling HIV	<u>Food and Nutrition</u>	\$ 125,000
SF Food Bank Food purchase and delivery of food boxes to HIV+ persons experiencing temporary crisis, targeting persons with HIV not registered with AIDS service providers	" "	\$ 112,720

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CARE Supplemental Awards
(in priority order)

<u>APPLICANT</u>	<u>SERVICE AREA</u>	<u>AMOUNT</u>
GCHP & Filipino Task Force Coordination and provision of client-oriented and advocacy services	<u>Eligibility/Advocacy/ Case Management</u>	\$ 75,000
CURAS Financial assistance and advocacy for entitlements for Latinos	" "	\$ 100,000
Walden House Augment long-term residential drug and alcohol treatment	<u>Housing</u>	\$ 214,030
Baker Places Medium term residential substance abuse treatment for HIV+	" "	\$ 208,800
Shanti Project Housing resource clearinghouse and computerized network, including roommate matching, shared housing referrals, monthly newsletter and resource room	" "	\$ 160,000
Shanti Project Housing subsidies for families with AIDS	" "	\$ 215,000
PPMC/VNH In-home practical support as respite to family members/informal care providers	" "	\$ 75,000
Maitri AIDS Hospice Residential hospice services, targeting indigent persons with end-stage disease	" "	\$ 50,000
University of the Pacific School of Dentistry Dental care for underinsured/ uninsured persons with HIV	<u>Primary Medical Care</u>	\$ 300,000

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Community Clinic Consortium	<u>Primary Medical Care</u>	\$ 300,000
Augment early intervention medical services at seven community based clinic sites		
PPMC/VNH	<u>Other Primary Care</u>	\$ 210,500
Augment home care services primarily in residential hotels or congregate sites		
Continuum Adult Day Health	" "	\$ 40,000
Substance abuse counseling in existing day health program		
Operation Concern	" "	\$ 115,000
Augment outpatient mental health and substance abuse services		
AIDS Health Project	" "	\$ 100,000
Augment services for substance abusers with HIV infection		
Family Service Agency	<u>Primary Medical Care</u>	\$ 87,000
Neuropsychologic and psychiatric evaluations in private office and possibly in-home		
AIDS Health Project	" "	\$ 62,000
Community-based psychiatric consultation service		
Bayview Hunters Point Fndn	<u>Psychosocial Support</u>	\$ 100,000
Recruit and train volunteers for emotional and practical support including childcare, in Southeast SF		
Shanti Project	" "	\$ 175,000
Recruit volunteers to provide peer counseling and practical support for indigent gay men		
BAHSES/BWMT/MACT	" "	\$ 5,000
Transportation services for program participants		
Operation Concern	" "	\$ 100,000
Early intervention psychosocial support services: needs assessment, crisis intervention, counseling, and as needed case management		

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2/12/91 memo to SRH

Page 7

Larkin Street Youth Center	<u>Psychosocial Support</u>	\$ 118,090
After care program for homeless HIV+ youth: outreach, case management, support groups and individual counseling		
SF AIDS Foundation	<u>Food & Nutrition</u>	\$ 137,280
Food for the AIDS Food Bank for persons with AIDS/disabling HIV		
Project Open Hand	" "	\$ 125,000
Food for home-delivered meals		

2/11/91 memo to SRH

1 of 4

(Revised 2/13/91 at 11:30 a.m.)

CARE Applicants Not Recommended for Funding

APPLICANTSERVICE AREA

Trials Search
 Central City Hospitality House
 Income Rights Project
 Operation Concern
 St. Luke's Hospital
 Catholic Charities
 Westside Community Mental Health

Eligibility/Advocacy/Case Management

BAART
 Immune Enhancement
 Quan Yin
 Westside Community Mental Health
 Mt Zion/UCSF
 Bayview Hunters Point Foundation

Other Primary Care

HOPE House
 Independent Housing Services

Housing

SF AIDS Foundation
 Bayview Hunters Point Foundation
 Davies Medical Center

Primary Medical Care

*The Rest Stop Support Center
 SF Black Coalition on AIDS
 *St Benedict Deaf AIDS Info Center
 PPMC - Dept. of Pastoral Care
 Walden House
 **Parents Pediatric AIDS Coalition
 AIDS Health Project
 *Kids Foundation

Psychosocial Support

*** Foundation of Wisdom Social Ministry

Service Area Not Identified

* Received and were distributed to review teams but did not get evaluated because they exceeded the 70% budget limit, or did not provide enough information to determine if they were within the 70% limit.

** Did not propose services for the eligible geographic area.

*** Accepted before the deadline, but on examination the AIDS Office determined that it did not follow the format specified nor identify a service area, and was in fact unreadable.



February 5, 1991

Reggie Williams
273 Church Street
San Francisco, CA 94114

Dear

Reggie,

The AIDS Office would like to thank you for your participation in the CARE review process. The six teams reviewed 67 Letters of Application, thoroughly and with good humor.

Your expertise and your commitment were invaluable. We recognize that for many people this review process was a substantial gift of time and energy. Consequently, our thanks go not only to you, but to your organizations and clients for their patience and generosity.

We'd like to remind you that review results, recommendations, and discussions must remain confidential until after letters of notification have been mailed. We expect to be sending notifications on February 19. Until that time, all inquiries should be forwarded to Judith Weld at 554-9044. After that time, you may respond to any inquiries from applicant organizations. However, please feel free to refer any questions to Judith if you prefer. Remember that all applicants will be permitted to review their scores and the team's comments.

Again, our sincerest thanks for your assistance.

Sincerely,

Sophia Chang

Sophia Chang, M.D.
Chief, Health Resources and Services Branch

2291aae



To: Planning Council
FYI

From: Sophia Chang

March 13, 1991

To: All Potential Contractors

From: Maria Lemus, Chief of Operations

Re: Request for Proposals #118-91

We will be issuing an RFP on Monday, March 18, 1991. You can either stop by to pick it up or phone our office (554-9000) to have one mailed to you. Please refer to this RFP by number. Below are descriptions and other pertinent information regarding this RFP. Please note that all amounts are approximate, contingent on available funding.

RFP # 118-91

Early Intervention Resource Center

Description

The AIDS Office is seeking proposals to: 1) identify, develop, and operate a facility which will house Early Intervention Resource services; 2) provide psychosocial, health education, intake, assessment, outreach, case management and advocacy services to HIV infected individuals at the Early Intervention Resource Center.

Amount Available

Approximately \$1,325,000 total, tentatively distributed as follows:

- | | | |
|----|--|-----------|
| A. | Site operation and administration | \$450,000 |
| B. | Psychosocial support and counseling | \$275,000 |
| C. | Health education and clinical trials advocacy | \$200,000 |
| D. | Linkage to early medical care services (including substance abuse treatment) | \$150,000 |
| E. | Centralized intake/assessment, outreach, and case management | \$250,000 |

Bidders Conference

March 25, 1991 at 3:30 p.m. This will be the only opportunity to ask questions about the services solicited. Minutes will be sent to everyone who requests or receives a copy of this RFP.

Due Date

Proposals will be due on April 5, 1991 by 12:00 noon. There will be no exceptions to this deadline.

cc: Judith Weld, RFP Coordinator

SF DEPT. OF PUBLIC HEALTH/AIDS OFFICE
HEALTH RESOURCES & SERVICES BRANCH (HRSB)
CONTRACTOR'S QUARTERLY REPORT: FY 1990-91

DRAFT

Contract Agency: _____ QTR: _____ Mar. _____ Jun. _____ Sep. _____ Dec. _____
Program (Cost Center): _____ Report Completed (date): _____ / _____ / _____
Agency Contact Person: _____ AIDS Office Pgm. Mgr: _____

PROGRAM SERVICES PROVIDED

I. UNITS OF SERVICE (UOS)

	<u>Calendar Quarter</u>	<u>Contract Period-to-Date</u>
A. Actual UOS	_____	_____
B. Projected UOS (from contract)	_____	_____
C. % Service Utilization	_____	_____
D. Actual Contract Cost/UOS	\$ _____ . _____	
E. Projected Cost/UOS (from contract)	\$ _____ . _____	
F. Actual Total Program Cost/UOS	\$ _____ . _____	
G. Projected Total Program Cost/UOS	\$ _____ . _____	

II. CLIENT INFORMATION (One item per client in each category unless otherwise indicated. Use actual counts for each item. Do not use percents.)

A. NUMBER CLIENTS SERVED (Undup.) _____ Total/Qtr. _____ Contract Period-to-Date _____
_____ Average number of clients served/day

B. SEX _____ Male
_____ Female

C. AGE _____ less than 12 yrs. _____ 30-39 yrs. _____ 60+ yrs.
_____ 13-19 yrs. _____ 40-49 yrs.
_____ 20-29 yrs. _____ 50-59 yrs.

D. ETHNICITY _____ White _____ Asian/Pac. Islander
_____ African-American _____ Native American
_____ Latino _____ Other: _____

E. TRANSMISSION CATEGORY _____ Gay/bisexual male _____ Transfusion recipient/ blood disorders
 _____ Injection drug user (IDU) _____ Partner of high risk group
 _____ Gay/bisexual and IDU _____ Other(specify): _____
 _____ Unknown _____

F. SOURCE OF REFERRAL _____ SFGH _____ Other (Churches, etc. specify): _____
 _____ Public Health Provider _____
 _____ Private Health Provider _____ Self
 _____ Comm. Service Provider (CBO, etc.) _____ Friend/Family/Lover
 _____ Unknown _____

G. LIVING SITUATION _____ Alone (at home, apt.) _____ Hotel
 _____ With lover/spouse _____ Comm. Svc. Provider (CBO)
 _____ With blood relative _____ Hospital/institution
 _____ With friends _____ Other (specify): _____
 _____ Unknown _____ Unstable, no permanent address

H. PAYMENT SOURCE (include all applicable insurance & payment sources) _____ Medi-Cal _____ Other (VA, CHAMPUS, etc): _____
 _____ Medicare _____ HMO
 _____ Private Insurance _____ Uninsured status (inc. undocumented)
 _____ Medi-Cal + other ins. _____ Unknown

I. CLIENT SELF-PAY a) _____ Yes b) If "Yes": _____ copayment?
 _____ No _____ sliding scale?
 _____ other(specify): _____

J. MEDICAL DIAGNOSES (may be more than one for each client) _____ Certified AIDS diagnosis _____ Hx of Mental Illness; other psychiatric disorders/conditions
 _____ AIDS Dementia _____
 _____ History (Hx) of alcohol or drugs _____ Other(specify): _____

FISCAL REPORTING

1. Is the cost/unit of service changing? _____ No _____ Yes
If "yes", please explain:

2. How does the contracted cost/unit of service reflect the true
/actual cost per unit of service (UOS)?

PROGRAM SERVICE DESCRIPTION

1. Has this program changed in any way? (include scope, goals and
objectives, staff, volunteers,) _____ No _____ Yes

If "yes", please comment:

2. How has the program succeeded?

What are its strengths?

3. Has the program noted any problems? _____ No _____ Yes
Please comment:

What steps have been taken towards their resolution?

4. Have you noted any gaps in available services? _____ No _____ Yes
If "yes", where do they occur?

UNMET DEMAND FOR SERVICES

1. Does your program maintain a waiting list? _____ No _____ Yes
How long is that list?

What is the average waiting time?

2. Where does the program refer those who are awaiting services?
(include those not accepted onto a waiting list)

EVALUATION and QUALITY ASSURANCE

1. What evaluation procedures have you undertaken this quarter?

2. What were their results?

INSTRUCTIONS FOR COMPLETING HRS/BRANCH CONTRACTOR'S QUARTERLY REPORT
To be completed by Agency Contact Person at all applicable contract sites
for clients served during the report quarter.

GENERAL INSTRUCTIONS

1. Reports will be completed for every calendar quarter of the contract period. Check appropriate quarter for each report.
2. Fill out name of your Contract Agency, the Program (cost center) for clients seen, and the name of your AIDS Office Program Manager in the spaces provided.
3. Fill out the date you are completing this report in month/day/year format (mm/dd/yy).
Example: 05/14/91.

CLIENT INFORMATION

1. Use actual counts reported during the report period for all items in this section.
DO NOT USE PERCENTS.
2. Enter the total number of different clients served: a) during the report quarter, and b) since the start of the current contract period. Also enter the average number of clients served per day.
(Total # qtr./90 days)
3. For Items B. thru G: Enter the total number of different clients served during the report quarter. Each of these items is mutually exclusive: an individual client can have only one entry for each of these items.
4. Items H thru J (Payment Source, Client Self-Pay, Medical Diagnoses): More than one (1) entry may be included under each of these items for each client. Include all that apply for all clients in your tabulations for each report period.
5. If you are uncertain how to include a particular client in your program in these categories, please contact your AIDS Office Program Manager.

SEND TO: HRS/BRANCH DATA MANAGER
 DPH/AIDS OFFICE
 25 VAN NESS AVENUE, SUITE 500
 SAN FRANCISCO, CA. 94102-6033

DRAFT

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET

P.O. BOX 942732

SACRAMENTO, CA 94234-7320

(916) 323-7415



March 8, 1991

The Honorable Art Agnos, Mayor
City of San Francisco
San Francisco, CA 94102

Dear Mayor Agnos:

As you know, I was invited to serve as a member of the San Francisco HIV Health Service Planning Council established for the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, Title I funds. Since I personally could not make the time commitment required by the Council, Anna Ramirez and Peggy Falknor, staff from the Office of AIDS, both attended in my stead. Through their reports, I was able to keep abreast of the activities and efforts that went into the application process as well as the allocation of funds to the various public and private entities. Both Ms. Ramirez and Ms. Falknor were very impressed with the dedication and efforts on the part of the San Francisco Public Health Department staff, cochairs, Sandra Hernandez, M.D., and Pierre Ludington, and the representatives from the various AIDS service agencies.

I have been informed that the San Francisco Public Health Department plans to continue meeting regularly with the Council on an ongoing basis. Because of the demands on Office of AIDS staff and statewide program priorities, we will be unable to attend regularly. Ms. Ramirez has contacted Dr. Hernandez and requested that we be kept informed of the meetings, and at any time Dr. Hernandez thinks it is in the best interest of the State and Council for State representatives to attend, we will do so.

Congratulations on an excellent application and process. The Council members and cochairs did an outstanding job under severe time constraints. Thank you for the opportunity to be a part of that process.

Sincerely,

A handwritten signature in black ink, reading 'Wayne E. Sauseda'.

Wayne E. Sauseda, Chief
Office of AIDS

cc: See next page

cc: Sandra Hernandez, M.D.
AIDS Office
City and County of San Francisco
25 Van Ness Avenue, Suite 500
San Francisco, CA 94102-6033

Mr. Pierre Ludington
Cochairperson
HIV Planning Council
AIDS Office
City and County of San Francisco
25 Van Ness Avenue, Suite 500
San Francisco, CA 94102-6033

Ms. Peggy Falknor, Chief
Pilot Care Project Unit
Ms. Anna Ramirez, Chief
Preventive Services Section
Office of AIDS
Department of Health Services
P. O. Box 942732
Sacramento, CA 94234-7320

RYAN WHITE CARE ACT

MEMORANDUM

TO : COMMISSIONERS

FROM: CARLTON LEE

DATE: NOVEMBER 1, 1990

SUBJ: AIDS & THE 101st CONGRESS

The 101st Congress produced a number of legislative successes relating to the HIV epidemic, with passage of the Americans with Disabilities Act and the Ryan White CARE Act being the most significant. Listed below are a number of actions taken by the Congress which will impact upon our nation's response to AIDS. Relevant materials are also attached. The National Commission on AIDS played an important role in the policy-making processes of each of these endeavors and, as it develops its final recommendations during the next year, the Commission will likely play an even greater role in the 102nd Congress.

APPROPRIATIONS

Federal spending on AIDS-related programs will grow from \$1.58 billion in FY 1990 to \$1.88 billion in FY 1991, an increase of about 19%. This is 11% more than the Administration requested. Nevertheless, the increase was disappointing given the excitement over recent passage of the Ryan White CARE Act, funding for which fell far short of what is needed. Nevertheless, with budget politics and constraints dominating the Washington scene, AIDS funding overall fared better than some expected for FY 1991.

All PHS agencies received some increase over last year, with the largest increase (132%) going to the Health Resources Services Administration (HRSA). The HRSA increase is primarily due to the monies appropriated under the CARE Act. A chart comparing the amounts appropriated for AIDS in Fiscal Years 1990 and 1991 is attached for your information.

RYAN WHITE CARE ACT (P.L. 101-381)

The Comprehensive AIDS Resources Emergency (CARE) Act of 1990, sponsored in the Senate by Ted Kennedy and Orrin Hatch, and by Henry Waxman in the House of Representatives, was signed by the President on August 18, 1990. As you know, this measure authorized programs to provide "disaster relief" to the 16 cities hardest hit by the HIV epidemic and grants to all states for the delivery of comprehensive health and support services for individuals and families with HIV disease in both urban and rural

areas. The total authorization for this bill was \$875 million.

Funding for the CARE Act in FY 1991 will total about \$350 million, including \$88 million for disaster relief, \$88 million for grants to states, much of which will fund ongoing programs, \$45 million for early intervention programs, and \$130 million for existing CDC counseling/testing programs. These monies are reflected in the attached chart on overall AIDS spending.

AMERICANS WITH DISABILITIES ACT (P.L. 101-336)

The ADA was signed by President Bush on July 26, 1990. The new law will provide sweeping protections for people with disabilities, including people with AIDS and HIV infection, in the areas of employment, public accommodations, public services, communications, and transportation. Additional materials about the ADA, including its implementation schedule, are attached.

As you may recall, one of the most controversial issues during consideration of the ADA was an amendment attached to the House version of the bill which allowed a business to transfer a "food handler" with HIV infection to a non-food handling position to alleviate public concerns. The outrage expressed towards the amendment by numerous entities, including the Commission, led to the amendment being dropped by the House/Senate conference committee on the ADA.

HIV IMMIGRATION POLICY

There was very good news on this front during the waning hours of the 101st Congress. An amendment to the Immigration Act of 1990, sponsored by Senator Kennedy, instructs the Secretary of HHS to issue a list of "communicable diseases of public health significance" for which an alien could be excluded from the United States. The list is to be restricted to only those diseases which pose a direct threat to the public health.

The decision as to whether HIV shall be a part of such a list now rests with the Administration. Given the recommendation of the CDC that current U.S. policy in this regard be revised, as well as statements by HHS officials in the past, it is expected that the new list will not include HIV infection.

On October 30, 1990 officials with the Harvard AIDS Institute announced that Harvard University will continue as sponsor of the 1992 VIII International Conference on AIDS to be held in Boston. Planning for the conference, they said, will proceed on schedule given the recent action by the Congress.

The Commission played a crucial role in the effort to revise current U.S. immigration policy relating to HIV infection.

AIDS HOUSING OPPORTUNITIES ACT

The AIDS Housing Opportunities Act was sponsored by Representatives Jim McDermott (D-WA), Nancy Pelosi (D-CA), and Charles Schumer (D-NY). The bill was incorporated into an omnibus housing bill called the National Affordable Housing Act of 1990, which was approved by the Congress prior to adjournment.

The "Housing Opportunities for Persons with AIDS" section of the bill authorizes \$75 million in FY 1991 and \$156 million in FY 1992 for special housing assistance for people with AIDS. Unfortunately, no monies were actually appropriated by the Congress for these programs in FY 1991. Unless a supplemental appropriation bill for FY 1991, which includes monies for these programs, is passed and signed next year, funding will not be possible until FY 1992. Under the bill, ten percent of the funds will be distributed by HUD on a competitive basis, and ninety percent will be distributed directly to cities and states through formula grants.

Cities and states may use the funds for a number of housing services, including rental subsidies, construction of new housing, renovation of existing housing, homeless prevention programs, community residential facilities, and information services.

ORPHAN DRUG AMENDMENTS ACT OF 1990

One of the Congress' final actions was the passage of the Orphan Drug Amendments Act of 1990, sponsored by Henry Waxman in the House and Howard Metzenbaum in the Senate. The Orphan Drug Act provides incentives for the development of drugs with a domestic market of fewer than 200,000 people. Under the new measure, current law is changed so that once the FDA makes a determination that over 200,000 individuals could benefit from an orphan drug, the manufacturer of such drug will lose its exclusivity rights to marketing.

It is thought that several AIDS-related drugs approved or in the "pipeline" under the Orphan Drug Act have marketing potential for populations exceeding the 200,000 mark. The new law also stipulates that in cases where two drug manufacturers are marketing the same drug, they will share exclusivity rights to the drug if they file applications with the FDA within six months of one another.

CONFIRMATIONS

Prior to leaving, the Senate confirmed Dr. David Kessler as Commissioner of the FDA. Kessler, 39, is the medical director of the Jack D. Weiler Hospital at the Albert Einstein College of

Medicine in New York.

In response to a question from Senator Kennedy about whether or not he supported the continuation of FDA initiatives such as expanded use of the Treatment IND program and Parallel Track, Dr. Kessler said:

"Yes, I support the use of Treatment INDs and the Parallel Track concept to make AIDS treatments available to patients prior to approval. However, I think it is vital to remember that we still have a great deal to learn from these experiences."

Earlier in the year, the Senate confirmed Dr. Antonia Novello as Surgeon General.

AIDS Appropriations for FY 1991 in Millions

<u>Agency</u>	<u>FY 1990</u>	<u>FY 1991</u>	<u>\$ Increase</u>	<u>% Increase</u>
HRSA	112.5	261.7	148.7	132
CDC	442.8	496.8	54.0	12
OASH	7.7	8.3	.6	8
NIH	743.5	821.0	77.4	10
ADAMHA	214.6	225.0	10.3	14
AHCPR	8.5	10.5	2.0	23
FDA	56.2	63.2	7.0	12
<u>TOTAL</u>	1585.8	1886.5	303.1	19

* NOTE - The National Commission on AIDS received an appropriation of \$2.9 million for FY 1991.

Title I - Emergency Relief Grants, FY 1991

Formula Grants (50% of Total in Title I)**

<u>Eligible Metropolitan Area</u>	<u>Total Grant</u>
New York	\$ 16,145,228
Los Angeles	4,003,841
San Francisco	6,523,700
Houston	1,865,099
Washington, D.C.	1,690,963
Newark	2,007,670
Miami	1,893,649
Chicago	1,378,174
Philadelphia	1,185,519
Atlanta	1,206,370
San Juan	1,206,963
Dallas	998,731
Boston	935,220
Fort Lauderdale	1,105,896
San Diego	873,650
Jersey City	892,826

TOTAL**\$43,913,900**

*The remaining 50% will be disbursed among the 16 eligible cities as competitive grants.

* Approximate. Final numbers will be available at a later date.

CARE Act: Title II - State Grants, Fiscal Year 1991¹

<u>States & Territories</u>	<u>Grants</u>	<u>States & Territories</u>	<u>Grants</u>	<u>States & Territories</u>	<u>Grants</u>
Alabama	488,827	Maine	126,192	Tennessee	228,923 -
Alaska	100,000	Maryland	1,487,704	Texas	4,340,707
Arizona	685,790	Massachusetts	1,593,573	Utah	169,814
Arkansas	226,423	Michigan	1,097,771	Vermont	130,000
California	13,050,535	Minnesota	363,150	Virginia	488,182
Colorado	752,449	Mississippi	429,628	Washington	1,033,059
Connecticut	833,845	Missouri	1,017,904	West Virginia	130,000
Delaware	172,214	Montana	100,000	Wisconsin	204,992
District of Columbia	1,056,000	Nebraska	100,000	Wyoming	130,000
Florida	7,545,162	Nevada	327,328	American Samoa	30,000
Georgia	2,397,031	New Hampshire	102,482	Guam	30,000
Hawaii	326,104	New Jersey	4,597,908	Marshall Islands	-0-
Idaho	100,000	New Mexico	204,542	N. Marianas	30,000
Illinois	2,408,854	New York	14,590,209	Virgin Islands	30,000
Indiana	538,244	North Carolina	973,837	TOTAL	\$79,047,900
Iowa	116,208	North Dakota	100,000		
Kansas	240,860	Ohio	1,185,083		
Kentucky	291,994	Oklahoma	222,310		
Louisiana	1,247,807	Oregon	295,030		
		Pennsylvania	1,958,699		
		Puerto Rico	3,709,892		
		Rhode Island	166,567		
		South Carolina	347,959		
		South Dakota	166,489		

¹Figures are provisional: Based on an appropriation of \$87.8 million with 10% set aside for the Secretary for special programs of national significance.

* Approximate. Final numbers will be available at a later date.



Americans with Disabilities Act Requirements Fact Sheet

Employment

- ✓ Employers may not discriminate against an individual with a disability in hiring or promotion if the person is otherwise qualified for the job.
- ✓ Employers can ask about one's ability to perform a job, but cannot inquire if someone has a disability or subject a person to tests that tend to screen out people with disabilities.
- ✓ Employers will need to provide "reasonable accommodation" to individuals with disabilities. This includes steps such as job restructuring and modification of equipment.
- ✓ Employers do not need to provide accommodations that impose an "undue hardship" on business operations.

Who needs to comply:

- ✓ All employers with 25 or more employees must comply, effective July 26, 1992.
- ✓ All employers with 15-24 employees must comply, effective July 26, 1994.

Transportation

- ✓ New public transit buses ordered after August 26, 1990, must be accessible to individuals with disabilities.
- ✓ Transit authorities must provide comparable paratransit or other special transportation services to individuals with disabilities who cannot use fixed route bus services, unless an undue burden would result.
- ✓ Existing rail systems must have one accessible car per train by July 26, 1995.
- ✓ New rail cars ordered after August 26, 1990, must be accessible.
- ✓ New bus and train stations must be accessible.
- ✓ Key stations in rapid, light, and commuter rail systems must be made accessible by July 26, 1993, with extensions up to 20 years for commuter rail (30 years for rapid and light rail).
- ✓ All existing Amtrak stations must be accessible by July 26, 2010.



Americans with Disabilities Act Statutory Deadlines

I. Employment

- The ADA requirements become effective on:
 - July 26, 1992, for employers with 25 or more employees.
 - July 26, 1994, for employers with 15-24 employees.

II. Public Accommodations

- The ADA requirements become effective on:
 - January 26, 1992, generally.
 - August 26, 1990, for purchase or lease of new vehicles that are required to be accessible.
 - January 26, 1993, for new construction.
- Generally, lawsuits may not be filed until January 26, 1992. In addition, except with respect to alterations, no lawsuit may be filed until:
 - July 26, 1992, against businesses with 25 or fewer employees and gross receipts of \$1 million or less.
 - January 26, 1993, against businesses with 10 or fewer employees and gross receipts of \$500,000 or less.

III. Transportation

A. Public bus systems

- The ADA requirements become effective on:
 - January 26, 1992, generally.
 - August 26, 1990, for purchase or lease of new buses.

B. Public rail systems -- light, rapid, commuter, and intercity (Amtrak) rail

- The ADA requirements become effective on:
 - January 26, 1992, generally.
 - August 26, 1990, for purchase or lease of new rail vehicles.
- By July 26, 1995, one car per train accessibility must be achieved.

CARE IMPLEMENTATION TIMELINE

1991
Mar Apr May Jun Jul Aug Sep Oct Nov Dec 1992
Jan Feb Mar Apr May Jun Jul

1. Hold public meeting re: allocations *
2. Develop quarterly report form x
3. Approve SM and Marin evaluation system x
4. Contracts and Dept. MOUs processed x
5. Supplemental funded services begin *
6. Receive quarterly reports *
7. Analyze quarterly reports x *
8. Develop schedule for presentations x *
9. Form 6 working evaluation groups x *
10. Send presentation notices to agencies x *
11. Call for updated needs assessments *
12. Identify all HIV service providers x
13. Final schedule for agency present's x
14. Develop site visit review teams/
develop criteria and review form x
15. Receive AIDS case and seroprev. data *
16. Working groups evaluate services/make
recommendations to Council x
17. Agency presentations to Council x
18. Receive needs assessments x
19. Hold public hearing *
20. Analyze needs assessments x
21. Identify new unmet needs and
target populations x
22. Develop updated Continuum of Care x
23. AIDS Office presents city funded
services progress to Council x
24. Cost data due to HRSA x
25. Develop site visit schedule *
26. Evaluate CARE service expenditures
from quarterly reports x
27. Site visits conducted to each agency x
28. Assess availability of other funding
sources/Determine re-allocation CARE \$ x
29. Council finalizes evaluations
of existing services x
30. Develop written plan to address
newly identified needs x
31. Review San Mateo and Marin County
evaluation reports x

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IMPLEMENTATION PLAN OUTLINE

G1

GOAL #1: Ensure the rapid allocation and distribution of CARE funds.

Objective 1.1: By 2-5-91, the HIV Planning Council develops and approves a final allocation of formula and supplemental funds by service area.

Activities:

- 1.1.0 By 12-28-90, develop Letter of Application process, in conjunction with City Attorney and Department of Public Health Office of Contracts Management.
- 1.1.1 By 1-7-91, obtain Planning Council approval of process and application instructions.
- 1.1.2 * By 1-10-91, develop announcement of request for applications; by 1-14-91, post announcement in public areas and publicize in newspaper.
- 1.1.3 Hold technical assistance meetings for applicants 1-18-91, 1-19-91, 1-20-91
- 1.1.4 By 1-24-91, develop and approve rating method and criteria for scoring applications.
- 1.1.5 By 1-24-91, finalize voting members and technical assistants to serve on review panels.
- 1.1.7 On 1-25-91, conduct informational meeting for review teams, and distribute letters of application for review.
- 1.1.8 By 2-1-91, receive review committees' recommendations for specific services to be funded, in priority order.
- 1.1.9 * By 2-4-91, develop draft budget for Supplemental funds and get Planning Council approval on overall use of funds (not contractor specific); by 2-5-91, finalize budget for Supplemental funds.
- 1.1.10 * By 3-31-91, the Planning Council will hold a public information meeting to report their assessment of HIV service needs, priorities, and the proposed use of CARE funds.

*indicates milestones

Objective 1.2: By 7-1-91, begin CARE Supplemental funded services

Activities:

- 1.2.0 By 5-1-91, AIDS Office negotiates and develops contractual agreements with CARE service agencies.
- 1.2.1 * By 6-5-91, Department of Public Health Contracts Office processes contracts.
- 1.2.2 By 6-5-91, Director of AIDS Office finalizes Departmental service memoranda of understanding.
- 1.2.3 * By 6-15-91, the Planning Council assesses the rapid implementation of contracts through monthly progress reports regarding contract development and processing.
- 1.2.4 * By 7-1-91, Supplemental funded services begin.

GOAL #2: Monitor the progress and impact of CARE funded program activities and services.

Objective 2.1: By one month post-quarterly reporting period (July 31, 1991; October 31, 1991; January 31, 1992; and April 30, 1992), the HIV Planning Council reviews and analyzes agencies' quarterly reports for progress in providing CARE services to target population as proposed.

Activities:

- 2.1.0 By April 1, 1991, the Planning Council develops and approves a quarterly report form for reporting purposes.
- 2.1.1 * By two weeks post-reporting period (July 15, 1991; October 15, 1991; January 15, 1992; and April 15, 1992), the Planning Council receives quarterly reports submitted by CARE services agencies.

- 2.1.2 * By six weeks post-reporting period (August 15, 1991; November 15, 1991; February 15, 1992; and May 15, 1992), the Planning Council discusses quarterly reports at Council meetings, and evaluates CARE service expenditures. These reports will be forwarded by AIDS Office staff to HRSA.
- 2.1.3 * By nine months after receiving the CARE Supplemental Grant award (January 1, 1992), the AIDS Office will provide HRSA with data on funded service categories, current or estimated average cost for providing the service, an estimate of the number of persons receiving the service, and the extent of third party reimbursement for each service.
- 2.1.4 At year end, AIDS Office staff will provide HRSA with a financial report identifying: (1) the cumulative obligation and disbursement of funds; and (2) financial statements from each service provider and all contractors identifying the amount of funds received and disbursed.

Objective 2.2: By July 1, 1992, HIV Planning Council site visit teams conduct at least one sit visit to each CARE service program.

Activities:

- 2.2.0 By 10-1-91, the Planning Council forms site visit teams.
- 2.2.1 By 10-1-91, the Planning Council develops a list of criteria, and a review form, for site visit assessment.
- 2.2.2 * By 12-31-91, the Planning Council develops a schedule for conducting site visits.
- 2.2.3 * By one month post-site visits, site visit teams report back to the Planning Council and make recommendations regarding program services.

* indicates milestones

Objective 2.3: By 7-1-92, each CARE program presents to the HIV Planning Council their progress in providing CARE services.

Activities:

- 2.3.0 By 7-1-91, the Planning Council develops a format for presentation by agencies.
- 2.3.1 * By 8-1-91, the Planning Council develops a schedule for presentations by agencies at Council meetings, by service area.
- 2.3.2 * By 8-15-91, the Planning Council sends out notices to each agency requesting their presentation as scheduled.
- 2.3.3 By 9-15-91, the Planning Council receives feedback and reschedules presentations as necessary.
- 2.3.4 * CARE programs present requested information to the Planning Council as scheduled.

GOAL #3: Amend CARE funded program activities, over time, to ensure their appropriateness and effectiveness in meeting identified service needs.

Objective 3.1: By 12-31-91, the HIV Planning Council develops an updated Continuum of Care for HIV Services, and identifies new/changing unmet needs.

Activities:

- 3.1.0 By 9-1-91, the Planning Council announces a call for updated needs assessments for HIV services by coalitions, task forces, and advisory groups representing the full spectrum of HIV infected populations and sub-populations.

* indicates milestones

- 3.1.1 * By 11-1-91, all updated needs assessments are submitted to the Planning Council for review and the Planning Council will hold a public hearing to hear publicly perceived gaps and problems with existing services.
- 3.1.2 By 12-1-91, an analysis of all needs assessments is developed by the Planning Council and staff to the Council.
- 3.1.3 * Quarterly, the Planning Council receives and reviews up to date AIDS Case data and Seroprevalence data for the San Francisco EMA.
- 3.1.4 As available, the Planning Council receives trends analyses developed by the Surveillance Branch staff of the Department of Public Health AIDS Office.
- 3.1.5 * By 12-15-91, the Planning Council identifies new unmet needs and target populations for HIV Services.
- 3.1.6 By 12-31-91, the Planning Council incorporates newly identified unmet service needs and populations into the Continuum of Care for HIV Services.

Objective 3.2: By 2-15-92, the HIV Planning Council conducts a system-wide evaluation of all existing HIV services.

Activities:

- 3.2.0 * By 8-1-91, the Planning Council forms 6 working groups (one for each service category) to evaluate service delivery.
- 3.2.1 * By 9-15-91, working groups identify all HIV service providers in the EMA (including non-CARE funded agencies) for their service category.
- 3.2.3 By 12-15-91, the AIDS Office staff presents information at Planning Council meetings regarding City funded services.
- 3.2.4 * By 1-15-92, working groups make recommendations to full Planning Council based on outcome of evaluations.

* indicates milestones

Objective 3.3: By 3-15-92, the HIV Planning Council develops a plan to address newly identified unmet service needs and populations.

Activities:

- 3.3.0 * By 1-15-92, the Planning Council evaluates CARE service expenditures from quarterly reports by CARE funded programs.
- 3.3.1 By 2-15-92, the Planning Council, with assistance from the AIDS Office, assesses the availability of other sources of funding for HIV services.
- 3.3.2 * By 2-15-92, the Planning Council determines re-allocation of CARE monies, as indicated.
- 3.3.3 By 3-15-92, staff to the Planning Council develop a written plan identifying service provision to meet newly identified needs.

GOAL #4: Ensure accountability for all HIV CARE Services provided within the EMA.

Objective 4.1: On a quarterly basis (by July 31, 1991; October 31, 1991; January 31, 1992; and April 30, 1992), the HIV Planning Council reviews and analyzes evaluation reports from San Mateo and Marin Counties on the use of Supplemental CARE funds within their respective counties.

Activities:

- 4.1.0 * By April 1, 1991, Marin and San Mateo Counties develop and propose an evaluation system for monitoring progress in providing CARE services in their respective counties.
- 4.1.1 By April 15, 1991, the Planning Council amends, if necessary, and approves the evaluation system.

*indicates milestones

- 4.1.2 Representatives from San Mateo and Marin Counties on the Intergovernmental Sub-Committee serve as liaisons to the respective counties' HIV Planning Committee and Advisory Commission regarding ongoing evaluation processes.
- 4.1.3 * As mutually agreed upon, the HIV Planning Council receives and analyzes quarterly and any other evaluation reports regarding San Mateo and Marin Counties' CARE funded programs.

* indicates milestones

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HIV/AIDS UPDATE

Volume 2, Number 1 - January, 1991



LEGISLATIVE AND POLICY UPDATE

CARE: States received final Title II CARE application and implementation guidelines as well as a listing of the dollar amounts of State awards at the HRSA-sponsored technical assistance meeting held January 16-17 in Washington, D.C. ASTHO worked with HRSA on development of the guidelines, provided comments from several States, and argued strongly against additional mandates in HRSA's application and reporting guidelines. HRSA was very receptive and responsive to the needs of the States in these discussions, and special thanks goes to the following States for providing comments under such a short deadline: **Arizona, Colorado, Connecticut, New York, Oregon, Rhode Island, South Carolina, and Texas.** A revised CARE implementation timetable is attached.

TRANSMISSION OF BLOODBORNE PATHOGENS: The January 18, 1991 MMWR provides an update on the issue of transmission of bloodborne pathogens from health care workers to patients. The lead article, "Update: Transmission of HIV Infection during an Invasive Dental Procedure-Florida", indicates that since the first case of possible transmission from a Florida dentist to a patient, four additional patients from the dentist's practice have been identified as HIV positive. The epidemiologic investigation outlined in the article "strongly suggests that at least three patients of a dentist with AIDS were infected with HIV during their dental care, however the precise mode of transmission remains unclear." Inconsistent application of universal precautions in the dental office was cited in the article though no conclusive evidence was found to substantiate this as the mode of transmission. CDC will convene a meeting in Atlanta February 21-22 to review current information on risks of transmission of HIV and HBV to patients during invasive procedures and to assess the implications of these risks. The ASTHO National HIV Network will be updated on the issue as information becomes available.

IMMIGRATION: Secretary Sullivan has decided to remove infection with the AIDS virus from the list of medical conditions for which immigrants and travelers can be excluded from the U.S. The decision was hailed by both public health experts as well as AIDS activists who have strongly opposed the 1987 policy barring HIV infected persons from the U.S. Sullivan has also proposed leaving active tuberculosis as the only disease for which immigration officials could deny immigrant or traveler entry to the U.S. Leprosy, syphilis, gonorrhea, chancroid, granuloma inguinale, and lymphogranuloma venereum would also no longer be considered medical reasons for exclusion and would all be deleted from the list. The proposed changes, expected to take effect June 1, 1991, will be published in The Federal Register. ASTHO was among many public health organizations advocating the new policy.

STATE NEWS

- *In order to allow more HIV positive persons to benefit from its AZT program, Nevada has developed a new State policy that no longer requires applicants for the program to have a history of an AIDS defining condition. The new Nevada policy for AZT assistance requires that individuals have T4 cell counts below 500/mm, be under the care of a physician who recommends and prescribes AZT treatment for that individual, and meet certain financial criteria. The number of clients receiving AZT assistance in Nevada has more than tripled since the program began in 1988, and is expected to continue to expand with the implementation of the new assistance policy. For additional information about the program contact Terri Ignacio or Vicki Hamilton at (702) 687-4804.*

Commissioner of the Massachusetts State Department of Health, and Molly J. Coye, M.D., from the Division of Public Health at Johns Hopkins University. Among presentations heard by the Commission was a report on the National Conference on HIV and Substance Abuse: State/Federal Strategies co-sponsored by ASTHO in November. Dr. Beny Primm of the Office for Treatment Improvement provided the Commission with an overview of the conference, and described it as an excellent vehicle through which improved collaboration could be fostered. The planning committee is continuing to develop a follow-up assessment of the conference, and the final conference report is expected in April.

- The National Conference on Women and HIV Infection, sponsored by NIAID and NIH in collaboration with all PHS agencies, was conducted on December 13-14, 1990. Dr. Fauci, Dr. Novello and many others spoke on epidemiology, education and prevention, psychosocial issues, and clinical manifestations of HIV infection in women. The CDC's AIDS definition was a topic of great controversy with some asserting that the current definition discriminates against women by not including cervical dysplasia, candidiasis, human papilloma virus, PID, and other recurrent STDs found to be refractory to treatment in HIV positive women. Others argued that the science does not yet conclusively indicate that these diseases should be categorized as AIDS defining conditions. Dr. Ruth Kirschstein of NIH's new Office of Research on Women's Health also addressed the group of about 2,200 with her plans to ensure that women are included in all NIH clinical trials.
- The Sixth Annual National Pediatric AIDS Conference, scheduled for February 9-12, 1991, in Washington, D.C., will highlight the importance of a family-centered response, strengthening multi-disciplinary approaches, and restructuring the nation's health care system. Workshops on the implementation of the Ryan White CARE Act will be among many sessions offered at the Conference. Contact the National Pediatric AIDS Conference at (301) 718-0581 for additional information.
- The American Society on Addiction Medicine's National Forum on AIDS and Chemical Dependency will be conducted February 21-24, 1991, in San Francisco, CA. Contact Meeting and Travel Services at (404) 458-3382 for additional information.
- Pages 51254-51258 of the December 12 edition of The Federal Register includes the FDA's final rule to: 1."define adulteration for patient examination and surgeons' gloves; and 2. establish the sample plans and test method the agency will use to determine if these gloves are adulterated as defined by the rule." The notice states that "with the prevalence of HIV infection and the risk of clinical transmission of other infections, the importance of the quality of an effective barrier to the transmission of HIV infection in health care settings is crucial."
- Dr. Ellen Cooper, Director of the FDA's Division of Anti-Viral Drug Products, has requested a transfer to another post within the agency. Dr. Cooper held the position as the top AIDS drug regulator for three years and both colleagues and AIDS activists alike view her decision as a major set back to the progress made in developing and licensing effective AIDS treatments.

INTERNATIONAL NEWS

- HHS Secretary Louis W. Sullivan and AID Administrator, Ronald W. Roskens, left last week for a 17-day trip to Africa to assess AIDS programs and child welfare. Accompanied by HHS Assistant Secretary for Health, Dr. James Mason, Rosken's Administrator for Africa, Scott Spangler, Centers for Disease Control Director, Dr. William Roper, National Institute of Child Health and Human Development director Duane F. Alexander, and William E. Rogers, vice chairman of the National Commission on AIDS, the delegation will visit South Africa, Mali, Nigeria, Ivory Coast, Uganda, Malawi, Zimbabwe and Senegal.

- The FDA has approved enzyme immunoassay (EIA) test kits for detection of antibody to an antigen (c100-3) associated with the hepatitis C virus. FDA is recommending that all whole blood and components for transfusion be screened to eliminate units that are repeatedly reactive for anti-HCV. The recommendations also provide guidance on labeling, quarantine, storage and shipment of blood and blood components. Contact FDA's Division of Transfusion Science, Laboratory of Blood Bank Services at (301) 402-0830 for additional information.
- FDA, in conjunction with CDC and the Office of the Assistant Secretary for Health, has recommended the following changes in blood donor deferral which focus on reduction of HIV-1 risk related to heterosexual exposure: 1. deferral based on a diagnosis of syphilis or gonorrhea in the last 12 months 2. extension of the existing deferral for use of a prostitute from six to 12 months and 3. extension of the existing deferral for recipients of transfusion from six to 12 months (to reduce risk of hepatitis C). These recommendations, which were adopted to address a broader range of risk factors, will replace the previous exclusion criteria for individuals from countries where heterosexual transmission is thought to play a major role in transmission of HIV-1. Those facilities that have implemented HIV-2 antibody testing should discontinue exclusion of donors from countries in which HIV-2 is prevalent. Contact FDA at (301) 402-0830 for additional information on the revised guidelines.
- Although the nationwide average length of inpatient hospitalization for AIDS during the 1985-1988 period decreased from 21.3 days to 17.7 days, according to the National Public Health and Hospital Institute, public hospitals still lose an average of \$8,000. per AIDS patient.
- Achieving a balance between ensuring drug safety and efficacy and making new treatments available to persons with AIDS, continues to characterize efforts to test and approve the two most promising new AIDS drugs now under evaluation-DDI and DDC. Although both drugs are currently being made available to about 15,000 persons through the expanded access program, researchers contend that it will be at least two years before adequate data can be amassed for trials to conclusively demonstrate efficacy and safety. Difficulty in thoroughly testing the new drugs arises from several issues: 1. Although preliminary data have suggested that the most effective use of DDI and DDC is in combination with AZT, the expanded access program prohibits using drugs in combination. It also restricts access to those who are intolerant of AZT or for whom AZT is no longer effective. 2. For ethical reasons, none of the trials involving the two drugs includes a control group. 3. The strain of today's virus may not be the same as that tested previously in patients making it difficult to compare efficacy among drugs 4. It is difficult to determine how much if any improvement is due to the superiority of DDI or DDC and how much can be attributed to other improvements in overall clinical care of the AIDS patient (ie: steroids and pentamidine) 5. Lastly, some researchers argue that the drugs' effects on surrogate markers such as T4 cells may be an imprecise measure of the health of the immune system.

RESOURCES

- AIDS in Michigan, A Progress Report 1985-1990, produced by the Michigan Department of Public Health, describes the current status of the epidemic, provides an overview of policy and programmatic advances since 1985, describes resources and funding developments, and concludes with a specific progress statement on each of the 26 key recommendations issued by Michigan's Expert Committee on AIDS. Additional information and copies of the report may be obtained by contacting Randall S. Pope, Chief, Special Office on AIDS Prevention (517) 335-8371.

CARE IMPLEMENTATION TIMETABLE

February 1, 1991	Title I formula grants to cities awarded.
February, 1991	CDC convenes panel of experts to address Title III early intervention implementation issues.
February/March, 1991	RFP's for Title II SPNS funds (10% retained by Secretary).
March 1, 1991	Applications due for Title II HIV Care grants to States.
First or Second Week In March, 1991	Federal Register notice and guidance on Title III HRSA categorical grants.
April 1, 1991	Title II formula grants to States awarded. States begin 150 day countdown to August 31, 1991 deadline for obligation of 75% of Title II funds.
April 4, 1991	Supplemental Title I discretionary competitive funds to cities awarded.
May, 1991	CDC convenes pre-application workshop for States regarding implementation of Title III CDC early intervention grants.
June 3, 1991	Title III HRSA categorical grant applications due.
August 31, 1991	Deadline for States to obligate 75% of Title II funds.
September 1, 1991	Deadline for State Comment Period for Title II funding. Title II Implementation Progress Report due to HRSA.
September, 1991	Title II SPNS grants awarded.
September 30, 1991	HRSA completes redistribution of Title II funds recovered from States unable to obligate 75% of their funds. Title III HRSA categorical grants awarded.
October, 1991	Application deadline for Title III CDC early intervention grants.
January 1, 1992	Title III CDC early intervention grants to States awarded.
June 30, 1992	Title II Year-End Progress Report due to HRSA.

CARE

*With a Great Sense of Accomplishment and
Deep, Satisfying Relief
You Are Cordially Invited To:*

A CELEBRATION OF (Tentative) COMPLETION

*To recognize the achievements of members of the
San Francisco HIV Health Services Planning Council
in surviving the distribution process of
Ryan White Care Funding over the last three months.*

*February 25, 1991
Monday evening
6:00-8:00pm*

*San Francisco AIDS Foundation
25 Van Ness, 3rd Floor
San Francisco*

*Significant Others Welcome
Appreciation Program at 6:45pm*

*Each council member is expected to provide one big tasty dish
(serving 6-10 people). We'll provide beverages, decorations,
paper products and festive music.*

*** NOTICE OF PUBLIC MEETING ***

The San Francisco HIV Health Service Planning Council, appointed by Mayor Agnos, has identified service gaps and priorities in HIV care in San Francisco, and developed a comprehensive plan for the organization and delivery of HIV services. This plan will be used for the implementation of the Ryan White Comprehensive AIDS Resource Emergency Act of 1990 (CARE) in San Francisco, which provides \$6,393,866 in Formula monies for delivery of HIV services. The San Francisco eligible metropolitan area (EMA) which has been awarded these funds encompasses San Francisco, Marin, and San Mateo Counties. The San Francisco EMA has applied for an additional \$6,319,965 in Supplemental CARE funds, and will receive notification of any award by April 4, 1991.

The Council will hold a public meeting to inform the public how Council decisions were made regarding allocations of CARE monies. Council members will discuss the Council's process for developing service priorities, the composition of the review panels, the review criteria used to evaluate applications, and CARE funding recommendations. The Council will also listen to public comment on the Council's decision-making process. Speakers are asked to keep their presentations to 3 minutes each; there will be a sign-in sheet for those wishing to speak at the entrance.

This hearing will be held from 4:00 pm. - 6:00 pm. on Monday, March 18, 1991, in Room 300 at the Department of Public Health at 101 Grove Street.

The Council encourages anyone with an interest in these issues who cannot attend this hearing to submit written comments to the Council c/o DPH AIDS Office, 25 Van Ness, 5th Floor, San Francisco, CA 94102. In addition, all Council meetings are open to the public, and each meeting includes a public comment period. For more information, call the AIDS Office at 554-9010.

ST.
SAN FRANCISCO CA 94114



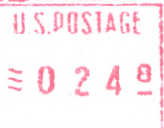
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SFDPH AIDS Office
Health Reso. & Serv. Branch
25 Van Ness Ave. Suite 500
San Francisco CA 94102-6033

POSTAGE
FIRST CLASS



PERMETER
6802200



REVIEW OF SAN FRANCISCO'S PEDIATRIC DEMONSTRATION PROJECT

A 3-year HRSA funded demonstration project targeting adolescents with HIV, Project AHEAD (Alliance for the Health of Adolescents).

Goal 1: Support of city-wide collaborative AIDS prevention reduction efforts, providing confidential HIV testing, and developing targeted mobile healthu outreach to high risk youth.

Goal 2: Community-based, family centered coordinated services for high risk and HIV-infected adolescents and their families. (Adolescent treatment teams at Huckleberry House and Youth Guidance Center and developing comprehensive HIV treatment at SFGH and UCSF.)

Goal 3: Programs to reduce spread of HIV infection to vulnerable youth (homeless, runaway, or in juvenile justice system). Includes support services to reinforce safe sex/drug practices, establishing referral system for services, and utilizing mobile health outreach.

Overall Budget:

Larkin Street Youth Center

Personnel	\$117,700	
Fringe	27,071	
Travel	3,500	
Equipment	26,000	
Supplies	4,787	
Other	9,000	
Contractual	143,242	
Youth Advocates		\$40,000
UCSF Adolescent Medicine		12,428
National Center for Youth Law		6,000
Special Programs for Youth (SFDPH)		56,136

Total	\$ 332,000
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17.December.90

preliminary data from

- The Service Utilization Study: 1990 (SUS:90) -

CONDITIONS

1. SUS:90 data covers patients with AIDS discharged from San Francisco hospitals in April, May, and/or June of 1990.
2. To date, participating hospitals are as follows:
 1. SFGH
 2. UCSF
 3. R.K. Davies (data incomplete)
 4. PPMC
 5. Kaiser
 6. Mt. Zion
 7. Veterans Administration
 8. St. Mary's

SOURCE OF PAYMENT FOR ALL SUS:90 PATIENTS

[mutually-exclusive categories]

PRIVATE INSURANCE only.....	288	[31%]
* MEDI-CAL only.....	250	[27%]
KAISER only.....	119	[13%]
* MEDI-CAL pending only.....	103	[11%]
VETERANS BENEFITS only.....	49	[5%]
MEDI-CAL + MEDICARE.....	23	[3%]
MEDICARE only.....	22	[2%]
* MIA/NO SOURCE OF PAYMENT.....	10	[1%]
MEDICARE + KAISER.....	10	[1%]
MEDICARE + PRIVATE INSURANCE.....	9	[1%]
MEDI-CAL + KAISER.....	8	[1%]
MEDI-CAL + PRIVATE INSURANCE.....	8	[1%]
UNKNOWN.....	8	[1%]
MEDI-CAL pending + PRIVATE INSURANCE.....	7	[<1%]
* SELF PAY.....	4	[<1%]
* SELF PAY + MEDI-CAL pending.....	3	[<1%]
MEDI-CAL pending + MEDICARE.....	1	[<1%]

total: 922

* 370 patients [40%] had MEDI-CAL or no insurance.

PLACE ALL PATIENTS (EXCEPT SFGH) WERE DISCHARGED TO

Value Label	Value	Frequency	Percent
OWN HOME	1	481	52.2
EXPIRED	13	66	7.2
SNF	9	32	3.5
HOSPICE	10	16	1.7
REL/FRIEND HOME	2	12	1.3
UNKNOWN	17	11	1.2
AMA	14	7	.8
OTHER	12	5	.5
TRANS.TO OTHER HOSP.	15	5	.5
AIDSRES:PERM	4	4	.4
OUT OF TOWN	16	3	.3
PSYCH:OTHER	8	2	.2
HOTEL	3	1	.1
AIDSRES:TEMP	5	1	.1
PSYCH:SFGH	7	1	.1
ETOH/DRUG	11	1	.1
.		274	29.7
TOTAL		922	100.0

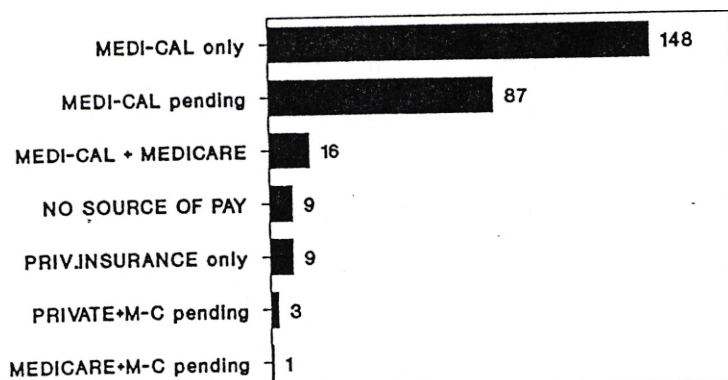
DISCHARGE PLACEMENT AND SOURCE OF PAYMENT
SUS:90

{SFGH}

Value Label	Value	Frequency	Percent
HOME	1	173	63.4
EXPIRED	4	33	12.1
SNF	14	21	7.7
HOTEL	2	13	4.8
AIDSRES:TEMP	9	8	2.9
TRANS.TO OTHER HOSP.	6	4	1.5
UNKNOWN	11	4	1.5
PSYCH:SFGH	17	4	1.5
SHELTER	3	3	1.1
AIDSRES:PERM	8	3	1.1
AMA	13	3	1.1
PSYCH:OTHER	15	2	.7
ETOH/DRUG	5	1	.4
OUT OF TOWN	10	1	.4
		-----	-----
	TOTAL	273	100.0

Valid Cases 273 Missing Cases 0

SOURCE OF PAYMENT
SFGH PATIENTS - APRIL/MAY/JUNE:1990



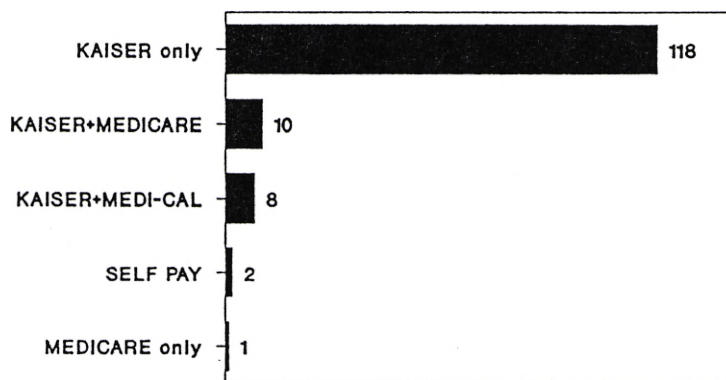
number of patients/category (n=273)

DISCHARGE PLACEMENT AND SOURCE OF PAYMENT
SUS:90

{Kaiser}

PLACE D/C TO	KAISER (only)	KAISER+ (public)	SELF PAY	MEDICARE (only)	ROW TOTAL
Own Home	92	13	1	0	106
Friend/ Relative	1	0	0	0	1
Hospice	4	3	1	0	8
Expired	18	2	0	0	20
Unknown	2	0	0	1	3
Other	1	0	0	0	1
COL. TOTAL	118	18	2	1	139 grandtotal

SOURCE OF PAYMENT
KAISER PATIENTS - APRIL/MAY/JUNE:1990



number of patients/category (n=139)

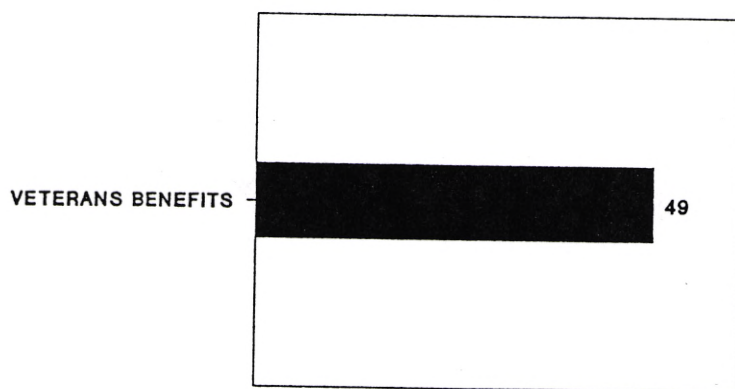
SUS:90

DISCHARGE PLACEMENT AND SOURCE OF PAYMENT
SUS:90

{VETERANS ADMIN.}

Value Label	Value	Frequency	Percent
OWN HOME	1	39	79.6
HOSPICE	10	2	4.1
EXPIRED	13	7	14.3
AMA	14	1	2.0
		-----	-----
	TOTAL	49	100.0
Valid Cases	49	Missing Cases	0

SOURCE OF PAYMENT
V.A. PATIENTS - APRIL/MAY/JUNE:1990



number of patients/category (n=49)

DISCHARGE PLACEMENT AND SOURCE OF PAYMENT
SUS:90

{UCSF,Davies,PPMC,Mt.Zion,St.Marys}

PLACE D/C TO	MEDI-CAL+ [1]	MEDICARE (only)	COMBO [2] (public)	PRIVATE (only)	COMBO [3] (pub/priv)	ROW TOTAL
Own Home*	82	13	7	211	18	336
Friend/ Relative	3	1	0	5	2	11
Hotel	1	0	0	0	0	1
AIDS Res/ PERM.	4	0	0	0	0	4
AIDS Res/ TEMP.	0	0	0	1	0	1
Psych: SFGH **	0	0	0	0	0	1
Psych: OTHER	1	0	0	1	0	2
SNF **	14	2	0	15	0	32
Hospice	0	0	0	4	1	5
ETOH/drug Rehab.	0	1	0	0	0	1
Expired **	10	2	0	26	0	39
AMA	2	0	0	4	0	6
Transfer	2	1	0	2	0	5
OutoTown	0	0	0	3	0	3
Unknown**	3	0	0	4	0	8
Other	2	0	0	2	0	4
COL. TOTAL	124	20	7	278	21	459 *** grandtotal

* source of payment: 4 UNKNOWN

1 Kaiser

- thus: *** +9 for COL. grandtotal

** source of payment: 1 unknown

[1] includes MEDI-CAL, MEDI-CAL pending, MIA, and SELF PAY

[2] includes any combination of public funds (e.g. MEDICARE + MEDI-CAL)

[3] includes any combination of public funds + private insurance
(e.g. MEDICARE + private insurance)

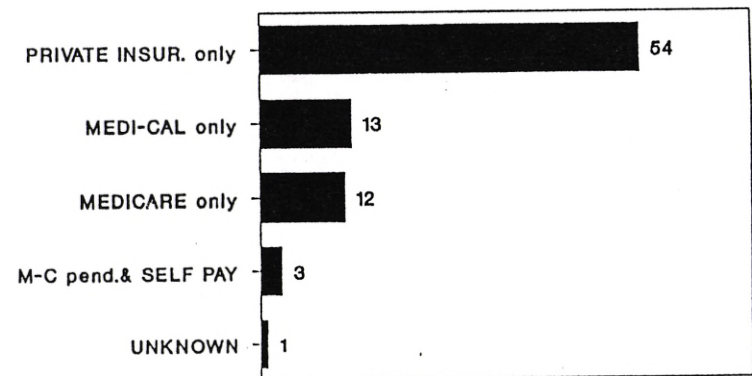
IN-HOME SUPPORT SERVICES PROVIDED TO THE 82 PATIENTS WITH MEDICAL,
MEDI-CAL pending, MIA, or SELF PAY DISCHARGED TO THEIR OWN HOME

{UCSF, Davies, PPMC, Mt.Zion, and St. Marys ONLY}

NO SERVICES.....	41	50.0%
>1 SERVICE.....	14	17.1%
VISITING NURSE (only).....	11	13.4%
PUBLIC HEALTH NURSE.(only).....	2	2.4%
HOME CARE.(only).....	6	7.3%
CASE MANAGEMENT (total).....	0	0.0%
OUT PATIENT FOLLOW-UP* (only).....	6	7.3%
PROJECT OPEN HAND* (only).....	2	2.4%
total =		82

* may be underreported

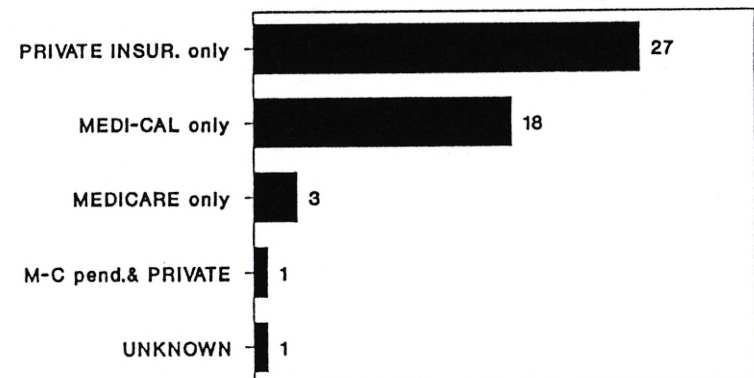
SOURCE OF PAYMENT MTZION PATIENTS-APRIL/MAY/JUNE:1990



number of patients/category (n=83)

8US:90

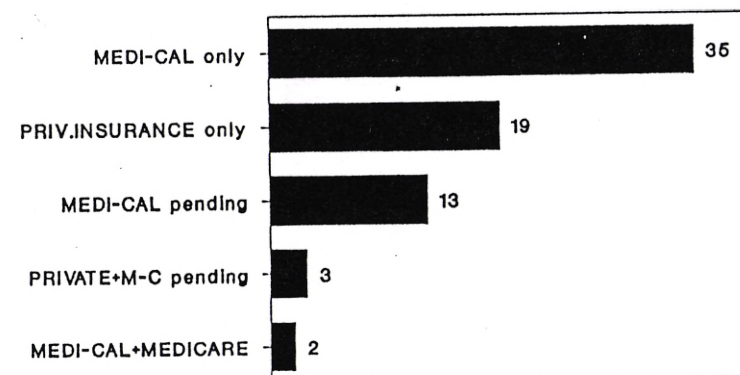
SOURCE OF PAYMENT STMARYS PATIENTS-APRIL/MAY/JUNE:1990



number of patients/category (n=50)

8US:90

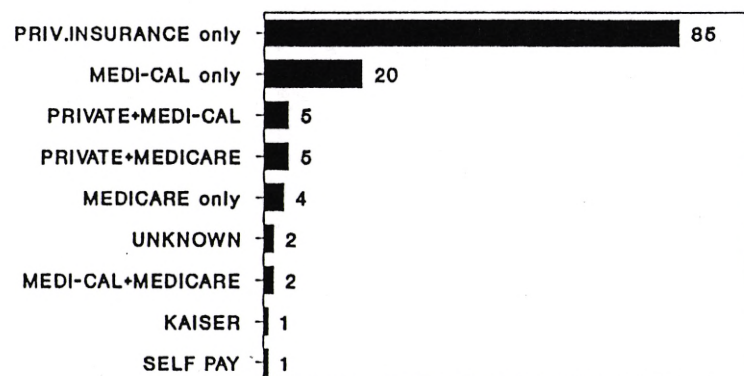
SOURCE OF PAYMENT UCSF PATIENTS - APRIL/MAY/JUNE:1990



number of patients/category (n=72)

SUS:90

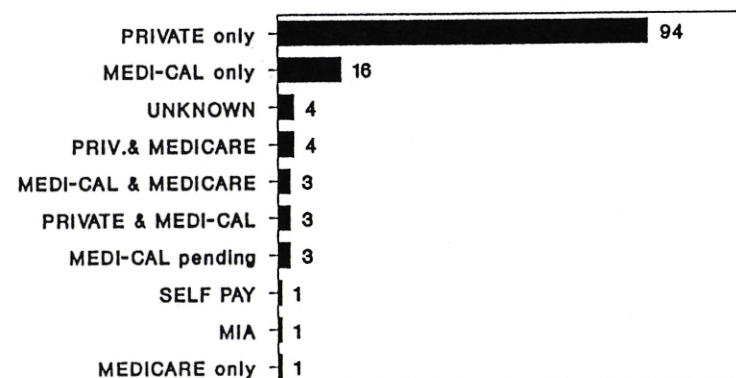
SOURCE OF PAYMENT DAVIES PATIENTS - APRIL/MAY/JUNE:1990



number of patients/category (n=125)

SUS:90

SOURCE OF PAYMENT PPMC PATIENTS - APRIL/MAY/JUNE:1990



number of patients/category (n=130)

SUS:90

HOUSING SERVICES MATRIX

	<u>Autonomous Living</u>	<u>Independent Living</u>	<u>Supervised Living</u>	<u>Residential Treatment</u>
<u>Emergency</u> (0 - 3 months)				
<u>Transitional</u> (3 - 6 months)				
<u>Permanent</u> (6 months or more)				