

Memo

file
Memo from
Jim

To: All Staff
From: James W. Dilley, MD
Date: May 5, 1995
RE: UC Domestic Partners Policy

Please find attached an article from today's *Bay Area Reporter* that I wanted to share. The issue of Domestic Partners benefits for UC employees is one that affects us all. I hope each of you will consider taking action in support of encouraging the University to adopt a policy endorsing Domestic Partner benefits for gay and lesbian employees of the University.

Thank you.

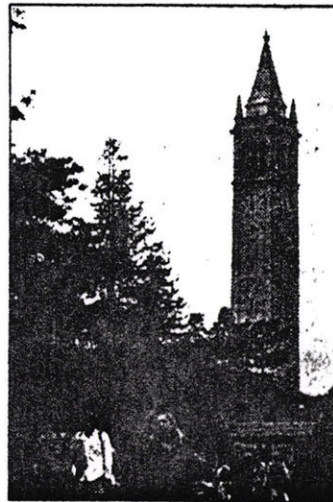
COMMUNITY NEWS

UC Domestic Partnership Campaign Seeks Your Support

by Mary Ann Swissler

More than a year after the conservative UC Berkeley Academic Senate endorsed a domestic partnership benefits proposal in March 1994, the plan's framers continue to push for its passage, and are now lining up support on both sides of the Bay Bridge — and beyond.

Angela Hunkler, a UC staff member on the Domestic Partners Task Force, told the *Bay Area Reporter* the United Professional and Technical Employees endorsed the idea in December 1993. What is needed now, she said, are letters from the community and its friends in support of health insurance, or so-called "hard" benefits, for domestic partners. (Some limited "soft" domestic partnership benefits,



UC Berkeley campus.

such as library card privileges,

are already offered, she said.)

Task Force member Susan Hagstrom added, "We've already amassed a supportive letter from UC faculty and staff, alumni, and students throughout the state. Now we also need a show of support from taxpayers, parents, voters, and California's residents in general."

Bay Area residents are urged to write to the following regents to press for passage of domestic partnerships rights throughout the UC system:

- Glenn Campbell, Hoover Institute, Stanford, CA 94305, Fax: 415-725-3076

- Delaine Eastin, State Superintendent of Public Instruction, P.O. Box 944272, Sacramento, CA 94244-2720, Fax: 916-6575701

- David Flinn, Pres., UC

Alumni Associations, c/o Leland, Parachini, Steinberg, Flinn, Matzger & Melnick, 333 Market St., 27th floor, SF, CA 94105. Fax: 415-974-1520

- Arnold Leiman, Prof., Dept. of Psychology, Tolman Hall, UCB, Berkeley, CA 94720-1650. Fax: 510-642-5293.

Hunkler summed up the sentiments of the Domestic Partners Benefits Campaign by stating, "This is a simple matter of justice. It is an issue of equal pay for equal work and is fully in keeping with the university's longstanding policy of non-discrimination on the basis of sexual orientation."

Fellow DPTF member Jonathan Winters pointedly listed the other institutions UC would join by endorsing domestic partnerships: Stanford,

Harvard, the State University of New York, Columbia, City University of New York, Princeton, and the Universities of Chicago, Pennsylvania, and Minnesota all provide some form of domestic partnership benefits. "It is high time that the University of California join its peers," he said. ▼



MEMO

Reissue: 12/17/94

To: Executive Team
From: James W. Dilley, MD
Date: March 21, 1994
RE: Administrative Issues

The purpose of this memo is to give some guidance on a couple of administrative issues. Please note the following:

1. Contract Development Issues: Please note that the agency standard in developing Units of Service and Unduplicated Client figures should consider the following formulae:

a. Use a 48 week year. This figure may even be a stretch but is acceptable to the AIDS Office. Note that UC grants 14 paid holidays per year, plus staff often have two or more weeks of vacation.

b. Ratio: For clinical people, please figure on a ratio of 75% direct service to 25% indirect service time. At times, for example in the Psych Consult Service, this ratio may be a bit lower because of the travel time involved to see clients in their homes, etc. However, we should shoot for this general breakdown of staff time.

2. Client Grievances and Incident Reports: copies of all client grievances must be sent to Dorothy who will maintain a central file. She will be responsible for following up with Managers who may have outstanding paperwork on any grievance. I will review each complaint and discuss with the relevant manager. The number of grievances and their handling will be used as a measure of manager effectiveness.

3. RE: Reclasses: any manager wishing to put forward a request for a reclass should first broach the issue with me by writing me a memo outlining your rationale. I will then discuss the request with Joanna who, as our personnel specialist and operations manager has the best view of the implications for the agency as a whole. Keep in mind that an individuals' job classification also can have an impact on others in the agency and that decisions regarding classification must include considerations of others in the agency performing similar duties.

Mailing Address

UCSF AIDS Health Project
Box 0884
San Francisco, CA
94143-0884

Street Address

1855 Folsom St., Suite 506
San Francisco, CA 94103
415-476-6430
FAX 415-476-7996



A project concerned
with AIDS Prevention
and Health Promotion

*Minutes
Admin Comm*

Testimony Before the
Agency for Health Care Policy and Research Committee
on Guidelines for Seropositive Asymptomatic Individual
February 10, 1992

Good morning. My name is James Dilley, MD, Associate Clinical Professor of Psychiatry at the University of California, San Francisco, and Project Director of the AIDS Health Project, a mental health and AIDS prevention education effort in San Francisco. The AIDS Health Project is a successful partnership between the University and the San Francisco Department of Public Health. It is from my experience as the director of an agency devoted to promoting the mental health of those affected by HIV over the past eight years, as well as my experience as a practicing psychiatrist that I address you this morning.

My purpose today is to draw your attention to the mental health needs of those with HIV disease; and, in keeping with the mandate of the Agency for Health Care Policy and Research (AHCPR), to argue that providing for mental health concerns must be a part of the guidelines to be developed for the clinical care of HIV positive but asymptomatic patients.

In the rush to provide services for those infected with HIV, attention is understandably focused on ensuring that appropriate medical care is available. No one would argue that primary medical care, drug access programs, or sufficient numbers of hospital beds to care for those with acute complications of HIV should not be a priority.. Unfortunately, however, policy developers and health care planners often stop there, and in the struggle to find adequate funding for basic medical care, providing for mental health services is often ignored, forgotten, or simply not considered. This phenomenon, in my view, is rarely the result of conscious hostility toward mental health concerns, but rather, more often results from a lack of appreciation for the contribution made by mental health workers to the quality of life of patients learning to live with HIV; an overly ambitious assessment of the capacity of primary care providers to provide counseling and mental health support to their patients as well as primary care; and, the failure to appreciate that providing adequate mental health support can reduce utilization of increasingly crowded medical services.

Thus, the guidelines developed by your agency must include guidelines for assessing mental health issues and should also offer suggestions about the types of services that are necessary to provide comprehensive care for HIV infected individuals. The presence of these guidelines will demonstrate to providers that their job is not done unless and until they have evaluated the patient's psychosocial situation. For example, providers must be trained to consider social support and common neuropsychiatric disorders in their evaluation of patients. It is only because of his or her training that the doctor recognizes congestive heart failure when the patient complains, "My legs seem a little swollen and I get short of breath even when I walk across the room..." So too must the provider be taught to think about psychiatric disease when the HIV infected patient complains of fatigue, sleeplessness and boredom. The quiet and withdrawn HIV infected patient who is actually suffering from major depression can easily be dismissed as "having a bad day" or simply "adjusting to the news of his infection" by the busy provider unless he or she is trained to recognize clinical signs and symptoms of depression. Furthermore, patients who are socially isolated, estranged from their families and quietly despairing

Address Correspondence To: UCSF AIDS Health Project • Box 0884 • San Francisco, CA 94143-0884

Administrative Offices: 1855 Folsom Street • Suite 506 • San Francisco, California • (415) 476-6430

Administrative Office Fax: (415) 476-7996 • Fiscal Unit Fax: (415) 476-3613

Affiliated with the University of California, San Francisco



THE AIDS HEALTH PROJECT

*A project concerned
with AIDS Prevention
and Health Promotion*

over their health and life situation are at increased risk for depression and potentially at risk of suicide. Lack of social support has been associated with increased risk of negative health outcomes in a number of studies--both in HIV populations as well as in other patient groups. The provider must become accustomed to assessing the patients' level of social support and, when it is lacking, make special efforts to help the patient find support. Finally, the relationship between HIV and substance abuse is most clearly obvious in those whose infection was contracted through intravenous drug use; however, substance abuse in other forms is also common among people with HIV. The practitioner must be taught to think about drugs and alcohol in their patients and must learn how to ask the right questions to elicit a history. The patient must be taught about the potential dangers of ongoing substance abuse and the provider must work to support the patient in seeking appropriate drug or alcohol treatment.

In sum, guidelines should be written that at a minimum, prod providers into performing a basic psychosocial assessment on all new patients with HIV. The presence of treatable psychiatric disease must not go unnoticed, patients without social support must be encouraged to develop a system, and substance use must be assessed in all patients with appropriate referrals made. Crisis intervention services need to be available, support groups, individual psychotherapy, drug and alcohol counseling, and competent psychiatric evaluation and treatment must be an integrated part of any comprehensive plan for caring for this group of patients.

People living with HIV must contend with multiple stressors. Despite advances in the social acceptance of people with AIDS, stigma and rejection are still very real and altogether too common. Providers must not forget that they may be the patients' first, and often only, contact with the health care and social service system. As such, providers need to assure their patients' the best care possible by identifying the patients' needs and making appropriate referrals. Providers hold a central place in this effort and must never underestimate their importance in the lives of their patients. Caring for people with HIV requires teamwork and a multidisciplinary approach. Primary care providers, as the central players on the team, must bring an understanding and awareness of the multifaceted problems faced by people with HIV. The guidelines from your committee will hopefully promote this understanding and encourage the role of the provider in fostering comprehensive care.

Thank you.

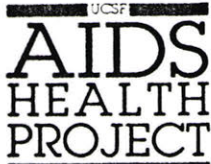
Address Correspondence To: UCSF AIDS Health Project • Box 0884 • San Francisco, CA 94143-0884

Administrative Offices: 1855 Folsom Street • Suite 506 • San Francisco, California • (415) 476-6430

Administrative Office Fax: (415) 476-7996 • Fiscal Unit Fax: (415) 476-3613

Affiliated with the University of California, San Francisco





A project concerned
with AIDS Prevention
and Health Promotion

MEMO

To: AHP Reception Staff

From: James W. Dilley, MD

Date: April 12, 1994

RE: Phone Screening for AHP Reception Staff

Please note that because of the Psychosocial Collaboration and the beginning of the HIV Services Partnership with the AIDS Foundation and Shanti, we need to change our standard phone answering procedures to make the new system understandable to clients. In that vein, receptionists should be sure to cover the following information with clients requesting psychosocial services:

"We ask that everyone requesting services at the AIDS Health Project schedule a 50 minute interview with one of our staff. The purpose of this interview is to find out more about your needs and make recommendations to you about services at the AIDS Health Project and the HIV Services Partnership.

The specific services we offer at the AIDS Health Project include:

- Support groups and individual therapy (counseling) for people with HIV or AIDS
- Support groups for people who are HIV-negative, including:
- support groups for HIV-negative gay and bisexual men
- support groups for friends, family members, and lovers of people with HIV or AIDS

Are you interested in any of these services? Which one/s?

In addition to these services, the AIDS Health Project collaborates with the San Francisco AIDS Foundation and the Shanti Project to make other psychosocial support services available and accessible to clients. These services include benefits counseling, emotional and practical support volunteers, and information and referral services (client advocacy services). You may access any of these services through an interview at the AHP.

You may get more specific information from your intake worker when you come in for your appointment."

NOTE: If you learn that the client is interested in seropositive services, please inform the caller that he/she should bring in an original letter of diagnosis from his physician. Also, if the caller identifies a specific service offered by the SFAF, explain that he or she can have an intake with us, or, they may prefer to call SFAF directly to set up an interview. This may save the client from having an intake with us and then being referred to SFAF. In other words, *clients should be given the option to go first to the primary provider of the service they identify*

Address Correspondence To: UCSF AIDS Health Project • Box 0884 • San Francisco, CA 94143-0884

Administrative Offices: 1855 Folsom Street • Suite 506 • San Francisco, CA 94103 • (415) 476-6430

Administrative Office Fax: (415) 476-7996 • Fiscal Unit Fax: (415) 476-3613

Affiliated with the University of California San Francisco



*A project concerned
with AIDS Prevention
and Health Promotion*

MEMO

To: AHP Training Staff and Executive Committee
From: James W. Dilley, MD
Date: May 18, 1993
RE: Viricidal Effectiveness of Bleach in Syringes Discussion and Implications for Prevention Messages

Information about the relative effectiveness of bleach in killing HIV has been forthcoming that calls into question the standard prevention message of "two times bleach, two times water". (See attached). This information is based on (as usual) incomplete research but the available information suggests that the usual message may be inadequate to fully protect IDUs.

The problems for us, of course, are two: one is essentially an ethical one--ie, given limited information what is the most appropriate message for us as AIDS prevention experts to be giving? The second is a pragmatic one--how do we ensure that our message is consistently given and how best can we ensure that it happens both in terms of our print material and counseling advice?

I would like to see the following:

1. We need to have a series of discussions on the question to ensure staff are aware of the information and aware that the Project is developing a policy statement.
2. I would like to suggest that one or two staff people be designated to attend a discussion on the subject to be held at the next Program Advisory Cmtee meeting, June 15, 1993.
3. John Watters, PhD and I have discussed pulling together a few focus groups of drug users to discuss the issue with them. For example, what do they think is the likelihood that users will comply with, for example, Watters' recommendation that users flush 5 times and hold the solution for up to 30 secs? What suggestions might they have for putting out the word? I would obviously like ASAP to take a leadership role in developing this concept.

Please put this issue on your respective agenda. We will discuss it further at the Program Advisory Committee on the 15th of June.

Thank you.

MEMO

From: James Dilley, MD
To: All Staff
DATE: July 19, 1993
RE: New NIAID recommendations concerning the

Distributed
7/19/93
Don

Please be aware that on June 25, 1993, the National Institute of Infectious Diseases (NIAID) issued new guidelines concerning HIV treatments.

There are three important changes from earlier guidelines issued by the federal government, and these changes were brought about by the findings of the CONCORDE study reported at the International AIDS Conference in Berlin. All AHP staff will want to be familiar with these changes:

1. NIAID now recognizes "that no 'average patient' exists." Some patients will do better, and others worse, than what clinical studies would predict. NIAID therefore encourages patients and doctors to work together as a team "to design a treatment strategy that is both clinically sound and appropriate for each individual patient's needs, priorities and circumstances of daily life."
2. Recommendations concerning treatment include suggestions for use of ddI and ddC in response to AZT intolerance or failure.
3. Most importantly, **recommendations for people who have low T-cell counts but do not have symptoms have been revised.** Previously, the guidelines suggested initiation of antiretroviral therapies regardless of symptomatology once an individual's T-cell count fell below 500. Currently, guidelines suggest persons whose counts are between 200 to 500/mm³ may either initiate antiretroviral therapy, or continue observation and clinical monitoring of signs or symptoms of disease progression, without initiating therapy.

The specific recommendations of the NIAID bulletin are on the other side.

(Note also that the spirit of these recommendations are absolutely in line with the approach advocated at AHP: that clients should be given information and then encouraged to make an informed decision.)

MEMO

From: James Dilley, MD
To: All Staff
DATE: July 19, 1993
RE: New NIAID recommendations concerning therapy for HIV Disease

Please be aware that on June 25, 1993, the National Institute of Allergy and Infectious Diseases (NIAID) issued new guidelines concerning HIV treatments.

There are three important changes from earlier guidelines issued by the federal government, and these changes were brought about by the findings of the CONCORDE study reported at the International AIDS Conference in Berlin. All AHP staff will want to be familiar with these changes:

1. NIAID now recognizes "that no 'average patient' exists." Some patients will do better, and others worse, than what clinical studies would predict. NIAID therefore encourages patients and doctors to work together as a team "to design a treatment strategy that is both clinically sound and appropriate for each individual patient's needs, priorities and circumstances of daily life."
2. Recommendations concerning treatment include suggestions for use of ddI and ddC in response to AZT intolerance or failure.
3. Most importantly, **recommendations for people who have low T-cell counts but do not have symptoms have been revised.** Previously, the guidelines suggested initiation of antiretroviral therapies regardless of symptomatology once an individual's T-cell count fell below 500. Currently, guidelines suggest persons whose counts are between 200 to 500/mm³ may either initiate antiretroviral therapy, or continue observation and clinical monitoring of signs or symptoms of disease progression, without initiating therapy.

The specific recommendations of the NIAID bulletin are on the other side.

(Note also that the spirit of these recommendations are absolutely in line with the approach advocated at AHP: that clients should be given information and then encouraged to make an informed decision.)

NIAID HIV THERAPY GUIDELINES

June, 1993

Patients who have never before received antiretroviral therapy:

- *Without symptoms, T-cell counts above or equal to 500:* continued observation, and clinical and immunological monitoring (measurement of CD4+ T cell counts) every six months.
- *Without symptoms, T-cell counts between 200 to 500, and stable over time:* consider either (1) initiation of antiretroviral therapy, or (2) continued monitoring for clinical or laboratory evidence of deterioration, at which point antiretroviral therapy should be initiated.
- *With symptoms, T-cell counts between 200 to 500:* start antiretroviral therapy.

Choosing an initial antiretroviral therapy:

- Use AZT as first-line therapy. Recommended dose: 600 mg/day.
- This applies to (1) patients with or without symptoms, T-cell counts between 200 to 500; (2) patients with or without symptoms, T-cell counts below 200; or (3) patients with severe AIDS-Related Complex or AIDS, regardless of T-cell counts.
- Combination therapies (with ddI or ddC) may be considered, though there is no conclusively demonstrated clinical benefit to date.

Whether to change initial therapy in patients who are tolerating initial antiretroviral therapy:

- Continue AZT for patients who appear to be stable with T-cell counts above 300.
- If T-cell counts drop below 300, consider either (1) continuing AZT, or (2) changing to ddI.

For patients who are intolerant to AZT, or who experience progression of disease despite AZT therapy:

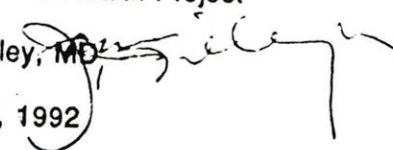
- AZT intolerant, T-cell counts above 500: discontinue antiretroviral therapy.
- AZT intolerant, T-cell counts between 200 to 500, or between 50 to 200: switch to ddI monotherapy.
- AZT intolerant, T-cell counts less than 50: switch to ddI or ddC monotherapy, or discontinue antiretroviral therapy.
- Experiencing progression of disease, T-cell counts between 200 to 500, or between 50 to 200: initiate alternative antiretroviral regimen, such as monotherapy with ddI, or initiation of combination therapy (AZT plus ddI or ddC).
- Experiencing progression of disease, T-cell counts below 50: switch to ddI or ddC monotherapy.

AIDS HEALTH PROJECT

A project concerned
with AIDS Prevention
and Health Promotion

MEMO

To: Friends of the AIDS Health Project

From: James W. Dilley, MD 

Date: November 17, 1992

RE: Changes in Administrative Personnel

This memo is to announce several significant changes in the administrative structure at the AIDS Health Project.

First, our Director of Operations for the past several years, Peter Campos, has accepted a position as Chief of Administration for the Cancer Research Institute in the School of Medicine. Congratulations are in order, though we will miss Peter's eye for detail and his penchant for developing computer systems. Best of everything in your new job, Peter.

Second, Peter's resignation gives us the opportunity to promote from within and it gives me great pleasure to announce that Ms. Joanna Rinaldi, our Director of Hospital Services for the past 8 years, has agreed to accept the position of Acting Director of Operations. Joanna has an enthusiasm for her work, is enormously committed to the struggle against HIV and has an eye for finding and securing money. This talent has stood the agency and San Francisco General Hospital in good stead: she has increased the budget of Hospital Services over her tenure by almost 400%. Joanna has an excellent reputation throughout the Dept. of Psychiatry and the Dept. of Public Health and we are delighted she is interested in accepting this position.

Third, Ms. Patricia Sullivan, MFCC, who has worked for AHP for the past two years as our Community Mental Health Liaison, has agreed to accept responsibility for portions of Joanna's position as the Acting Director of Hospital Services. In addition to having developed a clinical expertise in the area of HIV Associated Dementia, Patricia brings to her new position several years experience as the Director of Peter Claver Residence and the Director of Residential Programs for Catholic Charities of San Francisco. In these positions, Patricia was responsible for contract development, negotiation, and monitoring with the AIDS Office and has an excellent reputation for her writing and management skills. We are lucky to have her in position to take over similar responsibilities for Hospital Services and greatly appreciate her willingness to do so.

Finally, Patricia and I will share some of the job responsibilities for Hospital Services which will allow Patricia to continue providing for her current contract obligations as the Community Mental Health Liaison. Over the next few months we will be instituting personnel actions that will involve open recruitment for filling these positions.

Please join with me in welcoming Joanna and Patricia into their new positions.

Address Correspondence To: UCSF AIDS Health Project • Box 0884 • San Francisco, CA 94143-0884

Administrative Offices: 1855 Folsom Street • Suite 506 • San Francisco, CA 94103 • (415) 476-6430

Administrative Office Fax: (415) 476-7996 • Fiscal Unit Fax: (415) 476-3613

Affiliated with the University of California, San Francisco



*A project concerned
with AIDS Prevention
and Health Promotion*

MEMO

To: Ed Diaz

From: James Dilley, MD

Date: Febr. 21, 1992

RE: TB Screening for ATS Counseling Staff

This memo is to confirm our discussions of the last few weeks regarding screening for tuberculosis for the ATS Counseling staff and to outline the procedures that we will follow. Please note that the following recommendations were arrived at after discussions with Lee Wugofski, MD, Director, Employee Health Services at SFGH and Henry Chambers, MD, infectious disease investigator, SFGH.

WHY SCREEN FOR TB?

As many of you have undoubtedly heard, *Mycobacterium TB* has become an "epidemic" in San Francisco. The term "epidemic" of course, is relative and as you can see in the attached, there have been roughly 300 or so cases reported/year to the Dept. of Public Health for a ten year total of 3,432. I think the absolute numbers are helpful to put the issue in perspective. There are two main reasons for the spread of TB here: the first is the influx of immigrants from parts of the world where TB is endemic (Asia, Central America and other parts of the Developing World), and the second is the high incidence of HIV disease. People with HIV disease are at greater risk of contracting TB if they should come into contact with an active case, and those who are HIV infected who already have a latent infection with TB are at greater risk of developing serious active disease. Thus, because TB is generally a curable and preventable disease if it is identified in those carrying the organism, and, because left untreated it can be fatal it is vitally important that those who may be at risk be screened regularly.

BACKGROUND

Because of the importance of good information about whether our staff have been infected with TB, I am requesting that ATS staff undergo a two stage process of testing. This recommendation is in keeping with current recommendations, namely, that to be most accurate, TB testing should be done twice. Otherwise, and similar to the need to run ELISAS twice in HIV antibody testing, the possibility of false results exists. Essentially, the potential consequences of false readings are that individuals who are truly infected could be missed.

Two stage screening is important because TB is the kind of infection (again like HIV) that has a long latency period. Thus, as is sometimes the case, individuals may have been exposed many years prior to the time they are tested. After that initial exposure, individuals developed cell mediated responses to the infecting agent which kept it under control. Many years can go by and, if it has been many years since the body was challenged with TB, the body may have "forgotten" how to develop a response to the organism. If this is the case, a person infected with TB and then challenged with a PPD skin test, would not mount a response (Mounting a response occurs when an area of hard swelling, or induration, develops at the injection site) and therefore appear to be negative.

Address Correspondence To: UCSF AIDS Health Project • Box 0884 • San Francisco, CA 94143-0884

Administrative Offices: 1855 Polsom Street • Suite 506 • San Francisco, CA 94103 • (415) 476-6430

Administrative Office Fax: (415) 476-7996 • Fiscal Unit Fax: (415) 476-3613

Affiliated with the University of California, San Francisco



*A project concerned
with AIDS Prevention
and Health Promotion*

Two stage screening or "boosting" allows the body a chance to be "reminded" and then, if previously infected, to actively mount a response. The first test, which involves showing the body the organism, causes the immune cells to multiply and then, when the second challenge is given two-three weeks later, the body mounts a clearly positive response. Thus, two stage screening eliminates false negatives.

Procedures

Julie Lams, FNP (Family Nurse Practitioner) from SFGH Occupational Health Program will be coming on March 24, 1991 at 3:00PM to apply stage one tests to the ATS Counseling staff. This is the first stage of a two stage procedure.

Address Correspondence To: UCSF AIDS Health Project • Box 0884 • San Francisco, CA 94143-0884

Administrative Offices: 1855 Folsom Street • Suite 506 • San Francisco, CA 94103 • (415) 476-6430

Administrative Office Fax: (415) 476-7996 • Fiscal Unit Fax: (415) 476-3613

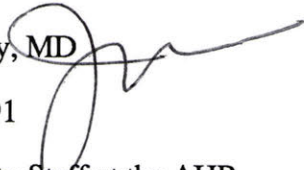
Affiliated with the University of California, San Francisco



A project concerned
with AIDS Prevention
and Health Promotion

MEMO

To: All Staff

From: James Dilley, MD 

Date: Nov. 23, 1991

RE: Ehtnic Minority Staff at the AHP

Per our multiple discussions on the multicultural nature of the Project and our wish to become increasingly multicultural in our staffing, the following should be noted:

As of toady, the AIDS Health Project, which has 99 employees on it's payroll boasts a rate of **51% of people of color**. Of these, 13 are African American, 1 is Native American, 8 are Asian/Pacific Islander, 29 are Latino and 48 are Euro-American. The proportion of people of color in our agency has risen dramatically over the past three years.

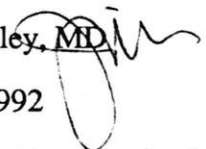
Thank you. We should all take pride in this fact about our agency.

AIDS HEALTH PROJECT

A project concerned
with AIDS Prevention
and Health Promotion

MEMO

To: Renetia Martin, LCSW, Acting Site Administrator at CPC

From: James W. Dilley, MD 

Date: August 19, 1992

RE: Proposal for addressing Intake, Assessment and Service Coordination problems at the Center for Positive Care

After lengthy discussions with the Steering Committee, the Management Team at the CPC, and the Community Advisory Board, please find below a proposal to address the problems we've encountered in establishing and managing the Intake, Assessment and Service Coordination aspects of the CPC. The following takes into consideration problems that have been identified as well as the fact that the contractual changes that we all know are needed, are not likely to happen until the end of the calendar year unless we can gain acceptance of this proposal. In sum, I believe we should renegotiate our existing collaborative relationship with NTFAP and Cal-Pep such that AHP would take primary responsibility for the Intake, Assessment and Service Coordination Program.

I. Identified Problems

- a. Lack of a standardized approach to intake, assessment and service coordination;
- b. The use of multiple agencies to provide these services without a shared definition of what constitutes these services;
- c. Inconsistent supervision of staff in carrying out these functions; staff confusion over their role and to whom they are responsible (do staff take direction from CPC staff or from their "home" agency?);
- d. Lack of consistent requirements for hiring staff to provide these services (note that due in large part to the lack of a clear understanding of these needs, tremendous staff turnover has resulted: in the 10 months since October 1, 1991, NTFAP has seen three Supervising Case Managers come and go and the position is again vacant, and Cal-Pep has had three different staff people in their Case Manager positions);
- e. Insufficient supervision to help staff deal with clients with multiple problems, including drug and alcohol problems, mental health disorders, homelessness, as well as physical problems of HIV disease (our ability to keep Clint Nix, MSW available to provide team supervision is at its end);
- f. Lack of consistent follow-up of clients' identified problems;
- g. Inability of the Steering Committee to secure consistent support from the ED's to ensure staff follow through; or inability of agency supervisory structures to ensure staff follow through;
- h. Inconsistent work attendance of staff assigned to perform intake, assessment and service coordination;

Address Correspondence To: UCSF AIDS Health Project • Box 0884 • San Francisco, CA 94143-0884

Administrative Offices: 1855 Folsom Street • Suite 506 • San Francisco, CA 94103 • (415) 476-6430

Administrative Office Fax: (415) 476-7996 • Fiscal Unit Fax: (415) 476-3613

Affiliated with the University of California, San Francisco

- i. No clear mechanism for "back-up" when assigned staff are unavailable;
- j. Use of part-time staff who have multiple responsibilities often at sites other than the CPC;
- k. Despite written MOU's, unwillingness of some staff to accept direction and supervision from CPC staff;
- l. Need for ongoing training for staff providing these services.

II. Why should AHP be the agency to take on the Intake, Assessment and Service Coordination?

- Strong clinical expertise and availability of supervision - Renetia Martin, LCSW and Jimmy Jones, MD, fourth year psychiatry resident
- Existing multicultural leadership
- Proven ability to hire and retain strong multicultural staff
- Proven ability to hire and retain strong professional staff
- Proven ability to successfully blend licensed and non-licensed staff in providing ongoing client services
- Availability of strong training staff at AHP
- Close ties to our clinical programs at SFGH, including the Ward 86 Mental Health Program, the AIDS and Substance Program, and the Case Management Program for HIV infected Substance Users
- Ability to provide back-up support staff and interns to augment service delivery
- Ability to capitalize on existing program staff familiar with the CPC and its service providers

III. How would the program operate?

A. Staffing (See attached Organizational Chart)

1. Service Coordination Staff

First, if approved by the AIDS Office, we could consolidate AHP's Women's Advocacy Program and the Linkage Programs into the Service Coordination structure at the Center. This approach would solve several ongoing problems and, I believe, provide for a better overall consistency in approach

<u>Job Title</u>	<u>% Time</u>	<u>Fund Source</u>
Supervising Case Manager (Renetia Martin, LCSW)	1.0 FTE	CPC
Women's Advocacy Coordinator (Marisa Davis)	0.8 FTE	CARE
Men's Team Leader - (Jeff Cotter, MSW)	1.0 FTE	Linkage/CARE
Women's Team Leader - (L White, MSW)* (Replacement: note this position should be increased to 1.0 FTE)	0.5 FTE	Advoca/CARE
Service Coordinators ____ Asst. III's** (TBH's) (At least two with Substance Abuse experience)	3./4.0 FTE	CPC

* Note that we have a clinically strong bicultural, bilingual person interested in this kind of position on file

**These individuals will be hired to reflect Af-American, Latino, Asian PI and Euro-American cultural traditions. Also note that these positions are flexible in their educational requirements making the potential applicant pool quite large. Also, could these positions be subcontracted? Potentially, yes (See Section IV).

2 Support Staff

<u>Job Title</u>	<u>%</u>	<u>Fund Source</u>
Contract Liaison (Ellen Goldstein)	1.0 FTE	CPC
Information & Referral Coordinator (Erik Wheaton)	1.0 FTE	CPC
Administrative Assistant (Michael Young)	1.0 FTE	CPC
Receptionists (Queta Rodriguez and TBH)	2.0 FTE	CPC

B. Operations

1. Team approach

Each MSW will function as a team leader as well as carry a caseload. This allows for solid clinical supervision to staff who need immediate questions answered, provides clear lines of clinical and administrative authority and provides the licensed and non-licensed staff clear reference groups. The Womens' Focus Team will incorporate the work of the Women's Advocacy Program and potentially subcontract with Phreda and Cal-Pep. The Men's Team could potentially subcontract with EACH and perhaps others.

2. Daily rounds

New intakes from the preceding day will be briefly reviewed each morning and follow-up plans reviewed.

3. Alternating Intake Blocks

Each team would alternate responsibility for three -four hour intake blocks. Thus, Team A would have the chance to work on the follow-up needed for its clients the afternoon following its morning intakes, etc.

Note that this plan would allow for a minimum of 240 intakes/month. Is this an unreasonable number? Two weeks ago the Center was up to 6 intakes/day. I don't believe doubling this number is unlikely once the program is up and running.

4. Philosophy

Note that this is not a mental health model of Case Management. Rather, it is a brokerage model of service coordination that uses good assessments to determine the most critical needs and then provides the appropriate referrals and follow-up to ensure clients succeed in making contact with the referral. Clients are always free to return, but this is not intended to be a model of ongoing close involvement with clients. Rather it is intended to help them get started, to learn about available resources, and to use the help of the service coordinator to get "hooked up" to appropriate services.

5. Use of Community Based Service Agencies

Active referrals would be made to existing agencies both in and out of the Center. Ethnic clients would be referred for short and/or long-term services by ethnic-specific agencies as their client load allowed and as the client wished. Regular contact with these agencies by the Supervising Case Manager would allow for knowledge of their client availability. Functional specific activities, eg., Spanish speaking support groups, AIDS Benefits counseling, etc., would be used regularly and help to ensure all groups would

meet their unit of service requirements. The CPC service coordinator would maintain quarterly contact with providers of these services to assure client follow through. As clients needs change, referral back to the CPC service coordinator will allow for a re-assessment and updated program planning.

6. Coordination with CPC staff

Through participation in the CPC management structure, the Supervising Case Manager would maintain contact with other CPC functions and ensure service coordinators' knowledge of these services.

IV. Potential Subcontracts

AHP is open to the possibility of subcontracting with other agencies to provide portions of the Intake, Assessment and Service Coordination service. However, the details of this plan would need negotiation and the only feasible approach would be one in which the subcontracted agency understood that for all practical purposes their CPC employee would be an employee of the Center, supervised in all facets of his or her employment by the AIDS Health Project. The employee would be expected to be at the Center full-time, and meet standards consistent with other coordinators, while having no responsibilities other than the Center.

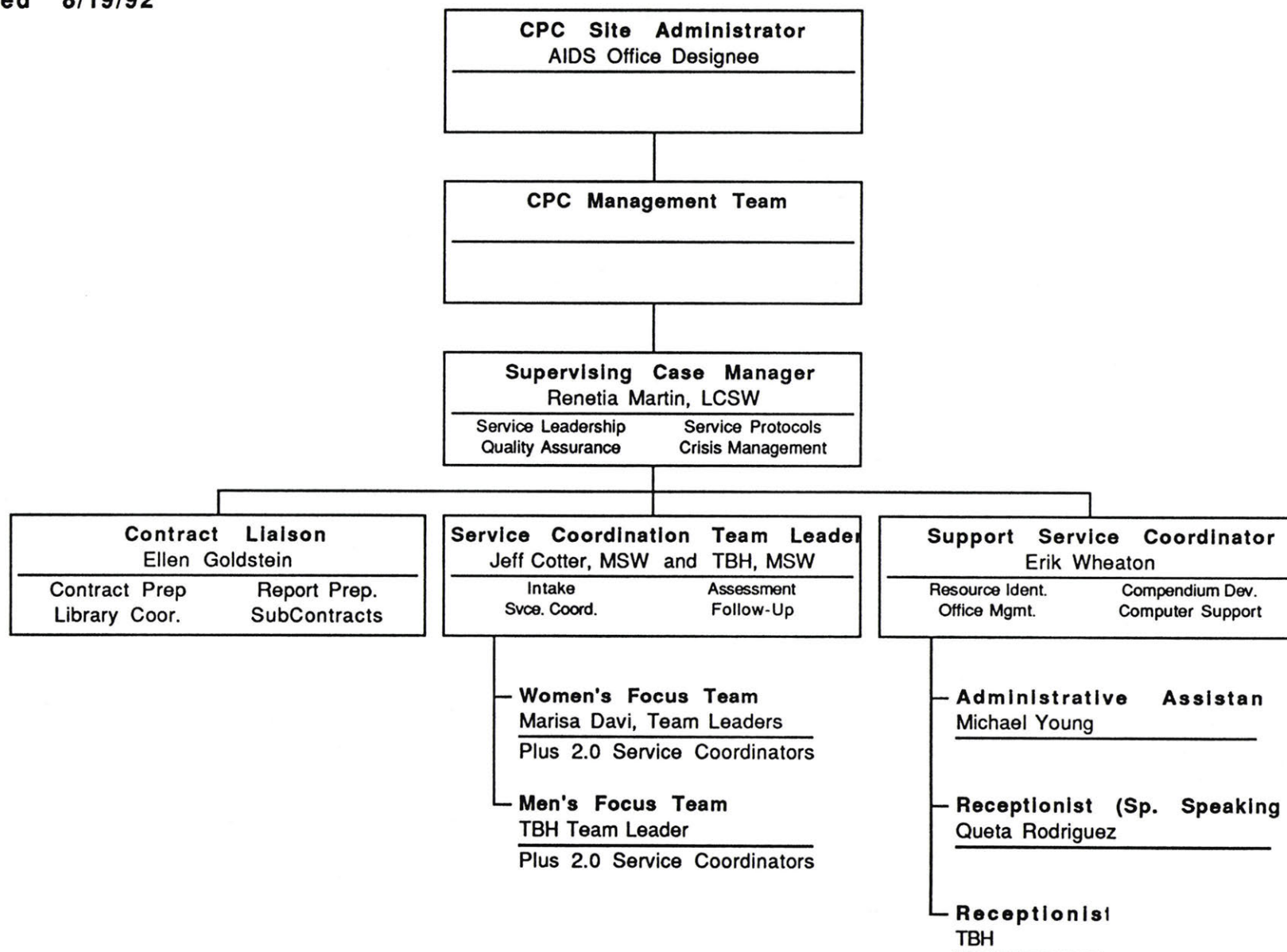
V. Summary

This plan provides for resolution of many of the existing difficulties at the Center by making one administrative structure responsible for the core service of Intake, Assessment and Service Coordination. Cultural competence would be achieved through the utilization of a multicultural staff and the liberal use of multicultural agencies for follow-up services.

As you know, with all its existing problems and relative lack of outreach and advertising, the Center has already had to limit its number of intakes. If this system were allowed to develop and a favorable reputation established in the community, there will be more than enough clients to go around. By providing efficient and careful intakes and assessments, the Center would be able to well serve its primary function: as an entry point into the service delivery system for those with HIV disease .

AHP / CPC Proposal

Presented 8/19/92





A project concerned
with AIDS Prevention
and Health Promotion

MEMORANDUM

Thu, Oct 17, 1991

To: Administrative Committee Members

JD Benson	Jim Dilley	Joanna Rinaldi
Peter Campos	Ellen Goldstein	David Silven
Paul Causey	Imelda Orlina	Dorothy Stinnett
Ed Diaz	Renetia Martin	

Through: James W. Dilley, MD
Project Director

From: Peter V. Campos
Deputy Director for Operations and Program Management

Re: P&P Recommendation: MIS Work Group (MISWG)

I would like to institute a Management Information System Work Group (MISWG) at the Project. The work group would meet on an ad hoc basis and receive periodic mailings.

The purpose of the MISWG would be to discuss systems issues and computer needs, to participate in the development of common formats for databases, spreadsheets, and quarterly reports, and to improve the overall efficiency in the use of computers. This committee has been improved in concept by the Administrative Cluster.

I would like the members of the MISWG to be the lead computer users from each of the functional units. My prospective list of participants includes the following:

MIS	Joseph Wilson (Chair Person)
Operations	Peter Campos
Fiscal	Johnny Molina
Front Office	Dorothy Stinnett
Marketing	Paul Causey
Shipping	Sandra Krilitech
Hospital Services	Dymond Austen
Ed. & Support Services	AA II TBH
ATS	Mae Araujo
Training	Roger Scroggs

I would like the initial meeting of the MISWG to be Monday, 10/28/91, 9:00am - 10:30am. At that meeting, topics discussed would include the following:

1. Need for AHP file server
2. Computer user training
3. MISWG work plan

This topic will be presented for discussion at the next AC meeting.

Thank you.

TO: Staff Attending National AIDS Update

FROM: Jim

DATE: May 13, 1991

RE: Networking

Answer from Jim

The National AIDS Update offers AHP an opportunity to showcase its services. We will have a booth (with two tables!) that will display all of our services and publications. You too are a part of this important marketing effort. As you network about your work here, introduce people to the range of services AHP offers. I have compiled a list of the project's programs, focusing on new services, and including a referral person and telephone number for each program. Please review this list, and keep it in mind as you work your way through the conference. When someone mentions a service, or the need for a service, similar to the ones we provide, offer them the name of our contact. In this way, we can network for each other.

ATS: Ed Diaz (476-6443)

Antibody testing and counseling; new programs include mobile testing and outreach to communities of color.

Hospital Services: Joanna Rinaldi (821-8764)

AIDS and Substance Abuse; inpatient social services; and psychiatric consultations (inpatient and at AIDS residence sites throughout the city). All of these programs have been expanded recently.

Prevention: David Silven (476-6441)

Support groups and intakes for seropositives and seronegatives. Volunteer Therapist program. Positives Being Positive and Living with AIDS forums. New program: facilitated, as well as self-facilitated, groups now offered. We train facilitators.

Women's Services: JD Benson (476-6444)

Youth Services: Scott Walker (821-8764)

Training: JD Benson (476-6444)

Trainings include: care for caregivers, antibody test counseling, AIDS law for mental health professionals, AIDS and substance abuse, AIDS 101, and our newest, antibody test counseling for the Department of Corrections.

Publications: Paul Causey (large orders and marketing deals: 476-6181);

Rob Marks (editorial: 476-6842)

FOCUS; Face to Face: A Guide to AIDS Counseling; AIDS Law for Mental Health Professionals (and its updates). More to come.

Neuropsychiatric Research and Dementia-related issues:

James Dilley (476-6442)



A project concerned
with AIDS Prevention
and Health Promotion

MEMO

Memos from Jim

To: Unit managers

From: James Dilley, MB

Date: may 28, 1991

RE: AHP Memorial

As you may recall from the last large staff meeting, the AHP Community Advisory Board has taken up the task of finding a piece of artwork to be donated to the Project for use as a memorial for all Project staff, volunteers, and Board members who have died of AIDS. The piece of art will be hung in the conference room and there will be a "perpetual plaque" dedicated with the piece that will contain the names of those who have died.

I have been asked by the Board to develop a list of all those who have died since the Project began so that a list may be prepared for the plaque.

Please be prepared to give your list to Dorothy by next Tues at the large staff meeting. For simplicity, I would suggest that each of you turn in the names of those from your units and/or volunteers that have worked with your programs. I will take responsibility for the Board.

Thank you.



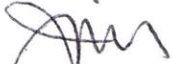
A project concerned
with AIDS Prevention
and Health Promotion

MEMO

*John Z. [unclear]
memo*

To: Management Team

Date: July 27, 1990

From: JIM 

Re: Potential transmission of HIV from a health care worker
with AIDS to a patient

This is in the vein of FYI. Please note that due to short xerox supplies, copies of this memo are only made for the management team, FOCUS editor, and one for the common area billboard. Please go over its contents with staff during your unit meetings.

In the July 26, 1990, MMWR (Morbidity and Mortality Weekly Report) from the CDC, a case report was presented in which a young woman with AIDS is alleged to have acquired HIV from a dentist with AIDS during a dental procedure. **The details of the case report do not prove that the woman's infection was acquired in this manner, but are consistent with that possibility.**

Features of the case that suggest the woman's infection may have been acquired during the dental procedure include:

1. The woman has no apparent risks for acquiring HIV; her only two prior boyfriends were tested and are HIV neg. A CDC "NIR" evaluation ("no identified risk") was conducted which includes detailed and thorough interviews. It was during this interview that the information was obtained that the dental procedure performed by a dentist who later developed AIDS, had occurred.
2. The dental procedure was a bilateral third molar extraction performed under local anesthesia. This procedure has previously been associated with transmission of hepatitis B from dental workers to patients.
3. Four weeks after the procedure, the woman developed ulcerative pharyngitis and cervical lymphadenopathy
4. Certain HIV viral DNA sequences from the woman are more similar to those from the dentist than to a panel of DNAs from reference HIV strains...the hypervariable portion of the virus differed by only 2%, suggesting the strains infecting both the dentist and the patient are the same.

Features which do not support transmission include:

1. The woman recalls the dentist wearing gloves and mask during the procedure; no needlestick or injury was noted in the patient's chart, and the dentist recalls no such injuries after he was diagnosed with AIDS;

2. Ulcerative pharyngitis alone is not a feature of acute retroviral illness; in fact, the woman's illness was diagnosed as aphthous ulcers, which is more commonly associated with more advanced HIV disease.
3. The woman developed oral candidiasis 17 months after the tooth extraction and PCP 2 years after the the procedure. (Note: only 1% of gay men and 5% of transfusion recipients progress to AIDS this quickly).
4. The reference DNA sequences used to determine the degree of similarity in the woman's and the dentist's virus were not obtained from the same geographic area, (leaving open the possibility that while the virus in each person was nearly identical, this particular strain may be the prevalent strain in the region); the reliability of DNA sequence analysis in determining virus identity is not yet established, and, the two samples were analyzed in the same laboratory, opening the possibility that contamination occurred and the analysis is flawed.

This information should be taken into consideration with the following facts:

1. Four studies to assess the risk of HIV transmission from infected health care workers to their patients during invasive procedures have been completed. In the largest, reported this week in JAMA (Mishu et al), 616 former patients of a general surgeon diagnosed with AIDS were tested for HIV. Only one, an IV drug user was found to be seropositive.
2. The CDC, AMA, AHA (American Hospital Assn), ADA (American Dental Assn) and other professional organizations have agreed that the risk of HIV transmission from a provider to a patient is too low to accurately quantify and is of concern only during invasive procedures.
3. Guidelines for managing HIV-infected providers who perform invasive procedures have not been established and decisions regarding practice restrictions are individualized at the local level. UCSF and SFGH do not preclude HIV-infected health care workers from providing direct patient care. Those performing invasive procedures are advised to double glove and to religiously adhere to infection control procedures.

Finally, the bulk of the evidence still rests with the unlikelihood of an infected health care worker transmitting the virus to his/her patient--even during invasive procedures. However, this case may open up the possibility that additional calls for restrictions and testing of health care workers performing these procedures should be mandatory.

It's important to be aware of the pros and cons of this particular case.

Thanks to Julie Gerberding, MD, for much of this information.



A project concerned
with AIDS Prevention
and Health Promotion

MEMORANDUM

Date: Wed, Feb 20, 1991

To: All Staff

From:

JAMES W. DILLEY / PWC
James W. Dilley, MD
Project Director

Subject: CARE Funding Proposal Update

This memo provides information on the resolution of our CARE proposals.

First, I would like to compliment the efforts of staff in developing and submitting the proposals. Although the results of the selection process are mixed, from the Project's point of view, I would like to reinforce that the value of each staff person's and unit's contributions were not mixed. Our proposals were uniform in their quality and all reflected the same high standards that we have always brought to the proposal submission process.

On the funded side, our Hospital Services proposals were well received and all were funded. Additionally, our proposal to provide advocacy services to women with HIV was funded. Unfortunately, none of our psychosocial services proposals were funded, nor were our proposals to provide T-Cell testing and case management services at the Anonymous Test Sites.

The proposal review process, although complete from the CARE-side of the funding, is not over. The City still has supplemental General Fund allocations that are to be distributed (referred to as the Britt money in an earlier memo). We will continue to remain optimistic that our proposals that were unfunded under CARE will still receive consideration. I will know more about this latter subject after my meeting tomorrow with Dr. Sandra Hernandez of the AIDS Office.

Please be assured that we will continue to pursue all avenues to obtain funding for the services which we feel are needed for persons at risk for HIV and for persons with HIV.

Area	Outcome	Services Bid
Primary Health Care		
	Funded	1. Expansion of Psychiatric Consult service
	Not Funded	2. New program: Clinical Marker testing at ATS
Other Pri. Hlth Care		
	Part. Funded	1. Expansion of ASAP Program (Supplemental CARE Budget - pending City receiving funding)
	Funded	2. Expansion of Ward 86 program
Psychosocial Support		
	Not Funded	1. Expansion of BAY Positive program for youth with HIV, including expansion of groups and addition of 1:1 counseling
	Not Funded	2. New program: Psychosocial Support for Health Care Workers with HIV, including drop-in group and 1:1 counseling

- | | |
|------------|--|
| Not Funded | 3. Expansion of Women's services program including expansion of groups and addition of 1:1 counseling and a "buddy" program. |
| Not Funded | 4. New program: Psychosocial Support and Training for HIV Care Workers. Like old MHEP program in some ways. |

Advocacy/Case Management

- | | |
|------------|--|
| Funded | 1. Expansion of Women's services program including finding women with HIV who have disappeared and establishing a self-advocacy training |
| Not Funded | 2. Expansion of ATS resource identification. |
| Not Funded | 3. New program: Short Term Case Management for persons testing positive at ATS. |

Funded Program Descriptions

Augmentation of Psychiatric Consult Service.

The proposed service will augment the Project's Psychiatric Consult service which provides consultation and evaluation services to the AIDS home based system of care in San Francisco to assist in their treatment of persons with HIV. This service was begun by the current Project Director in 1986. Funding from the Health Resources Service Administration (HRSA) was received in 1987 to hire a .025 FTE psychiatrist for this service. Due to the increasing numbers of patients living with AIDS and the increasing complexity of managing their care, the demand for this program has grown. In the 1991 HRSA contract, this position is funded at a 0.38 FTE level. This request is to increase the staffing to a 0.70 FTE. The increase will allow the service to meet the expanding needs of many providers, including Continuum HIV Day Care Services which provides day care services to those with HIV related cognitive impairment and those with pre-existing mental health and substance abuse problems. A projected 320 unduplicated clients will be served.

Mental Health Services at SFGH Ward 86

The proposed services will expand the current mental health services provided at San Francisco General Hospital's (SFGH) Ward 86 and allow additional persons with HIV and mental health needs to be seen. The proposal will add a .5 FTE Psychiatrist, increase the current Clinical Social Worker from a .7 FTE to 1.0 FTE, and add support staff. A projected 277 unduplicated clients will be served.

AIDS and Substance Abuse Program (ASAP)

The proposed services will expand the Project's SFGH-based ASAP program and allow additional persons with HIV and substance abuse problems to be seen. The proposal will add two 1.0 FTE clinical staff and support staff. This service augmentation will increase the number of HIV infected substance users/abusers who are offered aggressive intervention services, increase the amount of consultation services that can be provided to SFGH staff and community HIV providers, and impact on the spread of HIV disease to IDU partners, sexual partners, and unborn children. A projected 425 unduplicated clients will be served.

Women's Short-Term Advocacy and Outreach

a. Service Methodology and Relationship With Other Organizations

The proposed service targets women who are HIV positive and who are aware of their HIV status but who have dropped out of the system and not pursued medical and other care. The service is composed of three components: case finding, short term advocacy services, and self-advocacy training.

Case Finding

The program will identify women with HIV through presentations and advertisements at government and community-based agencies (jails, AFDC offices, EDD offices, clinics at SFGH, soup kitchens, homeless shelters, health clinics, and elsewhere), at drug and alcohol treatment settings, and in living environments (housing projects, bars, beauty parlors, etc.). Staff hours at the existing AHP-ATS Ethnic Community Outreach program will be increased to assist in this effort. Women will be offered the opportunity to work one-on-one with a treatment advocate.

Short Term Case Management

Short term advocacy services will be provided to 50 women located through the case finding service. The treatment advocate will assist the client in resolving a variety of issues, including identification of a medical provider, partner relations, accessing drug and alcohol treatment programs, resolution of child care and transportation problems, etc.

To ensure that the woman will actually utilize the referral resources, the advocate will maintain contacts at a variety of resource agencies and facilitate client access to agency services. In addition, the advocate will strategize with the client regarding techniques for accessing services and using the system. Travel tokens will be provided if necessary.

The objective of the program will be to successfully engage women in a program and to establish a treatment plan for managing their HIV disease.

Self-Advocacy Training

Six women who demonstrate success in becoming effective self-advocates will be asked if they are interested in being trained to train other women in self-advocacy techniques. Women who opt to do so will receive a 16 hour (two-day) training in how to do the self-advocacy trainings and will provide trainings (a minimum of six, two-hour trainings) to a total of 30 other women. Trainers will receive a stipend for all training activities. By thus empowering women and sharing the "how-to" aspects of accessing services, an effective peer support network will be created.

THE
**AIDS
HEALTH
PROJECT**

A project concerned
with AIDS Prevention
and Health Promotion

July 3, 1990

Willie L. Brown, Assembly Speaker
John L. Burton
Jackie Speier, Democratic Whip
Quentin Kopp
Milton Marks, Democratic Caucus Chair

Dear Sir/Madam:

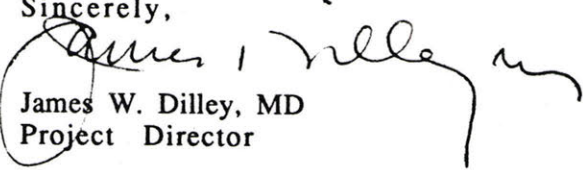
I am writing to express my deepest concern over the suggested funding cuts in the State health and human services budget put forward by Governor Deukmejian. These cuts are unacceptable and will most assuredly mean that those in the society who can least afford it will once again be asked to make sacrifices to balance the State budget.

The suggested cuts will also have a potentially devastating impact on the provision of services to those with AIDS as well as reducing funds available for AIDS prevention and education programs in San Francisco and throughout the state. As each of you must know, the AIDS epidemic is only getting larger and to reduce funding for either care or prevention services at this point in time is untenable and a true example of short sighted solutions to long-term problems.

On behalf of the staff of the AIDS Health Project, I strongly urge you to resist these suggestions and instead look to other areas and /or alternate sources of funding to reduce the state budget deficit.

I would be happy to talk to you further on this issue and hope that you are with us on this issue. We will follow this issue with the utmost interest.

Sincerely,


James W. Dilley, MD
Project Director

cc: Budget Conference Committee Members

7/10/90
To: All Staff

From: Jim Dilley

F Y I

This letter was sent
to a number of Assembly,
Senate, & Budget Com.
members.



A project concerned
with AIDS Prevention
and Health Promotion

AHP-ATS Internal Memo

October 30, 1989

TO: ATS Staff and
Management Team

FR: Peter Campos 

RE: Seropositive Handouts and ATS Service Listing Handout

Seropositive Handouts

Copies of the three versions of the seropositive handout (Standard English, Sheltered English, and Standard Spanish) are now available. We will provide this handout (the appropriate version as determined by the counselor) to persons who test positive. The handout is designed to be a take-home supplement to the counseling session.

1. Standard Version (Information About Your Health)

Developed for persons with approximately a high school level of education and reading ability.

2. Sheltered English Version (About Your Health)

Developed for persons with minimal reading ability. This document provides a very basic level of information about HIV and support services. It is expected that persons who receive this document will get most of their advanced information orally.

3. Spanish Standard Version (Información Sobre Su Salud)

Developed for mono-lingual Spanish speaking persons who read Spanish as part of their daily routine. We hope to be able to develop a limited literacy version in Spanish, pending receipt of funds.

Please note that this is a working document and that it will change over time as the needs of the clients change. We want to keep it up to date. If you think that something should be stated differently/added, please let me know and your ideas will be taken into account at the next revision (probably around April).

ATS Service Listing

This handout provides an easy reference to ATS program services. A sample has been placed in your box.

Thank you.



A project concerned
with AIDS Prevention
and Health Promotion

October 30, 1989

Bang Nguyen, ATS Coordinator
Department of Public Health AIDS Office
25 Van Ness, 5th Floor
San Francisco, CA

Dear Bang:

Enclosed please find copies of three versions of our Seropositive Handout - with the strengthening of the partner notification references requested by your office in your letter of 9/12/89. The other changes requested have been made with a few exceptions, noted below.

1. Standard Version (Information About Your Health)
All changes made (with minor editing for text flow and to maintain our counseling approach) with the exception of detailed listing of DPH district health centers due to space reasons and the fact that most have indicated to us that they are not prepared for, nor do they want, HIV asymptomatic referrals.
2. Sheltered English Version (About Your Health)
All changes made (with minor editing for text flow and to maintain our counseling approach) with the exception of detailed listing of DPH district health centers as noted above and because we do not want to include extensive listings of referrals in this version due to the limited reading abilities of the target clients.
3. Spanish Standard Version (Información Sobre Su Salud)
Most changes were presented in the form of questions that we have presented to Ms. Gannon, our consultant. She stated that the noted items had been checked by our review panel and had been approved. Two of the requested changes have been made: deletion of text indicating that safe oral sex on a male could include any sexual activity that did not include putting the tip of the penis in the mouth and inclusion of reference to the Partner Counseling Notification Program. The Spanish title of the program was provided by Kevin McKinney.

We have now put the documents into service at the ATS. Thank you for your assistance in this review.

Sincerely,

Peter V. Campos, Coordinator
AHP/ATS Program

c.c. Marshia Herring

Address Correspondence To: UCSF AIDS Health Project • Box 0884 • San Francisco, CA 94143-0884

Administrative Offices: 1855 Folsom Street • Suite 506 • San Francisco, California • (415) 476-6430

Affiliated with the University of California, San Francisco

INFORMATION ABOUT YOUR HEALTH

October 1989

You have tested positive for HIV infection.

You may be feeling scared, confused, or angry. Along with these emotions, you may have questions about your health condition and its impact on your life.

We hope these pages will help answer some of your questions and identify resources that will help you cope.

Meaning of Positive Test Results?

Does being antibody positive mean that I have AIDS or ARC?

No. The test does not diagnose AIDS. But it does mean that the virus that causes AIDS is in your body and that you can spread the disease to others.

What does testing HIV positive mean?

A positive test result means that you have been infected with the virus that causes AIDS (Acquired Immune Deficiency Syndrome) and ARC (AIDS Related Complex) conditions and that your body has produced antibodies against the virus.

The test does not directly detect the presence of the virus, called HIV (Human Immunodeficiency Virus). Instead, it detects the presence of antibodies, which indicate the presence of the virus.

Some of the terms used to refer to this positive condition are HIV positive, antibody positive, or seropositive.

If I have antibodies, doesn't that mean that I have antibodies that are fighting the HIV virus?

Yes, but unfortunately the kinds of antibodies that your body produces are effective for only a limited time in fighting the virus.

Will I get AIDS or ARC?

Based on what is known right now about the progression of HIV infection, your chance of developing AIDS or AIDS related symptoms in the future is probably quite high.

Recent studies indicate that most people infected with the HIV virus will develop AIDS or AIDS related symptoms within seven to twelve years of infection.

The critical issue is when - and that is where you can help yourself. (See the "Staying Health" Section)

Most people infected with the virus develop AIDS within 7 to 12 years.

Could my test results have been wrong?

Probably Not. If your test was done at a San Francisco County Alternative Test Site (ATS), your blood has tested positive in four (4) separate tests.

ATS blood samples are first tested using a test called the RELISA, which is a highly accurate test. If the sample tests positive for the HIV virus, it is re-tested two more times with the ELISA. If it still tests positive, another test called the IFA (immuno-fluorescence assay) is performed.

If the test is positive on all four of these tests, it is concluded that the sample is positive.

Can I be re-tested?

Yes. You can repeat the test as often as you like, but based on what we know about HIV infection, once your blood test is positive, it will continue to be positive.

What Now?

Why me?

We don't know why some people who are exposed to the virus test positive, while others who are equally exposed to the virus test negative.

The fact that you have antibodies to HIV in your blood simply tells us that you were exposed to the virus at some point in the past and became infected.

Am I contagious to others?

Yes. The virus can be transmitted through sexual contact involving body fluids (semen and vaginal secretions), by activities that can lead to the exchange of blood (such as sharing needles when using drugs), and from a mother to her unborn or nursing baby.

There is no evidence that HIV can be transmitted by casual contact. It is safe to continue working, to share eating utensils, to hug your friends, and to live in close quarters with others.

(See the "Stopping the Spread of the Disease" Section for more information.)

My partner is not positive, is (s)he immune?

No. There is no known immunity to HIV infection. We know that some people who have engaged in high risk behaviors test negative. However, we don't know if they will continue to test negative. We urge all people to avoid exposing themselves and others to the virus.

What do symptomatic and asymptomatic mean?

A person is described as symptomatic when s/he has tested HIV positive and has symptoms related to HIV infection. Some of these symptoms are swollen lymph glands, a yeast infection in the mouth (candidiasis), or chronic fevers or diarrhea. A person can be symptomatic and not have AIDS. To be diagnosed with AIDS, a person must have specific symptoms that meet the requirements of the AIDS diagnosis.

A person is described as asymptomatic when s/he has tested HIV positive, but does not show any symptoms.

Who Should I Tell?

Should I tell others that I'm HIV positive?

It is important for most people to have others they can talk to for support. However, you should be careful that your results are shared only with persons you can trust to keep the information confidential.

Discrimination has occurred in employment, housing and in obtaining insurance coverage. You should give careful thought to what could happen if your test results become common knowledge.

Since there is no risk to others through casual contact, it is not necessary to inform your boss, co-workers, or casual acquaintances that you are positive.

Should I tell sexual and/or needle sharing partners?

Consider informing partners who might not otherwise know that they may have been exposed to the virus.

If past or present partners are not aware of their risk for infection, they cannot make an informed decision about taking the test, taking care of their health, or preventing the spread of the disease.

If you need help in telling your partners, you may want to take advantage of the free, confidential and voluntary Partner Counseling Program offered by the San Francisco Department of Public Health. (See the "Resources" Section.)

What should I tell my partner(s)?

We encourage you to discuss safe sex practices and to agree on what kinds of sexual activities you will practice and which you will not.

If you are an IV drug user, talk about the importance of using clean needles. (See the "Staying Healthy" Section for more information.)

Should I tell my doctor and dentist?

Before telling your doctor and dentist, ask them how they will record the information. Decide if their method is acceptable to you.

Also before telling your current doctor, you may want to find out if s/he has experience treating HIV infection. If not, you may want to change physicians, which will eliminate the need to share this information. (See the "Medical Follow-Up" Section for more information.)

Cautions. Recent changes in state law give doctors the power to inform your partners of your HIV status. In addition, if your HIV status is in your medical record, it may affect your insurance coverage.

Why You May Want to Tell. Your doctor and dentist can both watch for signs or symptoms of HIV-related illnesses. Also, advances in medical treatments are being made and it is important for your doctor to actively assist you in dealing with the HIV infection.

Will information in my medical chart about my HIV status be confidential?

A Word of Caution. Insurance companies have access to medical records and have been known to cut-off coverage to persons with HIV infection.

All information contained in medical records is available to insurance companies when you apply for health, life, or disability insurance. An insurance company's knowledge of your positive test may result in the denial of future requests for coverage or benefits.

Dentists and physicians can keep your HIV status in a special section of your chart (or in a separate chart) that is not released to insurance companies.

Explore with your physician his or her willingness to keep HIV antibody test results (and the results of other tests that indicate antibody status) out of your records. You might ask: "If I tested positive, would you find it necessary to document that in my record?"

Medical Follow-up

Should I see a doctor?

Yes. It is important that you see a physician who is knowledgeable about HIV infection as soon as possible. There are treatments available that may help to delay the onset of symptoms. Don't wait to go to the doctor until you feel sick?.

If you are not feeling well, you should see a doctor immediately.

What will the doctor do?

The doctor will probably want to give you a complete physical exam to determine your current health status and to establish baselines against which changes in your health can be measured.

What should I do if I don't have a doctor?

If you have health insurance, you can call the Bay Area Physicians for Human Rights (673-3189) for a referral to a doctor who is HIV sensitive.

Unfortunately, if you do not have health insurance and cannot afford to pay for medical care, your options are more limited.

If you do not have a primary doctor, you can go to the city's free STD and TB clinics for medical follow-up.

(See the "Resources" Section" on the last page.)

What kinds of additional test should I take?

Some of the special HIV-related tests that your doctor might recommend include the following.

- A skin test for tuberculosis (TB) called a PPD.
- A blood test for syphilis called a VDRL.
- A test for intestinal parasites (particularly for persons who have anal sex).
- Tests that are used to measure your immune status and monitor the progression of the HIV infection. Such tests include the T4, which counts the number of T4 cells in your blood; the P24, which looks for the presence of P24 (a part of the AIDS virus) in your blood; and the Beta-2 Microglobulin, which is a test of the destruction of cells in your blood.

Please note that there is some controversy about the use and meaning of some of these tests, so you will want to work closely with your doctor on these matters.

Won't my insurance be cut off if I take additional tests?

A word of caution. If you can afford it, you may want to pay cash for AIDS-related tests and not have these tests appear on your insurance form. Even if the results of these tests are normal, insurance companies have been known to deny coverage to people who take these tests.

Should I start drug treatments?

There is a growing consensus that early intervention with antiviral treatments may slow the progression to AIDS. For this reason, some HIV positive people (especially those with AIDS-related symptoms) choose to take the FDA-approved medication AZT or other experimental drugs and treatments.

Project Inform (415/928-0293) provides extensive information regarding new drug treatments that are currently being studied and used by leaders in the HIV treatment field.

In all cases, talk with your doctor before starting any treatments or experimental drug protocols.

What about alternative healing?

Many HIV-positive people choose to use a variety of alternative healing resources, either alone or in conjunction with traditional western medicine.

See the "Resources" Section for agencies that provide alternative healing information and referral to services.

Acupuncture, chiropractic medicine, nutritional supplements/special diets, massage/bodywork, visualization, hypnosis, meditation, and spiritual exploration are among the treatments used.

How will I know if I start to get sick from AIDS?

AIDS is actually a term that includes several different kinds of illnesses. Although the progression of HIV disease from the asymptomatic condition to full-blown AIDS usually follows a pattern of progressive illness, the pattern varies in each individual.

Some common early symptoms are fever, night sweats, or a persistent cough. These condition may worsen, or you may develop other symptoms.

If you start to feel sick, see a doctor immediately. If you do not have insurance, contact the AIDS Hotline. They will direct you to the nearest county facility.

Staying Healthy

What should I do to stay healthy?

There is still much to be learned about why some people who are HIV positive develop AIDS and others do not. Follow a "common sense" approach to taking an active role in maintaining your health.

1. Sleep. Get enough sleep.
2. Diet. Eat a balanced diet.
3. Exercise. Exercise regularly.
4. Stress. Reduce the stress in your life. Seek out a stable support system and, above all, work at maintaining a healthy outlook and a positive attitude.

The AIDS Health Project (476-6430) offers a variety of groups for stress reduction, health promotion and emotional support.

5. Drugs, etc. Limit the use of tobacco, alcohol and other drugs. These drugs can suppress your immune system and weaken your body. If you use IV drugs and must share needles or syringes, flush the works twice with bleach followed by twice with water.
6. Sex. Always insist on safe sex.

What about exposure to other diseases or to vaccines to prevent diseases?

Protect yourself from exposure to diseases or to live vaccines, such as polio or measles vaccines.

Live vaccines cause a mild case of the disease being vaccinated against. This mild disease could be harmful to someone who has HIV infection and a weak immune system. If you have a child who is due for a vaccination, consult your physician about risks associated with your exposure.

Since I am already HIV positive, can I have unsafe sex with another person who is also positive without hurting myself?

No. As an HIV positive person, you need to do everything possible to stay healthy. Your good health is your best protection against the development of AIDS and AIDS related symptoms.

There are many strains of the HIV virus. Unsafe sex exposes you to these other strains and to other sexually transmitted diseases.

If you are having sex with someone who is also HIV-positive, you should always be practicing safe sex. It is protecting both of you.

Remember, your health is dependent on maintaining a strong immune system. When you are exposed to viruses, your immune system is further weakened.

Stopping the Spread of the Disease

What should I do to prevent infecting others?

Do not do anything that allows your blood or sexual body fluids to be transferred to another person.

- Do not have unsafe sex.
- Do not share IV drug needles.

- Do not donate blood or plasma for transfusion, sperm for artificial insemination, or body organs for transplantation. If you are listed as an organ donor, remove that designation from your driver's license.
- Do not share toothbrushes, razors, acupuncture or tattoo needles or other items which may be contaminated with blood.
- Do not leave accident surfaces uncleaned. If you have an accident that results in bleeding, wash surfaces with soap and warm water. For surfaces that require special care, wash with one part bleach to ten parts water.

Can I still have sex?

Yes. But, you need to practice safe sex in order to protect yourself and to keep from spreading the disease to others.

What sexual activities are considered safe?

Any activities which don't involve sharing body fluids (semen, blood, vaginal secretions, breast milk) are safe.

Kissing, hugging and mutual masturbation are safe.

What sexual activities are "probably safe"?

Anal and vaginal sex using a condom and nonoxynol-9 are probably safe. Use latex condoms and water-based lubricants. It is also recommended that the receptive partner use a spermicidal foam with nonoxynol-9.

Sexual acts in which the exchange of bodily fluids is stopped by a condom or barrier are probably safe.

Oral sex on a man is also probably safe if it is done with a condom.

Oral sex on a woman is probably safe if it is done with a barrier that keeps vaginal secretions from coming in contact with the partner.

What sexual activities are "unsafe"?

Unprotected (no condom) anal, vaginal, and oral sex is unsafe.

Always use a condom when having anal and vaginal sex. Always use a condom or barrier when performing oral sex and bodily fluids are involved.

Unprotected oral sex, whether performed on a man or woman, is considered unsafe when bodily fluids come into contact with a partner.

- When performed on a man, it is unsafe when pre-ejaculate or semen (cum) enter the mouth.
- When performed on a woman, it is unsafe when vaginal secretions enter the mouth.

What do I do if I like to drink and do casual drugs?

The best choice is to stop drinking and using drugs. People who are intoxicated or "high" are more likely to do things that place them at risk of contracting or transmitting HIV. For example, if you are "high", you may be more inclined to have sex without condoms.

What do I do if I am a IV drug user?

Get help to stop using. Sharing needles and syringes is the surest way to pass the AIDS virus from the blood stream of one person to another.

If you haven't stopped shooting drugs, don't share your needles. If you must share your needles, clean them first.

Here's how to clean a needle.

1. Flush the needle two times with bleach.
2. Flush the needle two times with water.
3. DO NOT shoot or drink the bleach.

What if I can't stop using IV drugs?

Get help. Most people need help to beat an addiction. (See the "Resources" Section for a referral to a drug treatment program.)

Special Considerations

PREGNANCY

I want to get pregnant. Should I?

A word of caution. It is estimated that there is a 40-60% chance of a woman passing the AIDS virus on to her baby. The virus can be transmitted while you are pregnant, when you give birth, or through breast feeding.

Most physicians recommend that women with a positive test result not become pregnant until more is known about AIDS and pregnancy.
--

Talk with your partner, doctor, a health worker, or an AIDS information agency.

What do I do if I am already pregnant?

It is possible to transfer this infection to your unborn child during pregnancy even if you remain healthy.

At some point, you will probably want to notify your doctor, since your HIV-positive status could influence your health care treatment needs.

Before sharing your results with your doctor, first explore their willingness to keep your positive test results out of your (and your baby's) permanent medical records.

I am positive and just had a baby. Could my child also be HIV positive?

Yes. There is a 40-60% chance that the AIDS virus will be transferred from you to your baby (see above). Talk with your doctor about whether your child should have the antibody test. Also, since HIV has been found in breast milk, your doctor will probably recommend that you bottle-feed rather than breast-feed your baby.

A Final Word

The news that you have been infected with HIV is not easy to receive. It is important that you establish a close relationship with someone you can trust so that you can speak openly about your feelings, problems and any fears you might have.

If you want a referral to an AIDS-sensitive mental health professional or peer support group, call the AIDS Health Project at 476-6430. Ask about our "Positives Being Positive" peer support program.

The U.S. Public Health Service has made AIDS and AIDS virus-related illnesses its number one priority. Scientists all over the world are working to find ways to eliminate this disease.

A great deal of progress has been made in a short period of time. There is every reason to expect that these advances will continue.

Resources

Information and Referral

San Francisco AIDS Foundation Hotline
(415) 863-AIDS or (800) FOR-AIDS

Emotional Crisis

San Francisco Suicide Prevention (415) 221-1423
Mission Crisis Center (415) 558-2071

Health Promotion and Mental Health Support

AIDS Health Project (415) 476-6430
AIDS Health Project, Positives Being Positive,
(415) 476-3902
Community Mental Health Services Team #1
(415) 558-567

Drug Treatment

AIDS & Substance Abuse Prog. (415) 821-8764

Treatment Information

AIDS Alternative Healing Project Hotline
(415) 558-9292
AIDS Treatment News (415) 255-0588
BETA (a newsletter), SF AIDS Foundation (415)
864-4376

Project Inform (415) 928-0293

Gay Men's Health Center, Department of Medical
Information - Prescription Issues, 129 West 20th
Street, New York, NY 10011.

Medical Referrals

The Bay Area Physicians for Human Rights
(BAPHR). Provides referrals to doctors who are
HIV knowledgeable (415) 673-3189

Medical Care - Sliding Fee

Department of Public Health, Health Center 1, for
persons who are HIV positive but asymptomatic,
(415) 558-3905
Ward 86, San Francisco General Hospital, for
persons who are showing symptoms of AIDS
(415) 821-8830

Partner Counseling and Notification

Department of Public Health (415) 554-9085

Legal Referrals and Services

Bay Area Lawyers for Individual Freedom
(BALIF) (415) 864-8186



Information About Your Health is a publication of the AIDS Health Project
(AHP), Box 0884, San Francisco, CA 94143-0884, (415) 476-6430.
Written by Neil Seymour. Edited by Peter V. Campos and Eileen Eya. Portions
derived from materials provided by the Contra Costa AIDS Program.
AHP appreciates the assistance of the many individuals and agency staff
members who reviewed this document.
© October 1989, Regents of the University of California, San Francisco

About Your Health

October 1989

You have tested positive for the AIDS virus.

This means that the virus that causes AIDS is in your body. This virus is called HIV.

You may be feeling scared, confused and angry. You probably have many questions about what this means for your health, your future, your family and friends.

A lot is known about helping people with HIV. There are things you can do to care for yourself. There are ways a doctor can help.

You don't have to face this alone.
You can get the help you need.



Testing positive for HIV does not mean you have AIDS.

It **does** mean that the virus that causes AIDS is in your body.

You may not feel sick at all. And you may go on feeling healthy for many years.

But because HIV is in your body, it's a good idea to see a doctor as soon as you can.

- Find a doctor who knows a lot about HIV and AIDS.
- Ask your doctor about ways you can keep healthy. There are treatments and tests that may help.
- Ask your doctor not to write your HIV test result on your chart. You could lose your health insurance.



Testing positive for HIV means that you could get sick with AIDS in the future.



Some signs to watch for are: fevers that come again and again, sweating a lot at night, a long lasting cough, or bad diarrhea.

If you start to feel sick, see a doctor right away. Choose a doctor who knows how to care for people with HIV.

Whether you are feeling sick or not, you should take special care of yourself. Try to follow this good advice:

- **Eat well.**
- **Get plenty of sleep.**
- **Exercise often.**
- **Find ways to feel good about yourself.**
- **Don't use drugs, tobacco or alcohol. If you can't quit, then cut back or get help.**



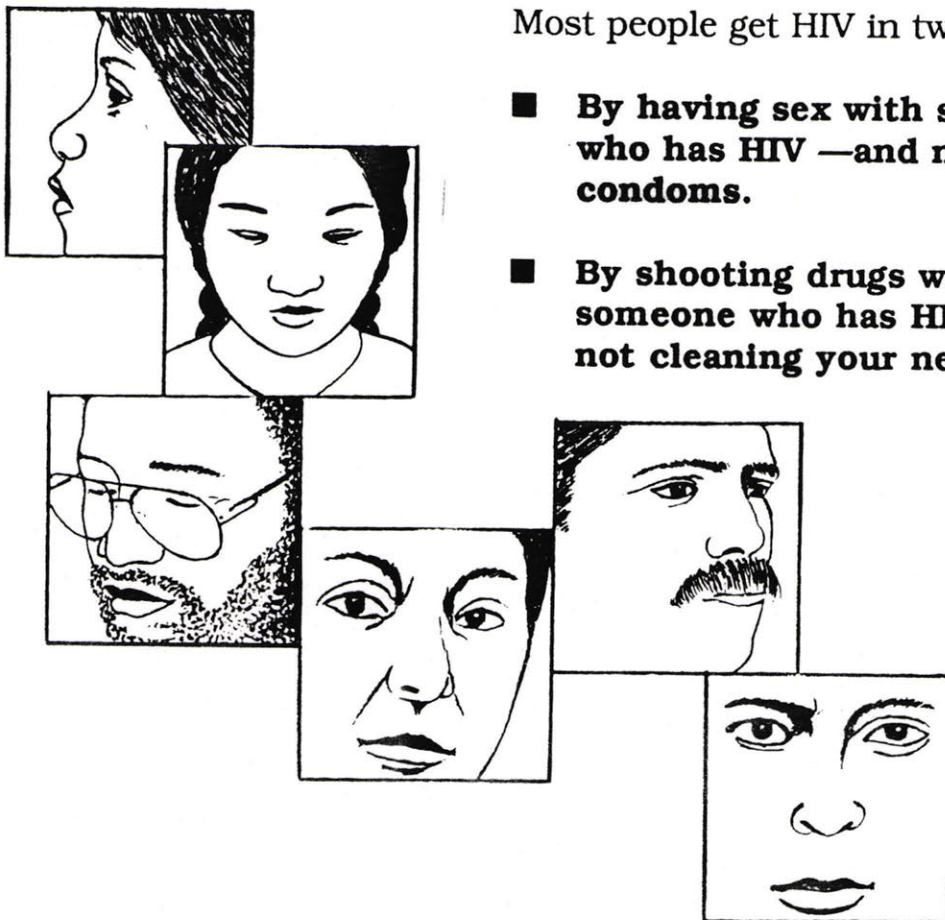
Testing positive for HIV means you can pass the virus to others.

But HIV is hard to pass to others.
You can't get it like you get a cold.

HIV can only be passed from person to person in blood, cum, and vaginal fluids. It can't live on dishes, doorknobs, or towels.

Most people get HIV in two ways:

- **By having sex with someone who has HIV —and not using condoms.**
- **By shooting drugs with someone who has HIV—and not cleaning your needles.**



It's easy to keep people around you safe from HIV.

Here's how:

■ **Have safer sex.**

Kissing, touching and hugging are safe.



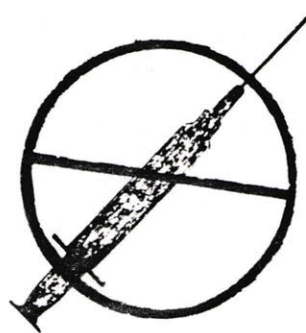
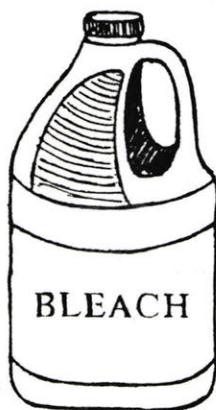
■ **Use condoms.**

If you have oral, anal, or vaginal sex, use condoms every time. Condoms with non-oxynol 9 give extra protection.

■ **Don't share your works.**

Or at least clean them first. Flush the needle two times with bleach. Then flush the needle two times with water.

Better yet, quit using drugs.

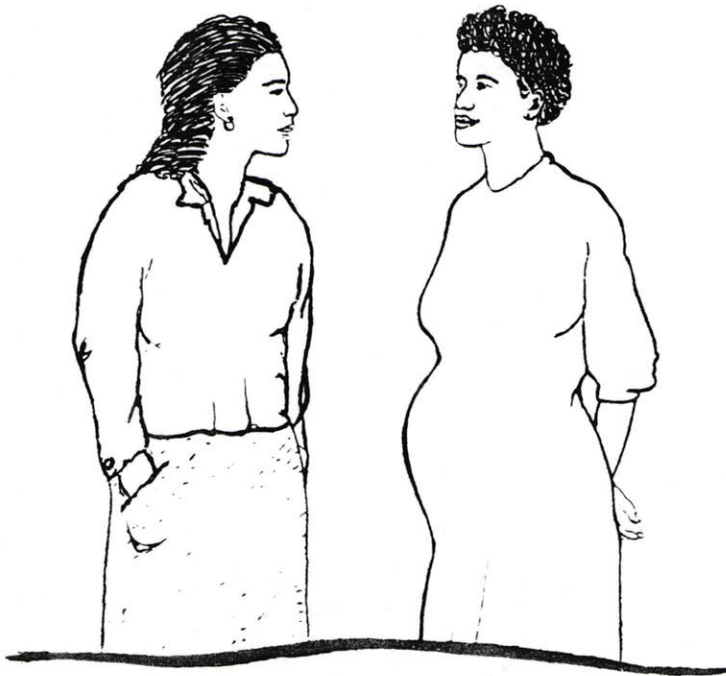


You could pass HIV to your baby while you are pregnant.

There is a good chance a woman with HIV will pass the virus to her baby while she is pregnant or giving birth.

Think about waiting to have a baby until you know more about HIV and pregnancy.

If you are already pregnant, see a doctor right away.



Remember, HIV is hard to get.

Other people can't get it just by being around you. You can work, eat, hug and live with others without worry.

And right now, you may need someone to hug and cry with. Tell someone you trust what you are going through.

Sometimes it helps just to talk with someone who understands. You may want to see a counselor or talk with other people who have HIV.



You decide who to tell.

It's a good idea to tell only people you can trust to keep a secret.

You do **not** need to tell your boss, your co-workers, or other friends.

Many people don't understand that living and working with someone with HIV can't hurt them. Because of the fear of AIDS, people with HIV have sometimes lost their jobs and homes.

You may want to tell people you have had sex with or have shared your works with. That way they can get help, too.



Get the help you need.

These people are here to help:

Have more questions?

AIDS Hotline

(415) 863-2437
or (800) 367-2437

Alone and afraid?

San Francisco Suicide Prevention

(415) 221-1423

Mission Crisis Center

(415) 558-2071

Want to talk to a counselor?

AIDS Health Project

(415) 476-6430

Community Mental Health Services

(415) 558-5671

**Want to talk to someone about
drugs or alcohol?**

SF General, ASAP Program

(415) 821-8764

Need medical help?

SF District Health Center #1

(415) 558-3905

SF Ivy Street Clinic

(415) 554-2950

Need help telling others?

SF Partner Counseling Program

(415) 554-9085



About Your Health is a publication of the AIDS Health Project (AHP),
Box 0884, San Francisco, CA 94143-0884, (415) 476-6430.

Developed by Education Program Associates (Campbell, CA) as the sheltered
English version of an AHP document entitled "Information About Your
Health". Illustrations by Juan Fuentes.

© October 1989, Regents of the University of California, San Francisco

INFORMACION SOBRE SU SALUD

Octubre 1989

Usted ha obtenido un resultado positivo en su prueba de anticuerpos del VIH, el virus que causa el SIDA.

Esto quiere decir que el laboratorio encontró anticuerpos del VIH en su análisis de sangre.

Quizás usted sienta miedo, confusión o enojo. Junto con estas emociones, tal vez usted tenga algunas preguntas.

Esperamos que estas páginas le conteste algunas de sus preguntas y le den información sobre lugares donde puedan ayudarle con el resto de sus preguntas.

¿Qué significa este resultado?

Si mi prueba salió positiva, ¿significa que tengo SIDA?

No. Esta prueba no le puede decir si tiene SIDA. Lo que significa es que el virus del SIDA (que se llama VIH) está en su cuerpo.

¿Me dará el SIDA?

Por ahora, con lo que sabemos, probablemente sí.

La mayoría de las personas infectadas con el virus desarrollan SIDA de 7 a 12 años más tarde.

Lo importante es tratar de mantenerse en buena salud para poder combatir el virus

¿Pueden estar equivocados mis resultados?

Probablemente no. Si su prueba fue hecha en un centro alternativo en el condado de San Francisco, le hicieron 4 pruebas separadas a su sangre.

¿Puedo hacerme el análisis de sangre de nuevo?

Sí. Puede hacersela cuantas veces quiera. Sin embargo, debe saber que si su prueba salió positiva, los resultados de otras pruebas en el futuro seguirán siendo positivos.

¿Y ahora qué?

¿Por qué me ha pasado esto?

El VIH se pasa de persona a persona principalmente por medio del sexo e inyectándose drogas con agujas (jeringas) sucias. Otras personas lo han adquirido por medio de transfusiones de sangre recibidas antes del año 1985.

¿Puedo pasarle el virus a otras personas?

¡Sí! Si usted tiene sexo sin condones. Si usted comparte agujas (jeringas) con otros sin limpiarlas con cloro. Si usted está embarazada o dándole pecho a su bebé.

¿De qué formas no se pasa el virus?

No se pasa por contacto casual. O sea, trabajando cerca de otras personas, compartiendo los cubiertos, abrazando a las personas, usando el baño, o viviendo cerca de otra persona.

Mi pareja tuvo un resultado negativo. ¿Será inmune al virus?

¡No! Nadie es inmune al virus. No sabemos por qué algunas personas expuestas al virus tienen resultados positivos mientras que otras personas expuestas obtienen resultados negativos.

Puede ser que obtenga un resultado positivo en el futuro. Es muy importante que tomen precauciones, usando condones y no compartiendo agujas.

¿Cómo sé si me está empezando a dar SIDA?

El SIDA incluye muchas enfermedades diferentes, algunos de los síntomas son:

- glándulas hinchadas
- infecciones en la boca
- una fiebre continua y sin explicación
- diarrea continua
- mucho sudor y escalofríos por las noches
- una tos continua

Si se siente enfermo, vea a un médico de confianza.

¿Qué le digo a los demás?

¿Debo decirle a los demás que mi resultado fue positivo?

Para muchas personas es importante tener con quien hablar. Sin embargo, debe de compartir esta información sólo con personas de confianza.

Ya que no se puede pasar el virus por contacto casual, no es necesario que le informe a su jefe, compañeros de trabajo y conocidos.

¿Por qué debo de tener cuidado a quien le informo de mis resultados?

Ha habido discriminación en el empleo, la vivienda y consiguiendo seguros de vida y seguros médicos. Piense bien lo que pudiera pasar si todos se enteran de sus resultados positivos.

¿Debo informar a mi(s) pareja(s) y personas con las que comparto agujas?

Debe informarle a estas personas, especialmente si no tienen otro modo de enterarse de que han sido expuestos al virus.

¿Qué debo decirle a mis parejas?

Deben hablar sobre como protegerse durante el acto sexual y ponerse de acuerdo sobre cuales serán las prácticas sexuales que harán. Deben hablar sobre el uso de condones. Si usted usa agujas, deben hablar sobre usar agujas limpias.

¿Qué le digo a mi familia?

Dígales que no los puede infectar. También dígales que va a necesitar mucho de su apoyo moral y emocional. Claro que esto puede ser algo muy difícil de decir y para ellos, difícil de escuchar y aceptar. Busque el momento adecuado.

¿Debo decírselo a mi médico y dentista?

Su médico y su dentista pueden ayudarle a buscar señales (síntomas) de SIDA en su cuerpo. Se están haciendo avances médicos en búsqueda de una cura para SIDA y en detener el desarrollo de la enfermedad. Su médico le puede ayudar a mantenerse informado.

¿Hay alguna razón para no decírselo a mi médico y dentista?

Antes de decirle algo, pregúntele, donde escribiría esta información. Y decida si está de acuerdo.

Si esta información es anotada en un archivo médico, podría caer en manos de las compañías de seguros.

Su médico y su dentista pueden anotar la información en una sección especial, que no será mandada a las compañías de seguros o en un archivo aparte.

Estoy solicitando la Amnistía. ¿Qué puedo hacer?

Vea la sección "La Amnistía y el VIH", página 12.

Asuntos médicos

¿Debo ver un médico?

Sí. Tan pronto como pueda, vea a un médico familiarizado con el virus del VIH. Al hacerle un examen general, será más fácil descubrir cualquier cambio en su salud en futuros exámenes.

¿Qué debo hacer si no tengo un médico; si no tengo seguro médico (aseguranza)?

Si usted no tiene médico o si no tiene seguro médico, aun puede ver un médico. Llame al Programa de Servicios Multiculturales Bilingües de SIDA/AIDS - SF AIDS Foundation, (415) 864-5855, ext. 2519 para que lo ayuden.

¿Debo hacerme algunos análisis adicionales?

Sí. Hay algunas pruebas que le recomendarán.

- La prueba (de piel) para la tuberculosis (PPD)
- La prueba de sangre para el sífilis (VDRL)
- La prueba para parásitos
- Pruebas de su inmunidad, tales como:
 1. Prueba T4
 2. Prueba P24
 3. Prueba Beta-2-Microglobulina

Su médico le puede explicar más sobre estas pruebas.

¿No me quitarán mi seguro (aseguranza) médico?

Le damos este consejo: Las compañías de seguro se han negado a cubrir a personas que se han hecho esta serie de pruebas, aunque los resultados hayan sido normales.

Si puede pagar por estas pruebas de su propio bolsillo, sería mejor. Así no aparecerán en los formularios de los seguros (aseguranza).

Si usted tiene Medi-Cal o Medicare, no van a quitarle su aseguranza.

¿Debo empezar con algún tratamiento de medicamentos?

Hay tratamientos anti-virales como la droga AZT que causan que la enfermedad del SIDA se desarrolle más lentamente.

En todo caso, hable con su médico antes de empezar algún tratamiento.

¿Debo probar algo distinto?

Algunas personas con resultados positivos han probado métodos distintos, tales como:

acupuntura	hipnosis
curanderismo	masajes
dietas especiales	medicina quiropráctica
espiritismo	visualizaciones

La decisión es suya. Escoja de acuerdo a sus creencias y valores.

Conservando la salud

¿Qué puedo hacer para conservar la salud?

1. Descanse. Duerma suficiente.
2. Nutrición. Lleve una dieta balanceada.
3. Ejercicio. Haga ejercicios regularmente. Empiece lentamente y haga un poquito más todos los días.

4. Ansiedad. Manténgase optimista, busque apoyo moral, reduzca las preocupaciones en su vida.

Vea la página 13 para una lista de agencias de habla hispana que ofrecen servicios para reducir la ansiedad

5. Drogas. Trate de no usar el tabaco, alcohol u otras drogas. Estas drogas debilitan su cuerpo. Si usa drogas intravenosas asegúrese de que sus agujas (jeringas) estén limpias. Enjuaguelas 2 veces con cloro (lejía) y 2 veces con agua.
6. Sexo. Tome todas las precauciones al tener sexo. Use condones.

¿Qué debo comer?

Muchas de nuestras comidas tradicionales latinas son muy saludables. Evite las comidas "FAST FOODS" porque contienen mucha grasa, sal y muy pocas vitaminas.

Las comidas buenas para usted incluyen:

tortillas de maíz	calabazas
sopas de vegetales	chayote
y pollo	chícharos, gandules
pescado y mariscos	chiles (ajies, pimientos)
frijoles (habichuelas)	maíz (elote)
limas y limones	repollo o col
naranjas (chinas)	yuca
	zanahorias

¡Y buen provecho!

¿Cómo puedo evitar otras enfermedades? ¿Debo vacunarme?

Protejase. Si sabe que alguien está enfermo con algo que se pega, manténgase alejado. También, si tiene que vacunarse o su hijo contra el polio o el zarampión hable con su médico sobre los peligros para su salud, ya que algunas vacunas contienen virus vivos.

¿Tengo que protegerme si tengo sexo con otra persona que también tiene el virus?

Sí. Siempre tiene que protegerse al tener sexo. Si no, queda expuesto al virus y a todas las demás enfermedades que se pasan sexualmente. Es muy importante no exponerse a ninguna enfermedad una vez infectado con el virus del VIH, pues se le pegan más fácilmente.

Evitando contagiar a otros

¿Qué debo hacer para no infectar a otros?

Evite cualquier actividad donde comparta su sangre o líquidos sexuales.

- Protéjase con condones al tener sexo
- No comparta agujas
- No done sangre
- No done esperma (semen)
- No done órganos para transplantes (si su licencia lo identifica como donante, asegúrese de cambiar este dato)
- No comparta cepillos de dientes, rasuradoras, ni agujas de acupuntura o tatuaje.
- No comparta ningún objeto que pueda tener sangre.
- Limpie cualquier superficie donde haya tenido algún accidente. Si sufre algún accidente y sangra, limpie la superficie con jabón y agua tibia. Para superficies que necesiten cuidado especial, límpielas con cloro y agua. (use una copita de cloro y agregue 10 copitas de agua.

¿Puedo tener sexo?

Sí, pero necesita protegerse. Pueden besarse, abrazarse y masturbarse juntos.

Use un condón. No tenga sexo donde se compartan líquidos del cuerpo, tales como el semen que sale del pene, la sangre, los fluidos de la vagina de la mujer y la leche de los senos.

¿Qué actividades sexuales son probablemente sanas?

Relaciones anales y vaginales usando condones y espuma o jalea con nonoxynol-9 (Lea la etiqueta)

El sexo oral con una mujer probablemente es sano si se usa una barrera como un plástico que evite que el líquido vaginal se ponga en contacto con su pareja.

El sexo oral con un hombre probablemente es sano si se hace al tener el hombre puesto un condon.

¿Qué relaciones sexuales no son sanas?

Relaciones orales, vaginales o anales, sin condon no son sanas.

¿Qué hago si tomo alcohol y uso drogas?

Trate de dejar de tomar y usar drogas. Cuando uno esta intoxicado se puede descuidar más facilmente y tener relaciones que no son sanas.

¿Qué hago si uso drogas intravenosas?

Busque ayuda para dejar las drogas.

No comparta agujas; es la forma más fácil de pasar el virus y adquirir otras enfermedades.

Para limpiar su aguja, haga lo siguiente.

1. Enjuague la aguja con cloro 2 veces
2. Enjuague la aguja con agua 2 veces
3. No se inyecte el cloro ni se lo tome.

Consideraciones Especiales

EMBARAZO

Quiero quedar embarazada. ¿Qué hago?

Muchos médicos recomiendan que no se embarace si tiene resultados positivos, pues le puede pasar el virus a su bebé.

¿Qué hago si ya estoy embarazada?

Debe de hablar con un médico de confianza que sepa sobre el VIH y le aconseje, puesto que puede pasarle el virus a su bebé.

Tuve un resultado positivo y acabo de tener un bebé. ¿Puede que mi bebé también sea positivo?

Sí. Es posible que le haya pasado el virus durante el embarazo, durante el parto o al darle leche de pecho. Por esta razón debe darle fórmula en botella a su bebé, en vez de leche de pecho. Consulte a su médico.

LA AMNISTIA Y EL SIDA

Estoy solicitando la Amnistía. ¿Qué hago?

Aunque usted tenga el virus, puede continuar su solicitud. Bajo la ley, todavía puede recibir la ciudadanía de los Estados Unidos.

¿Quién puede ayudarme?

Llame al número de información de la Asistencia Inmigratoria "Hotline" (415) 554-2444.

¿Qué hago si me enfermo de SIDA?

Si se enferma, tiene que ver a un medico. Llame al Programa de Servicios Multiculturales Bilingües del SIDA/AIDS - SF AIDS Foundation, (415) 864-5855, ext. 2519 para información adicional.

Unas Ultimas Palabras

No es fácil recibir la noticia de que su resultado es positivo. Es importante tener una persona de confianza con quien hablar.

En todo el mundo, los científicos están trabajando muy duro buscando una cura para el VIH. Han aprendido muchísimo en muy poco tiempo. Tenga fé.

Agencias que ofrecen servicios en español

Información y Educación

San Francisco AIDS Foundation Hotline
(415) 863-AIDS o (800) FOR-AIDS

Latino AIDS Project - Instituto Familiar de la Raza (415) 647-5450

Crisis Emocional

Clínica Latina, Mission Mental Health, SF
Depto. de Salud Pública (415) 558-2071

Instituto Familiar de la Raza (415) 647-4141

South of Market Mental Health 777-3311

Promoción de Salud y Ayuda Mental

Mano a Mano - Instituto Familiar de la Raza
(415) 647-6672

CURAS (415) 626-4111

Consejos Sobre Notificación de Sus Parejas

Departamento de Salud Pública (415) 558-2036

Información de Servicio Médico

Programa de Servicios Multiculturales Bilingües
del SIDA/AIDS - SF AIDS Foundation
(415) 864-5855, ext 2519

Servicios Médicos - VIH/SIDA

Departamento de Salud Pública, Centro #1
(415) 558-2036

Mission Neighborhood Health Center - Clínica
VIH/SIDA (415) 552-3870

Ward 86, San Francisco General Hospital, para
personas con síntomas del SIDA (415) 821-8830

Consejería Legal para la Amnistía

Asistencia Inmigratoria "Hotline" (415) 554-2444



Información Sobre Su Salud es una publicación del AIDS Health Project (AHP),
Box 0884, San Francisco, CA 94143-0884, (415) 476-6430.

Desarrollado de un documento escrito en inglés por Aixa Gannon, consultante.

Asistencia en producción fué brindada por Queta Rodriguez.

Agradecemos la asistencia de las muchas personas que revisaron esta publicación.

© October 1989, Regents of the University of California, San Francisco

This is the Standard Spanish version of Information About Your Health, a publication of the AIDS Health Project (AHP). This version was developed by Aixa Gannon, consultant, with production assistance provided by Queta Rodriguez. (October 1989 version.)



A project concerned
with AIDS Prevention
and Health Promotion

HIV Antibody Alternative Test Site Location and Hours

Test Site Services

Call 621-4858 to make an appointment for the test. (Except at the St. Anthony's site which is a drop-in site.) Services provided are as follows.

1. At the first visit, clients receive information about the test and see a video. After this session, clients make an appointment to return in about two weeks for their test results. Blood is then drawn.
2. At the return visit, clients receive results orally in a private session with a counselor. Results are never written down.

Test Site Locations and Appointment Hours

Test sites are located throughout the city. Appointments are scheduled at the half-hour. The times shown below indicate the first and last appointment time.

- Health Center #1
3850 17th Street (Between Noe and Sanchez in the Castro District)
Tue., Wed., Thu. 5-8:00pm; Fri. 1-4:00pm; Sat. 8:30am-3:30pm
- Health Center #2
1301 Pierce Street (Between Ellis and O'Farrell in the Western Addition)
Mon. 5-8:00pm
- St. Anthony's Clinic (Drop-In Clinic)
3105 Golden Gate (Corner of Jones in the Tenderloin)
Tue. 5-7:00pm
- Mission Neighborhood Health Center
240 Shotwell St. (Off 16th, between So. Van Ness and Folsom in the Mission)
Wed. 5:30-8:30pm
- South of Market Health Center
551 Minna St. (Between Market and Mission, 6th and 7th, South of Market)
Thu. 5-8:00pm

Site	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.
Health Center #1		5-8pm	5-8pm	5-8pm	1-4pm	830-3:30
Health Center #2	5-8pm					
St. Anthony's		5-7pm				
Mission Health			5:30-8:30pm			
So. Market Health				5-8pm		

Hours for Making Telephone Appointments - (621-4858)

Call 621-4858 to make an appointment at the ATS. (Do not call the clinic sites.)

Callers are asked to give two letters and two numbers as an identifying code.

(Note: Test site at St. Anthony's clinic is drop in only, no appointments taken.)

	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.
Call For Appointment	8:30-4:30	1:30-8:30	1:30-8:30	1:30-8:30	8:30-4:30	8:30-4:30

(10/30/89)

Address Correspondence To: UCSF AIDS Health Project • Box 0884 • San Francisco, CA 94143-0884

Administrative Offices: 1855 Folsom Street • Suite 506 • San Francisco, California • (415) 476-6430

Affiliated with the University of California, San Francisco



A project concerned
with AIDS Prevention
and Health Promotion

To: Management
From: James Dilley, MD & Renetia Martin, LCSW
Date: April 25, 1990
Re: Ian Barlow, MD, Injury

On April 24, after leaving a Peter Claver Community staff meeting, Ian Barlow was walking along Golden Gate Avenue to his car. A bullet from an unknown direction, source, or person struck Ian in his leg. It entered soft tissue only, not bone. He was treated at SFGH Emergency Room and released with medication. He is comfortable and able to work and drive normally.

We are concerned that this event occurred, but our impression at this time is that this was a random act, perhaps carelessness on someone's part, but not personally directed at Dr. Barlow. We have shared this event with Dr. Hernandez, Peter Claver, UCSF & SFGH Department of Psychiatry and Ward 86 staff.

We appreciate everyone's concern and will update you should further information be necessary. If you have any questions concerning this unfortunate event, please feel free to contact us.

THE AIDS HEALTH PROJECT

A project concerned
with AIDS Prevention
and Health Promotion

January 12, 1990

DS:
- copies to AS staff
pls c a note
FUI Tuf

Letters to the Editor
Bay Area Reporter
395 Ninth St.
San Francisco, CA 94103-3831

Dear Editor:

I am writing in response to the letter submitted by Ken Martin, January 11, 1989, about the AIDS Health Project and our recently published book, **Face to Face: A Guide to AIDS Counseling**. Several points should be made:

1. During the early years of the epidemic, I became acquainted with Mr. Martin in my role as the consulting psychiatrist to the AIDS Activities Division of San Francisco General Hospital. Mr. Martin served as a paid peer counselor on Ward 86. During that time, it became readily apparent to me that the needs of patients at the clinic sometimes went beyond those which could be successfully handled by a peer counselor. In particular, some patients developed serious depression, others experienced acute panic attacks, some came to the clinic acutely intoxicated on alcohol or other drugs, some developed severe disorders in thinking and memory, and some presented with serious suicidal thoughts and plans. Leaders in the Department of Psychiatry, those in the AIDS Activities Division, and eventually those in the AIDS Office at the Department of Public Health appropriately moved to provide mental health professionals to address these problems. Mr. Martin is correct in stating that I lobbied for these services. Providing appropriately trained practitioners to address these problems was the only appropriate course of action for those charged with providing for care of patients at the hospital.

2. Mr. Martin's review of our book, **Face to Face**, illustrates the principle that one can always find malicious intent in the actions of others when one is intent on finding it. I would encourage interested readers to read our book and judge its worth for themselves. Quotations taken out of context from any 400 page book written by 50 different authors can be easily misconstrued and misrepresented. (Copies of the book can be obtained at local bookstores or by calling the AIDS Health Project at 476-6430).

3. The AIDS Health Project provides a range of professional counseling services to those affected by HIV and holds an important position in the spectrum of services offered in the City's response to the AIDS epidemic. The Project was not "lucky to receive the contract for providing counseling at the Alternative Test Sites." In fact, in 1985, the Project lobbied hard against the originally proposed plan to

Address Correspondence To: UCSF AIDS Health Project • Box 0884 • San Francisco, CA 94143-0884

Administrative Offices: 1855 Folsom Street • Suite 506 • San Francisco, California • (415) 476-6430

Affiliated with the University of California, San Francisco

THE AIDS HEALTH PROJECT

*A project concerned
with AIDS Prevention
and Health Promotion*

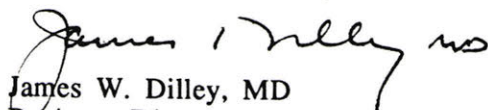
have antibody test results given by operators over the telephone. When the plans for establishing the test sites were announced and because of the Project's lobbying efforts, we were asked to develop a protocol for pre- and post-test counseling. This protocol has since become the model for giving test results throughout the country. The Project is internationally recognized for its work in this area.

4. Last year, over 15,000 individuals received services from Project staff. Staff do receive a salary for their work, just as staff at other AIDS service agencies receive salary support. This point merits no debate.

Finally, since its inception, the AIDS Health Project has actively advocated for humane and sensitive services for those with AIDS as well as those affected by HIV. There is no question that additional support is needed to address the growing need for housing, early medical intervention and long term medical care for those with HIV disease.

We will continue to work toward securing that additional support, and applaud the efforts of all who do.

Sincerely,


James W. Dilley, MD
Project Director



A project concerned
with AIDS Prevention
and Health Promotion

3/20/90

MEMO

To: All Personnel Handling Client Records and Telephone Coverage Calls

From: ^{Jim Dilley} Jim Dilley, ^{Renetia Martin} Renetia Martin

We have just received a complaint from a client who was questioned in a gymnasium about his contact with the Project, including his antibody status. The client felt extremely intruded upon and very angry.

Besides this being inappropriate and illegal, this serious breach of confidentiality is a slap against the Project's professional reputation. Staff should never say anything to clients outside the office.

This memo is to caution and remind you that in the course of handling client records and telephone coverage, all information is confidential. Any further complaints from clients will result in staff disciplinary action.



SAN FRANCISCO AIDS FOUNDATION P.O. BOX 6182, SAN F

To: Magnet Team

From: Jim

FYI — the joys
of public responsibility
and working with the media.

BOARD OF DIRECTORS

President
William D. Glenn
Vice President
Maureen S. O'Leary
Secretary
Barbara Cattolica-Hudson
Treasurer
James R. Harrison

Evelyn Balancio
Elizabeth C. Burrell
Skip Byron
Lokelani Devone
William Lang, M.D.
James Loyce, Jr.
Filberto Moreno
Curt H. Mueller
Henri E. Norris
Maureen S. O'Leary
Virginia K. Peacock
Mike Rankin, M.D.
Jude Sharp
Andrew P. Small
Philip S. Tsui
Ken Vargo
Jeffrey Zimman

HONORARY BOARD
OF DIRECTORS

James C. Anderson
Lia Belli
Herbert Blomstedt
The Reverend Amos C. Brown
William K. Coblenz
Mrs. Ralph K. Davies
Belva Davis
Vincent J. Friia
Richard Gere
Whoopi Goldberg
Robert D. Haas
Roger W. Heyns
Donald Kennedy
Mel Lane
Carole Shorestein-Hays
Leigh Steinberg
Carolyn Wean

ACTING EXECUTIVE DIRECTOR

Pat Christen

11 August 1989

Wendy Tokuda
KPIX - 5
855 Battery Street
San Francisco, CA 94111

Dear Wendy:

After viewing your news report on the San Francisco AIDS Foundation which aired on 2 August 1989, I am compelled to express my concern over the misrepresentation of the facts, the lack of balance in the choice of interview subjects, and the absence of a "larger picture" perspective in the report.

As you know, many days of staff time were spent over the past months to provide the information and documents you requested. In our discussions, we affirmed the Foundation's three areas of activity--education, public policy, as well as client services. We pointed out that approximately 20% of the agency budget goes to development, production and distribution of educational materials. Additionally, rent for both the Foundation's office sites totals only 8.9% of the agency budget. We discussed that the AIDS Walk San Francisco producers achieve a 5-to-1 return for every dollar expended on the Walk.

It was pointed out in our interviews that, like all similar agencies, the Foundation is required to spend dollars against government contracts before we are reimbursed. Difficulties with computers and with billing those contractors have been remedied; bills are submitted within 18 working days after the end of the month. And problems with cash flow prompted our Board members to offer personal loans to ease the difficulties. Finally, we urged you to consider that the Foundation's crisis could have been more effectively examined from the perspective of the funding crisis for all AIDS-related services in the Bay Area. The Foundation's perspectives and the information we provided you were virtually ignored in your report. I will elaborate upon each of these points below.

As you know, the Foundation was extremely cooperative in providing you with the documentation you requested. We

provided monthly financial reports and Board minutes from the last two years. Our Financial Services Director, Rich Hauser, spent hours answering questions, explaining how to read financial reports, and providing virtually unlimited access to our accounts payable and receivable records, budget, and specific expense payments.

In the report, however, you stated that KPIX had "obtained financial records" which led you to your conclusions. At best, this seems a misleading statement, implying that you had uncovered these documents. In fact, we provided these materials openly and in the spirit of full cooperation.

Tim Wolfred, Rich and I also spent significant time discussing the mission of the AIDS Foundation with you. As we explained, we have a "three-pronged" mission: 1) the provision of client services for PWA/ARCs; 2) the education of those at high risk for HIV infection, PWA/ARCs, and other members of the general population, regarding risk reduction and fear reduction measures; and 3) the development and implementation of effective AIDS-related public policy. All three of these components serve vital roles in our agency's purpose.

Yet, your report implied that one manifestation of the apparent "misdirected priorities" of the Foundation is that "out of its \$6 million budget, only 20% goes to client services." This statement denigrated the role of education and public policy in our mission and in the fight against AIDS, and it devalued the lives of those who remain uninfected. It denied the very real and immediate effects education and AIDS-related policies have on those affected by this disease. Education remains the primary weapon in our arsenal to fight the HIV epidemic.

For example, our Education Department is responsible for the development of materials and programs which have had a direct influence on behavior change in the gay and bisexual male community and among needle users and their partners. These are not "popular" populations, but they are the communities in gravest need of life-saving information and services. We are proud of our work in the education and policy arenas. The effective provision of these efforts is invaluable and costly, as you know, and--given our mission--a substantial portion of our resources is appropriately allocated to these areas.

We are also troubled by misinformation presented in the report. For example, one interviewee stated, "My god, it

doesn't take \$6 million to print out a glossy brochure or put out an ad to use condoms." The misinformation in this quote, with no clarification on your part, belittled the role of educational materials unnecessarily. Clearly the interviewee is entitled to his opinion regarding the appropriateness or inappropriateness of our materials development. You, however, then had an opportunity to substantiate or disavow his claims regarding the "\$6 million" for brochures. Allowing his statements to stand alone -- out of context -- implied that they are factual. They are not. As you know from the financial reports and budget documents we provided you, \$1,084,000 are spent on materials development, production and distribution.

You described the financial crisis -- which is very real -- without citing information discussed with you, that we have not received additional money from the City or the State in four years, even though our caseloads have increased by 400%, Hotline calls are up by 200%, and we've had to battle the likes of Propositions 64, 69, 96 and 102.

Misinformation also colored the remarks of Mr. Rector who alleged that "a large percentage of money has gone into plush offices, which are inappropriate, I think, for a community-based organization." Tim, Rich and I all explained that we pay less (on a full cost-per-square-foot basis) for office space at our Van Ness location than we do at our Valencia Street offices.

Still, the larger point is that Mr. Rector's statement was not clearly refuted in the report. As you know, the portion of the budget allocated to total rent at both sites is 8.9%, certainly not an "inappropriate" amount or a "large percentage."

Regarding the fee paid to the AIDS Walk producers, Miller and Zeichik were chosen because a) they have a formula that works; b) they have often and successfully raised large amounts of money for the fight against AIDS; and c) they brought experience in conducting other AIDS Walks. Over 10,000 walkers--backed by 90,000 sponsors--participated in the Walk on July 23, 1989. Obviously, the producers of AIDS Walk San Francisco have consistently created an event that excites and motivates diverse sections of the Bay Area to act, while generating \$5.00 for every \$1.00 spent. It is an unsurpassed track record.

The majority of benefitting agencies would not survive without the AIDS Walk. For the \$95K fee, participating agencies get two staffers, as well as their experience, for a significant number of months. Their fee is not high--either as a percent or comparatively--for a multi-million dollar event.

You also stated that the Foundation had a "pattern of spending money before it came in." Taken out of context, this gave viewers the impression that such practices are inappropriate for a non-profit AIDS agency. In fact, in order to bill the State, City or Federal government, the Foundation (like all similar agencies) is required to spend money against our government contracts and then be reimbursed for monies spent. We must spend money before it comes in, or the government will not pay for our services and programs.

You also stated that the Foundation did not receive money from the City or State for 6 months "simply because they didn't bill them." As you know from extensive discussions with us, there was nothing "simple" about our late billing situation. The delay (which was four months, not six) was caused by our switching over to a new computer/software system in the Financial Services Department. This change in system created a delay in our ability to close out the monthly financial reports. If the reports are not closed in any given month, we cannot bill the government for expenses incurred during that time period. This delay was unfortunate and frustrating, but it was remedied. In all fairness, these remedies could have been acknowledged in the report. As you know, currently we close the accounting books ten working days after the end of each month. The 25-page City invoice is submitted within five additional days, and the State invoice two to three days thereafter.

You also charged the Foundation with "sloppy billing procedures." It is clear that our billing system was inadequate in the past. As described above, we now have an accurate, timely billing system in place. This remedy, too, was not reflected in the report.

You stated that "the staff asked its own Board for loans" to help in the crisis, implying an action of dubious nature. In fact, the Board originated the idea of taking out personal loans to ease the agency's cash flow crisis. This was not a staff request. The fact that the Board was willing to take out personal loans shows a commitment to and confidence in the work of the agency.

With respect to the issue of balance in the report, you provided 2 minutes of air time to Audrey Doughty, Richard Rector, Allen White and Hank Cook. By contrast, Tim and I received 42 seconds. I am disturbed that you did not seek on-camera interviews with community members supportive of the Foundation to provide perspective to the report.

At one point following my interview with you, when I questioned the context in which you were viewing the story and your approach in the line of questioning you took with me, you challenged me to find another station (other than KPIX) which had done better reporting on AIDS or been more supportive of the issue.

As I stated at that time, I am deeply grateful for the fine work provided by KPIX AIDS reporters. Nevertheless, such fine reporting and clear support does not obviate the need for responsible journalism in every AIDS-related story presented by KPIX.

To conclude, I must restate that Tim, Rich and I were deeply disappointed that you failed to acknowledge in any meaningful way the full cooperation you received from the Foundation. Many days of staff time were spent to see that you had the information requested and that all questions were addressed in a timely and professional fashion. I continue to believe our willingness to be fully cooperative and forthcoming was the correct one. I hope I will not be proven wrong.

A crucial opportunity was missed to examine the Foundation's crisis in the context of the larger funding crisis for AIDS-related services in the entire Bay Area. Instead, the viewer is left with a sense of "misdirected priorities" at the Foundation. I don't believe the provision of client services, education, information and informed public policy are misplaced. It is unfortunate the full depth and breadth of the Foundation's priorities were not reflected in your story.

I remain concerned that your report will have long-lasting and potentially devastating effects on AIDS agencies citywide. The real issue which must be addressed is where we can garner the resources necessary to support AIDS care delivery in our city, provide the education, counselling, testing, monitoring and treatment necessary to those affected by HIV and see that reasoned public policies are implemented and enforced to protect those at risk from discrimination, inadequate health care, or future risk of infection or reinfection.

Hundreds of millions of dollars and thousands of volunteers need to come forth in the next few years to ensure that such services are provided. If these human and financial resources are not forthcoming, we will lose tens of thousands of lives. That, it seems to me, is the most compelling story that must be told, and it is disappointing that the opportunity was lost altogether in your report.

Sincerely,

Pat Christen
Acting Executive Director

PC/fj

cc: Carolyn Wean
Tim Wolfred
Peter Maroney



A project concerned
with AIDS Prevention
and Health Promotion

MEMO

TO: All AHP Staff

FROM: James Dilley, MD *James Dilley*
Project Director

DATE: September 11, 1989

RE: Threats against AHP Staff

As I'm sure you are all aware by now, a Mr. Paul Bergeron, (also known as Paul Chalice) has made threats to kill various staff members at Health Center #1, San Francisco General Ward 86 and unspecified members of AHP. Little is known about Mr. Bergeron at present except that he has reportedly had 18 years of outpatient psychiatric treatment, including multiple hospitalizations as a child for "temper tantrums and fits of anger". At this time, there is no clear history of any actual violence or history of incarceration. This information is actively being sought.

Mr. Bergeron was hospitalized at SFGH against his will on Friday, Sept. 8, 1989 as a "Danger to Others" because of the threats he made. He is currently being evaluated for evidence of any on-going dangerousness. Tomorrow, Tues, Sept. 12, Mr. Bergeron will be represented in a mental health court hearing by the Public Defender's Office and will request that he be released from the psychiatric wards at SFGH. His physician at SFGH has assured me that they will be asking the judge to extend Mr. Bergeron's hold for an additional 14 days. The judge will, after considering the facts as presented by the Public Defender and by the hospital staff, render a decision. Mr. Bergeron could potentially be released as soon as tomorrow afternoon.

Jerry Polon will call Renetia tomorrow following the hearing to let her know the judge's decision. She in turn, with the help of the Management Team, will let the rest of you know and will also notify UC and CED Security personnel.

Please know that the threat is being taken very seriously and that this will be an evolving situation. We will do the best we can to keep you abreast of developments as they occur.

Thank you for your patience.



A project concerned
with AIDS Prevention
and Health Promotion

MEMO

To: Pierre Ludington

From: James W. Dilley, MD *JD*

Re: Letters of Support for the Film "Absolutely Positive:
A Film about Living with HIV" from Kaiser Health
Care Providers

Date: March 28, 1989

Please kindly ask all Kaiser Health Care Providers to send
Letters of Support for the "Absolutely Positive" film to the
following:

Mr. Robert Crane
Senior Vice President
National Accounts and Public Relations
Kaiser Permanente
1 Kaiser Plaza
Oakland, CA 94612

and to:

Paul Lairson, MD
Physician Liaison
Kaiser Permanente
1 Kaiser Plaza
Oakland, CA 94612

Also, please kindly ask everyone to send cc's of their
Letters of Support to:

James W. Dilley, MD
UCSF AIDS Health Project
Box 0884
San Francisco, CA 94143-0884

We appreciate your assistance in this matter.

Please bring to management team meeting today, April 11, for discussion----JIM

DRAFT MANAGEMENT TEAM MISSION STATEMENT

The mission of the AHP management team is to :

1. share pertinent information about administrative issues and the activities undertaken in each program among the managers to ensure a high level of awareness about the activities and opportunities that exist throughout the project. New directions or new projects undertaken by a particular unit should be presented for input.

2. promote better communication and utilization of resources among the programs and among the managers.

3. provide an arena for discussion of shared agency problems as well as personnel, management or programmatic problems that may arise in a particular program.

4. provide an arena for the development of selected agency policy and procedures.

5. promote an atmosphere of general support among the managers and between the leadership and the management team.

RECEIVED

JUN 27 1989

ONE VIEW OF SAN FRANCISCO AND AIDS

By Grant G. Haven

To learn about the care of people infected with HIV, the place to look is the AIDS epicenter, San Francisco. I was privileged to work for one month with the AIDS Health Project, UCSF's program addressing the pandemic. I was able to observe efforts on the front line ranging from the disclosure of a positive HIV antibody test result, through the spectrum of disease, to helping a family cope with the imminent death of their son. Working with HIV disease and the young people it affects is inherently stressful and emotionally challenging. To my surprise, the overall sense that came across again and again was one of hopeful, yet realistic people living life to its fullest.

Medical school at the University of Missouri-Columbia had given me a very non-San Francisco perspective on HIV disease. This comes as no surprise when I remember that I was trained in a place where in mid-1988 my attending physician was unaware that you could not get AIDS from mosquitos. Discussions in the hospital frequently focused on whether or not we were ethically bound to treat "people who will die soon anyway", rather than how we could best treat them. I arrived in San Francisco with a pessimistic attitude, fearful that caring for AIDS patients would be overwhelmingly sad and gloomy.

The first night of my rotation I attended a support group called Positives Being Positive. The men and women in attendance were infected with the virus, some documented since 1979, but had experienced no symptoms. The discussion was upbeat and very action-oriented. For a significant portion of the meeting, it sounded like a room full of physicians and research scientists. Many of the "positives" had educated themselves in-depth about current drug trials and their protocols. Others were working on preventing illness from within, ie. reducing stress, exercising, eating right, and developing spiritually. Each person was creating their own plan for living with HIV.

One woman, in particular, had some worthwhile thoughts. She described how she was using the virus as a motivator in her life. Achieving her goals in the past had often been fraught with periods of laziness and eventual loss of interest. Now, she found a driving force in her HIV positivity that made her feel and act "more alive." She was working on her physical, mental, and spiritual health through dance, art, and positive visualization. She was remarkably alive—for someone facing a fatal illness. For her, one of the most difficult aspects of the infection was the negative, fatalistic views of people around her. I realized she was talking about me.

7

The importance of information to people infectedd with HIV became very clear when I visited Health Center #1. At this anonymous test site, people are tested for HIV antibodies and given an intensive training. The process of giving a test result is intended to allow the client to vent their feelings, ask questions, and begin to develop a plan for dealing with this information. Without the knowledge of available resources and a clear understanding of what a positive result means, some clients "freak out." One man was grateful to be assured that he would have access to services as he needed them. He was handed written information and told about medical and legal resources, Project Inform (a drug information service), and support groups. The counselor reviewed safe sex, needle use, who to tell about the test result, and where help was available. He left with a plan to learn more about taking care of himself.

Support groups are one of the key services sponsored by the AIDS Health Project. Combating isolation and hopelessness, they also provide the practical networking necessary to deal with the unique problems at each stage of the disease. In San Francisco, there is a fantastic array of support groups ranging from a group for people of color who use IV drugs and have AIDS to one for lesbian caregivers of AIDS patients.

The ARC support group is made up of people who are symptomatic, but have not had an opportunistic or life-threatening infection. On the evening I attended, the topics discussed included drug trials, "retiring," and spending vs. saving money. Once again, the discussion of drug trials was over my head, even after four years of medical school. Unlike the familiar patient who passively takes what the doctor prescribes, these men read extensively, questioned their doctors and negotiated over their treatments. The quality of life was of paramount importance. On the issue of retiring, one man asked if others had decided to leave their jobs because of stress or to pursue other interests. Another replied he preferred to view it as "taking a sabbatical like a university professor." He had left his engineering job to spend more time with his son and grow in other areas of his life, temporarily. The discussion of money showed an underlying conflict between living life to its fullest and saving to cover future health costs. Most of these men seemed to be compromising and coping well with the practical limitations of their disease.

The outpatient service, Ward 86, is where people infected with HIV receive much of their health care. The elevators open onto a festive, bustling ward. The waiting room is perpetually stocked with fruit and home-baked goodies. On the walls hang gay rights posters. Treatment of various HIV-related ailments is preferentially addressed on the outpatient ward, imposing only a minor disruption to everyday life. The ward is set up to efficiently provide high quality

care. I was struck by a feeling of community on this ward. The staff and patients were working together to fight this epidemic.

Those who became too sick were hospitalized on a special ward for AIDS patients in San Francisco General Hospital. Working as a psychiatric consultant, I had the chance to delve into the patients' feelings about their illness. Even though AIDS patients typically spend two-thirds of their time in the hospital once diagnosed, there still seemed to be an emphasis on living within the confines of debilitation and approaching death.

I followed one patient who nearly lost his life during that hospital stay. Psychiatry was consulted to find out if this 32 year old man had AIDS dementia. When I first talked to him, he seemed delirious, barely staying conscious long enough for me to ask questions. He was unsure of the year and this former accountant could not tell me how many nickels were in 65 cents. Investigating further, we discovered that he was on high doses of sleeping pills. The recommendation, realizing that the brains of AIDS patients seem to be very sensitive to most medications, was to taper off the sleeping medication. The next week saw him near death from sepsis. He was successfully treated with antibiotics. Two weeks after I first saw him, he was alert, had a clear head, and was cracking jokes with me. He was strong enough and aware enough to return to Indiana where his parents lived. His infirmity was significant, but he seemed grateful for the improved level of functioning and the extra time he had to live.

My apprehensions about working with people with HIV disease have been alleviated. I will admit that to get to know these people and eventually see many of them die, will be an extraordinary challenge as it is with many geriatric and oncology patients. However, the optimism and zest for life exhibited by most of the people I encountered in San Francisco helped to minimize the pain of this epidemic. Without prompting, many people seem to accept the progressively stricter limitations of HIV disease and to focus on what they are able to do. Undoubtedly, the ready access to services in San Francisco at every step of the illness, makes life easier. However, I think the success of San Franciscans in dealing with AIDS lies much deeper. There is an attitude, a feeling, a sense of acceptance from which I think we can all learn.



*A project concerned
with AIDS Prevention
and Health Promotion*

MEMO

To: Management Team

From: James Dilley, M.D.

Date: February 21, 1989

Re: Medical Student Rotation at the AIDS Health Project:
A Personal Training Experience

I wanted everyone to see this article by Grant Haven, a 4th year medical student, who spent a month with the Project from December, 1988 - January, 1989. Mr. Haven clearly had a positive experience with us and everyone should be commended for helping him.

Thank you to all involved in helping Grant make good use of his time here. Special thanks go to Joanna Rinaldi, John Baker, M.D. and Sharone Abramowitz, M.D.

cc: Samuel Barondes, M.D.
John Hopkin, M.D.
Graeme Hanson, M.D.
Nancy Kaltreider, M.D.
Ian Barlow, M.D.
John Baker, M.D.
Herb Ochitil, M.D.
Sharone Abramowitz, M.D.
Chris Hall, LPPI Medical Student Education

THE
**AIDS
HEALTH
PROJECT**

A project concerned
with AIDS Prevention
and Health Promotion

M E M O

To: All Staff
From: James W. Dilley, M.D.
Re: Contributions for "Californians Against Proposition 102"
Date: September 8, 1988

You will find posted on the bulletin board a flyer from the Defeat the Dannemeyer AIDS Reporting Initiative concerning an urgent plea for funds to help initiate the buying of media time statewide to defeat "Proposition 102". It is also to help sponsor a fundraising event to be held Friday, October 6, the goal of which is to raise \$15,000. We would like to have the AIDS Health Project listed as a sponsor and will need your pledges by Friday, September 9 and contributions by Monday, September 12. Please give your contributions to Jim who will forward them on to the "Californians Against Proposition 102" naming the AIDS Health Project as a sponsor of the event. Your support would be greatly appreciated. Thank you.