

AIDS TASK FORCE
March 8, 1985
Sacramento, California

Chairman, John Vasconcellos

(Initial two minutes not recorded)

MS. RUTH MELROSE: ...with Dr. Morin and the Citizens Advisory Council on, was it Monday afternoon?

MS. LESLEY CUMMINGS: Yes.

MS. MELROSE: We gave you a handout that outlined what the ideal program, what we think the ideal program would include, and I won't go back over the structural part, but I think it's real important that that be noted.

What you have today is a two page cost sheet that on one side says "base" and the other side says "projections." And what we used was the model that's been developed in San Francisco; one, because the council believes it's a good model and two, because very few people have developed as comprehensive a model and I think what you wanted was it broken down by testing and non-testing related activities. What you see, the top three items are testing-related activities. There's one, the brief counseling around reporting results probably needs to be expanded and we'll probably need - there's a typo I noticed in it - probably will require additional funds so that persons are counseled when they first come in to ask for testing in alternative sites, to explore the issues around why they want counseling and as Dr. Morin presented, most of those are psychological issues, rather than medical issues.

Provisions for counseling, or at least referral while people are awaiting the test results, which is a very high anxiety period, and finally, counseling to people at the time that they are actually given the results, no matter what the result, because in many cases, the result is not going to give them what they wanted which was some kind of way of reducing their anxiety in a positive sense.

And lastly, there's a component for follow-up group support for those persons who test positive to HTLV-3.

What we did was not particularly scientific in projecting the cost. We took the professional education piece and used a factor of eight; we used regions: Northern California, Mid-valley, Orange County, San Diego, two for L.A., and I guess two for the Central Valley because of the spread, and that gave us a factor of eight on the San Francisco.

On items two and three, which would be based on numbers of people expected to go in and get the test, which we all know is we don't know, we estimated that statewide, we would factor San Francisco somewhere between three and four times, so that's why you have that spread, and that was Dr. Morin's guess, but that's what it is.

DR. PAUL VOLBERDING: So what you're doing is saying for the professional education, it doesn't really matter how many people in any area are going to have the test?

MS. MELROSE: Right.

DR. VOLBERDING: But for two and three, it does.

MS. MELROSE: ...it does, and we don't really know that. You probably have a better idea than we do. But that's how we got it. Since that's all you're taking up today, I won't go into the not related to testing pieces; they're described in what we gave you on Monday.

DR. VOLBERDING: The other on component that we imagine being part of pre-testing was professional-directed materials and consumer-directed materials. Those are really the consumer-directed material to encourage people not to have the test unless we think it's indicated. I don't see as part of what you're program includes, is that right?

MS. MELROSE: That's correct. We were focusing seeing the pre-test, face-to-face interview as being the time that that would occur, not necessarily discouraging people, but for those people who...

DR. VOLBERDING: ...making them aware of the issues and using it appropriately. I think for the members of the committee, that's an important point that I think probably should be included, if not in the mental health part, at least in other parts of this, that in this estimate, there's no inclusion for education of the public before they get to the test center. And our hope would be is that if that educational material could be developed, that might be another way to - I wouldn't say discourage people - but to...

MS. MELROSE: At least have people have realistic expectations.

DR. VOLBERDING: Use it more wisely, right.

MS. MELROSE: I understand. If the data that was described by Drs. Coates and Morin on Monday, can be generalized, then we know that most people who seek the test are going to do so not for medical reasons, but for nonmedical reasons, and then it becomes complicated, because they are not going to be able to get the resolution that they want from the medical test.

DR. VOLBERDING: Okay, so is there any discussion on the committee? So between \$3.8 and \$4.8 million for the mental health component of pre, during, and post testing...

MS. MELROSE: Right.

MR. DAVE WILLIS: I'm sorry to be a little late. I am Dave Willis, Department of Finance. What kind of population poll were you looking at here?

MS. MELROSE: That was, we don't know, and I'm being real honest. San Francisco developed what they thought would be a budget, and we simply pirated it and said in terms of incidence, what can we say statewide, and we said, probably anywhere between three and four times San Francisco, in terms of population and...

MR. WILLIS: (Inaudible)

MS. MELROSE: I can't tell you.

DR. VOLBERDING: Ann, do you want to comment on this part of the San Francisco? Can you identify yourself?

MS. ANN RUGGIERI: I'm Ann Ruggieri from the Health Department in San Francisco. Numbers are based on 75 thousand at

risk citizens in San Francisco. Seventy thousand plus gays, and a few others that are sexually active and others that are just fearful. We figure that about 50 percent will seek the test and be tested, 20 thousand will be negative; 15 thousand will be positive.

MR. STAN CUBANSKY: I'm Stan Cubansky, Chief Deputy Director with the Department of Health Services. For planning purposes in terms of dealing with Assemblyman Roos' bill and Assemblyman Agnos' bill, in terms of trying to determine the cost of a testing program, we're making an assumption which may be high at this point, but we are making an assumption so that we don't expend the entire \$5 million contained in Assemblyman Roos' bill within a few months, and then have to go through a legislative process again and get delays. We're going to conservatively expend that money assuming it will be appropriated and enacted into law by the Governor.

We're making the assumption that there may be a need in the first year for 625 thousand tests, which from our perspective covers the entire gay population in this state, the balance of the high risk groups in the state, potential sexual partners of the gay population and basically, unexpected cases such as we've seen in San Francisco in the 17 individuals who were infected with the disease via the blood transfusion route.

DR. VOLBERDING: Did you use those numbers in coming up with the \$5 million estimate?

MR. CUBANSKY: The \$5 million is not an administration estimate, it was basically numbers put together by Assemblyman Agnos' office, again, dealing with estimates out of San Francisco. But our judgment is in terms of planning, at least for initial expenditures, and 625 thousand may definitely be high, but it is the number we're using in terms of trying make sure if there is a large demand for the test, that we initially at least can provide tests. The follow-up, the referral, the counseling, which may be a part of it, we're initially considering a secondary to being able to provide the test and indicate to individuals whether they are positive or negative on that test.

DR. VOLBERDING: It seems from our estimates, both in San Francisco and for the state, that I would guess that the 625 thousand is an over estimate...

MR. CUBANSKY: ...by how much?

DR. VOLBERDING: ...but obviously we don't know, we're all in the same boat in this. I wonder, so your current approach would be to focus on providing the finances to do the test, itself, buy the kits; hire the staff to draw the blood and report the results, because I think all of us sense a great importance and probably cost savings in really developing educational materials to educate the health providers and the consumers as to the indications for the test. I think that might ultimately result in real cost savings by letting people know the indications for the test, and hopefully, having people not take the test.

MR. CUBANSKY: It may be cheaper to administer the test than it would be to convince somebody that they shouldn't take it. That's basically where we're coming from. An education or prevention process, the state spends millions of dollars in terms of mental health prevention; we spend millions of dollars in terms of prevention of developmental disabilities. How effective that is, it is difficult to say.

DR. VOLBERDING: Except, my reaction would be that the more people you test, the more positive test results you're going to have and from what we've observed in people who are told the test results, we know that there is going to be a major psychological impact. We know that there is going to be need to do follow-up counseling of those people. Some of that's going to be provided by private sources, but a lot of it is going to fall on public facilities. So I don't think we can ignore the follow-up counseling, the education in mental health that's going to be required when you get positive test results. So I think our goal needs to be to provide that as part of the package of testing. And also I would think to provide educational materials to limit the number of people taking the test as much as possible, because I think that'll save you money in, not even in the long run, but in the short run.

MR. CUBANSKY: But the ethical question we find ourselves dealing with and I'm not a doctor although I work for one, Dr. Kizer, the Director of the Department, and the ethical question that he presents is one of, if you discourage

individuals from taking the test who would not only test positive, but maybe are carriers of AIDS, or are going to spread AIDS, then what have you accomplished if you discourage one person from taking it, and they, then, infect a thousand others?

MR. PETER TAYLOR: I'm Peter Taylor from Mike Roos' office. Stan, under the provisions of our bill, which mandates some kind of a pre-counseling session prior to the actual test administration, we don't delineate whether you should sit down and tell somebody and convince them that this is an awful thing. We simply say, tell them about the tests reliability and validity, period. And, frankly, I think it's up to health guys like you and local folks to determine how best that's handled.

Now, whether or not if you're arguing that we shouldn't have any kind of pre-counseling session at all, then that's a different question, but about what's contained in that, frankly, I think the way our bill is drafted, it's (inaudible) you folks.

MR. CUBANSKY: How we got on all this was just the difference in the numbers and that's still there, I guess.

DR. VOLBERDING: Other comments about the mental health component of the estimate?

MR. LARRY BUSH: I'm Larry Bush from Assemblyman Art Agnos' office. Stan, on your figures of 625 thousand, what percent are you figuring are going to be retested because they're showing up positive?

MR. CUBANSKY: I don't know. We're not making an assumption in that regard. We're saying in terms of the budget,

the initial budget, plan on 625 thousand. My judgment is, were I in a situation of a positive test, I would seek a retest. I would think because of the, and I can't speak with the authority of the scientist, but I would think from what I've heard, the validity or the accuracy of the test, it's not the best test in the world. It's not as reliable, surely it's not as reliable as the test we're using in the blood banks for hepatitis. It comes nowhere near that, such that being told you test positive on that test, it's not meaningless, because in fact, that being told you're positive, will in fact, serve to preclude you from donating blood, thus protecting the state's blood supply. But being told you're positive really does not mean - the test is not that accurate. So you may not, in fact, have AIDS antibodies in your blood. In addition to that, even if it was positive and you did have AIDS antibodies in your blood, you're not necessarily going to develop AIDS.

MR. BUSH: My point of the question was, depending upon what figure you decide are going to be likely positive, you're going to affect the budget, because those people will be retested.

The other question is, is this 625 thousand individuals who will be tested, and does not count the...

MR. CUBANSKY: Six hundred and twenty-five thousand tests available. Now if 300 thousand individuals come in and come back for a retest, that will deplete the 600 thousand tests that are available.

MR. BUSH: I see.

MR. CUBANSKY: We are planning in the Department of Health Services, now, on a purchase, assuming the availability of funding, we are planning on a statewide purchase of that amount of tests similar to the way on an annualized basis we purchase vaccine for distribution to the state's counties and then for inoculation of let's say, the state's senior population, nursing home population, a flu vaccine. We've got the distribution system in place, and we think we're going to get a better price if we purchase for the entire state, so we've got the mechanism in place and we're planning on doing that. Obviously, the subject requires a bit of discussion, but...

DR. VOLBERDING: Well, there are a lot of points to be made, I think. First of all, the test, you should understand, is very accurate, depending on how you play with the numbers, the test is extremely sensitive and specific for the presence or absence of the antibody. The problem is going to be, as you may be referring to, that in the blood bank there are going to be very many false positives compared to the number of true positives, but when this test is used in the alternative test sites, as I think we're mostly talking about in this bill, then the test becomes extremely good, both positive and negative values can really be believed.

MR. CUBANSKY: Well, why is it that in the blood bank, the false positive rate is somewhere between two and 30 percent, which is quite a range.

DR. VOLBERDING: In fact the false positive rate of this test is very small in the range of .5 percent. The problem is in the blood bank, and we could - I'll show you some calculations. It's not immediately obvious, but if you test in the blood bank, because not very many people have the antibody. many of the positive results that you get will be false positives. But in the alternative test sites, where we're imagining most of the people who are coming are at high risk, or at least at relatively high risk, to have the antibody, then the test becomes very good. I think the point about retesting is still there. You still need to confirm because you can't tell somebody they have it, if really in fact they don't, because it carries a heavy meaning for the person you're telling. But, I think we can rely on this test in the alternative test sites. It's a good test.

Lesley makes a point that at the same time it's not a diagnostic test. I think we all believe that.

MR. JIM FOSTER: I'm Jim Foster, Commissioner of Health in San Francisco. Paul, maybe you could enlighten me as to where we are right now concerning the false negative aspects of the test and specifically what I'm curious about because there have been so many changes over the last several weeks, what occurs with blood at blood banks where people go to those blood banks to be tested? What happens to that blood after it is tested, whether it is positive or negative?

DR. VOLBERDING: I'm not sure I exactly follow the point. The test is very good. There are false negatives. Let's

put it this way, there are negative results with people who are carrying the virus. Those can either be false negatives, which are going to be present in maybe four out of 100 cases in that situation, and there will be some that have the virus and really don't have the antibodies. So the test will be correctly negative, giving you the wrong answer, but

MR. FOSTER: ...but the blood will still be contaminated?

DR. VOLBERDING: The blood will still be contaminated. I think I would estimate from what I've seen that this test should be at least 90 percent effective in the blood bank, in eliminating contaminants from transfusion and my understanding is that the blood banks, when they test, when they find a positive result, will automatically discard that unit of blood, even though the second test might be negative.

MR. FOSTER: Well what happens if the person goes in for the test and tests negative, but in reality, let's say someone from a high risk population goes in and donates a pint of blood for their purposes of having their blood tested, although they know all the business about the 90 days and all the rest of it? They still go there, the test is made, the blood is evaluated as negative, then what happens to that pint of blood that that person has donated? Does that blood, then, go into the supply?

DR. VOLBERDING: Yes. That will be, hopefully, a rare failure of this test. No test at this point is going to completely eliminate...

MR. FOSTER: ...I realize that, but I think that we have an ethical responsibility, then.

DR. VOLBERDING: The responsibility has to be to discourage high risk donors.

MR. FOSTER: Pre-test discouraging anyone from a high risk group from taking this test. I mean it just makes sense. I mean, one pint of blood, contaminated blood, can lead to as many deaths as what you suggested, sir, about the ethical considerations about someone going out and spreading it. I feel very strongly that we must keep as many people from high risk populations from taking that test as we possibly can.

MR. WILLIS: I am Dave Willis, Department of Finance. If I recall the way we walked through all of this as we started out wanting to protect the blood, it was identified that the potential of high risk population coming in and using that as a means of having the test and finding the results, could in fact, offset the benefits of the test by having enough false negatives because of the high risk population, that you would have more contaminated blood than if you didn't give the test at all. So then we get into the whole question of alternative test sites and other ways as one of many ways of discouraging them from coming and using the blood banks for the purpose of testing. I think it's important and I think what Stan has been presenting, is that we don't get too far away in this immediate window, which is trying to get some legislation and some regulations and some activity right now, because we have the test, we don't get too

far away from the prime purpose, which is initially, and we recognize the needs and everything in the mental health area, but initially, the need is to protect the blood supply. That's where we want to put our focus.

DR. VOLBERDING: I don't think any of us are disagreeing with that. Let me express my sense of what the alternative test site is and if people have other feelings, let me know.

As I see it, the alternative test site is designed to provide a way of discouraging people who are in high risk groups from donating blood with the purpose of getting a test result. That has several components, and until the alternative test sites are in place, there needs to be a moratorium on blood banks giving results. That's the most immediate but short range solution to the problem.

The alternative test site will be a place where people, especially in high risk groups, can go to have blood drawn in an anonymous manner and get the results. I don't see that we could, in any good conscience, call it an alternative test site if we didn't make some provisions available for ongoing counseling. We know that people are going to be severely affected when they hear the test result. There needs to be education and counseling built into the alternative test site. It can't be just a place to get blood drawn, because then we're going to be turning people loose who aren't prepared for the information that they've been given. Admittedly, they've been given the information to protect the blood supply, but we've done that to them and then they are

having the consequence of our action. So I think that has to be seen. I think we would all agree that that has to be seen as an inherent part of the alternative test sites. And I would say that the pre-test education is just an additional cost saving measure that the more people we can inform about the test result, hopefully, the more educated they can be about deciding whether or not to have the test in the first place which in the long run, because we have to provide the education and counseling, will be cost savings.

MR. WILLIS: Let's go back, as I understand it, the blood banks now, and the evidence that I've heard sitting through the last two meetings, is that they have been, since the awareness of AIDS, doing a rather good job of screening out high risk populations from going to blood banks. Where we are now is a fear because of the fact, not that they want to give blood, but that they want to find out, being in a high risk population, whether or not they have the virus, is that they would use the blood bank if they have no other alternative. So again, we're dealing with a population that we've identified as wanting the test, not wanting to give blood, but wanting the test. The educational thing that we think is important, but Stan raised the question as to whether or not we were going to get the best, and again we're working with limited funds, the best bang for the dollar immediately, in terms of trying to discourage people and then drying up money that's available for the test, and then you're back to the point of the blood bank. So we don't disagree

in terms of the educational component, but again, we're dealing with people who want the test. If we make it known the results of the test and so forth, we are dealing with their judgment. The counseling afterwards, we think we can deal with as part of the overall budget process, rather than having to deal with it in the pressure cooker that we're under right now, trying to deal with the blood bank problem. That is really all we're saying in this.

MR. BUSH: This is Larry Bush from Art Agnos' office again. I agree with what you're saying, but I think we have to carefully understand what we mean when we say that the people want the test. The public perception at the time this test was announced was that we had something nearly failsafe and so, therefore, they could go to blood banks and not worry about contaminating blood, because it was going to get caught, and we know that's not true.

Secondly, the perception was that the test was going to tell them something that they needed to know. That part of the message is not necessarily clear yet to the public and that's what the pre-counseling component really deals with here, because this is not "the" test they want. This turns out to be "a" test along the road and the fact is that if they take this test now, we could, as Paul was saying, and as people from the Citizens' Advisory Committee has been saying, really intensify the mental health problems that we are facing with the attention around AIDS. So we're dealing with the realities that we have "a" test

for blood screening and that this test in being implemented in the state; is going to need additional work that we're constructing in this legislation.

MS. CUMMINGS: Excuse me Larry. Could you also make reference to the data that we've discussed in the past about surveys that have been done in San Francisco of gay men who indicated they were interested in the test and then received some information about the test?

MR. BUSH: That was a survey done by Irwin Memorial Blood Bank in which their survey showed the same figures that Ann is referring to here, 50 percent. Once they were told of the limitations of the test, that dropped down to about 10 percent.

What we're also hearing as I understand it, is that the residue of people who are insistent on taking the test are probably the people who are going to get the least advantage out of it. In fact, they are going to use this test to heighten their tension and anxiety about their susceptibility and being at risk for AIDS, and end up flooding all kinds of other parts of the state system.

DR. VOLBERDING: Before I let you talk Jim, if I could say, too, I don't think that the mental health problems and the need for counseling are something that we can easily say we can deal with later, because these are going to be problems the first day that we start doing the tests and getting results back to people. We've had this situation in our clinic of giving test results that have been done on a research basis to people who are

in high risk groups, who know about AIDS, and they are still shocked by the test results, because people especially in high risk groups, I think, have built up their defense mechanisms that tell them that they're really not at risk. So I don't think these are issues that we can easily put off. Jim.

MR. FOSTER: Jim Foster from San Francisco. I certainly don't want to add to the general level of paranoia, but I would like to share with the members of the group my particular concern. To tell you the honest truth, I'm not terribly concerned about the gay male population in the State of California regarding this test. I think the gay male population of this state has been bombarded with information around this test. What worries me enormously, however, are the casual contacts that are made with the gay male community in the State of California. Anecdotally, when I was in New York not long ago, I met with Roger McFarland, who is the Executive Director of the Gay Men's Health Crisis in New York, around this whole problem of education and how you reach that particular segment that has casual contact. And he was telling me that he had to go out to a home in New Jersey; a married man, wife and two children. The man had apparently developed AIDS and on his coffee table was a copy of National Enquirer and House Beautiful and Roger said how in the name of God am I going to communicate with this guy?

And I think that where my worry really is, is with those who have casual contact, who come in from the suburbs, say to San Francisco or come into the City of Los Angeles from Compton or

where have you, and who are probably sitting at home terrified that their casual contact has resulted in exposure to this disease and now they hear that there is this test that is going to be given and are going to try to take advantage of it.

MR. BUSH: Not to keep going on the subject, I think we should clarify -- this is Larry Bush, that we're not talking about casual sexual contact, we're just talking about casual contact. There was an article in the New York Times in January that the Castro section of San Francisco is dropping off in sales. The people didn't want to go to clothing stores and try on clothes that gay men had tried on for fear that they might get AIDS. And everywhere that we're talking about this test, we're talking about this test will show whether you've had contact or been exposed to the virus. And you're going to have, as Jim says, people who have the casual contact that we all mean in the everyday sense of that term who've eaten in a gay restaurant, who have a hairdresser who they believe is gay, or who sat next to two men at the movie theatre and one of them sneezed and they're going to run down and they're going to get panicky. I think we really have to deal with that reality.

MR. FARRELS: Jim Farrels, Executive Director of the San Francisco AIDS Foundation. Without being repetitive and repeating everything that Jim Foster has said and Larry Bush and Paul Volberding, I would simply like to concur with the statements already made that we, at the Foundation, feel that it's imperative that we both have the pretesting education and that we have post test counseling. I can't stress enough how imperative that is, and it will impact in a very, very negative way if we don't allow that to occur.

DR. VOLBERDING: I think that if I can summarize what we hoped to have been telling you, that we believe that education for the general public, not just directed at groups that we think are at highest risk of carrying the virus is a critical component of the whole testing package, and also that education at the testing site and follow-up education counseling is also, I would see as an integral part of the testing package. I think we might want to go on and keep looking at the cost estimates that we've made, and if there is serious disagreement about this, I'm sure it will be resolved later. Ann could I ask you to go through quickly the San Francisco estimates for the testing and maybe include briefly the educational and counseling services, but mainly to focus on the actual cost of the testing itself?

MS. RUGGIERI: Okay, one last pitch for the overall educational piece of this. Like I said before, we estimate 75,000 at risk individuals. We are basing our calculations on testing 35,000 as 50 percent or slightly under. 75 percent of the gay community indicated last November they wanted the test, so we're hoping that we'll discourage about 20 plus thousand from being tested. So that's what we anticipate \$250,000 would buy us, is discouraging 20,000 people. Education that covered ...

MS. CUMMINGS: Excuse me, Ann, are you working off of the information that was presented last week to the --

MS. RUGGIERI: Yes.

DR. VOLBERDING: I thought it would be useful to summarize that again because then I'd like to present our calculations from last week and they can then compare.

MS. RUGGIERI: Blood collection we estimate to be about \$20,000. I'm rounding these numbers off. I'm sorry, let me start over. Blood collection would be about \$271,000; the laboratory work would be about \$547,000; the appointment reporting and referral mechanism would be about \$350,000; the mental health support would be \$1 million, and the administration would be about \$140,000. We have done some additional calculating, looking at positive/negative test results and can give you some just ballpark numbers for each of these components, but I want to stress that while I can give you that, the budget started with an assumption of 35,000 tests. So if you decide you're only going to get 15,000, all these numbers change.

DR. VOLBERDING: Excuse me, did you distribute this copy at the last meeting?

MS. RUGGIERI: Dr. Silverman brought them up. I have some copies.

MS. CUMMINGS: I didn't bring mine with me.

MS. RUGGIERI: Maybe I could go up and get some additional copies made.

MS. CUMMINGS: Or if you could call Marisa and ask Marisa to xerox these for us.

MS. RUGGIERI: When you start looking at the per-test cost, what we did was, we calculated that, we went on the assumption that about a little less than 50 percent, about 40 percent of the people tested will come back positive, and therefore we'll have 20,000 people testing negative and 15,000 testing positive. The aggregate cost for someone testing negative to receive appointment referral, basically appointment

and some educational pretesting information, blood collection, lab work, counseling - there would be no counseling component obviously, and the administrative overhead comes to about \$21.43. For a positive who would receive the scheduling, the education, some initial crisis intervention with being given the positive results, the blood collection activity itself, the lab work, and then the counseling and administration comes to around \$125.28.

MS. CUMMINGS: Per person?

MS. RUGGIERI: Per person.

DR. VOLBERDING: Per person tested positive.

MS. RUGGIERI: Tested positive.

UNIDENTIFIED VOICE: How much was that per person?

MS. RUGGIERI: \$125.28.

MS. CUMMINGS: And a summary again of the negative?

DR. VOLBERDING: \$21.33.

MS. RUGGIERI: For a negative.

DR. VOLBERDING: Again, that includes then, not the general public education but it includes the...

MS. RUGGIERI: ...No, this is alternative site education.

DR. VOLBERDING: ... at-the-site education, blood drawing, testing, and follow up discussion.

MS. RUGGIERI: And counseling.

MR. TAYLOR: When you say follow up counseling are we talking about the initial visit, two visits, three visits?

MS. RUGGIERI: We're talking four hours at \$15.00 an hour with a, like an MSW, LCSW level therapist, not a clinical

psychiatrist or psychologist who would cost between four and ten times that much.

MR. TAYLOR: Much more.

MR. RUGGIERI: So, depending on how many sessions, the cost may change.

MR. TAYLOR: Okay.

MS. RUGGIERI: The other thing I wanted to say about the lab work is that in our lab work estimates, we also included western blot which is the test which is not yet on the market. We did that in anticipation of FDA approval within four to six months, and from a humane as well as a legal standpoint, thought that per positive results, initial positives we'd have to provide an alyza and a western blot.

MS. CUMMINGS: Question, are you clear on the western blot test like what happens after the -- would it be helpful for people to just run over that real quickly?

DR. VOLBERDING: The test that's being used, the elisa test is a very easy test that can be done inexpensively and rapidly in large numbers of specimens. The test is very good, as I mentioned, but it's not perfect, and it will generate false positive test results. So what is anticipated before someone is informed of the test result that a second test be performed on that blood to make as sure as we can that the test is truly positive. And so a second more expensive and more difficult test would then be reserved for that situation for those tests that are initially found to be positive to make sure it really is positive before the person is informed. There are a variety of those, but the one that's most likely to be available quickly is called the western blot -- it's a technique.

MR. WILLIS: Did I hear correctly that that would be not available from four to six months?

DR. VOLBERDING: It's available in a research setting now, but FDA approval will not be available until four to six months.

MR. CUBANSKY: Paul, Ann, could you tell me in terms of just the lab work component of what percentage of the \$550,000 reflected there is elisa versus western blot?

MS. RUGGIERI: I'd have to sit and do my math, but I believe it's 15,000 individuals that would have a positive -- it's probably about 10,000 western blot, that's my guess.

DR. VOLBERDING: At about \$20.00 per western blot?

MS. RUGGIERI: \$28.00, yes that's our calculation and this is very dependent ...

MR. CUBANSKY: So almost 300,000 of the 547,000 would be for the western blot, or somewhere in the neighborhood of half at least?

MS. RUGGIERI: No, because you have to look -- let's see.

DR. VOLBERDING: Of the one hundred and twenty-five twenty-eight per positive test, about 28 would be for the western blot.

MR. WILLIS: I thought she said 10,000 would get the western blot test at \$30.00 a test. That comes out the way I do math, I think the \$300,000 of the 547 for the western blot. The only point that I -- and keep in mind that we have to take positions like this in the Department of Finance at least to get the discussion on the table, is that given the unknowns we have

about the numbers of people who would come in, all the varieties of things, we would have a difficult time supporting knowing that we're going to have to probably come back in and recost these things and talk about additions or changes later on. We would have a hard time developing a cost figure based on a contingency of a test being available in four to six months.

DR. VOLBERDING: An alternative technique and the one that the blood banks are proposing until the western blot is available is to do a second elisa which is obviously less good. It's a worse approach because if you had a positive the first time, doing the same test might still give you a false positive the second time but that would be an interim thing that I would think could be done that would be better than just doing a single alyza.

MR. FOSTER: Question to either -- Jim Foster from San Francisco, either Ann or perhaps you Paul. Do we have any indication at all of how many people have been visiting Irwin Memorial since the test was available? I had seen a newspaper article that said 450 came the first day.

DR. VOLBERDING: I haven't seen any numbers.

MS. RUGGIERI: They collect 120,000 units of blood each year. I don't know how that calculates out but that wouldn't surprise me.

MR. FOSTER: The other -- in fact I absolutely agree with you and it just points out the difficulty of all of our positions. We're also to a great extent at the mercy of what the press does, I mean a story appearing in the San Francisco Chronicle saying that AIDS is transmitted by saliva could have, I

don't know what effect that may have had already, but it could have an enormous effect on the demand for the test.

MR. CUBANSKY: You know I have a question, and probably it's me missing some things but be patient. You indicated, and others have indicated discouraging people from taking the test.

MS. RUGGIERI: High risk people, not the public, high risk, in particular.

MR. CUBANSKY: Why?

DR. VOLBERDING: Our feeling is that -- if I could jump in, our feeling is that our knowledge of the implications of the positive test are far from perfect. We don't really know what it means for the health of a person. We don't really know what it means even about contagious risk of that person. The test is designed for use in the blood bank where it does a good job, but for the person who is in a high risk group, we feel that the recommendations for risk reduction should be the same regardless of whether he or she is positive or negative. If you don't have the virus, you should conduct your life in a way that insures that you don't get it, and if you have it you should conduct your life in a way that insures that you don't transmit it, and they are the same recommendations. So there is really nothing we would tell the person who is in a high risk group who tests positive, at least with what we know now about the test, that that is any more than we should be telling him or her otherwise.

MR. CUBANSKY: Thank you.

MR. WILLIS: Just to put it in my vernacular because I also am not a doctor or even close to it, but what you're saying in laymen's terms and maybe we can keep asking the press to do

this if I understand it right, is the virus does not mean that you have AIDS.

DR. VOLBERDING: Exactly.

MR. WILLIS: It does not mean that you're going to come down with AIDS.

MS. CUMMINGS: It's not just the virus, David, it's the antibodies of virus.

MR. WILLIS: So clearly all it does and all that the federal government and we are putting it in a place for, is as a way of trying to do a little bit better than we're doing now in terms of protecting the blood.

MR. FOSTER: I'd also like to point out that I think there is another exceedingly important reason to discourage people in the high risk group from taking this test at a blood bank.

MR. CUBANSKY: I understand that, at an alternative test site I wasn't tracking with ...

MR. NORM KEAR: Norm Kear for Red Cross Blood Services in L.A. In your cost workup, what factor did you estimate for the test kits? I'm just curious.

MS. RUGGIERI: I don't know the numbers, but I think it was somewhere around three or four dollars for the elisa, and the western blot was just a guess.

MR. CUBANSKY: Norm, we, as you're aware have been in contact, the Department of Health Services has been in contact with the blood banks throughout the state, and at a national level and the cost figures we're getting from the blood banks is obviously contingent on the volume (inaudible) with what you

purchase but nonetheless, the cost is in the range of ninety cents to \$1.50 per test.

MS. RUGGIERI: I've heard ninety-one cents for American Red Cross but that's how many million units of ...

DR. VOLBERDING: Thanks, I think that gives us a framework. That analysis was basically used in part by Lesley and me last week or earlier this week to do a similar thing. Lesley do you want to-- you all have the worksheet that we developed as another way to estimate the cost?

MS. CUMMINGS: The statewide cost of this. If you do not have a copy of the worksheet -- if God is good, there are still some copies back there on that briefcase. Basically, what we were hoping to do here, is to have everyone look at these numbers and react to them. And to the extent that you think that we have underestimated or overestimated costs or volume or anything like that, to let us know because this was our best judgment based on Dr. Volberding's knowledge of the area, and my knowledge of things like printing costs and that sort of thing. And so what we would like to do is to have everybody look at these and let's just go over this one cost at a time and hear people's reactions to the cost estimates that we developed. The first cost that we identified as being critical and necessary immediately, are materials for the counties and the public in general, basically, which is information on this test. We envisioned it being a pamphlet, some sort of video presentation in addition to a mailing by the Board of Medical Quality Assurance to every licensed health professional to provide them with information on the test. Paul has refined these numbers

since we last spoke perhaps I can turn it over to him for further detail here.

DR. VOLBERDING: Well, in terms of the educational materials, we, again, as has been the theme throughout this, we are operating somewhat in the dark but I've been talking to producers who have done and can do rapid development of educational video materials, and I think we could estimate that the cost to be somewhat higher for the development of those but again that would be a one time developmental cost for video materials to be distributed to health care providers and to consumers to be used in whatever settings are most appropriate for the counties that they're being used in. That the distribution of those materials would then be included in the printing costs which would also include printing of pamphlets. Jim Farrels, from the AIDS Foundation, may have a better sense of the cost of development of these.

MR. FARRELS: Jim Farrels from the AIDS Foundation. I think the cost of video development is really considerably low -- \$70,000 is your estimate?

DR. VOLBERDING: I'm saying 70 to 80 thousand. What we imagined at least to this point, was two 15-minute videos, one for health care professionals, one for the public, or something like that.

MR. FARRELS: Okay, but I think if you look at the cost of printing and you put in a distribution in that, I think you're probably about maybe as much as \$30,000 off there. I think you really need to speak more in terms of instead of 70, maybe \$100,000...

MS. CUMMINGS: ...For developmental costs?

MR. FARRELS: For developmental costs with distribution in that.

MS. CUMMINGS: And if you could just give us, just so that everybody understands your sense of why it costs \$100,000, just so everybody gets it.

MR. FARRELS: The Foundation is in the process of the developing some videos, and so our experience has been that it's going to be -- it will be more in that range than the \$70,000 range from the estimates that we have on our production costs.

MS. CUMMINGS: One question that we had while we were doing this is, to our knowledge, there is no one developing any videos or pamphlets on this subject. Do you know of anyone doing that now?

MR. FARRELS: Well, on the subject of HTLV₃, or on the subject of the test?

MS. CUMMINGS: I'm speaking of the test.

MR. FARRELS: Well, I think as you're aware, the San Francisco Department of Public Health and the San Francisco AIDS Foundation and the AIDS Health Project received a grant from the federal government from the CDC. Part of that grant will be working on some of those materials for San Francisco, so we're just in the very beginning stages of development.

MS. CUMMINGS: If you're doing it, do we need to do it too?

MR. FARRELS: Yes, I think you absolutely need to because I think some things that are developed for San Francisco have to be very specific to San Francisco.

DR. VOLBERDING: I would add that when we estimated this, we estimated the barebones cost of a consumer's video and a provider's video and clearly it would be to our advantage, and especially if the foundation is doing something targeted especially at a gay audience that for the State, and for the numbers of people who are going to want this test and who are concerned and who we can reach, that we have to be more flexible than just a single video.

MR. FARRELS: That's correct.

DR. VOLBERDING: And I would say along those lines that we do need more people working on this.

MR. BUSH: This is Larry Bush from Art Agnos' office. Our office obtained copies yesterday of a letter which has been signed by Frank Young, the Commissioner of the Food and Drug Administration and which is to be sent to all physicians in the country, and that would include physicians in California. I have a copy of that letter if you'd like to make a copy of it. It explains the procedures of the task and its limitations. In addition, we were able to obtain copies of the labeling that is going to be attached to the test, so that everyone who has it, including people at alternative sites, in bold letters on this label it will state that "the primary use of the HTLV₃ antibody test is to screen blood and plasma donations, so that units containing antibody can be identified and eliminated or restricted to further manufacturing into non-injectible projects. It is inappropriate to use this test as a screen for AIDS or as a screen for members of groups at increased risk for AIDS in the general population. The presence of HTLV₃ antibody is not a

diagnosis of AIDS," and then it goes on. It also states by the way, on the labeling of the test, that whenever there is a positive result, that there should be an immediate retest. And I think that that's another argument for the fact that when you're looking at the budget figures you're not looking at a single test but a retest, and I'll be happy to make those available to the Committee. So in terms of education, what we have is already some initial federal action to inform doctors and to inform those who will actually be conducting the test. This does not replace the other needs that we're going to have. As you also may know, the federal government is making \$12 million available for startups on the HTLV₃ antibody test in alternate sites. We delivered a letter to the Governor yesterday asking that California apply for a share of that \$12 million, and asking for additional information on how that money can be gotten.

MR. CUBANSKY: Stan Cubansky with Health Services again. We have, even though we have not yet seen the federal request for proposal because the feds are basically using a bidding process inviting all states in to bid on the piece of the \$12 million. We have nationwide 23 percent of the cases.

DR. VOLBERDING: Is that how it's going to be divided?

MR. CUBANSKY: Well, we're obviously going to argue that as a result of that we should get at least a quarter of the \$12 million, but our proposal will probably go in and ask for \$4 million of the \$12.

DR. VOLBERDING: Would that be then used to supplement the five million dollars that if it is included as an appropriation?

MR. CUBANSKY: We haven't gotten that far yet but when the feds are there with money and they say you have a week to put in for it, we're putting in for it and getting to that question later.

MR. BUSH: Now are you doing with \$4 million for the State of California in addition to what San Francisco and Los Angeles may request since they are able to --

MR. CUBANSKY: My understanding, at least from Los Angeles, was that they were requesting nothing of the \$12 million. I can't speak for San Francisco in that regard. Now, my judgment is that we obviously could put in for \$13 of the \$12 million, but in terms of the federal decision making level, I think it matters little whether it's San Francisco, Los Angeles, and the State of California apply, or whether just the State of California applies, I think we'll only get the same amount of money statewide.

DR. VOLBERDING: I have a question Stan, the cost you gave for purchasing the kits, how long, having seen something of county bureaucracies, how long does it take the state to actually go from putting in a request to buy those kits and have them delivered on a volume purchase like that? Is there a long delay in the paper channels?

MR. CUBANSKY: In terms of the entire process of setting up alternative test sites, we're saying six months statewide.

DR. VOLBERDING: But of actually getting the kits from the time you order them until the time they arrive.

MR. CUBANSKY: Well, we're saying in the neighborhood of three months. But even if it should take six months since the

rest of the process is then falling into place. We don't think the kits themselves are going to delay this process in any way shape or form.

DR. VOLBERDING: Thank you.

MR. CUBANSKY: That assumes a manufactured supply that is available to be purchased.

DR. VOLBERDING: Of course.

MR. KEAR: Norman Kear here. Could someone tell me what's intended by the word consumers here?

DR. VOLBERDING: The public, the people who are concerned about the test and who may or may not be inclined to have it. Non-health care providers.

MR. KEAR: But it's not I take it intended to encompass the public in terms of the process of blood donation and the blood supply other than how that might be affected by the test.

DR. VOLBERDING: My own sense is that what we're talking about is really outside of the blood bank altogether with the exception of, perhaps, blood bank positives who don't have any other resource for counseling coming into the system of counseling that set up for people who test positive in the alternative test sites.

MR. KEAR: And then I'm again presuming there are a number of different mechanisms by which these consumers will be reached, presumably.

DR. VOLBERDING: Would be reached?

MR. KEAR: We're not talking here about broad public education through the medias, I guess this is what I'm asking.

DR. VOLBERDING: Well, I think we in part are, but it's hard to budget that. We would imagine, and it's already started in San Francisco that public service announcements and articles would be planted in the press to educate the public.

MR. KEAR: Is that to be part of this process funded by this money?

DR. VOLBERDING: It's part of the process, but not included in the funding so much as the development of pamphlets, video materials, and mailing to health care providers.

MR. KEAR: Okay fine, thank you.

DR. VOLBERDING: I don't think that we imagine that this is going to be a massive public education campaign so much as at least making sure that we're doing what we can to provide some educational materials for the public.

If we can move on, so we in a sense then covered the mental health aspects, primarily education and follow-up counseling of people who are being tested that was presented initially, then we've just discussed another way of looking at that in a sense, the educational materials designed to educate the public and providers before a test is ordered. Why don't we, Lesley, could you discuss the second major point then; the training of staff?

MS. CUMMINGS: Yes, in our view on this, it seemed that most county staff will not be aware themselves of what the implications are of this test, what they ought to tell people who come to them for testing, what they ought not to, and that the Department needed to undertake a training program.

Counties that, those non-San Francisco, non-L.A. counties where the level of knowledge and sophistication just isn't there on this subject, and so we budget a figure of \$300 thousand envisioning that what would happen with that would be that the department would establish some sort of regional training curriculum and bring in people from other counties and pay their room and board for a couple of days and do this all over the state, and that was our idea on that.

DR. VOLBERDING: There again, I think that that's probably going to be critical. There are county employees in areas of the state that have been affected by AIDS that know a great deal about it and don't need much education, but I'm not so confident that in the large part of the state that that's going to be the case.

MS. CUMMINGS: Could I just ask if anybody here has any sense of the cost of this that is different than the cost that we estimated here?

MR. CUBANSKY: How many individuals are going to get this? I mean is this a thousand dollars a person? Is this 600 people at \$500 dollars a person? Can you give me some idea of that?

MS. CUMMINGS: No, because I didn't do it that way. Basically, what I did was - I mean it was more intuitive than that. If we were to approach it by how many people should we be educating here, then I would say you would at least want to have one person designated in each county, maybe more, under the

assumption that you need backup for the one person, okay? So that would be let's say maybe two people per county, traveling cost to the regional center...

DR. VOLBERDING: ...And cost of development of the curriculum, too.

MS. CUMMINGS: Yes, if we want to do it that way we could say 116 if we assume a cost - what do you think is reasonable, \$2 thousand? Then, that's like \$232 thousand?

MR. BUSH: This is Larry Bush again. Can you folks at the Department of Health and the Department of Finance get information for us on how the federal government came up with the \$12 million figure, because (laughter)

MR. CUBANSKY: We can try to find that out. We can ask people at the Center for Disease Control where it came from; how did they get to it. It's probably the amount of money that was left over after this was funded - that was funded - or maybe if the reverse is usually true, let's scrape a million out of this pot and two million out of here and a million out of there, but we'll try to find out.

MR. WILLIS: Probably about the same way that you and Mr. Roos came up with the \$5 million. (laughter).

MR. BUSH: But we talked to some people. (laughter).

MR. WILLIS: I've been connected with a variety of things that could come off the ground including the Farm Labor Board many years ago, and I can tell you that at any time when you're costing out something, you haven't even started, but by

and large, what you do is forget about half of the things that you should have thought about when you're putting it together. We look at these estimates as purely ballpark. We're more concerned with the assumptions in terms of what's going to be done.

DR. VOLBERDING: What components are included.

MR. WILLIS: what components are going to go in, as opposed to the finite costing because we're aware that you really can't...

DR. VOLBERDING: I would think also that no matter what the federal government ends up providing California and how that might be targeted for these areas, that we're still going to need to come up with some estimate of what kind of program California needs to put together, and if we can fill the holes of the budget in with other monies, then we're just that much farther ahead on the rest of the program.

MS. CUMMINGS: Let me also say, too, I don't know if you, Dave, were successful in finding out about the federal funding issue, but Larry has had some success and maybe what we can do after we finish going through these assumptions is talk for a second about what the expectation is about federal funds and all that.

MR. WILLIS: The man's name I think, didn't you say, Stan, is Joe Sanders and the department's been in contact with him in the Atlanta center. I understand, the report I got was that the Federal Register announcement is going to be next week

and the application has to be in by the 18th, that a letter has been sent both to the Director of the Department of Health Services and the Director of Public Health in Los Angeles and San Francisco.

MR. BUSH: I have copies of that correspondence and copies of the application.

MR. CUBANSKY: I would like that. I would like that, if you would, it would expedite our process and guarantee we make the 18th. We understand that the \$12 million, it's a federal expectation that that \$12 million is the amount of money that is available for the next 90 days.

MR. BUSH: That's correct.

MR. CUBANSKY: Oh, okay.

MR. BUSH: The application, to take a moment, the application form is somewhat at variance with what CDC is explaining the purposes of the funding to be, so that the 90-day period appears to be all that is being dealt with in the application. However, CDC explains that they are intending that this cover startup cost for exactly the kinds of things that training for county health officers and putting a whole alternate site program, including some information packets that will be given to people prior to testing and financed. The problem is figuring out did they really sit down and do some calculations? The \$12 million was not arrived at from superfluous funds since they had to admit in Congress that they don't know where they are getting the \$12 million from and they don't see any loose money

laying around. (laughter). That's not something I like to admit to Congress.

DR. VOLBERDING: We're going to spend it anyway.
(laughter).

MR. BUSH: It's certainly the impression that it's meant to cover the buying of kits for the first 90 days and it's meant to cover all of the start-up costs involved in getting alternate sites established and on the ground, going.

DR. VOLBERDING: It doesn't sound like a realistic amount from what we've seen.

MR. BUSH: The preliminary feedback, they sent an earlier letter to the health departments around the country asking them what they would need to establish alternate sites and my understanding, informally, is that the response from around the country was that the total would be about \$20 to \$30 million.

MR. WILLIS: That's probably how they got the \$12 million.

UNIDENTIFIED VOICE: And we don't have any sense of how much of that we might or might not get, right?

MR. BUSH: I think that, in all likelihood, California will come out second only to New York in the allocation of funds.

DR. VOLBERDING: We can assume. Maybe we can move on to the last component of our cost estimates and go through those.

MR. KEAR: Can you define retest for me again before you start?

MS. CUMMINGS: Do you mean describe what it is?

MR. KEAR: Yes.

MS. CUMMINGS: The pre-test in our view is just the process of someone coming in and saying, "I want this test," and then you say to them, "oh, let us tell you about this test." Either by presentation of video information or a human being talking to them and explaining to them what it means; some sort of way to educate them about the test, and then to say to them again, "now would you like to take this test?"

MR. KEAR: Understood. I don't want to make a semantic issue of this, only that in laboratory and testing circles, pre-test may mean something else. Particularly, there is a considerable interest in other quarters on having people pre-tested before they give in a blood bank. Just to make you aware of that.

MS. CUMMINGS: Okay.

MR. CUBANSKY: If I could, then, in my terminology, say that the average mental health worker in a county makes \$30.00 an hour, including overhead, desks, paper, pencil, their salary, retirement, social security, whatever benefits are paid for, just by my \$30.00 an hour, you are basically saying then, that a pre-test period of time would be 30 minutes per individual?

MS. CUMMINGS: What we're saying is two things with this cost. One is, yes, it could be 30 minutes or it could be 15 minutes, if there is a 15 minute video that's available. Like you could have a video running eight hours a day or 10 hours a day and all the people that come in and want to take this test,

you could say, "yes, we know you'd like to take this test. Please go down to room 200 and look at this video before, and now come back and let's talk about it for 10 minutes; do you still want to take it, okay."

DR. VOLBERDING: But included in that, we estimated that there would be additional costs for space, because this would be an additional volume of the facility that's doing the pre-testing; additional personnel to do it and then the cost of developing and providing materials that would be required to do that education.

MS. CUMMINGS: We picked this dollar figure for two reasons. One, it seemed to us a dollar amount that someone could perform this function for, the other was we wanted to be sure that the amount that a county would receive per capita, was at least the same as the amount that they would receive for a test, because we don't want them to have an incentive to perform a test.

DR. VOLBERDING: In a sense, we'd rather overpay at that level because it will save more money down the rest of the line.

MS. CUMMINGS: We've got to talk about the cost of the test, here, and the information that you're having about volume purchasing I think, should affect this per capita amount, but just continuing along this line for a second; we picked an estimated volume of 282 thousand and we did that by estimating the number of people in San Francisco and L.A. that we thought would take the test, which we estimated to be 282 thousand,

subtracting out 50 percent of them to control for people who would get their test from private doctors, or people who would not want to take the test, after being educated. That left us with a number of 141 thousand going on to take the test.

MR. CUBANSKY: Again, what's within the \$15.00 of the test cost, itself, given that the blood bank sources tell us that...

MS. CUMMINGS: Stan, can we hold that thought one second and just - we have this first pre-test issue appeals to people.

MR. WILLIS: If I remember a statistic somebody quoted a little while ago, it was that 50 percent of the people would come in and ask for the test, and after being explained what the test was, only 10 percent of them would want to go on with the test. Did someone say that a little while ago?

DR. VOLBERDING: I think you have to appreciate that was at Irwin Blood Bank, and also that we are clearly grappling with some numbers we don't really know. Stan estimated 625 thousand for the state to take the test. We estimate doing it this way, 141 thousand taking the test; clear, huge differences.

MR. WILLIS: Again, I'm not trying, as I said earlier, I don't think you can refine too far, but I wanted to make sure my thinking was the blood bank.

MR. KEAR: Admittedly, I didn't bring my notes, but at the last meeting of this group, I believe the man from Mental Health quoted 70 percent of the poll...

DR. VOLBERDING: ...wanted to take the test.

MR. KEAR: ...wanted to take the test. I remember the 70 percent distinctly.

MR. CUBANSKY: Excuse me, who was polled?

DR. VOLBERDING: Those were gay men.

MR. CUBANSKY: Okay, high risk men.

MR. FARRELS: And to clarify that that particular survey was done in I think October/November and the major amount of information that has been delivered regarding the test, has occurred since then. So I would anticipate that that figure would be much lower than it was in early October/November.

MR. KEAR: He used those figures and made the point, this was despite all the anti-test hype in the gay press.

DR. VOLBERDING: As I recall, that was back in November...

MR. KEAR: And yet, that hype began around the end of November, beginning of December.

MS. CUMMINGS: So that all having been said, isn't there anyone who wants to go, no, no, no, that seems too low, or no, no, no, that seems too high?

MR. CUBANSKY: I don't want to do that and give poor Dave an attack over there, but I just did want to reiterate again that there is, I think, a large unknown in this when you consider the possible, I wish we could in fact, in some way or other, devise a survey around this, or had the time to do that, but I think there really is a very large body of concern that's out there in the suburbs and I use that only as a term to describe those who have casual contact.

DR. VOLBERDING: Again, I think the way Lesley and I came at these numbers was to look just at the high risk community, because that's the one we see and hear the most about regarding this test, but I share the concern that when this is available, we might be surprised at the number of people in this state who we wouldn't think are at any risk at all having a positive testing, and yet who are concerned and want the test.

MR. MARK SMITH: Mark Smith from San Francisco General Hospital. I think the other question and perhaps there will be some discussion about exactly what the blood banks will do with their results, but the fact is that if we assume that the incidence of positive antibody testing in the general blood donor community, excluding high risk groups, is somewhere below one percent, then somewhere above 60 percent of all the positives that the blood banks get will actually be false positives. There will be a lot of false positives and some proportion of those people presumably will, as you indicated, want this to be confirmed and not believe it and probably rightly so, and will show up either at their private physician's office or at the County Health Department's office, or perhaps both, wanting to be confirmed. So aside from the high risk groups, the people who are post-transferred...

DR. VOLBERDING: We're going to see a spillover from the blood banks.

MR. SMITH: The blood banks, themselves, will produce a certain number as well.

MR. WILLIS: Could I, because I wrote it down a little while ago and you mentioned it again, the casual contact, and just to make sure we're not misleading anybody, particularly since the press now walked back into the room, when you mention casual and you mention gay restaurants and the barber and the other things, there was no implication there, that you can get it by touching or breathing or being around people.

MR. SMITH: Oh, of course not. No, and those particular contacts, casual contacts, or Mr. Bush's casual contacts or my casual contacts are sexual. (laughter).

DR. VOLBERDING: Don't confess anything.

MR. WILLIS: That's what I wanted to make sure I was clear on.

MR. BUSH: We're just afraid that the concern is going to cross those lines.

MS. CUMMINGS: Dave, I was at a presentation that Dr. Volberding and other people from UCSF gave, I guess it was on Monday, to a bunch of health professionals on the subject of how is this, and what they have learned at UCSF is that no one who is not in a high risk group has gotten it, despite how many...

DR. VOLBERDING: A number of studies have been conducted now on health care professionals, even people working closely with patients over a number of years with AIDS, and show essentially no risk whatsoever of even converting the antibody status. So, again, while I think the public is concerned, especially considering the media coverage recently about the

possibility of casual transmission, there's nothing that we are aware of that would suggest that it is a real possibility.

MR. WILLIS: Well, I just keep bringing it up because I mean there's articles in the newspapers that virus is a generic thing and it's easier to get it through shaking hands than kissing and a whole variety of things, so it's so important. I agree with you and it's this kind of thing that's important, particularly when they're here to make sure that we don't mislead specific things on the table.

MR. CUBANSKY: Lesley, in response to your question as to whether anyone disagrees with you on any of the numbers, I guess I would be remiss if I did not mention that of course I disagree with you. I don't think you factored in everyone who's had a blood transfusion in the last five years. And I would definitely think that despite a tremendous amount of pre-testing or pre-counseling before the test that if I've had a blood transfusion, I want the test.

MS. CUMMINGS: Okay, that's a good point. Does anybody have any sense of that number? Is there some reasonable way we can take that into consideration in this estimated volume?

MR. KEAR: I really should know that, but I'll give you a little formula that might work. If you take the average blood transfusion as four units per patient and estimate that one million units are transfused annually in California, and then take that back five years, you may get a rough idea of the number of patients. Now, how many have survived is another issue

(laughter), but divide it in half for the sake of trying to determine say 50 percent for survival rate. That might give you a pretty rough indication of the number of people.

MS. CUMMINGS: Was that two million? (laughter).

MR. KEAR: Well, you're talking about five million units divided by four;

UNIDENTIFIED VOICE: You said two million, five hundred thousand people, now...

DR. VOLBERDING: ...And if 50 percent of them are surviving...

MR. KEAR: That doesn't work, does it? It just doesn't work.

MS. CUMMINGS: Are they in California?

MR. KEAR: Pardon?

MS. CUMMINGS: Is all this four million units of blood in California?

MR. KEAR: We send to hospitals one million units of blood per year.

MS. CUMMINGS: In California.

MR. KEAR: In California, from community blood banks.

MR. BUSH: When we introduced AB 403, we went to the blood banks and got the numbers of people who are living who were recipients of blood transfusions in the past three years and used that as part of our calculations.

DR. VOLBERDING: And what's the number?

MR. BUSH: It was about 400 thousand who were alive and still living in California.

MR. WILLIS: It's a big success rate, then, isn't it?

MR. BUSH: We'll be happy to give you the more specific information from the testimony that we drafted.

DR. VOLBERDING: I think it's an important point, because it is a number that we didn't include at all in our estimates.

UNIDENTIFIED VOICE: (Inaudible)

MR. KEAR: Yes, I think that's very likely. I can't see a real...

DR. VOLBERDING: Yes, pretty much by definition, all have a doctor that's been in contact with them in the past few years.

MR. WILLIS: And as a member of Kaiser, I don't know the answer to this, but I would imagine that it is going to be a benefit that we can get through there, and there's just so many ponderables on these kinds of things, which brings us back to where we're coming from and why in the short term, particularly, we want to focus on the test.

MR. BUSH: Californias Blue Shield indicates in their preliminary, looking at this, that this is not going to be a reimbursable expense because this is not a medical test or a medical procedure; it's not diagnostic, and so therefore, you may well be going to your private physician for this.

DR. VOLBERDING: That might have a tremendous impact. I agree, Stan, I think what we're really trying to do is get a sense of what we all can agree on as a necessary part of the statewide program and to put this test into place, efficiently and safely.

MR. CUBANSKY: The anecdote that Dave mentioned earlier that he's been a part of many start-up efforts, including the Agricultural Labor Relations Board, the part of that story that he didn't tell was that the initial budget was put together for that agency in a given year, and when they ran out of money in the spring of the fiscal year, the department folded its tent and went into the desert until the Legislature appropriated more money for that agency, starting in July of that year. So for that three or four months, there was no Agricultural Labor Relations Board, even though it was on the state's books as being an established state agency.

Having learned from that experience, I can tell you from the perspective of the Department of Health Services, in terms of administering this program, regardless of what we agree or disagree on in terms of numbers, we don't want to get in that situation in terms of having a shortfall of tests four months downstream or five months downstream if the demand is there. We just can't live under the situation where we test like mad for four to five months; we then have depleted the appropriation that's available and then we have to wait another six months before we get going again. We're not going to get into that.

DR. VOLBERDING: What kind of budget processes are available in that situation?

MR. CUBANSKY: No question there are supplemental budget processes available, the state's statutes provide for supplemental processes. One would hope that the political realities would enable that to happen, but in the case of that particular agency, maybe because of the sensitivity of the agricultural labor relations issue, the issue of the farm worker versus the farmer, labor versus management, the political reality was not there, even though an appropriation could have been made.

MR. FOSTER: I hope I'm not alone here, but I sort of get the feeling that all of us are just sort of floundering around here with numbers now.

DR. VOLBERDING: It's better to be doing it this week with numbers than...

MULTIPLE VOICES: ...without numbers. (laughter)

MR. FOSTER: I was wondering, I mean, we have now added another couple of, I think, significant fields of consideration here, the number of blood transfusions being one, some population groupings that we may not have considered before, and I'm wondering from your standpoint, Stan, what looks reasonable to the Department of Health? Because, we are in effect, talking a lot more than \$5 million and we're certainly talking now more than \$11.9 million, so...

MR. CUBANSKY: I'll give you a hip shot in terms of the legislation that's moving through the process, keeping in mind

that the Administration does not yet have a position on the bill, not Assemblyman Agnos' bill dealing with confidentiality, we are generally supportive of that; but in terms of Assemblyman Roos' bill with money, my judgment would be that we are going to be able to sell the Department of Finance and the Governor's office on \$5 million. I think we can do that, although I think there are some real nasty things in the bills that may kill them both from the Governor's perspective.

I was part of the nursing home reform a little bit earlier this year and the Governor vetoed the bills that were all double-joined. I hate to tell you, but Assemblyman Agnos' and Roos' bills are double-joined. I can't guarantee, but I can pretty much tell you with a high degree of confidence and certainty, that those bills will be vetoed because of those provisions, and I speak for the Department of Health Services and not the Governor's office on that.

DR. VOLBERDING: Because there are some of us that are outside of this process, explain what a double-joined bill is.

MR. CUBANSKY: Double-joining provisions in a bill basically says that one doesn't go into effect unless another one does. And I think the Governor expressed two days ago at a press conference and I was there when he signed the nursing home reform bills, and he basically, both he and Senator Mello and a couple of Assemblymen were there, kind of replayed his action of last year when he vetoed the nursing home reform bills. The Governor basically said that the executive branch is one branch and the

legislative branch is another and he argued quite strongly for separation of powers.

Now, your question was one of fiscal and I expressed that I felt we would be able to sell, in the Department of Health Services, we would be able to sell the Department of Finance and the Governor's office on an appropriation of \$5 million. You can tell me that \$10 million is needed or that \$20 million is needed, but I'm telling you the political reality is I think we can sell \$5 million, okay?

Now, given that, and given some of the numbers you have seen, that may be on the low side in terms of numbers of people who may come in for the test, because I'm saying right now, our estimate is at least four to five times Lesley's estimate. My first charge with that \$5 million, again assuming we get it, is protection of the state's blood supply, to curb, to the extent we can, the spread of the disease to what would be low risk populations, I guess, if we talk the high risk groups.

DR. VOLBERDING: But the message we're giving you is that we feel it would be dangerous to do that, to do the testing without the other components.

MR. CUBANSKY: I know, but given the political reality of \$5 million, my responsibility as an administrator, or as an implementer since the Department of Health Services in the process, is thrust into and is given the role of implementation. I don't want to start a program which folds after six months because of lack of funding.

MR. TAYLOR: That's what we're going to do.

DR. VOLBERDING: If we're telling you that the program requires \$15 million...

MR. CUBANSKY: ...and the political reality of the situation says \$5 million, then my charge is to try to design a program that is going to go through the year, that is going to make tests available for those citizens of California who want tests, to protect the state's blood supply, to not have a program that starts and stops as does a defective automobile, and it's basically one of, okay for \$15.00 for a pre-counseling session and \$40.00 for a post-counseling session, might be in the ideal world, might be what we need. In terms of the amount of money that is available, we're going to design a system that provides a certain amount of information. There's a two or three page explanation of what a positive result on this test means; that's fundable within \$5 million and also some explanation, you can call it counseling, you can call it information, you can call it education, you can call it what you want, but some information that is available. You know, the human being at the other end of that pipeline, there, that says, "okay, you've read this information in terms of what does a positive test result mean, do you have any questions? Did you see this underlined part on Page two of the information? Do you understand that? Would you like any other information?" And then refer to the existing mental health systems that are in place throughout the state, or refer to a private physician, or refer on someplace else. But within

the context of the amount of money we have available, we're going to do our damndest to run a program, statewide.

MR. TAYLOR: I'm not sure I understood what you just said, that kind of program you just mentioned. You have the handout and you have somebody saying did you understand this and that? Is that the kind of thing you think you could run with \$5 million?

MR. CUBANSKY: Yes, but I don't know if I can talk to you for 30 minutes. See, which is why I asked Lesley in terms of her pre-test, I postulated well, gee, at \$30.00 an hour for a mental health worker, \$15.00 per capita per pre-test is basically 30 minutes of human interaction, the way I saw it. And Lesley explained, well, it might not be 30 minutes of human interaction, it might be watching a video tape for 15 minutes. Well, watching a video tape once it's produced is pretty darn cheap. It's not going to cost.

MR. TAYLOR: A request for that service might be six times greater than we've estimated. We've all agreed on ...

MR. CUBANSKY: Very possible, very possible. Like I say, because of the things that Dave has mentioned, because of the comments we've all made or comments we've heard in terms of the uncertainty of the numbers, we are kind of working from Assemblyman Roos' assumption \$5 million might be a viable figure, and we're going to run a program with that, assuming that that \$5 million has to last roughly 12 months. It's we, that's we in Department of Health Services.

DR. VOLBERDING: It's not clear to me why we're tied to a number that was pulled literally out of the air when we, on more reflection with some more information, earning up with an amount of money that's considerably more.

MR. CUBANSKY: Well, we've got two different processes going here. You're talking about this process which may go on for another couple of months, and may be impacting the '85-'86 budget or subsequent years' budgets versus talking about a process in which we have a bill or two bills, Assemblyman Agnos' and Assemblyman Roos' bill, that are on a pretty damn fast track. I would say those bills are going to come down before this process is complete. So whether you had assumed that this process would impact those bills, it seems to me that this process should not impact those bills because those bills should move quicker than this process is moving, and I may be delaying it.

MR. WILLIS: If I may, to answer your question directly, once a number gets out as far as this particular \$5 million has in the bills, it has a life of its own, and for reasons that are beyond me but having watched it, this could go on for 20 years, the variety of arguments, facts, and so forth, don't do a whole lot to change it as you go through particularly when we're rushing this fast.

I will say that I am grateful as a representative of the Department of Finance for participating in this. I've gotten a lot more information, a lot more background than I get on most bills, and it's made me a lot more cautious in my recommendations

that I'll make, and I do appreciate it. You may not all like what comes out, but it has been effective and it has been beneficial. One of the things that I would, and I haven't really discussed this except Stan and I, and it's the alternative when we look at federal funds, the first question is boy can we supplant general funds. I think our answer would be that given the uncertainties of this, we're talking about the five million and federal funds, not the five million as a total pot.

MR. FOSTER: So you're talking nine million?

MR. WILLIS: Approximately nine million. Well depending on what goes, and we don't know what time frame we're talking about, we don't know a lot of things. But I think what Stan and I are both trying to say is that within the Administration, what we are trying to focus on first is the protection of the blood bank. That doesn't close the doors for the other discussions. The gentleman the other day in answer to my question about Short-Doyle, said that he could not compete with the other demands for Short-Doyle funds with this particular thing. He couldn't stand the heat. In essence, from my point of view, that's exactly what we're doing here. We're competing with Short-Doyle funds and education funds and everything else. It's easy to talk about it when we talk about it with the blinders on. We're just looking at the AIDS now, but essentially we are, and we think that we have to continue and if it can stand the test of competing, maybe it can be part of the Short-Doyle program. But it has to compete with those funds, we can't pretend that it doesn't.

DR. VOLBERDING: I think the -- I'd be remiss if I didn't keep trying to drive home the point that I think we can expect to see really serious mental health problems as a result of this testing that while the testing itself, to some degree does help protect the blood supply that from what we've seen, they're going to be major problems as a result of the testing. And I would really hate to see us come away without at least some provisions for education and counseling after a positive test is discovered.

MR. WILLIS: I can guarantee you that you have driven that home with me to the point where I become suspect sometimes as whether I'm advocating or reviewing. But, yes, you have made your point.

MS. CUMMINGS: Another point that I would like to reemphasize here is particularly, and I'm not privy intimately on the negotiations of this bill, but I think that it is critical even if in the negotiations it was found that individual pretest information or pretest counseling would not occur, that it is critical that materials be developed now for giving to people who are considering taking this test because it is not a diagnostic test, it is not a diagnostic test, and people are expecting that.

DR. VOLBERDING: And many physicians won't know what the test means if we don't do something to get some information out there. That's obviously a fairly inexpensive part of what we're talking about, and probably one of the most critical parts.

MR. SMITH: Let me make one other point.

DR. VOLBERDING: Could you identify yourself?

MR. SMITH: Mark Smith, San Francisco General. I think I really understand Mr. Willis' point. This became a state program to protect the blood supply. It has and is growing and including a lot of other elements that while good things, and things everyone supports are not strictly speaking, part of this original effort and he's being responsible in protecting the original effort. One other thing I think that we might want to remember is, just as this program does not exist in isolation and has to compete for Short-Doyle funds, the effects of getting this positive test on the other programs that the state and the cities and counties are funding, will also exist in tandem so that I can guarantee from working in the emergency room where people come in freaked out about this disease, that someone who's told that he has AIDS who gets perhaps a quick and easy education process is probably going to cost ten times what the cost of education was in getting gallium scans and chest X-rays and white blood counts and everything else to try to assure himself or his physician who is inadequately educated about what this positive test means. And while on the one hand I think we have to recognize that this bill cannot be all things to all people, at the same time, I think we also have to recognize that people who slip through the cracks of this bill will wind up in the Medi-cal pot or in the MIA pot or in some other pot down the line, and I think that is something that needs to be considered.

DR. VOLBERDING: That's exactly right. Quickly go through the other lines, the testing, retesting, and post-testing, parts of the estimates.

MS. CUMMINGS: Let me just ask real quickly on the pretest cost per capita - is that a number that people sense can come down, that dollar amount per capita? People who have some experience, I'm looking to the San Francisco AIDS Foundation for example.

MR. FARRELS: I think the amount, Jim Farrels here, is probably a good ballpark figure. I doubt that it would go down at all. I would be skeptical about the amount.

DR. VOLBERDING: Even if video tapes were included as a component of that pretesting education?

MS. CUMMINGS: Once again, for the purposes of this discussion, what we mean by pretest is, when someone comes in and says I want to take this test, it's the process that you use to tell this person about the test and then that's what it is.

MR. WILLIS: I want to make a small observation in terms of the education. There are people, I think they are doctors, at this table smoking, which implies that all the education in the world and all the money we can spend doesn't really work a lot of times, so ...

MS. CUMMINGS: Cheap shot.

MR. WILLIS: That was a cheap shot

UNIDENTIFIED VOICE: I'm not a doctor.

DR. VOLBERDING: I don't think there are any doctors smoking at this table.

MR. WILLIS: Or at least health people and health connected, and I don't mean to take a shot but it emphasizes the point that we have a concern about in terms of our first priority

in putting the money out, and what we get for what we spend in the education. That I think is the only ...

DR. VOLBERDING: I agree with you, and it certainly has also come to my attention as well. Personally, however what we're talking about here is a one shot test, perhaps a two shot test, not a habit of 30 years.

MR. FOSTER: I think another issue that I can speak to, since the test has been released, the San Francisco AIDS Foundation has our first (inaudible) has increased by 30 percent of people in the community. I'm talking about non-gay, non-bisexual people who have great, great concerns about the test (inaudible) system. So that I know that just from this very small (inaudible) aspects, that we've had a horrendous amount of ...

DR. VOLBERDING: I've been reading about that in a newspaper article today. Yes, to say the very least, today has been another horrendous day.

MR. FOSTER: Paul, I'd like to just point something out briefly here, probably for my own edification but Dave, I think you and Stan gave us some very valuable civics lessons a few minutes ago in terms of what's realistic and what's doable and what we can expect. As appalling as I might think that may be, I would like to remind us that we are in fact the task force set up to deal with the '85-'86 fiscal budget, and so what we are discussing today, although we may, in fact, be forced to live within framework of present legislation, what we have the opportunity to do is build in to the fiscal year '85-'86 budget

for this very thing because this test, I assume, is going to be going on for the next couple of years, and the same problems that we're looking at today are the problems we're going to be looking at next year as well. So I think it is my first thought when I was listening to you and Stan was, "oh my God, what an exercise in futility, why have I come 90 miles to do this?" But then as I thought about it I realized that we could very well be building for the budget of next year.

MS. CUMMINGS: Although that's true, it's also true that Assemblyman Agnos requested that we meet today for the purpose of looking at these numbers and to the extent that they want to consider them in the bill, I mean the author's staff are here and they can do that. They have their political realities they have to deal with. To the extent that they cannot, and we continue to feel that our best judgment indicates that this is what it takes, the recommendations of the task force has to take into consideration ...

MR. CUBANSKY: Absolutely, absolutely. I certainly want us on record as doing that no matter what the Administration does.

MR. WILLIS: Well, I would answer two ways, 1) I think that, and you may never know how much or how little it impacts but I would argue that the discussion, even though it may not move, I think that you've made a good case and there will be probably some movement in terms of the way the Administration looks at particularly the pre-education. First I told Stan to call it deflection, which may have a ...

MS. CUMMINGS: That's good, that's good.

MR. WILLIS: Deflection, and I think that you're absolutely right. Unfortunately we can't, the first ones who see a problem convince and bring the collective wisdom and crisis to the point where people do something until such time, and this is something that's obviously going to have to germinate some additional time, and I think that this particular kind of task force and the exposure it gets and the exposure that we get to all of you and the public gets, is going to help you. So I would not say that your 180 miles round trip is at all wasted, I hope it's not. It hasn't been wasted as far as I'm concerned.

MS. CUMMINGS: We're going back through our numbers here. Do you want to try it, Paul?

DR. VOLBERDING: Yes. Do you have the worksheets in front of you because I've kind of re-roughed out some changes as we've gone along, trying to bring the numbers down considerably. The pretest, if we assume that we can do it for 10 instead of 15 admitting that might be tough, but also saying that based on what we've heard, the numbers we've come up with, the numbers the blood banks have come up with estimate the volume of requests at 400 thousand instead of 280 thousand. I think that sounds from what we've heard like still a very realistic number of the test requested.

MS. CUMMINGS: And let me just point out that the source of that number -- Norm, perhaps you can explain this, this is a document that Norm provided us with, it was estimated by Dr. H. Perkins.

MR. KEAR: Dr. Herb Perkins is a Medical Director of Irwin Memorial Blood Bank.

MS. CUMMINGS: And it includes, that number includes his summary of numbers estimated to want the test, are 125 thousand males, 25 thousand females, and 250 thousand transfusion recipients.

MR. KEAR: I don't necessarily endorse those figures, I think they are as much out of the air as anybody else's. It comes down fairly close to your estimate of 141 thousand at the bottom, doesn't it? Doesn't he estimate about 150 thousand total?

DR. VOLBERDING: We're off a bit on the non-transfusion recipients who initially wanted the test, but we didn't include the number of transfusion recipients so ...

MR. KEAR: I think he has, and I think his figure probably is pretty good there. That was my only copy which John supplied to me, so I don't have it here in front of me.

UNIDENTIFIED VOICE: Those figures are also worked out per person on and also Dr. Barbara Benjamin compiled those figures for Mr. Roos and Mr. Agnos.

MR. KEAR: Dr. Benjamin is from Alameda County.

MS. CUMMINGS: Oh these are the ones that Larry Bush was making reference to a little while ago?

UNIDENTIFIED VOICE: May have been.

MS. CUMMINGS: Okay.

DR. VOLBERDING: If we use those figures, then we'd say 400,000 at \$10.00 is \$4 million for the pretesting, \$10.00 per

pretest of those 400,000 people. If we still assume 50 percent are positive, which may be, it may be lower than that if you include the transfusion recipients, but if you do anyway, and drop the cost of the test itself from \$15.00 to \$7.00, assuming that the test can be had for \$2.00 or \$3.00 dollars, yes.

MS. RUGGIERI: Well, once you get your appointment and your blood collection in ...

MS. CUMMINGS: What are you saying Ann? Can't you do it for \$7.00? Is that what you're saying?

MS. RUGGIERI: Our figures come to 20.

MS. CUMMINGS: Does that include the assumption of volume purchase?

MS. RUGGIERI: Well, the lab work is only \$6.00.

MR. KEAR: But your estimate was based on a \$4.00 kit that you said before, and that's crazy.

MS. RUGGIERI: That was a soft number. I'll come back with the right number.

MR. KEAR: I'll give you a hard number, I think the State with its volume could get \$1.50 a test.

MS. RUGGIERI: But I don't know how much of that \$6.00 is our labor. I would have to go back and...

MR. KEAR: That you need to find out, yes.

MS. RUGGIERI: So I can go do that. It still leaves ...

DR. VOLBERDING: So you don't think we should reduce that \$15.00?

MS. CUMMINGS: Do us a favor, go make that phone call. Okay, thanks.

MR. SMITH: Excuse me. It seems to me that some portion depends on in what setting we see this test as being done. Are we setting up a whole apparatus that requires...

DR. VOLBERDING: I would guess that it's going to be done in existing clinic settings, probably VD clinics in some areas, and local screening clinics in others. But still, I think Ann's point that scheduling and appointment books and that staff time, needs to be budgeted in because it's going to be a large volume on top of the existing staff.

MR. SMITH: Then they have to call for an appointment?

DR. VOLBERDING: We can have Ann's comment because Lesley and I haven't figured anything that carefully at all. I would think that it could be done on a drop-in basis without a preschedule.

MR. WILLIS: And again, I don't want to be too much of a budget analyst because of my earlier points, but my first reaction in looking at this, and I looked at it a couple of times since earlier in the week when we got it, I think that there is some what we would call for want of a better term double budgeting.

MS. CUMMINGS: ...Not in mine.

MR. WILLIS: Not in yours Lesley -- I'm looking at the San Francisco Health one. And for example here, if you're going to set up a pretest activity, you're making an appointment, you've got the person already in there. You don't have to go through an elaborate process. If he or she decides they don't want the test, they go out; if they decide they do, you can take

the blood. There's a lot of efficiencies in activities, so I don't think you'll have to make too many assumptions of doubling in terms of your own ...

DR. VOLBERDING: Strikes me that if you can get the test for \$1.50 that you should be able to administer it for less than \$15.00, but I am eager to hear what Ann says.

MR. KEAR: Can I also just point out that I haven't seen any of the cost breakdown, but certainly the cost of equipment apart from test kits and labor should be included, and I didn't get that from the young lady's presentation from San Francisco.

MS. CUMMINGS: When she gets back we'll talk about that. So where are we? We're on test and volume of test which based on our new number we're going to say 200,000 estimated volume, and then for retest, the cost of that is going to be influenced again by this discussion.

DR. VOLBERDING: The method of a retesting at use with the cost of a retest with an elisa obviously much less, then you already have the blood in your hand so you don't have to have any scheduling or further patient contact. So that should get down close to the cost of the materials and the personnel to actually run the test again, or it could be as high as I would think somewhere around \$35.00 or \$40.00 if a western blot is your method of retesting.

MR. CUBANSKY: Lesley in your retest, did you on that \$40.00 per capita, use the \$28.00 figure that Ann mentioned earlier?

MS. CUMMINGS: No we did not. What we assumed was two tests.

DR. VOLBERDING: Basically we did. I had talked to Ann about that earlier, and so I knew that the amount of money they were budgeting for a western was in the range of \$20.00 to \$30.00. But if the elisa was your retest, then obviously the cost would be much less. I would think in the range of ...

MR. CUBANSKY: I assume you're making the assumption that there will be a retest for positives, and until the western test is available, elisa would be used.

DR. VOLBERDING: And maybe, after the western test is available, if you feel that it's too expensive, and doesn't add enough.

UNIDENTIFIED VOICE: Why two tests? If they have a positive test results from elisa, why would anyone want to go back and have another elisa?

MR. CUBANSKY: Because it might have been wrong.

DR. VOLBERDING: It may have been wrong the first time.

MR. CUBANSKY: Then you would want a third test if you got a positive and negative result, at least I would.

DR. VOLBERDING: Go ahead, Norm.

MR. KEAR: Well, I was just getting concerned about the cost figures here. If you're going to retest the elisa, you need not include, as I suspect has been included here, the drawing time ...

DR. VOLBERDING: No, I mentioned that just now that probably that the cost of the retest with an elisa is just the cost of the kit in the personnel.

MR. KEAR: That's correct. In that San Francisco material that was not the case, they do count drawing twice.

DR. VOLBERDING: That's a good point.

MS. CUMMINGS: Okay, what's the word?

MS. RUGGIERI: \$3.50 is the cost of the test. Now he raised two major points though on the test figures, one is the speed with which they can make a volume purchase because we're going to need those kits back.

DR. VOLBERDING: They estimated less than six months.

MS. RUGGIERI: Okay that's not going to do it to get them in the blood bank. If we're going to have to set up sites in 60 days, we've got to have kits.

MR. CUBANSKY: What's the requirement for sites in 60 days?

MS. RUGGIERI: We're being pressed to get sites set up as quickly as possible, and our goal is 60 to 90 days.

MR. CUBANSKY: That's admirable and we would like to do that, but even if you can't volume purchase you can still pick it up for a buck and a half.

MR. KEAR: Sure, a buck and a half is a good figure.

MS. RUGGIERI: Okay, we were told Abbott is \$3.50. We're looking also at Electroneucleonic which we've learned is better sensitivity and specificity.

MR. CUBANSKY: The blood folks have been purchasing it.

MS. RUGGIERI: Okay, and there is also a third test that's about to be licensed next week and they want the ability to be able to shop around and mix the test so as to be sure the confirmatory elisa is a different brand than the original one.

MS. CUMMINGS: Let's assume for a second \$1.50 for the test just for talking purposes, okay so what else?

MS. RUGGIERI: That's it. Just the speed with which we can get the test.

MS. CUMMINGS: No, but you were indicating that there were additional costs beyond cost of purchasing the test.

MS. RUGGIERI: Okay, it's labor.

MS. CUMMINGS: And what is that?

MS. RUGGIERI: It's microbiologists and ...

MS. CUMMINGS: But how much?

MS. RUGGIERI: Well, their salary figures.

MR. CUBANSKY: Per test, per test.

MS. CUMMINGS: How much per test?

MS. RUGGIERI: That's the difference, that's the difference, it's all labor.

MS. CUMMINGS: Okay, I'm sorry. So what is the difference?

MS. RUGGIERI: It would be \$2.50.

MS. CUMMINGS: So it's \$2.50 for labor, \$1.50 for the test?

MS. RUGGIERI: Right, that's what you're going with. You have to keep in mind these figures don't have startup which is training and purchase of equipment and supplies. We're going to do that up front, that's our goal, so that's not in these numbers. This is ongoing operation.

MS. CUMMINGS: So \$2.50, \$3.50, \$4.00 to do each test?

MS. RUGGIERI: Yes, I'm sure there's actually maybe probably 50 cents worth of supplies in there for test tubes and that sort of thing, but that's a minor--

DR. VOLBERDING: Does that include blood drawing?

MS. RUGGIERI: No, that is just the lab work.

MS. CUMMINGS: How much did we put in for blood drawing? What is a reasonable estimate?

MS. RUGGIERI: Our blood drawing, \$7.75 is what we have. \$7.75 for blood drawing, \$3.66 for making the appointment and notifying negative test results. You can't split those up unfortunately. We didn't have enough time to do that, to figure, to make an appointment, if it's \$1.00 of the \$3.66 or what.

MR. CUBANSKY: I won't seriously, Ann, question your cost estimates because you in San Francisco work from a county salary schedule that is unique to your county and a county benefit schedule unique to your county, etc.

MS. RUGGIERI: In some pieces of the ...

MR. CUBANSKY: I understand. In terms of how we have attempted to cost this thing as the blood banks have been this business of drawing the blood, of testing, doing the lab tests, I guess for our planning purposes, even though we may be high in terms of the numbers of tests we're purchasing, our figures that we have been proceeding on are based maybe on a high number of individuals who are coming in wanting the test, but our numbers are more closely aligned with the blood bank figures using that range of \$1.00 or \$1.50 per test. And I think the blood banks are in terms of the lab work and the drawing of the blood, are

also at about \$1.50, so that they're basically saying roughly \$3.00 for drawing, testing, and lab work.

MS. RUGGIERI: One thing to keep in mind though, even though you're saying it washes because you've got a high number of tests probably, but low per test figures, is that if you're going to reimburse us based on tests performed, we still lose because our costs are real. We've calculated based on county staff, some contracting out for those questionable pieces right now such as the general education and the counseling, but the rest of it is county administrative costs.

MR. CUBANSKY: I don't think the blood banks are interested in getting into the lab business...

MS. RUGGIERI: Oh no, of course not.

MR. CUBANSKY: ...but if the blood banks can do it for \$3.00 versus \$8.00 or \$10.00, the bills that are in the hopper now or Assemblyman Roos' bill that's in the hopper, does give counties the flexibility to contract out for that work as opposed to doing it themselves. Now, I'm not saying at the risk of slowing anything down, you go out and develop an RFP and try to get the best price originally, that might be a good second year effort. I'm not saying do that in the initial year, but it's obviously going to have to be a consideration.

MR. KEAR: I think you'll find that hardly any blood bank will be interested.

MR. CUBANSKY: I understand that.

MR. WILLIS: I keep getting forced here to be a budget analyst, and I keep saying I didn't want to do that, but I must

say that just \$7.75, having had blood drawn, does seem like an exorbitant amount of money to pay for a test of drawing blood out of a person's arm, and I would ask people from the hospital and others if that sounds reasonable.

MR. KEAR: I can tell you that it costs us to collect a unit of blood which is a totally different matter, and get it into our laboratory, \$26.00. But that includes the cost of mobile units and setting up sites and nurses' salaries for what is essentially a four unit per hour process. You're talking about drawing a tiny sample of blood. I would agree with you, I can't believe it'll come to over \$7.75.

MR. WILLIS: I have built budgets from the ground up, and I know that when we look at things globally we forget a lot of things and there's things in there, but even trying to add everything up in my mind and all of the administrative overhead, I can't come up with \$7.75.

MR. KEAR: It depends on the work flow. If you got the CAP work flow stuff ...

MS. CUMMINGS: All right we have an arbitrary, a capricious decision up here.

DR. VOLBERDING: \$8.00.

MS. CUMMINGS: \$8.00.

DR. VOLBERDING: Total.

MR. KEARS: I have a question of Ann if I may. I'm just curious why she used the term microbiologist for the test. Are you locked into microbiologist to do this test? You are?

MS. RUGGIERI: Yes, microbiologists in labs has been budgeted as a technical classification but we need both levels, one of each to do it.

MS. CUMMINGS: Having heard all the evidence, Dr. Volberding picks \$8.00.

DR. VOLBERDING: It's about half of what our initial cost was, so we think it's fair.

MR. WILLIS: It would be a \$1,600,000.00 then.

DR. VOLBERDING: The budget analyst takes it down to \$6.00.

MR. WILLIS: Oh no, I said that comes out to be a \$1,600,000.00. Oh no, I wouldn't take it down to \$6.00. I'm not going to get carried away.

DR. VOLBERDING: The retesting is obviously a difficult thing to estimate as well, because then you need to figure which retest you're using, and it should be as low, I would think, as \$3.00 from what we've heard if it's simply a matter of the same blood being retested using elisa kit that also costs just \$1.50. On the other hand, if it's a western blot then it could be as high as \$40.00. So building in a range of say \$7.00 to \$35.00 per retest and assuming that you're going to retest half of those that were tested initially, which is now down to a 100,000 retest for the State, that's a budget of then \$0.7 to \$3.5 million.

Post test has been, obviously, the most discussed part of this, and the sense I get is the least supported from the State at this point. Our initial cost of \$40.00 estimate was to include post test education and at least one counseling session face to face.

Now if, I think that should be included, if it's not included, then you could, I would assume, reduce the costs of that significantly to at least one educational session which could even be a group educational session and I would estimate \$15.00 then for a post-test educational session with the people who are tested positive. Which, again, is 100,000 so that's \$1.5 million.

MR. WILLIS: I think clearly you and your charge and request from Assemblyman Agnos should include that as a group even though there might be some dissenting opinions on the group but you should in terms of what you're putting forward to him.

MS. CUMMINGS: Could I just ask, should we assume that this number is the same, should we assume that there will not be any, that the re-test will not find any different results? I mean should there be a difference between here and here? That's the question I want to...

DR. VOLBERDING: Well...

UNIDENTIFIED VOICE: (inaudible)

MS. CUMMINGS: Well, there may be no point in doing it. I don't know.

DR. VOLBERDING: It depends on which setting you're doing your re-test in. If the re-testing isn't being done in the alternative test sites, which are screening large numbers of positives, then most of the re-test will be positive. If it's re-testing of blood bank positives, then most of the re-tests, depending on your method, should prove negative.

UNIDENTIFIED VOICE: But this number that's been generated to include half of the people who are status post blood transfused?

MS. CUMMINGS: That's correct.

UNIDENTIFIED VOICE: That would presumably will include a large number of negatives

DR. VOLBERDING: Of negatives. If we include then our initial request which would be to include a real post-test counseling session, an individual counseling session, with a mental health worker, leaving the cost per capita of the post-test at \$40.00, but dropping down to 50,000 the number of, so that would be half of those that are being re-tested who prove positive, then who would get into the system of post-test counseling. So, what's 50,000 times \$40.00?

MS. CUMMINGS: \$2.0.

DR. VOLBERDING: \$2.0

UNIDENTIFIED VOICE: (inaudible)

DR. VOLBERDING: Okay. Pre-test, cost per capita, \$10.00, estimated volume 400,000, total in million, four. Testing \$8.00 per capita, 200,000 tests, total cost \$1.4 million, isn't it?

MS. CUMMINGS: I think it's \$1.6 million isn't it?

MR. WILLIS: Would you run your first number again?

DR. VOLBERDING: Pre-test, cost per capita, \$10.00, estimated volume of 400,000.

MS. CUMMINGS: Source for that estimate is the document that I gave you.

DR. VOLBERDING: Testing \$8.00...

MR. WILLIS: So, that's \$4 million.

MS. CUMMINGS: Correct.

MR. WILLIS: I thought I heard you say \$1.4 million, that's...

MS. CUMMINGS: No, that's the next one.

DR. VOLBERDING: The next one, testing itself, \$8.00, 200,000 is the volume and the total in million is \$1.6 million. Re-testing, we have a range, \$7.00 to \$35.00 per re-test, volume of 100,000, \$0.7 to \$3.5 million for re-testing and post re-testing was \$0.7 to \$3.5 million total cost. Post-testing, again, now leaving the educational session and one counseling session and referral if necessary, \$40.00 cost per capita, estimated volume of 50,000 in the state, total cost \$2.0 million. So, a grand total of...

MS. CUMMINGS: I get \$8.3 to \$11.1. In both cases, it's \$4, in both cases it's \$1.6 million and one case it's \$0.7 ...

MR. WILLIS: You're right. I was adding the \$2 million in twice.

MS. CUMMINGS: That's okay and that's why you're kept out in the desert, Dave.

MR. WILLIS: I've got all those computers.

DR. VOLBERDING: I guess the encouraging thing to us is that that might put us, again, assuming that these wild guesses about volume are anywhere near the truth, if we can get the \$4 million from the feds and the \$5 million in this bill in the range that we might need to do what we want to do.

MS. CUMMINGS: Where did the \$4 million from the feds, where did...

DR. VOLBERDING: Well, 12 to the country and we have about a quarter of the cases so we're hoping that we can get a quarter of the \$12 million.

MS. CUMMINGS: Okay.

DR. VOLBERDING: \$3, \$4, what's a million dollars?

MR. KEAR: You're talking about such wealth, just let me make the point that none of this discussion has in any way indicated any interest in the kind of broad public education campaign that will keep the public donating blood so that we will continue to have a stable blood supply which is a very major issue in this whole AIDS thing and one that tends to get overlooked.

DR. VOLBERDING: I'd second that. That's been my observation in San Francisco in the last couple of weeks with all the publicity that, I don't know, and it's not as though blood transfusion needs is a new thing, it's not as though AIDS is a new thing anymore, but growing concern about transfusions of blood in the hospital.

MR. BUSH: This is Larry Bush. My conversations with Irwin Memorial yesterday indicated that they're prepared to spend \$100,000 on a public education effort immediately just to bring them back to what they call neutral. I think that that is something that absolutely has to be calculated in. I don't think that it's something we're going to calculate into 488 and 403. There is the funding from SB 910 that we're trying to use for broad-based public education on the blood thing and then, secondly, we have a standing request with the Governor to consider an emergency allocation from the existing budget for \$2 million and we specified in that that it should include funding to reassure the public on blood supplies as the result of the release of the new test. We have not yet heard from the

Governor's Office as to whether he's going to supplement that but we are not going to let that issue go away.

MR. KEAR: May I just continue to make my point perhaps a little clearer? If this effort is left to the private sector, to Irwin Memorial or to the Red Cross in Los Angeles or the San Bernardino Blood Bank, they will face the same problem they always face in getting appropriate attention to the problem because they are considered as charities and beggars for public service time. If this is truly a very, very serious public health concern, state backing, state funds and state interest is about the only thing that can do the job with the media and I speak from many years of experience in trying to do that job.

DR. VOLBERDING: Is it the sense of the committee that that's something that we would want to consider as part of the public educational campaign that we're building in as the first component of what we presented? I don't see any inherent reason why it couldn't be.

MR. KEAR: I don't either.

DR. VOLBERDING: If the purpose of this is to protect the blood supply, we're protecting it on the one hand from contaminated blood, but if that's happening at the cost of the flow of blood into the blood system, then it might be something we'd want to address. Jim.

MR. FARRELS: I would agree with you. I think that that is imperative that we support that effort.

MR. BUSH: May I just say that we are fully supportive of that effort and I would urge that this legislative task force urge the Governor to release the funds which he has now,

immediately, for this purpose, not even wait for the passage of 488.

DR. VOLBERDING: Well, I would like to ask Dave this -- we would like to see the development of educational materials exempted from our fees. Is that possible and how soon could funding be made available for that most important initial part of this effort?

MR. WILLIS: There are a couple of questions that have been asked. I'm not sure because I'm not a good lawyer in terms of the RFP process and how you can get around that kind of thing. I'm sure we can take a look and do some things. What \$2 million does the Governor have that he is holding?

MR. BUSH: Well, the Governor has the authority to release funds, if he has funds available. We sent a letter to him on December 11th...

MR. WILLIS: The Governor doesn't have any funds that aren't appropriated by the Legislature. The Governor does have the authority to, on an emergency basis and after advising the Legislature, to spend at a rate that's higher than he's been appropriated, which would still call for legislative action. I don't know...

MR. BUSH: The Legislature has acted when it passed funding for AIDS education and set aside \$1 million. What we asked was that the Governor now emergency supplement that \$1 million for this specific purpose.

MR. WILLIS: Well, yes, but I don't want you to leave the people here with the impression that there is some \$1 million that is sitting there just waiting. That \$1 million, at some

point, would have to be, before June 30th, appropriated by the Legislature. The Governor can't spend money on his own.

MR. BUSH: No, so that everyone is clear exactly why we're wrangling. \$1 million was appropriated by the Legislature...

MR. WILLIS: Right.

MR. BUSH: ...was signed by the Governor. The Governor has the authority to then, as you say, come back to the Legislature and say, "I am going to supplement what you already appropriated because of an emergency and I'm notifying you of that." He can do that. We have asked him in December to do that because we knew this test was coming and we knew the implications. We spelled it out. We're still waiting for a response from the Governor.

MR. WILLIS: And I don't want to go on with it but we were severely chastised for a variety of things last year by Mr. Vasconcellos and others for not toeing a very close mark in terms of our deficiency appropriation so we are very cautious in terms of what we do as a deficiency particularly with General Fund money because if we don't get that done by the end of June, then we are in a deficit situation.

MS. CUMMINGS: What is the status of expenditures from special needs and priorities in the current year?

MR. WILLIS: \$2.5 million.

MS. CUMMINGS: Has that money been obligated?

MR. WILLIS: It's been obligated twice. Once by Peter Abbott and once by AB 830 to the funds for capital construction.

MS. CUMMINGS: But I think, as you are aware, Assemblyman Bronzan sent you a letter indicating, etc., etc.

DR. VOLBERDING: Would it be possible to get an opinion about the RFP process and how quickly that could be circulated?

MR. WILLIS: Yeah, I will relay to Stan and see what we can do in terms of the RFP process.

DR. VOLBERDING: And I would say my sense, and the sense I get from other people on the committee, and if you have objections, let me know, is that we would like to see money for public education to encourage blood donation from low risk group members to be incorporated into this package to ensure the blood supply.

MS. CUMMINGS: Do we need to amend our estimated costs up here in order to...

DR. VOLBERDING: Yes, of course. Now if, can we assume and I ask Jim again and having had some experience with this, if we're seeing approximately \$50,000 for the development of a video piece that would be disseminated, that would be then duplicated, we're saying that we are budgeting for the development of one for health care professionals, one for the public, we hope to then, as I understand it, use the San Francisco AIDS Foundation for targeting the community of high risk gay men that we could add \$50,000 to the development of materials for the blood banks or what's the sense of the committee about how best to accomplish the goal of increasing the blood supply. I don't know, I guess really video is not the way to go. You want to go public service announcements and newspaper pieces.

MR. KEAR: I'm sure there are examples of state-placed public service announcements and radio and television which I believe is the most effective way and whatever costs could be, cost estimates, easily derived from state experience in similar campaigns could be applied here.

DR. VOLBERDING: We could have, Lesley can you...

MS. CUMMINGS: Yeah, I can try and take a crack at that. The Department of Mental Health developed a whole bunch of...

MR. WILLIS: And Alcohol and Drug has a variety of...

MR. KEAR: ...that kind of thing.

DR. VOLBERDING: Why don't we say when we, what I'll do is review this whole thing to amend that.

MR. FARRELS: When we did public service announcements about five months ago, I guess, a lot of the work was pro bono work. It was \$30,000.

DR. VOLBERDING: For a campaign.

MR. WILLIS: For the preparation of some good PSAs, I think \$50,000, from my experience, seems like certainly an adequate figure.

DR. VOLBERDING: Why don't we call it \$50,000 for PSAs, specifically for encouraging low-risk blood donation.

MR. WILLIS: And then you could, you know, relate to some very direct cost estimates on previous material. I think I'm as interested in seeing the state behind it as I am as interested in seeing the state pay for it or do it because I think that has more clout in terms of the charity-begging aspects of trying to get the PSA time on the part of a blood bank.

UNIDENTIFIED VOICE: (Inaudible) I used to be a public service director. The other thing would be perhaps a one event for the media release of what we're doing in education. There are times when I still feel the media is not fully aware exactly what's going on as far as terminology is concerned and needs more information.

DR. VOLBERDING: Mark.

MR. SMITH: They also seems to be some things that may be done without money and one point may be to have the Governor and the Legislature, the distinguished legislators march down and give blood, and explain....

MR. KEAR: We get one shot publicity that way, sure.

MR. SMITH: The second point is that the the Health Department, it seems to me, taking it upon itself to (inaudible) on behalf of the state to (inaudible.)

DR. VOLBERDING: Right. Good point.

UNIDENTIFIED VOICE: And we would be willing to work with anyone.

MS. CUMMINGS: Dr. Volberding is asking me what we ended up doing on the training of county staff and I think what we ended up saying was this number did not seem unreasonable.

DR. VOLBERDING: It's not unrealistic.

MS. CUMMINGS: Okay, that's the banana.

DR. VOLBERDING: In summary, what we're going to recommend, and Lesley you'll help prepare it and circulate it around, is the material for the first component of education including the blood banks, including health care providers and the public to encourage appropriate use or non-use of this test,

training of county staff and providing alternative testing sites which could do the test, a re-test if necessary and at least a brief pre-test education and post-test counseling session. So we'll rough that out and circulate it. Ann.

MS. RUGGIERI: One piece of information I think is real important. We got the announcement from the CDC about the test. They require that we apply (inaudible) April first, (inaudible) 90 days so the statement is really ...

DR. VOLBERDING: I think you were out of the room when they were discussing this. Larry is going to get them the information.

UNIDENTIFIED VOICE: Larry did.

DR. VOLBERDING: So, that's who's working on it now.

MS. RUGGIERI: But the point is, I mean (inaudible) ...

DR. VOLBERDING: Does the state need any assistance or advice from the committee?

MS. CUMMINGS: Let me just ask Dave, and I'm not sure if you know the details of the department's plans but, is what we were hearing Stan say, that the department would believe it would be unreasonable to expect to have alternate test sites established within the next three months?

MR. WILLIS: You heard the details, what they were, for the first time as I did.

MS. CUMMINGS: Is that what I heard?

DR. VOLBERDING: I heard him say about four to six months to get their kits.

MR. WILLIS: Three to six months for complete up and running in all areas. I think that the assumption there, and

this is me speaking, not the department, is that obviously in the higher risk areas where so much has already been done, i.e. San Francisco and L.A., you're going to be up and running much sooner but, you know...

DR. VOLBERDING: As soon as the kits are available.

MR. WILLIS: As soon as the kits are available, right.

DR. VOLBERDING: But that was three to six months, four to six months from what was suggested.

MR. WILLIS: I mean when we've gone out and had crises in flu vaccine and so forth, we've done a quick purchase and I think that expeditious can be applied here but it is a large bureaucracy.

MR. FOSTER: In addition, I would like to go back to Mr. Bush's suggestion that I think it may be appropriate for the task force to request Assemblyman Vasconcellos to write to the Governor, asking what is happening with the request of December 11th regarding blood and see if we can't get some movement from that direction. What I'm suggesting is that we ask Assemblyman Vasconcellos to follow up on the letter of December 11th and discover what is going on?

DR. VOLBERDING: With the status of money that might be made available immediately

MR. FOSTER: Yes, for the purposes that Norm discussed in addition to whatever we add for the '85-'86 fiscal year.

DR. VOLBERDING: Before we close, everyone has gotten this article from the New England Journal of Medicine. Has that been circulated? I think it's a good one that you might want to look at carefully estimating the real impact of this disease nationwide. It's a problem that we're not looking at alone.

MR. FOSTER: It would be real important for you to see it so...

MR. WILLIS: I don't think I got that.

DR. VOLBERDING: If not, I have others. Any other business?

MR. WILLIS: Just one point and I feel that it's necessary. This is an unusual operation where legislative and executive people get together to advise the Legislature. We participated and I think it's good that we participated but I don't want there to be any misunderstanding that the recommendations do not bind and are not really made by the ...

DR. VOLBERDING: We won't hold you to it.

MR. WILLIS: I just hope that when we take a different tack, it's not said that we had our chance and didn't make it. Clearly, we have made it and I hope you will relay, unfortunately, none of the legislators were here today, and this is the first time we really got into the meat of making recommendations but you can convey that to them.

MS. CUMMINGS: Yeah, we understand and I think Bruce Bronzan and all the other members participating on this task force understand that this is an extraordinary situation that is really requiring us all to work together and we understand that your policy isn't established in stone yet and it's far more important to us to have your presence and your ideas exchanged than have you sit back and say nothing and then at some point prove to be absolutely right about nothing.

MR. FOSTER: Lesley, I just wanted to add that I'm really delighted that you are here and that Stan was here. There

is a perception among those who are on the front lines of this in various places around the state that both the Administration and the Department of Health has been very slow to realize the impact of the effect of this disease. I am hopeful that by the participation of people from the Administration, and specifically from the Health Department, Health Services here in Sacramento, that that perception can be turned around and that the adversarial relationship which seems to have existed, occasionally camouflaged, but nevertheless there, can be stopped and that if there are ways in which we can be of assistance to bring an awareness, a more fuller awareness, of the implications of the disease to the attention of both the Health Services Department and the Administration, we'd be very happy to do that.

MS. CUMMINGS: And on behalf of Assemblyman Vasconcellos, who was not able to be here today, I just want to thank everybody for making an extraordinary effort to come together to talk about this issue because I think it's been really helpful.

MR. FOSTER: No question.

DR. VOLBERDING: The final meeting of the committee as a whole is...

MS. CUMMINGS: The final meeting of the committee on the whole is on April 8th although there are two other meetings before that date; March 18th at which issues related to the treatment of Medi-Cal, I mean the treatment of AIDS will be discussed, fiscal issues, and the meeting on the 20th at which research issues will be discussed.

MR. FOSTER: Dave, will you be at those meetings as well?

MR. WILLIS: Unfortunately, I won't. I'm going to be back in Washington at the National Budget Officers Conference Monday through Wednesday of that week to try to find out what's going to happen to us in terms of the federal budget. Tom Dithridge of my staff or Aisha Martin will be here not to participate quite at the level that I do but at least to listen and respond to questions, factual questions.

MR. FOSTER: And who will inform you then when you return.

MR. WILLIS: Yes, and I will be here at the last meeting. I'd like to be here for all of them. I did plan on it but they scheduled ...

DR. VOLBERDING: Thanks for coming. That concludes the meeting today, I think. Thank you.