FOIA Number: 2018-0764-F

FOIA MARKER

This is not a textual record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: National AIDS Policy Office

Series/Staff Member:

Subseries:

OA/ID Number: 21072

FolderID:

Folder Title:
CAEAR - Cities Advocating Emergency AIDS Relief [2]

Stack:	Row:	Section:	Shelf:	Position:
S	67	1	1	3

Cities Advocating Emergency AIDS Relief Coalition
Key Points of the Forthcoming
Position Paper: Ryan White CARE Act Reauthorization

The Cities Advocating Emergency AIDS Relief (CAEAR) Coalition is a national coalition that advocates for sound public health policies and resources related to the critical health care and supportive service needs of people living with HIV disease in the United States. CAEAR Coalition members are people living with HIV disease and their coalitions, CARE Act grantees, community health clinics, community health advocates, public health departments, and Title I planning council representatives throughout the United States.

The Coalition is a national representative organization focusing on the needs of individuals and programs dependent on resources from Title I and Title III of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The CARE Act, first passed by Congress in 1990, was reauthorized in 1996 for five years through September 30, 2000.

The CAEAR Coalition has prepared this document to inform the members of Congress, the Administration, and the public about key policy perspectives from consumers of HIV/AIDS services, HIV/AIDS service providers, and concerned citizens who are affiliated with Ryan White CARE Act Title I and Title III. The Coalition has received input from hundreds of individuals through its own regular membership meetings, planning council surveys, and at special meetings of CAEAR members which focused entirely on CARE Act reauthorization issues.

During the legislative process leading to reauthorization, the Coalition's members will continue to assess the policy positions presented here in the context of new information from Congressional leaders, national partners, and other interested parties.

The CAEAR Coalition's forthcoming reauthorization paper centers on key questions and their answers.

Question: Should the Comprehensive AIDS Resources Emergency (CARE) Act be reauthorized by the 106th Congress and signed into law by the President in order to ensure continued access to comprehensive primary care, HIV treatments, and supportive services for people living with HIV disease in the United States?

Answer: YES

Question: Does the existing structure of the CARE Act continue to provide comprehensive and coordinated medical and supportive care to people living with HIV/AIDS?

Answer: YES

Question: In 1996, the Title I formula was reconfigured in an effort to target resources to EMAs providing services to the majority of people living with AIDS—while maintaining

the Federal investment in HIV-related service capacity in existing public health infrastructures. Are there modifications to the Title I funding distribution that could responsibly address the ongoing crises in Title I EMAs?

Answer: YES. The CAEAR Coalition proposes the replacement of the 10-year weighted AIDS case band with the CDC living AIDS case data report as a mechanism to distribute Title I Formula funding. The Coalition continues to believe that sudden shifts in funding should be avoided with a hold harmless mechanism that will phase in changes over time, especially in those EMAs that would experience dramatic funding reductions. The hold harmless provision should limit the formula reductions in an EMA to a maximum of 2 percent a year for a maximum of 10 percent over five years.

Question: Should the Federal government continue to provide direct Title III grants to public and community-based health clinics to improve access to HIV early intervention medical and related supportive care—with special emphasis on underserved and geographically isolated communities?

Answer: YES.

Question: Have the administrative caps on CARE Act resources effectively targeted resources to essential medical and supportive services to people living with HIV/AIDS?

Answer: YES.

Question: Local decision-making and control over resources defines the CARE Act. Does the current design continue to provide appropriate access to essential HIV/AIDS medical care and treatment without Federal mandates?

Answer: YES.

Question: Should the current U.S. Public Health Service guidelines on HIV care be used as a minimum standard for medical care and treatment provided by CARE Act funded providers with assurances that both providers and consumers are informed of the rapid and ongoing developments in the clinical management of HIV disease?

Answer: YES.

Question: Should the Office of the Secretary of HHS ensure that resources appropriated by Congress to ensure appropriate data collection, analysis, and evaluation of CARE Act funded services be allocated to the Health Resources and Services Administration (HRSA) so that the appropriate level of staff and resources can be targeted to this purpose?

Answer: YES.

Question: Beyond the establishment of a continuum of quality HIV health care and supportive services, the success of the CARE Act is determined by the extent to which Americans living with HIV disease have access to and benefit from these services. Can

existing methods used by CARE Act grantees be improved to ensure access to and eliminate barriers to HIV health care and support services for specific target populations?

Answer: YES.

Question: HIV comprehensive systems of care are designed to provide broad access to medical and supportive services. Despite the best efforts of local communities, is there a need for additional targeted Federal allocations serving hard-to-reach populations disproportionately affected by the HIV/AIDS epidemic?

Answer: YES.

Question: AIDS Drug Assistance Program (ADAP) is an essential service of the CARE Act and a major resource for HIV-related medication for people living with HIV/AIDS. Is ADAP's current administrative structure, targeted funding mechanism, and distribution appropriate for the needs of eligible people living with HIV/AIDS?

Answer: YES.

Question: Should Medicaid programs and CARE Act programs work closely together to ensure the coordination of HIV care, non-duplication of services, and comprehensive support to people living with HIV/AIDS?

Answer: YES.

CAEAR

CITIES ADVOCATING EMERGENCY AIDS RELIEF

The CAEAR Coalition
1413 K Street N.W.
Suite 700
Washington, DC
20005

T 202 789 3565
F 202 789 4277

CAEARinDC@aol.com

May 3, 1999

The Honorable Arlen Specter
United States Senate
Washington, D.C. 20510

Dear Senator Specter:

Cities Advocating Emergency AIDS Relief (CAEAR) Coalition is a national grassroots organization advocating on behalf of people living with HIV/AIDS who depend on Title I and Title III of the Ryan White CARE Act for health care and support services. We include members of Title I planning councils, people living with HIV/AIDS, community-based AIDS service organizations, providers of HIV/AIDS health care, CARE Act grantees, and consortia. We are civic and business leaders, lesbians and gay men, health care providers, members of religious organizations, government representatives, local public health officials, drug treatment and mental health providers, and representatives from diverse communities of color.

We ask you, as a member of the Labor/HHS/Education Appropriations Subcommittee, to provide increases for all CARE Act Titles, and in particular, we strongly urge you to include in the FY 2000 appropriations legislation $625 million in funding for Title I of the CARE Act and $134 million in funding for Title III of the CARE Act. These funding levels represent increases over FY 1999 of $120 million for Title I and $40 million for Title III.

Increased funding for the CARE Act is urgently needed to address the ongoing HIV/AIDS emergency in communities across the nation. The AIDS epidemic in America has continued to expand relentlessly in historically underserved communities of color, and other populations that have severe social, economic, and persistent disparities in health care access and quality of care. In FY 1991, Title I provided assistance to 16 communities. In FY 1999, 51 American metropolitan areas qualify for disaster relief HIV/AIDS funding under Title I. These 51 communities are the home to about 74 percent of all reported AIDS cases in America. Tragically, in FY 2000, there may be as many as three additional newly eligible Title I areas that will require disaster relief to address their local HIV/AIDS crises. Title III programs, currently 181 in all, are located in 43 states plus Puerto Rico and Washington, D.C. and provide HIV-related medical services to more than 96,000 individuals. One-third of clients receiving treatment at Title III programs are women.

Current funding levels are inadequate to meet the growing needs of the increasing

number of people living with HIV/AIDS in America. Despite modest increases in CARE Act funding overall, some – but not always the same – Title I communities have lost funding in four of the last five fiscal years as compared with their previous year funding. In FY 1999, seven Title I areas lost funding as compared to the previous year. The CAEAR Coalition requests a $7 million increase in Title I funding to prevent further erosion of the existing continuums of care in these communities.

Federal funding shortfalls are evident in other important ways. In Title I, for example, aggregate Title I requests for funding in FY 1999 exceeded $551 million but total funding was almost $45 million less than needed. In Title III, the Federal government has already approved $11 million in grants to 28 new Title III community health care applicants, but cannot fund these applications due to a lack of funding. This is especially important if geographically isolated, underserved, and rural areas are ever going to be able to provide quality HIV-related medical care and support services to their patients. Almost 25 percent of Title III programs report being the only HIV medical outpatient program in their area.

An additional funding gap has emerged as a result of new treatment options. In 1997, the U.S. Public Health Service issued guidelines on the treatment of HIV-related Opportunistic Infections, and on the Use of Antiretroviral Treatments for HIV Disease in Adults and Adolescents. Current Title I and Title III funding is inadequate to assure the delivery of the standard of care required by these Federal guidelines to all people with HIV/AIDS who need it. The CAEAR Coalition requests an increase of $52 million for Title I and an increase of $11 million for Title III to address the unmet need for care and treatment to people living with HIV/AIDS.

Multiple challenges have presented themselves to Title I and Title III communities as a result of the new medications. Several overlapping trends are occurring. Overall annual rates of new HIV infections are continuing at 40,000 new infections per year; HIV-related deaths have dramatically declined by 43 percent nationally thereby increasing numbers of people are living with HIV/AIDS and seeking services for the first time; clients in care are needing services for significantly longer than ever before and many in care are remaining there significantly longer. A 1998 CAEAR Coalition study reveals an average increase of 43.5 percent in the number of HIV/AIDS patients between 1995 and 1997.

The Health Resources and Services Administration (HRSA) estimates that 20 percent of Title I clients receiving services annually are new clients. Meanwhile, Title I communities across the country have documented client increases ranging from 13 percent to 74 percent. For Title III providers, one-third of their patients are new clients each year. This surge of new clients entering Title I and Title III programs also require more medical visits and social services, including an initial assessment, diagnostic tests, and the determination of a treatment regime. The 1998 CAEAR study estimates that between 1995 and 1997 the total number of patient visits increased by 55.3 percent and the number of visits per patient rose 27.4 percent. Once treatment has begun, all patients must receive regular treatment education and ongoing monitoring, including expensive viral load testing.

Clearly, both the cost and the complexity of care provided by Title I and Title III programs are increasing. New therapies have placed significant pressure on Title I and Title III communities to ensure that access to these drugs is continuously available with no gaps in service that could destroy the hard-earned results achieved by many individuals on anti-retroviral therapy. It is very important to understand that these new therapies cannot be provided outside the context of overall primary care. Patients need a coordinated medical team that includes highly trained physicians, nurse practitioners, nurses, pharmacists, treatment educators, and case managers. Care teams must address treatment readiness issues prior to therapy, and educate patients about the importance of maintaining adherence to combination drug regimens. Indeed, the failure to take these medications as prescribed has been shown to increase the development of viral resistance-rendering the medications ineffective and potentially damaging the future effectiveness of other medications of the same type.

The evolution in the clinical management of HIV disease has increased the time health care providers must spend per medical visit. The 1998 CAEAR Coalition study shows that from 1995 to 1997 the average length of medical visits increased 65 percent. The same CAEAR study revealed that from 1995 to 1997 the average cost of HIV medical care rose 89.3 percent. Other studies indicate that the cost of HIV care would have escalated even higher without the significant reductions in emergency care and inpatient hospitalization resulting from outpatient Title I and Title III programs. These community-based outpatient care sites have reduced the rate of inpatient hospitalizations in some locales by as much as 75 percent since 1996. The CAEAR Coalition seeks an increase of $48 million for Title I and an increase of $12 million for Title III to address the increasing cost of HIV outpatient community-based care. The Coalition seeks an additional increase of $7 million for Title III specifically to meet the increasing cost of providing HIV social services.

Both Title I and Title III grants support HIV/AIDS case management, a service that is one of the most important reasons for the nationwide reductions in hospitalizations. One study has shown that patients with case-managed medical care, such as that provided in Title I and Title III programs, experience 46 percent fewer hospitalizations and live 66 percent longer than people with AIDS not receiving case-managed care. Title III grantees have reported to HRSA that more than $5 million was needed but not available for providing case management services to patients in 1996. They also have reported that the cost of providing case management services increased 55 percent between 1995 and 1996, due in part to an emerging medical model of case management stressing adherence to complex drug regimens.

Another important concern for Title I and Title III programs is that they provide the overwhelming majority of CARE Act funded medical care to people living with HIV/AIDS and approximately two-thirds of Title I and Title III clients are people of color. Despite significant improvement in access to medical care and antiretroviral treatment, the utilization patterns of people of color – especially African Americans – continue to lag significantly behind their representation in local HIV/AIDS epidemics. Communities of color experience cultural and environmental barriers to full access to health services, including HIV care. Many people of color living with HIV/AIDS are burdened by histories of other health

threatening conditions, including substance use, mental illness, homelessness, tuberculosis, and other sexually transmitted diseases.

These factors, when combined with economic hardships and community dislocation, results in disparities in access to health care and support services. Both Title I and Title III programs have enhanced outreach to HIV-infected people of color to ensure they are made aware of the availability of HIV services in an effort to link them to existing health care systems as early after diagnosis as possible. Delayed access to HIV care perpetuates the disparities in health outcomes and the unequal rates of reduction in AIDS mortality, and more work is needed in this area. The CAEAR Coalition requests an increase of $13 million for Title I and an increase of $10 million for Title III to address the disparities in outcomes, access, and utilization of care by people of color.

The AIDS epidemic has produced dangerous strains on our nation's public health systems. Data from the National Association of Public Hospitals and Health Systems estimated that in 1993 hospitals experienced losses exceeding $2,000 per AIDS patient per year. As the burdens mount, responding to the needs of the AIDS epidemic grows more difficult and imperils our ability to meet all the other health needs in our communities. Heavily reliant upon funding for all titles of the CARE Act, our communities request that the Labor/HHS/Education appropriations for FY 2000 include adequate funds for all titles of the CARE Act and other Federal HIV/AIDS efforts in prevention and research.

With funds provided under the Ryan White CARE Act, our communities can prolong the lives of people with HIV disease and AIDS and save the nation millions of dollars in unnecessary hospitalization and other health care costs. As we have demonstrated in the data presented here, proper care and supportive services enable people with AIDS to remain working and contributing to their communities.

Title I and Title III programs have been proven through multiple studies and audits to save the taxpayers' money as well as effectively and efficiently maintain the health and improve the quality of life for people with HIV disease and AIDS. We need your help to continue to meet the need. Please give people living with HIV/AIDS, their care givers, families, friends, and communities your continued support.

Sincerely,

Matthew McClain
Chair
CAEAR Coalition

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

P. Matthew McClain
Chair
1413 K Street, NW, Suite 700
Washington, D.C. 20005
(202) 789-3565 fax: (202) 789-4277

The Sheridan Group
Governmental Relations Representative
1808 Swann Street, N.W.
Washington, D.C. 20009
(202) 462-7288 fax: (202) 483-1964

RYAN WHITE
COMPREHENSIVE AIDS RESOURCES EMERGENCY (CARE) ACT

TITLE I BACKGROUND

The CAEAR Coalition is a national grassroots organization advocating on behalf of people living with HIV who depend on Ryan White CARE Act Title I and Title III programs for HIV medical health care and support services.

Congress adopted the Ryan White CARE Act in 1990 (Public Law 101-381) by a nearly unanimous vote in both chambers. In so doing, it declared an AIDS emergency and authorized over $880 million for all titles of the CARE Act. The Congress voted to reauthorize the Ryan White CARE Act in 1995 by a unanimous vote in the House of Representatives and by a vote of 97-3 in the Senate.

Title I of the CARE Act provides that any U.S. metropolitan area with over 2,000 AIDS cases reported during the last five calendar years be declared eligible for emergency assistance. Congress created local Title I planning councils to plan for and allocte this emergency relief assistance in the American communities most severely impacted by the AIDS epidemic. There were 49 Title I eligible metropolitan areas (EMAs) in FY 98. In FY 99, Norfolk, Virginia, and Las Vegas, Nevada, became eligible for Title I assistance, bringing the total number of eligible communities to 51.

Title I is the safety net for thousands of low-income people living with HIV/AIDS who live in metropolitan areas and are ineligible for entitlement programs. Many of these individuals have severe social and economic problems that complicate their ability to manage their HIV disease.

Increased funding of Title I is urgently needed in American communities. As the death rates from AIDS continue to decrease nationwide, the number of people living with HIV

disease increases every day. The 51 AIDS disaster relief communities eligible in FY 99 are home to about 74 percent of the nation's people living with AIDS.

Community-based services funded under Title I include: outpatient health care, including medical and dental care; home health and hospice care; housing; transportation and nutrition services; and case management services which prevent unnecessary hospitalization and expedite discharge from the hospital. The CARE Act mandates that within 150 days after enactment of the appropriations legislation, the Federal Government will fully disburse Title I funds for the fiscal year.

In FY 99, seven EMAs lost funding as compared to FY 98, including Bergen-Passaic, NJ; Denver, CO; Jersey City, NJ; Middlesex-Somerset-Hunterdon, NJ; Minneapolis-St.Paul, MN; San Francisco, CA; and Santa Rosa, CA.

In FY 98, thirteen EMAs lost funding as compared to FY 97, including Atlanta, GA; Austin, TX; Chicago, IL; Denver, CO; Detroit, MI; Kansas City, MO; Miami, FL; Oakland, CA; Orange County, CA; Portland, OR; San Francisco, CA; Tampa-St. Petersburg, FL; Vineland-Millville-Bridgeton, NJ.

In FY 96, fourteen EMAs lost funding as compared to FY 95, including Dallas, TX; Dutchess County, NY; Jersey City, NJ; Kansas City, MO/KS; Los Angeles, CA; Miami, FL; Nassau-Suffolk, NY; New Orleans, LA; New York, NY; Newark, NJ; Ponce, PR; San Juan, PR; Santa Rosa, CA; West Palm Beach, FL.

In FY 95, eight Title I communities - Atlanta, GA; Dallas, TX; Kansas City, KS/MO; Oakland, CA; Orlando, FL; Phoenix, AZ; St. Louis, MO/IL; West Palm Beach, FL - lost formula funding for the first time ever in the history of the CARE Act despite a modest increase in Title I funding.

In FY 92, two cities joined the original 16 AIDS disaster areas, bringing the total to 18. In FY 93, seven cities were added to the list of AIDS disaster communities: Anaheim, CA; Detroit, MI; Nassau/Suffolk, NY; New Orleans, LA; Seattle, WA; Tampa/St. Petersburg, FL; Ponce, Puerto Rico for a total of 25. In FY 94, nine new communities joined those eligible for Title I funding: Denver, CO; Bergen-Passaic, NJ; Kansas City, MO/KS; New Haven, CT; Orlando, FL; Phoenix, AZ; Riverside-San Bernardino, CA; Saint Louis, MO/IL; West Palm Beach, FL, bringing the number of Title I communities to 34. In FY 95, eight more cities became Title I disaster areas - Austin, TX; Caguas, PR; Dutchess County NY; Jacksonville, FL: Portland, OR; San Antonio, TX; Santa Rosa-Petaluma, CA; Vineland, NJ - for a total of 42 eligible communities. In FY 96, forty-nine communities met eligibility requirements for Title I assistance. The new Title I areas in FY 96 were: Cleveland, OH; Hartford, CT; Fort Worth, TX; Middlesex, NJ; Minneapolis-St.Paul, MN; Sacramento, CA; San Jose, CA.

In 1993, there was an 111 percent increase in AIDS diagnoses. The change in the case definition of AIDS by the Centers for Disease Control and Prevention (CDC), in 1993,

was responsible for much of this increase. Reported cases doubled in some Title I communities, including Baltimore, Houston, Nassau-Suffolk, Philadelphia and Seattle, and about tripled in Denver, New Haven and Phoenix. Though AIDS caseloads in the Title I cities before the definition change were averaging an annual 20 to 30 percent increase, Miami's caseload increase alone was almost 50 percent in 1991.

Inadequate resources are being stretched further and further as the Title I cities continue to require millions of dollars in HIV services and care. The shortfall in funding for AIDS care and services means that thousands of HIV-infected Americans will not have access to medical care, and therefore, will not benefit from or consider initiating anti-HIV drug treatments that could save their lives. HIV-positive Americans, who otherwise might remain healthy and working, will progress to AIDS, experience opportunistic infections and burden the already over-stressed hospital emergency facilities. The CDC estimates that only 50 percent of the estimated 900,000 HIV-positive Americans know they are infected, and that even fewer are receiving treatment.

TITLE III BACKGROUND

Title III of the Ryan White CARE Act provides grants directly to existing community-based clinics and public health providers to develop and deliver both early and ongoing comprehensive HIV services to persons with HIV/AIDS on an outpatient basis. Currently, 85,000 people living with HIV receive primary medical care from 181 Title III-funded providers, including community and migrant health centers, city and county health departments, health care for the homeless centers and diverse community-based organizations that specifically target communities of color and other historically underserved individuals and families. Title III grantees are located in 43 states, Puerto Rico and the District of Columbia. Title III services are coordinated with other CARE Act programs through Title I planning councils and statewide coordinated statements of need.

Two-thirds of Title III medical care patients are persons of color, and 27% are women. The Title III programs are the primary point of access to comprehensive health care for the most economically marginal populations from some of the poorest neighborhoods and rural communities in the country. Title III services, clinically and linguistically appropriate, are centralized within a client's existing health care network to build upon historical and familiar relationships between patients and their community health providers. Needs are addressed at the community level, so that individuals will not have to be turned away or put on waiting lists at overburdened public hospitals and clinics, or be forced to use more expensive alternatives such as emergency rooms for care.

Title III providers aggressively target outreach to high-risk communities, incorporate counseling and testing opportunities in the overall scope of services provided to a community, and focus on the earliest intervention possible in the onset of HIV disease. In 1997, Title III providers reached out to about 762,800 individuals. Of that number, about

315,000 received HIV counseling and testing..

Title III clinics create "one-stop-shopping" opportunities for HIV-related comprehensive medical care. Patients newly identified by a clinic's testing center can stay within the clinic itself and undertake a program of early intervention to treat their HIV infection. For example, HIV-positive pregnant women identified through basic prenatal visits can be counseled on the options for HIV early intervention and provided AZT to reduce the possibility of transmission of the virus to their children - all in one setting. This model seeks to avert wasteful administrative costs associated with fragmented service delivery.

Title III serves as a treatment safety net for thousands needing care. Two-thirds of new Title III patients have incomes below the poverty line, and one-half are uninsured. Furthermore, Title III funds build important health care infrastructure in some communities. Almost one-quarter of Title III programs are the only HIV medical outpatient program in their areas; Title III programs clearly function as the only accessible source of care in a number of states and communities, thus ensuring access to uninsured, indigent urban and rural populations. New planning grants have assisted existing primary care programs, particularly in rural areas, to enhance their capacity to offer HIV medical services to surrounding communities, or expand as demand has increased in urban settings. Title III funding builds on established infrastructure while averting the costly creation of entirely new clinics to treat people with HIV/AIDS.

THE IMPACT OF AIDS ON THE COMMUNITY

The 1998 Midyear HIV/AIDS Surveillance Report issued by the Centers for Disease Control and Prevention reported that the cumulative number of deaths from AIDS recently exceeded 400,000 -- approximately the number of American deaths in the Second World War. To date, about 665,000 persons living with AIDS have been reported to the CDC. The latest statistics indicate that over 270,000 people were reported to be living with AIDS in 1997.

Recent advancements in HIV treatment, including the introduction of anti-HIV combination therapies, have increased the life expectancy of HIV patients. The CDC reports that AIDS-related deaths continue to decline, with a 25 percent decrease between 1995 and 1996 and a 42 percent decrease between 1996 and 1997. In 1998, the U.S. Department of Health and Human Services indicated that HIV infection fell from eighth to fourteenth among leading causes of death in the U.S. between 1996 and 1997. For those aged 25-44, HIV dropped from the leading cause of death in 1995 to third-leading in 1996 and finally to the fifth-leading cause of death in 1997. The consistent decrease of AIDS-related deaths is reflective of the commitment and achievement of the CARE Act in providing medical and support services to people with HIV disease.

In 1997, the CDC reported for the first time a decrease in the occurrence of AIDS by 7 percent between 1995 and 1996. The CDC announced recently that incidence of AIDS

has continued to decline, dropping by 15 percent between 1996 and 1997. These successful outcomes are due in part to the comprehensive medical and support services provided by the Ryan White CARE Act.

HIV, however, continues to spread through the American population unchecked. The result is a startling increase in the number of people with HIV/AIDS who are seeking medical services. The CDC reports that the annual rate of new HIV infection in the United States continues to be approximately 40,000 per year. A 1998 CAEAR study revealed that between 1995 and 1997 the number of HIV/AIDS patients seeking service under the Ryan White CARE Act increased on average 43.5 percent.

Epidemiological studies continue to demonstrate a disproportionate number of AIDS cases among African-Americans, Latinos and Hispanics. The National Institute of Allergy and Infectious Disease reported in July of 1998 that African Americans and Hispanics represented 56 percent of AIDS cases reported among men in 1996 and 78 percent of those in women. For every 100,000 African-Americans, there were 89.7 cases of AIDS reported in 1996. This is about six times higher than among Caucasians (13.5) and about twice as high as the rate among Hispanics (41.3). African-American males exhibited the greatest increase in the number of new infections in 1996.

In October of 1998, the CDC reported that an estimated 240,000-325,000 African Americans are infected with HIV. Of those infected, it is estimated that 93,000 African Americans are living with AIDS. The CDC reports that approximately 1 in 50 African American males and 1 in 160 African American females are believed to be infected with HIV. Through 1997, the CDC had reports approximately 230,000 cases of AIDS among African Americans. Even though that is over 36 percent of the reported cases, African Americans represent an estimated 13 percent of the total U.S. population.

Black and Hispanic women have consistently experienced higher rates of AIDS than have white women. Between 1990 and 1995 new cases of AIDS rose 158 percent among black heterosexual women. In 1996 the CDC reported that over 76 percent of women infected with HIV were women of color. Currently, AIDS cases are approximately thirteen times more prevalent among African-American women than white women. Among women and children with AIDS, African Americans have been especially affected, representing 60 percent of all women with AIDS in 1997 and 62 percent of reported pediatric AIDS cases for 1997.

According to the CDC, the largest number of new infections in females in 1996 were among African American women; the second largest increase for females was among Hispanic women. In 1996, these two minority groups accounted for 78 percent of reported AIDS cases. In addition, in 1997, more African Americans were reported with AIDS than any other racial/ethnic group. Of the total AIDS cases reported to the CDC that year, 45 percent (27,075) were among African Americans, 33 percent (20,197) were among whites and 21 percent (12,466) were among Hispanics. The CDC reported that between 1994 and 1997, Hispanics diagnosed with HIV increased ten percent.

The need is expanding for outreach to people of color to ensure they are linked into the health care system as early as possible. Delayed access to care accounts for some of the disparity in health outcomes for historically underserved communities. In 1998, the National Medical Association stated that African-Americans are more likely to receive treatment when an AIDS-related infection requires hospitalization, and that significant numbers of African Americans are diagnosed with AIDS within one month of their death. The Clinton Administration recently reported that from 1995 to 1996, AIDS death rates declined 23 percent for the overall U.S. population, but only declined 13 percent for blacks and 20 percent for Hispanics. In fact, AIDS remains the number one killer among African-American's ages 25 to 44.

Titles I and III of the CARE Act serve as safety nets for people of color and other underserved communities. Approximately two-thirds of the patients served by Title I and Title III in 1998 were people of color.

The CDC reports that the proportion of AIDS cases among women has been increasing steadily. While women made up seven percent of all cases reported in 1985, they represented 22 percent of cases reported between July of 1997 and July 1998. According to the CDC, the number of AIDS cases among American women reported has totaled about 108,000 since 1980. Even though AIDS deaths are declining, nearly 42 percent between 1996 and 1997, the CDC reports that the decrease was less among women than men (32 percent and 44 percent, respectively).

Another disturbing trend is the steady number of new infections among young men and women. In 1996, the CDC reported that 25 percent of all new HIV infections in the United States occurred among young people under age 21. Also reported was that of persons in whom HIV infection was the initial diagnosis between 1994 and 1998, 15 percent were adolescents and young adults aged 13-24 years. As of June 1998, the CDC estimated incidence of AIDS was 24,000 for adolescents and young adults over age 13. In addition, 8,280 pediatric AIDS cases have been reported to the CDC. In 1998, the Office of National AIDS Policy issued a report to the President noting that on average at least one American under age 22 becomes infected with HIV every hour of every day.

In December, 1998, the *New York Times* reported that there have been an estimated 100,000 children orphaned by AIDS nationwide since 1981. The same article noted that New York City reports approximately 28,000 orphaned children and the state legislature predicts a possible increase of 50,000 by 2001. Approximately ten percent of these children are, themselves, infected with HIV.

THE COST OF CARING FOR PEOPLE WITH HIV DISEASE

A 1998 CAEAR study reported that the cost of medical services provided under Title I and Title III of the Ryan White CARE Act increased an average of 89.3 percent between 1995 and 1997. This accelerating cost of care has presented new challenges for health

care providers who are transitioning from providing predominantly acute, palliative treatment of patients with AIDS to more comprehensive, long-term care for many HIV infected individuals as they live longer.

Recent advancements in HIV treatment, specifically the introduction and widespread availability of antiretroviral therapies, have increased the longevity and improved the quality of the lives of many of those infected with the HIV virus. A 1998 report by the New York States AIDS Advisory Council addressed the difficulties faced by the clinician and patient in successful treatment management indicating that new therapies often involve multiple daily doses of seven to eight different drugs with varying time and dietary requirements.

These factors, in addition to the threat of resistance to one or more drugs when treatment is interrupted or discontinued, have prompted a reexamination and reinvention of HIV treatment management. Treatment now requires a deeper participation and understanding of the drug therapy by the patient. In addition, more involved and increasingly frequent physician-patient interactions have become integral to the success of these demanding regimens. Title I and Title III providers have made a serious commitment to respond to those needs by providing comprehensive, effective treatment management programs. The 1998 CAEAR study reported that the average length of medical visits in Title I and Title III communities increased by 65 percent and the number of medical visits per patient grew 27.4 percent between 1995 and 1997.

In addition to increased length in medical visits, comprehensive treatment programs necessitate other essential components for the effective treatment of HIV such as case management, substance abuse treatment, mental health services, nutritional guidance, and providing housing and transportation. The report of the New York State AIDS Advisory Council noted, "every patient with HIV should have access to support services that will enhance readiness to begin therapy and provide the maximum opportunity for effective treatment and maintenance of the treatment regimen." According to the Advisory Council, an interruption of support services "compromises access to HIV treatment, endangering the immediate health and future treatment options of individuals and potentially creates more widespread public health problems."

In 1997, Title III grantees allocated 29 percent of their annual budgets to other necessary services such as case management, counseling and testing, outreach, and referrals. Title I grantees spent eleven percent of their total budgets on case management and 20 percent on support services including transportation, patient outreach, day respite, and food bank and housing services. These services are critical to the successful treatment of HIV and AIDS. Funding for medications without sufficient financing for medical and other services is an ineffective policy which diminishes the efficacy of HIV drug therapy.

The advancements in HIV treatment have resulted in recent reductions in length of stay and hospitalization days. In 1993, the National Association of Public Hospitals and Health Systems estimated that hospitals experienced losses exceeding $2,000 per AIDS

patient per year. The cost of providing HIV-related care would have escalated even higher without early diagnosis and treatment provided by CARE Act programs. Title III programs have reduced hospital admissions in some locales by as much as 75 percent since 1996.

A direct effect of the new drug therapy is the increased monitoring of patients. For example, viral load testing which helps physicians determine whether and when to begin anti-HIV drug treatment, can cost as much as $250 per test. Preliminary data from a recent survey of Title III sites indicates that between 1996 and 1997, the volume of viral load tests increased by 37 percent. In 1998 the Health Resources and Services Administration (HRSA) estimated that there were 350,000 Title I clients and at least 30 percent of these clients were expected to use Title I funding to pay for viral load testing.

Another direct effect is the pharmaceutical cost of treating the human immunodeficiency virus. According to a 1998 *Washington Post* article, current estimates predict that in the near future the cost of combination therapy will possibly exceed the already high $15,000 a year. The same article noted that drugs needed to prevent opportunistic infections nearly double that expense for some. Many infected individuals cannot afford the new drug therapies, including those who have insufficient medical coverage. Each year, Title I transfers millions in funding to Title II AIDS Drug Assistance Programs (ADAPs). In FY 97, ten percent of Title I funds or $41,059,269 was transferred to ADAP. In addition, millions more in Title I and Title III funds are used to purchase medications not covered by state ADAP programs. Each state decides its own formulary, and some, for example, do not include medications for opportunistic infections.

As burdens mount, responding to the needs of the AIDS epidemic grows more difficult and imperils our ability to meet all the other health needs in our communities. Based on estimates of costs of care and utilization of services across the country, it is estimated that a total gap of over $4 billion exists between the services that are desperately needed and those which are available.

FY 99 TITLE I AREAS:

Anaheim, CA	Atlanta, GA	Austin, TX
Baltimore, MD	Bergen-Passaic, NJ	Boston, MA/NH
Caguas, PR	Chicago, IL	Cleveland, OH
Dallas, TX	Denver, CO	Detroit, MI
Dutchess Co., NY	Fort Lauderdale, FL	Fort Worth, TX
Hartford, CT	Houston, TX	Jacksonville, FL
Jersey City, NJ	Kansas City, MO/KS	Los Angeles, CA
Las Vegas, NV	Miami, FL	Middlesex, NJ
Minneapolis-St.Paul, MN	Nassau/Suffolk Co., NY	Newark, NJ
New Haven, CT	New Orleans, LA	New York, NY
Norfolk, VA	Oakland, CA	Orlando, FL
Portland, OR/WA	Philadelphia, PA/NJ	Phoenix, AZ
Ponce, PR	Riverside/San Bernardino, CA	Sacramento, CA
St. Louis, MO/IL	San Antonio, TX	San Diego, CA
San Francisco, CA	San Jose, CA	San Juan, PR
Santa Rosa/Petaluma, CA	Seattle, WA	Vineland, NJ
Tampa/St. Petersburg, FL	Washington, D.C.	W. Palm Beach, FL

THE RYAN WHITE CARE ACT SAVES MONEY

The Ryan White CARE Act and its provision of medical, pharmaceutical, and support services provided through community-based organizations, has already saved cities and states millions of dollars by reducing expensive in-patient hospitalizations, utilization of hospital based services, medical specialty care, treatment of opportunistic infections, and physical rehabilitation services.

KEY FACTS

- About 74 percent of the nation's people living with AIDS reside in Title I cities.
- In six years, "AIDS Disaster Areas" grew from 16 to 49, and this year became 51.
- The nation has seen over 650,300 cases of AIDS diagnosed; only two years elapsed between the diagnosis of the first 100,000 cases and the second 100,000 cases in late 1991; and less than two years elapsed when the third 100,000 cases were reported in mid-1993, and again, less than two years elapsed since the diagnosis of the 400,000th case of AIDS was diagnosed at the end of 1994 and the 500,000th case by the end of 1995.
- It is estimated that as many as 900,000 Americans are infected with the HIV virus.

- Title I and Title III of the CARE Act serve as safety nets for people of color and other underserved communities. Approximately two-thirds of the patients served by Title I and Title III in 1998 were people of color.

- Title III programs have reduced hospital admissions in some locales by as much as 75 percent since 1996.

- A 1998 CAEAR study reported that the cost of medical services provided under Title I and Title III of the CARE Act increased an average of 89.3 percent between 1995 and 1997.

May, 1999

THE ACCELERATING COST OF HIV HEALTH CARE:

An Analysis of Services Provided Under Title I and Title III of the Ryan White CARE Act

Conducted by
Cities Advocating Emergency AIDS Relief (CAEAR)

August, 1998

For more information, contact the CAEAR Coalition, a national coalition supporting Ryan White CARE Act Title I and Title III, 1413 K Street, NW, Suite 700, Washington, DC 20005 phone (202) 789-3565, fax (202) 789-4277 or Email: CAEARinDC@aol.com

CAEAR

Cities Advocating Emergency AIDS Relief (CAEAR) is a national grassroots coalition advocating on behalf of people living with HIV who depend on Title I and Title III of the Ryan White CARE Act for health care and support services. CAEAR includes members of Title I planning councils, people living with HIV/AIDS, organizations of people living with HIV, community-based AIDS service organizations, CARE Act grantees and consortia.

OVERVIEW

Over the past few months the CAEAR Coalition conducted the following study of HIV/AIDS related services in order to highlight the changing HIV health care system and subsequent need for increased funding. The analysis concentrated on data collected from 1995 through 1997, during which time combination anti-HIV therapy was introduced and became widely available. The CAEAR data suggest that advancements in HIV treatment have necessitated more comprehensive treatment regimens with greater participation of both the patient population and health care professionals. Through the evaluation of the medical services, patient population and health care cost, the following were identified as key components adding significant weight to the growing HIV health service need:

The Growing HIV Population

- Data show that between 1995 and 1997 there was an average increase of 43.5% in the number of HIV/AIDS patients among a representative sample of Title I and Title III sites, clearly illustrating one of the most obvious challenges to the HIV/AIDS health care community: the growing HIV population.

- In addition to new HIV cases, recently available combination therapies have increased the life expectancy of HIV patients. As the number of AIDS deaths has begun to decrease, the number of people dependent on treatment provided under the CARE Act has grown substantially. The data compiled by the CAEAR Coalition in this study reflects the impact of combination therapies that became widely available during the 1995-1997 period.

Increase in the Number of Patient Visits

- One effect of the swelling patient population is the dramatic increase in the number of patient visits reported by the medical community. CAEAR estimates that the total number of patient visits increased by 55.3% from 1995 to 1997.

- While the growing patient population is certainly contributing to the increasing number of visits, CAEAR found that the number of medical visits per patient also has grown by 27.4%. Individuals under care are finding that treatment requires longer and more frequent visits. The combination of a growing patient population and treatment regimens that necessitate more visits per patient will continue to burden limited Title I and Title III funding.

Costly Medical Care

- The CAEAR study revealed that the average cost of medical care has increased by 89.3%. The study also found that this escalating cost could not be attributed solely to the increase in patients (43.5%), or patient visits (55.3%), which are growing at less significant rates than the accelerating cost of medical care.

- Advancements in HIV treatment, are among the reasons for this increased cost in HIV medical health care. Complex treatment regimens are required, including increased viral load testing and greater emphasis on longer, more complex visits to promote adherence to drug dosing and scheduling. Data show that the average length of medical visits increased by 65% between 1995 and 1997. Neglecting to take medication as prescribed can lead to the failure of the therapy, the development of resistant viral strains, or both. Communities financially dependent on the CARE Act are, and will continue to be, inundated with patients in need of these costly medical services.

CONCLUSION

The Ryan White CARE Act allocates necessary resources to communities serving under Title I and Title III of the CARE Act. This funding provides HIV patients who are living below the poverty line or who are uninsured access to medical services they could otherwise not afford. The development of anti-HIV combination therapy has lead to significant improvements in the length and quality of life of those living with HIV. However, as this study revealed, health care is now a much more intensive and costly process for both the growing patient population and the medical community. Given current funding levels, the communities serving under the Ryan White Care Act will not have the necessary resources to meet the needs of those it serves nor will they be able to sustain the heightened level of health care necessary for successful treatment.

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

THE CARE ACT:

✔*SAVES LIVES*
✔*DECREASES AIDS DEATHS*
✔*INCREASES THE NUMBER OF PEOPLE GOING BACK TO WORK*

Support the CAEAR Coalition's FY 1999 appropriations requests for CARE Act Title I and Title III:

- ***CARE Act Title I FY 99 appropriation of $570 million (+$105 million over FY 1998)***
- ***CARE Act Title III FY 99 appropriation of $113 million (+$36.7 million over FY 1998)***

Combination anti-HIV therapy, including protease inhibitors, became available in 1995. In 1998, treatment choices range from 3-drug combinations for new patients to 4- or 5-drug combinations for experienced patients. However, adherence to these new drug regimens requires more complex and costly comprehensive clinical care for people with HIV.

Since 1994, Title I and Title III programs have seen:

- **Up to 166.7 percent increases in patient visits since 1994**
- **Up to 254.0 percent increases in average cost per patient for medical care (excluding pharmaceuticals)**

Presented below are summary data from selected Title I and Title III CARE Act grantees; see individual reports for details. These data are representative of the 51 CARE Act Title I areas eligible for funding in 1999 and the 183 CARE Act Title III grantees.

More Complex and More Costly Comprehensive Clinical Care for People with HIV Disease

City/State	*Reporting Organization*	*CARE Act Title I and Title III Funding*	*Percent Change in Number of Patient Visits*	*Percent Change in Average Cost of Medical Care Only*
Atlanta, Georgia	Grady Health System Infectious Disease Program	Title I	30.9% increase since 1995	68.5% (est) increase since 1995
Baltimore, Maryland	Chase Brexton Health Services	Title I, Title III	21.4% increase since 1995	29.0% increase since 1995
Chicago, Illinois	Chicago Health Outreach	Title I, Title III	214.0% (est) increase in the number of patients since 1994	170.4% increase since 1994
Chicago, Illinois	The CORE Center for the Prevention, Care, and Research of Infectious Disease	Title I, Title III	15.6% increase since 1995	13.3% increase since 1995
Philadelphia, Pennsylvania	Allegheny University Hospitals Hahnemann	Title I	166.7% increase since 1994	254.0% increase since 1994
Philadelphia, Pennsylvania	Health Federation of Pennyslvania	Title I	94.7% increase since 1994	not reported
Philadelphia, Pennsylvania	Department of Public Health	Title I	46.8% increase since 1994	55.7% increase since 1994
Riverside -- San Bernardino, California	Desert AIDS Project	Title I	71.4% increase since 1995	123.3% increase since 1995
San Francisco, California	San Francisco General Hospital	Title I	74.0% increase since 1994	not reported
Santa Cruz, California	Santa Cruz County Health Services Agency	Title III	63.7% increase since 1993	69.4% increase since 1993
Seattle, Washington	Country Doctor Community Health Centers	Title III	20.9% increase since 1995	13.2% increase since 1995
Washington, D.C.	Whitman-Walker Clinic	Title I, Title III	85.6% increase since 1994	177.7% increase since 1994

Sources: Reporting organizations. June - July, 1998.

For more information, contact the CAEAR Coalition.
1413 K Street NW Suite 700 Washington, DC 20005 T. 202/789-3565 F. 202/789-4277 CAEARinDC@aol.com

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

Combination Therapy For HIV In The Context Of Comprehensive Clinical Car

Grady Health System Infectious Disease Program Atlanta, Georgia

Funded By CARE Act Title I

Year	Number of Patients Receiving Medical Care	Number of Medical Visits	Average Number of Medical Visits per Patient per Year	Average Number of Medical Visits per Patient per Year (for patients with at least two visits)	Average Cost per Patient per Year (medical care & labs only -- no drugs)
1995 Combin-ation therapy not available	3,037	22,635	7.5	8.5	$1,200*
1997 Combin-ation therapy available	3,368	29,146	8.7	9.8	$2,022
Percent Change Since 1995	**10.9% increase**	**28.8% increase**	**16.0% increase**	**15.3% increase**	**68.5 % increase***

Source: Infectious Disease Program, Grady Health System, Atlanta, Georgia.

* 1995 average cost per patient per year (medical care and labs only -- no drugs) is an estimate, and therefore the percentage change is also an estimated figure.

Notes concerning complexity of visits:

1995:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- During this period, AZT was the major medication for the treatment of opportunistic infections. Combination therapy and various forms of counseling were used for primary health services to patients.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.
- While the number of patients was relatively stable (minimal increase), there were significant increases of visits per patient. Also, increases were noticed in patients' CD4 counts and decreases in viral loads.

For more information, contact the CAEAR Coalition,
a national coalition supporting
Ryan White CARE Act Title I and Title III
1413 K Street, NW, Suite 700, Washington, DC 20005
phone (202) 789-3565, or fax (202) 789-4277
Email: CAEARinDC@aol.com

CAEAR
CITIES ADVOCATING
EMERGENCY AIDS RELIEF

Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

Chase Brexton Health Services Baltimore, Maryland

Funded By CARE Act Title I and Title III

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year	Average Number of Visits per Patient per Year (for patients with at least two visits)	Average Cost per Patient per Year (medical care & labs only -- no drugs)
1995 Combination therapy not available	762	4,191 (20 min. each)	5.5	6.6	$1,187
1997 Combination therapy available	795	5,088 (35 min. each)	6.4	7.2	$1,532
Percent Change Since 1995	**4.3% increase**	**21.4% increase**	**16.3% increase**	**9.0% increase**	**29.0% increase**

Source: Chase Brexton Health Services, Baltimore, Maryland.

Notes concerning complexity of visits:

1995:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- Supportive care for terminal cases.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.
- Adherence counseling.
- Adjustments in medications as needed for increased viral loads.
- Increased labs.
- Reduced late in life activities (80 per year before combination therapy, 28 in 1997).
- Increased support staff (additions, nutrition, case management, nursing and mental health).

For more information, contact the CAEAR Coalition,
a national coalition supporting
Ryan White CARE Act Title I and Title III
1413 K Street, NW, Suite 700, Washington, DC 20005
phone (202) 789-3565, or fax (202) 789-4277
Email: CAEARinDC@aol.com

CAEAR
CITIES ADVOCATING
EMERGENCY AIDS RELIEF

Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

Chicago Health Outreach
Chicago, Illinois

Funded By CARE Act Title I and Title III

Year	Number of Patients (Actual)	Average Number of Visits per Patient per Year (Estimated for patients with at least two visits)	Average Cost per Patient per Year (Estimated medical care & labs only -- no drugs)
1994 Combination therapy not available	243	4.0	$740
1997 Combination therapy available	764	8.0	$2,000
Percent Change Since 1994	**214.4% increase**	**100.0% increase**	**170.4% increase**

Source: Chicago Health Outreach, Chicago, Illinois.

Notes concerning complexity of visits:

1994:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- Palliative care for terminal cases.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.
- Labs monitorning and education realted to medications.
- Providing triple combination therapies and medication(s) for side effects.
- Monitoring interactions between triple combination medications and medications for side effects.
- Changing triple combination medications when viral loads increase.
- Increased lab work involved all monitoring activities.
- Reduction in incidence of opportunistic infections.
- Reduction in late stage and terminal care activities.
- More time involved in adherence issues and nutrition related to the use of new medications.

For more information, contact the CAEAR Coalition,
a national coalition supporting
Ryan White CARE Act Title I and Title III
1413 K Street, NW, Suite 700, Washington, DC 20005
phone (202) 789-3565, or fax (202) 789-4277
Email: CAEARinDC@aol.com

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

The CORE Center for the Prevention, Care, and Research of Infectious Disease (formerly known as the Cook County HIV Primary Care Center) Chicago, Illinois

Funded By CARE Act Title I and Title III

Year	Number of Patients	Number of Visits	Number of Patients on Protease Inhibitors	Average Cost per Patient per Visit (medical care & labs only -- no drugs)
1995 Combination therapy not available	1,796	9,454 (20 min. each)	not reported	$375
1997 Combination therapy available	2,113	10,933 (30+ min. each)	1,430 (68% of patients)	$425
Percent Change Since 1995	**17.7% increase**	**15.6% increase**	**n/a**	**13.3% increase**

Source: The CORE Center for the Prevention, Care, and Research of Infectious Disease (formerly known as the Cook County HIV Primary Care Center (CCHPCC)), Chicago, Illinois.

Notes concerning complexity of visits:

1995:

- CD4 monitoring, treatment of opportunistic infections and monitoring of small numbers of medications available at the time (e.g., AZT).
- Palliative care for terminal cases.
- Treating and monitoring care for common health problems in patients such as hypertension, asthma, and diabetes.

1997:

- Minimum quarterly monitoring of viral loads. Monitoring CD4 counts.
- Providing and monitoring combination therapies and medications for side-effects. Ensuring compliance with NIH guidelines and quality standards.
- When necessary, determining most appropriate changes in medications when viral loads increase or when patients experience side-effects.
- Increased lab work in all monitoring activities.
- Establishing individualized adherence plans and follow-up on a regular basis.
- Engaging in intensive client education about medications and combination therapies.
- Treating and monitoring care for common health problems in patients such as hypertension, asthma, and diabetes -- ensuring safe interactions between any medications taken for various conditions and HIV/AIDS medications.
- Reduction in incidence of opportunistic infections.
- Reduction in late stage and terminal care activities.
- Delivering preventative interventions, such as vaccine, prophylaxis, annual screening for tuberculosis, and pap smears for women every 6 months.
- Increasingly complex case management: housing, entitlement, supports, transportation, nutrition, mental health assessment, counseling, intervention, group prescription referral, chemical dependency assessment, counseling and intervention.

For more information, contact the CAEAR Coalition,
1413 K Street, NW, Suite 700, Washington, DC 20005
phone (202) 789-3565, fax (202) 789-4277,
or Email: CAEARinDC@aol.com

CAEAR
CITIES ADVOCATING
EMERGENCY AIDS RELIEF

Combination Therapy For H
In The Context Of
Comprehensive Clinical C

Allegheny University Hospita
Hahnemann
Philadelphia, Pennsylvania

Funded By CARE Act Title I

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year	Average Cost per Patient per Ye (medical care & labs only – no d
1994 Combination therapy not available	297	1,255 (20 min. each)	4.2	
1997 Combination therapy available	650	3,348 (40 min. each)	5.2	$1,5
Percent Change Since 1994	**118.8% increase**	**166.7% increase**	**23.8% increase**	**254.0% increase**

Source: Allegheny University Hospitals, Hahnemann, Philadelphia, Pennsylvania.

Notes concerning complexity of visits:

1994:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- Palliative care for terminal cases.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.

For more information, contact the CAEAR Coalition,
a national coalition supporting
Ryan White CARE Act Title I and Title III
1413 K Street, NW, Suite 700, Washington, DC 20005
phone (202) 789-3565, or fax (202) 789-4277
Email: CAEARinDC@aol.com

CAEAR
CITIES ADVOCATING
EMERGENCY AIDS RELIEF

Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

Health Federation of Pennsylvania
Philadelphia, Pennsylvania

Funded By CARE Act Title I

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year
1994 Combination Therapy Not Available	270	1,170	4.3
1997 Combination Therapy Available	350	2,274	6.5
Percent Change Since 1994	**29.6% increase**	**94.7% increase**	**51.1% increase**

Source: CareLink (an HIV/AIDS care network comprised of five federally qualified community health centers), The Health Federation of Philadelphia, Philadelphia, Pennsylvania.

Notes concerning complexity of visits:

1994:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- Palliative care for terminal cases.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.

For more information, contact the CAEAR Coalition,
a national coalition supporting
Ryan White CARE Act Title I and Title III
1413 K Street, NW, Suite 700, Washington, DC 20005
phone (202) 789-3565, or fax (202) 789-4277
Email: CAEARinDC@aol.com

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

Philadelphia Department of Public Health Philadelphia, Pennsylvania

Funded By CARE Act Title I

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year	Average Number of Visits per Patient per Year (for patients with at least two visits)	Average Cost per Patient per Year (medical care & labs only – no drugs)
1994 Combination therapy not available	824	4,000	4.85	6.27	$724
1997 Combination therapy available	1,019	5,874	5.76	7.14	$1,127
Percent Change Since 1994	**23.7% increase**	**46.8% increase**	**18.8% increase**	**13.9% increase**	**55.7% increase**

Source: Ambulatory Health Services, Department of Public Health, Philadelphia, Pennsylvania.

Notes concerning complexity of visits:

1994:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- Palliative care for terminal cases.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.

For more information, contact the CAEAR Coalition,
a national coalition supporting
Ryan White CARE Act Title I and Title III
1413 K Street, NW, Suite 700, Washington, DC 20005
phone (202) 789-3565, or fax (202) 789-4277
Email: CAEARinDC@aol.com

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

Desert AIDS Project Riverside/San Bernardino, California

Funded By CARE Act Title I

Year	Number of Patients	Number of Visits (30 min. each)	Average Number of Visits per Patient per Year	Average Cost per Patient per Year (medical care & labs only -- no drugs)
1995 Combin-ation therapy not available	638	2,303	3.5	$450
1997 Combin-ation therapy available	748*	3,360	6.0	$1,005
Percent Change Since 1995	**17.2% increase**	**45.8% increase**	**71.4% increase**	**123.3% increase**

Source: Desert AIDS Project, Palm Springs, California.
* 560 of 748 (75%) patients in 1997 were on triple combination therapy.

Notes concerning complexity of visits:

1995:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- 3% (22) of 658 patients were on triple combination therapy through clinical trials.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.
- Increasing reliance on viral resistance monitoring tools to inform changes of therapy.
- Addition of substance abuse counselor to enable patients to stay on therapies.
- Triple, and in some cases quadruple, combinations (as salvage therapy).
- 75% of patients on triple combination.

For more information, contact the CAEAR Coalition,
a national coalition supporting
Ryan White CARE Act Title I and Title III
1413 K Street, NW, Suite 700, Washington, DC 20005
phone (202) 789-3565, or fax (202) 789-4277
Email: CAEARinDC@aol.com

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

Combination Therapy For HIV In The Context Of Comprehensive Clinical Care

San Francisco General Hospital/Outpatient Clinic San Francisco, California

Funded By CARE Act Title I

Date	Unduplicated Clients	Patient Visits	Visits Per Patient	Percentage on Antiretroviral Therapy	Percentage on Triple Drug Combination
Dec. 1994	988	1,025	1.04	N/A	N/A
Dec. 1995	904	1,674	1.85	50%	None
Oct. 1996	1,037	2,007	1.94	71%	33%
Jun. 1997	1,156	1,781	1.54	82%	59%

Source: San Francisco General Hospital, Ward 86 HIV/AIDS Outpatient Clinic.

Key Findings:

- From 1994 to 1997, patients seen per month increased by 17%, reflecting increased demand for primary care.
- The total number of visits to the clinic per month increased more quickly, by 74% between the end of 1994 and mid-1997.
- The number of visits per patient increased by 50% in the same time frame, after hitting a high point of nearly two visits per patient per month in October 1996.
- The percent of patients on any antiviral treatment jumped from 50% to 82% in less than two years, for a a 61% increase in demand for treatment.
- The percent of patients on a three drug combination, including a protease inhibitor, increased even more dramatically, from zero in 1995 to 59% of all patients in 1997.
- In 1995, 42% of the patients on antiretroviral therapy were on monotherapy, taking only one drug. After the development of new treatment guidelines indicating that three or two drug combinations were more effective, the number of patients on monotherapy dropped to zero.

Demand for primary care has increased significantly with the availability of protease inhibitors and combination therapy. Total volume of patients as well as number of visits per patient have increased hand in hand with the proportion of patients on combination antiretroviral therapy.

For more information, contact the CAEAR Coalition,
a national coalition supporting
Ryan White CARE Act Title I and Title III
1413 K Street, NW, Suite 700, Washington, DC 20005
phone (202) 789-3565, or fax (202) 789-4277
Email: CAEARinDC@aol.com

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

Santa Cruz County Health Services Agency
Santa Cruz, California

Funded By CARE Act Title III

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year	Average Number of Visits per Patient per Year (for patients with at least two visits)	Average Cost per Patient per Year (medical care & labs only – no drugs)
1993 Combin-ation therapy not available	123	430 (30 min. each)	3.5	6.2	$314
1997 Combin-ation therapy available	160	704 (40 min. each)	4.4	8.1	$532
Percent Change Since 1993	**30.0% increase**	**63.7% increase**	**25.7% increase**	**30.6% increase**	**69.4% increase**

Source: Santa Cruz County Health Services Agency, Santa Cruz, California.

Notes concerning complexity of visits:

1993:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.
- Additional visits to adjust for "side effects" of new therapies.

For more information, contact the CAEAR Coalition,
a national coalition supporting
Ryan White CARE Act Title I and Title III
1413 K Street, NW, Suite 700, Washington, DC 20005
phone (202) 789-3565, or fax (202) 789-4277
Email: CAEARinDC@aol.com

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

Country Doctor Community Health Centers Seattle, Washington

Funded By CARE Act Title III

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year	Average Length of DoctorVisit in Minutes	Average Cost per Patient per Year (medical care & labs only -- no drugs)
1995 Combin-ation therapy not available	259	1,579	6.0	15	$2,431
1997 Combin-ation therapy available	282	1,910	6.7	25	$2,753
Percent Change Since 1995	**8.8% increase**	**20.9% increase**	**11.6% increase**	**66.6% increase**	**13.2 % increase**

Source: Country Doctor Community Health Centers, Seattle, Washington.

Notes concerning complexity of visits:

1995:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- During this period, AZT was the major medication for the treatment of opportunistic infections. Combination therapy and various forms of counseling were used for primary health services to patients.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.
- The monitoring of viral loads has increased lab costs over 600%.

For more information, contact the CAEAR Coalition,
a national coalition supporting
Ryan White CARE Act Title I and Title III
1413 K Street, NW, Suite 700, Washington, DC 20005
phone (202) 789-3565, or fax (202) 789-4277
Email: CAEARinDC@aol.com

CAEAR
CITIES ADVOCATING
EMERGENCY AIDS RELIEF

Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

Whitman-Walker Clinic Washington, D.C.

Funded By CARE Act Title I

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year	Average Number of Visits per Patient per Year (for patients with at least two visits)	Average Cost per Patient per Year (medicalcare & labs only -- no drugs)
1994 Combin-ation therapy not available	1,292	4,639 (20 min. each)	3.6	7.0	$180
1997 Combin-ation therapy available	1,743	8,613 (40 min. each)	5.0	13.0	$500
Percent Change Since 1994	**34.9% increase**	**85.6% increase**	**38.8% increase**	**85.7% increase**	**177.7% increase**

Source: Whitman-Walker Clinic, Washington, D.C.

Notes concerning complexity of visits:

1994:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- Palliative care for terminal cases.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.
- Labs monitoring and education related to medications.
- Providing triple combination therapies and medication(s) for side effects.
- Monitoring interactions between triple combination medications and medications for side effects.
- Changing triple combination medications when viral loads increase.
- Increased lab work involved all monitoring activities.
- Reduction in incidence of opportunistic infections.
- Reduction in late stage and terminal care activities.
- More time involved in adherence issues and nutrition related to the use of new medications.

For more information, contact the CAEAR Coalition,
a national coalition supporting
Ryan White CARE Act Title I and Title III
1413 K Street, NW, Suite 700, Washington, DC 20005
phone (202) 789-3565, or fax (202) 789-4277
Email: CAEARinDC@aol.com

The Washington Post
FRIDAY, APRIL 24, 1998

HIV's Spread Is Unchecked

AIDS-Slowing Treatments Eclipse Rising Infection Rate, Study Says

By RICK WEISS
Washington Post Staff Writer

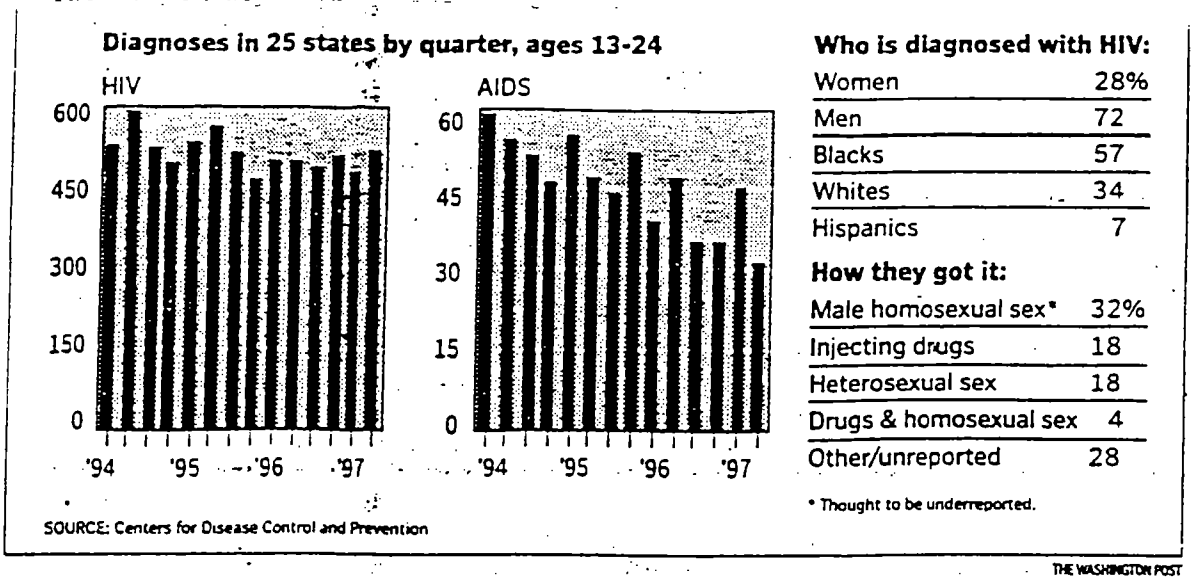
Although the number of new AIDS cases in the United States has declined substantially in recent years, HIV continues to spread through the population essentially unabated, according to data released yesterday by the Centers for Disease Control and Prevention.

The first direct assessment of HIV infection trends shows that the recent decline in U.S. AIDS cases is not due to a notable drop in new infections. Rather, improved medical treatments are allowing infected people to stay healthy longer before coming down with AIDS, overshadowing the reality of an increasingly infected populace.

"The findings of this report give us a very strong message, that mortality may be going down—therapy is working—but HIV continues its relentless march into and through our population," said Thomas C. Quinn, an AIDS specialist at the National Institute of Allergy and Infectious Diseases. "These data tell us we have a lot of work to do."

The findings also confirm previously identified trends showing that women and minorities are increasingly at risk. Especially worrisome, officials said, is that the annual number of new infections in young men and women 13 to 24 years old—a group that has been heavily targeted for prevention efforts—is virtually unchanged in recent years.

See AIDS, *A17, Col. 1*



HIV Spread Not Slowed in U.S.

AIDS, *From A1*

"It certainly documents that we have ongoing new infections in young people," said Patricia L. Fleming, chief of HIV/AIDS reporting and analysis at the CDC in Atlanta.

The report also shows continuing high numbers of new infections among intravenous drug users, a population that has recently been the focus of a political debate over the value of needle exchange programs that offer drug users clean syringes to prevent the spread of HIV, the virus that causes AIDS. [International financier George Soros on Thursday offered $1 million in matching funds to support needle exchange programs around the country, the Associated Press reported.]

CDC officials would not comment directly on President Clinton's controversial decision earlier this week to extend a ban on federal funding of needle exchanges. But both Fleming and Quinn said that AIDS prevention programs in this population need to be improved.

"It's clear that something stronger is needed to slow this epidemic," Quinn said.

The new figures, in today's issue of the CDC's Morbidity and Mortality Weekly Report, are based on HIV test results compiled by 25 states from January 1994 to June 1997. They indicate that the number of new infections during that period remained "stable," with just a "slight" decline of 2 percent from 1995 to 1996, the most recent full year included in the new analysis. By contrast, deaths from AIDS declined 21 percent in 1996 and dropped another 44 percent in the first six months of last year.

From 1995 to 1996, the number of HIV infections increased 3 percent in women. And it jumped 10 percent in Hispanics, although officials said that figure was imprecise. Infections declined by 2 percent in whites and 3 percent in African Americans.

All told, the study tallied 72,905 infections during the survey period. The number nationwide is much higher, since participating states account for only about 25 percent of U.S. infections.

The single biggest risk category was men having sex with other men, but heterosexual transmission continued its steady increase. Most of those cases involved women contracting the virus through sex with male drug users, Fleming said.

The survey is the first to track infection trends by looking directly at HIV test results in people coming to clinics and other health care outlets. That's a major change from the previous system, in which officials simply estimated the number of new infections by counting the number of people newly diagnosed with AIDS.

The old "back calculation" method worked fine during the first 15 years of the epidemic, when HIV infection progressed predictably to disease over a period that averaged about 10 years. With drug therapies now slowing disease progression, however, the number of new AIDS cases no longer reflects the number of new infections, and public health officials were becoming uncertain about how they were doing in prevention efforts.

The new reporting system, now spreading to other states, has helped officials regain those bearings, Fleming said. And although everyone wishes the numbers were more encouraging, she said, at least officials now have a clearer picture of the task at hand.

FOR MORE INFORMATION

To read Post coverage about the AIDS academic, click on the above symbol on the front page of The Post's Web site at www.washingtonpost.com

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

$625 MILLION NEEDED IN FY 2000 FOR CARE ACT TITLE I

For FY 2000, the CAEAR Coalition seeks a total of $625 million in funding for Title I of the Ryan White CARE Act. Title I of the CARE Act provides emergency assistance to the 51 metropolitan areas most heavily impacted by the AIDS epidemic to support comprehensive HIV health care and treatment for the increasing number of low-income uninsured and underinsured persons living with HIV/AIDS. An estimated 74 percent of people in the U.S. diagnosed with AIDS reside and receive their health care in Title I areas. During FY 2000, an estimated 156,000 people with HIV will be served by CARE Act Title I programs.

Need for HIV Primary Medical Care Escalating

For FY 2000, the CAEAR Coalition seeks an increase of $52 million to provide HIV primary medical care for existing clients and uninsured and underinsured people living with HIV/AIDS coming into care for the first time.

- Title I is the safety net for thousands of low-income people living with HIV/AIDS who live in metropolitan areas and are ineligible for entitlement programs. Most of these individuals have severe social and economic problems that complicate their ability to manage their HIV disease. The majority of Title I clients are dually or triply diagnosed with substance abuse and mental illness in conjunction with HIV/AIDS.

- The aggregate Title I request for funding in FY 1999 was $570 million; actual Title I funding in FY 1999 amounted to $505,200,000-- almost $65 million less than the need.

- Primary medical health care services and transfers to the AIDS Drug Assistance Program (ADAP) account for 69% of Title I service funding, 59% and 10% respectively.

- Overall rates of new HIV infections are remaining stable while HIV-related deaths dramatically decline. This means that increasing numbers of people living with HIV/AIDS will be seeking services. A 1998 CAEAR Coalition study indicates that Title I communities saw a 43% average increase in the number of people living with HIV/AIDS receiving services between 1995-97.

- In 1998, the U.S. Public Health Service issued guidelines for the prevention of opportunistic infections, the use of anti-HIV medications for adults and adolescents and for the use of anti-HIV drugs in pregnant women to reduce perinatal transmission of HIV. Title I funding remains inadequate to assure the delivery of the standard of care required by these guidelines to all eligible people living with HIV/AIDS in Title I areas.

- The availability and success of combination drug therapies have motivated many people living with HIV/AIDS to seek care for the first time. In FY 1998, the Health Resources and Services Administration estimates that 20 percent of Title I clients were new to care.

Cost and Complexity of HIV Care Increasing

For FY 2000, the CAEAR Coalition seeks an increase of $48 million to address the increasing complexity and cost of delivering quality HIV medical care.

- Advances in the clinical management of HIV/AIDS require more and longer medical visits, including an initial assessment, diagnostics and the determination of a treatment regime. A 1998 CAEAR study found the average length of medical visits increased 65% from 1995-97, and the average cost of medical care rose 89.3%.

- Once treatment is begun, patient education, ongoing monitoring, including expensive viral load testing, is required. A 1998 CAEAR study estimates that between 1995-97 the total number of patient visits increased by 55.3% and the number of visits per patient rose by 27.4%.

- More than ever, people in care need a coordinated medical and support service plan that includes higher levels of expertise among doctors, nurses, pharmacists, case managers and peer advocates. Care teams must develop plans that include ongoing education about the importance of adherence to combination drug regimens to prevent resistant strains of HIV and regular updates on new treatment developments.

- CARE Act services have significantly reduced the costs of medical care by reducing the amount of hospital-based emergency and inpatient care being provided to people living with HIV/AIDS.

Outreach to People of Color

For FY 2000, the CAEAR Coalition seeks $13 million to address the disparity in outcomes, access, and in the utilization of care and treatment by people of color living with HIV/AIDS.

- About 64% of Title I clients are people of color. However, their utilization patterns of medical care and antiretroviral treatments continue to lag significantly below their representation in local epidemics. Many people of color living with HIV/AIDS are burdened by co-morbid factors such as other sexually transmitted diseases, substance abuse, mental illness, homelessness, poverty, tuberculosis and a lack of education. The combination of these factors often results in difficulties in accessing health care and support services, which perpetuates the disparities in health outcomes and slows the reduction in AIDS deaths in racial and ethnic minority communities.

New Title I Metropolitan Areas -- Existing Areas Continue To Lose Funding

For FY 2000, the CAEAR Coalition seeks an increase of $7 million to address the addition of as many as three new Title I eligible metropolitan areas and a loss in funding to existing Title I areas.

- In FY 99, 7 Title I areas lost funding as compared to the previous year. Despite modest increases in CARE Act funding overall, some, though not always the same Title I communities, have lost funding in four of the last five fiscal years as compared with their previous year funding.

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

$134 MILLION NEEDED IN FY 2000 FOR CARE ACT TITLE III

For FY 2000, the CAEAR Coalition seeks a total of $134 million in funding for Title III of the Ryan White CARE Act. Title III of the CARE Act provides grants directly to 181 community-based clinics and public health providers in 43 states, Puerto Rico, and the District of Columbia, to develop and deliver both early and ongoing comprehensive HIV medical services to more than 85,000 persons with HIV/AIDS, on an outpatient basis. On average, each of these community-based, HIV primary care programs provide early diagnosis and treatment to over 450 clients. Title III ensures a rapid clinical response to ever-changing medical treatment practices and a means to address inadequacies in primary care services, particularly in poor areas, smaller cities and rural communities.

Increasing Cost of Primary Health Care

For FY 2000, the CAEAR Coalition seeks an increase of $12 million for the increasing costs of providing primary health care services to more than 85,000 individuals.

- A 1998 CAEAR Coalition study indicates that between 1995-97 the average cost of medical care per patient rose 89.3%.
- In 1996, over 30% of all Title III patients were new patients, who require intensive and complex medical care, including an overall medical assessment, viral diagnostics, and a stabilizing anti-AIDS treatment regimen.
- Recently, the standard care for people with HIV/AIDS has been altered to promote wellness and adherence to new and complex drug regimens. This has required intensive client education, intervention, and ongoing support. A 1998 CAEAR study revealed that between 1995-97, the average number of visits per patient increased by 27.4%, primarily to monitor the efficacy of and adherence to complex regimens and to provide quarterly viral load testing.
- Changes in the HIV standard of care have also increased the amount of time needed for each visit per patient. A 1998 CAEAR study revealed that between 1995-97, the average length of medical visits increased by 65%.
- Over 73% of all new Title III patients in 1996 entering the health care system were moderately to severely ill and in great need of health care services.
- The overall cost of providing access to HIV-related primary care would have escalated even higher without the early diagnosis and treatment provided by Title III programs. Title III programs have reduced hospital admissions in some locales by as much as 75% since 1996.

Outreach to People of Color and Other Underserved Communities

For FY 2000, the CAEAR Coalition seeks an increase of $10 million for outreach and care for people of color and other underserved communities who have historically lacked access to the health care system.

- The FY 1999 HHS appropriation included targeted funding for Title III planning grants to African American community-based medical care providers. These funds will ensure the expanded capacity of African American agencies to provide HIV-related medical services in the African American community-disproportionately affected by HIV disease. These agencies must maintain this essential capacity in FY 2000.
- Two-thirds of the patients served by Title III grantees in 1996 were people of color.

- One-third of the patients served by Title III grantees in 1996 were women.
- The largest number of new infections in males in 1996 were among African Americans.
- The largest number of new infections in females in 1996 were among African American women; the second largest increase for females was among Hispanic women.
- Outreach to HIV-infected people of color must be expanded in order to ensure early linkages to the health care system. Delayed access to care accounts for much of the disparity in health outcomes for historically underserved racial and ethnic minority communities.
- In 1996, 3% of all individuals tested by Title III grantees were HIV positive; for the homeless, this rate was 8%. The rate for the US population at large was 0.26% to 0.36%.
- The return rate in 1996 for post-counseling among those who tested positive for HIV was 99%. This remarkably high return rate reflects the effective results from aggressive outreach by Title III grantees.
- In 1998, the National Medical Association stated that African Americans are more likely to receive treatment when an AIDS-related infection requires hospitalization, and that significant numbers of African Americans are diagnosed with AIDS within one month of their death. In both rural and urban areas, Title III providers are critical to efforts to increase the early diagnosis and treatment of HIV within the African-American community.
- Based on 1996 data, Title III grantees are targeting high risk populations, such as:
  - the incarcerated population
  - homeless persons
  - runaway youth
  - injecting drug users (IDUs)
  - migrants
  - women and children

Communities in Need -- Unfunded Grants for Underserved Areas

For FY 2000, the CAEAR Coalition seeks an increase of $11 million for unfunded grants to underserved communities.

- The federal government has already approved over $11 million in grants to 28 qualified Title III applicants, but cannot fund these applications due to a lack of appropriations.
- These qualified, but unfunded, applicants are located in rural and underserved urban areas. A total of 23% of Title III programs report being the only HIV medical outpatient program in their area.
- Approximately 50% of all currently funded Title III providers are located in rural areas.

Increasing Cost of Social Services

For FY 2000, the CAEAR Coalition seeks an increase of $7 million for the increasing costs of providing social support services.

- Title III grantees reported to the Health Resources and Services Administration (HRSA) that over $5 million was needed but not available for providing case management services to patients in 1996. In part, this was reflected in fewer clients being able to receive case management service in 1996 than in 1995.
- Title III grantees reported to HRSA that the costs of providing case management services increased by 55% per patient between 1995 and 1996. In part, this can be attributed to the following:
  - an emerging model of case management that stresses adherence to complex drug regimens;
  - a changing welfare and health care environment, requiring more time spent with patients on issues of benefits and entitlements;
  - changing health status of some patients who are considering entering the work force; and
  - housing needs for many Title III patients.

Complete citations of data sources are available upon request.

For further information, contact the CAEAR Coalition,
1413 K Street, NW, Suite 700, Washington, D.C. 20005, 202.789.3565, fax 202.789 4277; or
The Sheridan Group, 1808 Swann Street, NW, Washington, D.C., 20009, 202.462.7288, fax 202.786 1964

RYAN WHITE CARE ACT FUNDING FY 1996 -- FY 2000

(IN MILLIONS OF DOLLARS)

	Reauthorization (1996)	FY 1996 Final	FY 1997 Final	FY 1998 Final [c]	FY 1999 Community Request (+/- FY 98)	FY 1999 Presidential Budget Request [d] (+/- FY98)	FY 1999 Final (+/- FY 98)	FY 2000 Community Request (+/- FY99)	FY 2000 Presidential Budget Request (+/- FY99)
Title I	Title I is funded at "such sums as may be necessary" for the fiscal years 1996-2000.	391.7 (+35.2)	449.943 (+58.243)	464.736 (+14.793)	570.0 (+105.264)	488.974 (+24.238)	505.2[e] (+40.464)	625.0 (+119.8)	521.2 (+16.0)
Title II [ADAP]	Title II is funded at "such sums as may be necessary" for the fiscal years 1996-2000.	260.847 (+62.7)	416. 954 (+156.107) [167.0][b]	542.783 (+125.829) [285.5][b]	801.0 (+258.217) [458.5][b]	668.870 (+126.087) [385.5][b]	738.0 (+195.217) [461.0][b]	921.0 (+183.0) [n/a]	783.0 (+45.0) [496.0]
Title III	Title III is funded at "such sums as may be necessary" for the fiscal years 1996-2000.	56.918 (+4.6)	69.568 (+12.650)	76.211 (+6.643)	113.0 (+36.789)	86.154 (+9.943)	94.3[f] (+18.089)	134.0 (+39.7)	130.3 (+36.0)
Title IV	Title IV is funded at "such sums as may be necessary" for the fiscal years 1996-2000.	29.0 (+3.0)	36.0 (+7.0)	40.803 (+4.803)	61.0 (+20.197)	43.926 (+3.123)	46.0[g] (+5.197)	61.0 (+15.0)	48.0 (+2.0)
AIDS Education & Training Centers[a]	AETCs are funded at "such sums as may be necessary" for the fiscal years 1996-2000.	12.0	16.287 (+4.287)	17.216 (+0.929)	25.0 (+7.784)	17.271 (+0.055)	20.0[h] (+2.784)	25.0 (+5.0)	20.0 (+0.0)
Dental School Reimbursement Program[a]	Dental programs are funded at "such sums as may be necessary" for the fiscal years 1996-2000.	6.937	7.5 (+0.563)	7.763 (+0.263)	9.0 (+1.237)	7.787 (+0.024)	7.8 (+.037)	9.0 (+1.2)	8.0 (+0.2)
TOTALS		757.402 (+105.5)	996.252 (+238.850)	1149.512 (+153.26)	1,579.0 (+429.488)	1,312.982 (+163.47)	1411.3 (+261.788)	1775.0 (+363.7)	1510.5 (+99.2)

a -The AIDS Education and Training Centers (AETCs) and the Dental School Reimbursement programs were made part of the Ryan White CARE Act in FY 1996.
b -Amount of Title II funding either requested or allocated to be earmarked specifically for the AIDS Drug Assistance Program (ADAP).
c -The FY 1998 final allocation was adjusted mid-year to account for an across-the-board HHS administrative shave during FY 1998.
d -The FY 1999 Presidential budget request was adjusted to account for an across-the-board HHS administrative shave during FY 1998.
e -$5 million of the FY 1999 Title I allocation is earmarked to address underserved communities of people of color.
f - $3 million of the FY 1999 Title III allocation is earmarked to address underserved communities of people of color.
g -$2 million of the FY 1999 Title IV allocation is earmarked to address underserved communities of people of color.
h -$2 million of the FY 1999 allocation for Education and Training Centers is earmarked to address underserved communities of people of color.

S:\DOCUMENT\Caear99\Jan-March\rwcafundingchartFY2000CommunityRequest-PresidentBudget2.1.99.wpd

RYAN WHITE CARE ACT FUNDING FY 1991 -- FY 1995
(IN MILLIONS OF DOLLARS)

	Original Authorization (FY 91 & 92)	FY 1991	FY 1992[a] (+/- FY 91 funding)	FY 1993[b] (+/- FY 92 funding)	FY 1994 (+/- FY 93 funding)	FY 1995 (+/- FY 94 funding)
Title I	275.0	87.831	120.518 (+32.687)	184.757 (+64.239)	325.5 (+140.743)	356.5 (+31.0)
Title II	275.0	87.831	106.690 (+18.859)	115.288 (+8.598)	183.897 (+68.609)	198.147 (+14.25)
Title III (A) (B)	c 75.0	c 44.891	c 48.859 (+3.966)	c 47.968 (-0.891)	c 47.968 (+/- 0)	c 52.318 (+4.35)
Title IV	20.0[d]	0	0	0	22.0[e] (+6.0)	26.0 (+4.0)
TOTALS		220.533	275.067 (+54.534)	348.013 (+72.946)	579.365 (+231.352)	632.965 (+53.6)

a Revised FY 92 Appropriation with Administrative costs subtracted.
b Revised FY 93 Appropriations with Federal Consultants Services Reduction subtracted.
c Funding for testing and counseling provided under the Centers for Disease Control.
d Title IV's original authorization was $26.5 million plus certain provisions to be funded by "such sums necessary." The Pediatric Demonstration Grant portion of Title IV was originally authorized at $20.0 million.
e Includes $20.9 million in Pediatric Demonstration Grants separately appropriated prior to FY 94.

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

Ryan White CARE Act
Title I Eligible Metropolitan Area
42 Month AIDS Growth Chart

Eligible Metropolitan Area	Cumulative Total (December, 1994)	Cumulative Total (June, 1998)	42 Month % Growth Rate
Atlanta	8,858	13,753	55.26
Austin	2,335	3,348	43.38
Baltimore	6,915	11,824	70.99
Bergen-Passaic	3,292	4,880	48.24
Boston	8,252	11,759	42.50
Caugus	N/A	N/A	
Chicago	12,489	18,288	46.43
Cleveland	*	2,917	
Dallas	7,444	10,837	45.58
Denver	3,723	5,031	35.13
Detroit	4,358	6,632	52.18
Dutchess County	N/A	N/A	
Ft. Lauderdale	6,979	10,749	54.02
Ft. Worth	*	2,853	
Hartford	*	3,459	
Houston	11,414	16,860	47.71
Jacksonville	2,530	3,810	50.59
Jersey City/Hudson County	4,047	6,037	49.17
Kansas City	2,611	3,514	34.58
Las Vegas	*	3,047	
Los Angeles	27,247	37,886	39.05
Miami	14,050	20,743	47.64
Middlesex-Somerset-Hunterdon	*	2,911	
Minneapolis-St. Paul	*	2,893	
Nassau-Suffolk	3,938	5,924	50.43
New Haven -- Fairfield	3,355	5,765	71.83
New Orleans	3,867	6,013	55.50
New York	71,934	105,704	46.95
Newark	10,096	15,027	48.84
Norfolk	*	3,056	
Oakland	5,326	7,233	35.81
Orange County	3,523	4,943	40.31
Orlando	2,993	4,982	66.46
Philadelphia	9,897	15,564	57.26
Phoenix	2,715	4,085	50.46
Ponce	N/A	N/A	
Portland	2,492	3,459	38.80
Riverside -- San Bernardino	3,900	6,016	54.26
Sacramento	*	2,832	
San Antonio	2,255	3,497	55.08
San Diego	6,284	9,371	49.12
San Francisco	20,750	25,885	24.75
San Jose	*	2,813	
San Juan	8,790	13,525	53.87
Seattle	4,312	6,040	40.07
Sonoma	N/A	N/A	
St. Louis	2,773	4,074	46.92
Tampa -- St. Petersburg	4,845	7,184	48.28
Vineland-Millville-Bridgeton	N/A	N/A	
Washington	12,527	19,324	54.26
West Palm Beach	3,930	6,424	63.46

N/A Figures are unavilable due to confidentiality regulations. * This city was not yet an EMA in 1994.

For more information, please contact CAEAR Coalition, 1413 K Street, NW, Suite 700, Washington, DC 20005
202.789.3565 fax 202.789.4277

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

Ryan White CARE Act
Title I Eligible Metropolitan Area
Fiscal Year 1999 Awards

Eligible Metropolitan Area	FY '98 Awards	FY '99 Awards	+/-
Atlanta	$12,021,454	$13,147,268	$1,125,814
Austin	$2,856,752	$3,175,509	$318,757
Baltimore	$12,184,481	$13,478,549	$1,294,068
Bergen-Passaic	$4,354,291	$4,320,176	-$34,115
Boston	$9,463,130	$10,647,381	$1,184,251
Caugus	$1,405,197	$1,610,314	$205,117
Chicago	$15,995,512	$18,227,884	$2,232,372
Cleveland	$2,459,443	$2,933,058	$473,615
Dallas	$9,082,217	$10,164,078	$1,081,861
Denver	$4,278,161	$4,150,341	-$127,820
Detroit	$5,628,350	$6,585,744	$957,394
Dutchess County	$854,481	$1,220,662	$366,181
Ft. Lauderdale	$10,128,631	$10,810,324	$681,693
Ft. Worth	$2,618,024	$2,935,543	$317,519
Hartford	$3,613,029	$4,019,409	$406,380
Houston	$12,722,479	$15,489,996	$2,767,517
Jacksonville	$3,443,168	$3,683,146	$239,978
Jersey City/Hudson County	$5,320,300	$5,015,785	-$304,515
Kansas City	$2,622,409	$2,952,910	$330,501
Las Vegas	$0	$3,402,697	$3,402,697
Los Angeles	$30,637,106	$33,540,737	$2,903,631
Miami	$18,472,153	$21,248,387	$2,776,234
Middlesex-Somerset-Hunterdon	$2,597,923	$2,555,029	-$42,894
Minneapolis-St Paul	$2,570,712	$2,548,603	-$22,109
Nassau-Suffolk	$4,939,871	$5,632,012	$692,141
New Haven -- Fairfield	$5,348,730	$6,100,471	$751,741
New Orleans	$4,921,857	$5,695,360	$773,503
New York	$95,325,334	$96,961,856	$1,636,522
Newark	$12,630,257	$14,390,269	$1,760,012
Norfolk	$0	$3,665,087	$3,665,087
Oakland	$5,926,194	$6,218,532	$292,338
Orange County	$3,810,759	$4,300,690	$489,931
Orlando	$4,609,839	$4,907,180	$297,341
Philadelphia	$14,081,773	$16,011,451	$1,929,678
Phoenix	$3,412,037	$3,865,319	$453,282
Ponce	$2,200,114	$2,487,768	$287,654
Portland	$3,057,466	$3,115,251	$57,785
Riverside -- San Bernardino	$5,634,427	$6,463,388	$828,961
Sacramento	$2,389,370	$2,578,873	$189,503
San Antonio	$2,952,239	$3,014,654	$62,415
San Diego	$8,452,437	$8,872,685	$420,248
San Francisco	$36,394,914	$36,218,513	-$176,401
San Jose	$2,445,480	$2,486,136	$40,656
San Juan	$11,658,912	$11,912,865	$253,953
Seattle	$5,060,533	$5,303,343	$242,810
Sonoma	$1,225,807	$1,127,018	-$98,789
St. Louis	$3,561,850	$3,664,771	$102,921
Tampa -- St. Petersburg	$6,536,189	$7,236,728	$700,539
Vineland-Millville-Bridgeton	$594,001	$688,648	$94,647
Washington	$16,710,726	$18,322,558	$1,611,832
West Palm Beach	$5,965,481	$6,711,944	$746,463
TOTAL	$445,176,000	$485,816,900	$40,640,900

$0 This city was not yet an EMA in 1998.

For more information, please contact CAEAR Coalition, 1413 K Street, NW, Suite 700, Washington, DC 20005
202.789.3565 fax 202.789.4277

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

U.S. AIDS Cases Reported Through June, 1998
Ryan White CARE Act Eligible Metropolitan Areas (EMAs)
Eligible for Fiscal Year 1999 Funding

Eligible Metropolitan Area	Cumulative Total	% of U.S. Total
Atlanta	13,753	2.07
Austin	3,348	0.50
Baltimore	11,824	1.78
Bergen-Passaic	4,880	0.73
Boston	11,759	1.77
Caugus	N/A	
Chicago	18,288	2.75
Cleveland	2,917	0.44
Dallas	10,837	1.63
Denver	5,031	0.76
Detroit	6,632	1.00
Dutchess County	N/A	
Ft. Lauderdale	10,749	1.62
Ft. Worth	2,853	0.43
Hartford	3,459	0.52
Houston	16,860	2.53
Jacksonville	3,810	0.57
Jersey City/Hudson County	6,037	0.91
Kansas City	3,514	0.53
Las Vegas	3,047	0.46
Los Angeles	37,886	5.69
Miami	20,743	3.12
Middlesex-Somerset-Hunterdon	2,911	0.44
Minneapolis-St. Paul	2,893	0.43
Nassau-Suffolk	5,924	0.89
New Haven -- Fairfield	5,765	0.87
New Orleans	6,013	0.90
New York	105,704	15.89
Newark	15,027	2.26
Norfolk	3,056	0.46
Oakland	7,233	1.09
Orange County	4,943	0.74
Orlando	4,982	0.75
Philadelphia	15,564	2.34
Phoenix	4,085	0.61
Ponce	N/A	
Portland	3,459	0.52
Riverside -- San Bernardino	6,016	0.90
Sacramento	2,832	0.43
San Antonio	3,497	0.53
San Diego	9,371	1.41
San Francisco	25,885	3.89
San Jose	2,813	0.42
San Juan	13,525	2.03
Seattle	6,040	0.91
Sonoma	N/A	
St Louis	4,074	0.61
Tampa -- St. Petersburg	7,184	1.08
Vineland-Millville-Bridgeton	N/A	
Washington	19,324	2.90
West Palm Beach	6,424	0.97
Total All Reporting EMAs	492,771	74.06*
Total Nationwide	665,357	100.00

N/A Figures are unavilable due to confidentiality regulations. * Figure would be higher if cumulative totals for all EMAs were available.

For more information, please contact CAEAR Coalition, 1413 K Street, NW, Suite 700, Washington, DC 20005
202.789.3565 fax 202.789.4277

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

Ryan White CARE. Act -- Title I
FY 96 Expenditures for Drug Reimbursement and Medications

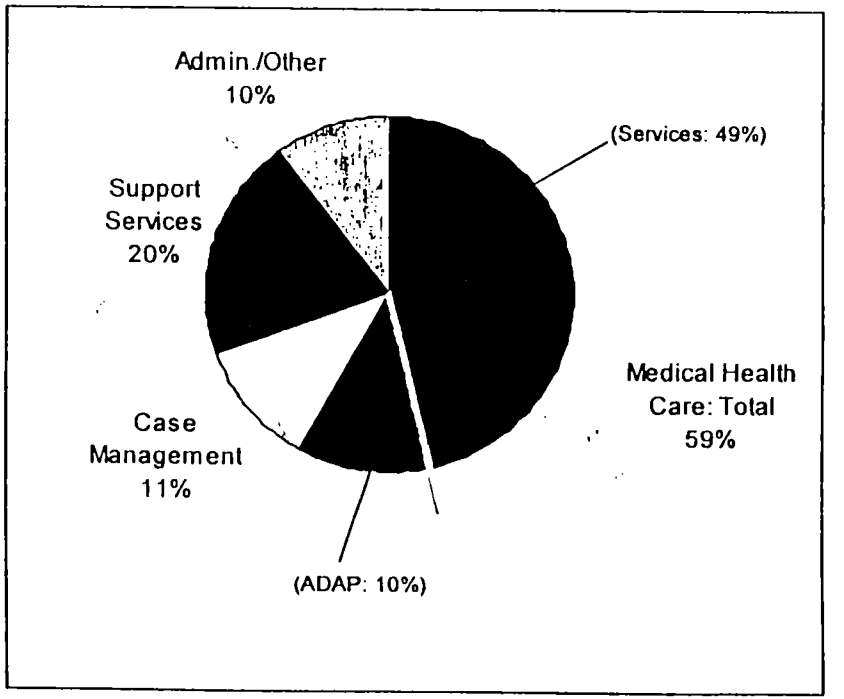
Eligible Metropolitan Area	Drug Reimbursement/Medications Expenditures
Atlanta	1,064,645
Austin	0
Baltimore	410,310
Bergen-Passaic	189,792
Boston	845,772
Caugus	206,113
Chicago	890,274
Cleveland	148,000
Dallas	30,000
Denver	381,661
Detroit	400,000
Dutchess County	0
Ft. Lauderdale	771,286
Ft. Worth	0
Hartford	212,000
Houston	681,233
Jacksonville	424,837
Jersey City	346,109
Kansas City	670,808
Los Angeles	2,508,817
Miami	1,694,865
Middlesex-Somerset-Hunterdon	225,000
Minneapolis-St. Paul	99,648
Nassau-Suffolk	0
New Haven -- Fairfield	230,056
New Orleans	101,554
New York	12,520,862
Newark	571,486
Oakland	0
Orange County	0
Orlando	363,224
Philadelphia	0
Phoenix	665,544
Ponce	746,724
Portland	24,800
Riverside -- San Bernardino	503,177
Sacramento	15,289
St. Louis	533,577
San Antonio	70,304
San Diego	129,228
San Francisco	0
San Jose	224,516
San Juan	2,185,118
Sonoma	33,000
Seattle	253,264
Tampa -- St. Petersburg	716,312
Vineland-Millville-Bridgeton	14,175
Washington	1,820,761
West Palm Beach	0
TOTAL	**$33,924,141 (9% of FY 96 Allocated Award)**

For more information, please contact CAEAR Coalition, 1413 K Street, NW, Suite 700, Washington, DC 20005
202.789.3565 fax 202.789.4277

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

1997 Ryan What CARE Act Title I Aggregate Allocations By Service Category and Percentage of Total Grant

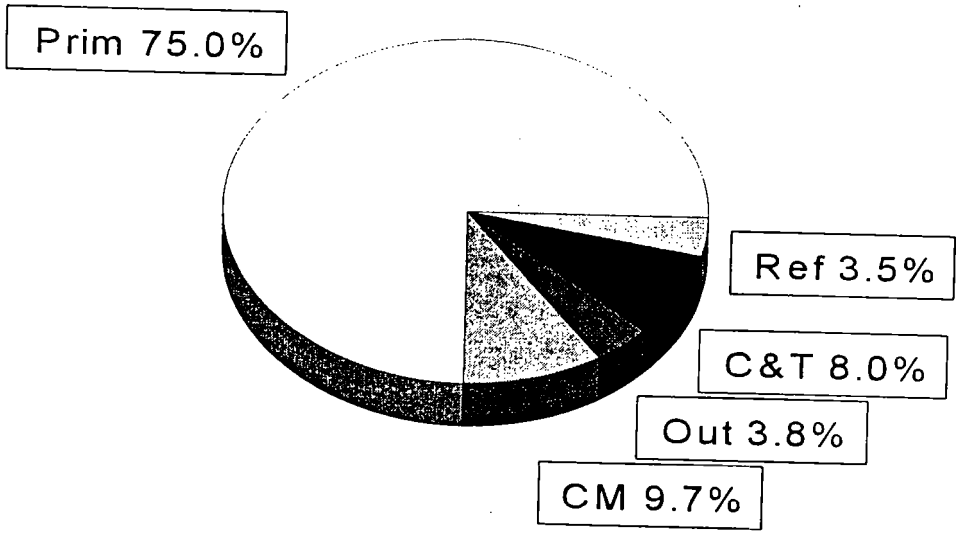
Service Category	Allocation
Medical Office Visits	$106,811,410
Substance Abuse Treatment	27,519,914
Mental Health Services	26,137,997
Home Health Care	16,168,635
Dental	12,094,813
Other Local Health Priorities	11,428,946
Hospice	4,406,081
Nutritional Services	1,359,926
Health Insurance Continuation	1,293,570
Rehabilitation	729,783
In-patient Services	368,081
Medical Health Care: Services	**$208,319,156**
AIDS Drug Assistance Program	$41,051,269
Medical Health Care: ADAP	**$41,051,269**
Case Management	$48,818,440
Case Management	**$48,818,440**
Housing	$23,764,978
Food Bank	17,680,014
Client Advocacy	9,430,658
Transportation	9,032,725
Direct Emergency Financial Assistance	6,604,307
Day Respite	6,269,079
Other Local Service Priorities	4,209,865
Buddy Services	3,264,191
Patient Outreach	2,128,873
Permanency Planning	2,115,853
Other Counseling	2,010,816
Health Education/Risk Reduction	106,459
Support Services	**$86,617,818**
Administrative Support	$43,152,533
Other	1,033,954
Admin./Other	**$44,186,487**
Total 1997 Award Allocated	**$428,993,170**



Source: Health Resources and Services Administration

For more information, please contact CAEAR Coalition, 1413 K Street, NW, Suite 700, Washington, DC 20005
202.789.3565 fax 202.789.4277

Title III Allocations for FY '97



- Primary Health Care
- Case Management
- Outreach Services
- Counseling & Testing
- Referrals

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

Ryan White CARE Act Title III Grantees By State and City/Town

State	Cities/Towns
Alaska	Anchorage
Alabama	Birmingham Hobson City Mobile Montgomery
Arizona	Phoenix Tucson
Arkansas	Pine Bluff
California	Bakersfield Guernville Long Beach Los Angeles Oakland Panorama City San Bernadino San Diego San Francisco San Jose San Marcos Santa Ana Santa Barbara Santa Cruz Stockton Ukiah Venice
Colorado	Denver
Connecticut	Bridgeport New Haven
Delaware	Wilmington
Florida	Fort Lauderdale Immokalee Key West Miami Miami Beach Pompano Beach West Palm Beach
Georgia	Albany Atlanta Augusta Brunswick Savannah Waycross
Idaho	Boise
Illinois	Chicago Peoria Rockford
Indiana	Indianapolis Richmond
Iowa	Davenport Des Moines Iowa City Sioux City
Kansas	Wichita
Kentucky	Paducah
Louisiana	Lake Charles New Orleans
Maine	Portland
Maryland	Baltimore
Massachusetts	Boston Dorchester East Boston Holyoke Lawrence New Bedford Roxbury Somerville Truro Worcester
Michigan	Ann Arbor Detroit Grand Rapids
Mississippi	Biloxi Marks
Missouri	Kansas City Springfield St. Louis
Montana	Billings
Nebraska	Omaha
Nevada	Las Vegas Reno
New Jersey	Hoboeken New Brunswick Newark Paterson Trenton
New Mexico	Albuquerque
New York	Albany Amityville Bronx Brooklyn Buffalo Elmhurst Far Rockaway New York City Ossining Peekskill Rochester Syracuse Yonkers
North Carolina	Asheville Durham
Ohio	Chillicothe Cincinnati Columbus
Oklahoma	Oklahoma City Tulsa
Oregon	Portland
Puerto Rico	Arrogo Bayamon

For more information, please contact CAEAR Coalition, 1413 K Street, NW, Suite 700, Washington, DC 20005
202.789.3565 fax 202.789.4277

Puerto Rico (cont'd)	Gurabo Humacao Lares Mayaguez Ponce Rio Piedras

Pennsylvania	Allentown Philadelphia Pittsburgh York
Rhode Island	Providence
South Carolina	Columbia Ridgeland
Tennessee	Rossville
Texas	Austin Dallas El Paso Fort Worth Harlingen Houston San Antonio
Utah	Salt Lake City
Vermont	Burlington
Virginia	Charlottesville Fairfax
Washington	Seattle Yakima
Washington, DC	District of Columbia
Wisconsin	Madison Milwaukee

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

Ryan White CARE Act
Title III Grantees
FY '97

Alaska

Anchorage	
Anchorage Neighborhood Health Center	$228,988
Total	**$228,988**

Alabama

Birmingham	
Jefferson County Commission/Cooper Green	$483,816
Hobson City	
AIDS Services Center	$335,725
Mobile	
Franklin Memorial Primary Halth Center	$320,970
Mobile County Health Dept./Family Hlth. Care Clinic	$407,607
Montgomery	
Montgomery AIDS Outreach/MAO Health Monitoring	$461,086
Total	**$2,009,204**

Arkansas

Pine Bluff	
Jefferson Comprehensive Care	$373,902
Total	**$373,902**

Arizona

Phoenix	
Maricope County Health System/McDowell Healthcare	$600,000
Tucson	
El Rio Santa Cruz Neighborhood Health Ctr.	$622,225
Kino Community Hospital	$132,072
Total	**$1,354,297**

California

Bakersfield	
Clinica Sierra Vista/34th St. Community Health Ctr.	$222,667
Guernville	
Russian River Health Center	$357,355
Long Beach	
Catholic Healthcare West/CARE Program	$487,750

For more information, please contact CAEAR Coalition, 1413 K Street, NW, Suite 700, Washington, DC 20005
202.789.3565 fax 202.789.4277

AIDS Healthcare Foundation	$530,756
AltaMed Health Services	$519,626
Goodman Special Care Clinic/LAGLSC	$600,000
Watts Health Fdn. South LA Comm. AIDS Program	$400,000
Oakland	
Tri-City Health Center/Alameda Health	$550,000
Panorama City	
Northeast Valley Health Corp./HIV/AIDS Programs	$380,699
San Bernardino	
San Bernadino County Department of Public	$371,298
San Diego	
Logan Heights Fam. Hlth. Ctr./North Park Fam. Hlth.	$564,874
Univ. of California San Diego Med. Ctr./Owen Clinic	$378,595
San Francisco	
San Francisco Community Clinic Consortium	$585,000
San Jose	
Santa Clara Cty. Health & Hosp. Syst./PACE Clinic	$584,136
San Marcos	
North County Health Services	$255,000
Santa Ana	
County of Orange Health Care Agency	$600,000
Santa Barbara	
Santa Barbara County Health Care Services	$314,640
Santa Cruz	
County of Santa Cruz Health Services	$363,299
Stockton	
Community Medical Centers	$283,974
Ukiah	
Mendocino Community Helath Clinic	$175,772
Venice	
Venice Family Clinic	$281,380
Total	**$8,806,821**

Colorado

Denver	
Denver Health and Hospitals	$600,000
Total	**$600,000**

Connecticut

Bridgeport	
Bridgeport Community Health Center	$292,329
Southwest Community Health Center	$329,351
New Haven	
Hill Health Center	$389,796
Total	**$1,011,476**

District of Columbia

Washington	
Family & Medical Counseling	$339,864
Unity Health Care	$499,980
Whitman-Walker Clinic	$392,441
Total	**$1,232,285**

Delaware

Wilmington	
Christiana Care Health Services	$373,634
Total	**$373,634**

Florida

Fort Lauderdale	
North Broward Hospital District	$434,615
Immokalee	
Colier Health Services	$309,975
Key West	
Monroe County Health Department	$420,298
Miami	
Economic Opportunity Family Health Ctr.	$763,325
University of Miami Sch. of Med./Dept. of OB-GYN	$521,836
Miami Beach	
Stanley C. Meyers Community Health Center	$237,745
Pompano Beach	
Sunshine Health Center	$500,000
W. Palm Beach	
Florida Community Health Centers	$424,057
Total	**$3,611,851**

Georgia

Albany	
Albany Area Primary Health/Rural HIV Model	$453,666
Atlanta	
Hemophilia of Georgia	$488,962
St. Joseph's Mercy Care/Mercy Mobile Health Program	$385,382
Augusta	
Medical Coll. of Georgia Dept. of Med./Infec. Dis. Div.	$467,921
Brunswick	
Glynn County Board of Health	$145,253
Savannah	
Chatham County Health Department	$463,388
Waycross	
Ware County Board of Health	$535,977
Total	**$2,940,549**

Iowa

Davenport	
Community Health Care/QCR Virology	$191,525
Received grants in subsequent years.	$0
Des Moines	
Primary Health Care/Broadlawns Med. Ctr.	$271,391
Iowa City	
University of Iowa	$24,830
Sioux City	
Siouxland Community Health Center	$228,000
Total	**$715,746**

Idaho

Bosie	
Family Practice Residency of Idaho	$295,575
Total	**$295,575**

Illinois

Chicago	
Cermack Health Services/Cook Cty. Board of	$227,574
Chicago Health Outreach	$624,250
City of Chicago Dept. of Health/STD/HIV Prev. Prog.	$478,000

Erie Family Health Ctr./Integrated Care Consortium		$291,798
Hektoen Inst. for Medical Rsrch./CORE Center		$553,197
Howard Brown Health Center		$492,193
Peoria		
Univ. of Ill. Coll. of Med./Heart of Ill. HIV/AIDS Ctr.		$380,846
Rockford		
Crusaders Central Clinic/Living with HIV Program		$353,450
	Total	**$3,401,308**

Indiana

Indianapolis		
Hlth. & Hosp. Corp. of Marion County/HIV/AIDS Prev.		$506,032
Richmond		
	Total	**$506,032**

Kansas

Wichita		
University of Kansas School of Medicine		$433,348
	Total	**$433,348**

Kentucky

Paducah		
Heartland Cares		$421,050
	Total	**$421,050**

Louisiana

Lake Charles		
Bayou Comprehensive Health Foundn./Ext.Svcs. Prog.		$348,300
New Orleans		
Charity Hospital Medical Center		$400,000
	Total	**$748,300**

Massachusetts

Boston		
Fenway Community Health Center		$473,761
Dorchester		
Harbor Health Services		$235,970
East Boston		

East Boston Neighborhood Health Center		$289,518
Holyoke		
Holyoke Health Center		$434,875
Lawrence		
Greater Lawrence Family Health Center		$339,250
New Bedford		
Gtr. New Bedford Comm. Health Ctr./HIV Early Intv.		$323,890
Roxbury		
Dimock Comm. Health Ctr. (NE Hosp.Corp.)		$459,953
Somerville		
Cambridge Health Alliance		$426,788
Family Planning Council		$412,650
Truro		
Outer Cape Health Services		$157,524
Worcester		
Family Health & Social Service Center		$312,928
	Total	**$3,867,107**

Maryland

Baltimore		
Chase-Brexton Health Services/Baltimore Consortium		$577,400
	Total	**$577,400**

Maine

Portland		
Received grants in subsequent years.		$0
	Total	**$0**

Michigan

Ann Arbor		
Regents of the University of Michigan		$277,125
Detroit		
Detroit Community Health Connection		$407,141
Wayne State Univ. Sch. of Medicine/Detroit Med. Ctr.		$575,075
Grand Rapids		
St. Mary's McAudey Health Center		$340,863
	Total	**$1,600,204**

Missouri

Kansas City	
Kansas City Free Health Clinic/Gtr. KC Early Intv.	$800,000
Springfield	
AIDS Project of the Ozarks	$396,002
St. Louis	
St. Louis Connect Care Infectious Disease Clinic	$309,974
Total	**$1,505,976**

Mississippi

Biloxi	
Marks	
Deporres Delta Ministries	$122,225
Total	**$122,225**

Montana

Billings	
Yellowstone City-County Health Dept./Dearing Clinic	$267,715
Total	**$267,715**

North Carolina

Asheville	
Western NC Community Health Services	$385,725
Durham	
Lincoln Comm. Hlth. Ctr./Durham Early Intv. Clinic	$354,417
Total	**$740,142**

Nebraska

Received grants in subsequent years.	$0
Omaha	
Total	**$0**

New Jersey

Hoboeken	
Franciscan Health Center	$332,370
New Brunswick	
Eric B. Chandler Health Center-UMDNJ	$335,431
Newark	

Newark Community Health Centers	$700,000
St. Michael's Med. Ctr./Div. of Infectious Disease	$481,392
Univ. of Med. & Dent. of NJ/Infectious Disease Clinic	$440,000
Paterson	
St. Joseph's Hospital & Med. Ctr./Comp. Care Ctr.	$497,158
Trenton	
Barnert Memorial Hospital	$215,970
Helene Fuld Med. Ctr./Mercer Area Early Intv. Svcs.	$595,225
Total	**$3,597,546**

New Mexico

Albuquerque	
Univ. of New Mexico-Univ. Hospital/Partners in Care	$499,778
Total	**$499,778**

Nevada

Las Vegas	
University Med. Ctr. of Southern Nevada	$552,371
Reno	
Northern Nevada HOPES	$328,215
Washoe County District Health Dept./Early Intervention	$305,990
Total	**$1,186,576**

New York

Albany	
Albany Med. Coll. AIDS Prog./Mid-Hudson HIV Care	$451,262
Whitney M. Young Jr. Health Ctr./CHEER Program	$220,225
Amityville	
Suffolk County Dept. of Health Services	$145,500
Bronx	
Bronx Community Health Network	$495,061
Bronx Lebanon Hospital	$407,543
Montefiore Med. Ctr./AIDS Ambulatory Care	$540,312
Morris Heights Health Center	$765,000
NARCO Freedom Neighborhood/Family Comm. Health	$550,000
Brooklyn	
Brooklyn Hospital Center	$400,000
Brooklyn Plaza Med. Ctr./Rising Heights Program	$338,145
Cumberland Neigh. Fam. Care Ctr./(NYC Hosp.)	$470,450

Luthern Med. Ctr./Sunset Park Family Health Ctr.		$359,742
STAR Clinic/Health Secience Ctr. at Brooklyn		$558,964
Buffalo		
Erie County Medical Center/AIDS Designated Center		$522,562
Elmhurst		
Elmhurst Hospital Center		$500,000
Far Rockaway		
Joseph P. Addabbo Family Health Center		$200,722
New York City		
Belances Health Unit		$400,000
Boniken Neighborhood Health Ctr./East Harlem		$398,508
Care for the Homeless		$475,000
Community Healthcare Network		$480,614
NYU Medical Center/Dept. of Pediatrics/Lower NY		$536,768
Renaissance Health Care Network/(NYC Hosp.)		$485,000
Settlement Health and Medical Services		$190,000
St. Clare's Hospital/The Spellman Center		$471,133
St. Luke's Roosevelt Hospital		$400,000
St. Vincent's Hospital & Medical Center		$550,000
William F. Ryan Community Health Center		$449,685
Ossining		
Ossining Open Door Health Center		$100,000
Peekskill		
Peekskill Area Health Center/Genesis Department		$300,000
Rochester		
Rochester Primary Care Net./Comm. Health Net.		$303,615
Syracuse		
Syracuse Counnity Health Center		$150,909
Yonkers		
Valentine Lane Family Practice		$152,632
	Total	**$12,769,352**

Ohio

Chillicothe	
Family Healthcare	$40,072
Cincinnati	
Cininnati Health Network/Univ. of Cincinnati	$621,591
Columbus	
Ross County Health District	$52,285

Total	**$713,948**

Oklahoma

Oklahoma City	
Univ. of Oklahmoa College of Medicine	$428,894
Tulsa	
Oklahoma State Univ./Coll. of Osteopathic Med.	$404,513
Tulsa City/County Department of Health	$0
Total	**$833,407**

Oregon

Portland	
Muitnemah County Health Dept.	$559,692
Total	**$559,692**

Pennsylvania

Allentown	
Lehigh Valley Hospital	$325,725
Philadelphia	
Allegheny Univ. of the Health Sciences	$400,000
ChesPenn Health Services	$368,382
City of Philadelphia Dept. of Public Helath/AACO-El	$600,000
Greater Philadelphia Health Action	$534,727
The Graduate Hospital/Ambulatory Care Services	$277,764
Pittsburgh	
Univ. of Pittsburgh Med. Ctr./Off of Research	$549,296
York	
York Health Corp.,YHESS! Clinic	$258,947
Total	**$3,314,841**

Puerto Rico

Arrogo	
Bayamon	
Municipality of Bayamon/Epi. Ctr. of Bayamon	$500,000
Gurabo	
Gurabo Community Health Center	$260,750
Humacao	
Ryder Memorial Hospital	$458,076
Lares	

Centro de Salud de Lares	$567,225
Mayaguez	
Migrant Health Ctr., W. Reg./Programme SSIMA	$611,850
Ponce	
Consejo de Salud de la Commudad/Diag. & Treat. Ctr.	$659,955
Rio Piedras	
Puerto Rico CoNCRA	$533,209
Total	**$3,591,065**

Rhode Island

Providence	
The Miriam Hospital	$280,195
Total	**$280,195**

South Carolina

Columbia	
Richland Community Health Care Assn.	$320,000
Ridgeland	
Beaufort-Jasper Comprehensive Health Service	$399,655
Total	**$719,655**

Tennessee

Rossville	
Received grants in subsequent years.	$0
Total	**$0**

Texas

Austin	
Austin Hlth. and Hum. Svcs. Dept./Travis County	$491,155
Dallas	
Dallas Cty. Hosp. Dist./Comm. Oriented Primary Care	$354,862
El Paso	
Centro de Salud Famillar La Fe	$399,161
Fort Worth	
Tarrant County Hospital District	$524,686
Harlingen	
Valley AIDS Council/CASE Project	$423,480
Houston	
Harris County Hospital District	$490,002

San Antonio	
El Centro del Barrio/South Park Medical Care Center	$424,071
Total	**$3,107,417**

Utah

Salt Lake City	
Community Health Centers	$375,000
Univ. of Utah Sch. of Med./Div. of Infectious Dis.	$397,225
Total	**$772,225**

Virginia

Charlottesville	
University of Virginia	$343,025
Fairfax	
INOVA Health Systems	$400,000
Total	**$743,025**

Vermont

Bulington	
Fletcher Allen Health Care	$333,746
Total	**$333,746**

Washington

Seattle	
Country Doctor Community Health Center	$408,368
Harborview Med. Ctr./Madison Clinic	$366,070
Yakima	
Yakima Valley Farm Workers Clinic/New Hope	$296,820
Total	**$1,071,258**

Wisconsin

Madison	
University of Wisconsin, Madison	$359,774
Milwaukee	
Milwaukee Health Services/Isaac Coggs Health	$455,025
Total	**$814,799**

GOVERNMENT AND PUBLIC RELATIONS

THE Sheridan GROUP

FAX TRANSMITTAL

DATE: 9/8/99

TO: Sandy Thurman

FAX #: 456-2438

FROM: Jennifer Drazek

9 PAGES INCLUDING COVER SHEET

NOTE:

Per Tom's request-for you.

Thanks!

1808 SWANN STREET NW ▪ WASHINGTON DC 20009

phone 202.462.7288 *fax* 202.483.1964 *e-mail:administration@* sheridangroupdc.com

MEMORANDUM

TO: DAVID BEIER, CHIEF DOMESTIC POLICY ADVISER TO THE VICE PRESIDENT

CARE OF: ANDREW SCHNEIDER

FROM: GRAYSON FOWLER, THE SHERIDAN GROUP

RE: REQUEST FOR AN APPOINTMENT WITH THE VICE PRESIDENT ON SEPTEMBER 16, 1999

DATE: AUGUST 11, 1999

This memorandum is a follow-up to a conversation I had today with Andrew Schneider regarding the possibility of the Executive Committee of Cities Advocating Emergency AIDS Relief (CAEAR) meeting with the Vice President on Thursday, September 16, 1999. At Andrew's suggestion, I sent the attached memo to Lisa Berg requesting a meeting.

The Sheridan Group represents CAEAR which is a national coalition of advocates for people living with HIV/AIDS who receive services under Title I and Title III of the Ryan White CARE Act. Members of the CAEAR coalition will be in town to participate in federal advocacy efforts regarding budget/appropriations for Title I and Title III of the CARE Act and regarding reauthorization of the act. The coalition's Executive Committee is eager to discuss these issues with the Vice President and to thank him for his support for AIDS funding. Tom Sheridan and I would greatly appreciate your assistance in arranging a meeting on Thursday, September 16 at the Vice President's convenience. If he is unable to meet with the Executive Committee, we hope we could persuade you to fill in.

The following members of the CAEAR Executive Committee will be able to participate in the meeting:

- Matthew McClain, Chair, CAEAR; AIDS Policy Advisor, Philadelphia Dept. of Health; President, Public Health Policy and Planning
- Suzi Rodriguez, Vice Chair, CAEAR; Los Angeles County HIV Drug & Alcohol Task Force; Commissioner, LA County Commission on HIV Health Services; Professor, Cypress College
- Daryl Flynn, Commissioner, LA County Commission on HIV Health Services; Co-Chair,

1808 SWANN STREET NW ▪ WASHINGTON DC 20009
phone 202 462 7285 fax 202 483 1964

LA County HIV Drug and Alcohol Task Force; Co-Chair, Client Committee, LA County HIV-DATF; Chair, San Gabriel Valley AIDS Consortium

- Gene Copello, Executive Director, Northeast Florida AIDS Network
- Matt Hamilton, New York City Office of the Mayor, Health Services Planning and Policy Coordination; Member, New York State Dept. of Health ADAP Steering Committee; Member, New York State Dept. of Health Statewide AIDS Service Delivery Consortium
- Ernest Hopkins, former Chair, CAEAR; Chair, Policy Committee, CAEAR; Director of Federal Affairs, San Francisco AIDS Foundation; Member, Dept. of Health and Human Services Office of Minority Health Working Group on HIV/AIDS; Member, NORA Ryan White Reauthorization Committee; Advocacy Chair, Board of Directors, National AIDS Housing Coalition; former Chair, Metropolitan Washington Regional HIV Health Services Planning Council
- Jacque Muther, Treasurer, CAEAR; Director, Pediatric/Adolescent HIV/AIDS Program, Infectious Disease Program, Grady Health System, Atlanta; Member, Metropolitan Atlanta HIV Health Services Planning Council
- David Reznik, Secretary, CAEAR; Director, Oral Health Center, Infectious Disease Program, Grady Health System, Atlanta; President, HIVdent; Dental Director, Southeast AIDS Training and Education Center (AETC); Chair, Dental Care Task Force, Metropolitan Atlanta HIV Health Services Planning Council
- Pat Bass, Co-Director, AIDS Activities Coordinating Office, Philadelphia Dept. of Health
- Tracy Fischman, Director for Policy and Legislative Affairs, Division of STD/HIV/AIDS Public Policy and Programs, Chicago Dept. of Health
- Herb Schultz, Director of Public Policy, AIDS Project Los Angeles (APLA); Co-Chair, AIDS Action Council Public Policy Committee

Jennifer Drazek of The Sheridan Group will be arranging this appointment as well as a number of other appointments for coalition members. Jennifer or Tom may be reached at (202) 462-7288. We are very grateful for your and Andrew's assistance and the Vice President's consideration.

MEMORANDUM

TO: JUDY, OFFICE OF EARL FOX, ADMINISTRATOR,
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

FROM: GRAYSON FOWLER, THE SHERIDAN GROUP

RE: APPOINTMENT WITH EARL FOX ON
SEPTEMBER 16, 1999

DATE: AUGUST 11, 1999

This memorandum is a follow-up to our conversation today regarding the possibility of the Executive Committee of Cities Advocating Emergency AIDS Relief (CAEAR) meeting with Dr. Fox on September 16, 1999. Members of the CAEAR coalition will be in town to participate in federal advocacy efforts regarding budget/appropriations for Title I and Title III of the Ryan White CARE Act and regarding reauthorization of the act. The coalition's Executive Committee is eager to discuss these issues with Dr. Fox and would greatly appreciate your assistance in arranging a meeting on Thursday, September 16 at his convenience. For logistical reasons, the Executive Committee would appreciate as well if Dr. Fox could meet with them at the Hubert H. Humphrey Building downtown.

The following members of the CAEAR Executive Committee will be able to participate in the meeting:

- Matthew McClain, Chair, CAEAR; AIDS Policy Advisor, Philadelphia Dept. of Health; President, Public Health Policy and Planning
- Suzi Rodriguez, Vice Chair, CAEAR; Los Angeles County HIV Drug & Alcohol Task Force; Commissioner, LA County Commission on HIV Health Services; Professor, Cypress College
- Daryl Flynn, Commissioner, LA County Commission on HIV Health Services; Co-Chair, LA County HIV Drug and Alcohol Task Force; Co-Chair, Client Committee, LA County HIV-DATF; Chair, San Gabriel Valley AIDS Consortium
- Gene Copello, Executive Director, Northeast Florida AIDS Network
- Matt Hamilton, New York City Office of the Mayor, Health Services Planning and Policy Coordination; Member, New York State Dept. of Health ADAP Steering Committee; Member, New York State Dept. of Health Statewide AIDS Service Delivery Consortium

1808 SWANN STREET NW ▪ WASHINGTON DC 20009
phone 202 462 7289 fax 202 483.1964

- Ernest Hopkins, former Chair, CAEAR; Chair, Policy Committee, CAEAR; Director of Federal Affairs, San Francisco AIDS Foundation; Member, Dept. of Health and Human Services Office of Minority Health Working Group on HIV/AIDS; Member, NORA Ryan White Reauthorization Committee; Advocacy Chair, Board of Directors, National AIDS Housing Coalition; former Chair, Metropolitan Washington Regional HIV Health Services Planning Council
- Jacque Muther, Treasurer, CAEAR; Director, Pediatric/Adolescent HIV/AIDS Program, Infectious Disease Program, Grady Health System, Atlanta; Member, Metropolitan Atlanta HIV Health Services Planning Council
- David Reznik, Secretary, CAEAR; Director, Oral Health Center, Infectious Disease Program, Grady Health System, Atlanta; President, HIVdent; Dental Director, Southeast AIDS Training and Education Center (AETC); Chair, Dental Care Task Force, Metropolitan Atlanta HIV Health Services Planning Council
- Pat Bass, Co-Director, AIDS Activities Coordinating Office, Philadelphia Dept. of Health
- Tracy Fischman, Director for Policy and Legislative Affairs, Division of STD/HIV/AIDS Public Policy and Programs, Chicago Dept. of Health
- Herb Schultz, Director of Public Policy, AIDS Project Los Angeles (APLA); Co-Chair, AIDS Action Council Public Policy Committee

Jennifer Drazek of The Sheridan Group will be arranging this appointment as well as a number of other appointments for coalition members. She may be reached at (202) 462-7288. Thank you very much for your assistance.

S:\CAEAR99\July-Sept\Request9-16M\gWithEarlFax8-11-99.wpd

MEMORANDUM

TO: SECRETARY DONNA E. SHALALA

FROM: JENNIFER DRAZEK, THE SHERIDAN GROUP

RE: APPOINTMENT WITH SECRETARY SHALALA – SEPTEMBER 16, 1999

DATE: AUGUST 19, 1999

This memorandum is regarding the possibility of the Executive Committee of Cities Advocating Emergency AIDS Relief (CAEAR) meeting with Secretary Shalala on September 16, 1999. Members of the CAEAR coalition will be in town to participate in federal advocacy efforts regarding appropriations for Title I and Title III of the Ryan White CARE Act and reauthorization of the act. The coalition's Executive Committee is eager to discuss these same issues with the Secretary and would greatly appreciate your assistance in arranging a meeting on Thursday, September 16 at the Secretary's convenience.

The following members of the CAEAR Executive Committee will be able to participate in the meeting:

- Matthew McClain, Chair, CAEAR; AIDS Policy Advisor, Philadelphia Dept. of Health; President, Public Health Policy and Planning
- Suzi Rodriguez, Vice Chair, CAEAR; Los Angeles County HIV Drug & Alcohol Task Force; Commissioner, LA County Commission on HIV Health Services; Professor, Cypress College
- Daryl Flynn, Commissioner, LA County Commission on HIV Health Services; Co-Chair, LA County HIV Drug and Alcohol Task Force; Co-Chair, Client Committee, LA County HIV-DATF; Chair, San Gabriel Valley AIDS Consortium
- Gene Copello, Executive Director, Northeast Florida AIDS Network
- Matt Hamilton, New York City Office of the Mayor, Health Services Planning and Policy Coordination; Member, New York State Dept. of Health ADAP Steering Committee; Member, New York State Dept. of Health Statewide AIDS Service Delivery Consortium

1808 SWANN STREET NW ▪ WASHINGTON DC 20009
phone 202.462.7288 *fax* 202.483.1964

- Ernest Hopkins, former Chair, CAEAR; Chair, Policy Committee, CAEAR; Director of Federal Affairs, San Francisco AIDS Foundation; Member, Dept. of Health and Human Services Office of Minority Health Working Group on HIV/AIDS; Member, NORA Ryan White Reauthorization Committee; Advocacy Chair, Board of Directors, National AIDS Housing Coalition; former Chair, Metropolitan Washington Regional HIV Health Services Planning Council
- Jacque Muther, Treasurer, CAEAR; Director, Pediatric/Adolescent HIV/AIDS Program, Infectious Disease Program, Grady Health System, Atlanta; Member, Metropolitan Atlanta HIV Health Services Planning Council
- David Reznik, Secretary, CAEAR; Director, Oral Health Center, Infectious Disease Program, Grady Health System, Atlanta; President, HIVdent; Dental Director, Southeast AIDS Training and Education Center (AETC); Chair, Dental Care Task Force, Metropolitan Atlanta HIV Health Services Planning Council
- Pat Bass, Co-Director, AIDS Activities Coordinating Office, Philadelphia Dept. of Health
- Tracy Fischman, Director for Policy and Legislative Affairs, Division of STD/HIV/AIDS Public Policy and Programs, Chicago Dept. of Health
- Herb Schultz, Director of Public Policy, AIDS Project Los Angeles (APLA); Co-Chair, AIDS Action Council Public Policy Committee

I will be arranging this appointment as well as a number of other appointments for coalition members. I may be reached at (202) 462-7288. As always, we are very grateful for your assistance and the Secretary's.

MEMORANDUM

TO: TODD SUMMERS, DEPUTY DIRECTOR
OFFICE OF NATIONAL AIDS POLICY

FROM: GRAYSON FOWLER, THE SHERIDAN GROUP

RE: APPOINTMENT WITH DAN MENDELSON --
SEPTEMBER 16, 1999

DATE: AUGUST 11, 1999

This memorandum is a follow-up to our conversation today regarding the possibility of the Executive Committee of Cities Advocating Emergency AIDS Relief (CAEAR) meeting with Dan Mendelson on September 16, 1999. Members of the CAEAR coalition will be in town to participate in federal advocacy efforts regarding appropriations for Title I and Title III of the Ryan White CARE Act and reauthorization of the act. The coalition's Executive Committee is eager to discuss these same issues with Dan Mendelson and would greatly appreciate your assistance in arranging a meeting on Thursday, September 16 at Dan's convenience.

The following members of the CAEAR Executive Committee will be able to participate in the meeting:

- Matthew McClain, Chair, CAEAR; AIDS Policy Advisor, Philadelphia Dept. of Health; President, Public Health Policy and Planning
- Suzi Rodriguez, Vice Chair, CAEAR; Los Angeles County HIV Drug & Alcohol Task Force; Commissioner, LA County Commission on HIV Health Services; Professor, Cypress College
- Daryl Flynn, Commissioner, LA County Commission on HIV Health Services; Co-Chair, LA County HIV Drug and Alcohol Task Force; Co-Chair, Client Committee, LA County HIV-DATF; Chair, San Gabriel Valley AIDS Consortium
- Gene Copello, Executive Director, Northeast Florida AIDS Network
- Matt Hamilton, New York City Office of the Mayor, Health Services Planning and Policy Coordination; Member, New York State Dept. of Health ADAP Steering Committee; Member, New York State Dept. of Health Statewide AIDS Service Delivery Consortium

1808 SWANN STREET NW ▪ WASHINGTON DC 20009
phone 202 462 7268 fax 202 483 1964

- Ernest Hopkins, former Chair, CAEAR; Chair, Policy Committee, CAEAR; Director of Federal Affairs, San Francisco AIDS Foundation; Member, Dept. of Health and Human Services Office of Minority Health Working Group on HIV/AIDS; Member, NORA Ryan White Reauthorization Committee; Advocacy Chair, Board of Directors, National AIDS Housing Coalition; former Chair, Metropolitan Washington Regional HIV Health Services Planning Council
- Jacque Muther, Treasurer, CAEAR; Director, Pediatric/Adolescent HIV/AIDS Program, Infectious Disease Program, Grady Health System, Atlanta; Member, Metropolitan Atlanta HIV Health Services Planning Council
- David Reznik, Secretary, CAEAR; Director, Oral Health Center, Infectious Disease Program, Grady Health System, Atlanta; President, HIVdent; Dental Director, Southeast AIDS Training and Education Center (AETC); Chair, Dental Care Task Force, Metropolitan Atlanta HIV Health Services Planning Council
- Pat Bass, Co-Director, AIDS Activities Coordinating Office, Philadelphia Dept. of Health
- Tracy Fischman, Director for Policy and Legislative Affairs, Division of STD/HIV/AIDS Public Policy and Programs, Chicago Dept. of Health
- Herb Schultz, Director of Public Policy, AIDS Project Los Angeles (APLA); Co-Chair, AIDS Action Council Public Policy Committee

Jennifer Drazek of The Sheridan Group will be arranging this appointment as well as a number of other appointments for coalition members. She may be reached at (202) 462-7288. As always, we are very grateful for your assistance and Dan's.

S:\CAEAR99\July-Sept\Request9-16MtgWithDanMendelson8-11-99.wpd

December 29, 1999

Mr. Matthew McClain
Chair
The CAEAR Coalition
Suite 700
1413 K Street, N.W.
Washington, D.C. 20005

Dear Matthew:

Thank you for your letter regarding funding for the Ryan White Care Act in my fiscal 2001 budget. I appreciate knowing your thoughts on this important issue, and I've forwarded your correspondence to Sandra Thurman, of my National AIDS Policy Office, and Chris Jennings, my health care policy advisor.

As you may already be aware, in recent budget negotiations for the fiscal 2000 budget, we secured an increase of $183 million for the Ryan White CARE Act. As we work to develop a fiscal 2001 budget that meets the critical health needs of all of our citizens, I will keep your thoughts in mind. Best wishes.

Sincerely, BILL CLINTON

BC/JHC/DA/DC/emu-lynn-ckb (Corres. #7052351)
(12.mcclain.m)

cc: Sandy Thurman, 736 Jackson Place, w/copy of inc.
cc: Chris Jennings, DPC
cc: John Corcoran, 97 OEOB

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

The CAEAR Coalition
1413 K Street N.W.
Suite 700
Washington, DC
20005

T 202 789 3565
F 202 789 4277

CAEARinDC@aol.com

September 13, 1999

The Honorable William Jefferson Clinton
President
The White House
Washington, D.C. 20500

Dear President Clinton:

Cities Advocating Emergency AIDS Relief (CAEAR) Coalition is a national grassroots organization advocating on behalf of people living with HIV/AIDS who depend on Title I and Title III of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act for health care and support services. We include members of Title I planning councils, people living with HIV/AIDS, community-based AIDS service organizations, providers of HIV/AIDS health care, CARE Act grantees, and consortia. We are civic and business leaders, lesbians and gay men, health care providers, members of religious organizations, government representatives, local public health officials, drug treatment and mental health providers, and representatives from diverse communities of color.

We write to you today to ask that the Administration request FY 2001 budget increases for all CARE Act programs, and in particular, we strongly urge you to include in the Administration's FY 2001 budget a request to Congress for $635 million in funding for Title I of the CARE Act and $184 million in funding for Title III of the CARE Act. These levels represent increases over FY 1999 of $130 million for Title I and $90 million for Title III.

The HIV Cost and Services Utilization Study (HCSUS) performed for the Department of Health and Human Services by RAND has revealed important new findings. HCSUS shows that despite the development of comprehensive systems of care, and the ongoing expansions in access to care and treatment for people living with HIV/AIDS, people of color -- especially African-Americans -- continue to experience widespread and significant levels of disparity in access to care, service utilization, service quality, and outcome of care. HCSUS estimates that 250,000 to 300,000 individuals who know they are HIV-positive remain outside systems of medical care and treatment.

Funding levels consistently below community needs have limited Title I access, the emergency safety net for an estimated 74 percent of people in the U.S. diagnosed with AIDS. This persistent lack of resources has prevented Title I areas from providing access to the full complement of

SEP 21 1999

services needed by individuals in care. The aggregate funding request of Title I communities in FY 1999 was $570 million, while actual Title I funding fell $65 million short. In FY 1999, seven Title I areas lost funding as compared to the previous year. Despite modest increases in CARE Act funding overall, some (though not always the same) Title I communities have lost funding in four of the last five fiscal years as compared with their previous year funding.

The 51 Title I eligible metropolitan areas and the 197 Title III funded community-based health centers are critical components of the comprehensive care systems developed by local communities through the CARE Act. Both Title I systems and Title III programs provide high quality medical and support services for individuals living with HIV/AIDS -- approximately two-thirds of whom are people of color.

Women composed one-third of the 96,000 clients of Title III programs seen in FY 1998, accessing early intervention services for HIV disease in existing primary medical care centers. One quarter of the Title III sites represent the only HIV medical program in their areas, many of which are located in geographically isolated and underserved communities. Yet funding shortages in FY 1999 prevented 28 qualified community-based health centers from receiving Title III grants last year.

The persistent disparities among communities of color, aggravated by these acute funding shortages, demand innovative responses from both the Title I systems and Title III providers. These disparities suggest the need to create new heath care infrastructure and capacity for underserved communities and to apply additional resources to novel, targeted approaches to health care outreach, and medical and supportive services in both Title I areas and Title III communities.

Our goal for FY 2001 is to create new, high-quality HIV/AIDS medical infrastructure and capacity for underserved communities where it does not now exist, and to increase the quality of care, infrastructure, and capacity of existing minority providers. That goal, we believe, requires $50 million in additional funding for Title I and $30 million in additional funding for Title III.

New data from the Centers for Disease Control and Prevention (CDC) demonstrates that the recent reductions in death rates have leveled off and that the number of individuals dying – especially in communities of color -- is on the increase. Meanwhile, the CDC estimates that the overall rate of HIV infection in the United States remains unchanged at 40,000 individuals diagnosed annually. Each of these individuals must receive initial medical evaluations, including expensive viral load testing to determine the appropriate course of treatment. In addition, many of these individuals have other severe health, social, and economic problems that complicate their ability to manage their HIV disease and that require additional medical and social services.

As the resulting complexity of HIV care increases, the cost of providing high-quality care escalates as well. A 1998 CAEAR coalition study showed an 89.3 percent increase from 1995 to 1997 in the average cost of HIV medical care. This is partly the result of the advent of combination therapies, which have placed significant pressure on Title I areas and Title III communities to assure access to these drugs. Medications, however, cannot be provided outside the context of overall primary care, including education about adherence to combination drug regimens. Failure to take these medications as prescribed runs the risk of rapid development of resistant viral strains. These changes in standard practices for providing HIV care increase the time needed for each medical visit. The 1998 CAEAR study also showed that from 1995 to 1997 the average length of medical visits increased 65 percent.

Multiple challenges have presented themselves to Title I and Title III communities as a result of the new medications. Several overlapping trends are occurring. Overall annual rates of new HIV infections are continuing at 40,000 new infections per year. HIV-related deaths, while initially declining dramatically, are inching back up -- especially in communities of color. This trend exacerbates the increasing numbers of people who are living with HIV/AIDS and seeking services for the first time as well as those who are in need of critical and expensive end stage care. Those clients in care that are receiving benefit from the medications need services for significantly longer than ever before and many in care are remaining significantly longer. A 1998 CAEAR Coalition study reveals an average increase of 43.5 percent in the number of HIV/AIDS patients between 1995 and 1997.

Other HIV service delivery pressures are also present. The same study revealed an average increase of 43.5 percent in the number of HIV/AIDS patients, an increase of 55.3 percent in patient visits, and a 27.4 percent increase in the number of visits per patient. These increases occurred as the rate of new HIV infections remained stable and the decline in HIV-related deaths -- after initially dramatic drops -- began to rise back up and create the need for expensive end-of-life care. As ever larger numbers of people with HIV/AIDS seek services, longer waits develop for outpatient, community-based care, and the threat of high-cost emergency room visits returns. As people live longer with AIDS, they continue to require essential medical and supportive services. Providing access for new clients is dependent upon new resources. With the availability of combination drug therapy, many people with HIV have sought care for the first time. The Health Resources and Services Administration (HRSA) estimates that 20 percent of Title I and Title III clients receiving services annually are clients.

In 1997, the U.S. Public Health Service issued guidelines on HIV treatment. Funding remains inadequate to assure the delivery of the standard of care required by these federal guidelines to all that need it. CAEAR believes that these guidelines should become the minimum standard of care and treatment nationally. Our goal in FY 2001 is to expand the number of new clients in Title I systems of care by 50 percent at a cost of $80 million and those receiving early intervention care at Title III sites by 30 percent at a cost of $60 million.

The AIDS epidemic has produced dangerous strains on our nation's public health systems. Hospitals have long reported average losses of $401 per day for each AIDS patient. As the burdens mount, responding to the needs of the AIDS epidemic grows more difficult and imperils our ability to meet all the other health needs in our communities. Heavily reliant upon resources from the entire CARE Act, our communities request that the Administration's budget include adequate funds for all CARE Act titles, as well as other federal AIDS efforts in prevention, housing, and research.

With funds provided under the Ryan White CARE Act, our communities can prolong the lives of people with AIDS, assist thousands in their quest to regain full function and productivity, and save the nation millions of dollars in unnecessary hospitalizations and other health care costs. With case-managed care such as that provided with Title I and Title III resources, patients have been shown to realize 46 percent lower hospitalization costs and live 66 percent longer than those individuals not receiving case-managed care. Proper care and supportive services improve the quality of life for people with HIV/AIDS and can enable many to remain working and contributing to their communities.

The AIDS emergency in the United States continues. People with HIV/AIDS, their caregivers, family, friends, and communities need your continued support.

Sincerely,

Matthew McClain
Chair
CAEAR Coalition

CAEAR Executive Committee

Patricia A. Bass
Philadelphia Department of Public Health
Philadelphia, Pennsylvania

Errol Chin-Loy
Mayor's Office of AIDS Policy Coordination
New York, New York

A. Gene Copello
Northeast Florida AIDS Network
Jacksonville, Florida

Harold Cox
City of Cambridge
Cambridge, Massachusetts

Tracy Fischman
Chicago Department of Public Health
Chicago, Illinois

Daryl Flynn
HIV Drug and Alcohol Task Force
Los Angeles, California

Susan Geissler
Office of the Mayor
Denver, Colorado

Matthew Hamilton
Mayor's Office of AIDS Policy Coordination
New York, New York

Patricia Hawkins
Whitman-Walker Clinic
Washington, District of Columbia

Eugenia Handler
Fenway Community Health Center
Boston, Massachusetts

Ernest Hopkins
San Francisco AIDS Foundation
San Francisco, California

Matthew McClain
Philadelphia Department of Public Health
Philadelphia, Pennsylvania

Jacqueline T. Muther
Grady Health System
Atlanta, Georgia

David Reznik, D.D.S.
HIVdent
Atlanta, Georgia

Suzi Rodriguez
HIV Drug and Alcohol Task Force
Los Angeles, California

Herb K. Schultz
AIDS Project Los Angeles
Los Angeles, California