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Evaluating
Recovery Services:
The California
Drug and Alcohol
Treatment Assessment
(CALDATA)

State of California
Pete Wilson, Governor

Health and Welfare Agency
Sandra R. Smoley, R.N., Secretary

State of California
Department of Alcohol and Drug Programs
Andrew M. Mecca, Dr.P.H., Director

National Opinion Research Center

Lewin-VHI, Inc.

Executive Summary

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

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August, 1994

Dear Colleagues:

Twenty-two years ago I was administering the drug treatment program in Vietnam. We did not know what worked then. Now we do! The recent California Outcome Study brought the most rigorous science ever applied to our treatment system and documented that treatment and recovery programs are a good investment.

In California, we have assumed that alcohol and other drug abuse treatment works. We have viewed it as an investment and not a cost. Recognizing the significant return on investment, economically, and in terms of social and individual opportunity, we asked the next question: Does treatment work well enough to justify the use of scarce public funds to help pay for it?

Governor Pete Wilson has taken this question very seriously. As Governor, he invested more than \$2 million in this landmark study of the effectiveness and benefits of alcohol and other drug abuse treatment. This monograph summarizes the most rigorous, retrospective outcome study ever conducted on drug abuse treatment. This scientific investigation documents the success of treatment and recovery.

In 1992, there were approximately 150,000 persons in treatment in California. A rigorous probability sample of 1900 were included in this study with follow-up covering as much as two years of treatment. This sample was drawn from all four major treatment modalities including therapeutic communities, social model, outpatient drug free and methadone maintenance.

Results indicate three major points. First, treatment is very cost beneficial to taxpayers. The cost benefit averages \$7 return for every dollar invested. Second, criminal activities significantly declined after treatment. In 1992, the cost of treating approximately 150,000 individuals was \$200 million. The benefits received during treatment and in the first year afterwards totaled approximately \$1.5 billion in savings. The largest savings were due to reductions in crime. Finally, significant improvements in health and corresponding reductions in hospitalizations were found during and after treatment. Emergency room admissions, for example, were reduced by one-third following treatment.

The next phase of our research will focus on extending these projections to cover lifetime benefits, and better recognizing cost-beneficial forms of treatment. This California study corroborates a number of smaller studies in the United States which prove that appropriate alcohol and other drug abuse treatment works. Treatment is a good investment!

Sincerely,



ANDREW M. MECCA, Dr.P.H.
Director

EVALUATING RECOVERY SERVICES:
THE CALIFORNIA DRUG AND ALCOHOL TREATMENT
ASSESSMENT
(CALDATA)

Executive Summary

Submitted to

State of California
Department of Alcohol and Drug Programs

by

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Copies of this report may be obtained by contacting:

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PURPOSE

Under the leadership of Governor Pete Wilson, the California Department of Alcohol and Drug Programs (CADP) launched an initiative, in 1992, to determine the epidemiology of substance abuse and the outcomes of substance abuse treatment. The California Drug and Alcohol Treatment Assessment (CALDATA) is the first product of this initiative. CALDATA is a pioneering large-scale study of the effectiveness, benefits, and costs of alcohol and drug treatment in California, using state data bases, provider records, and follow-up interviews with participants in treatment. CALDATA's primary source of information is a voluntary survey of publicly supported participants. CALDATA is the first follow-up interview study to use random sampling techniques with this population.

The purpose of CALDATA was to study:

- the effects of treatment on participant behavior;
- the costs of treatment; and
- the economic value of treatment to society.

The **effects of treatment** are the differences in behavior and experience reported by respondents before and after treatment. The **costs of treatment** were calculated from financial records collected directly from the providers involved in CALDATA. These cost figures have been verified for consistency with other data about these programs and are quite consistent with other study results on treatment costs. The **economic value of treatment** was based largely on the costs avoided due to reductions in the burden of crime and illness, as well as a careful review of shifts in income sources.

The California Department of Alcohol and Drug Programs in partnership with the National Opinion Research Center (NORC) at the University of Chicago and Lewin-VHI, Inc., conducted the study during the period of September, 1992 through March, 1994.

METHODS

Phase One

CALDATA gathered information in two phases. The first phase involved sampling counties, providers, and participants in four types of treatment programs in California. The treatment types include:

- Residential programs
- Residential "social model" programs in particular
- Outpatient programs
- Outpatient methadone

Participants were selected at random from discharge (or in-treatment) lists developed on site at cooperating providers. Sixteen counties, 97 providers, and approximately 3,000 participants who were in treatment or were discharged between October 1, 1991 and

September 30, 1992 were selected into the study sample. The random sample was specifically designed to represent the nearly 150,000 participants in treatment.

The number of programs involved in CALDATA is larger than any prior treatment follow-up study. Further, these programs were systematically selected with known probabilities from a rigorously developed sampling framework, so that those individuals followed up are representative of all participants in treatment in the selected modalities throughout California.

As authorized by federal and state law and permitted by consent obtained routinely on admission to treatment, the program records of participants selected for the follow-up sample were read and abstracted to determine additional important research information and to verify the self-reported data¹. Using a combination of methods including letters, postcards, telephone calls, visits to last known addresses, contacting relatives or institutional connections, and searching various accessible public records, CALDATA staff sought to locate members of the sample and seek their participation in the study.

In order to protect the privacy of respondents, strict confidentiality was maintained throughout the data collection period. The methods used to protect confidentiality were approved by the California Health and Welfare Protection of Human Subjects Committee.

Phase Two

In the second phase, more than 1,850 individuals drawn from 83 cooperating providers were successfully contacted and interviewed in 9 months. The participant follow-up interview was developed for CALDATA based on extensive work with previous research studies. The questionnaire took approximately one hour and fifteen minutes to administer on average. Follow-up interviews occurred an average of 15 months after treatment, with the longest interval being 24 months. Part of the sample was comprised of individuals who were in continuing methadone maintenance treatment, since this type of treatment is typically longer term than other services.

The results of this study will fill many of the gaps in the research literature--such as the detailed coverage of social model programs and the side-by-side comparison of cost and effectiveness of treatment for alcohol, cocaine, and heroin abuse.

The major goal of the study was to provide CADP a thorough analysis of the data on which data-driven policy decisions can be made. Public policy based on fact ensures the best return on investment for taxpayers.

¹Studies of the reliability and validity of responses to surveys by drug abusers show that addicts provide generally truthful and accurate information (Hubbard, R.L., et .al., 1989, *Drug Abuse Treatment: A National Study of Effectiveness*, Chapel Hill: The University of North Carolina Press, p. 31).

KEY FINDINGS

THE COSTS-BENEFITS OF TREATMENT IN CALIFORNIA

Taxpaying Citizens

- **Costs and benefits to taxpaying citizens²:** The cost of treating approximately 150,000 participants represented by the CALDATA study sample in 1992 was \$209 million, while the benefits received during treatment and in the first year afterwards were worth approximately \$1.5 billion in savings to taxpaying citizens, due mostly to reductions in crime.
- **Daily trade-off:** Each day of treatment paid for itself (the benefits to taxpaying citizens equaled or exceeded the costs) on the day it was received, primarily through an avoidance of crime.
- **Cost-benefit ratios for taxpaying citizens:** The benefits of alcohol and other drug treatment outweighed the costs of treatment by ratios from 4:1 to greater than 12:1 depending on the type of treatment.
- **Differences by treatment types:** The cost-benefit ratio for taxpaying citizens was highest for discharged methadone participants, lowest—but still clearly economically favorable—for participants in residential programs, including social model recovery houses.

Total Society: Economic Benefits

- **Cost-benefit ratios for the total society:** Findings differed when cost-benefit ratios for the total society were calculated. The cost-benefit ratios ranged from 2:1 to more than 4:1 for all treatment types, except methadone treatment episodes ending in discharge. For methadone episodes ending in discharge, there were net losses—mainly from earnings losses to the treatment participants themselves.

Benefits Projection

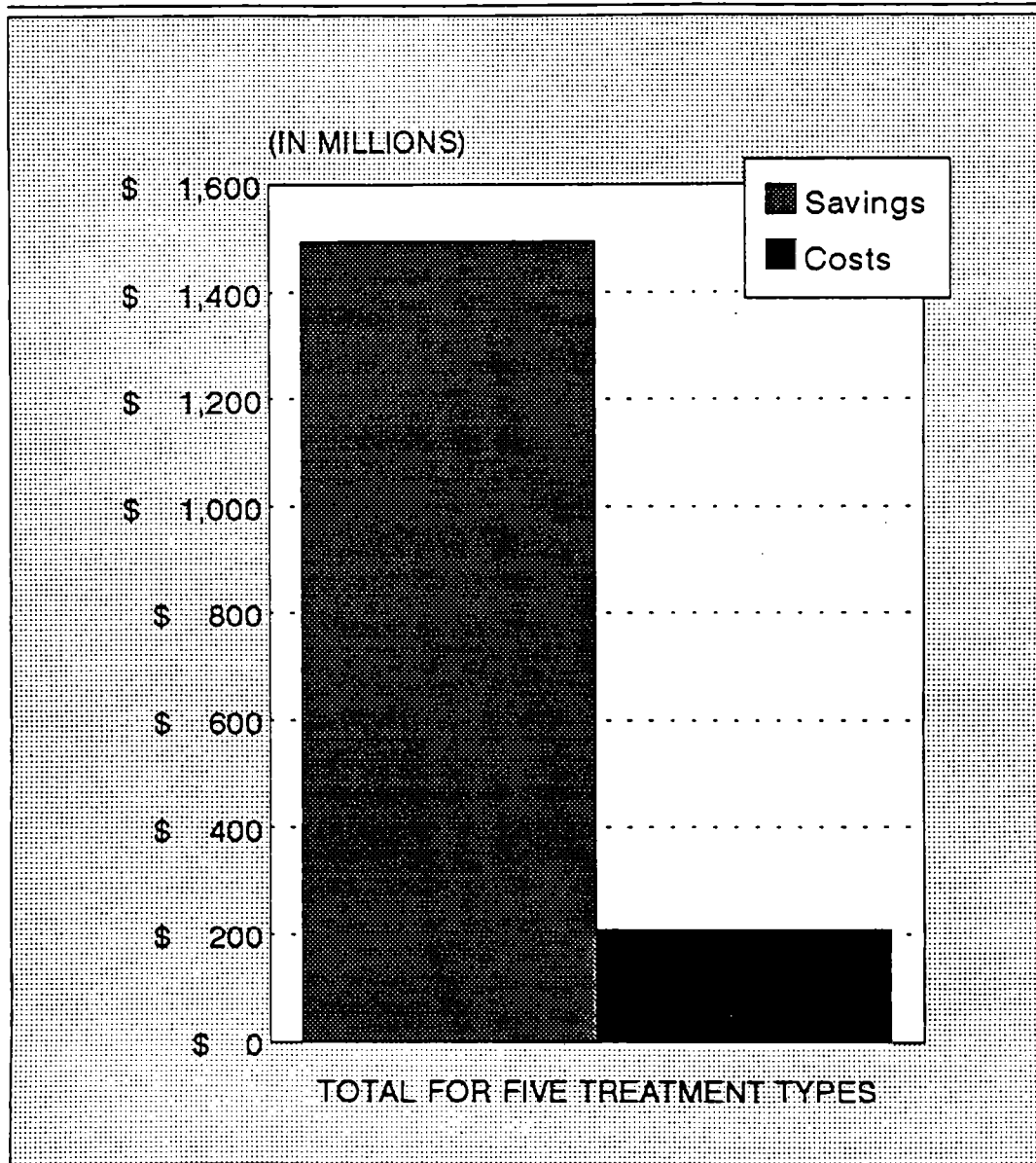
- **Benefits projection:** Benefits after treatment persisted through the second year of follow-up for the limited number of participants followed for as long as two years. This suggests that projected cumulative lifetime benefits of treatment will be substantially higher than the shorter-term figures. An additional phase of follow-up interviews and analyses would permit a more valid projection of lifetime treatment costs and benefits.

²The economic benefits of treatment were calculated two ways: benefits to *taxpaying citizens* and benefits to the *total society*. The major difference is that taxpaying citizens benefit when there is less theft and other crime and when the State makes fewer drug-related disability payments and other welfare-type transfers. However, these transfers of income and property are considered economically neutral to the total society, since one person's loss equals another's gain.

TREATMENT EFFECTIVENESS

- **Crime:** The level of criminal activity declined by two-thirds from before treatment to after treatment. The greater the length of time spent in treatment, the greater the percent reduction in criminal activity.
- **Alcohol/Drug Use:** Declines of approximately two-fifths also occurred in the use of alcohol and other drugs from before treatment to after treatment.
- **Health Care:** About one-third reductions in hospitalizations were reported from before treatment to after treatment. There were corresponding significant improvements in other health indicators.
- **Differences by substance:** There has been concern that stimulants, and crack cocaine especially, might be much more resistant to treatment than more familiar drugs such as alcohol or heroin. However, treatment for problems with the major stimulant drugs (crack cocaine, powdered cocaine, and methamphetamine), which were all in widespread use, was found to be just as effective as treatment for alcohol problems, and somewhat more effective than treatment for heroin problems.
- **No gender, age, or ethnic differences:** For each type of treatment studied, there were slight or no differences in effectiveness between men and women, younger and older participants, or among African-Americans, Hispanics, and Whites.
- **Ethnic differences in selecting treatments:** There were ethnic differences in the selection of treatment types and in reported main drugs of use. Hispanics were disproportionately in methadone programs for heroin addiction and African-Americans were disproportionately in residential programs (primarily for alcohol and cocaine) compared with non-Hispanic Whites and with African-Americans in other types of treatment.
- **Employment and economic situation:** Overall, treatment did not have a positive effect on the economic situation of the participants during the study period. However, the data indicate that longer lengths of stay in treatment have a positive effect on employment. This finding is greater for those in social model or other residential programs than for the other treatment types. The largest gains in employment occur with those individuals staying in treatment beyond the first month.
- **Disability and Medi-Cal:** In every type of treatment there were greater levels of enrollment and payments received from disability and Medi-Cal after treatment; these increases ranged from one-sixth to one-half. The study analyses indicated that treatment increased the eligibility to receive disability payments and led to overall improvements in health status.

TOTAL SAVINGS AND COSTS OF TREATMENT SYSTEM FOR TAX-PAYING CITIZENS



NOTES

Executive Summary:

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**A New Era
For HIV/AIDS Care, Treatment and Services**

An Agenda for California Government in 1997-98

**Public Policy Department
San Francisco AIDS Foundation
January 1997**

A New Era For HIV/AIDS Care, Treatment and Services

An Agenda for California Government in 1997-98

1996 will be remembered as a year of great change in the HIV/AIDS epidemic. The most profound of these new developments is the availability of new drug treatments which have demonstrated remarkable effectiveness in combating the HIV virus in many individuals living with HIV/AIDS when used in combination with previously available drugs. As a result of these new treatments, many individuals who were extremely ill have regained much of their health, showing astonishing improvement from debilitating opportunistic infections. These improved clinical outcomes have in turn produced great hope among many people living with HIV/AIDS, but have also resulted in expanded demands on government funds to pay for these expensive treatments and the primary medical care associated with them.

Meanwhile, numerous appropriations and policy changes on the federal level occurred during the past year, reauthorization of the Ryan White CARE Act and enactment of welfare reform being perhaps the most significant of these. In addition to these changes, the health care service industry has been undergoing a fundamental shift over the past several years as it becomes increasingly dominated by managed care; as a result, larger and larger numbers of people living with HIV/AIDS are finding themselves in these types of health care plans.

These developments have not only affected those living with HIV/AIDS, but have also dramatically altered some of the ways in which California must respond to the epidemic. As a result, these factors are sure to play a prominent role in state policy discussions and deliberations during the 1997-98 state legislative session.

In light of these changes, it is imperative that Californians living with HIV/AIDS have full access to new treatments. This includes ensuring that primary care and supportive services are available to address the ongoing and new challenges facing individuals with HIV/AIDS. It is also essential that California recommits to primary and secondary prevention and appropriate HIV/AIDS education. The state must ensure that Californians with HIV/AIDS or those at risk for HIV infection have all the information that they need to take care of themselves and the opportunity to access appropriate medical care.

This document will supply an overview of the HIV/AIDS epidemic in California, current federal funding that impacts the state, and the HIV/AIDS programs available through the state. Certain issues have been highlighted that are crucial for the state of California to address in the 1997-98 legislative year as we acknowledge both ongoing and new realities confronting us in our battle with HIV/AIDS.

Recommendations have also been made on many issues presented herein that will facilitate the San Francisco AIDS Foundation's mission to hasten an end to the HIV/AIDS epidemic and to reduce the human suffering that it continues to cause.

HIV/AIDS IN CALIFORNIA

Since the first cases of AIDS were discovered in 1981, California has been among the hardest hit states in the nation. Over fifteen years into the epidemic, the number of AIDS cases in California continues to grow dramatically.

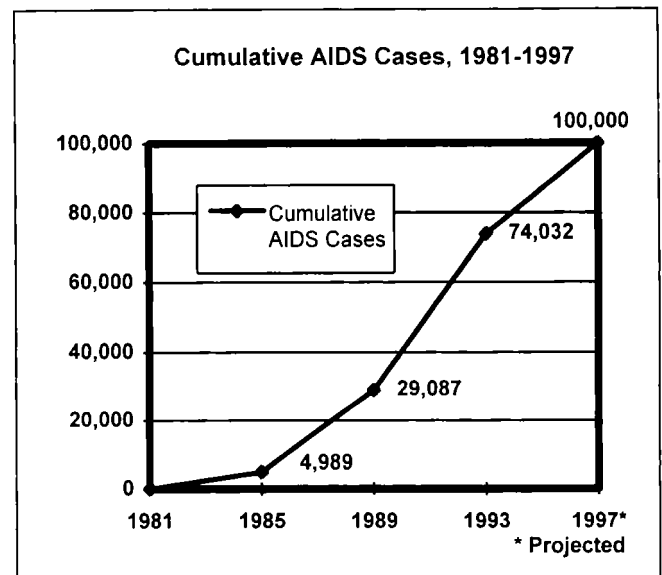
HIV/AIDS Cases in California

As of December 31, 1996 there have been:

- **98,297 diagnosed AIDS cases** in California since 1981, and
- **63,313 deaths due to AIDS**,
- leaving **34,984 people currently living with AIDS**.

The State Office of AIDS projects that over **100,000 cases** will have been reported by March of 1997.

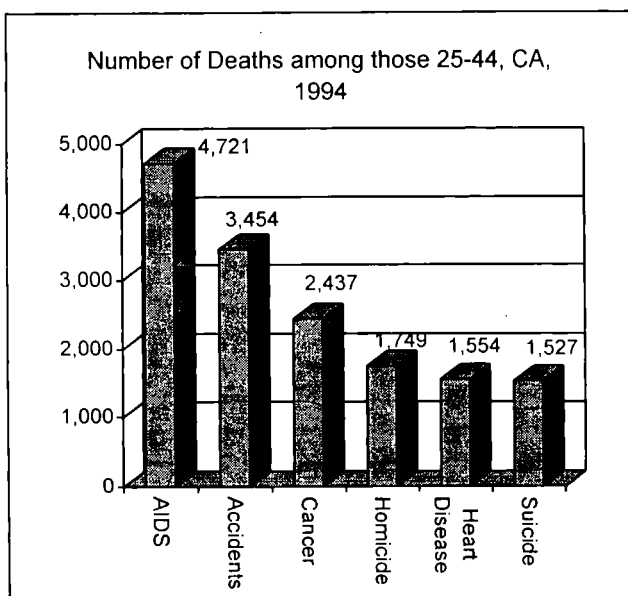
It is estimated that approximately **150,000 Californians are HIV-positive**; there are up to **8,000 new infections** annually in the state.



Geographically, AIDS affects the entire state--cases have been identified in 57 of California's 58 counties.

Overall, California accounts for approximately 18% of all AIDS cases in the United States and is second only to New York in the total number of cases reported.

Cause of Death



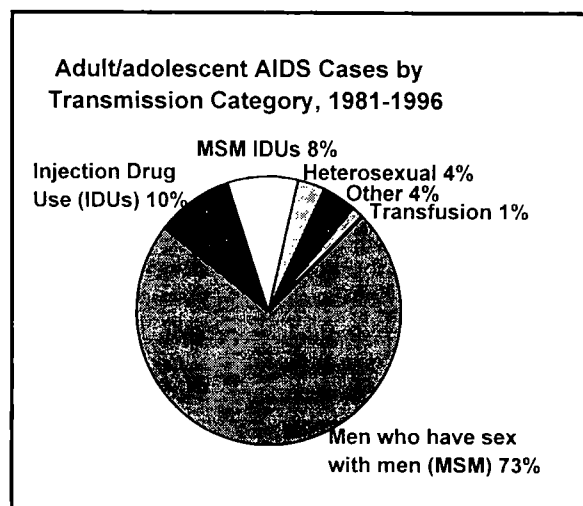
- Nationally and state-wide, AIDS is the leading cause of death for all individuals between the ages of 25 and 44.
- Individuals in this age group make up the majority of California's workforce; thus, these deaths result in important lost years of talent, skills, and contributions to society.
- In California, AIDS takes away more years of potential life before the age of 65 than any other single factor, except cancer.

Transmission Categories

The majority of cases in California continue to be among men who have sex with men (MSM), including those who inject drugs (83% of all cases reported since 1981).

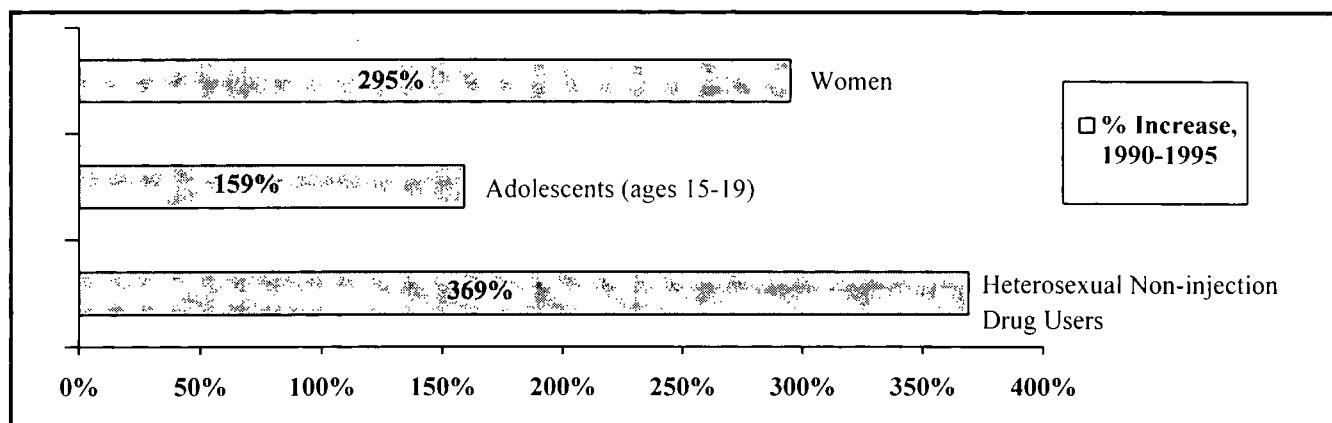
Injection drug users (IDUs) (other than gay and bisexual men) are the next largest group, at 10%.

The category of other includes people with hemophilia (.5%) and those where the cause of transmission is not known (3.4%).



Transmission Rates Have Been Steadily Changing

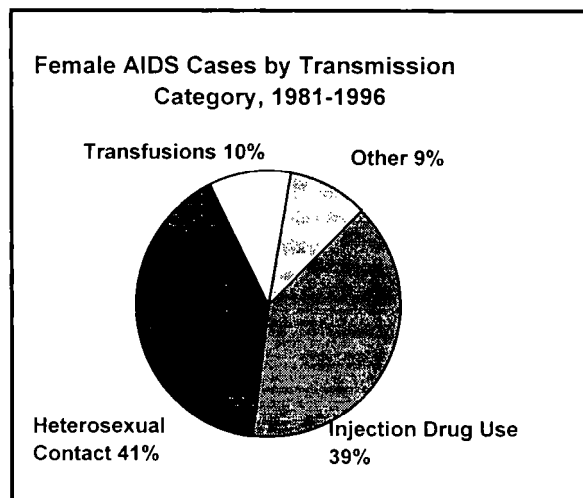
Over the last few years, the proportion of new cases due to injection drug use and heterosexual transmission has increased substantially while cases among men who have sex with men have decreased. As a result of these changes in transmission rates, many communities are increasingly affected by HIV/AIDS in California.



Women

Women account for over 6% of cumulative AIDS cases California, but this has been increasing. While women made up 1.4% of all cases in reported 1984, they made up 8.8% of cases reported in 1994.

According to the State Office of AIDS, women are one of the populations with the fastest growing incidence of HIV. The number of cumulative AIDS cases among women in California increased from a total of 1,386 in 1990 to over 5,479 cases in 1995, a 295% increase.



Adolescents

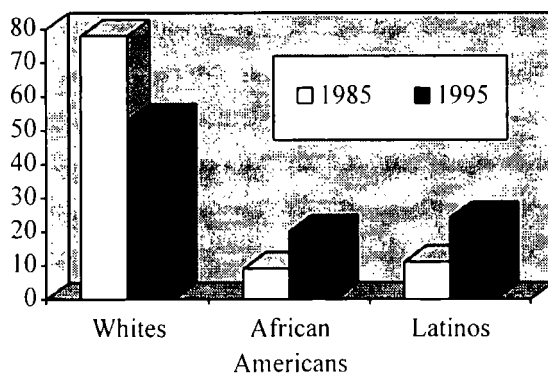
The median age of HIV infection during the 1980s was over 30. The median age dropped to 25 between 1987 and 1991 and continues to drop. A recent White House report has estimated that **one in four new HIV infections** in the United States occur among people between the ages of 13 and 20. Rates among young gay and bisexual men have been found to be especially high.

Although young people between ages 13-19 account for less than 1% of all reported cases of AIDS in California, it most often takes 10-12 years for an HIV-positive young person to develop full-blown AIDS. Thus, many of the individuals living with AIDS who are ages 20-29 were infected during their adolescence; over 15,000 cases (16% of all AIDS cases in California) fall into this age group.

Race/Ethnicity

As of December 31, 1996, there have been 62,176 cases of AIDS among whites, 15,822 among African-Americans, 17,809 among Latinos, 1,919 among Asian/Pacific Islanders, and 403 among Native Americans.

Percentage of AIDS Cases by Race/Ethnicity, 1985 and 1995



Although the majority of Californians diagnosed with AIDS since 1981 are white, the relative proportions of people of color are increasing.

While the percentage of new cases among whites declined from 78% in 1985 to 53% in 1995, the new cases represented by African Americans increased from 9% to 20% and the percentage represented by Latinos increased from 11% to 24% during the same time period.

Trends and Projections

- It is estimated that there are approximately 8,000 new infections each year in California. Although this represents a reduction from the high infection rates of the mid-1980s, this is still unacceptable. Prevention efforts continue to be our best means of further eroding this infection rate.
- Thanks in part to better treatments, people with HIV/AIDS are living longer. As a result, larger and larger numbers of people are living with HIV/AIDS and need care and treatment.
- The demographics of HIV/AIDS epidemic in California are changing: more young people, more injection drug users, more people of color, more heterosexuals, and more women are making up the state's AIDS case load.

Sources: California HIV Comprehensive Care Working Group, *DRAFT California HIV/AIDS Care and Treatment Plan*, May 1996; Department of Health Services - Office of AIDS - *California HIV/AIDS Update*, January, 1996; Department of Health Services - Office of AIDS - *HIV/AIDS Reporting System, Surveillance Report*, 12/31/96; Department of Health Services - Vital Statistics Section - September, 1996.

ADEQUATE FUNDING FOR HIV/AIDS SERVICES IS CRUCIAL

Californians living with HIV/AIDS rely on wide array of care, treatment, and social services which are absolutely critical in providing the best possible environment for improved health and quality of life. These vital services include such varied items as food and nutrition programs, outpatient medical care, case management, home health care, access to life-enhancing HIV/AIDS medications, and a range of other needed programs. Because the majority of people living with HIV/AIDS are either low-income from the onset of their illness or become impoverished due to decreased capacity to work and the expenses associated with the disease, provision of these services through government funding is particularly important. Without access to these services, many individuals would be unable to afford housing, medications, and medical care, leaving them far more vulnerable to advanced illness and death.

Funding Sources for California HIV/AIDS Care Services: Using a combination of state and federal dollars, the state funds and administers much-needed health care and support services to help ensure a continuum of care for Californians living with HIV/AIDS.

The majority of federal funds come through the Ryan White CARE Act. This piece of legislation supports a wide range of vital community-based care and treatment services for people living with HIV/AIDS. Most Ryan White dollars go directly to local areas or to specific programs and the state--by federal law--has no control over the use of these funds. The CARE Act includes a variety of HIV/AIDS programs under several titles (sections). Title II funds represent the largest chunk of the funds that go directly to the state to provide HIV/AIDS services (further explanation of the CARE Act is included in the section below).

The majority of state funds for HIV/AIDS services come from California's general fund, the budget that supports the majority of the state's services. The HIV/AIDS services funded by these various sources and administered by the state include:

Early Intervention Program (EIP): EIP offers services to those in the early stages of HIV disease with the goal of prolonging their life, health and productivity. Ten locally-operated EIPs based throughout areas of the state hardest hit by the epidemic provide primary health care, certain laboratory tests, case management, psychosocial support and short-term counseling. In addition, health education and behavior change is also provided with the goal of preventing further transmission of HIV. There are also two other EIPs which serve the specific needs of HIV-infected women. Finally, additional dollars are used to support early intervention services in 22 rural counties. The majority of EIP dollars come from the state general fund, with a small portion supported by Title IIIB of the Ryan White CARE Act.

AIDS Drug Assistance Program (ADAP): This program provides drugs that prolong and/or improve the quality of life to individuals with HIV/AIDS who could not otherwise afford them. Individuals who are not eligible for Medi-Cal, lack health insurance which provides prescription drug coverage, and meet financial eligibility requirements may access the program. Depending on the individual's ability to pay, a copayment may be required. California's ADAP currently provides 47 drugs, including the protease inhibitors and other drugs necessary for effective combination therapy. This program is supported by mix of state general funds, Ryan White Title II dollars, and manufacturer rebates.

AIDS Case Management Program (CMP): CMP provides nurse case management and home-based care to individuals living with AIDS and symptomatic HIV, replacing costly hospitalization. Services include in-home skilled nursing, attendant and hospice care, home intravenous therapy, subsidies for housing and food, and provision of vital medical equipment. This program is funded primarily through state general fund dollars with some additional funds provided by Ryan White Title II.

AIDS Medi-Cal Waiver Program: Like CMP, this program provides nurse case management and home-based care to persons with AIDS, reducing the need for placement in nursing facilities or hospitals. However, clients in this program must meet Medi-Cal eligibility requirements and are generally more frail and ill than those enrolled in CMP. State and federal governments provide equal funding through the Medi-Cal program.

HIV Care Consortia: These consortia are based in areas most affected by HIV disease and are responsible for the planning, development, and delivery of essential health care and support services to individuals living with HIV/AIDS. These consortia include public and nonprofit health care and support service providers and community-based organizations operating within the area. California has a total of 44 HIV care consortia throughout the state. These consortia are entirely funded by Ryan White Title II.

CARE/Health Insurance Premium Program (CARE/HIPP): This program helps people with HIV/AIDS pay their health insurance for up to 12 months, maximizing individuals' access to private health insurance and reducing state costs. Like the Care Consortia, CARE/HIPP is funded in full by Ryan White Title II.

Recommendations

- California should ensure that all individuals living with HIV/AIDS have access to these various services.
- The state should investigate existing and potential needs for care and treatment services and provide increased funds where necessary in order to provide access to the entire continuum of care for all Californians living with HIV/AIDS.
- At the absolute minimum, the state *must* maintain current levels of service in all of these areas; this should include funding increases to account for expanding case loads and inflationary pressures.

RYAN WHITE CARE ACT REAUTHORIZATION AND ITS IMPACT ON CALIFORNIA

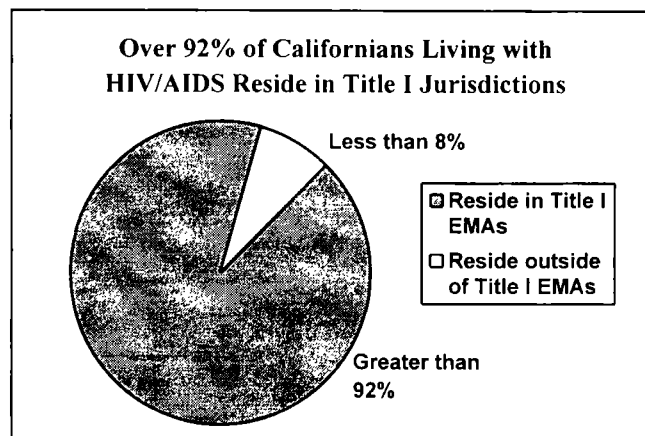
One of the AIDS community's greatest victories in 1996 was the reauthorization of the Ryan White CARE Act on the federal level. This vital piece of legislation, initially passed in 1990, supports a wide range of community-based services, including primary and home health care, case management, substance abuse treatment and mental health services, nutritional and some

housing related services. Besides Medicaid, the Ryan White CARE Act represents the single largest federal investment in the care and treatment of people living with HIV/AIDS in the United States. Since its enactment, the law has greatly improved the quality and availability of health care and critical support services for individuals living with HIV/AIDS around the country.

CARE Act Titles: The Ryan White CARE Act is divided into a number of sections, each with a different emphasis and impact. Title I of the CARE Act provides federal financial assistance to cities hardest hit by the HIV/AIDS epidemic; those areas which qualify are designated as “eligible metropolitan areas” (EMAs). These funds are used to provide a broad array of vital care and treatment services to individuals living in these areas, including primary health care, food, dental care, mental health care, substance abuse treatment, and case management.

California currently has nine EMAs which receive this funding: Alameda/Contra Costa, Los Angeles, Orange County, Riverside/San Bernardino, Sacramento (which includes El Dorado, Sacramento, and Placer Counties), San Diego, San Francisco (which includes Marin, San Francisco, and San Mateo Counties), Santa Clara, and Sonoma.

The vast majority of Californians living with HIV/AIDS reside in these EMAs.



Title I funds for these nine areas for fiscal year (FY) 1996 totaled about \$86.6 million. Funds are allocated in each jurisdiction based on priorities set by local community planning bodies as dictated by federal law.

Title II of the CARE Act provides grants to all 50 states to develop effective and cost-efficient systems for delivery of HIV/AIDS health care. Specifically, Title II funds are used by states to provide people living with HIV/AIDS with assistance in paying health insurance subsidies (CARE/HIPP), ensure access to AIDS drugs for those who cannot afford them (ADAP), increase access to home health care services, and develop local HIV consortia which deliver essential health care and support services to individuals living with HIV/AIDS in those areas.

Finally, Title IIIB provides AIDS early intervention service grants to clinics throughout the country while Title IV provides specific HIV/AIDS care and treatment services for children, youth, women, and families.

Reauthorization: As was required when the initial CARE Act was signed into law, the program expired in September, 1995 and unless it was reauthorized for a second five-year period, thousands of individuals living with HIV/AIDS were at risk for losing essential care and treatment services. Fortunately, after intense lobbying and community pressure for nearly two years, the Ryan White CARE Act was successfully reauthorized by Congress in May, 1996, ensuring continued access to vital services.

While the reauthorization maintained the fundamental structure of the original Ryan White CARE Act, it also made several changes which will affect the state. One of the most significant of these was the modification of the various funding formulas that the federal government uses in calculating grants to localities. As a result of formula changes to Title I, some eligible metropolitan areas (EMAs) in California, particularly the San Francisco EMA, have seen sharp decreases in their Title I funding--in FY 1996, there was a \$6 million decrease in San Francisco's portion of these federal funds.

Perinatal Transmissions: In addition, the reauthorized CARE Act also included a troubling provision regarding counseling and testing of pregnant women and newborns. Although less than 1% of new AIDS cases in 1995 involved perinatal transmission, this issue had become prominent as a result of studies which indicated that pregnant women who received the antiviral medication AZT were less likely to transmit the virus to their child. Thankfully, the new provision of the CARE Act does not mandate HIV testing of pregnant women or their newborns (which had been initially proposed), but instead largely emphasizes the importance of *voluntary* counseling and testing. However, it does require states to demonstrate by the year 2000 that there has been either a 50% reduction in the rate of perinatal AIDS cases or that 95% of women in prenatal care are tested for HIV; any state that does not meet these goals risks losing CARE Act funding.

Fortunately, even before this provision was enacted, California had successfully dealt with this issue in 1995 by enacting Senate Bill (SB) 889, a state law which requires counseling and voluntary testing for all women receiving prenatal care.

Recommendations

- Title I funds are critical to California metropolitan areas in providing adequate care and treatment services. Given the Title I reductions experienced by some EMAs and the possibility for similar reductions in the future, the state should not reduce any state funds that are currently provided to these localities for HIV/AIDS services.
- California should provide adequate funding and training to aggressively implement SB 889 in order to help the state attain the goals regarding reduced perinatal transmissions laid out in the reauthorized CARE Act. This will help the state avoid the possibility of either mandatory testing of newborns or pregnant women or the loss of Ryan White funds to California and its cities.

AIDS DRUG ASSISTANCE PROGRAM IS A PRIORITY FOR CALIFORNIA

The past year has seen tremendous breakthroughs in the treatment of HIV/AIDS. Since December, 1995, five new drugs, including three protease inhibitors, have been approved by the federal Food and Drug Administration (FDA). When used in combination with other drugs, such as AZT, these treatments are designed to impede HIV's ability to reproduce and have shown remarkable promise in improving the health of many individuals living with HIV/AIDS, including many who had been near death. In certain cases, these new drug "cocktails" (typically

composed of three different drugs including one protease inhibitor) have reduced the amount of HIV in the bloodstream to undetectable levels for more than a year when patients followed a strict treatment regimen.

Although these breakthroughs warrant both hope and optimism, it is important to recognize that these drugs do not represent a “cure” to AIDS. The long-term effects of these drug combinations are still widely unknown because very few patients have been using these treatments for longer than nine months; already, there have been many cases in which these drugs have stopped working as effectively or have begun producing painful side effects in patients who had previously been taking them successfully. In addition, these drugs have had virtually no impact on a sizable number of cases (up to 30%), either because individuals do not respond to the new drugs or cannot tolerate the sometimes horrible side effects. This is particularly true of individuals who are in very advanced stages of the disease.

Despite these caveats, these drugs represent the most profound breakthroughs in HIV/AIDS research ever and are a vital first step towards the goal of making HIV/AIDS a manageable disease. Because of these new treatments, viral load counts (indicating the amount of virus in the body) of many individuals with HIV/AIDS have been dramatically reduced while T-cell (immune system cells) counts have risen.

Importance of ADAP: The AIDS Drug Assistance Program (ADAP) provides prescription drugs to lower income Californians who could otherwise not afford them. With the emergence of these new and promising therapies, the need for ADAP has grown enormously in the last year. In 1995-96 the program’s original budget was \$17.5 million, composed of state and federal dollars. However, the state’s ADAP budget more than doubled during the last budget cycle to cover the costs of both the new drugs and expanding case loads, jumping to nearly \$37 million in FY 1996. This was due to increases in federal appropriations directly to ADAP through Title II of the Ryan White CARE Act, pharmaceutical rebates, increases in state general funding, and an unfortunate shift from Title II local consortia. In 1994-95 ADAP filled 89,600 prescriptions while in 1995-96 this figure had surpassed 100,000.

	State General Fund	Federal Ryan White Title II	Pharmaceutical Manufacturer Rebates	Shift from Title II local consortia funds	Total ADAP Funding
Original 1995-96 Budget	\$9.1 million	\$8.4 million	\$0	\$0	\$17.5 million
Original 1996-97 Budget	\$15.6 million	\$16.4 million	\$3.5 million	\$1.4 million	\$36.9 million
Increase between 1995-96 and 1996-97 ADAP budgets	\$6.5 million	\$8 million	\$3.5 million	\$1.4 million	\$19.4 million

These therapies are extraordinarily expensive--costing from \$12,000 to well over \$20,000 per patient annually and are therefore out of reach for many Californians who are underinsured or uninsured. It is imperative that all Californians have access to these drugs which have shown remarkable efficacy in over 70% of patients.

Current Funding Situation: Although ADAP received an increase in funding for 1996-97 (July 1, 1996 - June 30, 1997), the demand for new therapies has placed this vital program in jeopardy once again. Many counties are estimating that they will have used all their ADAP funds by January or February of 1997 in order to keep pace with the demand. Therefore the state will be faced with a shortfall for this year and will need to address adequate funding for ADAP in 1997-98 so another crisis does not occur.

California will receive \$26.3 million in direct ADAP funding from the federal government for federal FY 97. Additionally, the state will see a \$3.4 million increase in its Title II grant award. Using all of these funds to address the current year's shortfall, although an option, is a short sighted solution to a long term problem.

Centralization: California's ADAP has been administered locally through the counties and this has caused poor tracking and data collection and has also been cited by the federal Health Resources Service Administration (HRSA) as an inefficient way to run ADAP. The State Office of AIDS is presently crafting a program that will centralize the program but will leave eligibility screening at the cost of the counties.

Reliance on local Title I funds to fund California's ADAP shortfall: There have been proposals to reduce the state's commitment to addressing ADAP's shortfall by using funds from local governments, specifically funds received through Title I of the Ryan White CARE Act by Title I Eligible Metropolitan Areas (EMAs). There are nine Title I EMAs in California, which receive direct federal funding through the Ryan White CARE Act. The 9 California EMAs have often used some of their resources to augment ADAP locally--for additional prescriptions of drugs that are available on the ADAP formulary as well as drugs that are important components of HIV/AIDS care that are not available on the state's ADAP formulary.

Due to the differences in the needs for people living with HIV/AIDS in these nine California localities, it is important that these areas maintain control over all the resources allocated to them through both Title I and Title II grants. Efficient use of these resources through community-based control is an essential component in effective HIV/AIDS care, treatment and prevention and is the basic tenet behind the Ryan White CARE Act.

The funds provided by the federal government to cities through Title I of the Ryan White CARE Act are essential in order to guarantee appropriate care and services for people living with HIV/AIDS. The services provided through this funding facilitate care and access to these new treatments. Title II Consortia funding provides similar services and care to Californians living with HIV/AIDS in various areas of the state. It is essential that both Title I funding and Title II Consortia funding for care and access to treatment remain intact.

It is inappropriate and antithetical to federal guidelines for the state of California to require cities to transfer their own federal funds back to the state. Additionally, local jurisdictions are already being financially burdened as a result of welfare reform and changes in federal disability regulations exempting substance abuse as a category of disability. To further burden cities and counties will cause a further breakdown in the continuum of care that is currently stretched in many localities.

Recommendations

- The current shortfall for ADAP must be addressed by the state without complete reliance on new federal allocations.
- A long term solution, which includes additional state funds must be used to address the current situation and the state must adequately address future needs of the program by significant increases in ADAP funding for 1997-98.
- Centralization of ADAP must be consumer friendly and be easily accessible to clients.
- Title I EMAs should retain control over all Title I and Title II grants they receive in order to adequately address the particular needs of these diverse communities and the state of California should assure that these jurisdictions retain control over the federal moneys that they receive.
- The Governor and the Legislature should aggressively advocate that the federal government increase funding for care and treatment through all Titles of the Ryan White CARE Act.

VIRAL LOAD TESTING SHOULD BE AVAILABLE TO ALL CALIFORNIANS LIVING WITH HIV/AIDS

In addition to the many new HIV/AIDS treatments, there have also been significant breakthroughs in the development of diagnostic tools which provide improved information regarding the progression of HIV disease. These sensitive tests accurately measure the amount of HIV in the bloodstream, providing valuable information regarding the patient's disease stage and helping to predict the likelihood of progression to AIDS, serious illness and death.

With this important information regarding an individual's viral load levels, both the patient and physician can make rational, informed decisions about starting, changing, or adding various drug therapies to a treatment regimen. Recent studies have clearly demonstrated the value of viral load tests in managing the health of HIV-infected individuals. As a result, virtually all HIV/AIDS medical experts and advocates agree that these tests are an integral component of the standard of care for HIV disease.

However, these tests are quite expensive--ranging from \$150 to \$200 for each test. In order for these tests to be most useful, it is recommended that between four and six tests be taken each year, adding up to \$600 to \$1200 annually. Most private insurers, HMOs, and Medi-Cal will now reimburse for or provide access to some viral load testing, though they may not pay for the full number of tests that are currently recommended. Much more disturbing is the fact that numerous Californians living with HIV/AIDS have no access to these tests because they are uninsured or underinsured, not covered by Medi-Cal, and lack sufficient funds to pay for them out of their own pocket. Because these individuals and their physicians cannot monitor their viral load count, they are not be able to accurately evaluate the effectiveness of drug therapies or

to make informed decisions about future treatments and, as a result, *these individuals are receiving substandard care.*

As more and more new treatments are being utilized by Californians living with HIV/AIDS, it is absolutely critical that viral load tests be available to all who need them so that their physicians can use these important markers to help decide when to begin or change antiviral therapy and determine the likelihood of progression to HIV illness and/or death.

Recommendations

- California must ensure that all individuals living with HIV/AIDS have access to high quality care and treatment, including regular viral load testing.
- State funds should be made available to pay for these tests for individuals who are uninsured or underinsured and not covered by Medi-Cal.
- The state should accomplish this by creating a separate line item for viral load tests in the state budget, perhaps under the HIV testing program and by increasing funds to the state's HIV Early Intervention Program (EIP) to pay for these tests for those enrolled in EIP.

CALIFORNIANS AT RISK FOR HIV INFECTION SHOULD BE ENCOURAGED TO SEEK VOLUNTARY HIV TESTING

With total AIDS cases in California reaching 100,000 in the spring of 1997, it is imperative that the state of California finds the most effective way to encourage "at-risk" populations to be tested. In doing so it is critical that individuals who test positive receive the counseling and information that they need in order to begin early treatment if they so choose and the opportunity to notify sexual and needle sharing partners of potential exposure to HIV.

The development of promising new therapies makes the need for ample access to and encouragement of voluntary testing all the more critical. It is important to ensure that there are no disincentives to HIV testing. If an individual is aware of his/her HIV status early, there is greater potential than ever before that treatments can prolong life and ensure a higher quality of life.

The San Francisco AIDS Foundation has consistently advocated that government policies should encourage individuals to voluntarily seek testing and treatment, not increase their fears and discourage them from doing so. A policy that requires reporting of names of individuals testing positive for HIV would result in individuals avoiding or delaying HIV testing and/or early treatment because of their fears of discrimination and stigmatization.

Numerous studies have supported this position. For example, a study conducted in South Carolina showed that after names reporting was instituted, there was a 43% decrease in identification of persons with HIV positive test results and a 51% decrease in attendance at test sites of men reporting having sex with men, a high risk group (*Johnson, Sy and Jackson, 1989*).

Another study in Oregon indicated that after anonymous testing became available, there was a 50% overall increase in testing, a 125% increase in testing for men having sex with men and two times the amount of HIV positive individuals were identified (*Fehr et al, 1988*).

If statutes to criminalize certain behaviors of individuals who know that they are HIV positive are enacted, the fears of these individuals will be heightened. Not only would individuals be reluctant to be tested but they would hesitate informing their partners of possible exposure. All of these elements combine to create a negative public health impact that could be of enormous magnitude. The San Francisco AIDS Foundation has always advocated that individuals should voluntarily inform their sexual and needle sharing partners that they may have been exposed to HIV. Education, not the penal code, is the answer.

Also, it is not necessary to create new crimes for HIV status. Laws regarding attempted homicide or assault with a deadly weapon have already been used to punish individuals who intend to infect others with HIV.

Educating individuals who are possibly at risk for HIV infection and encouraging them to seek HIV testing and possible early treatment and to voluntarily notify their sexual and needle sharing partners have always been and continue to be the best tools in our arsenal to fight the spread of HIV.

Recommendations

- California should increase educational initiatives that will encourage at risk individuals to seek voluntary testing and voluntarily notify partners. Additionally, state funding for anonymous HIV testing should be maintained and increased as needed to ensure all who need and want testing can access it.
- Additional initiatives should be developed to outline the benefits of knowing one's HIV status in order to begin early treatment.
- The state should not institute a policy which would require that the names or other identifying information of individuals who are HIV-positive be reported to the state. Such policies would result in either a real or perceived problem of identification and would act as a disincentive to seeking an HIV test.
- Laws which would criminalize certain acts by HIV infected individuals would also serve as a disincentive to testing and should also not be instituted by the state.

HIV HOME COLLECTION KITS: ENSURING APPROPRIATE STANDARDS FOR THEIR USE IN CALIFORNIA

In addition to new drug therapies and viral load tests, 1996 also saw the Food and Drug Administration (FDA) approval of the very controversial in-home HIV collection kits. These products allow a person to take a blood sample on paper at home, send the specimen into the company which will have it tested by a laboratory, and then telephone in for the results several days later.

These products provide another option for individuals to determine their HIV antibody status and may increase overall access to testing. Because of these potential benefits, the San Francisco AIDS Foundation has endorsed these kits in concept if manufactured, sold, marketed and used properly. However, SFAF also recognizes that in order for these home collection kits to be most effective and to reduce the possibility of misuse, certain guidelines had to be met, including the following:

- Guaranteed anonymity of all individuals being tested, especially to the testing lab, phone counselors, and all government officials; home collection kits should be labeled and marketed to explain how collection samples and related information are controlled and what safeguards are in place to assure confidentiality and anonymity;
- Live phone counseling for those testing both positive and negative by a properly trained, qualified counselor; counselors should be well-trained in dealing with crisis situations and should also have adequate and culturally-appropriate referral information for services in the test-taker's community;
- Pre-test information should be provided in the literature accompanying the home collection kit; both this information and post-test counseling must include information on the appropriate time window for the development of HIV-antibodies following potential exposure to HIV;
- All information at every step of collection, testing and counseling should be multi-lingual (English, Spanish, and other appropriate languages);
- These products should not be sold to individuals under age 18 unless and until the company selling the kit is able to address the particular counseling and referral concerns associated with children and adolescents;
- Testing must be done at an appropriately licensed laboratory using FDA approved HIV testing procedures; protocols must be developed for handling inconclusive results and dealing with old and/or defective collection kits;
- Companies that produce these kits should perform appropriate post-marketing data collection and evaluation to ensure the kit and all protocols are both workable and effective;
- Misuse of the product, such as forcing or unduly influencing someone to send in a specimen or sending in a specimen on behalf of someone without that individual's complete knowledge or approval, must be prohibited and result in strong penalties.

Unfortunately, home test kits as they are currently approved may not meet all of the above guidelines that are necessary to ensure confidentiality, effective prevention counseling, and protections against possible misuse.

Recommendations

- California should provide specific guidelines and requirements regarding the marketing, sale, and use of HIV home collection kits.
- These guidelines and requirements should include the principles listed above, even if currently approved home collection kits meet some or many of these principles already. This will ensure that any products approved to date or in the future meet these important guidelines and requirements in order to be sold in California.

CALIFORNIA SHOULD ALLOCATE ADDITIONAL FUNDS FOR HOUSING FOR PEOPLE LIVING WITH HIV/AIDS

Assistance with housing is a high priority for many Californians living with HIV/AIDS. HIV/AIDS disproportionately affects indigent populations and the costs associated with the disease cause many individuals to spend down to poverty. This has obvious and severe implications for the housing needs of people living with HIV/AIDS. It is estimated that 60% of people living with HIV/AIDS will need assistance with housing at some point during the course of their illness, and that one third to one half of all people living with AIDS are either homeless or in danger of losing their homes. For example, 30% of the clients seen at the San Francisco AIDS Foundation are homeless.

The promising new therapies available for people living with HIV/AIDS actually make the housing crisis even more problematic in the overall battle against HIV/AIDS. These treatments have strict regimens that are required in order to be effective and if the individual does not have adequate shelter it is difficult to remain compliant with this regimen. Thus more than ever before, basic human needs such as food and shelter are essential in order to maintain the health and quality of life of individuals who are living with HIV/AIDS.

All of the housing programs specifically for people with HIV/AIDS in California are provided by the federal Housing Opportunity for People with AIDS (HOPWA) program. Most of this money goes to severely affected communities directly from the federal government. However, program funding has sharply lagged behind the increased needs.

In 1996-97 the state eliminated funding for residential AIDS shelters which had been the only funds that the state allocated for HIV/AIDS specific housing. Currently, the state receives nearly \$ 2 million in HOPWA funds for use in jurisdictions throughout the state that do not receive direct federal support from HOPWA. The state adds no money to this small federal allotment.

Housing is a vital component of the continuum of care for people living with HIV/AIDS and is likely to become more important in the coming years. California must finally be realistic about housing needs for people with HIV/AIDS and must begin to explore meaningful ways to ensure that individuals and families living with HIV/AIDS throughout the state have adequate shelter. Many of the options utilized by other states to accomplish this goal do not require expending state funds but require the creative use of resources already available to the state.

Recommendations

- California receives a grant of housing funds from HUD under its HOME program. This money is flexible in its use which is determined by the state. California should explore use of some of its HOME funds for statewide rental assistance for people with HIV/AIDS.
- Many states use state bond funds to pay the capital costs of HIV/AIDS housing programs and California should explore this option. This could be accomplished not only for HIV/AIDS specific housing but for other disabilities as well in California.
- States frequently receive an allocation of Section 8 federal housing subsidy certificates, some of which can be project-based (tied to specific developments) and others of which can be tenant-based (not restricted to any specific location). Some states have allocated a portion of these Section 8 certificates to HIV/AIDS housing programs. California should explore doing the same.
- Several Medicaid programs could potentially be used to pay for non-medical services in HIV/AIDS housing programs. In some states, Medicaid funds some HIV/AIDS housing programs through its group adult foster care and personal care attendant programs. California should explore doing the same.

PREVENTION REMAINS ABSOLUTELY CRITICAL

Although new treatments have increased hope and the quality of life for many people living with HIV/AIDS, preventing HIV transmission continues to be essential. Effective prevention programs are currently the only means by which the estimated 8,000 new infections that occur annually in California can be reduced. Until there is a cure or a viable vaccine, prevention programs are imperative to our efforts to stem this devastating epidemic and save lives and save the significant resources required by every HIV infection.

Numerous studies have demonstrated that targeted, culturally-sensitive and appropriate prevention programs can greatly reduce the number of new HIV infections. For example, researchers have found that intensive prevention campaigns among gay men in San Francisco have reduced new infections from over 8,000 a year in the early 1980s to less than 1,000 today. In addition, these programs are extremely cost-effective. The lifetime costs of treating a person with HIV/AIDS has been previously estimated at \$119,000, but this figure is growing with the new expensive treatments now available. There are even larger costs to individuals and to the state economy associated with the loss of earnings due to illness and death associated with HIV/AIDS. These individuals are no longer paying taxes and many of them end up relying on government funded entitlement programs, such as Supplemental Security Income (SSI) and Medi-Cal. Every case averted represents substantial savings to all levels of government and society.

State Prevention Funding: Currently, the state provides \$18.1 million to support HIV/AIDS prevention programs throughout California. It is critical that these funds continue to be available in order to effectively reduce HIV infections in the state. This may be especially important in light of exaggerated news reports and rumors regarding the new treatments which have led some individuals to believe that the virus cannot be transmitted when these drugs are in use or that they will be “cured” by using these new therapies if they do get infected. As a result, some behaviors that place individuals at greater risk for HIV infection could rise. It is vital that these individuals receive accurate information and recognize the continued need for safe sexual and safe needle use practices.

In addition, prevention education programs must be broadly available, especially to youth. A recent White House Report estimated that 25% of new infections are occurring among those aged 13-20. It is essential that adolescents be provided with vital prevention information which can help to save their lives. California requires that HIV prevention education be provided to youth once in both junior high school and high school. These school programs are an important component of California’s strategy to reduce HIV infections throughout the state.

Needle Exchange: Another population at particularly high risk for HIV infection are injection drug users and their sexual partners. The most effective prevention program available to reduce infections in these communities is needle exchange, which allows the exchange of used syringes for clean ones in order to reduce the rate of HIV infection that can result from sharing needles. These services not only offer the opportunity to exchange used needles, but also provide important prevention counseling and serve as a bridge to drug treatment, HIV services, and other primary health care services.

Numerous scientific studies have shown that needle exchange does not increase drug use and does decrease unsafe needle sharing and slows the spread of HIV. In New Haven, Connecticut, for example, a 33% reduction in the rate of new HIV infections was found among needle exchange program clients. Furthermore, needle exchange is one of the most cost-effective means of reaching extremely disenfranchised individuals at highest risk for HIV--a new needle costs as little as ten cents while the lifetime costs of treating a person living with HIV/AIDS exceeds \$119,000. Although some counties have wisely recognized the benefits of these services and have legally authorized needle exchange programs in their jurisdictions, the legality of these programs has not been recognized by the state.

Community Planning: Community input is critical in the development of effective prevention programs. The California Community Planning Working Group was initiated in 1993 and assists the state in analyzing the epidemic and its impact on various communities throughout California and prioritizing prevention needs and services. This process allows community representatives to bring their unique perspectives to the planning table and has been essential in generating new energy and ideas regarding California’s prevention efforts.

Recommendations

- California must continue to ensure that necessary state prevention dollars are available in order to consistently reduce the number of infections occurring in the state.

- HIV prevention education should be provided broadly, especially to youth. The mandate for HIV/AIDS education in schools should be expanded to younger grade levels and should not be restricted further than the law currently proscribes.
- California should formally allow counties and cities to establish needle exchange programs in order to effectively prevent HIV infections among injection drug users and their sexual partners.
- The state should continue to strongly support community prevention planning and should utilize the resulting community input to ensure that prevention programs are responsive to existing and emerging needs and trends in the epidemic.

HIV/AIDS AND THE INCARCERATED POPULATION IN CALIFORNIA

California has the largest prison population in the country--over 136,000 prisoners are currently incarcerated in the state's 31 prisons. Many of these individuals are living with HIV/AIDS or are at high risk for HIV infection. A 1994 seroprevalence survey found that 2.4% of males and 3.2% of females in state correctional facilities are HIV infected; these figures are substantially higher than the HIV seroprevalence rate for the general population, which is estimated at .4%. California's prison system ranks third in the nation for AIDS-related deaths.

Prisoners living with HIV/AIDS have needs similar to those outside the prison setting, such as access to high quality health care, including new and experimental treatments, and to supportive services and counseling. Especially given the new treatments now available, prisoners must be guaranteed access to drugs which can enhance quality and/or length of life. Incarcerated individuals living with HIV/AIDS also need and deserve protections from discrimination and/or harassment in the prison setting.

In addition to these important needs, prisoners with AIDS should also be granted compassionate release from prison when their illness becomes terminal and incapacitating. Such a process allows seriously ill individuals to spend their final days with loved ones. Unfortunately, the state's current compassionate release or "recall of sentence" procedure is lengthy, cumbersome, and misunderstood by most judges and prison administrators. As a result, most prisoners who are eligible for compassionate release die in prison before the process is ever completed.

In regards to HIV antibody testing, voluntary testing is currently available to all prisoners in California; however, some individuals fear coming forward for testing because of the potential for stigma and discrimination in the prison setting. In general, HIV testing, treatment, and housing policies in correctional facilities should be congruent with those in the general community, meaning that inmates should be allowed to make their own choices about HIV testing and treatment and should not be forced to be tested; nor should HIV infected individuals be segregated from other inmates, unless they choose to be separated, or discriminated against in any other way due to their HIV status.

Finally, prevention efforts in prison are extremely important, especially given the large seroprevalence rate in the system. Peer education programs are effective in providing information to prisoners on how HIV is transmitted and what behaviors should be avoided in order to reduce the risk of infection. In addition, condoms and clean needles would play a critical role in reducing HIV infection rates in California's prisons but are currently not permitted in the state's correctional institutions.

Recommendations

- California prisoners must have access to high quality medical care, supportive services, counseling, and protections from discrimination and harassment.
- California's compassionate release program should be streamlined to allow more individuals to spend their final days with loved ones.
- Voluntary testing should remain accessible to prisoners and testing must never be required or forced. Inmates living with HIV/AIDS should not be segregated from the general prison population unless this is their desire, nor should inmates with HIV/AIDS suffer any other form of discrimination.
- Prevention efforts in the prison setting, especially peer based programs, should be strengthened and condoms and clean needles should be made available to those who request them.

CALIFORNIANS LIVING WITH HIV/AIDS MUST BE ASSURED ACCESS TO MEDICINAL MARIJUANA

In November, California voters passed Proposition 215 which legalized the compassionate medical use of marijuana for any individual whose physician has determined that their health would benefit from its use. Many people with life-threatening diseases, including HIV/AIDS, have seen clear improvements in their health due to the medical use of marijuana, in both the pill (Marinol) and smokeable form. In addition to HIV/AIDS, marijuana has been used to treat many other medical conditions such as glaucoma, cancer, anorexia, arthritis, multiple sclerosis, epilepsy, migraines and nausea associated with chemotherapy.

The San Francisco AIDS Foundation and many other HIV/AIDS advocacy organizations strongly supported Proposition 215 because it expands the right of people with HIV/AIDS to access potentially useful HIV-related treatments. However, there are a number of issues that may need to be clarified and/or addressed by the State Legislature in regards to Proposition 215. Some of the most important issues include the following:

Research: Although there is strong anecdotal evidence and other data to show that marijuana used under a physician's supervision can reduce the wasting, nausea, and day-to-day suffering of

illnesses such as AIDS, more research should be done on its effects on people with HIV/AIDS to assist in the effective use of this treatment. The federal government has refused to allow additional medical research on marijuana to continue despite clear scientific evidence that it may be a useful medication. State legislation should include provisions which help to ensure that controlled, clinical research of the effects of marijuana is conducted.

Added Protections for Physicians: Although physicians who prescribe marijuana do not face state penalties because of Proposition 215, they may still be prosecuted under federal drug laws. As a result, provisions should be written to allow confidential “in-judges chambers” hearings for physicians who are arrested. This will ensure some of the physician’s privacy and help to ease some of the fears of federal sanctions.

Distribution System: Proposition 215 calls upon the state and federal governments to “implement a plan to provide a safe and affordable distribution of marijuana” but does not provide details of what this would entail. Legislation should include provisions that outline such a plan.

Other possible provisions include a clearer definition of diseases or types of illnesses to which this law applies, a restriction of the locations where medical marijuana can be used, and increased guidelines regarding the “recommendation” that must be provided by a physician before a patient can legally use marijuana.

In addition to legislation meant to clarify Proposition 215, another bill or set of bills may be introduced to limit the scope of the new law in order to reduce access to medical marijuana and increase the risk for criminal sanctions. These bills run against the spirit of the popular measure and should be defeated.

Recommendations

- Any legislation which is enacted must ensure continued access to medical marijuana for people living with HIV/AIDS.
- Scientific research should be conducted and/or encouraged so that the effectiveness of medical marijuana can be clearly and finally established.
- Expanded protections for both physicians and patients are appropriate, with the goal of reducing physicians’ and patients’ fears about possible criminal penalties.
- The state should be responsible for developing a plan to implement a safe and affordable distribution system.
- Any bills which are intended to greatly reduce access to medical marijuana or to increase likelihood for criminal sanctions should be defeated.

SHIFT TOWARDS MANAGED CARE AFFECTS CALIFORNIANS LIVING WITH HIV/AIDS

Over the past decade, health maintenance organizations (HMOs) and other managed care plans--which pay the health care contractor a fixed per capita fee (or capitation payment) for each eligible enrollee--have rapidly replaced traditional fee-for-service health insurance. California has lead the nation in this shift and has one of the highest rates of managed care in the commercial health insurance market. As a result of these changes, growing numbers of Californians living with HIV/AIDS are receiving their health care from managed care providers.

Ideally, managed care is designed to control health care costs by creating a more efficient means by which health care services are delivered without hurting patient care. In doing so, managed care is dramatically redefining the traditional roles and relationships within the health care industry. Receiving a set, single monthly payment for each individual enrollee (rather than a fee for each service provided) is supposed to provide insurers with a strong incentive to keep their members in good health through preventive care and to keep costs low through operational efficiencies. Unfortunately, this arrangement can also produce disincentives to providing needed health care services to patients. When profits and cost containment are put ahead of the need for quality care, patients can face reduced access to primary and specialty care providers and new or expensive treatments, clinical decisions based on cost rather than appropriate standards of care, and health care providers who are not permitted to truly serve as the patient's advocate.

These potential problems can be particularly worrisome in the context of HIV/AIDS, which can require multiple visits to primary care providers and specialists, intensive daily management of HIV/AIDS and many treatment regimens. As increasing numbers of individuals living with HIV/AIDS rely on managed care providers, it is absolutely critical that these individuals be ensured high quality care, including access to medical specialists and to new and in some cases experimental drugs and all necessary diagnostic tests. In addition, physicians within managed care settings must be able to provide vital information regarding new medical developments and options for treatment and also serve as an advocate for their patients.

There has been an attempt by the California Legislature to reduce some of the possible abuses of managed care systems. Several bills were signed into law in 1996 which may provide some safeguards. These measures prohibit health care service plans from interfering with the ability of physicians to communicate with their patients regarding their health care and from providing incentives to doctors to deny or limit medically necessary and appropriate services. However, further efforts must be made to ensure that managed care delivery systems provide individuals with high quality health care. This is especially important as more and more individuals with life threatening and/or chronic illnesses, such as HIV/AIDS, are enrolled in these systems.

Recommendations

- As the number of people with HIV/AIDS in managed care increases, the state must aggressively and carefully monitor the managed care industry and ensure that these individuals' needs are being met.

- Managed care consumers must be guaranteed timely access to specialists, including the use of HIV specialists as primary care physicians for individuals living with HIV/AIDS.
- The state should enact reforms including the rights to a second opinion when care is denied and shifting liability to the managed care plan when denial of specialist care results in injury.
- The state should enact laws or regulations which protect consumers from inappropriate hospital discharges and/or failure to appropriately admit patients who need care; when care is denied, HMOs and insurers should be required to disclose the criteria used in making this decision.
- In order to ensure that physicians and other health care workers are able to provide appropriate care and advocate on their patient's behalf, the state should enact legislation which would protect these employees from termination without cause.
- Managed care consumers must have access to information to help them choose among their managed care options, including information about the prescription drugs that are covered by the plan, the ability to access specialists, rules governing experimental or investigational treatments, and the availability of practitioners experienced with specific diseases, such as HIV/AIDS.

HEALTH INSURANCE COVERAGE SHOULD BE EXPANDED FOR LOW INCOME CALIFORNIANS

Since many of the Californians living with HIV/AIDS are not Medi-Cal eligible and do not have private insurance, an expansion of private health insurance coverage to low-income individuals is vital for people living with HIV/AIDS. Health coverage for low income Californians would be an important step in maintaining the health of people with HIV/AIDS. Additionally, since some counties in California may abandon their obligation as health provider of the last resort (Section 17000 of the California Welfare and Institutions Code) due to provisions and allowances in Governor Wilson's implementation of welfare reform, a restructuring is essential to ensure that a safety net is in place for California's most vulnerable populations. All Californians living with HIV should have access to appropriate primary care, regardless of their ability to pay.

The California Medical Association (CMA) is proposing a restructuring of the state and county indigent health care programs and simultaneously expanding health care coverage to low-income, uninsured working families, single adults and children who are not eligible for Medi-Cal.

If implemented, the CMA's proposed program could provide coverage to an additional 3.5 - 4.5 million uninsured Californians at a cost of just over \$5 billion annually. The proposal would consolidate medically indigent health care programs and funding sources.

The CMA's proposal sets eligibility solely on income level. 60% of uninsured adults and 70% of uninsured children live under 200% of the federal poverty level, with an additional 16% of uninsured adults and 12% of uninsured children living between 200% and 300% of poverty.

According to the CMA the greatest need for coverage is for two-parent families, single adults and children living below 200% of poverty.

Under the CMA's proposal individuals under 200% of the federal poverty level would not pay any fee. However a sliding fee schedule would be in place for individuals at 201% to 299% of poverty and assumption of full contributions at 300% of poverty.

The CMA is considering offering a basic benefits package that would provide access to preventive care, sick care, hospitalization emergency care, x-rays, lab tests, prescription drugs and mental health services. It does not include vision or dental benefits, two important components of care for people living with HIV/AIDS.

A public state wide health insurance purchasing pool would be established patterned after the Health Insurance Plan of California (HIPC). Initially, this proposal would be separate from HIPC but administered through the same agency. Indemnity plans as well as private and public HMO's could participate. Also, under this structure, employers could purchase health insurance for low-income employees through the pool.

Recommendations

- California must ensure access to appropriate and adequate health care to all Californians, regardless of their ability to pay.
- The California Medical Association's proposal to expand health coverage to low income Californians should be further explored.
- Any health plan for low income individuals must include guidelines for managed care programs participating in order to ensure quality health care for individuals with diseases like HIV/AIDS. The recommendations included in the above section on managed care should be incorporated into these requirements.
- Any plan should include comprehensive provision of benefits, including dental and vision coverage.

MEDI-CAL PROVIDES VITAL CARE AND TREATMENT TO CALIFORNIANS LIVING WITH HIV/AIDS

Medicaid (in California it is known as Medi-Cal) is a joint federal and state program. In California, state funds cover 50% of Medi-Cal costs while the federal government covers the other 50%. Medi-Cal is the publicly financed health insurance system for those with limited financial resources. The majority of people living with HIV/AIDS are either low-income from the onset of their illness or become impoverished because of decreased capacity to work and the tremendous expense associated with the disease. As a result, Medicaid has come to represent the largest government investment in the care and treatment of people living with HIV/AIDS and is indispensable to the continued health care of these individuals. Nationally, this program

provides health coverage to over 40% of all people living with AIDS and to over 90% of children with pediatric HIV or AIDS. In California, these numbers are even higher, with approximately 50% of people living with AIDS relying on Medi-Cal for their health care. For these individuals, Medi-Cal provides the only means by which they are able to access essential primary health care as well as the new combination therapies and other vital treatments.

As a result of increases in the number of people living with HIV/AIDS and the developments of new treatments that prolong life, Medi-Cal expenditures for people living with HIV/AIDS have been increasing dramatically, from \$24.4 million in 1986 to \$165.8 million in fiscal year 92-93 (the last year for which Medi-Cal data is available). Given these increases, the importance of Medi-Cal for Californians living with HIV/AIDS will not decrease. In fact, overall need for the program will probably increase as individuals are able to live longer as a result of combination therapy.

Optional benefits: In addition to standard medical care, Medi-Cal also offers a number of optional benefits that are of importance to people living with HIV/AIDS (these benefits are considered “optional” because the state can choose not to provide funding to cover these expenses). These benefits include such services as adult dental care medical supplies, non-emergency health care transportation, and several others. These benefits are critical to providing adequate health care for people living with HIV/AIDS. Dental care is not simply oral hygiene, but is often a medical necessity for people with HIV/AIDS, who often develop oral manifestations of HIV disease which must be treated. Furthermore, the medical supplies benefit includes such important items as external catheters, disposable syringes, gauze pads, and IV drips; without access to these supplies, some people living with HIV/AIDS may have to seek out expensive hospitalizations. In previous years, the Governor proposed eliminating these optional benefits, but the Legislature wisely ensured that these services were maintained.

Access to experimental treatments: Experimental treatments are also of great importance to people living with HIV/AIDS. Often, individuals may have utilized all current treatments available to counter a particular opportunistic infection with little or no success. Experimental treatments may provide another possible course of treatment in these cases. In 1995, Medi-Cal approved reimbursement for Serostim, a human growth hormone used in the treatment of AIDS-related wasting which had not yet received full approval from the Federal Food and Drug Administration, but had received status as a Treatment Investigational New Drug. This was an important step in ensuring that individuals with AIDS related wasting had access to a wide range of possible treatments.

Medi-Cal Managed Care: Increasingly, Medi-Cal and Medicare beneficiaries are being shifted into managed care systems. Managed care is designed to lower health care costs and is thus an attractive alternative for the Medi-Cal program which is trying to control costs at both the state and federal levels. Eventually, California’s Medi-Cal managed care program is likely to be the largest in the nation, serving up to 3.3 million people. Because of the great importance of Medi-Cal to people living with HIV/AIDS, the growing trend of shifting the Medi-Cal population into managed care is of particular concern to people living with HIV/AIDS and AIDS advocates.

Currently, California has established what is known as the Two-Plan Model for Medicaid Managed Care in several California counties. This model requires the managed care enrollment

of all those individuals who are served by Aid to Families with Dependent Children program (AFDC) while enrollment is voluntary for other groups, including the aged, blind and disabled (including individuals with HIV/AIDS). It is imperative that individuals with HIV/AIDS are not forced into Medi-Cal managed care at this time since it has been shown that poor, chronically ill individuals have worse physical health outcomes in managed care environments.

Individuals enrolled in the Medi-Cal managed care have the choice of receiving their health care from one of two plans, either a private commercial plan or a new locally developed plan. These “local initiatives” involve a partnership among the state Medi-Cal program, county government, safety-net and traditional Medi-Cal providers and the community and utilize both county and private health care providers. Ideally, these local initiatives are supposed to support the health care safety net and allow local providers and community members to design a plan that fits with the community needs. As these plans are implemented throughout the state it is essential that they be monitored to ensure that high quality health care is being provided to those who rely on Medi-Cal managed care. Once this is ensured and can be guaranteed for Medi-Cal recipients with disabilities, people with HIV/AIDS could be placed in such a system.

Potential Medi-Cal Expansions: In recent years, there has been some discussion about expanding Medi-Cal to cover larger numbers of the disabled population and/or additional uninsured populations with slightly higher--but still limited--incomes than current Medi-Cal eligibility requirements allow. Given the large number of Californians who are uninsured or underinsured, this appears to be a worthwhile goal, but it must be done without damaging or reducing the quality of care that current Medi-Cal recipients receive.

Recommendations

- California must ensure that Medi-Cal continues to be available at its current level of service to low income Californians and that current optional benefits are maintained.
- Medi-Cal should also provide access to experimental treatments, especially when other courses of treatment have been found to be ineffective.
- If the Medi-Cal program is expanded to include other populations, this should be done in a manner which does not reduce services to current Medi-Cal recipients.
- California should either expand Medi-Cal and/or implement significant private sector health insurance reform to bring millions of Californians without adequate health insurance coverage into the system of care.
- It is essential that disabled people, including individuals living with HIV/AIDS are not placed into Medi-Cal managed care plans until full guarantees to high quality health care are assured for these individuals. The recommendations included in the above section on managed care should be incorporated into the requirements that Medi-Cal managed care plans must meet before any disabled populations are enrolled.

WELFARE REFORM IMPLEMENTATION MUST AVOID A PUBLIC HEALTH CRISIS FOR PEOPLE LIVING WITH HIV/AIDS

HR 3734, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (also known as welfare reform), was passed by Congress and signed into law by President Clinton in August, 1996 and includes some of the most sweeping changes to welfare policies in over 60 years. The California Medical Association (CMA) has reported that the law will significantly impact the health care of Californians by an increase in the uninsured population and a lowering of health status. This is significant for people living with HIV/AIDS in California. Among the over 30,000 Californians living with AIDS, the population most impacted by the measures of HR 3734 is immigrants living with HIV/AIDS, whether legally residing in the state or “undocumented”.

Supplemental Security Income/State Supplementary Program (SSI/SSP): The welfare reform bill eliminates SSI, the cash assistance program for the aged, blind, and disabled, for most legal noncitizens. For many people living with AIDS, SSI/SSP is their sole source of income. Since they cannot work, the elimination of this \$626.40 per month for individuals will force legal immigrants to turn to the county General Assistance (GA) program for their financial support. GA grants are usually lower than the current SSI/SSP levels, thus the impact on those forced to turn to GA alone will be harsh. This could spell disaster for California counties. The California State Association of Counties, for example, estimates that annual costs of General Assistance (GA) which are currently about \$450 million--could balloon to as much as \$1.3 billion. A likely result would be even further lowering of GA grants per individual.

Medi-Cal: Because HR 3734 bans Medicaid (Medi-Cal) benefits for legal immigrants during their first five years in the United States, these new immigrants will be limited to emergency health care services only. The most recent statistics for 1996 indicate that over half the Californians living with HIV/AIDS rely on Medi-Cal for their health care. Although there are no firm statistics on the number of legal immigrants with HIV, it is clear that this provision of welfare reform will have a drastic impact on these Californians living with HIV/AIDS.

Aid to Families with Dependent Children (AFDC): This program, which almost exclusively serves women and children, will be replaced by a block grant to states called the Temporary Assistance to Needy Families (TANF) program. California will have the option of maintaining current eligibility levels but must meet strict work participation standards and a 60 month (five year) time limit for these benefits. This means that legal immigrants may receive TANF if California chooses to provide it for them. Also, at its discretion, states are allowed to exempt 20% of its caseload from the time limit. For women and children living with HIV/AIDS, it is imperative that they be included in this 20% exemption from time limits. TANF and food stamps will not be available to newly arriving immigrants for their first five years in the US. In addition, according to new regulations, cash assistance and food stamps are not available to individuals who have been convicted of drug felonies, even if these individuals are seeking drug treatment.

Prenatal Care: In response to the passage of welfare reform, proposals to eliminate prenatal care to undocumented women have been requested by the state Department of Health Services and were granted by the Office of Administrative Law. However, the courts have temporarily

blocked this request. This proposal is poor policy. For women living with HIV/AIDS, or at risk for HIV infection, prenatal care offers an opportunity for women to be counseled and offered HIV testing and to learn how vertical transmission of HIV can be prevented. It is much more cost effective for women to receive prenatal care to reduce the chance of perinatal transmission than to pay for care for an HIV infected child.

“Communicable Disease” Requirements: Welfare reform exempts immunizations, testing and treatment of symptoms of communicable diseases from the ban of services to undocumented immigrants. Although there is a question for California as to what is considered a “communicable disease” and what the level of services is that would be considered “treatment of symptoms for communicable diseases,” it is important that the state understands that it must provide a wide range of services in order to protect the public health.

State Reforms are Necessary: Steps must be taken to avoid a public health disaster in California. To that end, certain remedies must occur. Although, it would be wise to implement these remedies at the federal level, the state must be ready to find ways to ensure that they occur in the state in case no federal corrections are offered.

Recommendations

- Medi-Cal eligibility for legal immigrants should be retained for those who are disabled after entry and current recipients of these services.
- Disabled immigrants should be held harmless should they lose SSI payments, whether through a state-funded program or by provision of financial support to counties.
- The state must continue to provide prenatal care to undocumented women.
- The state should maintain TANF eligibility for legal noncitizens; women and children living with HIV/AIDS should be included in the 20% caseload exemption from the time limit for TANF benefits.

Acknowledgments

Thanks to Fred Dillon and Randy Allgaier for writing this report, to Laura Thomas and Paul Di Donato for editing and invaluable input, and to Nick Valenziano for formatting and distribution.

HIV/AIDS Public Policy Information

The San Francisco AIDS Foundation Public Policy Department advocates for adequate funding for HIV/AIDS programs and appropriate HIV/AIDS public policies at federal, state and local levels of government. Additionally, the Department operates a grassroots network throughout Northern California, the HIV Advocacy Network (HAN).

For information on HIV/AIDS public policy, please call the San Francisco AIDS Foundation, Public Policy Department at 415-487-3080.

For information on California HIV/AIDS issues, please contact Randy Allgaier, Director HIV Advocacy Network at 415-487-3085.

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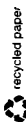
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Profile of AIDS and HIV in Los Angeles County

The Los Angeles County HIV/AIDS epidemic differs significantly from the epidemic nation wide with a higher percentage of cases among men who have sex with men, and a smaller proportion of cases among injection drug users.

HIV Exposure Categories of Adult and Adolescent AIDS Cases for 1995 - 1996		
Exposure Category	Los Angeles County	United States
Male-male sex (MSM)	68.8%	41%
Injection-drug use (IDU)	7.7%	26%
MSM/IDU	4.7%	5%
Heterosexual contact	0.4%	1%
Hemophilia	6.0%	12%
Transfusion	0.9%	1%
Unidentified risk	11.4%	14%

Persons living with AIDS in Los Angeles County are ethnically diverse.

Ethnicity and Gender of Adult and Adolescent AIDS Cases for 1995 - 1996		
Race/Ethnicity	Los Angeles County	United States
White	45.9%	39.5%
African American	20.5%	40.5%
Latino	30.5%	19.0%
Asian Pacific Islander	2.2%	1%
American Indian	0.4%	<2%
Not Specified	0.4%	0%
Proportion of Males	90.2%	80.5%

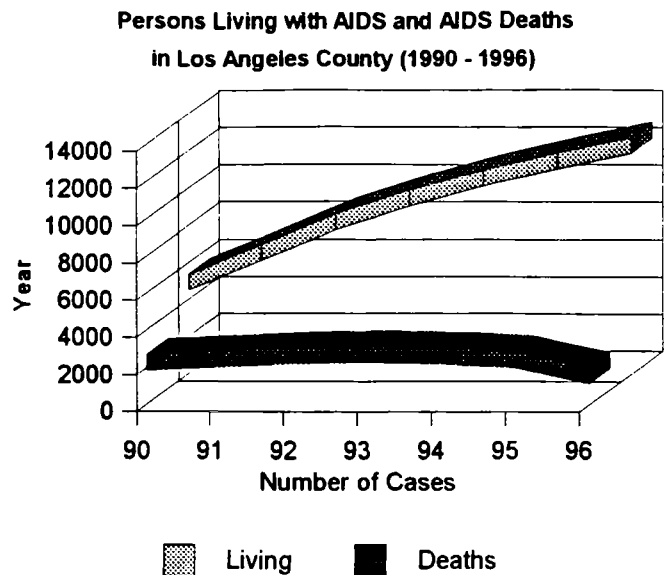
More males are affected by AIDS in Los Angeles County when compared to cases nationally.

Other factors impacting the provision of care to Los Angeles County residents with HIV/AIDS:

- **Homelessness:** Los Angeles County has the largest number of homeless persons in the nation. A study conducted among homeless adults in Skid Row indicated that seroprevalence among specific sub-groups was as high as 20 percent (MSM) and averages 3.7 percent.
- **Income:** A significant proportion of Los Angeles County residents live below the poverty level. 1992 data indicated that the AIDS rate was three time higher among residents of low income areas than among residents of high income areas.
- **Lack of Medical Insurance:** 1997 data indicated that lack of medical coverage of any type is common among County residents with AIDS. For example, 43 percent of foreign born Latinos with AIDS were medically indigent.

Estimates of unmet need in Los Angeles County indicate that there are approximately 22,000 persons with HIV not receiving care.

The recent decreases in mortality rates among those with HIV and AIDS have resulted in an ever increasing number of persons living with AIDS that require comprehensive medical coverage.



In response to the HIV/AIDS epidemic, Los Angeles County has developed a comprehensive system of HIV prevention programs and HIV/AIDS health and support services.

<u>SOURCE OF FUNDS</u>	<u>AMOUNT</u>
Ryan White Care Act (CARE)	\$33,476,997
Centers for Disease Control and Prevention (CDC)	\$15,751,338
California State (STATE)	\$16,554,679
<u>Los Angeles County (NCC)</u>	<u>\$15,900,000</u>
TOTAL	\$81,683,014

Highlights of this system of care include:

- Over 45 percent of all CARE funds are used to support a complex system of HIV/AIDS health and medical services.
- A significant and complex HIV prevention system including counseling and testing, behavior change programs and health education and risk reduction programs.
- Over 8.6 million dollars for AIDS drugs.

Los Angeles County Health Survey

Los Angeles County
Department of Health Services
Field Research Corporation

1997

Purpose

- Broad community wide health indicators
- Baseline data to assess impact of the 1115 demonstration
- More precise county estimates
- Sub county estimates
- Public perceptions of DHS
- Opinions toward tobacco policy options

Structure of the Survey

Main	8,004 interviews completed
Parent	2,374 interviews completed
Tobacco Policy	500 interviews completed

Elements of Survey

- MAIN
 - Access to care, barriers and utilization
 - Perceptions of DHS effectiveness
 - Health Behaviors
 - socio-demographics
 - Socio-economic
 - Health status
 - Preventive services
- PARENT
 - Parenting
 - Access to care, barriers and utilization
 - Child program participation
 - Health Status
 - Preventive services
- POLICY
 - Property tax
 - Tobacco companies
 - Raising the tobacco tax

Los Angeles County Health Survey

Languages

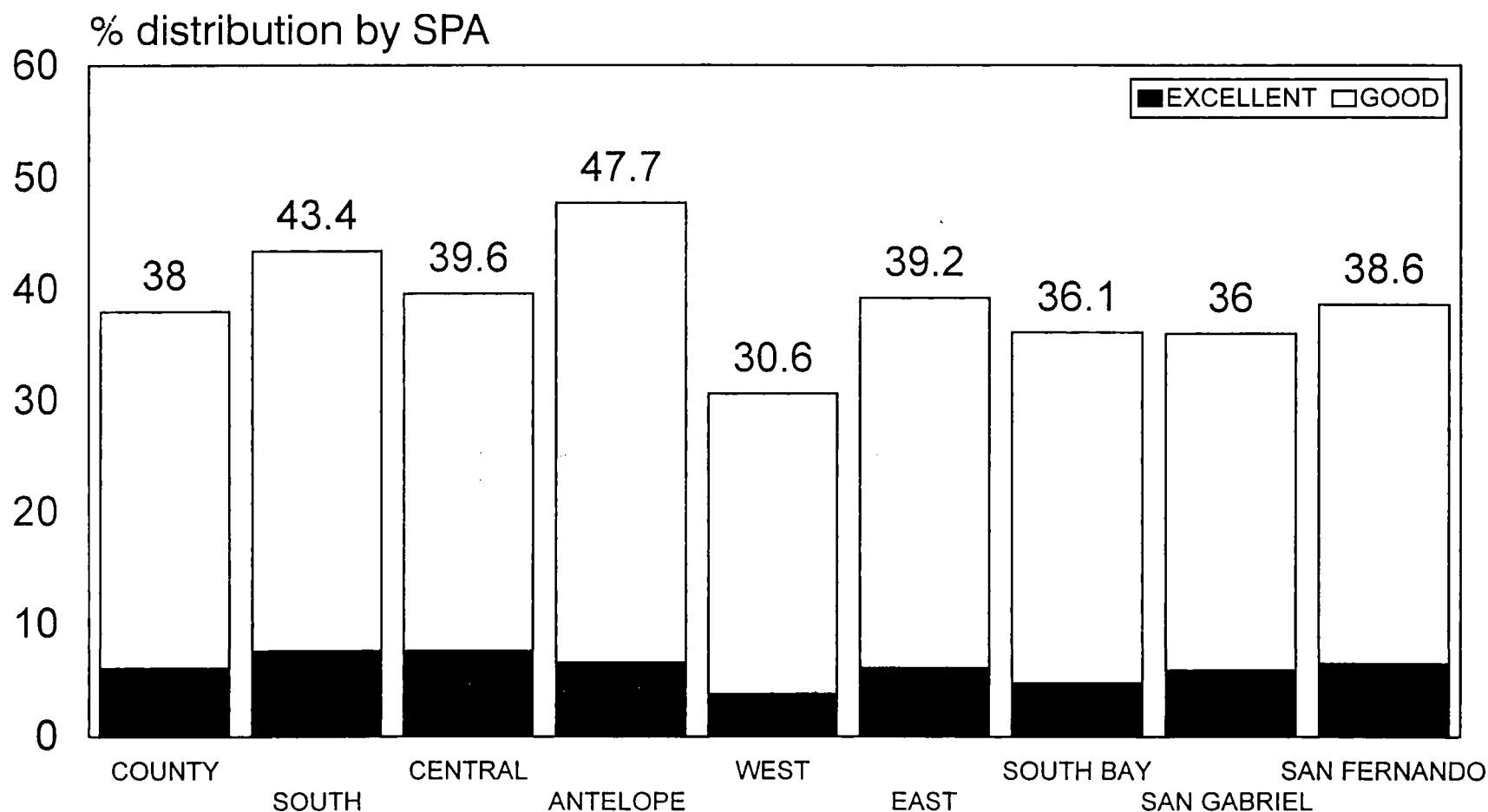
- English
- Spanish
- Chinese
- Tagalic
- Korean
- Vietnamese

"What kind of job do you think the Los Angeles County Department of Health Services is doing in safeguarding the health of the people living here?"



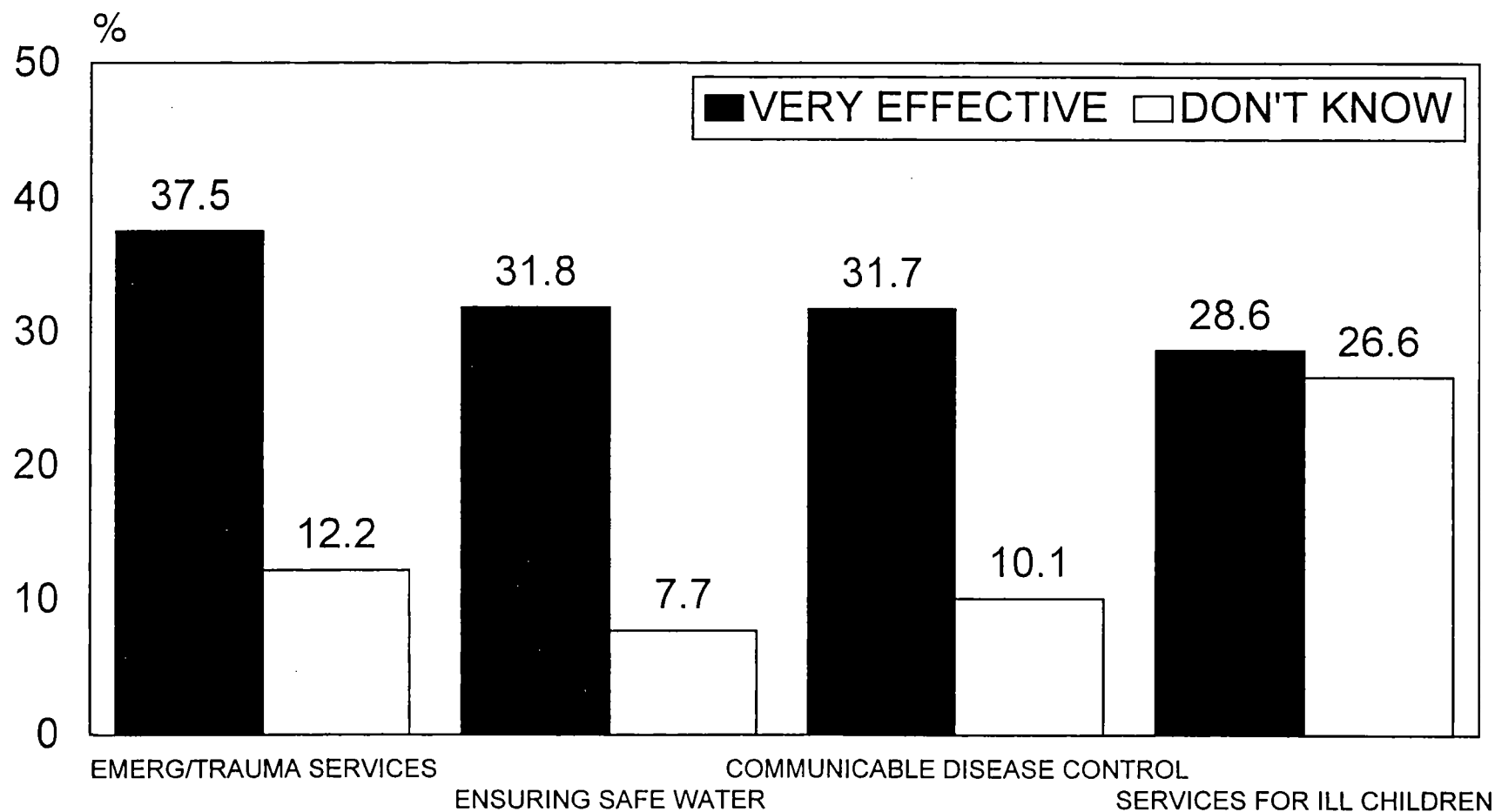
Source: Los Angeles County Health Survey, 1997. Main survey, adults only.
N=6,633,000 n=8,004

"What kind of job do you think the Los Angeles County Department of Health Services is doing in safeguarding the health of the people living here?"



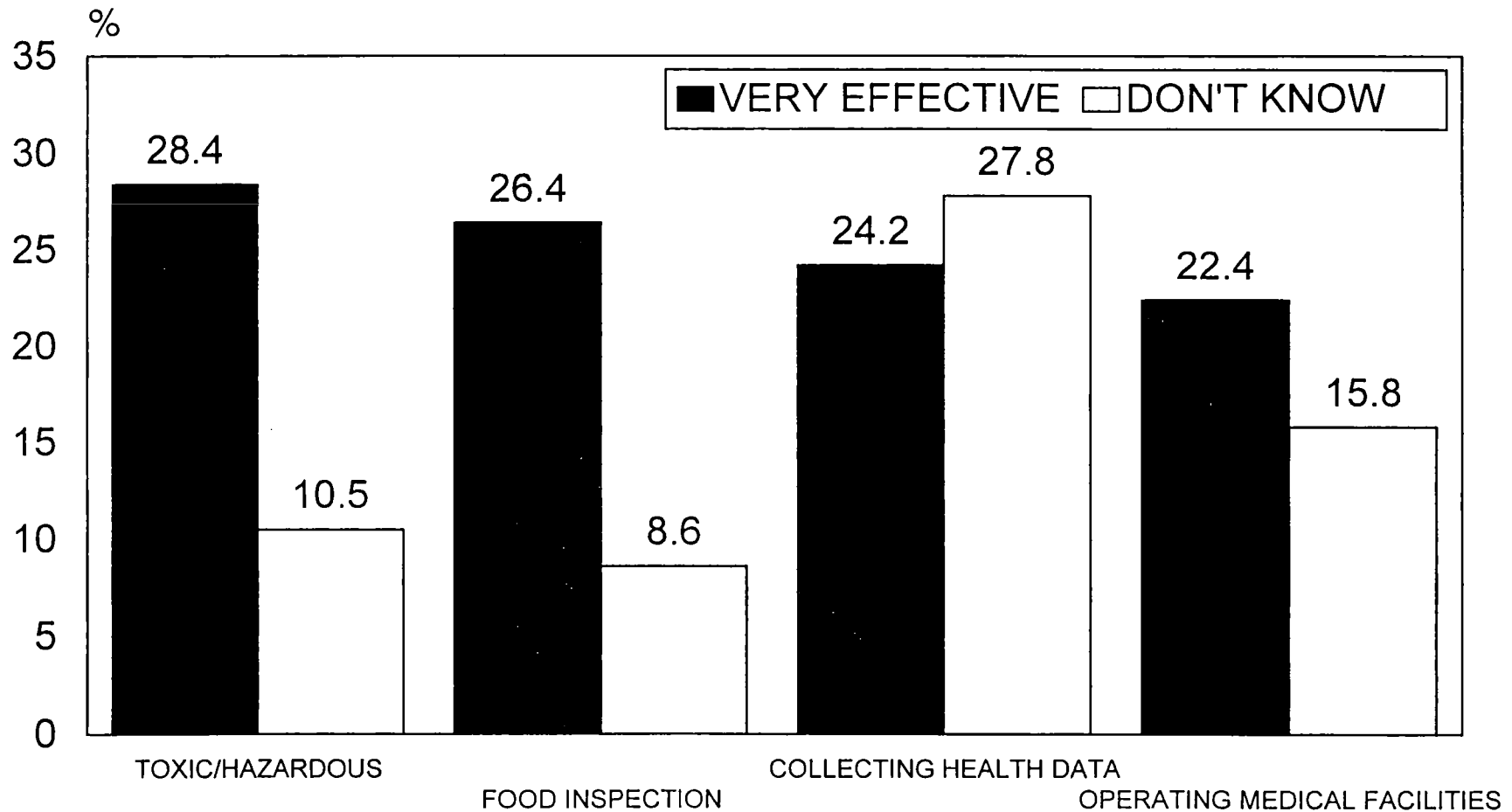
Source: Los Angeles County Health Survey, 1997. Main survey, adults only.
N=6,633,000 n=8,004

Perception of DHS Effectiveness in Selected Programs and Services, 1997



Source: Los Angeles County Health Survey, 1997. Main survey, adults only.
N=6,633,000 n=8,004

Perception of DHS Effectiveness in Selected Programs and Services, 1997



Source: Los Angeles County Health Survey, 1997. Main survey, adults only.
N=6,633,000 n=8,004

Perceptions of DHS Medical Care, 1997

Percent who feel that. . .	People wait too long at County DHS facilities	Quality of DHS care is same as private facilities	Clinical staff at DHS are friendly and helpful	Front office staff at DHS are unhelpful and unfriendly
	88.4	36.7	72.3	59.1

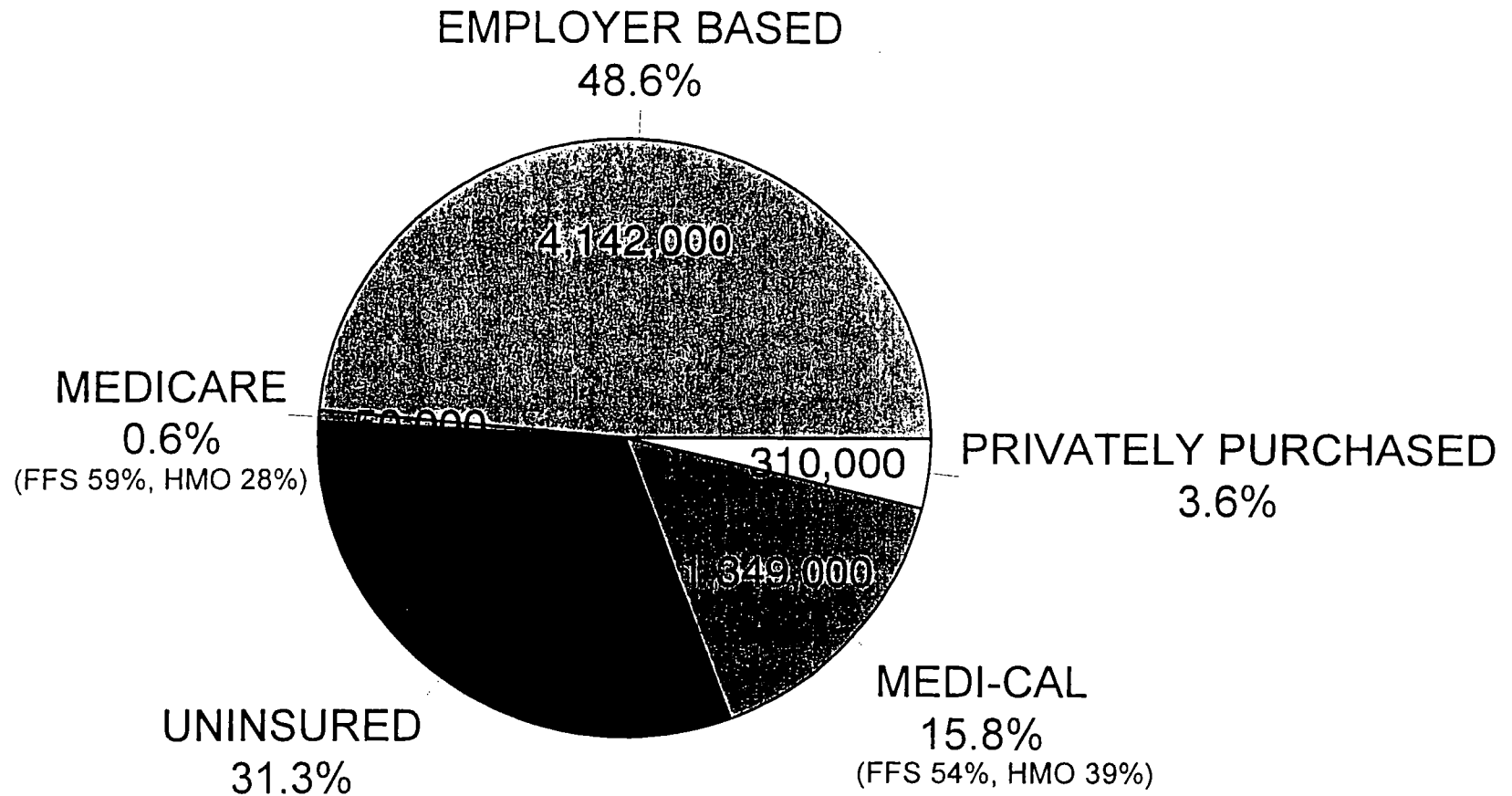
Source: Los Angeles County Health Survey, 1997. Main survey, adults only.

Note: For Q59_1(long wait) N=5,525,000 n=6,685; Q59_2(quality same) N=5,219,000 n=6,307;

Q59_3 (MDs and RNs) N=4,858,000 n= 5,831; Q59_4 (front staff) N=4,689,000 n=5,625.

Does not include cases with a value of "no opinion" on perception of DHS medical care variable.

Health Insurance Status Ages 0 to 64, 1997

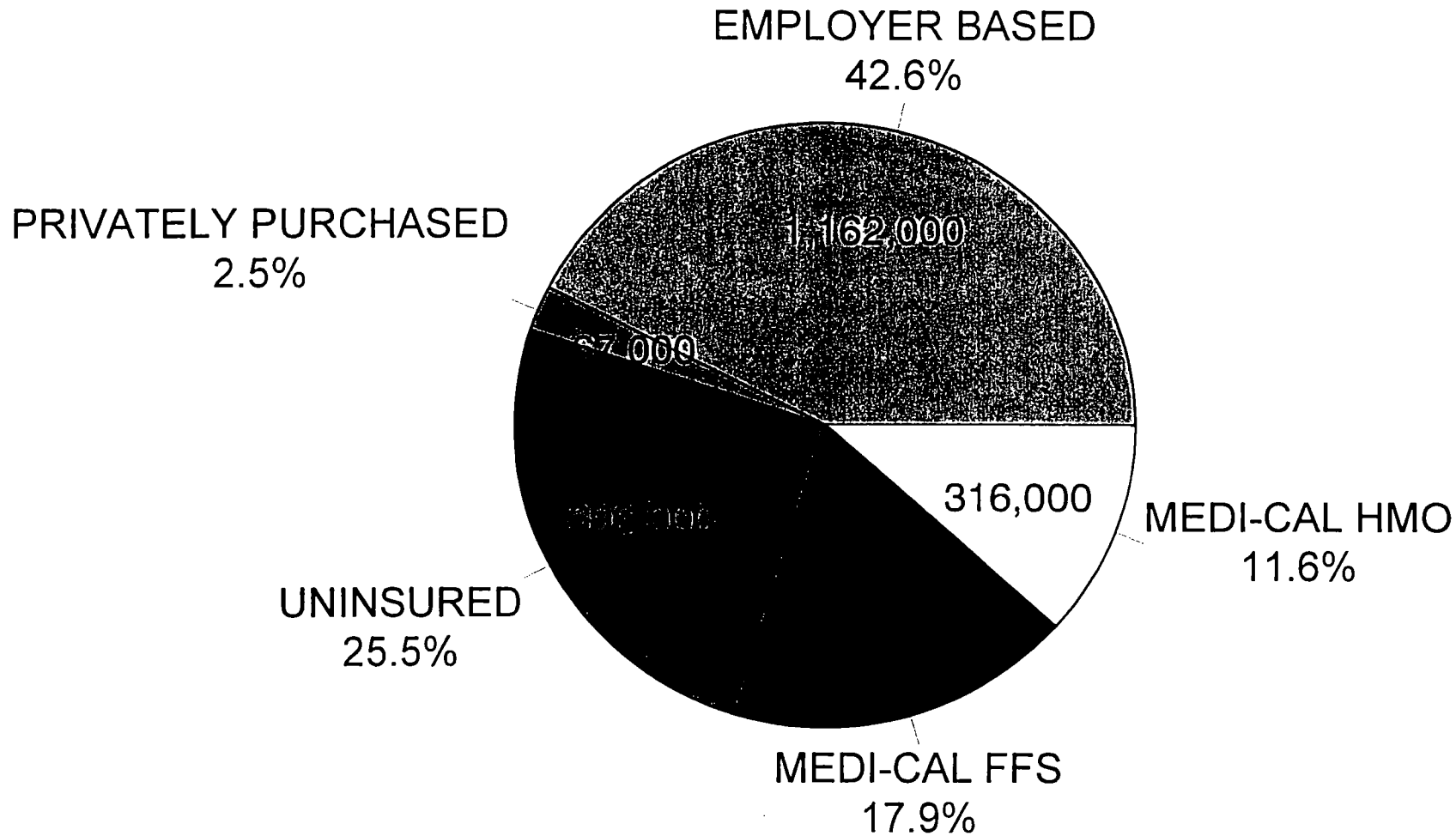


Source: Los Angeles County Health Survey, 1997. Main and Parent surveys.

Note: N=8,519,000 n=9,304; does not include cases with a value of "refused" on age group variable or "don't know/refused" on insurance status variable.

Employer-based insurance also includes those with military ,ChampUS, ChampVA insurance.

Health Insurance Status Children, Ages 0 to 17, 1997

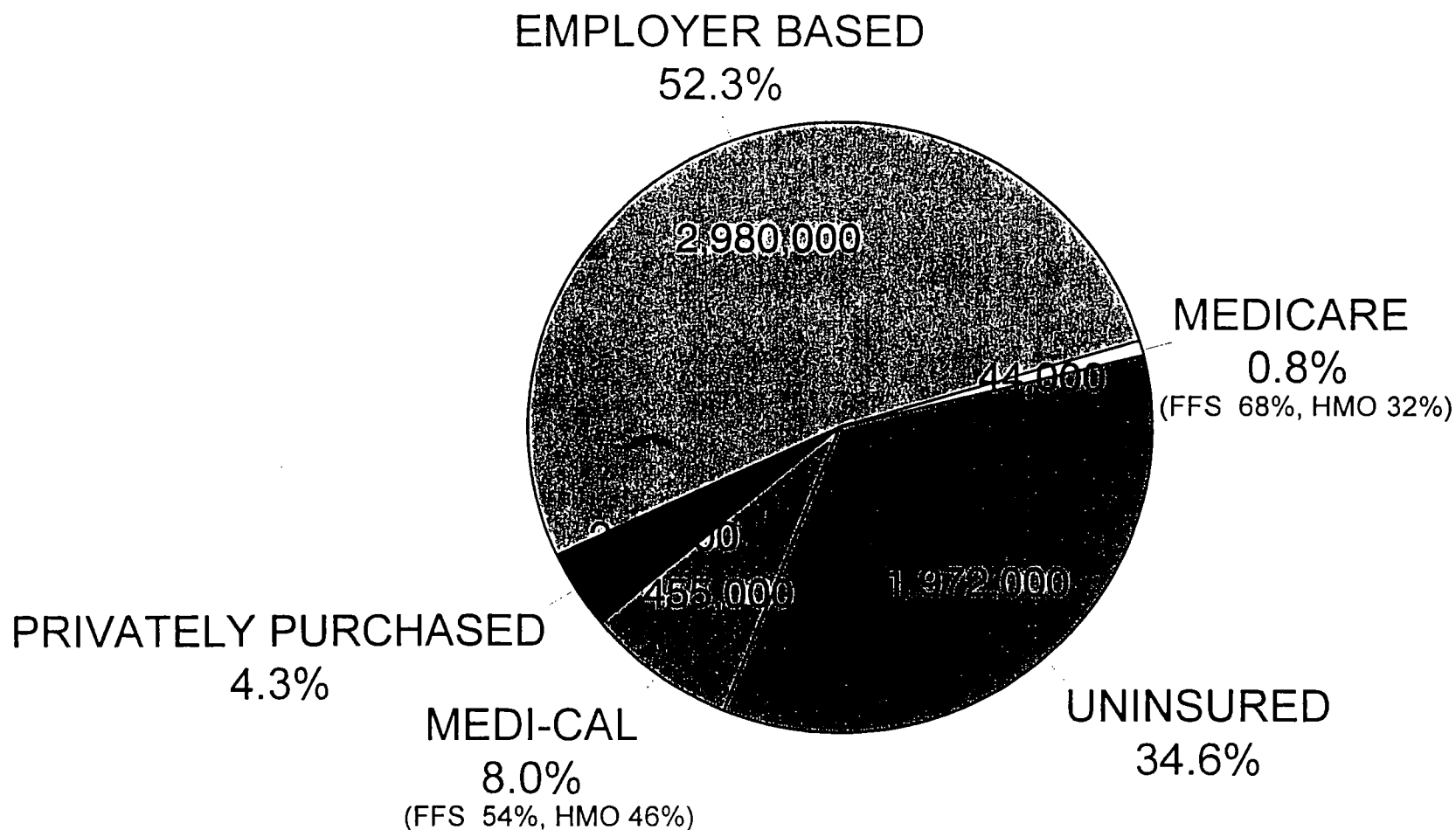


Source: Los Angeles County Health Survey, 1997. Parent survey.

Note: N=2,729,000 n=2,289; does not include cases with a value of "don't know/refused" on insurance status variable or "don't know/refused" on Medi-Cal type of plan variable.

Employer-based insurance also includes those with military, ChampUS, ChampVA insurance.

Health Insurance Status Adults, Ages 18 to 64, 1997

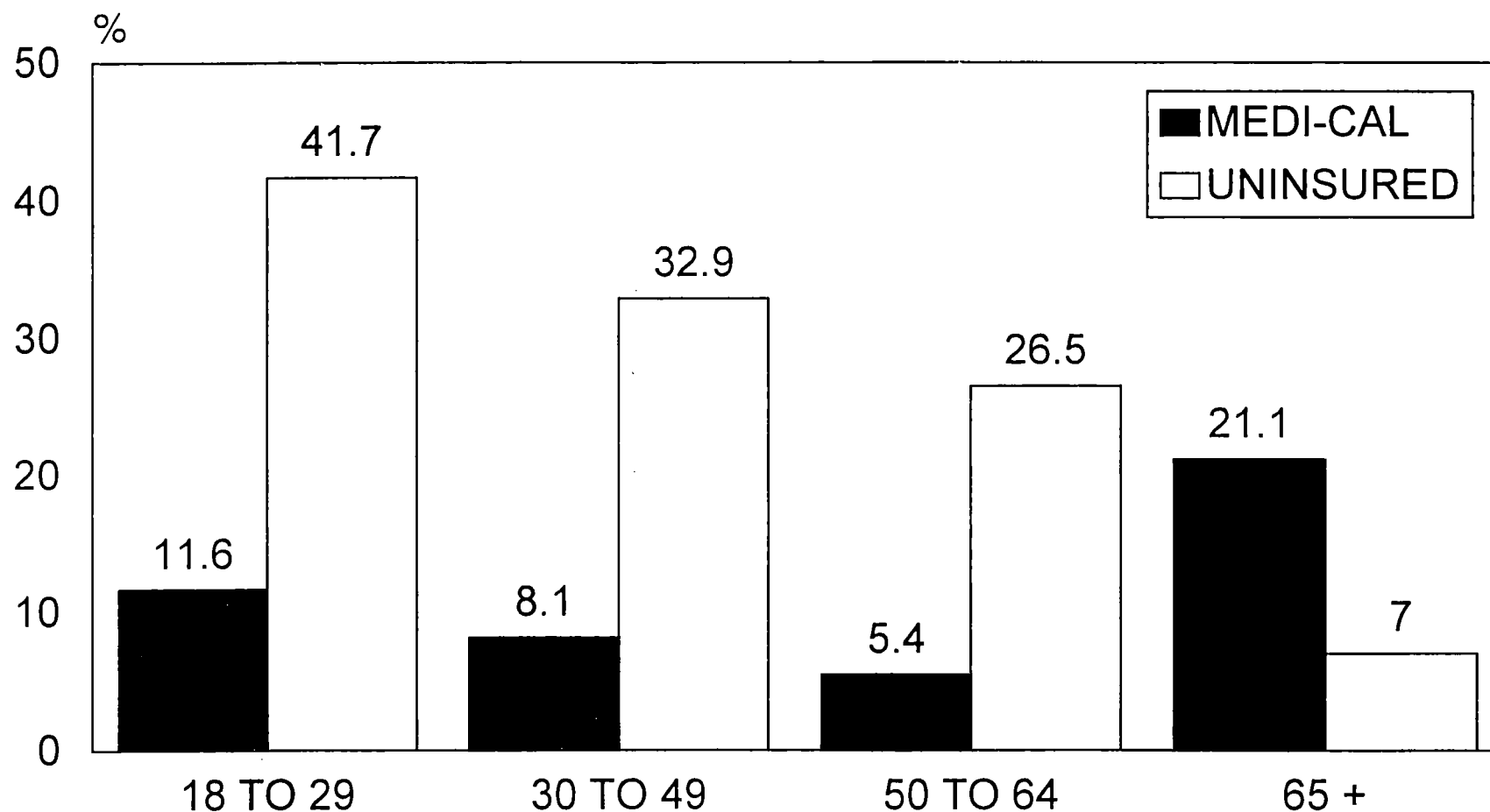


Source: Los Angeles County Health Survey, 1997. Main and Parent surveys.

Note: N=5,695,000 n=6,843; does not include cases with a value of "refused" on age group variable or "don't know/refused" on insurance status variable.

Employer-based insurance also includes those with military, ChampUS, ChampVA insurance.

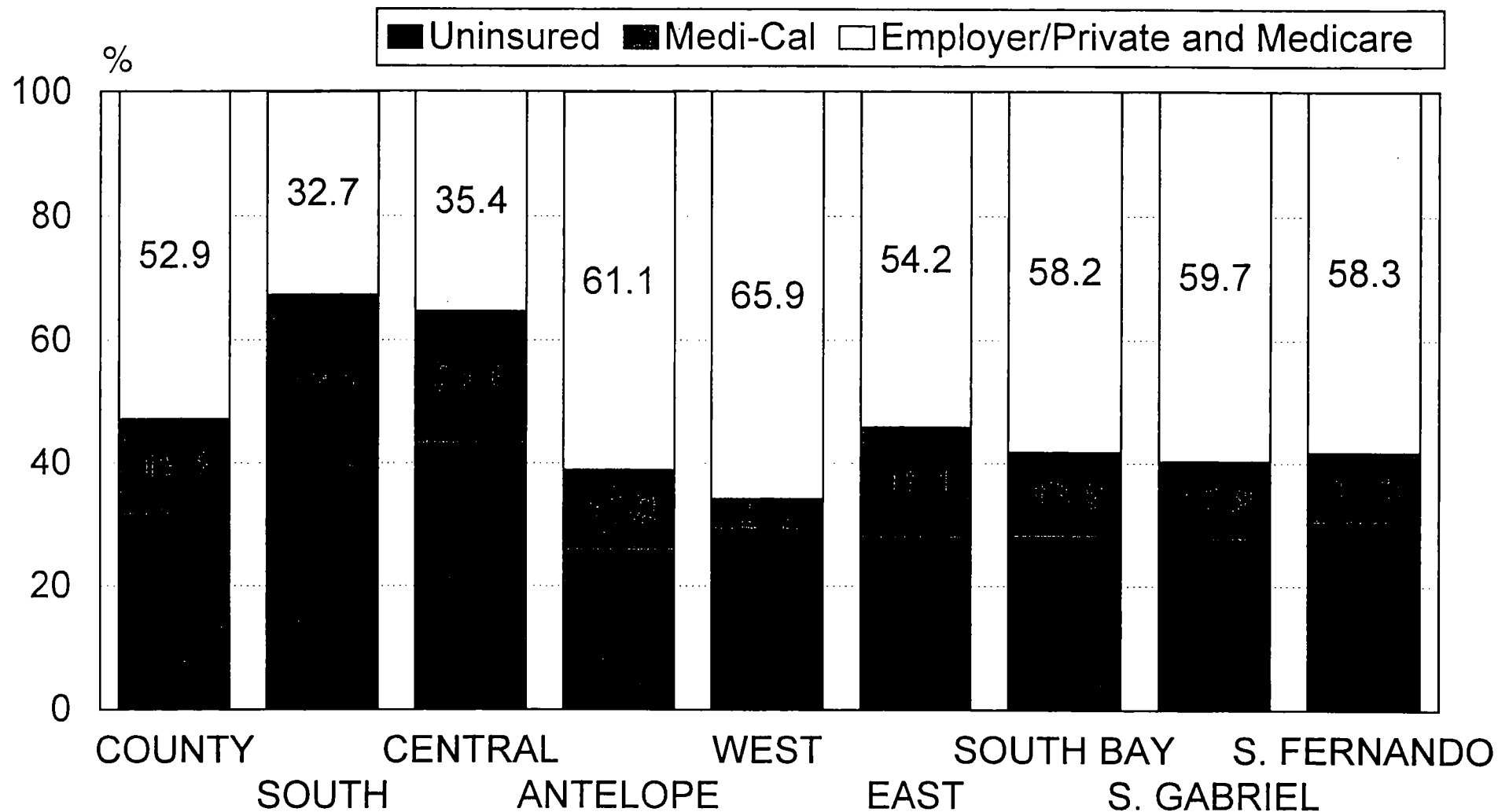
Percent of Adults Covered by Medi-Cal and Who are Uninsured, by Age, 1997



Source: Los Angeles County Health Survey, 1997. Main survey, adults only.

Note: N=6,581,000 n=7,945; does not include cases with a value of "refused" on age group variable or "don't know/refused" on insurance status variable.

Health Insurance Status by Service Planning Area, Ages 0 to 64, 1997

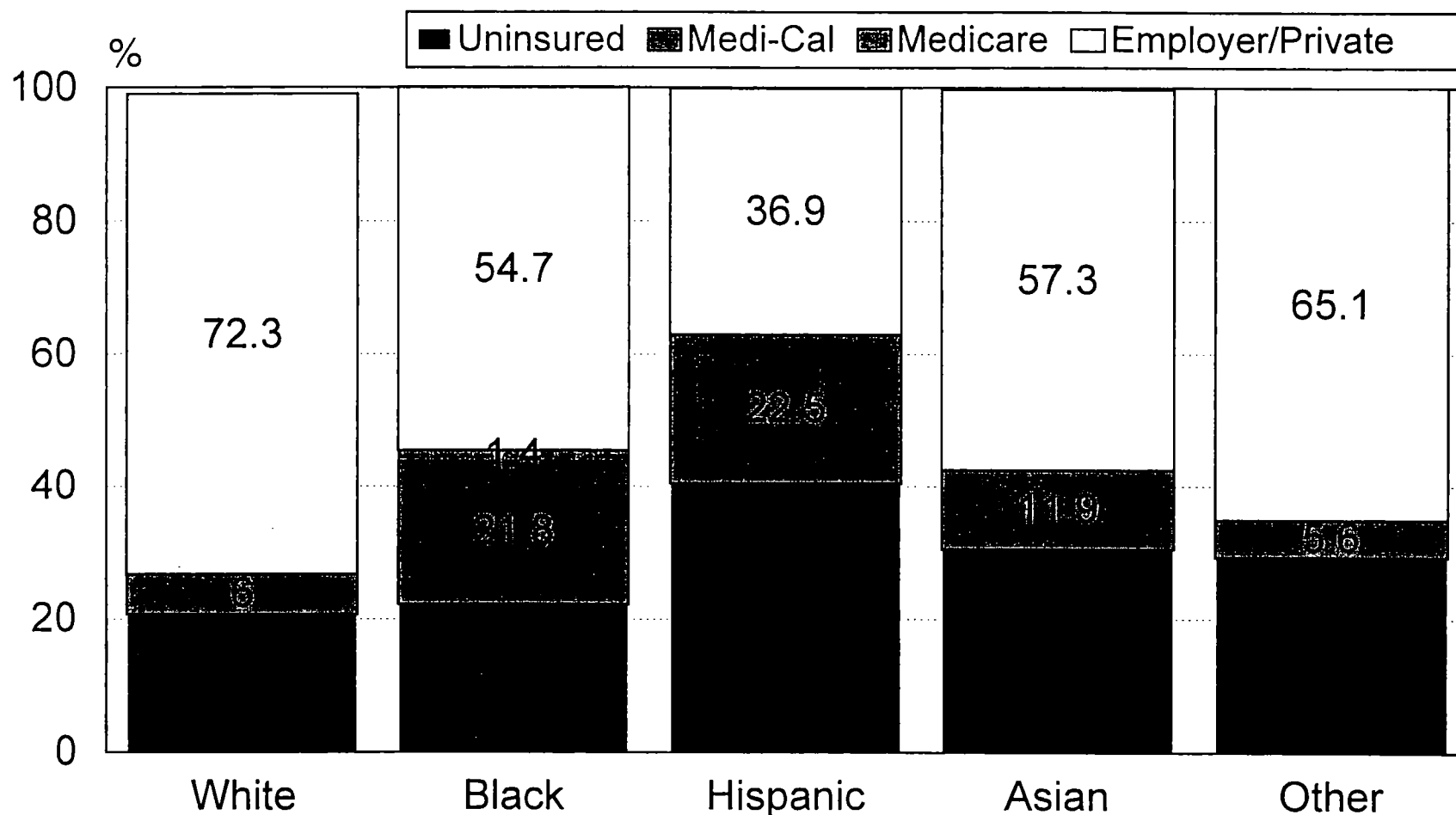


Source: Los Angeles County Health Survey, 1997. Main and parent survey.

Note: N=8,519,000 n=9,304; does not include cases with a value of "refused" on age group variable or "don't know/refused" on insurance status variable.

Employer/Private insurance includes those with employer-based insurance, military, ChampUS, ChampVA insurance, and privately purchased policies.

Health Insurance Status by Race and Ethnicity, Ages 0-64, 1997



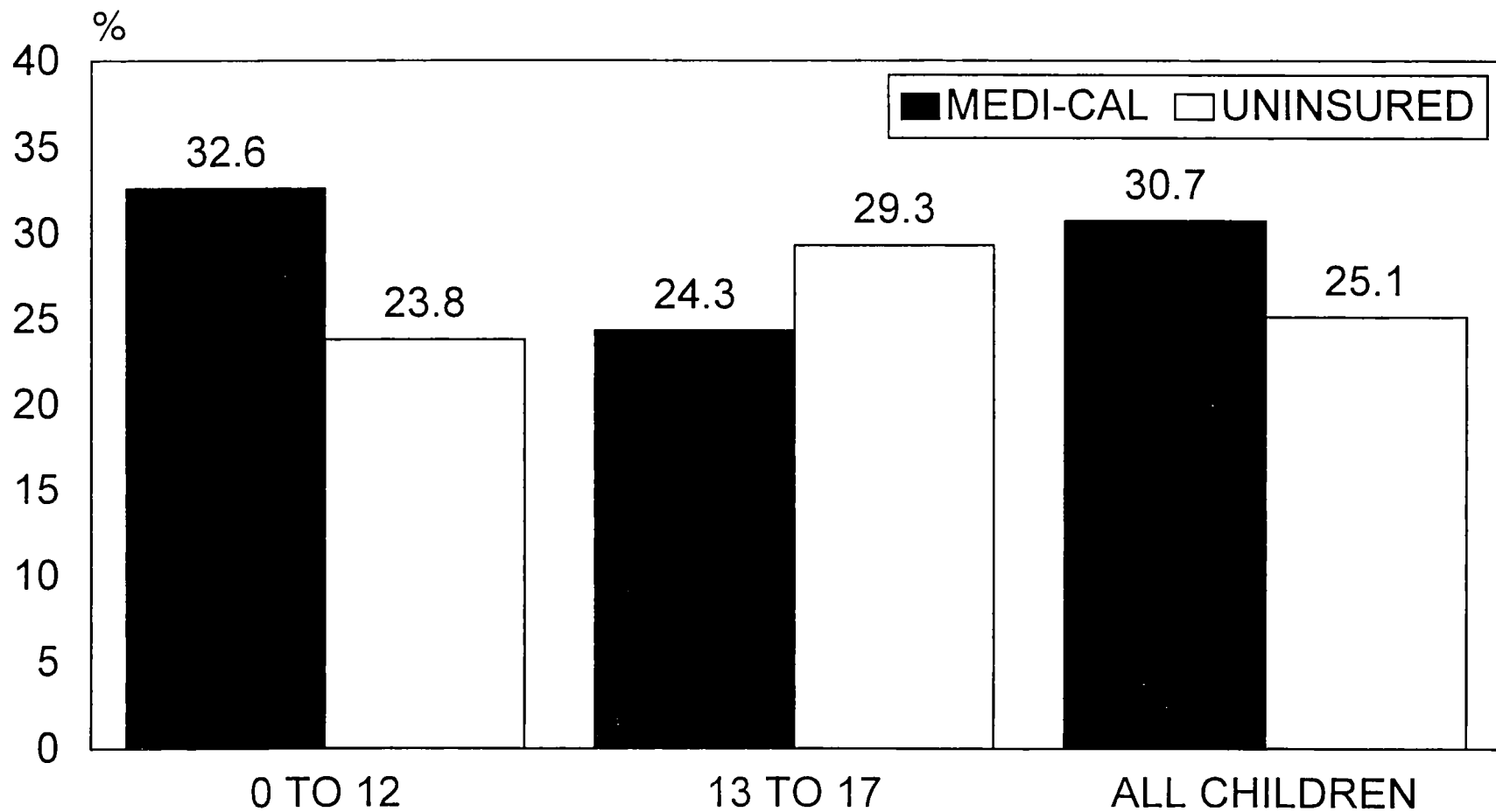
Source: Los Angeles County Health Survey, 1997. Main and Parent surveys.

Note: N=8,439,000 n=9,128; does not include cases with a value of "don't know/refused" on hispanic origin or race variables or cases with a value of "don't know/refused" on insurance status variable.

Employer/Private insurance includes those with employer-based insurance, military, ChampUS, ChampVA insurance, and privately purchased policies.

Values of 1.0% or less are not shown.

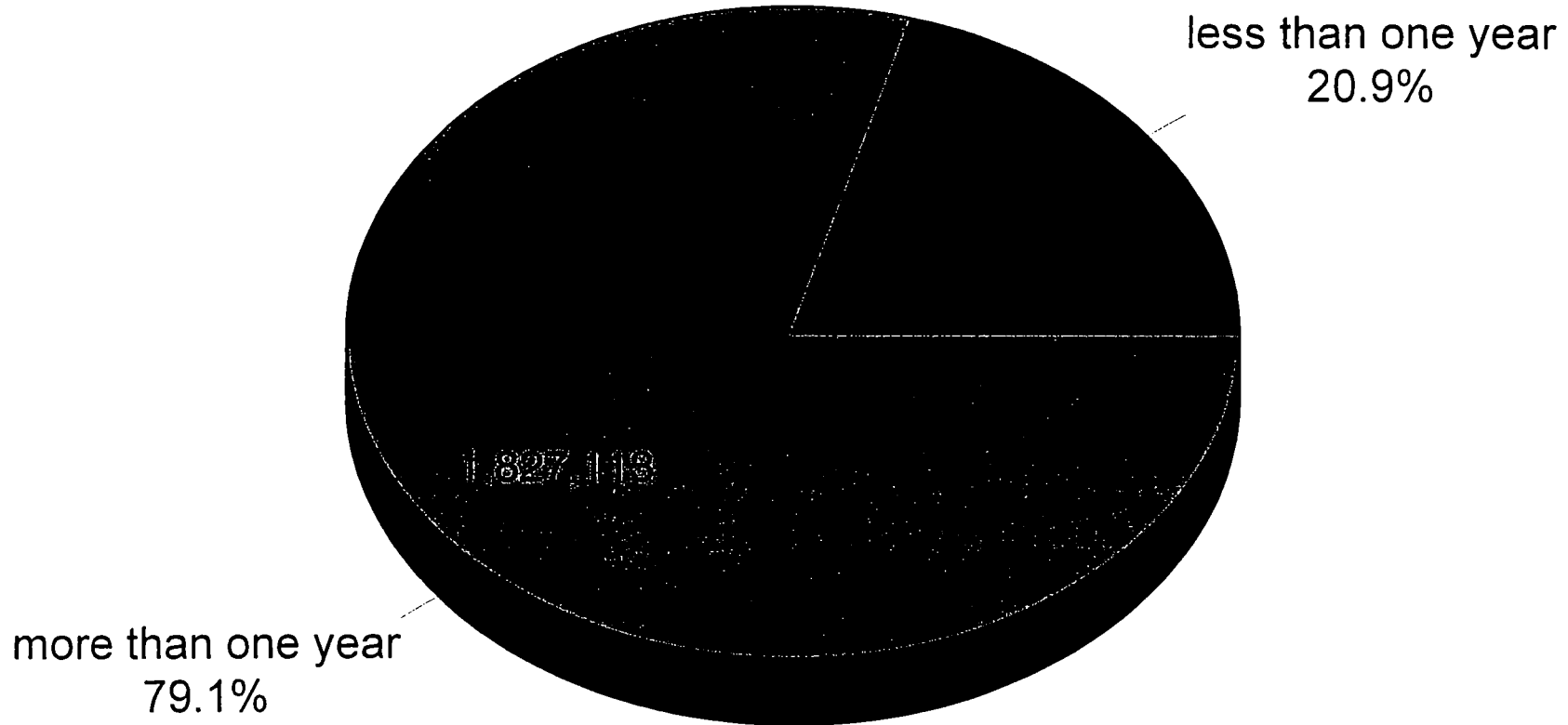
Percent of Children Covered by Medi-Cal and Who are Uninsured, by Age, 1997



Source: Los Angeles County Health Survey, 1997. Parent survey.

Note: N=2,776,000 n=2,322; does not include cases with a value of "refused" on age group variable or "don't know/refused" on insurance status variable.

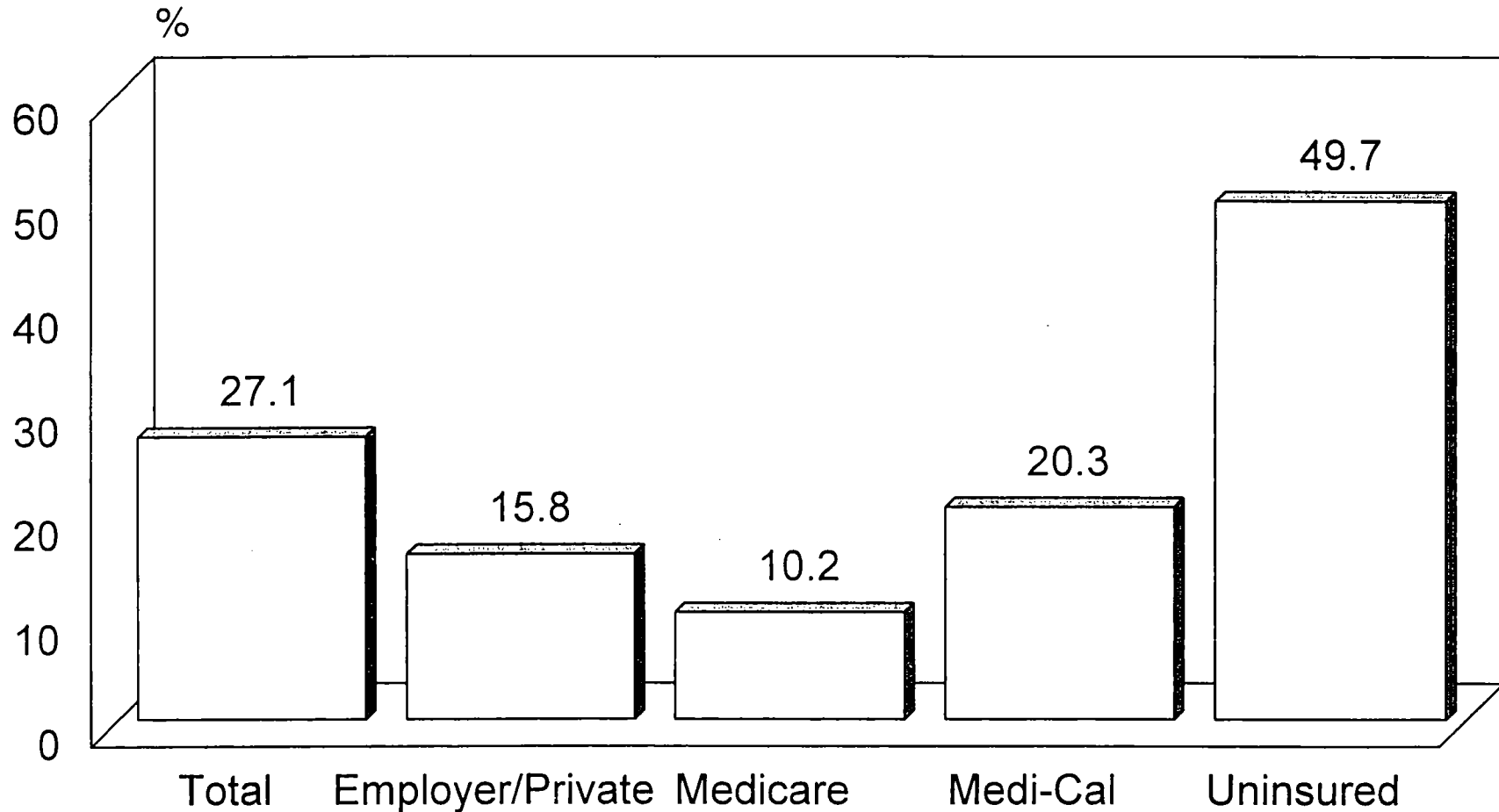
Length of Uninsured Status, Ages 0-64, 1997



Source: Los Angeles County Health Survey, 1997. Main and Parent surveys.

Note: N=2,309,000 n=2,427; does not include cases with a value of "refused" on age group variable or "don't know/refused" on last insurance coverage variable.

Percent Reporting No Regular Source of Care by Insurance Status, Ages 0-64, 1997

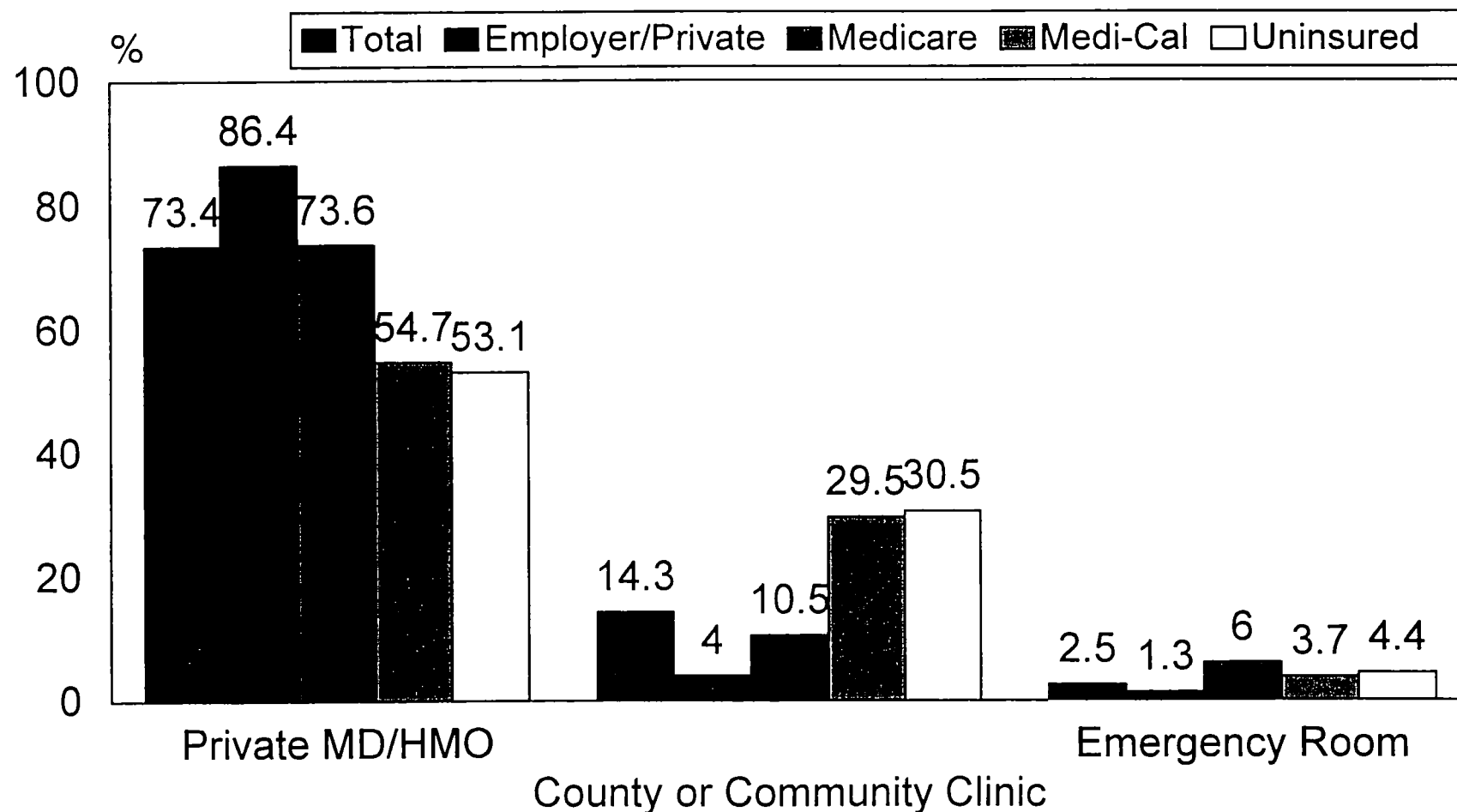


Source: Los Angeles County Health Survey, 1997. Main and Parent surveys.

Note: N=8,451,000 n=9,157; does not include cases with a value of "don't know/refused" on the regular source of care variable.

Employer/Private insurance includes those with employer-based insurance, military, ChampUS, ChampVA insurance, and privately purchased policies.

Percent Reporting Regular Source of Care by Insurance Status, Ages 0-64, 1997

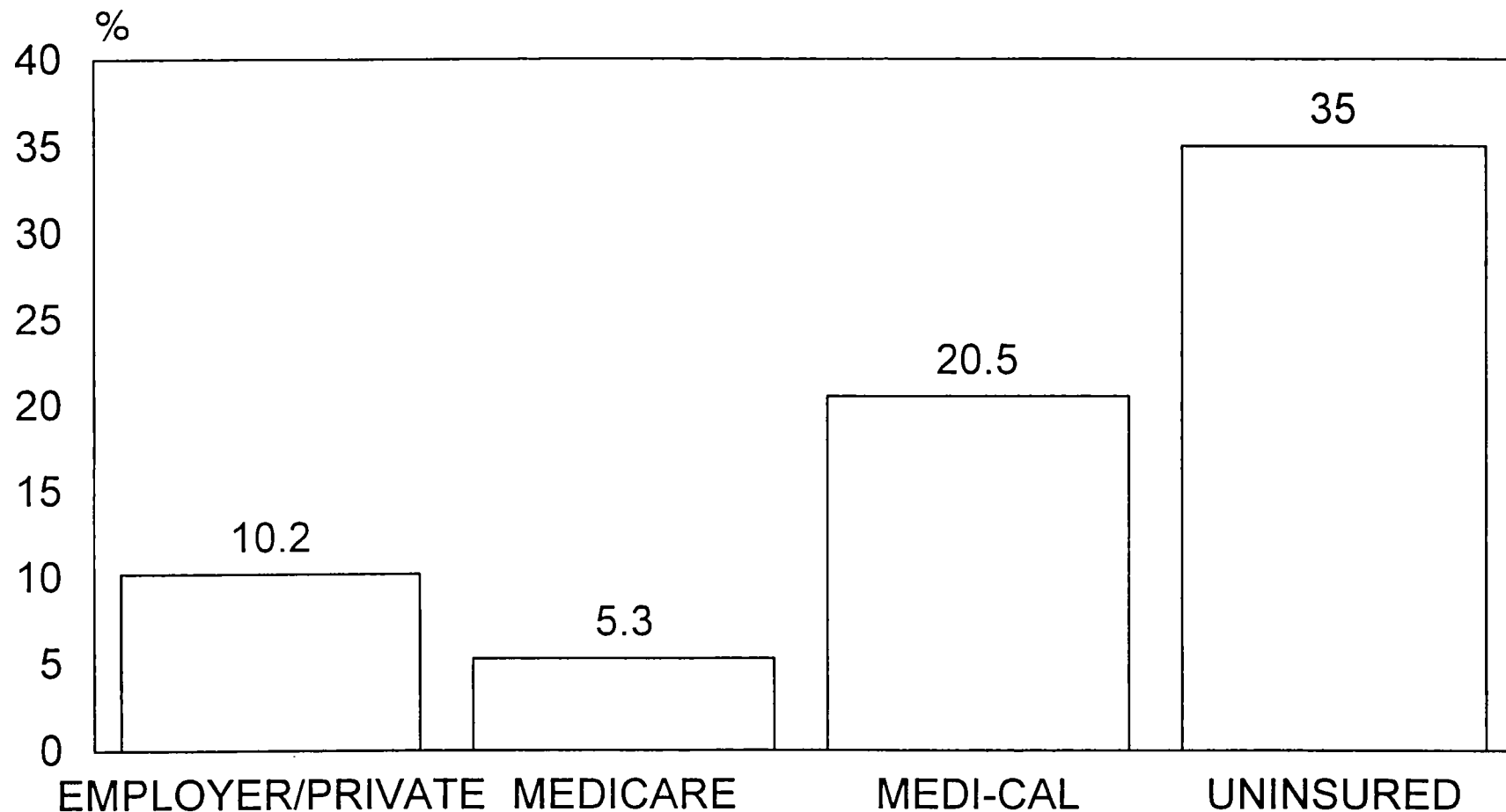


Source: Los Angeles County Health Survey, 1997. Main and Parent surveys.

Note: N=6,138,000 n=6,748; does not include cases with a value of "no" or "don't know/refused" on the regular source of care variable or "don't know/refused" or "outside LA County" on the source of regular care variables.

Employer/Private insurance includes those with employer-based insurance, military, ChampUS, ChampVA insurance, and privately purchased policies.

Percent of Adults Reporting Financial Difficulty Obtaining Medical Care in Past Year, by Insurance Status, 1997

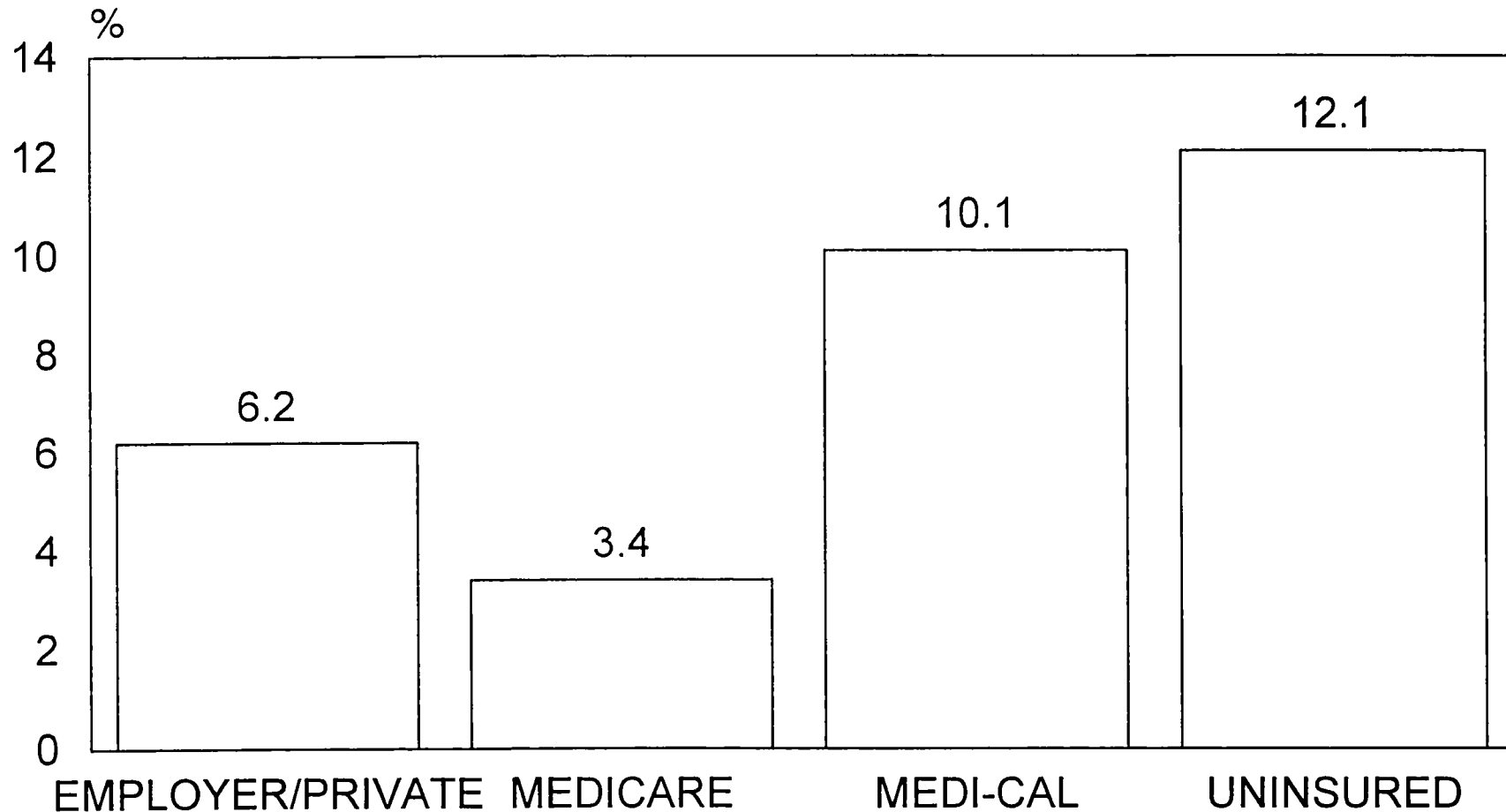


Source: Los Angeles County Health Survey, 1997. Main survey.

Note: N=6,573,000 n=7,937; does not include cases with a value of "don't know/refused" on insurance status variable or "don't know/refused" on difficulty seeing a doctor variable.

Employer/Private insurance includes those with employer-based insurance, military, ChampUS, ChampVA insurance, and privately purchased policies.

Percent of Adults Reporting Financial Difficulty Obtaining Mental Health Care in Past Year, by Insurance Status, 1997

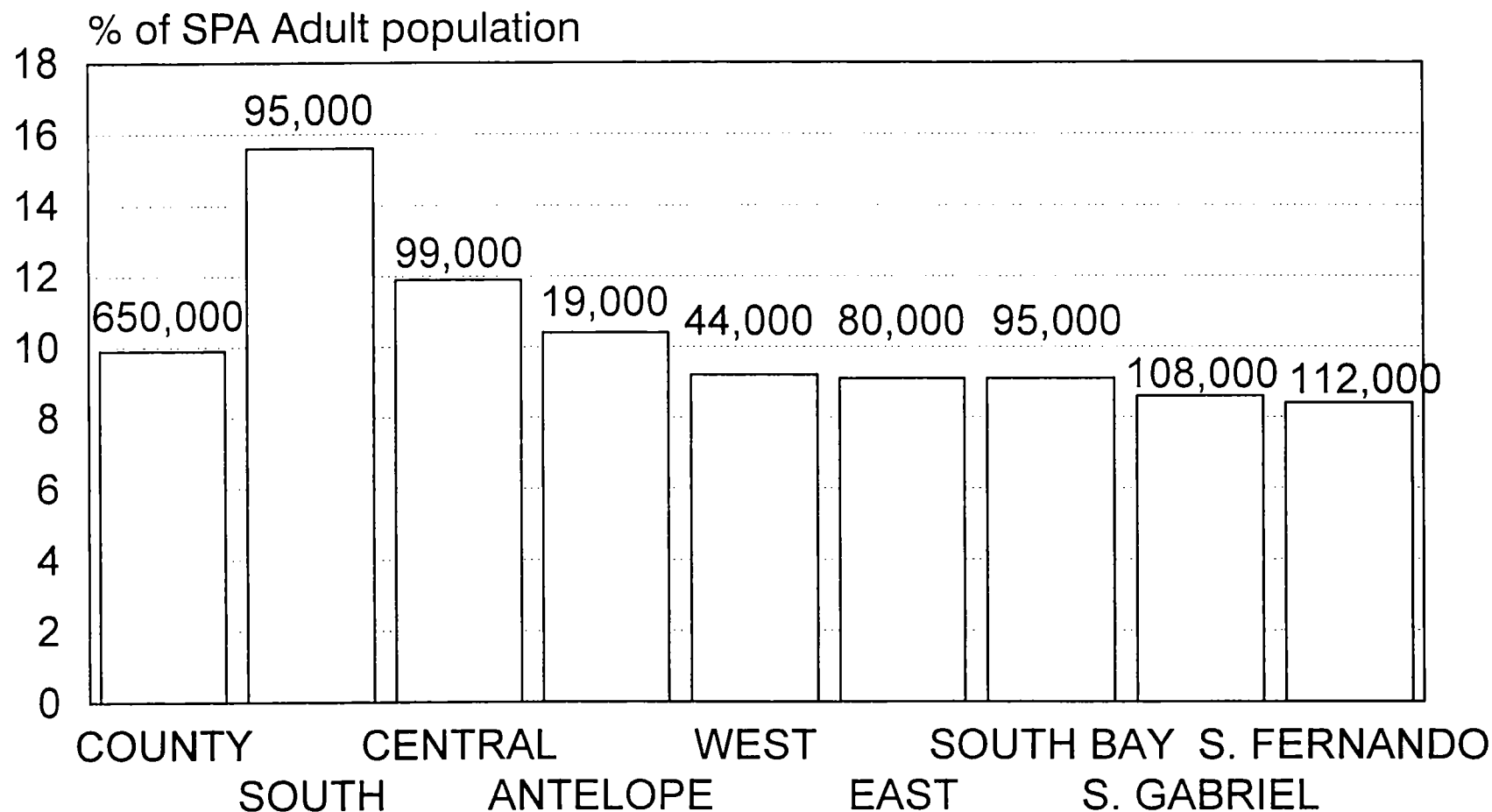


Source: Los Angeles County Health Survey, 1997. Main survey.

Note: N=6,479,000 n=7,826; does not include cases with a value of "don't know/refused" on insurance status variable or "don't know/refused" on access to health services variable.

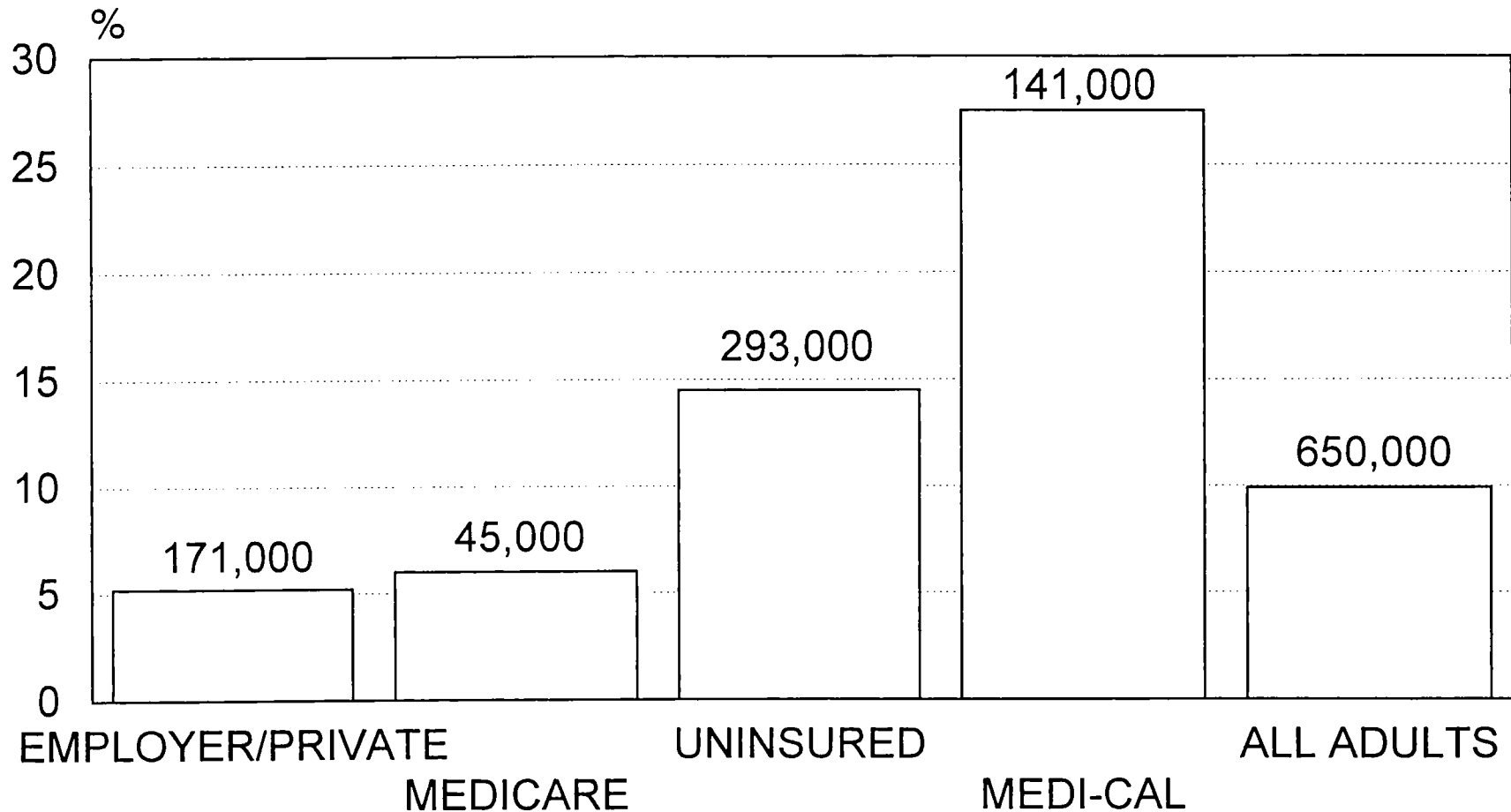
Employer/Private insurance includes those with employer-based insurance, military, ChampUS, ChampVA insurance, and privately purchased policies.

Number and Percent of Adults Using DHS Facilities in Past Year, in Each Service Planning Area, 1997



Source: Los Angeles County Health Survey, 1997. Main survey.
N= 6,633,000 n=8,004

Number and Percent of Adults Reporting Using DHS Facilities in the Past Year, by Insurance Status, 1997



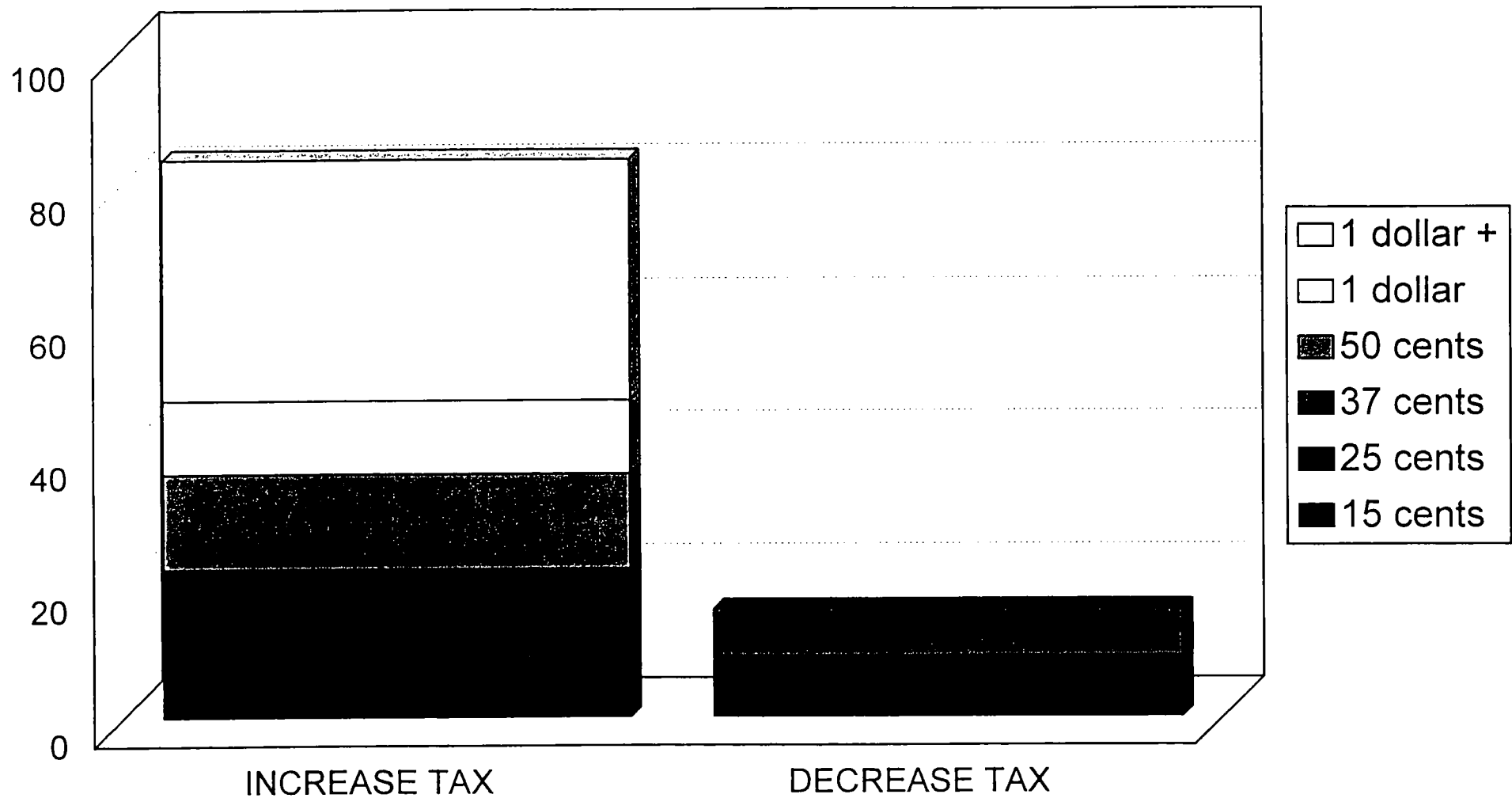
For example: Of all adults with private insurance, 5.2% used DHS in past year.

Source: Los Angeles County Health Survey, 1997. Main survey.

Note: N=6,548,000 n=7,900; does not include cases with a value of "don't know/refused" on insurance status variable or "don't know/refused" on DHS use variable.

Employer/Private insurance includes those with employer-based insurance, military, ChampUS, ChampVA insurance, and privately purchased policies.

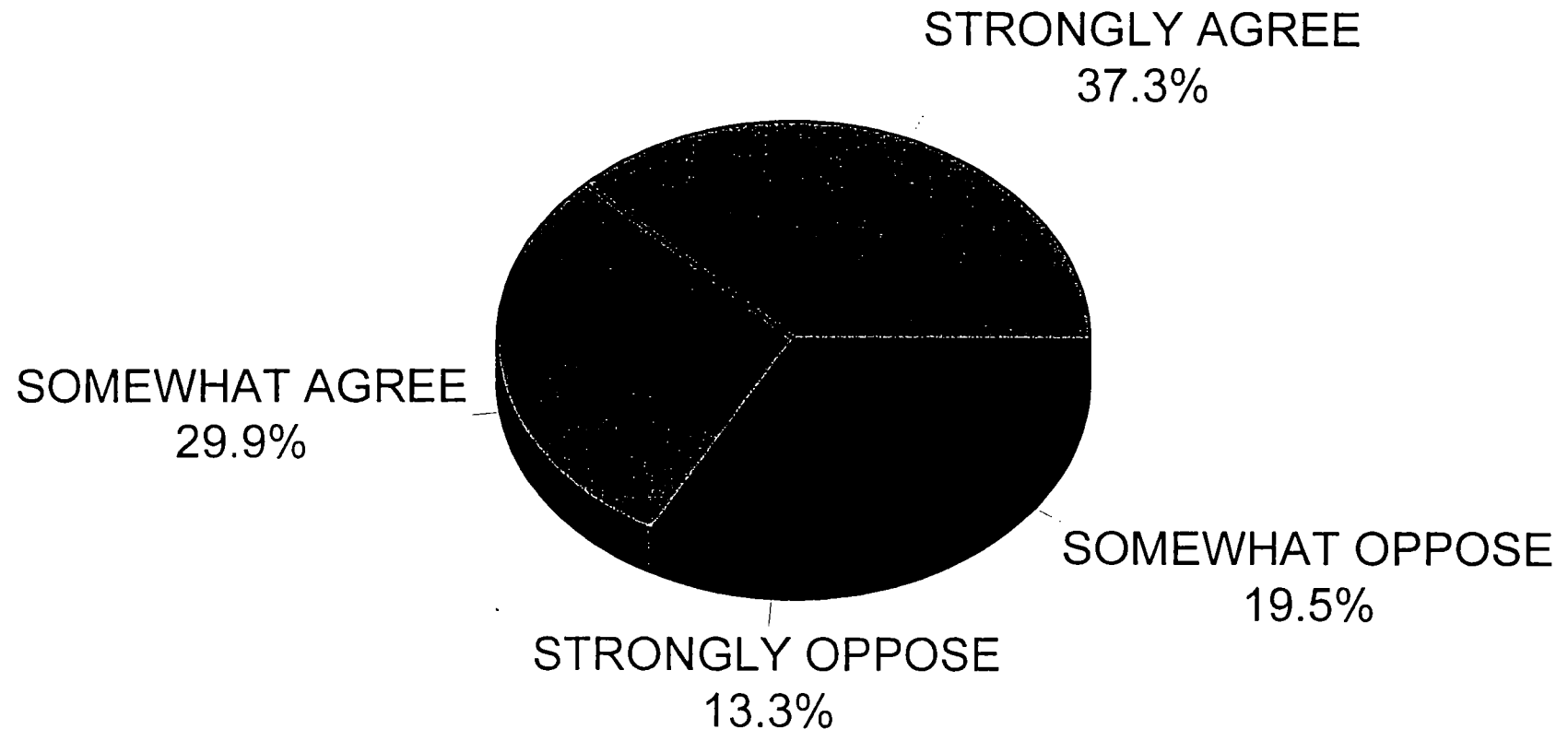
Percent in Favor of Increasing or in Favor of Decreasing State Tobacco Tax , 1997



Source: Los Angeles County Health Survey, 1997. Tobacco survey.

Note: N=5,078,000 n=407; does not include cases with a value of "stay the same" on tobacco tax variable or "don't know/refused" on amount of tobacco tax increase/decrease variables.

Percent in Favor of or Opposed to Increasing Property Taxes to Support Public Health, 1997



Source: Los Angeles County Health Survey, 1997. Tobacco survey.

Note: N=6,413,000 n=499; does not include cases with a value of "don't know/refused" on property tax increase/decrease variables.

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The Newsletter for Dolores Street Community Services

Volume VIII, Number 3

Fall 1997

A Year in Review

Fiscal year 1996-1997 was one of much challenge and many opportunities for Dolores Street Community Services. The organization has grown, matured and can better address the needs of the over 2,000 working homeless of San Francisco's Mission District and homeless people with AIDS each year.

It seems to be our lot to be continuously tried by fire. Our Community Center was devastated by a fire that destroyed Dolores Street Baptist Church in 1993. We successfully recovered and expanded programs since then. In January, a fire severely damaged St. Peter's Catholic Church where we rent space for our emergency housing program. We needed to move from a site which provided emergency food and housing for 50 working poor individuals in a culturally appropriate setting. Instead of seeing this as a defeat, the staff and board have seen this as an opportunity to meet the expanding needs of the program guests and the community. To do this, we have created the vision of a Mission District drop-in center with job and life skills training, employment placement, a medical clinic, links to substance abuse treatment, meals, and other services with 100 emergency housing beds.

We have met and are continuing to meet with major community and government stakeholders. As we engage the community in our process, it has become evident that the working poor, particularly immigrant men, are a population that are rapidly "falling through the cracks" of society's unraveling safety net. More San Franciscans find themselves homeless. The number of people that we have had to turn away, due to lack of space has increased to an average of 200 per month (from around 100/mo. the previous year).

This has made us stronger in our determination to provide a place where these people can achieve the American Dream.

There is a critical need for places to live if a person is not able to secure permanent housing. We have applied for federal HUD/McKinney funding to develop a Victorian cottage at 214 Dolores Street (next to, and a twin building of, the Cohen Residence) into a transitional housing facility for some of these people, particularly those with dual and triple diagnoses and AIDS. This program will provide a safe, clean, and culturally appropriate place for people to carry on the next stage of their lives to ensure a transition into permanent housing. Even with government funding, we must raise a substantial amount of private funds to ensure that this home becomes a reality.

As we develop and expand our employment and emergency housing services, we continue to provide benchmark housing services to people with HIV. The Richard M. Cohen Residence is a 24 hour residential care licensed level facility for people living with AIDS located in a charming Victorian cottage in a beautiful San Francisco neighborhood. As the epidemic changes, we are serving the most disadvantaged and marginalized. The most urgent needs we currently face at the Cohen Residence are those brought on by the changing face of the epidemic. Some of our residents are feeling better and would like to move to more independent living situations. We are also seeing an increase in the number of dually and triply diagnosed individuals and people with greater need requesting this model of supportive housing. We will need your help to find the resources to meet their service needs.

The Doors are Open Wide at Santa Maria Y Marta Lutheran Church

What a difference a season can make! In the Spring of 1997, the Dolores Housing Program (DHP) was in desperate need of finding a new space for the Emergency Housing Program, due to a fire at St. Peter's Catholic Church. The DSCS staff gave many hours to this quest and went everywhere in the City enlisting the help of anyone and everyone. The search was two-pronged: to find a permanent space that would house an expanded program and drop-in center and a temporary space that would house the 50 men who would be displaced from St. Peter's Church. Several options were considered including buying a new building. But it soon became clear that there was not enough time to locate and buy or lease just the right space for our vision. The focus then became finding a temporary space.

As the time drew near for the emergency program to move, the Lutheran Church at 1050 South Van Ness stepped forward and generously answered our plea. David Rodriguez, DHP Program Director, made the first contact with this congregation. In a flurry of activity, including meeting with members of the Departments of Health, Planning, and Fire, we were able to meet all the requirements needed to open a new, temporary shelter for 30 men at this new location. Unfortunately, we were unable to move all 50 beds at this time and are hoping that, when construction is completed on their new sanctuary, we will be able to move the remaining 20 beds to this location as well. The new space has some limitations that we hope to rectify with funds from the City. Pastor Ronald Geikow, Council President Felix Conde, the congregation, and council of this church have welcomed the Dolores Housing Program and our guests with open arms and for that we are extremely grateful. We hope this will be the beginning of a long and fulfilling cooperative relationship.

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California HIV/AIDS Update



The Northern California Pediatric HIV Consortium and the Pediatric Spectrum of Disease Project

Yvonne A. Maldonado, M.D., and the Northern California
Pediatric HIV Consortium*

In This Issue:

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Report** page 72

Description

In January 1989, the Centers for Disease Control and Prevention (CDC) established the Pediatric Spectrum of Disease (PSD) project. This project consists of active surveillance for children less than 13 years old infected with HIV or born to infected mothers in eight U.S. areas which report 40% of pediatric AIDS cases. The areas include Los Angeles, Massachusetts, New York City, North Carolina, Puerto Rico, Texas, Washington DC, and Northern California.

In Northern California, the PSD project is conducted by the Northern California Pediatric HIV Consortium under the coordination of the Department of Pediatrics, Stanford University School of Medicine. The PSD project involves surveillance of records

from hospital-based clinics and from HIV positive pediatric patients cared for through the California Children's Services program (CCS), which supports case identification and care of

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