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Collection/Record Group: Clinton Presidential Records
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Series/Staff Member: Kristine Gebbie
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Albuquerque, New Mexico Trip 3/25-27/94 [1]

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RECEIVED
MAY 13 1994
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THE ZIA CHAPTER
ASSOCIATION OF NURSES IN AIDS CARE
c/o Rick Fendrick
2716D Herradura
Santa Fe, New Mexico 87505

April 2, 1994

Ms. Kristine Gebbie
National AIDS Policy Coordinator
750 17th Street, NW (Suite 1060)
Washington, DC 20503

Dear Ms. Gebbie:

On behalf of the Zia Chapter (Albuquerque/Santa Fe) of the Association of Nurses in AIDS Care, I would like to thank you for your recent visit to New Mexico and the enthusiasm with which you presented the administration's program of prevention, research and service around HIV infection.

Nurses from our chapter were present in many of the sessions in which you heard about New Mexico's unique problems and solutions to the prevention and the development of services to a rural population.

We are particularly proud of your perspective as a professional nurse and how this determines your focus on client issues.

Thank you for taking the time to visit with us in New Mexico.

Sincerely,



Rick Fendrick, RN, MPH
President, ZIA Chapter
Association of Nurses in AIDS Care



RECEIVED

MAR 3 - 1994

NEW MEXICO AIDS SERVICES - PROJECT FOR WOMEN
CONFERENCE

Itinerary for Kristine Gebbie

Friday March 25
7:00 pm

Kristine Gebbie Lecture in Woodward Hall at UNM

Saturday March 26
~~12:00 to 1:15~~ pm

Meet with Hispanic Community Leaders

Invitees: Emma Lou Rodriguez - State Board of Education
Stephanie Gonzales - Secretary of State
Senator Manny Aragon - President Pro Tem of Senate
Senator Mary Jane Garcia
Representative Raymond Sanchez - Speaker of the House
Martin Chavez - Mayor of Albuquerque
Patsy Trujillo - Director of Nueva Vida
Nadine Ulibarri-Keller - NMAS Board of Directors
Ramon Gonzales - NMAS Board of Directors
Art Garcia - NMAS Board of Directors
Don Sanchez - NMAS Board of Directors

~~1:30 to 2:30~~ pm

Meet with Native American Community Leaders

Invitees: Lydia Hubbard-Pourier - Director Division of Health, Navajo Nation
Senator Leonard Tsosie
Dr Emmett Chase - National Coordinator Indian Health Service AIDS Advisory Council
Rachel Chicarello - Albuquerque Area Indian Health Services
Leslie White Temple Gipp - Albuquerque Area Indian Health Services
Darlene Tso
Elsie White Elk - NMAS Board of Directors

~~2:45 to 3:30~~ pm

Meet with African American Community Leaders

Invitees: Alice Hoppes - President NAACP
Sheila Cort - African American Community Coalition and Centers for Disease Control
Mary Juzang - African American AIDS Education & Prevention
Tony Franklin - Director African American Center, UNM

~~3:45 to 4:30 pm~~

State Leaders Focus Group

Invitees: Janet Voorhees - HIV/AIDS/STD Bureau Chief,
Department of Health
Bill Jordan - Director HIV Coordinating Council
Barbara Rickert - UNM Associate Professor of
Nursing
Keith Smith - Director NMAS
Paul Stoesz - President NMAS Board of Directors

Kathleen Kelly -
Keith Smith

THE WHITE HOUSE
WASHINGTON

AIDS 101 EDUCATION
IN THE WORKPLACE INITIATIVE

Why important

Global as well as a national policy of research, treatment,
prevention

Virus

1 million infected
200,000 already dead
150,000-200,000 opportunistic

Transmission

Blood transfusions
Hemophilia
Substance abuse
sexual transmission

Personal behavior

Managerial behavior

Leadership behavior

Programmatic redesign

Agenda Los Alamos National Laboratory

KRISTINE GEBBIE
NATIONAL AIDS POLICY COORDINATOR
EXECUTIVE OFFICE OF THE PRESIDENT

JOANNA STANCIL
DOE PRESS OFFICER

JEANNIE G. LOZOYA
AIDS COORDINATOR
DOE/AL

MARCH 25, 1994

8:30 - 8:45	Visitors met at Los Alamos Airport and escorted to University House, TA-3, SM-443	*Protocol Officer
8:45 - 9:15	Welcome/Opening Remarks	Anne E. Khoury
9:15 - 10:00	Molecular Epidemiology of AIDS	Gerald Myers
10:00 - 10:15	Break	
10:15 - 10:40	Media Availability	
10:40 - 10:45	Visitors escorted to J. Robert Oppenheimer Study Center, TA-3, SM-207, Room 216	Protocol Officer
10:45 - 11:45	Training Session "AIDS in the Workplace"	Kristine Gebbie
11:45 - 12:00	Break and Lunch Setup	
12:00 - 12:30	**Working Lunch (by invitation only) o What's Next for the Laboratory regarding AIDS Training	
12:30 - 1:00	Visitors escorted to Los Alamos Airport for departure	Protocol Officer

Technical Host: Anne E. Khoury, T&D

*Protocol Officer - Norma L. Jorgensen

**Food Services by BUS-5

KRISTINE GEBBIE
MARCH 25, 1994

LABORATORY PARTICIPANTS

S. S. Hecker, Director,
667-5101, MS-A100

James F. Jackson, Deputy Director,
667-4168, MS-A101

Anne E. Khoury, Group Leader, Training and Development,
Human Resources Division, 667-5247, MS-M589

Gerald Myers, Staff Member, Theoretical Biology and Biophysics,
Theoretical Division, 665-0480, MS-K710

Protocol Officer - Norma L. Jorgensen

MINNIE M. WHITEHEAD

**MSW, LISW
Psychotherapist**



March 31, 1994

APR 5 1994

Ms. Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator
Office of National AIDS Policy
Executive Office of The President
Washington, DC., 20500

Dear Ms. Gebbie:

I want to thank you for taking the time to meet with members of the various ethnic/racial and cultural communities while you were recently in Albuquerque, New Mexico.

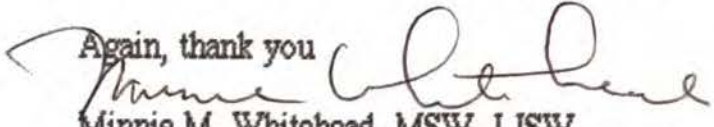
I am extremely pleased with your meeting with some of the members of The African American Community of which I was a part. There are commonalities regarding the impact of AIDS on those infected as well as the larger community that is affected, in that, it is traumatic emotionally, physically, spiritually and economically. I believe the major differences are in certain ways prevention, education and treatment about this dreadful disease is disseminated and actualized in the various communities.

I believe the issues raised by some of the members of The African American Community in Albuquerque has helped you to better understand both the commonalities and distinct differences.

Very often the lack of adequate funding has an equally devastating impact in our community. As I stated during our meeting, historically, there has been a perception from funding agencies; local, state and federal who believe that African Americans only require meager financial resources whether for AIDS prevention, education and treatment or for any other reasons. This, I am sure you can easily document. At least I can.

I do hope that you will do what you know must be done!

Again, thank you


Minnie M. Whitehead, MSW, LISW



Children • Adolescents • Adults • Individual • Couples • Family • Consultation

MINNIE M. WHITEHEAD

**MSW, LISW
Psychotherapist**



1819 Carlisle, N.E.
Albuquerque, New Mexico 87110



**Ms. Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator
Office of National AIDS Policy
Executive Office of The President
Washington, DC., 20500**



MINNIE M. WHITEHEAD

MSW, LISW

Psychotherapist

Children · Adolescents · Adults
Individual · Couples · Family
Consultation



Albuquerque
(505) 242-2403

**KRISTINE M. GEBBIE
SCHEDULE FOR
MARCH 24-27, 1994
(as of March 24, 1994)**

THURSDAY, MARCH 24, 1994

Washington/Albuquerque.

9:40a Staff car pick-up for travel to Anacostia Senior High School, 16th and R Streets S.E.

10:00a Speech at Anacostia Senior High School. Staff present: J. Gurrola, F. Page. (1h).

11:00a Staff car pick-up for travel to White House, West basement. C. Rasco's office.

2:00p Follow-up interview with Andrew Betts of the Times-Argus (Burlington, VT) to get your reaction to the skits presented by the children last week at the Vermont CARES event. NAPC places call to (802) 479-1307 ext.180.

2:45p Staff car pick-up for travel to National Airport.

3:25p Depart American Airlines Flight #853/1757 for travel to Albuquerque.

7:30p Arrive Albuquerque.

KRISTINE M. GEBBIE
SCHEDULE FOR
MARCH 24-27, 1994
(as of March 24, 1994)

HIV/women
workplace - 101

FRIDAY, MARCH 25, 1994
Albuquerque.

8:00a Depart Albuquerque on Ross Aviation for travel to Los Alamos. Staff contact: Joanna Stancil, DOE press office. Other DOE contacts: Norma Jorgenson (505) 667-6574 and Annie Corry (505) 667-5247.

8:30a Arrive Los Alamos. Escort to University house by Protocol Officer.

8:45a Welcome and opening remarks by Anne Khoury, technical host from DOE. (15m)

9:15a Remarks on molecular epidemiology of AIDS by Gerald Myers. (45m).

10:15a Tour of Advance Computing Laboratory (ACL) conducted by David Forslund of DOE. (40m).

10:45a Training for DOE staff on AIDS in the Workplace. (1h).

11:45a Break.

12:00p Working lunch to discuss "What's next for the laboratory regarding AIDS training."

1:00p Depart Los Alamos on Ross Aviation for travel to Albuquerque.

1:30p Arrive Albuquerque.

6:00p Meeting with Jeremy Landau, National Rural AIDS Network. Woodward Hall, University of New Mexico. (45m).

7:00p Lecture before Project for Women conference sponsored by the New Mexico AIDS Services, Inc. Woodward Hall, University of New Mexico on HIV and women. Secretary of State Stephanie Gonzales is making the introduction. Followed by Q & A. Contact: Kathleen Kelly (505) 822-3043 pager, 266-0911 office. (2h).

KRISTINE M. GEBBIE
SCHEDULE FOR
MARCH 24-27, 1994
(as of March 24, 1994)

SATURDAY, MARCH 26, 1994

Albuquerque.

- 10:30p Travel to New Mexico AIDS Services, 4200 Silver S.E. Suite D (2 blocks west of Washington, 1 block south of Central).
- 11:00p Meeting with Hispanic community leaders (8 people). (1h15m).
- 12:30p Meeting with Native American community leaders (6 people). (1h15m).
- 2:00p Meeting with African American community leaders (5 people). (1h15m).
- 3:30p Meeting with state leaders focus group (7 people). (1h15m).
- 5:30p Reception for community-at-large (50-75 people). (2h). Petroleum Club, 500 Marquette.
- 7:30p Dinner at Petroleum Club.

KRISTINE M. GEBBIE
SCHEDULE FOR
MARCH 24-27, 1994
(as of March 24, 1994)

SUNDAY, MARCH 27, 1994

Albuquerque/Washington.

1:30p Depart for travel to Washington.

9:00p Arrive Washington National Airport.

MONDAY, MARCH 28, 1994

Washington.

10:00a Meeting with Jackie Pollard of the Chaing Mai Empower
AIDS Prevention Program to discuss AIDS in southeast
Asia. Staff present: P. Tran, T. Beswick, N.
Hazleton. 750 office. (1h).

12:30p Drop by meeting of people representing the interests of
women.

3:00p Monthly ONAP policy meeting on needle exchange. Staff
Agenda to be determined. (1h).

MEARS RACING

of San Diego

AFTER 1:00 PM PAC

619-420-3454

Thad C. Tinney



~~1458 Lilac~~

~~Chula Vista, CA 91911~~

~~(619) 421-7047~~

293 E. ORANGE AVE

CHULA VISTA, CA 91911



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APR 12 1994

April 5, 1994

Kristine Gebbie
White House AIDS Policy Coordinator
White House
Washington, DC 20500

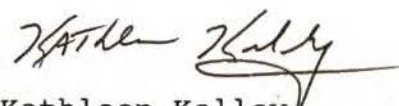
Dear Kristine,

It was such a pleasure to have you as our guest in Albuquerque last weekend. We know that you have a very busy schedule; it was very generous on your part to spend a weekend in a state where the incidence of AIDS is relatively low. I especially appreciated the time you gave to three of our racial minority groups. It is so important that those communities gear up to fight the onslaught of AIDS.

And it was such a pleasure to get to know you and to meet your mother. Now we know that we have a cheerleader in Washington, and we will be more than happy to be your cheerleader here.

Sincerely,


Keith Smith
Executive Director


Kathleen Kelley
Director, Project for Women

THE WHITE HOUSE
WASHINGTON

March 6, 1994

Kathleen Kelly
Women's Project Coordinator
New Mexico AIDS Services, Inc.
4200 Silver Avenue Southeast
Suite d
Albuquerque, New Mexico 87108-2721

Dear Ms. Kelly:

This letter confirms the visit of Kristine M. Gebbie, National AIDS Policy Coordinator, to Albuquerque for the "Juantas in La Lucha, Together in the Struggle. Education, Prevention and Treatment for HIV/AIDS in Women, on March 25-26, 1994. In addition to her keynote speech Friday evening, the proposed Saturday itinerary looks very good, and I will be touch soon with some more ideas.

Please call me at (202) 632-1090 with any questions or for further clarification.

Sincerely,

W. Steve Lee

W. Steve Lee, Executive Assistant
and Scheduler to the
National AIDS Policy Coordinator



December 7, 1993

Kristine Gebbe
White House AIDS Policy Coordinator
White House
Washington, DC 20500

Dear Ms Gebbe,

I am writing to invite you to be a speaker at a conference focussing on women and HIV/AIDS. This two day conference is entitled "Juntas in la Lucha, Together in the Struggle. Education, Prevention and Treatment of HIV/AIDS in Women." It is sponsored by the Women's Committee of New Mexico AIDS Services (NMAS) and will take place in March of 1994 at the Radisson Hotel in Albuquerque. This conference is critical to providing essential information and support for women who are living with HIV/AIDS, for the Health and Social Service Providers, administrators and clergy who work in this field in the state of New Mexico.

New Mexico's diverse population requires a culturally sensitive response in combating the spread of HIV in women. Our conference will focus on devising such a strategy. Multicultural panels of both prevention/treatment health care providers and HIV positive women will examine the impact of the disease on the various peoples of New Mexico. We will then work toward specific solutions, while keeping in sight our ultimate goal of empowering all women in this state to protect themselves from HIV/AIDS.

We would like very much to have you address our conference and will be as flexible as possible to schedule you. The conference is scheduled for March 24 & 25. You could be a keynote speaker on the evening of March 23, you could address the conference on either the 24th or the 25th. And if none of those options will work for you, we could have you as a post-conference speaker on Saturday, March 26th.

We hope you will seriously consider our invitation to speak in Albuquerque. There are many people here who are eager to hear what you have to say about women and AIDS. If you have any questions or would like more information about the conference or the NMAS Project for Women, please feel free to call me at (505) 266-0911.

U N N

Thank you for your consideration of this request. I look forward to hearing from you in the next two or three weeks.

Sincerely,

A handwritten signature in cursive script, appearing to read "Kathleen Kelley".

Kathleen Kelley
NMAS Women's Project Coordinator

NEW MEXICO AIDS PREVENTION PROGRAM SURVEY

Please help us learn what people like you think and do about AIDS and HIV (the virus that causes AIDS). Your answers are CONFIDENTIAL. Do NOT put your name on this.

1. Are you: ☐ Male ☐ Female
 2. How old are you? _____ Years
 3. What is your ethnic group? ☐ Native American ☐ Asian ☐ African American
☐ Hispanic/Latino ☐ White/Anglo ☐ Other _____
 4. Have you ever had your blood tested for HIV (the virus that causes AIDS)? ☐ Yes ☐ No ☐ Not Sure
 5. Have you had sex with: ☐ Men ☐ Women ☐ Both ☐ None
 6. How many different sex partners have you had:

	0	1	2-5	6-9	10 or more
in the last year that were FEMALE?	☐	☐	☐	☐	☐
in your lifetime that were FEMALE?	☐	☐	☐	☐	☐
in the last year that were MALE?	☐	☐	☐	☐	☐
in your lifetime that were MALE?	☐	☐	☐	☐	☐
 7. Have you injected street drugs in the last year? ☐ Yes ☐ No
 If YES, please answer the next two questions.

	Always	Sometimes	Never
Do you share your IV drug needles?	☐	☐	☐
Do you clean your drug "works" by boiling, bleaching, or with alcohol?	☐	☐	☐
 8. Have you ever accepted drugs or money for sex? ☐ Yes ☐ No
 9. Do you know someone who is infected with HIV or is sick with AIDS? ☐ Yes ☐ No
-
- | | Agree Completely | Agree Somewhat | No Opinion | Disagree Somewhat | Disagree Completely |
|--|------------------|----------------|------------|-------------------|---------------------|
|--|------------------|----------------|------------|-------------------|---------------------|
10. AIDS is a major health problem in New Mexico. ☐ ☐ ☐ ☐ ☐
 11. Protecting myself from AIDS at all times is just too much trouble. ☐ ☐ ☐ ☐ ☐
 12. People with the AIDS virus (HIV) should be treated just like everyone else. ☐ ☐ ☐ ☐ ☐
 13. Some things health officials tell us about AIDS are not true. ☐ ☐ ☐ ☐ ☐
-
- | | Always | Sometimes | Never |
|--|--------|-----------|-------|
|--|--------|-----------|-------|
14. I avoid casual sex or "one night stands." ☐ ☐ ☐
 15. I or my sex partner use condoms. ☐ ☐ ☐
 16. I avoid touching a person if I think they are infected with the AIDS virus. ☐ ☐ ☐
 17. I get my blood tested for HIV (the virus that causes AIDS) whenever my behavior puts me at risk of infection. ☐ ☐ ☐
-
18. To your knowledge, are there drugs available which can lengthen the life of a person infected with the AIDS virus? ☐ Yes ☐ No ☐ Not sure
 19. Do you think a person infected with the AIDS virus can look and feel well and healthy?
☐ Yes ☐ No ☐ Not sure
 20. Have you had HIV/AIDS education or counselling before today? ☐ Yes ☐ No

	Definitely True	Probably True	Possibly True	Probably False	Definitely False
21. AIDS public education is not necessary because everyone knows how you get HIV (the virus that causes AIDS).	☐	☐	☐	☐	☐
22. Public service announcements have saturated the media with AIDS information.	☐	☐	☐	☐	☐
23. AIDS education for the general public is not necessary because AIDS is not spreading beyond gay or drug users.	☐	☐	☐	☐	☐
24. Approximately 50% of known AIDS cases in African-Americans are related to IV drug use.	☐	☐	☐	☐	☐
25. Approximately 60% of AIDS cases in women occur in African-American women.	☐	☐	☐	☐	☐
26. Approximately 57% of AIDS cases in children occur in black and hispanic children.	☐	☐	☐	☐	☐
27. AIDS education for drug users is a waste of time and money because they don't care about their health.	☐	☐	☐	☐	☐
28. It is difficult to give AIDS education in schools and churches because so many parents object.	☐	☐	☐	☐	☐
29. AIDS education for gays and lesbians is not necessary because they have adopted "safer sex" practices.	☐	☐	☐	☐	☐
30. If AIDS education is provided in the schools, adolescents do not need any additional information.	☐	☐	☐	☐	☐
31. AIDS education in minority communities should be culturally sensitive to these populations.	☐	☐	☐	☐	☐
32. Everyone knows who should and should not donate blood.	☐	☐	☐	☐	☐
33. If people are given accurate information they will change their attitudes and behavior.	☐	☐	☐	☐	☐
34. Fear of death is the most effective motivation in changing behavior.	☐	☐	☐	☐	☐
35. Blacks comprise 12% of the U.S. population but 27% of AIDS cases.	☐	☐	☐	☐	☐

KABB PROVIDER FORM

CONTRACTOR:

- | | |
|---|--|
| ☐ AIDS Prevention Program | ☐ Planned Parenthood of Southern New Mexico |
| ☐ Albuquerque Area Indian Health Board | ☐ Shiprock Community Health Center |
| ☐ Albuquerque Family Health Center | ☐ SWAC - Hispanic Outreach |
| ☐ Albuquerque Health Care for the Homeless | ☐ SWAC - Stop AIDS |
| ☐ Indian Health Service | ☐ YDI - Amistad |
| ☐ NMAS - Afro-American Outreach | ☐ YDI - IVDU |
| ☐ NMAS - Gay Men's Health Project | ☐ Other _____ |

ADMINISTRATION

DATE: _____

CITY: _____

LOCATION: _____
(i.e., Church, Bar, Classroom, Detention center, street, etc.)

ADMINISTRATION TYPE:

- ☐ Group-self administered ☐ Individual-self administered ☐ Interview

COMPLETION RATE: (ESTIMATE)

- ☐ 1-25% ☐ 26-50% ☐ 51-75% ☐ 75-100%

PLEASE RETURN COMPLETED SURVEYS TO:

MINNICK & ASSOCIATES, INC.
2403 SAN MATEO NE; SUITE P-4
ALBUQUERQUE, NM 87110
(505) 889-9358

THANK YOU!!



New Mexico AIDS Services, Inc.

DATE: 2/1/94PAGE 1 OF 4 PAGE(S)TO: STEVE LEEFROM: KATHLEEN KELLEY PROJECT FOR WOMENRE: EXECUTIVE DIRECTOR KEITH SMITH WANTED MS. GEARICTO HAVE THIS INFORMATION TAKEN FROM THE ADVOCATE AUG. 1993

MESSAGE FAXED BY: _____

IF FAX IS NOT RECEIVED IN FULL
OR IF THERE ARE QUESTIONS, PLEASE
CALL
(505) 266-0911

MESSAGE OR SPECIAL INSTRUCTIONS:

~~ANY CHANCE FOR A BIO SOON?~~

did this get
done?

4200 Silver Ave SE, Suite D, Albuquerque NM 87108-2721

ARCHIVE PHOTOS

Albuquerque: Its generosity toward sick newcomers may hurt its own residents.

Paradise Lost?

An influx of people with AIDS strains health care services in New Mexico and other small states

By John Gallagher



Chad Boutte could be just another of the thousands of people who have moved to New Mexico during the '90s. He says he moved from New Orleans to Albuquerque for the clean air and mountains as well as to be close to his mother. But for Boutte, who has AIDS, there was a special consideration: "There is so much more here in services for people with AIDS," he says.

Boutte's experience is not unique, says A. Cornelius Baker, director of public policy at the National Association of People With AIDS, an advocacy group based in Washington, D.C. "As people generally get weaker or near end stage, many do go back

home," migrating from big cities to the small rural states where they grew up, says Baker. "In some cases, they don't really have a choice." Many people with failing health often have no choice but to escape the pressures of big-city life and to depend on their family's care.

While health officials have reported a significant migratory trend in scores of rural states, in few states is the trend as apparent as it is in New Mexico. And while the state's health officials say that New Mexico is still far from being a mecca for people with AIDS, the trend has accelerated in the past year, straining some

health services and complicating planning for future caseloads.

"We've always had some influx, but since last July we've had a lot of

people moving in," says Nadine Ulibarri-Keller, a clinical nurse who manages the HIV clinic at the University of New Mexico hospital. "It's not just the phenomenon of people moving back home, although that's part of it. Some people are moving here because they've heard good things about the state."

Eventually, she says, state officials will have no choice but to address the influx, and the fallout may be unpleasant. "We're not being very responsive at looking at the direction we should take as a state," she says.

Nationally, the federal government ranked New Mexico 13th in per capita spending on AIDS programs in fiscal 1992. The state subsidizes purchase of 19 drugs for people with AIDS, more than many other states. It subsidizes home-care services. It reimburses travel costs for people in rural areas who need to seek treatment, including alternative therapies, at medical centers in

The big spenders

Top states in per capita AIDS spending in 1992

1. D.C.	\$6.92	11. Florida	\$1.75
2. New York	\$5.81	12. Illinois	\$1.21
3. Louisiana	\$4.72	13. New Mexico	\$1.13
4. New Jersey	\$3.47	14. Virginia	\$1.11
5. Hawaii	\$3.14	15. Rhode Island	\$1.02
6. Massachusetts	\$3.12	16. Alaska	\$0.98
7. California	\$3.05	17. Maryland	\$0.88
8. Connecticut	\$2.68	Michigan	\$0.85
9. Washington	\$2.11	19. Kansas	\$0.80
10. Delaware	\$1.99	20. Pennsylvania	\$0.77



SOURCES: AIDS Policy Center, Intergovernmental Health Policy Project, George Washington University, April 1993

**For most
people,
Time
is Money.
For
people
with AIDS,
Money
is Time.**

CHARTER BANK BUILDING
2401 FOUNTAINVIEW
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HOUSTON, TEXAS 77057

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Drug list

New Mexico subsidizes the purchase of 19 drugs by people with AIDS, more than most other states.

- acyclovir
- alpha interferon
- amphotericin b
- AZT
- Bactrim
- Dapsone
- ddC
- ddI
- Epogen
- erythropoietin alpha
- foscarnet
- fluconazole
- ganciclovir
- ketoconazole
- megestrol
- Mycellex Troches
- mycobutin
- neupogen
- pentamidine

cities. And no residency period required to qualify for state AI programs.

"I truly think that New Mexico is a model state in the services it provides for people with HIV," says Keith Smith, executive director of New Mexico AIDS Service (NMAS), a statewide service and education group. "There's a very supportive state government and a compassionate and supportive community."

But at least in part because of supportive environment, New Mexico has become the home of a growing number of people with AIDS. Of the 71 people with AIDS who responded to a state survey earlier this year, 56 were not native New Mexicans. Many of those people moved to the state in the '70s and '80s, but nine moved to the state in 1992. Thirty-one of the 71 said their first tested HIV-positive in a state other than New Mexico.

Because federal AIDS program funding to states is based on the number of AIDS cases diagnosed each state, the allotment of funds to states does not take into consideration the number of AIDS patients residing in each state. All programs are underfunded in every state, but Baker states that in some

cases under the current system "the funding money is going to New York, but responsibility for the actual care is going to local areas elsewhere, where services are not getting adequate support."

"We suspect that we're not getting our fair share of federal dollars," says Bill Jordan, executive director of the HIV Coordinating Council of New Mexico, a statewide consortium for planning and evaluation of HIV services. "We have never gotten a good handle on the numbers moving into the state."

Without an accurate count, AIDS service providers in New Mexico find themselves scrambling to estimate just how many people have AIDS and how many are asymptomatic but HIV-positive so they can plan for the drain on services. So far, they say, they have not been successful.

"We haven't planned well enough for funding to meet services for people who are already here, and we haven't done good growth analysis," says Ulibarri-Keller. Already, she says, inadequate planning has forced the state to institute a waiting list for some services.

Community-based organizations have also been feeling the pinch of rising numbers, says NMAS director of client services Gregg Ferran. "The state makes all these plans, and then we have all these people coming in for services, and we don't have a lot of money," he says. "The influx puts a real strain on resources, especially in a small organization like ours."

The solution, AIDS care providers say, lies in pressing the federal government to revamp its AIDS tracking, forecasting, and funding mechanisms to keep up with the migratory behavior of people with the disease. Says Baker: "There needs to be a better way to monitor not only the epidemic itself but the flow of the epidemic."

And for New Mexico, lack of planning could soon create a paradise lost, warns Ulibarri-Keller. "We have to take a hard look at the issue" of newcomers with AIDS moving into the state, she says. "Do we institute residency requirements? It's a serious issue, but it's a worrisome feeling when you start to deny services to someone." ●

RAN MISSION STATEMENT

THE NATIONAL RURAL AIDS NETWORK (RAN) is a national and regional coalition-building organization. Our constituency is both regional and national in scope in a rural context. Clients/staff/volunteers reflect this mission both in terms of geographic demographics and HIV-affected representation.

RAN works in specific locales to support and train leadership towards provision of culturally relevant AIDS education, prevention, advocacy & service delivery.

THE NATIONAL RURAL AIDS NETWORK works with community activists local AIDS/HIV leadership to establish regional networks designed to enable peer support during the AIDS pandemic where large geographic areas are often an obstacle.

RAN brings together national leaders, enabling coalitions to develop, assist in training & skills building as well as avoiding duplication of services in areas with limited resources.

THE NATIONAL RURAL AIDS NETWORK began in 1986 as a collaboration between people living with AIDS, health care providers and services providers. RAN exists to highlight the unique resources of rural/non-urban locales and the inter-relationships possible without reliance on often inappropriate urban resources. Since 1986, RAN has served hundreds of persons in over two-dozen states. Rural AIDS Network acknowledges the uniqueness and diversity of rural and frontier communities, as well as the need for emerging coalitions of AIDS-affected persons, in each locale.

NATIONAL RAN is committed to programs generated for and by people living with HIV/AIDS and local service providers in cooperation with state and federal health authorities in order to make maximum use of existing resources and collaborations unique to each locale. In addition, a basic component of RAN is Regional Networks, bringing together diverse people and locales providing HIV/AIDS services and education.

PROGRAMS

Regional Conferences

RAN has established and sponsored regional conferences, as well as regional trainings and technical assistance seminars in over twenty states throughout the United States. RAN also participated in the national HRSA Rural AIDS Summit Conference in 1990.

Since 1991, Rural AIDS Network has provided significant leadership in regional conferences in California, Illinois, New Mexico, Wisconsin, Ohio, Oregon, Vermont, Washington D.C., Connecticut, Missouri and Louisiana. RAN also co-sponsors the annual "Hidden Epidemic" conference with the U. S. Public Health Service.

Local Training Development Workshops

- *Needs Assistance:* Establishes a baseline concerning community need in order to design trainings that identify available resources and potentials within a community, inclusive of all interested constituents.
- *Leadership Development:* Facilitation in assisting with Staff/Board Development, long-range planning, non-profit personnel policies and procedures and media relations.
- *Evaluation:* Follow-up evaluation and assistance is provided.

Technical Assistance Through Publications

Our expanded publications series includes: the Annual Rural Communities AIDS Journal; the *Networker*, a quarterly newsletter; Legislative and Funding Alerts and *Personnel Policies & Procedures for Nonprofit Organizations*.

Governmental Affairs Advocacy

In addition to conducting legislative advocacy and policy advising, RAN is currently developing a seven-point Government Relations Program which will serve rural constituents in up to sixteen rural states during its first year of implementation.

National Pass Through Grants

In conjunction with various corporations and grant giving institutions, RAN has undergone the selection of recipients for this special program designed to assist rural projects in need of funding. Pass through grants are publicized as they become available, along with application process.

THE WHITE HOUSE

WASHINGTON

Health Care Reform and the HIV Epidemic Top Ten Issues

For those infected with HIV, the assurance of comprehensive health insurance is an essential public health goal.

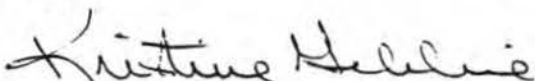
The Office of the National AIDS Policy Coordinator has provided advice on policy formulation during the development of the Health Security Act (HSA). These efforts were directed towards assuring adequate care and services for people with HIV/AIDS. As the Congress now debates the HSA, the Administration is making every effort to assure that modifications to the President's proposal maintain equity and sensitivity to the special needs of HIV-infected individuals.

Private insurance companies, like other businesses, seek to maximize profits by choosing only "acceptable" insurance risks. Under the HSA, universal coverage is guaranteed. Universal means everyone! What does Health Security mean to you?:

- * **Universal coverage - HIV status or other health conditions do not prevent you from getting coverage.**
- * **Community ratings prevent persons with HIV infection from being charged more for premiums.**
- * **Prescription drugs will be covered.**
- * **Ryan White CARE Act services will not be lost.**
- * **Any form of discrimination is prohibited.**
- * **Essential providers - specialists in treating HIV and AIDS will be available to all people who need them.**

Based on a series of focus groups with people with AIDS and HIV/AIDS service organizations, a list of "top ten" concerns for the HIV community were identified. Information regarding these concerns is attached for your review.

I hope this information will be helpful to you. If I can be of further assistance or provide any additional information, please contact me or Andrew E. Barrer, Ph.D. at (202) 632-1090. Thank you.



Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

Top Ten Issues

- 1. Premium Financing and Risk Adjustment**
- 2. Availability of and Assured Access to "Essential Providers"**
- 3. Long-term and Home Care Coverage**
- 4. Availability of Mental Health and Substance Abuse Services**
- 5. Impact of the HSA on the Ryan White CARE Act**
- 6. Medicaid and Medicare Funding and Program Transition Issues, especially as related to the Medicare and Medicaid programs**
- 7. Confidentiality**
- 8. Grievance Procedures**
- 9. Effects of "State Options" on the HSA package of benefits**
- 10. Funding for Public Health System Core Functions (e.g. Behavioral Research, Prevention Services, etc.)**

1. Premium Financing and Risk Adjustment

Issue: Will the risk adjustment mechanism prevent "redlining" for persons with HIV/AIDS or other life threatening illnesses?

Summary: Yes. Redlining, or any attempts to limit access to people with HIV or AIDS is clearly prohibited. The HSA provides mechanisms which require states to spread the financial risks associated with special communities by adjustments which would take into account such factors known to affect utilization of services, such as age, sex, health status and services to disadvantaged populations. The health plans have to meet specific rules on enrollment, community rating, information, and grievance procedures.

2. Availability of HIV Specialist, "Essential Providers"

Issue: Will HIV positive persons be able to continue using their local HIV medical specialist?

Summary: The Health Security Act establishes a special category of health care provider which is referred to as an "essential provider". Any health care provider or organization can make application to be certified as an essential provider. Within the HSA, a Ryan White grantee or subgrantee can be automatically certified as an essential provider. Each health plan must enter into a written agreement with each essential provider located within its service area.

3. Long-term Care and Home Health Care

Issue: Persons with HIV/AIDS often need home health care and long-term care services. Will the Health Security Act provide those needed services?

Summary: Home health care is included in the nationally guaranteed comprehensive benefits package. A new long-term care initiative will expand coverage of home and community-based care. This will make it possible for more elderly and disabled persons, including persons living with HIV/AIDS to live in their homes and communities while receiving long-term care. The Act will improve

Medicaid coverage for persons in nursing homes.

The HSA will improve the quality and reliability of private long-term care insurance and provide tax incentives for persons to buy it; and tax incentives to help individuals with disabilities work.

4. Availability of Mental Health and Substance Abuse Services

Issue: Mental health needs in the HIV/AIDS community tend to be greater than the average. What will HSA do to provide these services? Injecting drug users, at high risk of HIV infection and transmission, currently have inadequate treatment and preventive services available to them. Will adequate services be available to treat these individuals in order to ameliorate their additive disease and halt the epidemic?

Summary: A base level of mental health services will be provided to all persons through the Health Security Act. We know that viable mental health services are part of a good program of health care and especially beneficial to HIV infected persons.

In order to make a significant difference in the rate of new infections in the injecting drug use population and their sexual partners, the HSA will provide substance abuse treatment to everyone.

5. Health Care Reform and the Ryan White CARE Act

Issue: Will the financial restructuring of the health care system assure the delivery of health care services appropriate to the needs of vulnerable populations whose access problems go beyond lack of insurance?

Summary: The comprehensive benefits package provided by the HSA may not provide all essential services for persons with HIV/AIDS. Conversely, a variety of services currently provided by the CARE Act would be covered under the HSA benefits package. These would include primary care services, medications, assistance for health insurance coverage, home-based services, case management,

transportation, and outreach. It may be necessary to utilize Ryan White CARE Act funds "freed up" by the provision of these services under HSA to subsidize the supplemental and client's share of insurance premiums, co-payments, deductibles, and expenditures that exceed spending caps.

The CARE Act is not a "band-aid" that can be discarded after health care reform. The Act will serve as a critical resource to sustain health care delivery systems and insure the continued delivery of essential and comprehensive health and support services to those infected with HIV.

6. Medicaid and Medicare Funding and Program Transition Issues

Issue: What impact will the HSA have on funding for the Medicaid and Medicare programs? What programs will be available during the transition from the old system to the one provided under the HSA?

Summary: Under the HSA adult Medicaid recipients who now receive cash supplements (currently 9 million beneficiaries) would be enrolled in the new system, but would not have to pay premiums. Further, they would be entitled to join a new state and federally-matched program providing wrap-around services similar to those now available under the Medicaid program. Children less than 18 years of age who are currently eligible or would be Medicaid recipients, with eligibility for wrap-around services (primarily based on poverty level), would be provided those services through a new federally funded (but state administered) program, *regardless of their cash assistance status*.

The Medicare program will be preserved and strengthened under the HSA, which will add new coverage for prescription drugs and expanded coverage of home and community-based care.

7. Health Security Act (HSA) and Confidentiality Issues

Issue: What safeguards are envisioned for the handling of health information on HIV affected persons under the Health Security Act ?

Summary: The HSA addresses the issue of how information will be handled and what penalties will be imposed for misusing information. The HSA will provide guidance level information on creation of the oversight board, users and uses of information, privacy standards, enrollee rights, outright prohibitions, training of information handlers, and comprehensive health information privacy protection. The development of the Comprehensive Health Information Privacy Protection Act will be implemented within two years from the date of passage.

8. Grievance Procedures

Issue: How can individuals ensure that their health plan will provide the health benefits and services they require?

Summary: The HSA is intended to provide adequate health care coverage for all citizens and legal residents of the United States. The Act requires States to approve each health plan before it can engage in providing health care under the Act. The law prohibits exclusions because of pre-existing conditions or through "red-lining," the practice of excluding a particular group of individuals because of perceived high risk.

The Health Security Act includes a comprehensive grievance process for any person aggrieved by acts or practices which result in denial or delay of benefits or payments. Individuals must work within the individual plan's grievance process before going to adjudication through the Complaint Review Offices set up in each state. If there is a question as to an individual's eligibility for a plan, subsidies or cost sharing, the individual may go directly to court and all costs can be reimbursed if the court finds for the individual.

The complaint office must rule in under 30 days, although a 24 hour appeal is available in cases of emergency. Appeals must be processed within 60 days. There are means of appealing, with the national board being the ultimate administrative appeal.

9. "State Options"

Issue: What impact will "State Options" have on coverage under the HSA? What impact will it have on services, availability, and affordability?

Summary: Some states cover additional services under federally matched Medicaid programs. Under the HSA, a number of programs will become available at each state's option. To assure that there is not a loss of services to the person with AIDS, Ryan White will continue to act as the safety net to assure needed services reach all people in need. The expanded use of case management, will help follow individual needs and assure services are provided.

10. Public Health System Core Functions

Issue: What is the nature of the funding for research on behavior, health services and Core Functions of Public Health Programs?

Summary: The Health Security Act will provide funding for AIDS specific research and public health initiatives that will have to be provided under the authority of the Public Health System. Behavioral research into those behaviors that may cause or contribute to disease will be conducted by the National Institutes of Health. The Act will also provide funding for strengthening the public health core function of states, including those components related to diseases of public health significance. This support will allow communities to maintain strong programs to prevent the spread of HIV, tuberculosis, and other conditions of public health importance.

THE WHITE HOUSE
WASHINGTON

PRESS RELEASE

FOR IMMEDIATE RELEASE
FEBRUARY 7, 1994

FOR MORE INFORMATION:
JOHN PAUL GURROLA 202/632-1090
ANDREW BARRER 202/632-1090

FEDERAL AIDS BUDGET FOR 1995 INCREASES

WASHINGTON, D.C. -- Kristine M. Gebbie, President Clinton's National AIDS Policy Coordinator discussed the increases in the Federal budget on AIDS today. "In a time of over-all budget cuts and other budget-related program reductions, the President's continued commitment to HIV/AIDS is shown in a budget increase of nearly ten percent" Gebbie said. The Office of National AIDS Policy has three focus areas in its mission -- research, treatment/services and prevention. The budget requests for these three areas and the requests for the specific departments that are closely related to HIV/AIDS issues are described below.

The President's Budget proposes a 6% increase in NIH basic and preventive research for HIV and AIDS. This provides \$1.379 billion for NIH AIDS research, a 29% increase since 1993. The President proposes an additional \$231 million for AIDS research in other federal agencies, bringing the total federal investment to \$1.61 billion.

This investment is combined with the Administration's commitment to improved management of AIDS research planning and budgeting at the NIH, and to enhancing government-wide and

HIV/AIDS BUDGET RELEASE
FEBRUARY 6, 1994
PAGE TWO

private sector coordination.

HIV/AIDS treatment and care services are primarily funded through the Ryan White CARE Act. The Administration is recommending an increase in these treatment funds of 16.1% for a dollar increase of 93 million dollars. These funds will be split between the four titles of the Act as follows: Title I (cities) 39 million, Title II (states) 30 million, Title III (primary care systems) 19 million, Title IV (pediatric and maternity care centers) 5 million.

In FY 94 \$1.1 billion was appropriated for block grants to states for substance abuse treatment, of which approximately \$25 million were specifically earmarked for HIV related programs. The FY 95 budget shows an increase of \$310 million for substance abuse treatment under the Substance Abuse and Mental Health Services Administration. This amount will go to the block grants given to states and will have direct impact on HIV prevention for persons with chronic substance abuse issues, including injecting drug users. This number will be adjusted based on the number of states that qualify in the coming weeks. Of the new amount, \$15.5 million have been specifically earmarked for HIV prevention activities. Since drug abusers are at high risk for HIV transmission, we consider this budget line a significant part of our Federal AIDS prevention programs. HIV prevention activities under the Centers for Disease Control and Prevention will receive the same level of funding as in FY 94.

HIV/AIDS BUDGET RELEASE
FEBRUARY 6, 1994
PAGE THREE

The Department of Health and Human Services, budget requests an increase of 592 million dollars over the 1994 level of spending. This raises the 1995 AIDS spending for HHS to nearly 6.0 billion. The increases within the Public Health Service include 93 million for the Ryan White AIDS services, 78 million for NIH and one million at AHCPR.

At the Department of Defense the 1995 budget request is divided between research, prevention and services/treatment money. \$14 million is earmarked for research; \$22 million for prevention and \$63 million for treatment services for military members and their families.

The Department of Housing and Urban Development's (HUD) FY 95 budget requests \$257 million towards the housing needs of people with HIV and AIDS. HUD funds can be used for a wide range of housing related services to prevent homelessness. Services can include emergency housing, transitional housing, and permanent housing arrangements; and the acquisition, rehabilitation and leasing of existing housing. Appropriate supportive services must be provided as part of HUD's HIV-related housing and include such activities as health and mental health services, permanent housing placement, chemical dependency treatment and counseling, day care, nutritional services, intensive care when required, and assistance in gaining access to local, state and federal government benefits and services. Housing Opportunities for People with AIDS remains stable at \$156 million.

HIV/AIDS BUDGET RELEASE
FEBRUARY 6, 1994
PAGE FOUR

The Department of Veterans affairs, through its large system of hospitals, provides AIDS prevention education, performs research and provides treatment services to Veterans. The total VA budget request for FY 95 is increased by \$18 M overall. Of the \$349 M requested for FY 95, \$312 M is earmarked for treatment services; \$6 M for research and \$31 M for prevention education.

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THE WHITE HOUSE

WASHINGTON

OFFICE OF NATIONAL AIDS POLICY
PUBLIC HEALTH SERVICE FY 95 BUDGET INFORMATION

Summary

The FY 1995 budget includes \$2.7 billion in budget authority for the PHS for research, prevention and other related activities in the battle against AIDS and HIV infection. This is an increase of \$177 million, or 7 percent, over the FY 1994 appropriations. The funds requested for HIV/AIDS activities are included in the budget for each of the PHS components. The tables below summarize the entire PHS-wide HIV/AIDS effort, both by PHS agency and by function.

For FY 1995, the President's Budget proposes a \$93 million, or 16 percent, increase for HRSA's Ryan White AIDS health care services, and a \$78 million, or 6 percent increase for NIH basic and preventive research on AIDS. (More detailed discussions of these program increases for AIDS are included in the individual agency sections.)

HIV/AIDS FUNDING BY PHS COMPONENT
(Dollars in millions)

	1993 Actual	1994 Approp.	1995 Request	+/-
FDA.....	\$73	\$72	\$72	
HRSA.....	390	608	701	+\$93
IHS.....	3	4	4	
CDC.....	498	543	543	-
NIH.....	1071	1301	1379	+\$78
SAMHSA.....	26	28	33	+\$5
AHCPR.....	10	11	12	+\$1
OASH.....	5	5	5	-
TOTAL, HIV/AIDS				
Budget Authority.....	2077	2572	2749	+177

SUBSTANCE ABUSE DOLLARS

In FY 94 \$1.1 Billion was appropriated for block grants to states for substance abuse treatment. Through the efforts of the Office of the National Drug Control Policy Coordinator an additional \$310 Million will be added to FY 95. This money is to be used by states for the most severe substance abuse cases, such as injecting drug abusers, who are at great risk for HIV transmission. \$15.5 Million of the new money will be specifically earmarked for HIV-related substance abuse programs. Of the original \$1.1 Billion, approximately 25 Million is also specifically earmarked for HIV related programs. (This number will be adjusted based on number of states that qualify in the coming weeks.) Because such abusers are at high risk for HIV transmission, this budget line is a significant part of federal AIDS prevention programs.

Office of National AIDS Policy

Federal HIV Funding

(In Millions of Dollars)

	FY 1994 <u>Enacted</u>	FY 1995 <u>Budget</u>	Dollar Increase <u>FY 94 to FY</u> <u>95</u>	Percent Increase <u>FY 94 to FY</u> <u>95</u>
Public Health Service	2,572	2,749	+ 177	+ 7%
Office of Civil Rights	3	3	+ 0	+ 0%
Veterans	331	349	+ 18	+ 5%
Defense	129	99	-30	-23%
Housing	253	257	+ 4	+ 2%
OPM-FEHB	193	213	+ 20	+ 10%
*Other	129	131	+ 2	+ 2%
Total Appropriations	3610	3,801	+ 191	+ 5%
Medicaid (Federal Share)	1,490	1,640	+ 150	+ 10%
Medicare	500	600	+ 100	+ 20%
Social Security	835	1,015	+ 180	+ 22%
Total Entitlement	2,825	3,255	+ 430	+ 15%
Total Spending	6,435	7,056	+ 621	+ 10%

* Includes USDAID, Bureau of Prisons, State, and Labor.

Note: Provided as draft by Office of Management and Budget 2/7/94.

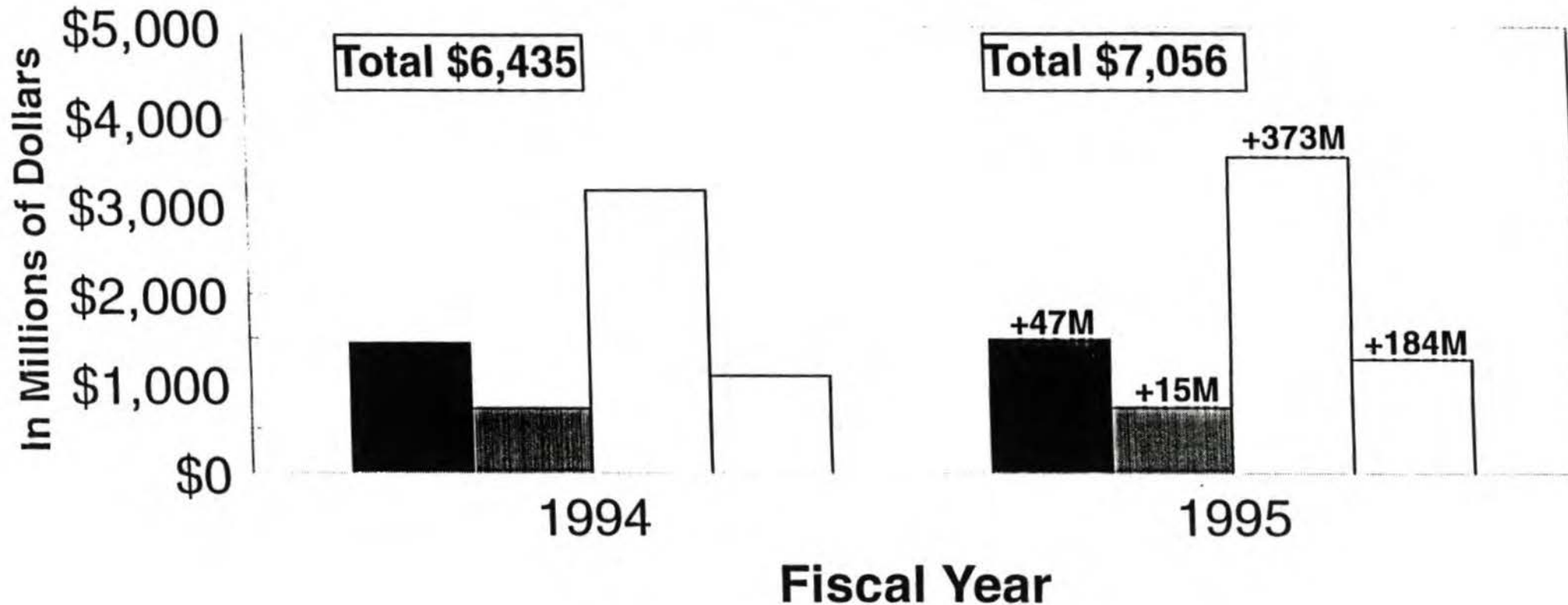
HHS HIV/AIDS Funding

(Dollars in thousands)

	1993 Enacted	1994 Approp.	1995 Pres. Budget	1995 Chg. +/-	
				'94 Appro.	% Chg.
<u>PUBLIC HEALTH SERVICE:</u>					
FDA.....	\$72,628	\$72,399	\$72,399	\$0	0.0%
<u>HRSA:</u>					
<u>Ryan White:</u>					
Title I.....	\$184,757	\$325,500	\$364,500	\$39,000	12.0%
Title II.....	115,288	183,897	213,897	30,000	16.3%
Title III.....	47,968	47,968	66,968	19,000	39.6%
Title IV.....	---	22,000	27,000	5,000	22.7%
Sub, Ryan White.....	\$348,013	\$579,365	\$672,365	\$93,000	16.1%
Other HRSA AIDS.....	42,328	28,431	28,431	0	0.0%
Sub, HRSA.....	\$390,341	\$607,796	\$700,796	\$93,000	15.3%
IHS.....	\$3,303	\$3,556	\$3,556	\$0	0.0%
CDC.....	\$498,253	\$543,253	\$543,253	\$0	0.0%
NIH.....	\$1,071,457	\$1,301,045	\$1,379,052	\$78,007	6.0%
SAMHSA.....	\$25,655	\$28,111	\$32,986	\$4,875	17.3%
AHCPR.....	\$9,624	\$10,624	\$12,000	\$1,376	13.0%
OASH.....	\$5,330	\$5,323	\$5,323	\$0	0.0%
Subtotal, PHS.....	\$2,076,591	\$2,572,107	\$2,749,365	\$177,258	6.9%
<u>ENTITLEMENTS:</u>					
<u>HCFA:</u>					
Medicaid (Fed Share).....	\$1,290,000	\$1,490,000	\$1,640,000	\$150,000	10.1%
Medicare.....	385,000	500,000	600,000	100,000	20.0%
Sub, HCFA.....	1,675,000	1,990,000	2,240,000	\$250,000	12.6%
<u>Social Security:</u>					
DI.....	505,000	635,000	775,000	\$140,000	22.0%
SSI.....	165,000	200,000	240,000	40,000	20.0%
Sub, Social Security.....	670,000	835,000	1,015,000	\$180,000	21.6%
Subtotal, Entitlements.....	\$2,345,000	\$2,825,000	\$3,255,000	\$430,000	15.2%
<u>OTHER:</u>					
OS/Office for Civil Rights....	\$2,600	\$2,600	\$2,600	\$0	0.0%
TOTAL, HHS.....	\$4,424,191	\$5,399,707	\$6,006,965	\$607,258	11.2%

Office of National AIDS Policy

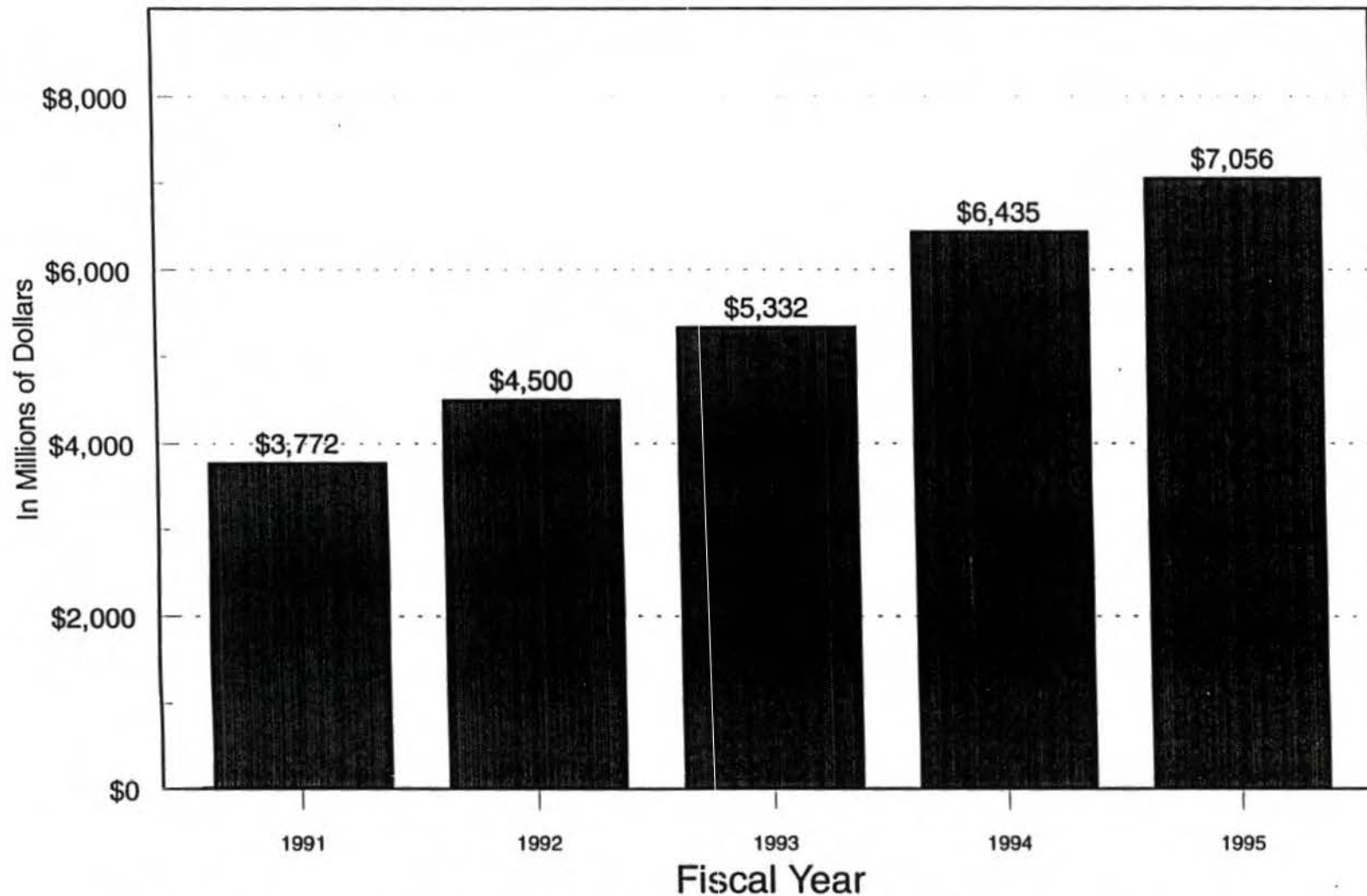
Federal HIV Funding



■ Research ▨ Prevention
□ Medical Care □ Income Maintenance

Office of National AIDS Policy

Total Federal Spending for HIV/AIDS 1991 THRU 1995



FY95 includes an estimated \$15.5 million in HIV/AIDS prevention services in the Hard Core Drug Treatment Initiative, an increase of approximately \$6 million above previous HIV/AIDS programming in SAMSHA.

THE WHITE HOUSE
WASHINGTON

PRESS RELEASE

FOR IMMEDIATE RELEASE
FEBRUARY 7, 1994

FOR MORE INFORMATION:
JOHN PAUL GURROLA 202/632-1090
ANDREW BARRER 202/632-1090

FEDERAL AIDS BUDGET FOR 1995 INCREASES

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HIV/AIDS BUDGET RELEASE
FEBRUARY 6, 1994
PAGE TWO

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HIV/AIDS BUDGET RELEASE
FEBRUARY 6, 1994
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HIV/AIDS BUDGET RELEASE
FEBRUARY 6, 1994
PAGE FOUR

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THE WHITE HOUSE

WASHINGTON

OFFICE OF NATIONAL AIDS POLICY
PUBLIC HEALTH SERVICE FY 95 BUDGET INFORMATION

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Office of National AIDS Policy

Federal HIV Funding

(In Millions of Dollars)

	FY 1994 <u>Enacted</u>	FY 1995 <u>Budget</u>	Dollar Increase <u>FY 94 to FY</u> <u>95</u>	Percent Increase <u>FY 94 to FY</u> <u>95</u>
Public Health Service	2,572	2,749	+177	+7%
Office of Civil Rights	3	3	+0	+0%
Veterans	331	349	+18	+5%
Defense	129	99	-30	-23%
Housing	253	257	+4	+2%
OPM-FEHB	193	213	+20	+10%
*Other	129	131	+2	+2%
Total Appropriations	3610	3,801	+191	+5%
Medicaid (Federal Share)	1,490	1,640	+150	+10%
Medicare	500	600	+100	+20%
Social Security	835	1,015	+180	+22%
Total Entitlement	2,825	3,255	+430	+15%
Total Spending	6,435	7,056	+621	+10%

* Includes USDAID, Bureau of Prisons, State, and Labor.

Note: Provided as draft by Office of Management and Budget 2/7/94.

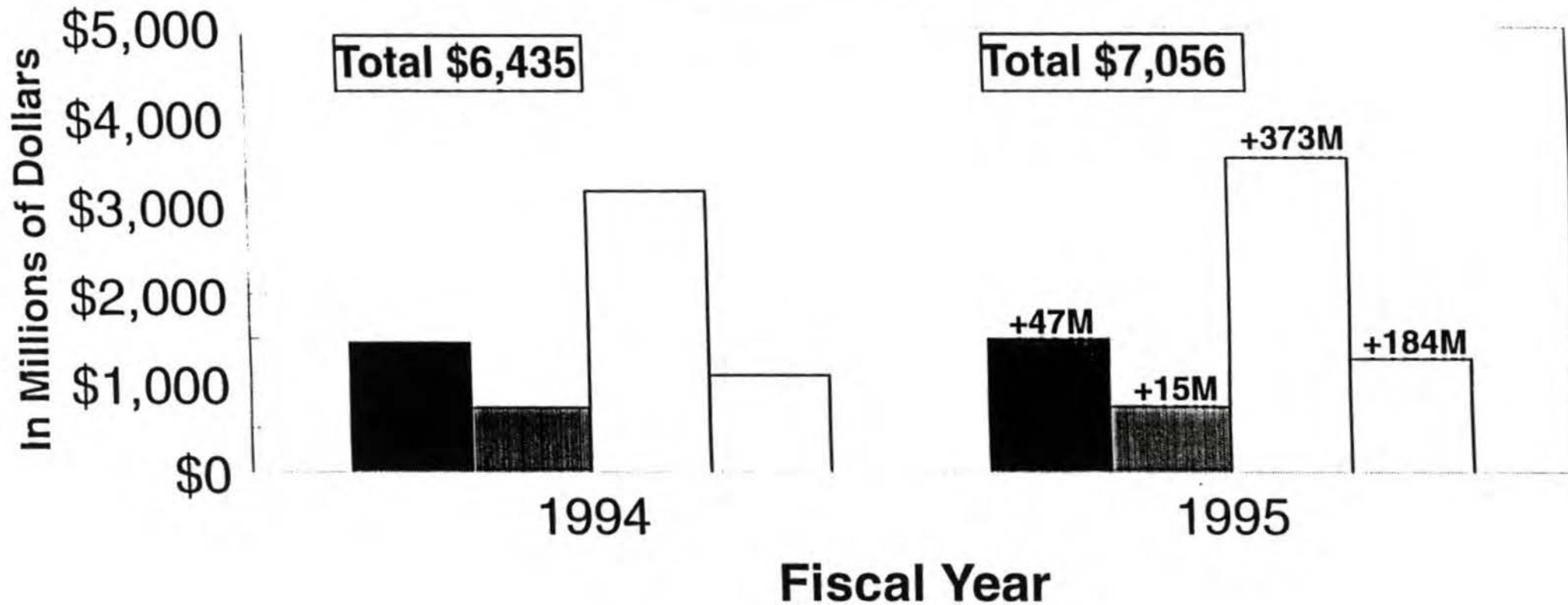
HHS HIV/AIDS Funding

(Dollars in thousands)

	1993 Enacted	1994 Approp.	1995 Pres. Budget	1995 Chg. +/-	
				'94 Appro.	% Chg.
<u>PUBLIC HEALTH SERVICE:</u>					
FDA.....	\$72,628	\$72,399	\$72,399	\$0	0.0%
<u>HRSA:</u>					
<u>Ryan White:</u>					
Title I.....	\$184,757	\$325,500	\$364,500	\$39,000	12.0%
Title II.....	115,288	183,897	213,897	30,000	16.3%
Title III.....	47,968	47,968	66,968	19,000	39.6%
Title IV.....	—	22,000	27,000	5,000	22.7%
Sub, Ryan White.....	\$348,013	\$579,365	\$672,365	\$93,000	16.1%
Other HRSA AIDS.....	42,328	28,431	28,431	0	0.0%
Sub, HRSA.....	\$390,341	\$607,796	\$700,796	\$93,000	15.3%
IHS.....	\$3,303	\$3,556	\$3,556	\$0	0.0%
CDC.....	\$498,253	\$543,253	\$543,253	\$0	0.0%
NIH.....	\$1,071,457	\$1,301,045	\$1,379,052	\$78,007	6.0%
SAMHSA.....	\$25,655	\$28,111	\$32,986	\$4,875	17.3%
AHCPR.....	\$9,624	\$10,624	\$12,000	\$1,376	13.0%
OASH.....	\$5,330	\$5,323	\$5,323	\$0	0.0%
Subtotal, PHS.....	\$2,076,591	\$2,572,107	\$2,749,365	\$177,258	6.9%
<u>ENTITLEMENTS:</u>					
<u>HCFA:</u>					
Medicaid (Fed Share).....	\$1,290,000	\$1,490,000	\$1,640,000	\$150,000	10.1%
Medicare.....	385,000	500,000	600,000	100,000	20.0%
Sub, HCFA.....	1,675,000	1,990,000	2,240,000	\$250,000	12.6%
<u>Social Security:</u>					
DI.....	505,000	635,000	775,000	\$140,000	22.0%
SSI.....	165,000	200,000	240,000	40,000	20.0%
Sub, Social Security.....	670,000	835,000	1,015,000	\$180,000	21.6%
Subtotal, Entitlements.....	\$2,345,000	\$2,825,000	\$3,255,000	\$430,000	15.2%
<u>OTHER:</u>					
OS/Office for Civil Rights.....	\$2,600	\$2,600	\$2,600	\$0	0.0%
TOTAL, HHS.....	\$4,424,191	\$5,399,707	\$6,006,965	\$607,258	11.2%

Office of National AIDS Policy

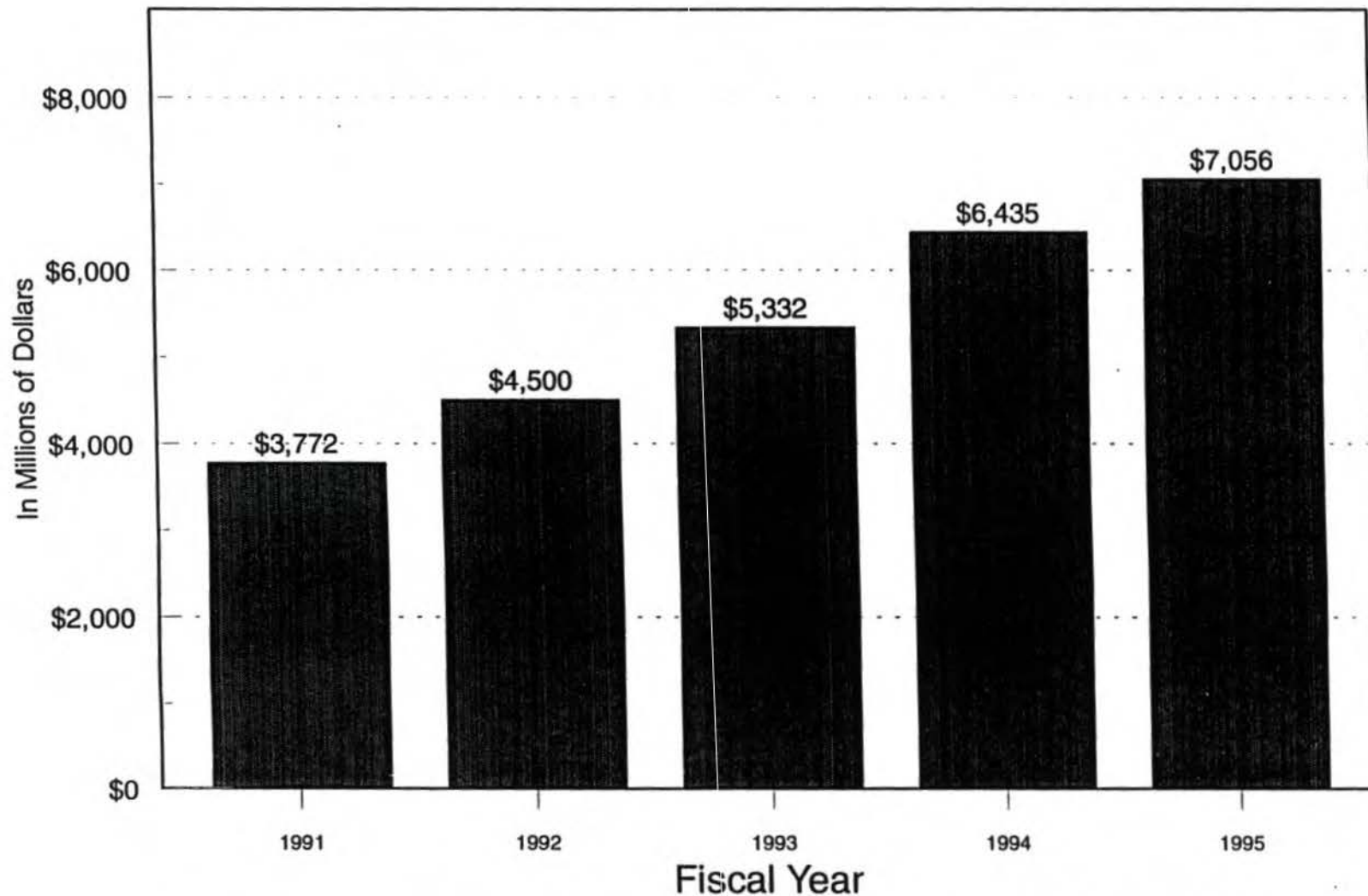
Federal HIV Funding



■ Research ■ Prevention
□ Medical Care □ Income Maintenance

Office of National AIDS Policy

Total Federal Spending for HIV/AIDS 1991 THRU 1995



FY95 includes an estimated \$15.5 million in HIV/AIDS prevention services in the Hard Core Drug Treatment Initiative, an increase of approximately \$6 million above previous HIV/AIDS programming in SAMSHA.

HIV/AIDS

SURVEILLANCE REPORT

Third Quarter Edition

U.S. AIDS cases reported through September 1993

Issued October 1993, Vol. 5, No. 3

Contents

Table 1. AIDS cases and annual rates per 100,000 population, by state	3
Table 2. AIDS cases and annual rates per 100,000 population, by metropolitan area with 500,000 or more population.	4
Table 3. AIDS cases by age group, exposure category, and sex	6
Table 4. Male adult/adolescent AIDS cases by exposure category and race/ethnicity	7
Table 5. Female adult/adolescent AIDS cases by exposure category and race/ethnicity	8
Table 6. Pediatric AIDS cases by exposure category and race/ethnicity.	9
Table 7. AIDS cases in adolescents and adults under age 25, by sex and exposure category	10
Table 8. AIDS cases by sex, age at diagnosis, and race/ethnicity	11
Table 9. AIDS cases, case-fatality rates, and deaths, by half-year and age group.	12
Table 10. AIDS cases by year of diagnosis and definition category	13
Table 11. Health-care workers with documented and possible occupationally acquired AIDS/HIV infection, by occupation	13
Table 12. Adult/adolescent AIDS cases by single and multiple exposure categories	14
Figure 1. Male adult/adolescent AIDS annual rates per 100,000 population	15
Figure 2. Female adult/adolescent AIDS annual rates per 100,000 population	15
Figure 3. Male adult/adolescent AIDS cases.	16
Figure 4. Female adult/adolescent AIDS cases	16
Figure 5. Pediatric AIDS cases	17
Figure 6. Results of investigations of AIDS cases with risk not identified	17
Technical notes	18

Acquired immunodeficiency syndrome (AIDS) is a specific group of diseases or conditions which are indicative of severe immunosuppression related to infection with the human immunodeficiency virus (HIV).



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service
Centers for Disease Control
and Prevention

National Center for Infectious Diseases
Division of HIV/AIDS
Atlanta, Georgia 30333



Table 1. AIDS cases and annual rates per 100,000 population, by state, reported October 1991 through September 1992, October 1992 through September 1993;¹ and cumulative totals, by state and age group, through September 1993, United States²

State of residence	Oct. 1991- Sept. 1992		Oct. 1992- Sept. 1993		Cumulative totals ¹		
	No.	Rate	No.	Rate	Adults/ adolescents	Children < 13 years old	Total
Alabama	465	11.4	705	17.0	2,275	43	2,318
Alaska	18	3.2	60	10.2	154	2	156
Arizona	408	10.9	1,202	31.3	3,059	14	3,073
Arkansas	237	10.0	420	17.5	1,239	21	1,260
California	8,641	28.4	17,474	56.4	62,201	356	62,557
Colorado	415	12.3	1,193	34.5	3,516	18	3,534
Connecticut	538	16.3	1,693	51.4	4,415	98	4,513
Delaware	126	18.5	346	49.9	830	7	837
District of Columbia	724	121.0	1,370	232.3	5,231	78	5,309
Florida	5,007	37.7	9,613	70.6	32,008	751	32,759
Georgia	1,348	20.4	2,597	38.4	9,255	87	9,342
Hawaii	175	15.4	324	27.9	1,250	10	1,260
Idaho	36	3.5	71	6.6	203	2	205
Illinois	1,842	16.0	3,005	25.8	10,522	140	10,662
Indiana	370	6.6	831	14.6	2,443	17	2,460
Iowa	86	3.1	196	7.0	577	6	583
Kansas	188	7.5	335	13.3	1,031	5	1,036
Kentucky	207	5.6	316	8.4	1,148	13	1,161
Louisiana	829	19.5	1,172	27.4	4,811	67	4,878
Maine	50	4.0	126	10.2	427	4	431
Maryland	1,096	22.6	2,353	47.6	7,187	152	7,339
Massachusetts	767	12.8	2,532	42.4	7,238	132	7,370
Michigan	784	8.4	1,752	18.6	4,904	62	4,966
Minnesota	237	5.3	624	13.9	1,829	13	1,842
Mississippi	231	8.9	468	17.9	1,483	20	1,503
Missouri	650	12.6	1,679	32.3	4,626	33	4,659
Montana	22	2.7	35	4.3	134	2	136
Nebraska	68	4.3	179	11.1	469	4	473
Nevada	235	18.3	601	44.0	1,641	15	1,656
New Hampshire	48	4.3	99	9.0	368	6	374
New Jersey	2,051	26.4	4,390	56.3	18,106	423	18,529
New Mexico	90	5.8	307	19.4	831	2	833
New York	8,232	45.6	16,031	88.4	63,660	1,321	64,981
North Carolina	648	9.6	1,059	15.5	3,735	75	3,810
North Dakota	4	0.6	4	0.6	32	—	32
Ohio	696	6.4	1,490	13.5	4,944	68	5,012
Oklahoma	228	7.2	716	22.3	1,795	15	1,810
Oregon	283	9.7	732	24.4	2,233	9	2,242
Pennsylvania	1,338	11.2	2,556	21.2	9,086	120	9,206
Rhode Island	102	10.2	305	30.3	842	9	851
South Carolina	347	9.7	1,395	38.4	3,022	38	3,060
South Dakota	8	1.1	23	3.2	57	2	59
Tennessee	442	8.9	967	19.2	2,734	26	2,760
Texas	2,944	17.0	7,164	40.4	23,572	213	23,785
Utah	145	8.2	270	14.9	818	20	838
Vermont	26	4.6	60	10.5	176	2	178
Virginia	606	9.6	1,590	24.9	4,710	82	4,792
Washington	573	11.4	1,459	28.2	4,765	18	4,783
West Virginia	61	3.4	78	4.3	359	5	364
Wisconsin	224	4.5	700	13.9	1,705	19	1,724
Wyoming	4	0.9	36	7.7	91	—	91
Subtotal	44,900	17.8	94,703	37.0	323,747	4,645	328,392
Guam	1	0.7	2	1.5	12	—	12
Pacific Islands, U.S.	—	—	—	—	2	—	2
Puerto Rico	1,796	50.5	2,621	73.1	10,436	256	10,692
Virgin Islands, U.S.	19	18.6	42	40.8	147	5	152
Total	46,716	18.2	97,368	37.5	334,344	4,906	339,250

¹Includes 9 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

²During the third quarter of 1993, CDC received reports of 23,664 cases and 9,951 deaths among adults/adolescents and 196 cases and 105 deaths among children.

Table 2. AIDS cases and annual rates per 100,000 population, by metropolitan area with 500,000 or more population, reported October 1991 through September 1992, October 1992 through September 1993;¹ and cumulative totals, by area and age group, through September 1993, United States — Continued

Metropolitan area of residence ²	Oct. 1991– Sept. 1992		Oct. 1992– Sept. 1993		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children < 13 years old	Total
Orlando, Fla.	331	26.1	870	66.3	2,249	42	2,291
Philadelphia, Pa.	1,005	20.3	2,110	42.5	7,082	87	7,169
Phoenix, Ariz.	292	12.8	863	36.9	2,236	9	2,245
Pittsburgh, Pa.	148	6.2	214	8.9	1,026	6	1,032
Portland, Oreg.	249	15.9	655	40.3	1,943	6	1,949
Providence, R.I.	96	10.5	285	31.1	791	8	799
Raleigh-Durham, N.C.	128	14.5	189	20.8	787	18	805
Richmond, Va.	140	15.9	385	42.9	1,006	13	1,019
Riverside-San Bernardino, Calif.	435	16.0	1,045	36.6	2,727	27	2,754
Rochester, N.Y.	76	7.1	243	22.4	742	8	750
Sacramento, Calif.	287	20.7	453	31.5	1,490	14	1,504
Saint Louis, Mo.	290	11.6	841	33.3	2,224	21	2,245
Salt Lake City, Utah	129	11.7	241	21.3	726	14	740
San Antonio, Tex.	217	16.1	426	31.1	1,591	14	1,605
San Diego, Calif.	631	24.8	1,474	56.7	4,877	32	4,909
San Francisco, Calif.	1,896	116.9	4,592	279.8	17,397	27	17,424
San Jose, Calif.	183	12.2	502	33.2	1,514	11	1,525
San Juan, P.R.	1,075	57.9	1,638	87.3	6,577	168	6,745
Sarasota, Fla.	90	18.0	148	28.9	570	12	582
Scranton, Pa.	26	4.1	54	8.4	188	3	191
Seattle, Wash.	424	20.4	1,043	49.1	3,536	10	3,546
Springfield, Mass.	92	15.3	210	35.0	574	15	589
Stockton, Calif.	34	6.9	109	21.6	307	8	315
Syracuse, N.Y.	71	9.5	168	22.2	497	6	503
Tacoma, Wash.	38	6.3	137	21.9	360	7	367
Tampa-Saint Petersburg, Fla.	535	25.5	1,421	66.6	3,781	53	3,834
Toledo, Ohio	33	5.4	90	14.6	271	4	275
Tucson, Ariz.	93	13.7	258	37.6	619	5	624
Tulsa, Okla.	70	9.7	236	32.1	549	5	554
Ventura, Calif.	73	10.8	130	19.0	378	1	379
Washington, D.C.	1,345	31.3	2,560	58.7	9,366	138	9,504
West Palm Beach, Fla.	529	59.7	787	86.5	2,916	107	3,023
Wichita, Kansas	62	12.6	96	19.2	276	2	278
Wilmington, Del.	93	17.8	261	49.1	617	6	623
Youngstown, Ohio	23	3.8	29	4.8	148	—	148
Metropolitan areas with 500,000 or more population	39,112	24.8	81,352	50.9	284,441	4,131	288,572
Metropolitan areas with 50,000 to 500,000 population	4,821	10.5	10,306	22.0	31,977	485	32,462
Non-metropolitan areas	2,587	4.9	5,288	10.0	16,621	268	16,889
Total³	46,716	18.2	97,368	37.5	334,344	4,906	339,250

¹Includes 9 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

²Based on Metropolitan Statistical Areas (MSA) revised June 1993. See technical notes.

³Totals include 1,327 persons whose area of residence is unknown.

Table 4. Male adult/adolescent AIDS cases by exposure category and race/ethnicity, reported October 1992 through September 1993,¹ and cumulative totals, through September 1993, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	30,094	(73)	125,392	(78)	9,614	(37)	34,166	(42)	5,638	(42)	21,475	(4)
Injecting drug use	4,285	(10)	12,670	(8)	9,667	(37)	29,762	(36)	5,094	(38)	18,143	(3)
Men who have sex with men and inject drugs	3,001	(7)	11,959	(7)	1,568	(6)	5,974	(7)	712	(5)	3,021	(1)
Hemophilia/coagulation disorder	794	(2)	2,349	(1)	110	(0)	260	(0)	68	(1)	224	(0)
Heterosexual contact:	607	(1)	1,654	(1)	2,125	(8)	6,279	(8)	570	(4)	1,375	(0)
<i>Sex with injecting drug user</i>	227		804		682		2,118		185		599	
<i>Sex with person with hemophilia</i>	6		13		1		4		2		4	
<i>Born in Pattern-I² country</i>	1		8		605		2,571		—		10	
<i>Sex with person born in Pattern-II country</i>	10		52		31		86		2		11	
<i>Sex with transfusion recipient with HIV infection</i>	25		72		26		51		6		28	
<i>Sex with HIV-infected person, risk not specified</i>	338		705		780		1,449		375		723	
Receipt of blood transfusion, blood components, or tissue	431	(1)	2,519	(2)	157	(1)	606	(1)	91	(1)	385	(0)
Risk not identified ³	2,032	(5)	4,380	(3)	2,807	(11)	5,127	(6)	1,234	(9)	2,728	(0)
Total	41,244	(100)	160,923	(100)	26,048	(100)	82,174	(100)	13,407	(100)	47,351	(100)

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals ⁴			
	Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	445	(74)	1,583	(79)	158	(63)	388	(63)	46,025	(56)	183,344	(6)
Injecting drug use	28	(5)	79	(4)	23	(9)	62	(10)	19,142	(23)	60,835	(2)
Men who have sex with men and inject drugs	22	(4)	57	(3)	42	(17)	107	(17)	5,353	(7)	21,142	(0)
Hemophilia/coagulation disorder	12	(2)	35	(2)	6	(2)	16	(3)	990	(1)	2,890	(0)
Heterosexual contact:	15	(2)	29	(1)	4	(2)	10	(2)	3,328	(4)	9,361	(0)
<i>Sex with injecting drug user</i>	6		12		1		5		1,102		3,539	
<i>Sex with person with hemophilia</i>	—		—		—		—		10		22	
<i>Born in Pattern-II country</i>	—		3		—		—		607		2,597	
<i>Sex with person born in Pattern-II country</i>	—		1		—		—		43		150	
<i>Sex with transfusion recipient with HIV infection</i>	2		2		—		—		59		154	
<i>Sex with HIV-infected person, risk not specified</i>	7		11		3		5		1,507		2,899	
Receipt of blood transfusion, blood components, or tissue	12	(2)	72	(4)	1	(0)	5	(1)	695	(1)	3,596	(0)
Risk not identified	69	(11)	152	(8)	15	(6)	26	(4)	6,174	(8)	12,474	(0)
Total	603	(100)	2,007	(100)	249	(100)	614	(100)	81,707	(100)	293,642	(100)

¹Includes 9 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

²See technical notes.

³"Risk not identified" refers to persons whose mode of exposure to HIV is unknown. This includes persons under investigation; persons who died, were lost to follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.

⁴Includes 573 men whose race/ethnicity is unknown.

Table 6. Pediatric AIDS cases by exposure category and race/ethnicity, reported October 1992 through September 1993, and cumulative totals, through September 1993, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	13	(9)	141	(14)	1	(0)	24	(1)	4	(2)	33	(1)
Mother with/at risk for HIV infection:	118	(84)	663	(68)	489	(97)	2,556	(95)	197	(93)	1,074	(9)
<i>Injecting drug use</i>	38		290		153		1,133		69		483	
<i>Sex with injecting drug user</i>	22		132		70		390		40		318	
<i>Sex with bisexual male</i>	4		39		2		28		3		20	
<i>Sex with person with hemophilia</i>	2		13		—		5		1		3	
<i>Born in Pattern-II¹ country</i>	—		3		37		300		—		2	
<i>Sex with person born in Pattern-II country</i>	—		—		5		22		—		1	
<i>Sex with transfusion recipient with HIV infection</i>	1		6		1		5		1		8	
<i>Sex with HIV-infected person, risk not specified</i>	10		45		57		148		27		77	
<i>Receipt of blood transfusion, blood components, or tissue</i>	6		29		12		43		5		25	
<i>Has HIV infection, risk not specified</i>	35		106		152		482		51		137	
Receipt of blood transfusion, blood components, or tissue	9	(6)	167	(17)	6	(1)	74	(3)	7	(3)	76	(1)
Risk not identified ²	1	(1)	9	(1)	8	(2)	29	(1)	4	(2)	11	(1)
Total	141	(100)	980	(100)	504	(100)	2,683	(100)	212	(100)	1,194	(100)

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals ³			
	Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	—		3	(14)	—		1	(7)	18	(2)	202	(1)
Mother with/at risk for HIV infection:	2	(50)	10	(45)	2	(100)	13	(93)	814	(94)	4,328	(8)
<i>Injecting drug use</i>	1		3		1		6		264		1,920	
<i>Sex with injecting drug user</i>	—		2		1		2		133		846	
<i>Sex with bisexual male</i>	—		1		—		—		9		88	
<i>Sex with person with hemophilia</i>	—		—		—		—		3		21	
<i>Born in Pattern-II country</i>	—		—		—		—		37		305	
<i>Sex with person born in Pattern-II country</i>	—		—		—		—		5		23	
<i>Sex with transfusion recipient with HIV infection</i>	—		—		—		—		3		19	
<i>Sex with HIV-infected person, risk not specified</i>	1		1		—		2		96		275	
<i>Receipt of blood transfusion, blood components, or tissue</i>	—		1		—		—		23		98	
<i>Has HIV infection, risk not specified</i>	—		2		—		3		241		733	
Receipt of blood transfusion, blood components, or tissue	2	(50)	9	(41)	—		—		24	(3)	327	(1)
Risk not identified	—		—		—		—		13	(1)	49	(1)
Total	4	(100)	22	(100)	2	(100)	14	(100)	869	(100)	4,906	(100)

¹See technical notes.

²"Risk not identified" refers to persons whose mode of exposure to HIV is unknown. This includes persons under investigation; persons who died, were lost follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.

³Includes 13 children whose race/ethnicity is unknown.

Table 8. AIDS cases by sex, age at diagnosis, and race/ethnicity, reported through September 1993,¹ United States

Male Age at diagnosis (years)	White, not Hispanic		Black, not Hispanic		Hispanic		Asian/Pacific Islander		American Indian/ Alaska Native		†Total ²	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Under 5	329	(0)	1,167	(1)	478	(1)	8	(0)	8	(1)	1,992	(1)
5-12	248	(0)	183	(0)	155	(0)	7	(0)	1	(0)	594	(0)
13-19	473	(0)	299	(0)	186	(0)	11	(1)	11	(2)	980	(0)
20-24	4,735	(3)	3,282	(4)	1,938	(4)	75	(4)	23	(4)	10,071	(3)
25-29	23,298	(14)	12,067	(14)	7,742	(16)	267	(13)	123	(20)	43,576	(15)
30-34	37,653	(23)	19,017	(23)	11,723	(24)	420	(21)	173	(28)	69,100	(23)
35-39	35,879	(22)	19,483	(23)	10,671	(22)	443	(22)	126	(20)	66,742	(23)
40-44	25,717	(16)	13,213	(16)	7,088	(15)	346	(17)	85	(14)	46,548	(16)
45-49	15,223	(9)	6,869	(8)	3,793	(8)	218	(11)	34	(5)	26,191	(9)
50-54	8,173	(5)	3,800	(5)	2,012	(4)	108	(5)	17	(3)	14,140	(5)
55-59	4,671	(3)	2,121	(3)	1,174	(2)	62	(3)	9	(1)	8,066	(3)
60-64	2,775	(2)	1,155	(1)	587	(1)	20	(1)	10	(2)	4,551	(2)
65 or older	2,328	(1)	869	(1)	437	(1)	37	(2)	3	(0)	3,680	(1)
Male subtotal	161,502	(100)	83,525	(100)	47,984	(100)	2,022	(100)	623	(100)	296,231	(100)
Female												
Age at diagnosis (years)												
Under 5	320	(3)	1,143	(5)	455	(5)	1	(0)	5	(5)	1,933	(4)
5-12	81	(1)	189	(1)	106	(1)	6	(3)	—		384	(1)
13-19	102	(1)	262	(1)	68	(1)	1	(0)	1	(1)	435	(1)
20-24	672	(6)	1,347	(6)	594	(7)	12	(5)	10	(9)	2,641	(6)
25-29	1,875	(18)	3,801	(16)	1,699	(19)	23	(10)	23	(21)	7,430	(17)
30-34	2,455	(23)	5,618	(24)	2,126	(24)	48	(20)	34	(31)	10,300	(24)
35-39	1,918	(18)	5,094	(22)	1,707	(19)	38	(16)	14	(13)	8,792	(20)
40-44	1,093	(10)	2,826	(12)	988	(11)	37	(16)	9	(8)	4,961	(12)
45-49	594	(6)	1,187	(5)	472	(5)	21	(9)	5	(5)	2,286	(5)
50-54	359	(3)	706	(3)	273	(3)	14	(6)	2	(2)	1,356	(3)
55-59	344	(3)	381	(2)	168	(2)	8	(3)	1	(1)	903	(2)
60-64	249	(2)	248	(1)	87	(1)	12	(5)	3	(3)	599	(1)
65 or older	632	(6)	258	(1)	91	(1)	16	(7)	1	(1)	999	(2)
Female subtotal	10,694	(100)	23,060	(100)	8,834	(100)	237	(100)	108	(100)	43,019	(100)
Total	172,196		106,585		56,818		2,259		731		339,250	

¹Includes 9 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

²Includes 575 males and 86 females whose race/ethnicity is unknown.

Table 10. AIDS cases by year of diagnosis and definition category, diagnosed through September 1993,¹ United States

Definition category	Period of diagnosis										Cumulative total	
	Before Sept. 1989		Oct. 1989–Sept. 1990		Oct. 1990–Sept. 1991		Oct. 1991–Sept. 1992		Oct. 1992–Sept. 1993			
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Pre-1987 definition	106,479	(79)	28,634	(64)	29,523	(58)	28,340	(47)	13,876	(29)	206,852	(61)
1987 definition	26,788	(20)	13,559	(30)	16,078	(31)	17,521	(29)	9,537	(20)	83,483	(25)
1993 definition ²	1,610	(1)	2,402	(5)	5,467	(11)	15,032	(25)	24,404	(51)	48,915	(14)
Severe HIV-related immunosuppression ³	1,181		2,021		4,669		13,587		22,718		44,176	
Pulmonary tuberculosis	362		333		706		1,195		1,115		3,711	
Recurrent pneumonia	55		44		85		223		541		948	
Invasive cervical cancer	16		8		13		38		48		123	
Total	134,877	(100)	44,595	(100)	51,068	(100)	60,893	(100)	47,817	(100)	339,250	(100)

¹Includes 9 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

²Persons who meet only the 1993 AIDS case definition and whose date of diagnosis is before January 1993 were diagnosed retrospectively. The sum of diagnoses listed for the four conditions under the 1993 definition do not equal the 1993 definition total because some persons have more than one diagnosis from the added conditions of pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.

³Defined as CD4+ T-lymphocyte count of less than 200 cells/μL or a CD4+ percentage less than 14 in persons with laboratory confirmation of HIV infection.

Table 11. Health-care workers with documented and possible occupationally acquired AIDS/HIV infection, by occupation, reported through September 1993, United States¹

Occupation	Documented occupational transmission ²	Possible occupational transmission ³
	No.	No.
Dental worker, including dentist	—	6
Embalmer/morgue technician	—	3
Emergency medical technician/paramedic	—	8
Health aide/attendant	1	9
Housekeeper/maintenance worker	1	6
Laboratory technician, clinical	15	14
Laboratory technician, nonclinical	1	1
Nurse	13	15
Physician, nonsurgical	5	8
Physician, surgical	—	2
Respiratory therapist	1	2
Technician, dialysis	1	1
Technician, surgical	1	1
Technician/therapist, other than those listed above	—	3
Other health-care occupations	—	2
Total	39	81

¹Health-care workers are defined as those persons, including students and trainees, who have worked in a health-care, clinical, or HIV laboratory setting at any time since 1978. See *MMWR* 1992;41:823-5.

²Health-care workers who had documented HIV seroconversion after occupational exposure: 34 had percutaneous exposure, 4 had mucocutaneous exposure, 1 had both percutaneous and mucocutaneous exposures. Thirty-six exposures were to blood from an HIV-infected person, 1 to visibly bloody fluid, 1 to an unspecified fluid, and 1 to a concentrated virus in a laboratory. Eleven of these health-care workers have developed AIDS.

³These health-care workers have been investigated and are without identifiable behavioral or transfusion risks; each reported percutaneous or mucocutaneous occupational exposures to blood or body fluids, or laboratory solutions containing HIV, but HIV seroconversion specifically resulting from an occupational exposure was not documented.

Figure 1. Male adult/adolescent AIDS annual rates per 100,000 population, for cases reported October 1992 through September 1993, United States

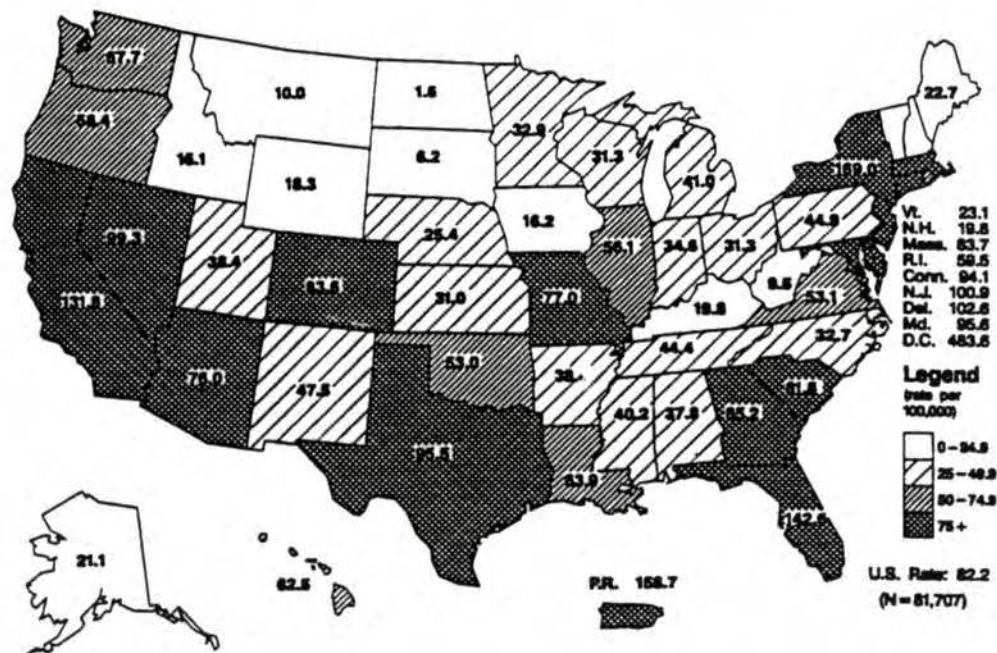


Figure 2. Female adult/adolescent AIDS annual rates per 100,000 population, for cases reported October 1992 through September 1993, United States

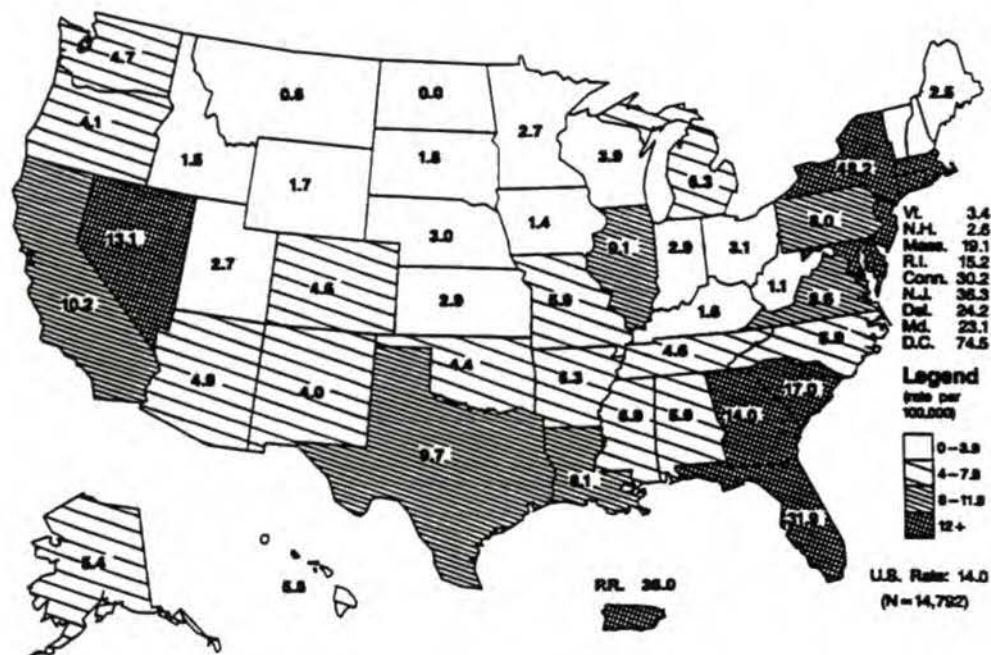
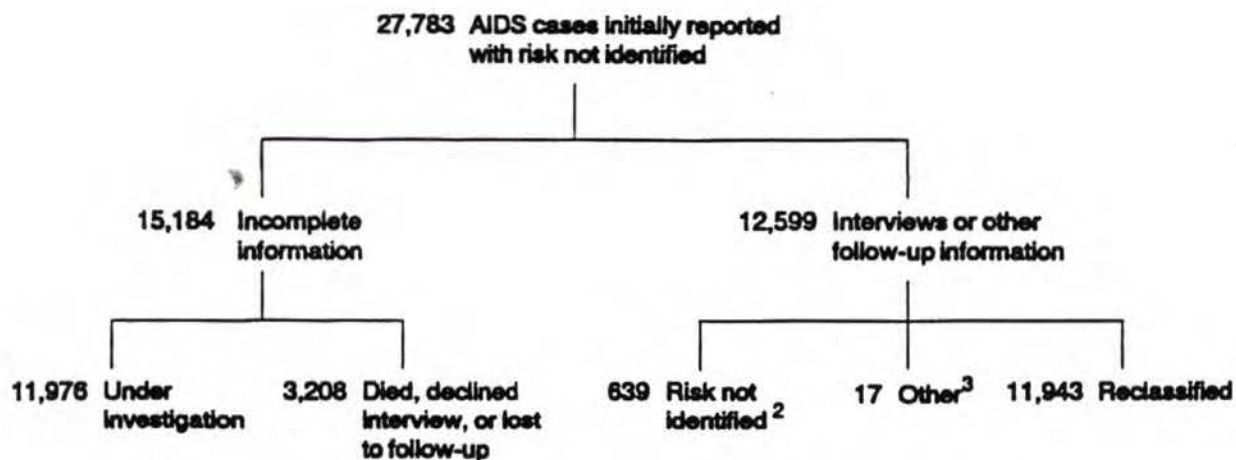


Figure 5. Pediatric AIDS cases reported October 1992 through September 1993, United States



Figure 6. Results of investigations of adult/adolescent AIDS cases with risk not identified, reported through September 1993¹



¹Excludes 49 children under 13 years of age whose risk is not identified: 40 children who are under investigation and 9 who have died, declined interview, or were lost to follow-up. An additional 228 children who were initially reported with a risk not identified have been reclassified after investigation.

²Heterosexual transmission. 553 of the 639 persons who had no risk identified after follow-up responded to a standardized questionnaire: 185 (36% of 511 persons responding to questions related to sexually transmitted diseases gave a history of such diseases and 123 (36%) of 342 interviewed men reported sexual contact with a prostitute. Some of these persons may represent unreported or unrecognized heterosexual transmission of HIV. See *MMWR*;38:423-4, 429-34.

³Eleven are health-care workers who developed AIDS after occupational exposure to HIV-infected blood, as documented by evidence of seroconversion; 4 are patients who developed AIDS after exposure to HIV within the health-care setting, as documented by laboratory studies; 1 is a person who acquired HIV infection perinatally and was diagnosed with AIDS after age 13; and 1 is a person with intentional self-inoculation of blood from an HIV infected person.

mined or reported for all cases. Caution should be used in interpreting case-fatality rates because reporting of deaths is incomplete.

Exposure categories

For surveillance purposes, AIDS cases are counted only once in a hierarchy of exposure categories. Persons with more than one reported mode of exposure to HIV are classified in the category listed first in the hierarchy, except for men with both a history of sexual contact with other men and injecting drug use. They make up a separate category.

"Men who have sex with men" cases include men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact). "Heterosexual contact" cases include persons who report either specific heterosexual contact with a person with (or at increased risk for) HIV infection (e.g., an injecting drug user), or persons presumed to have acquired HIV infection through heterosexual contact if they were born in countries with a distinctive pattern of transmission termed "Pattern II" by the World Health Organization (*MMWR* 1988;37:286-8, 293-5). Pattern-II transmission is observed in areas of sub-Saharan Africa and in some Caribbean countries. In these countries, most of the reported cases occur in heterosexuals and the male-to-female ratio is approximately 1:1. Injecting drug use and homosexual transmission either do not occur or occur rarely.

"Risk not identified" cases are persons with no reported history of exposure to HIV through any of the routes listed in the hierarchy of exposure categories. Risk not identified cases include persons who are currently under investigation by local health department officials; persons whose exposure history is incomplete because they died, declined to be interviewed, or were lost to follow-up; and persons who were interviewed or for whom other follow-up information was available and no exposure mode was identified. Persons who have an exposure mode identified at the time of follow-up are reclassified in the appropriate exposure category.

Rates

Rates are calculated on an annual basis per 100,000 population, based on U.S. Bureau of Census data from the 1990 census, and on extrapolations from the 1990 census and official Census Bureau estimates for 1991. Each 12-month rate is the number of cases for a 12-month period divided by the 1991 or 1992 population, multiplied by 100,000.

Case-fatality rates are calculated for each half-year by date of diagnosis. Each 6-month case-fatality rate is the number of deaths ever reported among cases diagnosed in that period (regardless of the year of death), divided by the number of total cases diagnosed in the period, multiplied by 100. Reported deaths are not necessarily caused by HIV-related disease.

PM69B175691093

the national
**RURAL
AIDS
NETWORK**

Jeremy Landau
Executive Director

March 25, 1994

Kristine Gebbie, RN,
National AIDS Policy Coordinator
Hubert Humphrey Building #738G
200 Independence Ave., S. W.
Washington, D. C. 20201

Dear Ms. Gebbie:

On behalf of the National Rural AIDS Network, thank you for scheduling today's meeting.

The National Rural AIDS Network believes that it is crucial to work with your office towards improvements in AIDS policy and delivery of federal assistance and leadership, especially in rural locales. There are three areas which require urgent attention:

1. **Treatment Access.**

Particularly in rural communities there are a dearth of resources available to persons with HIV/AIDS. However, there are numerous resources which might be mobilized for easier access and improved mentorship of rural clinicians.

2. **Prevention Services.**

Much in the way of prevention services has not worked in the past. Other resources need development and wider dissemination. A greater latitude in program implementation must be granted to federal fundees in order to accomplish this. This is a priority before rural communities become victims rather than partners in the AIDS epidemic.

3. **Service Delivery.**

Federal Ryan White Title II & III funding has received shortfalls in funding. In addition, due to access and state funding problems, rural areas are becoming the hardest hit in the AIDS epidemic. Obviously, this affects rural poor, women and minorities disproportionately. I urge you to work diligently towards full funding of Ryan White Titles II and III as well as support of new and progressive AIDS-related legislation now coming before the Congress of the United States.

1915 Rosina
Santa Fe, NM 87501
Phone: 505.986.8337
Fax: 505.986.3938

page 2 of 2

I would like to recommend a national meeting to discuss rural AIDS policy in the near future? The national Rural AIDS Network would be glad to take initiative in developing a list of people, agencies, and issues which should be represented in such a meeting. Among the issues which might be discussed at such a time could be:

- a. Health Care Reform
- b. A Rural Title to the Ryan White CARE Act
- c. Access and Mentorship Programs for rural PLWA's
- d. Streamlining the FDA Clinical Trials System
- e. Interagency networking between all Federal AIDS service agencies

Much of this is already consistent with recommendations coming from the 1993 External Review Report of the Centers for Disease Control and Prevention.

I look forward to meeting with you, later this week, and to working with you in the future. I will also come prepared to share with you our efforts towards the Fourth Western Hidden Epidemic Conference, which has previously been a joint project of departments of the United States Public Health Service, some of which are now under your jurisdiction.

Sincerely,

Jeremy Landau
Executive Director
NATIONAL RURAL AIDS NETWORK

HIV CLINIC UNIVERSITY HOSPITAL

George
Tim
fcp

University Hospital has been working and involved in the fight with HIV since the first AIDS patient was diagnosed in the state of New Mexico. I have been in that partnership since 1987. By the time I joined the staff there had been fifty diagnosed HIV+ patients cared for by University Hospital Infectious Diseases physicians. I was the first full time nurse employed specifically to work in a developing clinic and patient population.

I have had a unique opportunity to see in a very personal way the growth and spread of this infection. I have also been blessed with the opportunity to help shape and direct the manner in which care is given to those of our clients and their family and significant others. As I write this I am overwhelmed by sadness; the toll that this disease has taken goes beyond mere death. It disturbs the very core of all that is humane within us - within me.

I would like to share some glimpses of what our clinic looks like. First the staff: there are three Registered Nurses, one Social Worker, one Therapist, two volunteer Psychiatrist (one a resident), one Family Practitioner, and six Infectious Disease Specialists. We have a medical model clinic that is available for appointment every day. Two of the registered nurses have full time clinical responsibility and the third is administrative/clinical. The ideal of a case management nursing focus is difficult because of the Patient/Nurse ratio, however this is our goal and aspiration.

Our patient population is described in greater detail in the attached enclosure. Briefly, as of the end of February, we have 351 current patients. We describe current as; a patient that has been seen by a health care provider within six months. Approximately fifty percent of our patients have an AIDS diagnosis. Twenty-nine of those patients were women of which twenty-five percent have AIDS. We have a relatively small clinic population, however it is the largest clinic in the state. In some ways we can be used as a barometer for trends and as a model of rural state and urban city description.

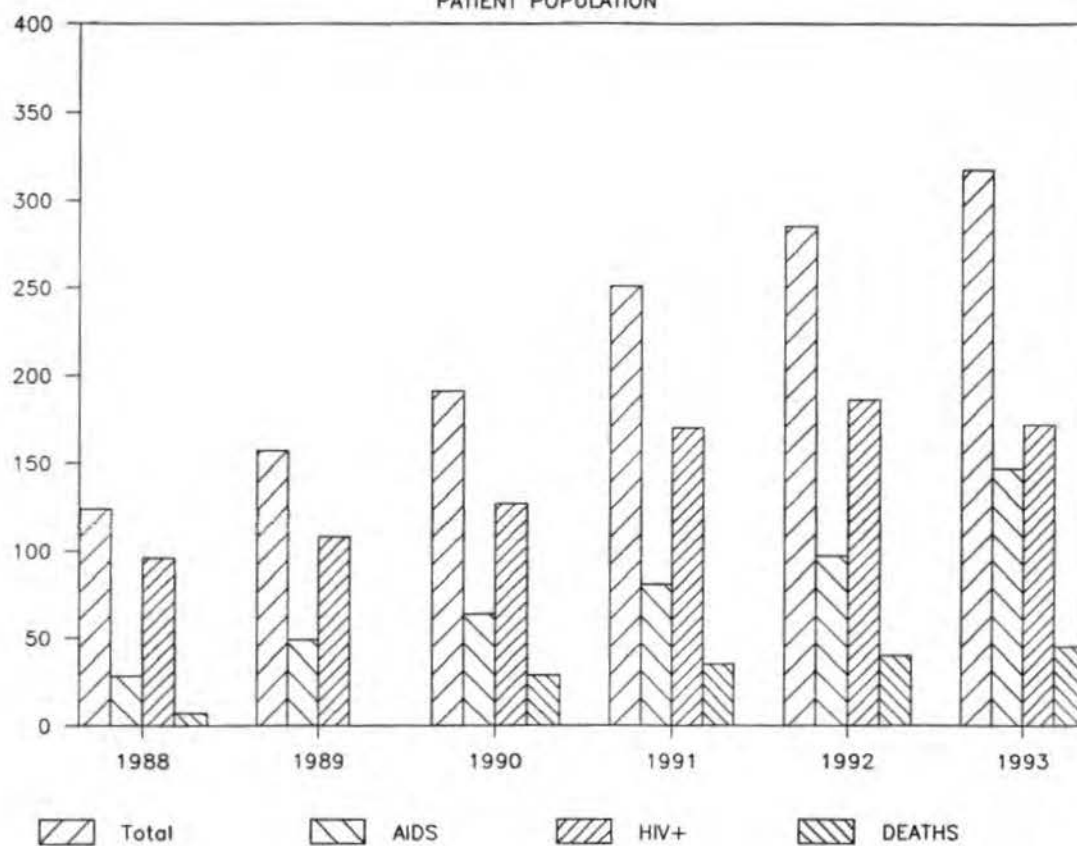
I have one trend that I consider very important and indicative of future development. It is the one bit of information I would like all to consider, remember, and think about. Within the enclosure of data there is a section that addresses "Time in New Mexico". This is a question we began asking every new patient to our clinic less than a year ago. We also, with the creation of our database, were able to take a retrospective look for this particular item. In some instances we were unable to ascertain a response. Not being a statistician I still feel that the amount of responses are indicative of our population.

Forty percent of our population had been in New Mexico one year or less at the time they presented to our clinic.
Thirty-two percent had been here less than six months.

M. Nadine Ulibarri-Keller, RN
Coordinator HIV Clinic University Hospital
March 25, 1994

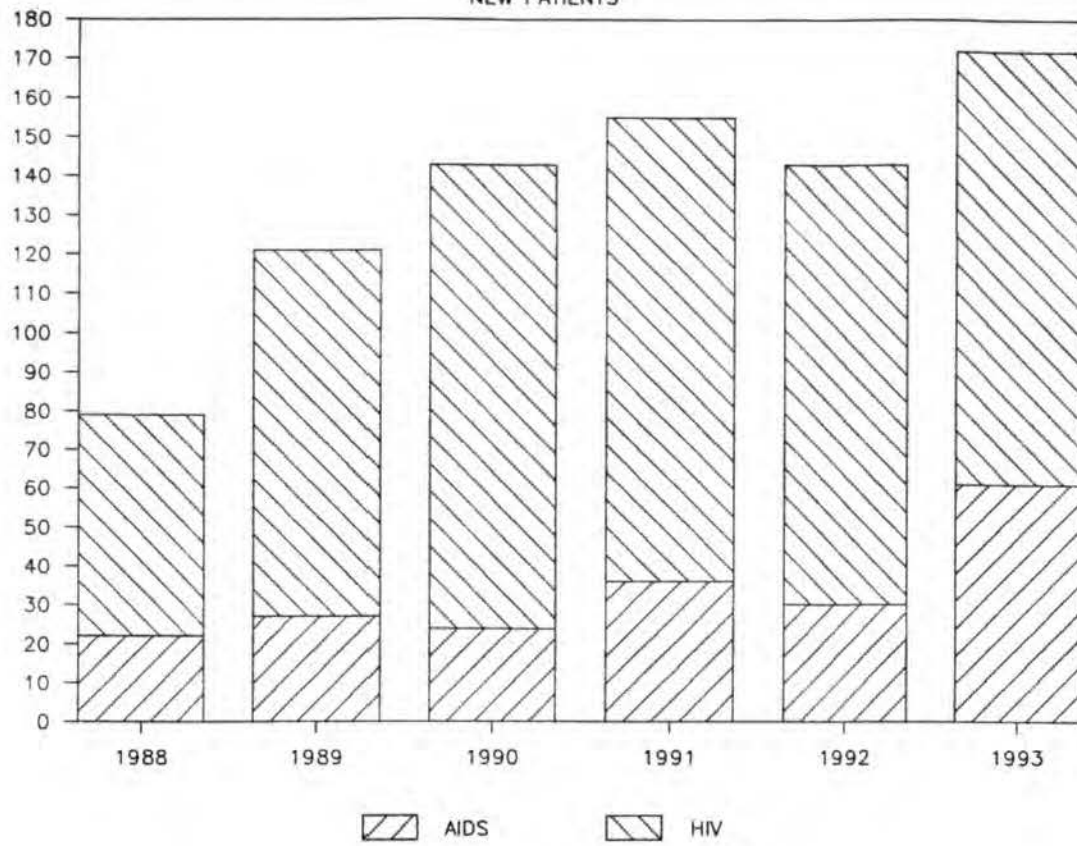
HIV CLINIC

PATIENT POPULATION



HIV CLINIC

NEW PATIENTS



ETHNICITY	Freq	Percent	Cum.
1	200	57.5%	57.5%
2	122	35.1%	92.5%
3	10	2.9%	95.4%
4	12	3.4%	98.9%
6	4	1.1%	100.0%
Total	348	100.0%	

Sum = 546.00
Mean = 1.57
Standard deviation = 0.86

LEGEND

1 = Caucasian
2 = Hispanic
3 = African American
4 = Native American
6 = Other

SEX	Freq	Percent	Cum.
F	27	7.7%	7.7%
M	318	91.1%	98.9%
T	4	1.1%	100.0%
Total	349	100.0%	

F = Female
M = Male
T = Transexual

AGEGROUP	Freq	Percent	Cum.
0 TO	1	0.3%	0.3%
10 TO	1	0.3%	0.6%
20 TO	91	26.1%	26.6%
30 TO	161	46.1%	72.8%
40 TO	77	22.1%	94.8%
50 TO	13	3.7%	98.6%
60 TO	2	0.6%	99.1%
TO .	3	0.9%	100.0%
Total	349	100.0%	

TIMEINNM	Freq	Percent	Cum.
1	75	32.2%	32.2%
2	19	8.2%	40.3%
3	25	10.7%	51.1%
4	45	19.3%	70.4%
5	69	29.6%	100.0%
Total	233	100.0%	

Sum = 713.00
Mean = 3.06
Standard deviation = 1.66

1 = less than 6 months
2 = 6 months to 1 year
3 = 1 year to 5 years
4 = more than 5 years
5 = life time

Current selection: SEX="F"

ETHNICITY	AGEGROUP					Total
	10 TO	20 TO	30 TO	40 TO	50 TO	
1	0	5	4	3	1	13
2	1	1	7	0	0	9
3	0	1	1	0	0	2
6	0	1	1	0	0	2
Total	1	8	13	3	1	26

An expected value is < 5. Chi square not valid.

Chi square = 10.10

Degrees of freedom = 12

p value = 0.60715053

Current selection: SEX="M"

ETHNICITY	AGEGROUP							Total
	0 TO	20 TO	30 TO	40 TO	50 TO	60 TO	TO .	
1	0	43	83	50	8	2	1	187
2	1	35	51	19	3	0	0	109
3	0	2	4	1	1	0	0	8
4	0	2	6	4	0	0	0	12
6	0	0	1	0	0	0	1	2
Total	1	82	145	74	12	2	2	318

An expected value is < 5. Chi square not valid.

Page 1

LEGEND

- 1 = Caucasian
- 2 = Hispanic
- 3 = African American
- 4 = Native American
- 5 = Asian or Pacific Islander
- 6 = Other

TIMEINNM	Freq	Percent	Cum.
1	75	32.2%	32.2%
2	19	8.2%	40.3%
3	25	10.7%	51.1%
4	45	19.3%	70.4%
5	69	29.6%	100.0%
Total	233	100.0%	

Sum = 713.00
Mean = 3.06
Standard deviation = 1.66

Current selection: TIMEINNM="1" or TIMEINNM="2"

FAMNM	Freq	Percent	Cum.
+	40	54.1%	54.1%
-	34	45.9%	100.0%
Total	74	100.0%	

LEGEND

- 1 = less than 6 months
- 2 = 6 months to 1 year
- 3 = 1 year to 5 years
- 4 = more than 5 years
- 5 = life time

This data represents the amount of time that patients presenting to the HIV Clinic have been in New Mexico. The first set of data is all patients (233) responding to the question "How long have you been in New Mexico?" The second set of data is representative of those patients that have been in New Mexico less than six months or from six months to one year. The question is then asked "Do you have family or friends in New Mexico?"

LOST	Freq	Percent	Cum.
01/27/93	1	4.5%	4.5%
05/18/93	1	4.5%	9.1%
06/23/93	1	4.5%	13.6%
07/20/93	1	4.5%	18.2%
08/23/93	1	4.5%	22.7%
11/01/93	13	59.1%	81.8%
11/08/93	1	4.5%	86.4%
12/15/93	1	4.5%	90.9%
01/31/94	1	4.5%	95.5%
03/09/94	1	4.5%	100.0%
Total	22	100.0%	

LOST This describes the group of patients that have been lost to follow up, or not seen by a health care provider within six months.

MOVED	Freq	Percent	Cum.
04/28/93	1	5.9%	5.9%
08/10/93	1	5.9%	11.8%
09/30/93	1	5.9%	17.6%
10/01/93	2	11.8%	29.4%
12/01/93	1	5.9%	35.3%
12/19/93	1	5.9%	41.2%
12/21/93	1	5.9%	47.1%
01/01/94	2	11.8%	58.8%
01/19/94	1	5.9%	64.7%
01/25/94	1	5.9%	70.6%
03/03/94	1	5.9%	76.5%
03/07/94	1	5.9%	82.4%
03/09/94	1	5.9%	88.2%
03/12/94	1	5.9%	94.1%
03/21/94	1	5.9%	100.0%
Total	17	100.0%	

MOVED This describes the group of patients that have either moved entirely from the state of New Mexico or have transferred their care to another health care provider within the state or Albuquerque area.

DEATH	Freq	Percent	Cum.
03/13/93	1	3.4%	3.4%
09/14/93	1	3.4%	6.9%
10/07/93	1	3.4%	10.3%
10/12/93	1	3.4%	13.8%
10/18/93	1	3.4%	17.2%
10/27/93	1	3.4%	20.7%
10/31/93	1	3.4%	24.1%
11/02/93	2	6.9%	31.0%
11/22/93	1	3.4%	34.5%
11/24/93	1	3.4%	37.9%
11/25/93	1	3.4%	41.4%
11/27/93	1	3.4%	44.8%
11/29/93	2	6.9%	51.7%
12/06/93	1	3.4%	55.2%
12/11/93	1	3.4%	58.6%
12/21/93	1	3.4%	62.1%
01/17/94	1	3.4%	65.5%
01/22/94	1	3.4%	69.0%
01/31/94	1	3.4%	72.4%
02/02/94	1	3.4%	75.9%
02/11/94	1	3.4%	79.3%
02/15/94	1	3.4%	82.8%
02/17/94	1	3.4%	86.2%
02/28/94	1	3.4%	89.7%
03/07/94	1	3.4%	93.1%
03/13/94	1	3.4%	96.6%
03/21/94	1	3.4%	100.0%
Total	29	100.0%	

HEMO	Freq	Percent	Cum.
-	332	100.0%	100.0%
Total	332	100.0%	

Hemophellia as identified risk

BLOOD	Freq	Percent	Cum.
+	19	5.7%	5.7%
-	312	94.3%	100.0%
Total	331	100.0%	

Blood transfusion as identified risk

TISSUE	Freq	Percent	Cum.
+	1	0.3%	0.3%
-	330	99.7%	100.0%
Total	331	100.0%	

Tissue recipient as identified risk

MSM	Freq	Percent	Cum.
+	190	56.9%	56.9%
-	144	43.1%	100.0%
Total	334	100.0%	

Men who have sex with men as identified risk

BI	Freq	Percent	Cum.
+	84	25.2%	25.2%
-	249	74.8%	100.0%
Total	333	100.0%	

Bisexual as identified risk

IDU	Freq	Percent	Cum.
+	70	21.1%	21.1%
-	261	78.9%	100.0%
Total	331	100.0%	

Injecting Drug Use as identified risk

HETERO	Freq	Percent	Cum.
+	60	18.1%	18.1%
-	272	81.9%	100.0%
Total	332	100.0%	

Heterosexual as identified risk

Dear _____

Thank you for giving up part of your Saturday to meet with me in Albuquerque, ~~last~~ ^{last} week. I appreciate the opportunity to learn more about day-to-day ^{efforts} ~~work~~ ^{from} to developing & managing HIV prevention and services in New Mexico, especially the combined challenges of inclusion of all ethnic groups in a big, rural state.

I look forward to hearing from you as you continue your work. You have my best wishes for success in
the
Sincerely

NAME	ADDRESS	TITLE/AFFILIATION
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TERENCE L. GIBBS, MD.	P.O. Box 26665 Albuq. NM. 87125-6665	Executive Director African American Community Coalition
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Sheda Cort	"	"
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Mary Suzanne	1777 Apache NE 87504	Director NAACP (of Albu?) AIDS Educ Pres
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Doris Fields	P.O. Box 9814, Santa Fe	Program Manager TB Control Program
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Karyn Rae Daddymd	3317 Ave San Marcos SF NM 87505	Med Director Rehab Services St Vincent Hospital
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MINNIE M. WHITEHEAD, LISW	1819 CARLISLE NE ALBU, NM 87102	Private Psychotherapist APS Employee
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Alice Hopps	13113 Pinehurst NE	NAACP President Elect.
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PETER COUNTERMAN	111 Montclair SE Albu, NM	EXEC. DIR. NM APLA (Living w/ AIDS)
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Bill Jordan	4200-B SILVER SE ALBU, NM 87108	EXECUTIVE DIRECTOR HIV COORDINATING COUNCIL
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Janet Voorhees	1190 St. Francis Dr. Santa Fe 87501	Chief, HIV/AIDS/STD Bureau NM Department of Health
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LINDA SIEGLE	POB 8602 SF 87504	Resources For Change
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LIZ STEFANICS	PO BOX 10127 SANTA FE, NM 87504	NM STATE SENATE
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Carole Otero	5028 Pheasant NW Albuq NM 87120	Program Manager UNM - CASAA
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Barbara Rickert	College of Nursing UNM, Albuq 87131	Prof of Nursing
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Paul C. Stead	14 Columbine Drive Santa Fe, NM 87501	Pres. BOD, NMAS
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Dale J. Guillot	1223 C St. Francis Dr. Santa Fe, NM 87505	Assistant Director New Mexico AIDS Services
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NAME

ADDRESS

TITLE/AFFILIATION

TERENCE L. JONES MD.	P.O. Box 26665 Albq. NM. 87125-6665	Executive Director African American Community Coalition
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Shelia Cort	"	"
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Mary Susan	17717 Apache NE 87504	Director NAACP AIDS Educ Fund
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Doris Fields	P.O. Box 9814 Santa Fe	Program Manager TB Control Program
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Karyn Rae Dodd MD	3317 Ave San Marcos SF NM 87505	Med Director Rehab Services St Vincent Hospital
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MINNIE M. WHITEHEAD / LISW	1819 CARUSLE NE ALB, NM 87102	PRIVATE Psychotherapist APS Employee
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**DEPARTMENT OF ENERGY
"PUTTING ENERGY INTO AIDS AWARENESS"**

PRELIMINARY SUMMARY - DOE LABORATORY WORK IN AIDS RELATED AREAS

**ARGONNE NATIONAL LABORATORY, CHICAGO, ILLINOIS
DIRECTOR, ALAN SCHRIESHEIM**

DOE employees at the Argonne National Laboratory are using a Synchrotron X-ray source for defining structures of proteins and to examine protein drugs that bind and regulate gene expression. In collaboration with pharmaceutical laboratories and drug companies, DOE labs use Synchrotron beam-lines to identify various structures of drug molecules.

**BROOKHAVEN NATIONAL LABORATORY, LONG ISLAND, NEW YORK
DIRECTOR, NICHOLAS SAMIOS,**

The Brookhaven National Laboratory is investigating the nutritional and intestinal complications of AIDS, and is researching why AIDS patients suffer from malnutrition and wasting. By using the PET Scan (positron emission tomography), a higher order of instrument than a CAT scan, they can research the causes of mass depletion.

**LOS ALAMOS NATIONAL LABORATORY, LOS ALAMOS, NEW MEXICO
DIRECTOR, SIGFRIED HECKER**

The Los Alamos National Laboratory maintains an international AIDS database that includes all HIV genetic sequencing used by all research laboratories throughout the world and is funded by the National Institute of Health. The facility and training is supplied by the Department of Energy. Dr. Gerald Myers, director of the HIV Sequence Database and Analysis Project at Los Alamos National Laboratory is a critical player in monitoring the progressive changes and transference of HIV.

**LAWRENCE LIVERMORE, LIVERMORE VALLEY, CALIFORNIA
DIRECTOR, JOHN NUCKOIS**

Lawrence Livermore Laboratory has developed a unique instrument called the high-speed flow cytometer which can analyze and purify cells at very high rates of speed, approximately 20,000 per second. The instrument and associated electronics have been licensed to industry, which uses this flow cytometer for sorting specific blood cells that might be involved in the cause and progression of HIV.

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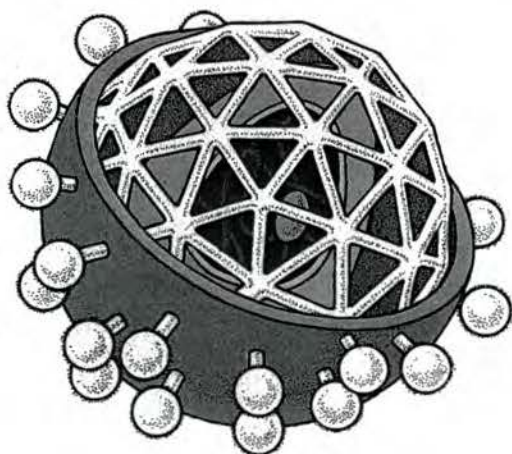
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HIV

ADVANCES IN RESEARCH AND THERAPY



SCIENTIFIC RESEARCH:

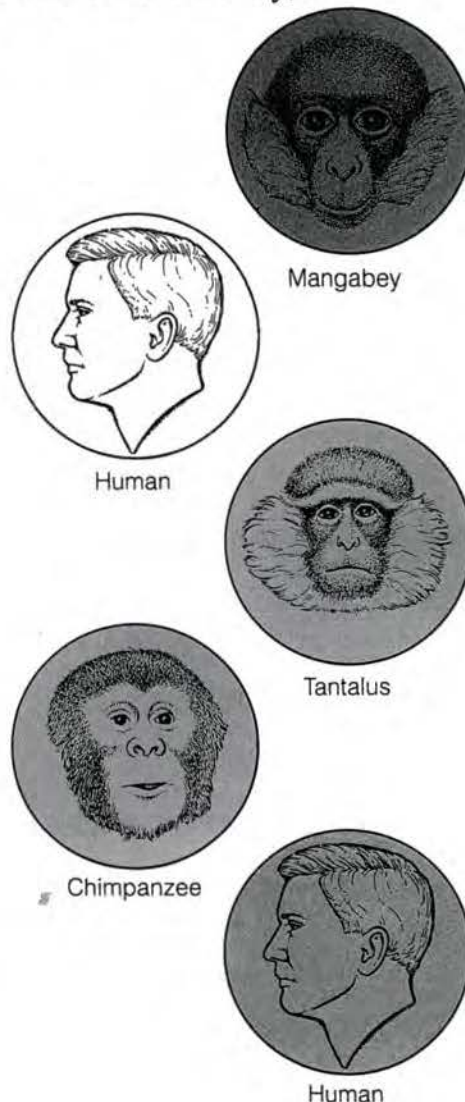
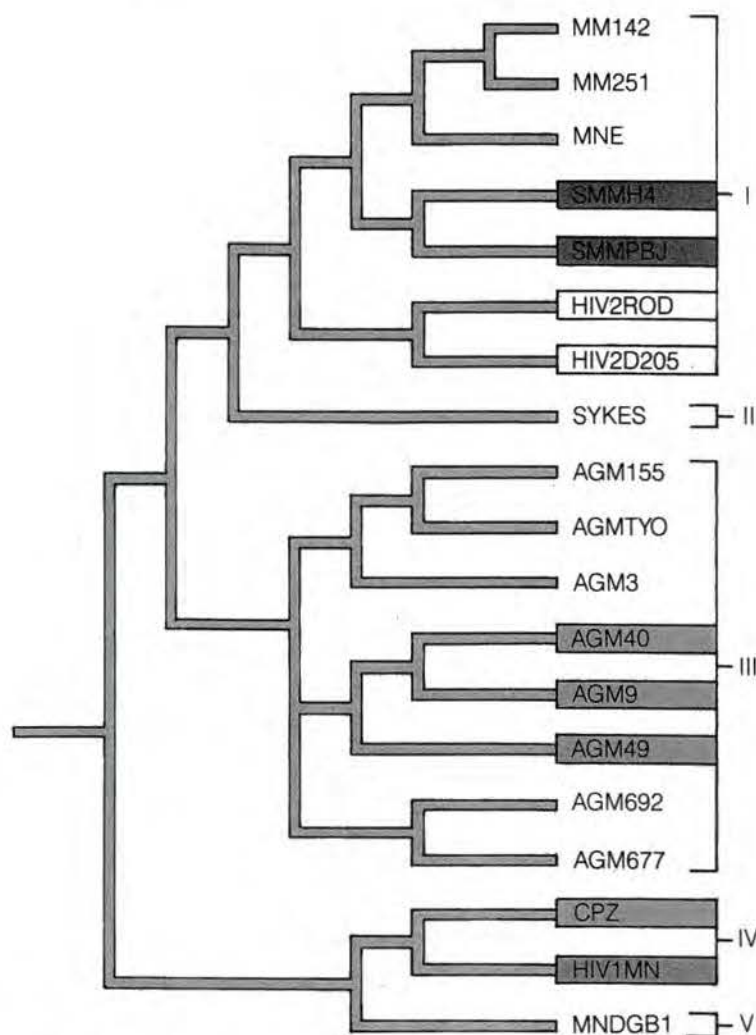
HIV: Its Origin and Its Future
Gerald Myers, PhD

CLINICAL UPDATE: COMBINATION THERAPY

Refining Disease Markers
Thomas C. Merigan, Jr, MD

Nucleoside Analogue Combinations
Margaret Ragni, MD

ZVD and Nonnucleoside Analogues
Thomas B. Campbell, MD,
and Robert T. Schooley, MD



Phylogenetic tree of
primate immunodeficiency viruses

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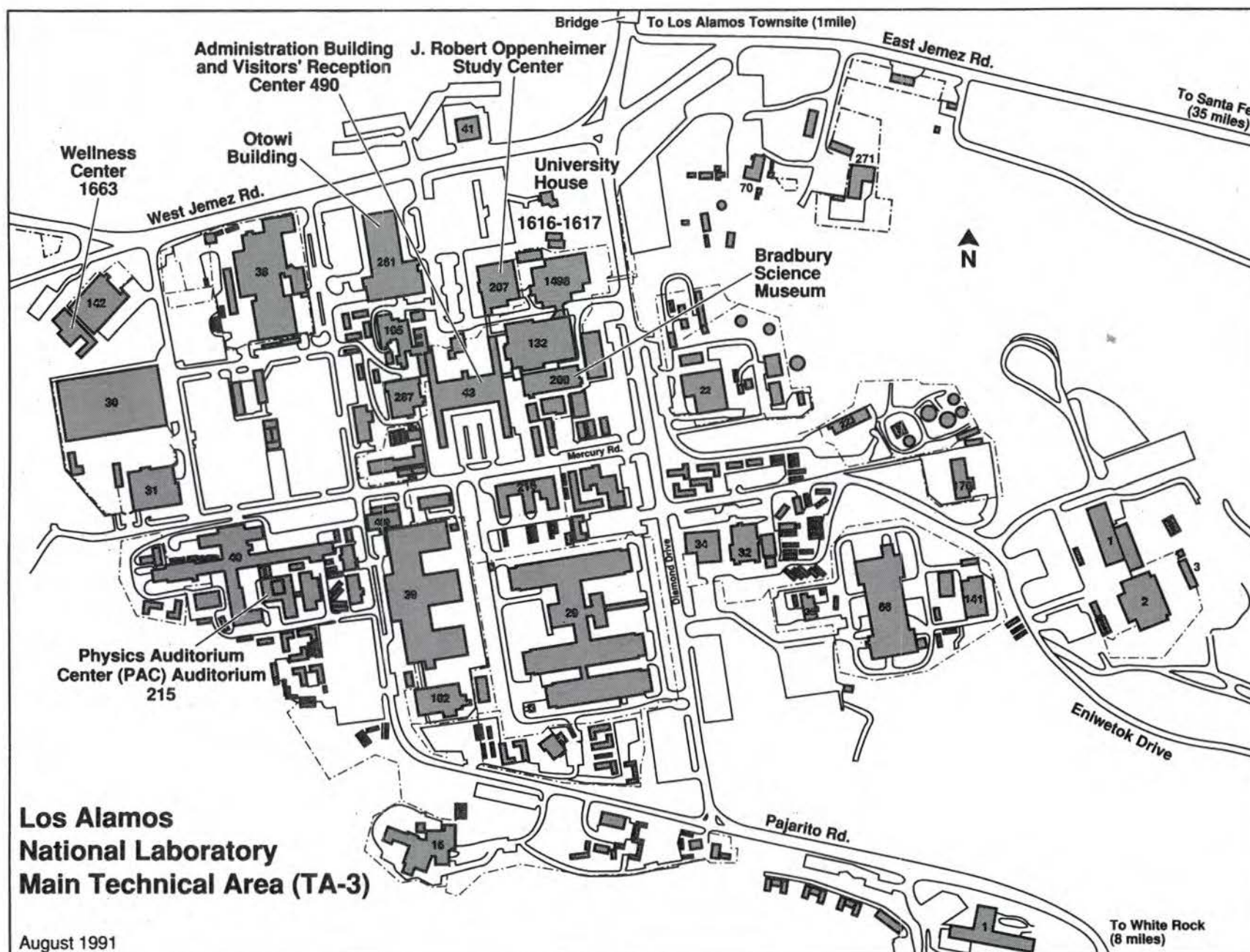
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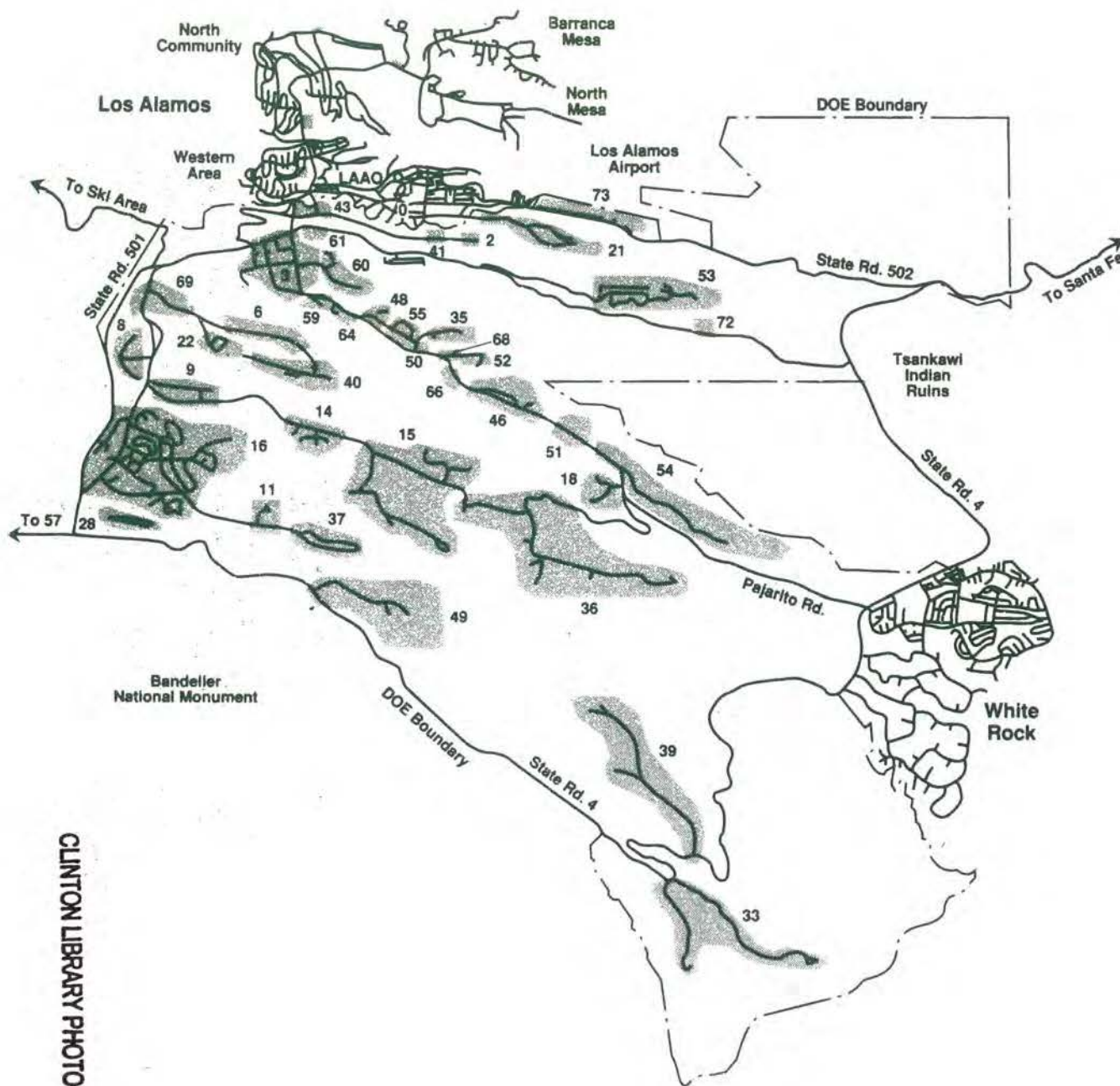
Los Alamos Visitor Guide
to Environment, Safety, Health, &
Security

25pgs

**Los Alamos
Visitor Guide**
to Environment, Safety, Health, & Security







Los Alamos

NATIONAL LABORATORY

Technical Area Locations

TA-0	Unassigned Land Reserve
TA-2	Omega Site
TA-3	South Mesa Site
TA-6	Two Mile Mesa Site
TA-8	Anchor Site West
TA-9	Anchor Site East
TA-11	K-Site
TA-14	Q-Site
TA-15	R-Site
TA-16	S-Site
TA-18	Pajarito Laboratory
TA-21	DP-Site
TA-22	TD-Site
TA-28	Magazine Area A
TA-33	HP-Site
TA-35	Ten Site
TA-36	Kappa Site
TA-37	Magazine Area C
TA-39	Ancho Canyon Site
TA-40	DF-Site
TA-41	W-Site
TA-43	Health Research Lab & DOE Headquarters
TA-46	WA-Site
TA-48	Radiochemistry Site
TA-49	Frijoles Mesa Site
TA-50	Waste Management Site
TA-51	Radiation Exposure Facility
TA-52	Reactor Development Site
TA-53	Meson Physics Facility
TA-54	Waste Disposal Site
TA-55	Plutonium Facility Site
TA-57	Fenton Hill Site
TA-59	OH-Site
TA-73	Airport

TA-60,61,64,66,68,72
(unnamed TAs)

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A National Resource

