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CAEAR [Cities Advocating Emergency AIDS Relief] Letter to POTUS

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**The CAEAR
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The Sheridan Group
Government Relations
Representative

September 13, 1999

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

Dear President Clinton:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

A handwritten signature in black ink, appearing to read 'McClain', with a stylized flourish at the end.

Matthew McClain
Chair
CAEAR Coalition

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CAEAR

**CITIES ADVOCATING
EMERGENCY AIDS RELIEF**

June 1999

Advocating for CARE Act Title I & Title III

Policy Position Paper: Ryan White CARE Act Reauthorization



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RYAN WHITE COMPREHENSIVE AIDS RESOURCES EMERGENCY (CARE) ACT

TITLE I BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TITLE III BACKGROUND

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

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

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

315,000 received HIV counseling and testing..

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

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

THE IMPACT OF AIDS ON THE COMMUNITY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COST OF CARING FOR PEOPLE WITH HIV DISEASE

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

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

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

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

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

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

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

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

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

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

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

FY 99 TITLE I AREAS:

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

THE RYAN WHITE CARE ACT SAVES MONEY

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

KEY FACTS

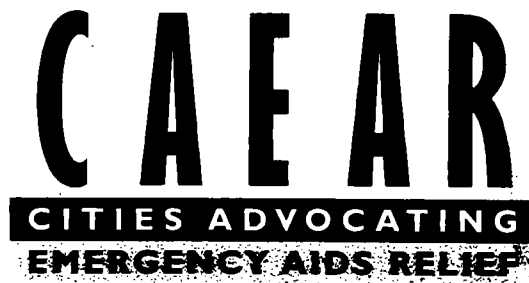
- ▶ About 74 percent of the nation's people living with AIDS reside in Title I cities.
- ▶ In six years, "AIDS Disaster Areas" grew from 16 to 49, and this year became 51.
- ▶ The nation has seen over 650,300 cases of AIDS diagnosed; only two years elapsed between the diagnosis of the first 100,000 cases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

- ▶ Title I and Title III of the CARE Act serve as safety nets for people of color and other underserved communities. Approximately two-thirds of the patients served by Title I and Title III in 1998 were people of color.
- ▶ Title III programs have reduced hospital admissions in some locales by as much as 75 percent since 1996.
- ▶ A 1998 CAEAR study reported that the cost of medical services provided under Title I and Title III of the CARE Act increased an average of 89.3 percent between 1995 and 1997.

May, 1999

THE ACCELERATING COST OF HIV HEALTH CARE:

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



**Conducted by
Cities Advocating Emergency AIDS Relief (CAEAR)**

August, 1998

*For more information, contact the CAEAR Coalition, a national coalition supporting
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CAEAR

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

OVERVIEW

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

The Growing HIV Population

- Data show that between 1995 and 1997 there was an average increase of 43.5% in the number of HIV/AIDS patients among a representative sample of Title I and Title III sites, clearly illustrating one of the most obvious challenges to the HIV/AIDS health care community: the growing HIV population.
- In addition to new HIV cases, recently available combination therapies have increased the life expectancy of HIV patients. As the number of AIDS deaths has begun to decrease, the number of people dependent on treatment provided under the CARE Act has grown substantially. The data compiled by the CAEAR Coalition in this study reflects the impact of combination therapies that became widely available during the 1995-1997 period.

Increase in the Number of Patient Visits

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

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

Costly Medical Care

- The CAEAR study revealed that the average cost of medical care has increased by 89.3%. The study also found that this escalating cost could not be attributed solely to the increase in patients (43.5%), or patient visits (55.3%), which are growing at less significant rates than the accelerating cost of medical care.
- Advancements in HIV treatments, are among the reasons for this increased cost in HIV medical health care. Complex treatment regimens are required, including increased viral load testing and greater emphasis on longer more complex visits to promote adherence to drug dosing and scheduling. Neglecting to take medication as prescribed can lead to the failure of the therapy, the development of resistant viral strains, or both. Communities financially dependent on the CARE Act are, and will continue to be, inundated with patients in need of these costly medical services.

CONCLUSION

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



THE CARE ACT:

- ✓ SAVES LIVES
- ✓ DECREASES AIDS DEATHS
- ✓ INCREASES THE NUMBER OF PEOPLE GOING BACK TO WORK

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

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

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

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

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

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

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

Sources: Reporting organizations. June - July, 1998.

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

**Grady Health System
Infectious Disease Program
Atlanta, Georgia**

Funded By CARE Act Title I

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

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

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

Notes concerning complexity of visits:

1995:

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

1997:

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

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

**Chase Brexton Health Services
Baltimore, Maryland**

Funded By CARE Act Title I and Title III

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

Source: Chase Brexton Health Services, Baltimore, Maryland.

Notes concerning complexity of visits:

1995:

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

1997:

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

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

**Chicago Health Outreach
Chicago, Illinois**

Funded By CARE Act Title I and Title III

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

Source: Chicago Health Outreach, Chicago, Illinois.

Notes concerning complexity of visits:

1994:

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

1997:

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

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

The CORE Center for the Prevention,
Care, and Research of Infectious Disease
(formerly known as the
Cook County HIV Primary Care Center)
Chicago, Illinois
Funded By CARE Act Title I and Title III

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

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

Notes concerning complexity of visits:

1995:

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

1997:

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

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

**Allegheny University Hospitals
Hahnemann
Philadelphia, Pennsylvania**

Funded By CARE Act Title I

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year	Average Cost per Patient per Year (medical care & labs only – no drugs)
1994 Combination therapy not available	297	1,255 (20 min. each)	4.2	\$441
1997 Combination therapy available	650	3,348 (40 min. each)	5.2	\$1,561
Percent Change Since 1994	118.8% increase	166.7% increase	23.8% increase	254.0% increase

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

Notes concerning complexity of visits:

1994:

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

1997:

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

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

**Health Federation of Pennsylvania
Philadelphia, Pennsylvania**

Funded By CARE Act Title I

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

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

Notes concerning complexity of visits:

1994:

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

1997:

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

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

**Philadelphia Department of Public Health
Philadelphia, Pennsylvania**

Funded By CARE Act Title I

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

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

Notes concerning complexity of visits:

1994:

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

1997:

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

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

**Desert AIDS Project
Riverside/San Bernardino,
California**

Funded By CARE Act Title I

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

Source: Desert AIDS Project, Palm Springs, California.

* 560 of 748 (75%) patients in 1997 were on triple combination therapy.

Notes concerning complexity of visits:

1995:

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

1997:

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

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

**San Francisco
General Hospital/Outpatient Clinic
San Francisco, California**

Funded By CARE Act Title I

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

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

Key Findings:

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

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

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

**Santa Cruz County Health Services
Agency
Santa Cruz, California**

Funded By CARE Act Title III

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

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

Notes concerning complexity of visits:

1993:

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

1997:

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

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

**Country Doctor
Community Health Centers
Seattle, Washington**

Funded By CARE Act Title III

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

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

Notes concerning complexity of visits:

1995:

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

1997:

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

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

**Whitman-Walker Clinic
Washington, D.C.**

Funded By CARE Act Title I

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

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

Notes concerning complexity of visits:

1994:

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

1997:

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

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HIV's Spread Is Unchecked

AIDS-Slowing Treatments Eclipse Rising Infection Rate, Study Says

By RICK WEISS
Washington Post Staff Writer

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

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

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

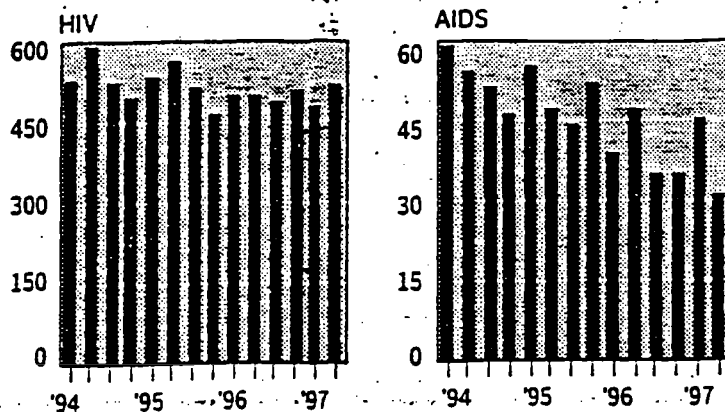
The findings also confirm previously identified trends showing that women and minorities are increasingly at risk. Especially worrisome, officials said, is that the annual number of new infections in young men and women 13 to 24 years old—a group that has been heavily targeted for prevention efforts—is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

See AIDS, A17, Col. 1

FRIDAY, APRIL 24, 1998

The Washington Post

Diagnoses in 25 states by quarter, ages 13-24



SOURCE: Centers for Disease Control and Prevention

Who is diagnosed with HIV:

Women	28%
Men	72
Blacks	57
Whites	34
Hispanics	7

How they got it:

Male homosexual sex*	32%
Injecting drugs	18
Heterosexual sex	18
Drugs & homosexual sex	4
Other/unreported	28

* Thought to be underreported.

THE WASHINGTON POST

HIV Spread Not Slowed in U.S.

AIDS, From A1

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

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

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

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

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

cent in 1996 and dropped another 44 percent in the first six months of last year.

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

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

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

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

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

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

FOR MORE INFORMATION

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

CAEAR

CITIES ADVOCATING EMERGENCY AIDS RELIEF

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May 3, 1999

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

Dear Senator Specter:

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T. Andrew Lewis, Esq.

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

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

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

The Sheridan Group
Government Relations
Representative

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Matthew McClain
Chair
CAEAR Coalition

CAEAR Executive Committee

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Philadelphia, Pennsylvania

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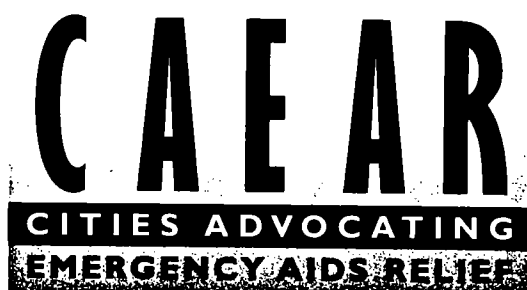
Draft FY 2000 Appropriations Report Language
for
Title I and Title III of the Ryan White CARE Act

The Committee recommends \$ 625,200,000 for Title I emergency assistance grants to the 51 eligible metropolitan areas disproportionately affected by the HIV/AIDS epidemic and recognizes the importance of the local control provided by Title I Planning Councils. These funds are provided to areas with a cumulative total of more than 2,000 cases of AIDS or a per capita incidence of 0.0025 for cases prior to fiscal year 1995. One-half of the funds are awarded by formula and one-half are awarded through supplemental competitive grants. The Committee is concerned that the significant health improvements and reductions in deaths, observed in some individuals living with HIV/AIDS, are not being evenly realized by all affected Americans regardless of race, ethnicity, socio-economic status, gender and age. Recent national improvements in access to combination therapies require that the essential medical and supportive services, provided by Title I, be bolstered in order to promote and sustain participation in health care services. The demonstrated impact of Title I services on improved patient survival and care justify the Committee's recommendation of a \$120 million increase in Title I funding over FY 1999. The Committee also recommends that the targeted initiatives to reduce the disparity in health outcomes and utilization of existing services between populations remain a high priority for all funded localities, particularly Title I communities serving the majority of people with AIDS in the country.

The Committee recommends \$134,000,000 for Title III HIV/AIDS Early Intervention and Care Programs to maintain and enhance access to primary care services in 197 rural and urban communities that are disproportionately affected by the HIV/AIDS epidemic. This is an increase of \$40 million over FY 1999. Title III of the Ryan White CARE Act provides grants directly to community based health centers and public health providers in 44 states plus Washington, DC and Puerto Rico to develop and deliver early and ongoing comprehensive outpatient HIV health care to more than 93,000 persons with HIV/AIDS. On average, each of these community-based, HIV primary care programs provide early diagnosis and treatment to over 513 clients. Title III is intended to be a medical safety net for populations that have been historically underserved. Two-thirds of Title III patients are people of color, and one-third are women. Nearly one-quarter of Title III programs report being the only HIV medical program in their area. Direct funding to these community based health centers and public health providers ensures their capacity to respond to advances in medical treatment practices and strengthens access to experienced practitioners, thus ensuring the provision of quality services to populations in greatest need. The demonstrated impact of Title III services on improved patient survival and care justify the Committee's recommendation of a \$40 million increase in Title III funding over FY 1999.

THE ACCELERATING COST OF HIV HEALTH CARE:

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



**Conducted by
Cities Advocating Emergency AIDS Relief (CAEAR)**

August, 1998

*For more information, contact the CAEAR Coalition, a national coalition supporting
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CAEAR

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

OVERVIEW

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

The Growing HIV Population

- Data show that between 1995 and 1997 there was an average increase of 43.5% in the number of HIV/AIDS patients among a representative sample of Title I and Title III sites, clearly illustrating one of the most obvious challenges to the HIV/AIDS health care community: the growing HIV population.
- In addition to new HIV cases, recently available combination therapies have increased the life expectancy of HIV patients. As the number of AIDS deaths has begun to decrease, the number of people dependent on treatment provided under the CARE Act has grown substantially. The data compiled by the CAEAR Coalition in this study reflects the impact of combination therapies that became widely available during the 1995-1997 period.

Increase in the Number of Patient Visits

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

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

Costly Medical Care

- The CAEAR study revealed that the average cost of medical care has increased by 89.3%. The study also found that this escalating cost could not be attributed solely to the increase in patients (43.5%), or patient visits (55.3%), which are growing at less significant rates than the accelerating cost of medical care.
- Advancements in HIV treatments, are among the reasons for this increased cost in HIV medical health care. Complex treatment regimens are required, including increased viral load testing and greater emphasis on longer more complex visits to promote adherence to drug dosing and scheduling. Neglecting to take medication as prescribed can lead to the failure of the therapy, the development of resistant viral strains, or both. Communities financially dependent on the CARE Act are, and will continue to be, inundated with patients in need of these costly medical services.

CONCLUSION

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



THE CARE ACT:

- ✓ SAVES LIVES
- ✓ DECREASES AIDS DEATHS
- ✓ INCREASES THE NUMBER OF PEOPLE GOING BACK TO WORK

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

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

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

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

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

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

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

Sources: Reporting organizations. June - July, 1998.

For more information, contact the CAEAR Coalition.

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

**Grady Health System
Infectious Disease Program
Atlanta, Georgia**

Funded By CARE Act Title I

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

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

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

Notes concerning complexity of visits:

1995:

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

1997:

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

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

**Chase Brexton Health Services
Baltimore, Maryland**

Funded By CARE Act Title I and Title III

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

Source: Chase Brexton Health Services, Baltimore, Maryland.

Notes concerning complexity of visits:

1995:

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

1997:

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

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

Chicago Health Outreach
Chicago, Illinois

Funded By CARE Act Title I and Title III

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

Source: Chicago Health Outreach, Chicago, Illinois.

Notes concerning complexity of visits:

1994:

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

1997:

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

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

**The CORE Center for the Prevention,
Care, and Research of Infectious Disease
(formerly known as the
Cook County HIV Primary Care Center)
Chicago, Illinois
Funded By CARE Act Title I and Title III**

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

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

Notes concerning complexity of visits:

1995:

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

1997:

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

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

**Allegheny University Hospitals
Hahnemann
Philadelphia, Pennsylvania**

Funded By CARE Act Title I

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year	Average Cost per Patient per Year (medical care & labs only – no drugs)
1994 Combination therapy not available	297	1,255 (20 min. each)	4.2	\$441
1997 Combination therapy available	650	3,348 (40 min. each)	5.2	\$1,561
Percent Change Since 1994	118.8% increase	166.7% increase	23.8% increase	254.0% increase

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

Notes concerning complexity of visits:

1994:

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

1997:

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

***For more information, contact the CAEAR Coalition,
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1413 K Street, NW, Suite 700, Washington, DC 20005
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Email: CAEARinDC@aol.com***



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

**Health Federation of Pennsylvania
Philadelphia, Pennsylvania**

Funded By CARE Act Title I

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

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

Notes concerning complexity of visits:

1994:

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

1997:

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

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

**Philadelphia Department of Public Health
Philadelphia, Pennsylvania**

Funded By CARE Act Title I

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

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

Notes concerning complexity of visits:

1994:

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

1997:

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

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

**Desert AIDS Project
Riverside/San Bernardino,
California**

Funded By CARE Act Title I

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

Source: Desert AIDS Project, Palm Springs, California.

* 560 of 748 (75%) patients in 1997 were on triple combination therapy.

Notes concerning complexity of visits:

1995:

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

1997:

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

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

**San Francisco
General Hospital/Outpatient Clinic
San Francisco, California**

Funded By CARE Act Title I

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

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

Key Findings:

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

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

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

**Santa Cruz County Health Services
Agency
Santa Cruz, California**

Funded By CARE Act Title III

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

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

Notes concerning complexity of visits:

1993:

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

1997:

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

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

**Country Doctor
Community Health Centers
Seattle, Washington**

Funded By CARE Act Title III

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

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

Notes concerning complexity of visits:

1995:

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

1997:

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

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

**Whitman-Walker Clinic
Washington, D.C.**

Funded By CARE Act Title I

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

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

Notes concerning complexity of visits:

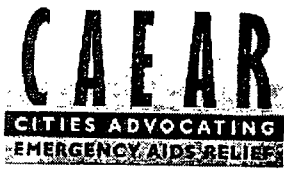
1994:

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

1997:

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

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

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

Need for HIV Primary Medical Care Escalating

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

- Title I is the safety net for thousands of low-income people living with HIV/AIDS who live in metropolitan areas and are ineligible for entitlement programs. Most of these individuals have severe social and economic problems that complicate their ability to manage their HIV disease. The majority of Title I clients are dually or triply diagnosed with substance abuse and mental illness in conjunction with HIV/AIDS.
- The aggregate Title I request for funding in FY 1999 was \$570 million; actual Title I funding in FY 1999 amounted to \$505,200,000-- almost \$65 million less than the need.
- Primary medical health care services and transfers to the AIDS Drug Assistance Program (ADAP) account for 69% of Title I service funding, 59% and 10% respectively.
- Overall rates of new HIV infections are remaining stable while HIV-related deaths dramatically decline. This means that increasing numbers of people living with HIV/AIDS will be seeking services. A 1998 CAEAR Coalition study indicates that Title I communities saw a 43% average increase in the number of people living with HIV/AIDS receiving services between 1995-97.
- In 1998, the U.S. Public Health Service issued guidelines for the prevention of opportunistic infections, the use of anti-HIV medications for adults and adolescents and for the use of anti-HIV drugs in pregnant women to reduce perinatal transmission of HIV. Title I funding remains inadequate to assure the delivery of the standard of care required by these guidelines to all eligible people living with HIV/AIDS in Title I areas.
- The availability and success of combination drug therapies have motivated many people living with HIV/AIDS to seek care for the first time. In FY 1998, the Health Resources and Services Administration estimates that 20 percent of Title I clients were new to care.

Cost and Complexity of HIV Care Increasing

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

- Advances in the clinical management of HIV/AIDS require more and longer medical visits, including an initial assessment, diagnostics and the determination of a treatment regime. A 1998 CAEAR study found the average length of medical visits increased 65% from 1995-97, and the average cost of medical care rose 89.3%.
- Once treatment is begun, patient education, ongoing monitoring, including expensive viral load testing, is required. A 1998 CAEAR study estimates that between 1995-97 the total number of patient visits increased by 55.3% and the number of visits per patient rose by 27.4%.
- More than ever, people in care need a coordinated medical and support service plan that includes higher levels of expertise among doctors, nurses, pharmacists, case managers and peer advocates. Care teams must develop plans that include ongoing education about the importance of adherence to combination drug regimens to prevent resistant strains of HIV and regular updates on new treatment developments.
- CARE Act services have significantly reduced the costs of medical care by reducing the amount of hospital-based emergency and inpatient care being provided to people living with HIV/AIDS.

Outreach to People of Color

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

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

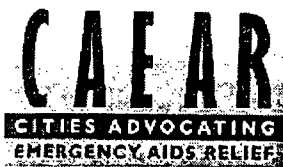
New Title I Metropolitan Areas -- Existing Areas Continue To Lose Funding

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

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

Complete citations of data sources are available upon request.

For further information, contact the CAEAR Coalition, 1413 K Street, NW, Suite 700, Washington, D.C. 20005, 202.789.3565, fax 202.789.4277; or The Sheridan Group, 1808 Swann Street, NW, Washington, D.C., 20009, 202.462.7288, fax 202.786.1964



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

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

Increasing Cost of Primary Health Care

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

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

Outreach to People of Color and Other Underserved Communities

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

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

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

Communities in Need -- Unfunded Grants for Underserved Areas

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

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

Increasing Cost of Social Services

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

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

Complete citations of data sources are available upon request.

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RYAN WHITE CARE ACT FUNDING FY 1996 -- FY 2000
(IN MILLIONS OF DOLLARS)

	Reauthorization (1996)	FY 1996 Final	FY 1997 Final	FY 1998 Final _c	FY 1999 Community Request (+/- FY 98)	FY 1999 Presidential Budget Request _d (+/- FY98)	FY 1999 Final (+/- FY 98)	FY 2000 Community Request (+/- FY99)	FY 2000 Presidential Budget Request (+/- FY99)
Title I	Title I is funded at "such sums as may be necessary" for the fiscal years 1996-2000.	391.7 (+35.2)	449.943 (+58.243)	464.736 (+14.793)	570.0 (+105.264)	488.974 (+24.238)	505.2 _e (+40.464)	625.0 (+119.8)	521.2 (+16.0)
Title II [ADAP]	Title II is funded at "such sums as may be necessary" for the fiscal years 1996-2000.	260.847 (+62.7)	416.954 (+156.107) [167.0] _b	542.783 (+125.829) [285.5] _b	801.0 (+258.217) [458.5] _b	668.870 (+126.087) [385.5] _b	738.0 (+195.217) [461.0] _b	921.0 (+183.0) [n/a]	783.0 (+45.0) [496.0]
Title III	Title III is funded at "such sums as may be necessary" for the fiscal years 1996-2000.	56.918 (+4.6)	69.568 (+12.650)	76.211 (+6.643)	113.0 (+36.789)	86.154 (+9.943)	94.3 _f (+18.089)	134.0 (+39.7)	130.3 (+36.0)
Title IV	Title IV is funded at "such sums as may be necessary" for the fiscal years 1996-2000.	29.0 (+3.0)	36.0 (+7.0)	40.803 (+4.803)	61.0 (+20.197)	43.926 (+3.123)	46.0 _g (+5.197)	61.0 (+15.0)	48.0 (+2.0)
AIDS Education & Training Centers _a	AETCs are funded at "such sums as may be necessary" for the fiscal years 1996-2000.	12.0	16.287 (+4.287)	17.216 (+0.929)	25.0 (+7.784)	17.271 (+0.055)	20.0 _h (+2.784)	25.0 (+5.0)	20.0 (+0.0)
Dental School Reimbursement Program _a	Dental programs are funded at "such sums as may be necessary" for the fiscal years 1996-2000.	6.937	7.5 (+0.563)	7.763 (+0.263)	9.0 (+1.237)	7.787 (+0.024)	7.8 (+.037)	9.0 (+1.2)	8.0 (+0.2)
TOTALS		757.402 (+105.5)	996.252 (+238.850)	1149.512 (+153.26)	1,579.0 (+429.488)	1,312.982 (+163.47)	1411.3 (+261.788)	1775.0 (+363.7)	1510.5 (+99.2)

a - The AIDS Education and Training Centers (AETCs) and the Dental School Reimbursement programs were made part of the Ryan White CARE Act in FY 1996.

b - A mount of Title II funding either requested or allocated to be earmarked specifically for the AIDS Drug Assistance Program (ADAP).

c - The FY 1998 final allocation was adjusted mid-year to account for an across-the-board HHS administrative shave during FY 1998.

d - The FY 1999 Presidential budget request was adjusted to account for an across-the-board HHS administrative shave during FY 1998.

e - \$5 million of the FY 1999 Title I allocation is earmarked to address underserved communities of people of color.

f - \$3 million of the FY 1999 Title III allocation is earmarked to address underserved communities of people of color.

g - \$2 million of the FY 1999 Title IV allocation is earmarked to address underserved communities of people of color.

h - \$2 million of the FY 1999 allocation for Education and Training Centers is earmarked to address underserved communities of people of color.

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

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

a Revised FY 92 Appropriation with Administrative costs subtracted.

b Revised FY 93 Appropriations with Federal Consultants Services Reduction subtracted.

c Funding for testing and counseling provided under the Centers for Disease Control.

d Title IV's original authorization was \$26.5 million plus certain provisions to be funded by "such sums necessary." The Pediatric Demonstration Grant portion of Title IV was originally authorized at \$20.0 million.

e Includes \$20.9 million in Pediatric Demonstration Grants separately appropriated prior to FY 94.

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

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

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

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

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

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

N/A Figures are unavailable due to confidentiality regulations.

* This city was not yet an EMA in 1994.

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202.789.3565 fax 202.789.4277



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

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

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

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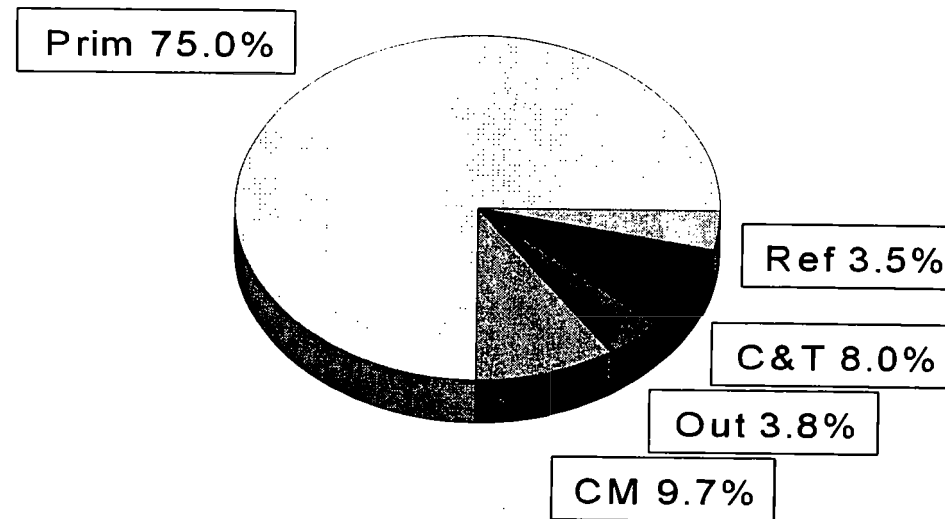


Ryan White CARE. Act – Title I
FY 96 Expenditures for Drug
Reimbursement and Medications

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

*For more information, please contact CAEAR Coalition, 1413 K Street, NW, Suite 700, Washington, DC 20005
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Title III Allocations for FY '97



Primary Health Care

Case Management

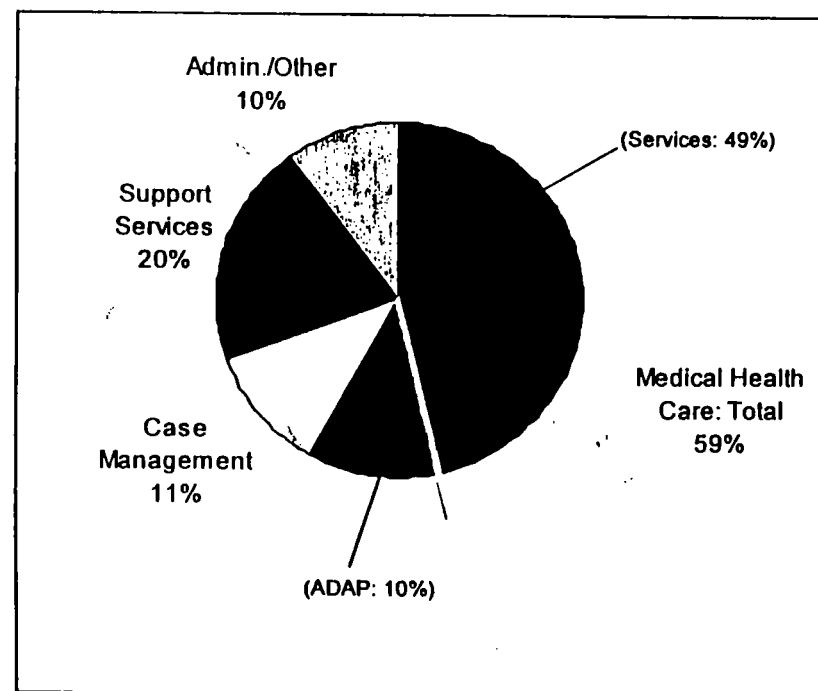
Outreach Services

Counseling & Testing

Referrals

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

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



Source: Health Resources and Services Administration

For more information, please contact CAEAR Coalition, 1413 K Street, NW, Suite 700, Washington, DC 20005
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Ryan White CARE Act Title III Grantees By State and City/Town

State	Cities/Towns
Alaska	Anchorage
Alabama	Birmingham Hobson City Mobile Montgomery
Arizona	Phoenix Tucson
Arkansas	Pine Bluff
California	Bakersfield Guernville Long Beach Los Angeles Oakland Panorama City San Bernadino San Diego San Francisco San Jose San Marcos Santa Ana Santa Barbara Santa Cruz Stockton Ukiah Venice
Colorado	Denver
Connecticut	Bridgeport New Haven
Delaware	Wilmington
Florida	Fort Lauderdale Immokalee Key West Miami Miami Beach Pompano Beach West Palm Beach
Georgia	Albany Atlanta Augusta Brunswick Savannah Waycross
Idaho	Boise
Illinois	Chicago Peoria Rockford
Indiana	Indianapolis Richmond
Iowa	Davenport Des Moines Iowa City Sioux City
Kansas	Wichita
Kentucky	Paducah

Louisiana	Lake Charles New Orleans
Maine	Portland
Maryland	Baltimore
Massachusetts	Boston Dorchester East Boston Holyoke Lawrence New Bedford Roxbury Somerville Truro Worcester
Michigan	Ann Arbor Detroit Grand Rapids
Mississippi	Biloxi Marks
Missouri	Kansas City Springfield St. Louis
Montana	Billings
Nebraska	Omaha
Nevada	Las Vegas Reno
New Jersey	Hoboken New Brunswick Newark Paterson Trenton
New Mexico	Albuquerque
New York	Albany Amityville Bronx Brooklyn Buffalo Elmhurst Far Rockaway New York City Ossining Peekskill Rochester Syracuse Yonkers
North Carolina	Asheville Durham
Ohio	Chillicothe Cincinnati Columbus
Oklahoma	Oklahoma City Tulsa
Oregon	Portland
Puerto Rico	Arrogo Bayamon

Puerto Rico (cont'd)	Gurabo Humacao Lares Mayaguez Ponce Rio Piedras
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Pennsylvania	Allentown Philadelphia Pittsburgh York
Rhode Island	Providence
South Carolina	Columbia Ridgeland
Tennessee	Rossville
Texas	Austin Dallas El Paso Fort Worth Harlingen Houston San Antonio
Utah	Salt Lake City
Vermont	Burlington
Virginia	Charlottesville Fairfax
Washington	Seattle Yakima
Washington, DC	District of Columbia
Wisconsin	Madison Milwaukee



Ryan White CARE Act Title III Grantees

Alaska

Anchorage

Anchorage Neighborhood Health Center

\$228,988

Total

\$228,988

Alabama

Birmingham

Jefferson County Commission/Cooper Green

\$483,816

Hobson City

AIDS Services Center

\$335,725

Mobile

Franklin Memorial Primary Health Center

\$320,970

Mobile County Health Dept./Family Health Care Clinic

\$407,607

Montgomery

Montgomery AIDS Outreach/MAO Health Monitoring

\$461,086

Total

\$2,009,204

Arkansas

Pine Bluff

Jefferson Comprehensive Care

\$373,902

Total

\$373,902

Arizona

Phoenix

Maricopa County Health System/McDowell Healthcare

\$600,000

Tucson

El Rio Santa Cruz Neighborhood Health Ctr.

\$622,225

Kino Community Hospital

\$132,072

Total

\$1,354,297

California

Bakersfield

Clinica Sierra Vista/34th St. Community Health Ctr.

\$222,667

Guernville

Russian River Health Center

\$357,355

Long Beach

Catholic Healthcare West/CARE Program

\$487,750

*For more information, please contact CAEAR Coalition, 1413 K Street, NW, Suite 700, Washington, DC 20005
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AIDS Healthcare Foundation	\$530,756
AltaMed Health Services	\$519,626
Goodman Special Care Clinic/LAGLSC	\$600,000
Watts Health Fdn. South LA Comm. AIDS Program	\$400,000
<i>Oakland</i>	
Tri-City Health Center/Alameda Health	\$550,000
<i>Panorama City</i>	
Northeast Valley Health Corp./HIV/AIDS Programs	\$380,699
<i>San Bernardino</i>	
San Bernadino County Department of Public	\$371,298
<i>San Diego</i>	
Logan Heights Fam. Hlth. Ctr./North Park Fam. Hlth.	\$564,874
Univ. of California San Diego Med. Ctr./Owen Clinic	\$378,595
<i>San Francisco</i>	
San Francisco Community Clinic Consortium	\$585,000
<i>San Jose</i>	
Santa Clara Cty. Health & Hosp. Syst./PACE Clinic	\$584,136
<i>San Marcos</i>	
North County Health Services	\$255,000
<i>Santa Ana</i>	
County of Orange Health Care Agency	\$600,000
<i>Santa Barbara</i>	
Santa Barbara County Health Care Services	\$314,640
<i>Santa Cruz</i>	
County of Santa Cruz Health Services	\$363,299
<i>Stockton</i>	
Community Medical Centers	\$283,974
<i>Ukiah</i>	
Mendocino Community Helath Clinic	\$175,772
<i>Venice</i>	
Venice Family Clinic	\$281,380

Total	\$8,806,821
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Colorado

Denver

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

Connecticut

Bridgeport

Bridgeport Community Health Center	\$292,329
Southwest Community Health Center	\$329,351

New Haven

Hill Health Center	\$389,796
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Total	\$1,011,476
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District of Columbia

Washington

Family & Medical Counseling	\$339,864
Unity Health Care	\$499,980
Whitman-Walker Clinic	\$392,441

Total	\$1,232,285
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Delaware

Wilmington

Christiana Care Health Services	\$373,634
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Total	\$373,634
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Florida

Fort Lauderdale

North Broward Hospital District	\$434,615
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Immokalee

Colier Health Services	\$309,975
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Key West

Monroe County Health Department	\$420,298
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Miami

Economic Opportunity Family Health Ctr.	\$763,325
University of Miami Sch. of Med./Dept. of OB-GYN	\$521,836

Miami Beach

Stanley C. Meyers Community Health Center	\$237,745
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Pompano Beach

Sunshine Health Center	\$500,000
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W. Palm Beach

Florida Community Health Centers	\$424,057
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Total	\$3,611,851
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Georgia

Albany

Albany Area Primary Health/Rural HIV Model	\$453,666
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Atlanta

Hemophilia of Georgia	\$488,962
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St. Joseph's Mercy Care/Mercy Mobile Health Program	\$385,382
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Augusta

Medical Coll. of Georgia Dept. of Med./Infec. Dis. Div.	\$467,921
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Brunswick

Glynn County Board of Health	\$145,253
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Savannah

Chatham County Health Department	\$463,388
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Waycross

Ware County Board of Health	\$535,977
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Total	\$2,940,549
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Iowa

Davenport

Community Health Care/QCR Virology	\$191,525
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Received grants in subsequent years.	\$0
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Des Moines

Primary Health Care/Broadlawns Med. Ctr.	\$271,391
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Iowa City

University of Iowa	\$24,830
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Sioux City

Siouxland Community Health Center	\$228,000
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Total	\$715,746
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Idaho

Bosie

Family Practice Residency of Idaho	\$295,575
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Total	\$295,575
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Illinois

Chicago

Cermack Health Services/Cook Cty. Board of	\$227,574
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Chicago Health Outreach	\$624,250
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City of Chicago Dept. of Health/STD/HIV Prev. Prog.	\$478,000
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Erie Family Health Ctr./Integrated Care Consortium	\$291,798
Hektoen Inst. for Medical Rsrch./CORE Center	\$553,197
Howard Brown Health Center	\$492,193
<i>Peoria</i>	
Univ. of Ill. Coll. of Med./Heart of Ill. HIV/AIDS Ctr.	\$380,846
<i>Rockford</i>	
Crusaders Central Clinic/Living with HIV Program	\$353,450
Total	\$3,401,308

Indiana

Indianapolis

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

Total	\$506,032
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Kansas

Wichita

University of Kansas School of Medicine	\$433,348
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Total	\$433,348
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Kentucky

Paducah

Heartland Cares	\$421,050
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Total	\$421,050
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Louisiana

Lake Charles

Bayou Comprehensive Health Foundn./Ext.Svcs. Prog.	\$348,300
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New Orleans

Charity Hospital Medical Center	\$400,000
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Total	\$748,300
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Massachusetts

Boston

Fenway Community Health Center	\$473,761
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Dorchester

Harbor Health Services	\$235,970
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East Boston

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

Maryland

<i>Baltimore</i>	
Chase-Brexton Health Services/Baltimore Consortium	\$577,400
Total	\$577,400

Maine

<i>Portland</i>	
<i>Received grants in subsequent years.</i>	\$0
Total	\$0

Michigan

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

Missouri

Kansas City

Kansas City Free Health Clinic/Gtr. KC Early Intv. \$800,000

Springfield

AIDS Project of the Ozarks \$396,002

St. Louis

St. Louis Connect Care Infectious Disease Clinic \$309,974

Total \$1,505,976

Mississippi

Biloxi

Marks

Deporres Delta Ministries \$122,225

Total \$122,225

Montana

Billings

Yellowstone City-County Health Dept./Dearing Clinic \$267,715

Total \$267,715

North Carolina

Asheville

Western NC Community Health Services \$385,725

Durham

Lincoln Comm. Hlth. Ctr./Durham Early Intv. Clinic \$354,417

Total \$740,142

Nebraska

Received grants in subsequent years. \$0

Omaha

Total \$0

New Jersey

Hoboken

Franciscan Health Center \$332,370

New Brunswick

Eric B. Chandler Health Center-UMDNJ \$335,431

Newark

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

New Mexico

Albuquerque

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

Nevada

Las Vegas

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

New York

Albany

Albany Med. Coll. AIDS Prog./Mid-Hudson HIV Care	\$451,262
Whitney M. Young Jr. Health Ctr./CHEER Program	\$220,225

Amityville

Suffolk County Dept. of Health Services	\$145,500
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Bronx

Bronx Community Health Network	\$495,061
Bronx Lebanon Hospital	\$407,543
Montefiore Med. Ctr./AIDS Ambulatory Care	\$540,312
Morris Heights Health Center	\$765,000
NARCO Freedom Neighborhood/Family Comm. Health	\$550,000

Brooklyn

Brooklyn Hospital Center	\$400,000
Brooklyn Plaza Med. Ctr./Rising Heights Program	\$338,145
Cumberland Neigh. Fam. Care Ctr./(NYC Hosp.)	\$470,450

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

Ohio

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

Total	<u>\$713,948</u>
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Oklahoma

Oklahoma City

Univ. of Oklahoma College of Medicine	\$428,894
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Tulsa

Oklahoma State Univ./Coll. of Osteopathic Med.	\$404,513
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Tulsa City/County Department of Health	\$0
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Total	<u>\$833,407</u>
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Oregon

Portland

Multnomah County Health Dept.	\$559,692
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Total	<u>\$559,692</u>
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Pennsylvania

Allentown

Lehigh Valley Hospital	\$325,725
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Philadelphia

Allegheny Univ. of the Health Sciences	\$400,000
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ChesPenn Health Services	\$368,382
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City of Philadelphia Dept. of Public Health/AACO-EI	\$600,000
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Greater Philadelphia Health Action	\$534,727
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The Graduate Hospital/Ambulatory Care Services	\$277,764
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Pittsburgh

Univ. of Pittsburgh Med. Ctr./Off of Research	\$549,296
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York

York Health Corp., YHESS! Clinic	\$258,947
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Total	<u>\$3,314,841</u>
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Puerto Rico

Arrogo

Bayamon

Municipality of Bayamon/Epi. Ctr. of Bayamon	\$500,000
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Gurabo

Gurabo Community Health Center	\$260,750
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Humacao

Ryder Memorial Hospital	\$458,076
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Lares

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

Rhode Island

<i>Providence</i>	
The Miriam Hospital	\$280,195
Total	\$280,195

South Carolina

<i>Columbia</i>	
Richland Community Health Care Assn.	\$320,000
<i>Ridgeland</i>	
Beaufort-Jasper Comprehensive Health Service	\$399,655
Total	\$719,655

Tennessee

<i>Rossville</i>	
<i>Received grants in subsequent years.</i>	\$0
Total	\$0

Texas

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

San Antonio

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

Utah

Salt Lake City

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

Virginia

Charlottesville

University of Virginia	\$343,025
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Fairfax

INOVA Health Systems	\$400,000
Total	\$743,025

Vermont

Burlington

Fletcher Allen Health Care	\$333,746
Total	\$333,746

Washington

Seattle

Country Doctor Community Health Center	\$408,368
Harborview Med. Ctr./Madison Clinic	\$366,070

Yakima

Yakima Valley Farm Workers Clinic/New Hope	\$296,820
Total	\$1,071,258

Wisconsin

Madison

University of Wisconsin, Madison	\$359,774
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Milwaukee

Milwaukee Health Services/Isaac Coggs Health	\$455,025
Total	\$814,799