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Issues - Areas - Cities - Los Angeles

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Los Angeles Meeting

5/21/99

County-wide crisis
Af-Am & Latinos

① Ryan White reauthorization
inequity in distribution
— formula & supplemental
— hold-harmless clause

② Prevention
A national priority
- flat funding
— rhetoric x shifting/ expanding

— Coordinating efforts locally
— directly-funded agencies

— mandates review/evaluation
w/o local dialogue

— double-speak w/ respect to community planning
— importance of capacity building

— stop being defensive about prevention

- move off of names v. VIs
- get to real surveillance

Boundries of Blackness

- surveillance prejudices

- good - prevention for HIV+ persons

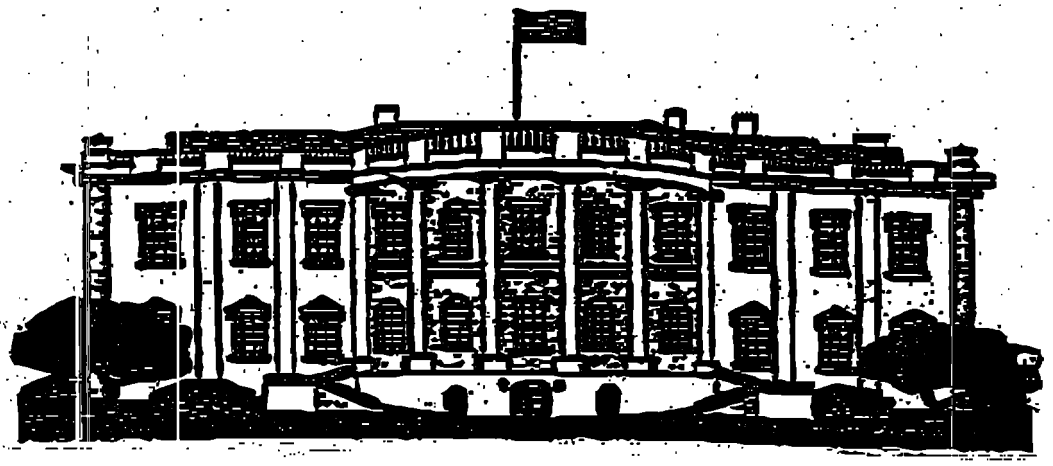
- reimbursement systems

AIDS ✓ Substance Abuse
disability

HRSA - indicators of need -

intervention studies — targeting communities of color

THE WHITE HOUSE



OFFICE OF PUBLIC LIAISON

Phone: (202) 456-2930
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To: Todd Summers
Date: 5/27/99
Page: One of 7 including cover
Fax: 202-456-2438
Phone: _____
Comments: From Richard Socarides

WHITE HOUSE PROVIDES RENEWED HOPE TO AIDS WATCH DELEGATES

Rep. Barney Frank Presents Award to America's Proud Gay Veteran at Stonewall Democrats Event

Please Post on LGBT and HIV/AIDS Internet List Serves

(Washington D.C. – May 10) -- Todd Summers, Deputy Director of the White House National AIDS Policy Office met with Southern California AIDS Watch delegates for almost two hours last Monday and sounded the theme for the 3 day event when he said:

"This administration will not rest until AIDS has been cured and this terrible epidemic is finally over!"

With that renewed hope, AIDS activists across Southern California met with both U.S. Senators and almost every member of Congress. When some people think the AIDS crisis is over because of protease inhibitors – the numbers on Capitol Hill tell a different story. People are living longer but the infection rate remains at a staggering 40,000 cases per year. So the largest delegation ever came all the way to Washington to fight for adequate funding, sound prevention measures, research, housing and a vaccine. Summers made sure the activists knew President Clinton still is working hard for an AIDS cure.

The meeting was scheduled by Tom Swann, an openly-gay HIV-positive member of the Riverside County Democratic Party Central Committee and former State Vice-President of California Young Democrats.

Swann is a board member of Lambda Letters Project, California's oldest Statewide LGBT and HIV/AIDS civil rights organization. Also he is an officer of the Democrats of the Desert and Desert Stonewall Democrats.

Swann's relationship with the Clinton administration began in December 1992 when he met with the deputy director of the transition team in a Washington D.C. Hotel about lifting the military ban. When the Navy retaliated he received advice from Bob Hattoy who met with him and his ACLU counsel Alan Friel at the April 1993 ACLU Garden Party. In July 1993 Maria Echaveste called from the White House offering support after Swann suffered a mild heart attack. In 1994 he won his ACLU case against the Navy which included discrimination based on his AIDS status. In 1996 Swann led a group of veterans to meetings with Jeff Levi and Richard Socarides. In 1996 he personally asked the President's Chief of Staff to fix the *Don't Ask, Don't Tell* Policy in a second Clinton term. Sadly this objective has not been realized.

Swann said the most inspirational visit with a White House official came at the Lesbian and Gay Caucus of the California Democratic Party in Los Angeles in 1996. He was sitting in the front row listening to Marsha Scott. Swann weighed only 105 pounds and had just lost his left eye to CMV Retinitis. He was also fighting Kaposi Sarcoma. A long-time friend Dan Zingale told Bob Hattoy to spend some time with Swann thinking he might not be around much longer. Swann recalls what happened next:

Bob Hattoy put his arm around me and reminded me that doctors did not give him much time either when he was diagnosed with Lymphoma. Bob said, "Look at me now! Tom, you took on the Navy and won and you can take on CMV and KS and win. Hang in there, take your medicine, do those infusions and stay alive. We need you!"

It's nice to be needed. Swann said, *"When I was sitting there listening to Mr. Summers I realized he cared about me and everyone sitting at that table. I was also very impressed with Mr. Daniel Montoya, executive director of the Presidential Advisory Council on HIV/AIDS."*

Swann talked about having 260 lasers on his right eye just days before the trip to the White House. Swann's silicone oil, which holds the retina in his right eye in place, bubbled from the heat during the surgery. In fact, an experiment by Mark Repass showed Swann's right eye glows under a black light, which explains why he can't see in daylight. Swann said there is a perception that AIDS research has stalled in the Clinton second term and that people like him with silicone oil are forgotten since protease inhibitors have made CMV Retinitis less of a threat. Summers asked how many AIDS patients currently have silicone oil and the name of his eye doctor. Montoya said emphatically that AIDS research is a very high priority for the President.

Summers thanked Swann for supporting the President's Patients' Bill of Rights, which enables AIDS patients to bypass their general practice and family practice physicians and go directly to AIDS Specialists. This legislation saves time, lives and it reduces the anxiety and worry AIDS patients have wondering if their doctor has enough experience and is prescribing the proper drug combination.

One participant quipped that Blue Cross was providing him with good care and someone suggested if there is ever a problem, tell the HMO you know Swann. Everyone laughed but in fact several AIDS patients have mentioned Swann's medical malpractice AIDS suit in letters to Kaiser and other HMO's asking for referrals to specialists. Blue Cross CaliforniaCare made Swann wait six months before he could have a dilated eye exam after indicating the bottom half of the Amsler grid was missing.

At the trial family practice Doctor Manuel Marquez testified he had no experience and said the HMO should never have assigned advanced AIDS patients to his Oxnard medical office.

Herb Schultz, the hard working public policy director of AIDS Project Los Angeles (APLA), facilitated the meeting. Herb and Christina Schultz (no relationship) organized and set-up the visits with Congressmembers from San Luis Obispo to San Diego. Their enthusiasm generated the large turn out of AIDS Watch delegates.

John L. Brown, executive director of Desert AIDS Project and Michael J. Van Essen, Clients' Services Manager of AIDS Assistance Program in Palm Springs discussed funding issues. The APLA covered prevention and other topics. Joe Acosta, a Navy veteran talked about the AIDS epidemic in the Latino community. Other speakers were Mark Repass of the Alexander Hamilton Post 448 of the American Legion in San Francisco and Paul Hagen.

Edward Clayton, national president of the Gay, Lesbian and Bisexual Veterans of America (GLBVA) told Summers and Montoya he was investigated and later arrested for being gay and became infected with HIV in a military brig. He has Ganciclovir implants to prevent CMV Retinitis. He stressed the importance of more AIDS research.

Rep. Mary Bono, a Republican from California's 44th Congressional District was one of the few members that held face to face meetings with constituents. The meeting was held in the House Judiciary Committee conference room. Bono asked for a Judiciary Committee recess to hold the meeting, which included all three legislative analysts from her office.

On the way to the conference room the AIDS activists were greeted by Judiciary Committee Chair Rep. Henry Hyde who smiled and nodded his head to Mark Repass after seeing his Alexander Hamilton Post 448 cap with gay buttons.

AIDS Action, a non-partisan Washington, D.C. organization that monitors voting records on AIDS issues reports that Mary Bono, like her late husband, has consistently voted for two of the five main AIDS issues. She has supported the overall AIDS funding requested in the budget and the Housing Opportunities for People With AIDS (HOPWA) program. She pledged her continued support and summarized: *"I know people think that because I'm a Republican I don't support AIDS issues. I want you to know I support people living with AIDS."*

Other important meetings Swann held while in Washington D.C. were with board members of Historic Congressional Cemetery, United States Department of Agriculture Gay, Lesbian or Bisexual Employees (GLOBE), GLBVA D.C. Officers, Servicemembers' Legal Defense Network (SLDN) and the Associate Director of the Center for Minority Veterans of the Department of Veterans Affairs.

After returning to Palm Springs, Swann received an award on Saturday May 8 from Rep. Barney Frank at a standing room only event hosted by Desert Stonewall Democrats, the largest and fastest growing Democratic Club in the Inland Empire. Frank said, *"Tom Swann is a Proud Gay Veteran. He was better to the military than the military was to him. I am proud of you."* On Sunday Swann wore his veteran Marine Corps dress uniform and gave the Pledge of Allegiance at the 1999 Stoney Awards Banquet held by the Stonewall Democratic Club of Los Angeles. Frank received a Lifetime Achievement Award and was serenaded by the Los Angeles Gay Men's Chorus. The club was the first in America to endorse Vice President Al Gore, Jr. for President.

Swann said the point of this article is this:

The Clinton administration has done more for AIDS issues than any previous administration. Swann believes that if President George Bush had been re-elected in 1992 that protease inhibitors and Ganciclovir implants would still be in trial at the Food and Drug Administration and he would be dead. Todd Summers, Daniel Montoya, Bob Hattoy, Jeff Levi, Marsha Scott, Eric Bauman, Richard Socarides and others have inspired Swann to stay active in public affairs. Rep. Frank saluted his work to elect Democrats that will lift the military ban and cure AIDS.

Frank believes the 2000 March on Washington, veteran wreath ceremonies at Arlington and Gay pride parades are important but the most expedient way to lift the ban, pass the Employment Non-Discrimination Act (ENDA) and other LGBT civil rights is to Change the Congress. Frank said, *"It is important to march in these parades but until we get people to march to the polls on election day we won't get our civil rights."*

So when you feel depressed about taking your medicine and doing daily infusions remember many others have faced adversity before you and they persevered and are still alive. You can make it! We need you! In summary:

"YOU MUST NEVER GIVE UP HOPE OR GIVE IN TO DISCRIMINATION. YOU MUST NEVER GIVE UP HOPE OR GIVE IN TO AIDS."

Thanks for reading and sharing with others. Tom Swann can be reached on the Internet at:
TASwann@aol.com

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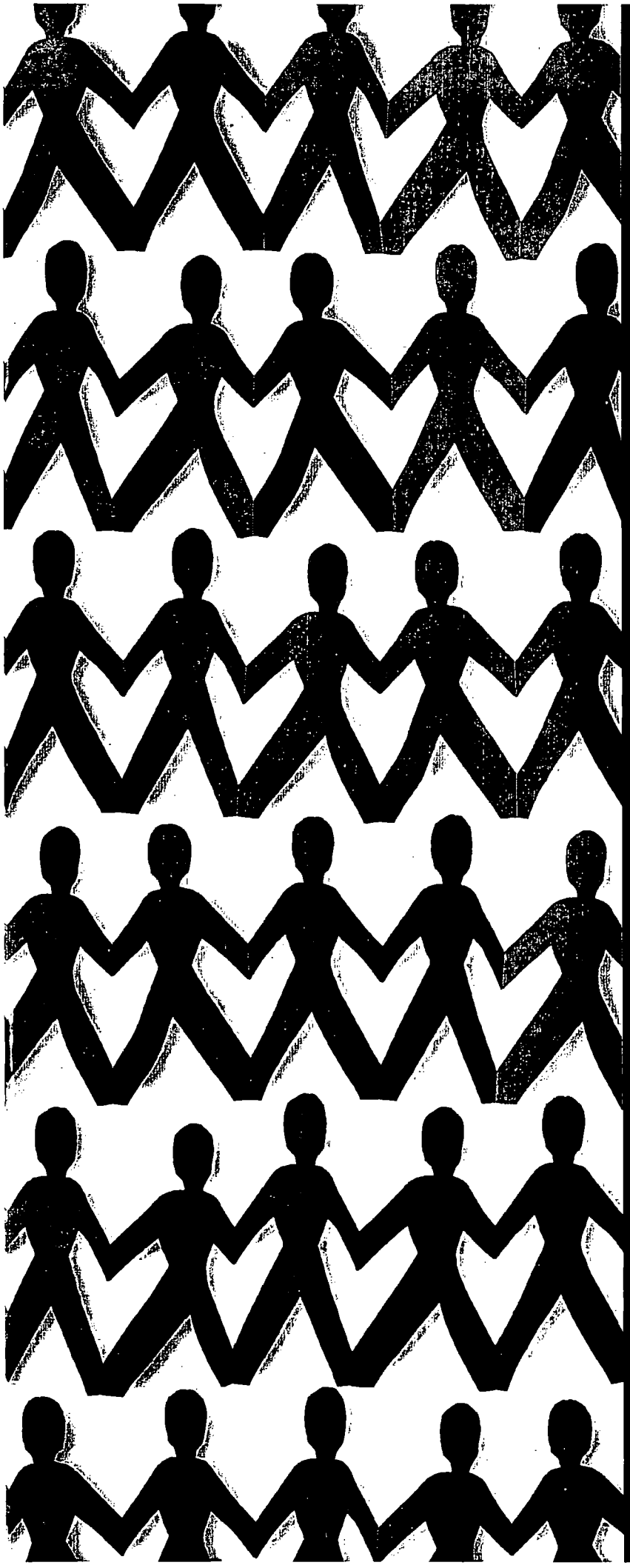

An Epidemiologic Profile of HIV and AIDS in Los Angeles County

January 1999

HIV Epidemiology Program
Los Angeles County
Department of Health Services

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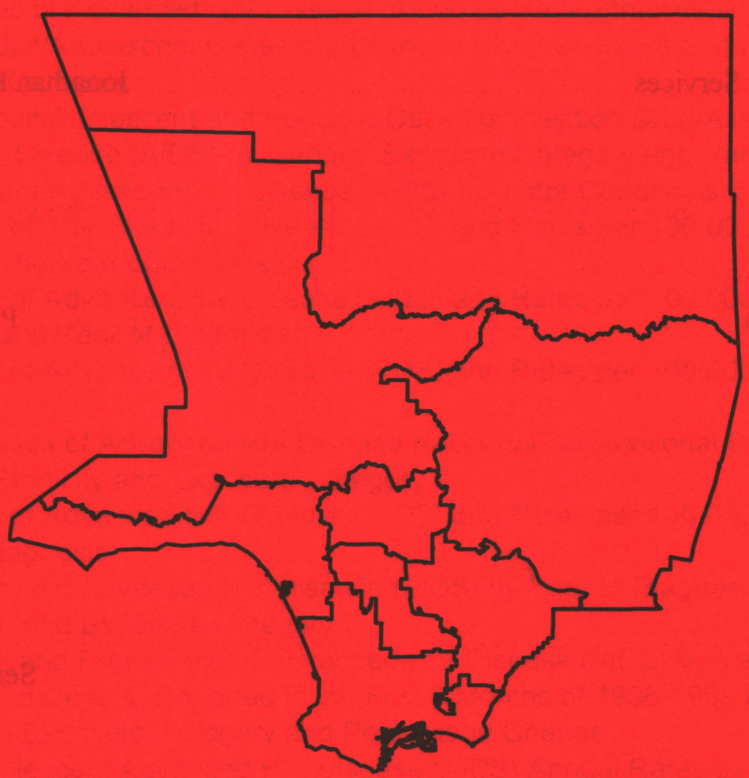
LOS ANGELES COUNTY
DEPARTMENT OF HEALTH SERVICES
HIV EPIDEMIOLOGY PROGRAM

ADVANCED HIV DISEASE (AIDS) QUARTERLY SURVEILLANCE SUMMARY

Cases Reported as of March 31, 1999 **Issued April 15, 1999**



600 S. Commonwealth Ave., Suite 1920
Los Angeles, CA 90005
(Phone) (213) 351-8196
(Fax) (213) 487-9386

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES DHS

HIV EPIDEMIOLOGY PROGRAM

600 S. COMMONWEALTH AVE., SUITE 1920 - LOS ANGELES, CA 90005
PHONE: (213) 351-8196 - FAX (213) 487-9386

May 6, 1999

Dear Colleague:

Enclosed is the AIDS Quarterly Surveillance Summary through March 31, 1999 and a copy of 'An Epidemiologic Profile of HIV and AIDS in Los Angeles County, January 1999' for your information.

Our 'Epidemiologic Profile' provides a narrative summary of the latest AIDS trends in Los Angeles County(LAC) primarily using AIDS surveillance data and HIV seroprevalence data collected by the HIV Epidemiology Program. As outlined by the U.S. Centers for Disease Control and Prevention(CDC), the objective of this document is to: 1) describe the sociodemographic characteristics of the population of LAC; 2) describe the impact of HIV/AIDS on LAC's population; 3) describe who is at risk for becoming infected with HIV in LAC; and 4) describe the geographic distribution of HIV/AIDS in LAC.

We hope that the 'Epidemiologic Profile' will be useful to you in your HIV prevention and service-related activities. If you have any questions regarding the 'Epidemiologic Profile' or need additional copies, please call the HIV Epidemiology Program at 213-351-8196.

Sincerely,

Peter R. Kerndt, MD MPH
Director

PRK:mt
g:\analy\common\aw\apr99qr.wpd

Enclosures

County of Los Angeles ♦ Department of Health Services
Office of AIDS Programs and Policy
600 South Commonwealth Avenue Sixth Floor, Los Angeles, CA 90005-4001 Phone: (213) 351-8000

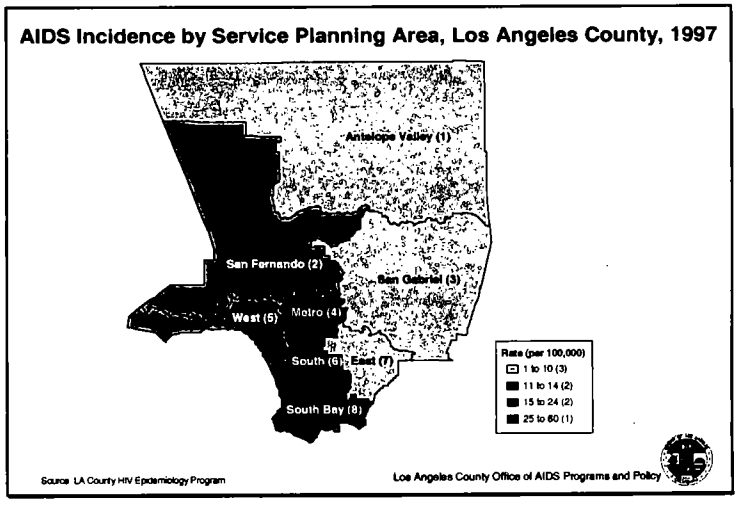
HIV/AIDS in Los Angeles County
FACT SHEET

Introduction

What is now known as Acquired Immune Deficiency Syndrome (AIDS) was first identified in 1981 in Los Angeles County. As the end of the second decade of the AIDS epidemic nears, it is critical to understand the impact of the epidemic in Los Angeles County and the similarities and differences between Los Angeles County and other parts of the United States. It is important to grasp the shifts in the epidemiology and to nurture the capacity to respond to future and ongoing need for services.

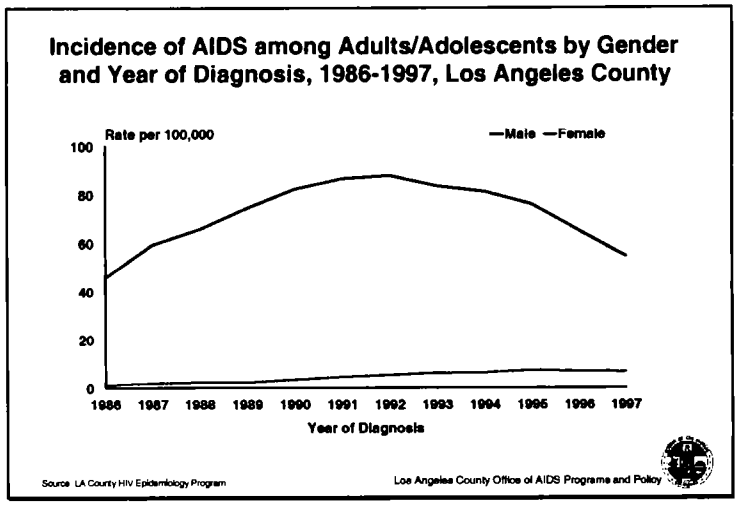
Demographics

- **The population was estimated in 1997 at 9,634,763.**
- **Los Angeles County includes more than 4,060 square miles, 88 incorporated cities and three health jurisdictions (Los Angeles County, the City of Long Beach and the City of Pasadena).**



Racial / Ethnic Composition

- **People of color account for nearly two-thirds of the Los Angeles County population.**
- **Los Angeles County residents are forty-four percent Latino/a, thirteen percent Asian or Pacific Islander, nine percent African-American and less than one percent Native American.**



AIDS in Los Angeles County

- **More than 38,000 Los Angeles County residents have been diagnosed with AIDS, accounting for more than thirty-five percent of all cases in California and six percent of all cases in the United States.**
- **More than 24,000 Los Angeles County residents have died from AIDS-related conditions, a cumulative case fatality rate of 63%.**

- More than 14,000 Los Angeles County residents are living with AIDS, with an additional estimated 25,000 infected with HIV.

State and Local Epidemic

- Los Angeles County accounts for approximately 35% of the AIDS cases reported in California yet represents 28% of California's population.
- Of all African-Americans living with AIDS in California, almost forty percent were diagnosed with AIDS while living in Los Angeles County.
- Of all Latino/as living with AIDS in California, forty-nine percent were diagnosed with AIDS while living in Los Angeles County.
- Of all people of color living with AIDS in California, forty-four percent were diagnosed with AIDS while living in Los Angeles County.

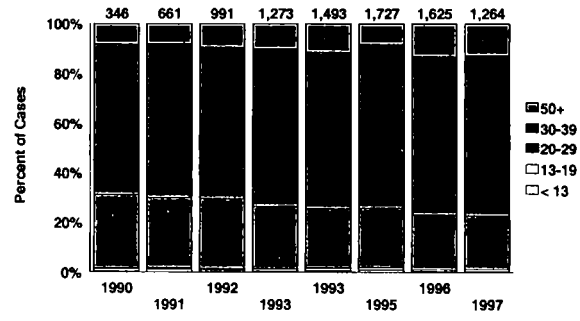
Impacted Communities

- African Americans are nine percent of Los Angeles County, but account for twenty-three percent of living AIDS cases.
- Latinos represented the plurality of AIDS cases diagnosed in 1997.
- The AIDS case rate among African-American women is ten times greater than that of White women.
- The AIDS case rate for African-Americans is the highest of any racial or ethnic group, with a County-wide rate of 347 per 100,000.
- For African-Americans in one part of Los Angeles County, the case rate is 1,194 per 100,000.

HIV Transmission

- In Los Angeles County, male-to-male sex is the most common mode of HIV transmission for men of all racial and ethnic groups.
- Injection drug use is a far less common mode of HIV transmission in Los Angeles County when compared to national data.

Proportion of AIDS Cases by Age Group and Year of Report, 1990-1997, Los Angeles County



Source: LA County HIV Epidemiology Program

Los Angeles County Office of AIDS Programs and Policy

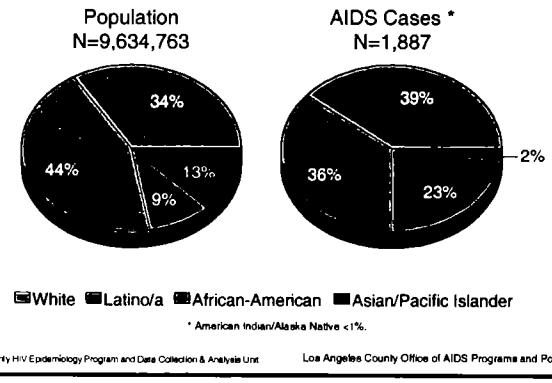
Demographic Characteristics of Reported AIDS Cases, Los Angeles County, California, and US, 1997

Demographic Characteristic	Los Angeles County (N=2,422)	California (N=6,341)	United States (N=60,634)
Race/Ethnicity			
White	39%	49%	33%
African-American	23%	21%	45%
Latino/a	36%	27%	21%
Asian/Pacific Islander	2%	3%	<1%
American Indian/Alaska Native	<1%	<1%	<1%

Source: CDC, California DHS, and LA County HIV Epidemiology Program

Los Angeles County Office of AIDS Programs and Policy

Estimated 1997 Population and AIDS Cases Reported in 1997 by Race/Ethnicity, Los Angeles County



* American Indian/Alaska Native <1%.

Source: LA County HIV Epidemiology Program and Data Collection & Analysis Unit

Los Angeles County Office of AIDS Programs and Policy

- Alcohol and other substance use are co-factors for HIV transmission.
- The proportion of AIDS cases among women remains low and stable.
- Important opportunities for prevention of HIV are present among women and injection drug users.

Young Gay Men and HIV

- The Centers for Disease Control and Prevention studied six hundred young gay and bisexual men in Los Angeles County. Overall, one in eleven was infected with HIV (9%), but the rates of infection varied by ethnic and racial groups.
  - * Almost one in five African-Americans was infected with HIV (17.6%).
  - * One in six mixed race men was infected with HIV(16.1%).
  - * One in eight Asian or Pacific Islanders was infected with HIV (11.8%).
  - * One in twelve Latinos was infected with HIV (7.7%).
  - * One in twenty-five Whites were infected with HIV (3.9%) and is eight times greater than the rate in the general population.

AIDS as Cause of Death

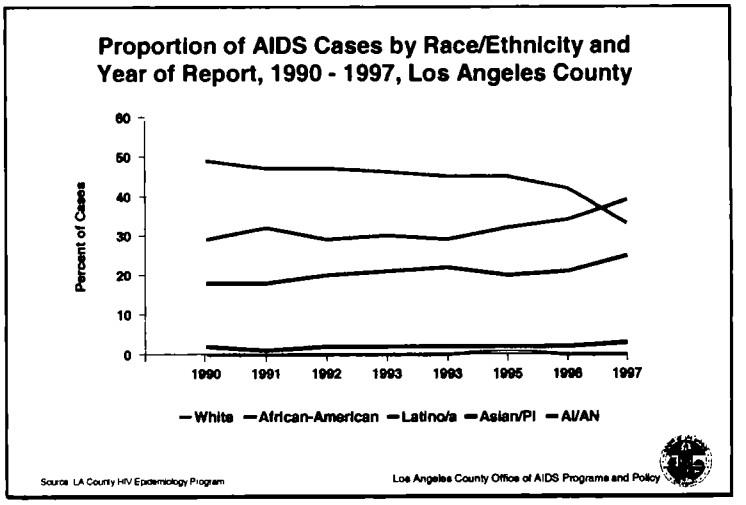
- Since 1990, AIDS has been the leading cause of death among men between the ages of twenty-five and forty-four in Los Angeles County.
- AIDS is the fourth leading cause of death among women between the ages of twenty-five and forty-four in Los Angeles County.
- Decreases in death from AIDS has declined dramatically among men since 1995. A much smaller decrease has been seen among women.
- Evidence suggests that people of color have not had the same decreases in AIDS deaths as Whites.

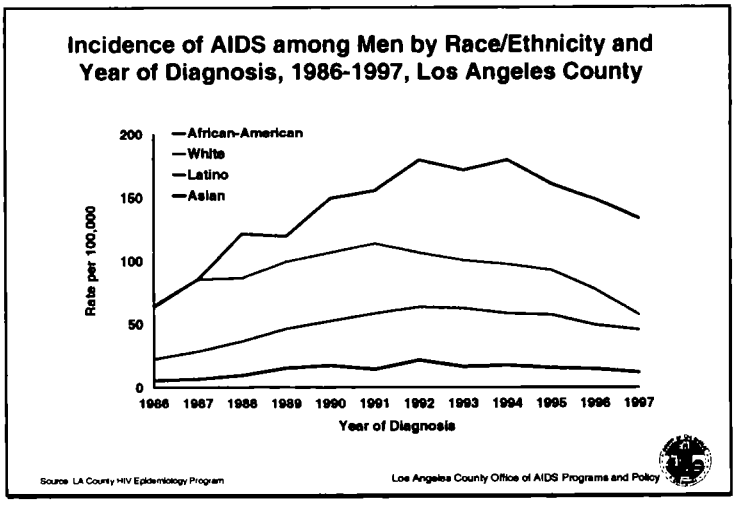
Living AIDS Cases by Race/Ethnicity per 100,000 through 02/99, Los Angeles County

Demographic Characteristic	Cases	Rate
Race/Ethnicity		
White	6,209	192
African-American	3,133	347
Latino/a	4,851	115
Asian/Pacific Islander	310	25
American Indian/Alaska Native	58	118
Total	14,618	152

Source: LA County HIV Epidemiology Program

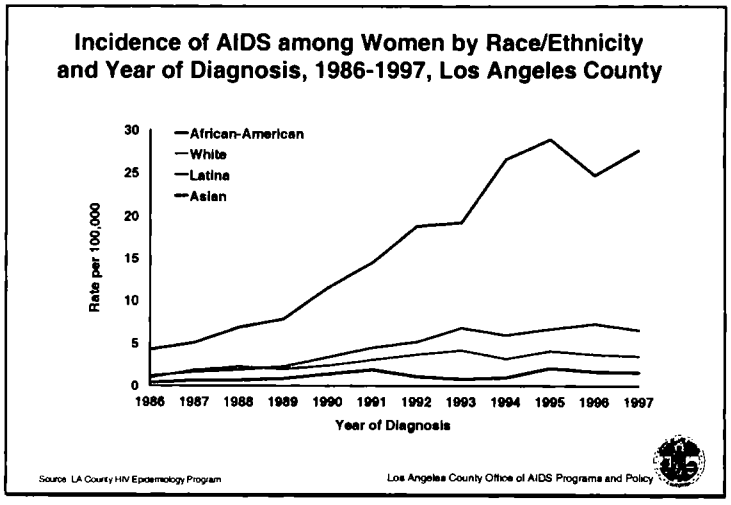
Los Angeles County Office of AIDS Programs and Policy

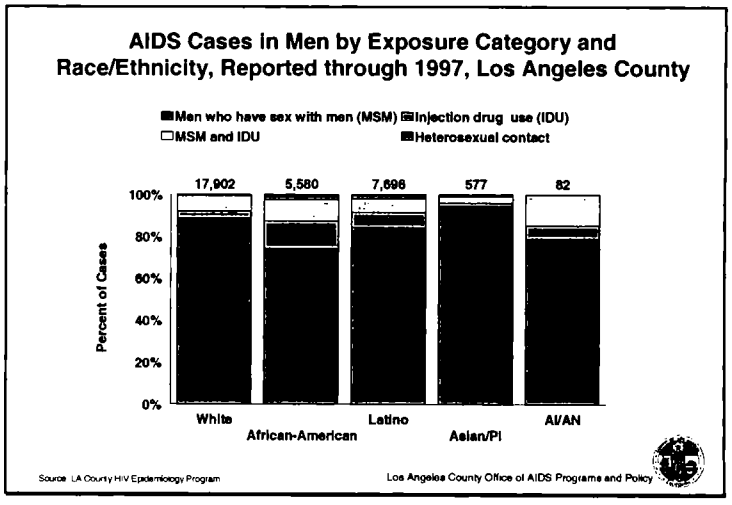


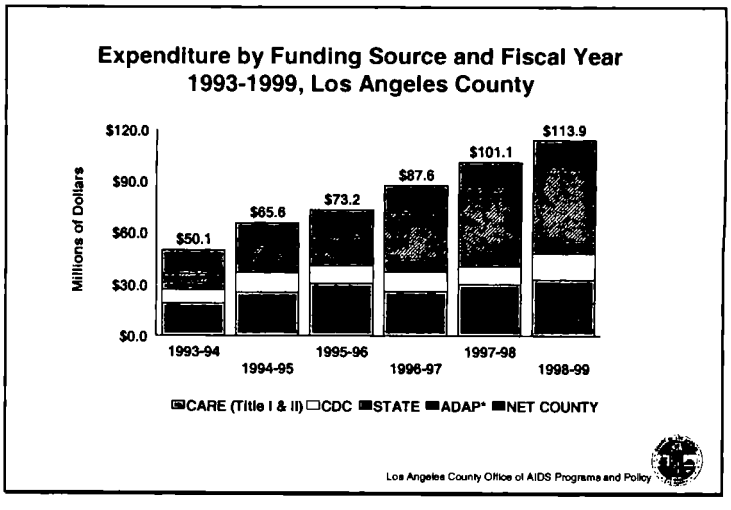


Policy Positions

- **Reauthorize the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act.**
  - * **Los Angeles County is the second most impacted jurisdiction in the country, but does not receive the second highest Title I formula award.**
  - * **The "hold harmless" provision of the CARE Act undermines the ability of local jurisdictions to respond to shifts in the epidemic.**
- **Reinvigorate HIV/AIDS Prevention.**
  - * **Federal funding for HIV/AIDS prevention has been flat for three of the last four years.**
  - * **The need for HIV/AIDS prevention continues to expand. There is a need to fund new strategies for increasingly impacted populations.**
- **Commit to Building Capacity.**
  - * **Technical assistance and infrastructure development are critical to the viability of HIV care and prevention services.**
  - * **Needs of providers also remain critical to the success of HIV care and prevention services.**
  - * **Without support, the ability of community partners to deliver and sustain effective care and prevention programs is severely compromised.**
- **Address Needs Comprehensively.**
  - * **The needs of people with HIV/AIDS are becoming increasingly complex.**
  - * **New treatment therapies require supportive services to ensure compliance.**
  - * **Effective HIV services must address the intersection of racism, homophobia, poverty, mental illness, and substance use.**







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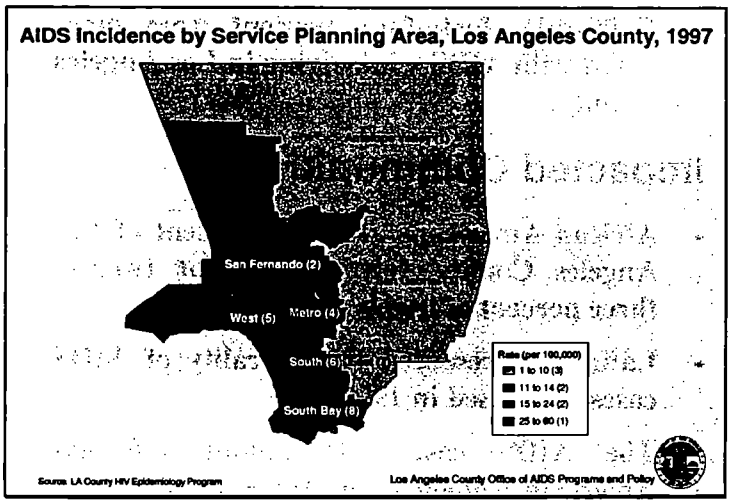

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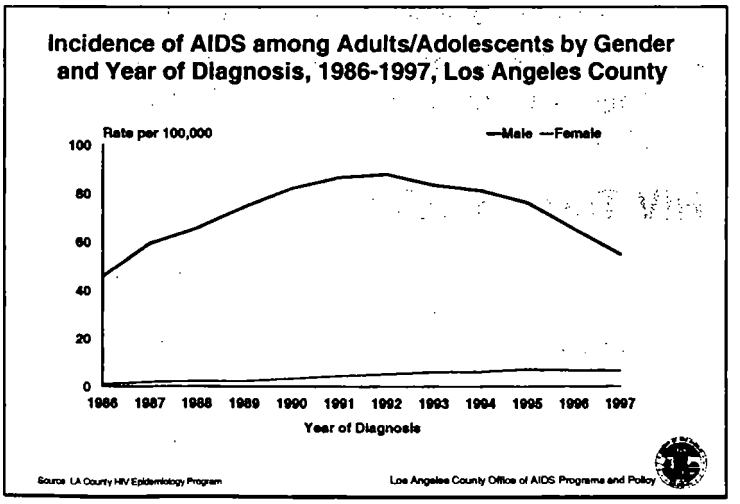

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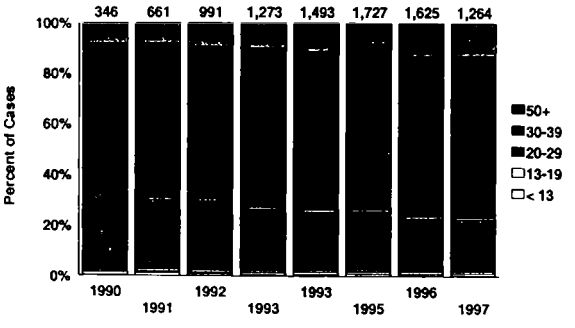

Source: LA County HIV Epidemiology Program

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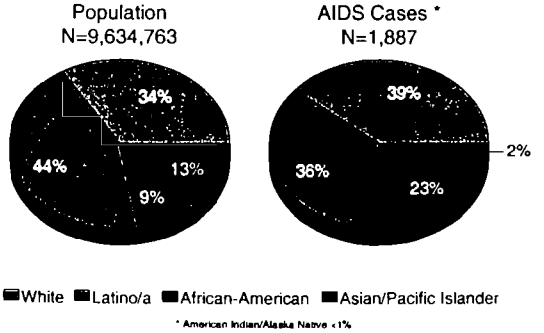

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Los Angeles County Office of AIDS Programs and Policy

- Alcohol and other substance use are co-factors for HIV transmission.
- The proportion of AIDS cases among women remains low and stable.
- Important opportunities for prevention of HIV are present among women and injection drug users.

Young Gay Men and HIV

- The Centers for Disease Control and Prevention studied six hundred young gay and bisexual men in Los Angeles County. Overall, one in eleven was infected with HIV (9%), but the rates of infection varied by ethnic and racial groups.
  - * Almost one in five African-Americans was infected with HIV (17.6%).
  - * One in six mixed race men was infected with HIV(16.1%).
  - * One in eight Asian or Pacific Islanders was infected with HIV (11.8%).
  - * One in twelve Latinos was infected with HIV (7.7%).
  - * One in twenty-five Whites were infected with HIV (3.9%) and is eight times greater than the rate in the general population.

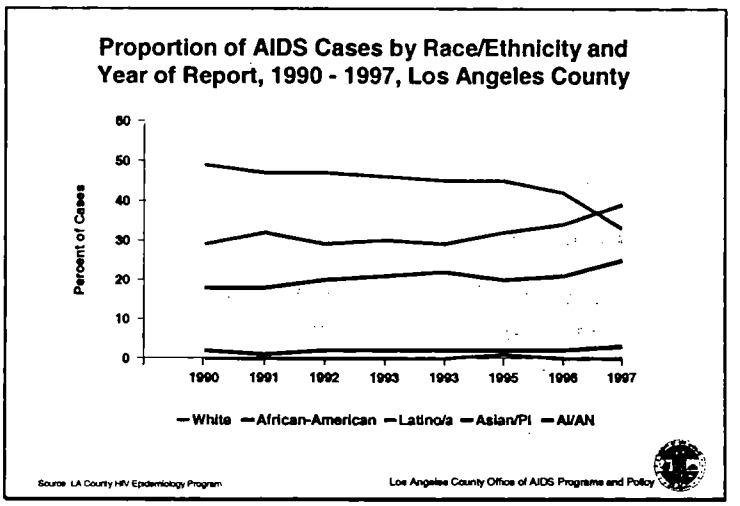
AIDS as Cause of Death

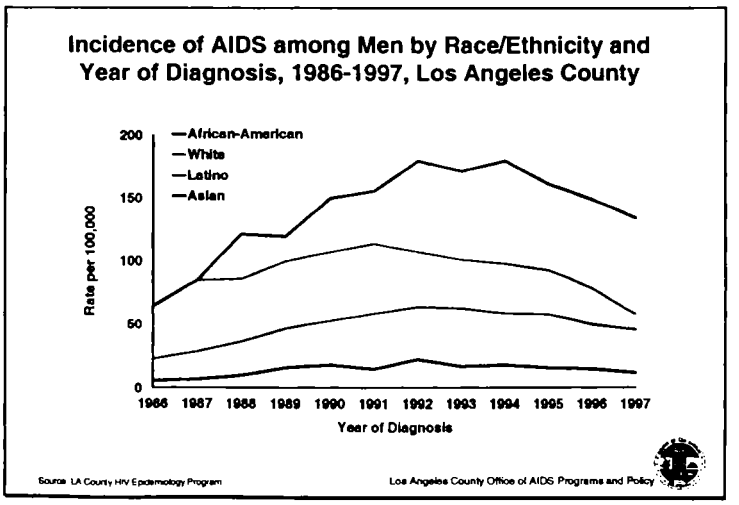
- Since 1990, AIDS has been the leading cause of death among men between the ages of twenty-five and forty-four in Los Angeles County.
- AIDS is the fourth leading cause of death among women between the ages of twenty-five and forty-four in Los Angeles County.
- Decreases in death from AIDS has declined dramatically among men since 1995. A much smaller decrease has been seen among women.
- Evidence suggests that people of color have not had the same decreases in AIDS deaths as Whites.

Living AIDS Cases by Race/Ethnicity per 100,000 through 02/99, Los Angeles County

Demographic Characteristic	Cases	Rate
Race/Ethnicity		
White	6,209	192
African-American	3,133	347
Latino/a	4,851	115
Asian/Pacific Islander	310	25
American Indian/Alaska Native	58	118
Total	14,618	152

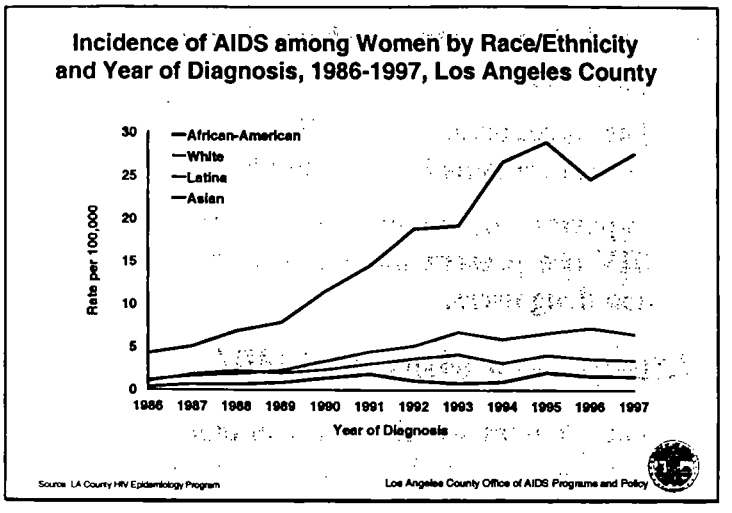
Source: LA County HIV Epidemiology Program — Los Angeles County Office of AIDS Programs and Policy

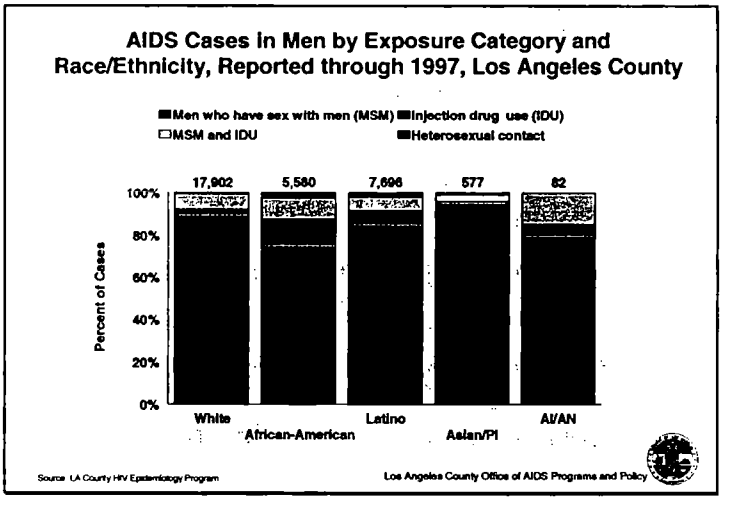


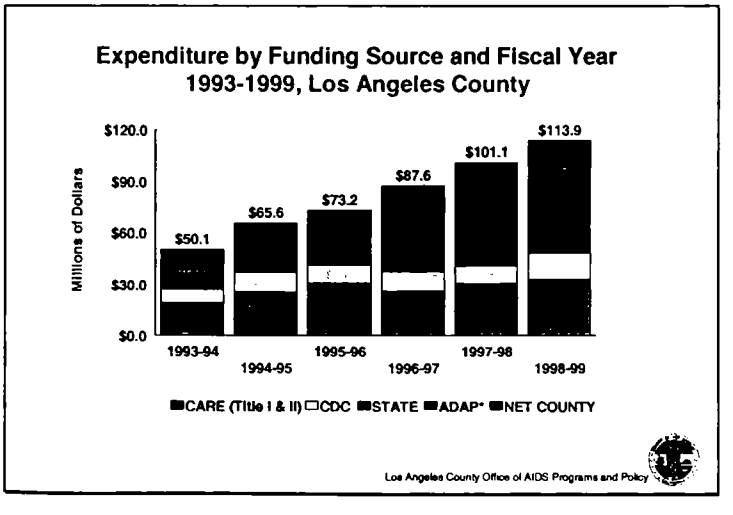


Policy Positions

- Reauthorize the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act.
  - * Los Angeles County is the second most impacted jurisdiction in the country, but does not receive the second highest Title I formula award.
  - * The "hold harmless" provision of the CARE Act undermines the ability of local jurisdictions to respond to shifts in the epidemic.
- Reinvigorate HIV/AIDS Prevention.
  - * Federal funding for HIV/AIDS prevention has been flat for three of the last four years.
  - * The need for HIV/AIDS prevention continues to expand. There is a need to fund new strategies for increasingly impacted populations.
- Commit to Building Capacity.
  - * Technical assistance and infrastructure development are critical to the viability of HIV care and prevention services.
  - * Needs of providers also remain critical to the success of HIV care and prevention services.
  - * Without support, the ability of community partners to deliver and sustain effective care and prevention programs is severely compromised.
- Address Needs Comprehensively.
  - * The needs of people with HIV/AIDS are becoming increasingly complex.
  - * New treatment therapies require supportive services to ensure compliance.
  - * Effective HIV services must address the intersection of racism, homophobia, poverty, mental illness, and substance use.







COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES
OFFICE OF AIDS PROGRAMS AND POLICY
600 S. Commonwealth Avenue • Los Angeles CA 90005
(213) 351-8000

April 12, 1999

TO: Los Angeles County Commission on HIV Health Services

FROM: Charles L. Henry, Director
Office of AIDS Programs and Policy

RE: CARE Act Re-authorization

At the request of the Los Angeles County Commission on HIV Health Services (Commission), I am providing a written version of my remarks at the April 8, 1999 meeting. Attached are tables listing additional information about current CARE Act Title I allocations and the distribution of AIDS cases in California.

Making Policy

AIDS is political. It has been since the beginning of the epidemic. As we approach the end of the second decade of the epidemic, I want to ask all of us to reflect for a moment on what the political work around AIDS means, what it does, what it should do, what we have learned and what new directions we want to take.

Each year, our federal partners raise the bar for all of us by asking that we justify our plans for services with a basis on evidence. It seems a good practice to me, and I want to propose that we hold ourselves to the same standard when crafting POLICY.

Too frequently, important policy discussions get caught up with interpersonal dynamics, transitory demands and narrow interests. I am concerned that we address the important issues facing us from a rational basis of facts and want to suggest that we all can do better at checking assumptions, challenging assertions and assimilating evidence into our thinking.

I also want to be frank about some of the dynamics. For all of our good intentions and solid commitment, we are inevitably going to be, from time to time, at cross-purposes with our counterparts in other health jurisdictions, our State and federal partners, and one another.

I think that at least part of the confusion about policy initiatives stem from our unwillingness to address those cross-purposes. "All roads lead to Rome," wrote Aldous Huxley, "provided, of course, it is to Rome and not some other place the traveler wishes to go."

We need to be clear about where we are going before we can say with any certainty whether or not we have gotten there.

Putting Funding Where the Need Is

As a central principle, I want to propose that we always ask each allocation decision to put the money where the need is. It is a principle that we can apply at all levels of decision making, to OAPP allocating funds among providers, to the Commission establishing priorities among services, to providers allocating funds among the programs they manage. It is only fair and appropriate that we apply the same principle to State and federal allocations.

In order to use "fair share," we need to have agreement that it has been calculated fairly, considers all appropriate factors and uses data that are comparable and replicable among all jurisdictions. I acknowledge that the particular components of a fair share calculation remain open to discussion, but for the immediate purposes, I am using the allocations of funds per estimated case as the measure of "fair share."

Let me start with Title I of the CARE Act. Unfortunately, the commitment of the Los Angeles County Office of AIDS Programs and Policy (OAPP) to a full and frank discussion of the allocation of Title I has been characterized as a feud between Los Angeles and San Francisco. Let me be clear. There is no feud.

Nor is this personal, as some have suggested. It is professional. I, along with all of you, as well as our local government and community partners, have the responsibility to ensure that Los Angeles County has adequate resources to meet the needs of people with HIV and AIDS.

The problem is that any effort to correct disparate distribution of CARE Title I funds leads to San Francisco because that is where the disparity is.

Each year, the federal Health Resources and Services Administration (HRSA) calculates an estimate of the number of living cases of AIDS in each of the Title I jurisdictions. Cases are weighted to estimate mortality; in other words, the more recent the diagnosis, the larger the weight since the premise is that more recently diagnosed people are more likely to be alive. This is a flawed methodology. It assumes, among other things, that all people with AIDS die within ten years of diagnosis, an assessment that is increasingly foiled by new treatments. As a general rule, the estimated number of living cases is about twenty percent lower than the reported living cases within most jurisdictions.

At a minimum, this allows federal appropriators to set overall funding levels based on assumptions that under-estimate the need.

Whatever its flaws, every year HRSA makes this calculation to estimate living cases. Dividing the total funds available by the total estimated living cases yields a "fair share" of $2,878 per case. (For the record, Los Angeles County has an allocation of $2,803 per case, yielding a discrepancy when compared to our "fair share" of almost $830,000.) Attachment I lists the allocations, estimated cases and "fair share" for each of the Title I jurisdictions.

For Year 08 – the year that just ended – there were forty-nine Title I eligible metropolitan areas (EMA). Ten of those EMAs received more than the "fair share" allocation per case. Of those

ten, nine had an allocation between $2,878 and change per case and $3,143 per case, or in other words, a discrepancy as high as one hundred and twelve percent.

The tenth above average area – San Francisco – had an allocation of $5,987 per case, more than twice the national average and very nearly twice the per case allocation of any other Title I area. The allocation exceeded the "fair share" by almost $19 million ($18,896,879)

Attachment II is a similar analysis of Title I allocations and a different estimation of living AIDS cases. This estimate of living AIDS cases is provided by the federal Centers for Disease Control and Prevention (CDC), and estimates the number of AIDS cases in Title I EMAs as of December 31, 1997. The estimates were made based on cases reported by September, 1998. Data are available only for those EMAs with a population of one-half million or greater, which removes six of the Title I EMAs funded in Year 08.

The same disparities persist in this estimation. The total number of AIDS cases in the forty-three Title I EMAs considered is estimated by the CDC at the end of 1997 to be 192,726. This yields a per case "fair share" of $2,310. Seven EMAs receive an allocation greater than this "fair share," six of those seven are within about ten percent (10.1%) of the fair share. The allocation of funds to San Francisco is $4,356 per case, almost twice the "fair share," and seventy-five percent higher than any other Title I EMA.

So the reason we must talk about San Francisco is because San Francisco is where the disparity is. Let me say a few things about what that means.

Less funding goes to provide services to people of color. Attachment III lists data from the State Office of AIDS regarding the racial and ethnic distribution of living AIDS cases as of March, 1999, among the nine Title I EMAs in California and the remainder of the state.

Los Angeles County has about one-third (34.86%) of all cases in California. Of all African Americans living with AIDS in the state of California, a greater proportion -- about forty percent (39.1%) -- were diagnosed with AIDS while living in Los Angeles County. Of all Latinos living with AIDS in the state of California, a greater proportion still -- almost half (49.6%) -- were diagnosed with AIDS while living in Los Angeles County. Of all people of color living with AIDS in the state of California, 44.3% were diagnosed with AIDS while living in Los Angeles County.

Now compare. Overall, the San Francisco EMA (including San Francisco, San Mateo and Marin Counties) accounts for about half of the cases of Los Angeles. Nineteen percent of all people living with AIDS in the state were diagnosed while living in San Francisco. The San Francisco EMA is home to a smaller proportion of African Americans with AIDS in California (16.1%), and smaller still of Latinos with AIDS in California (9.9%). Thirteen and one-half percent (13.5%) of all people of color living with AIDS in the state were diagnosed with AIDS while living in San Francisco.

Almost sixty percent (57.7%) of all people living with AIDS in Los Angeles County are people of color. Just under one-third (32.7%) of all people living with AIDS in the San Francisco EMA are people of color. Los Angeles County has more than three times as many people of color living with AIDS than does the San Francisco EMA.

San Francisco gets an allocation of CARE Title I funds that is twice the national average per case of AIDS and that diverts funds away from communities of color. Additionally, with approximately twice as many living AIDS cases as San Francisco, Los Angeles County receives $3 million fewer Title I dollars than San Francisco.

Now I don't begrudge for one minute all the health care and other services that every person with AIDS can consume. But needs persist throughout the country, including Los Angeles County. San Francisco is where the disparity is. Some would argue that we should not dismantle the infrastructure that has been created in San Francisco. I want to be clear about what that means. It means that communities increasingly impacted will continue not to have the resources necessary to develop adequate health care infrastructure.

Next Steps

I want to acknowledge deeply held differences of opinion about CARE Act allocation strategies. More important than those differences, though, is the commitment we share to ensure that funding is directed to areas of need. I want to propose that we devise a formula that accomplishes that distribution and apply it straightforwardly.

Anything else that we might do means one of two things: either we have crafted a formula that does not reflect need, or we are not truly committed to directing funds to areas of need.

One of the most difficult choices that we will have to face is the relative value of continuing existing funding levels as opposed to directing funds to new services or different areas. This will – and should – be a painful discussion, because it will mean taking a careful and honest look at our principles. In the same way that all of us worked so hard to ensure the establishment of services when HIV first became an epidemic among gay white men, it is now only fit and proper that we direct those same efforts to establish services among communities of color.

The shift of funds should follow the shift in burden. When we assess burden, however, we have to consider factors such as the expensive costs of creating infrastructures for service delivery, the relative abilities of different communities to generate privately raised funds and the relative costs of providing care.

I want to be clear. In my view, maintenance of existing systems of care does not occupy a higher moral ground that the establishment of infrastructures in those communities in which it is lacking. That is our next great task.

There is more we can do to ensure larger allocation of funds for the CARE Act, and that will certainly ease the way to establishing new systems. I look forward to working with you in our efforts to accomplish this.

CLH:gf

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Distribution of CARE Title I Year 08 Funds and HRSA Estimated Living Cases

Attachment I

	A	C	D	E	F	G	H	I	J	K	L	M	N
1	Eligible Metropolitan Area (EMA)	Formula Year 08		Supplement Year 08		Fiscal 1998		HRSA Estimated Living Cases (1988 - 1998)		Allocation per case	"Fair Share" (Cases Only)	Variance	
2													
3	Atlanta	6,529,820	2.8%	5,491,634	2.6%	12,021,454	2.7%	4,471	2.9%	2,689	12,869,504	(848,050)	(7.1%)
4	Austin	1,496,584	0.6%	1,360,168	0.6%	2,856,752	0.6%	1,072	0.7%	2,665	3,085,687	(228,935)	(8.0%)
5	Baltimore	6,369,185	2.7%	5,815,296	2.7%	12,184,481	2.7%	4,498	2.9%	2,709	12,947,222	(762,741)	(6.3%)
6	Bergen Passaic	2,282,358	1.0%	2,071,933	1.0%	4,354,291	1.0%	1,553	1.0%	2,804	4,470,217	(115,926)	(2.7%)
7	Boston	5,159,067	2.2%	4,304,063	2.0%	9,463,130	2.1%	3,423	2.2%	2,765	9,852,899	(389,769)	(4.1%)
8	Caguas	757,663	0.3%	647,534	0.3%	1,405,197	0.3%	556	0.4%	2,527	1,600,412	(195,215)	(13.9%)
9	Chicago	8,193,733	3.5%	7,801,779	3.7%	15,995,512	3.6%	5,836	3.8%	2,741	16,798,574	(803,062)	(5.0%)
10	Cleveland	1,343,981	0.6%	1,115,462	0.5%	2,459,443	0.6%	973	0.6%	2,528	2,800,722	(341,279)	(13.9%)
11	Dallas	4,774,881	2.1%	4,307,336	2.0%	9,082,217	2.0%	3,295	2.1%	2,756	9,484,459	(402,242)	(4.4%)
12	Denver	2,163,221	0.9%	2,114,940	1.0%	4,278,161	1.0%	1,378	0.9%	3,105	3,966,490	311,671	7.3%
13	Detroit	2,994,508	1.3%	2,633,842	1.2%	5,628,350	1.3%	2,150	1.4%	2,618	6,188,645	(560,295)	(10.0%)
14	Dutchess County	467,181	0.2%	387,300	0.2%	854,481	0.2%	393	0.3%	2,174	1,131,227	(276,746)	(32.4%)
15	Fort Lauderdale	5,122,924	2.2%	5,005,707	2.4%	10,128,631	2.3%	3,585	2.3%	2,825	10,319,206	(190,575)	(1.9%)
16	Fort Worth	1,361,383	0.6%	1,257,248	0.6%	2,618,631	0.6%	972	0.6%	2,694	2,797,843	(179,212)	(6.8%)
17	Hartford	1,816,516	0.8%	1,796,513	0.8%	3,613,029	0.8%	1,311	0.8%	2,756	3,773,634	(160,605)	(4.4%)
18	Houston	6,990,308	3.0%	5,732,171	2.7%	12,722,479	2.9%	5,356	3.5%	2,375	15,416,923	(2,694,444)	(21.2%)
19	Jacksonville	1,783,051	0.8%	1,660,117	0.8%	3,443,168	0.8%	1,221	0.8%	2,820	3,514,575	(71,407)	(2.1%)
20	Jersey City	2,774,973	1.2%	2,545,327	1.2%	5,320,300	1.2%	1,896	1.2%	2,806	5,457,522	(137,222)	(2.6%)
21	Kansas City	1,445,717	0.6%	1,176,692	0.6%	2,622,409	0.6%	955	0.6%	2,746	2,748,910	(126,501)	(4.8%)
22	Los Angeles	16,562,826	7.1%	14,074,280	6.6%	30,637,106	6.9%	10,932	7.1%	2,803	31,467,103	(829,997)	(2.7%)
23	Miami	9,806,778	4.2%	8,665,375	4.1%	18,472,153	4.1%	6,785	4.4%	2,722	19,530,213	(1,058,060)	(5.7%)
24	Middlesex-Somerset-Hunterdon	1,338,627	0.6%	1,259,296	0.6%	2,597,923	0.6%	909	0.6%	2,858	2,616,502	(18,579)	(0.7%)
25	Minneapolis-St. Paul	1,285,081	0.6%	1,285,631	0.6%	2,570,712	0.6%	833	0.5%	3,086	2,397,740	172,972	6.7%
26	Nassau (Suffolk County)	2,670,560	1.1%	2,269,311	1.1%	4,939,871	1.1%	1,862	1.2%	2,653	5,359,655	(419,784)	(8.5%)
27	New Haven	2,874,031	1.2%	2,474,699	1.2%	5,348,730	1.2%	2,014	1.3%	2,656	5,797,178	(448,448)	(8.4%)
28	New Orleans	2,762,925	1.2%	2,158,932	1.0%	4,921,857	1.1%	1,979	1.3%	2,487	5,696,432	(774,575)	(15.7%)
29	New York	47,663,305	20.5%	47,662,029	22.4%	95,325,334	21.4%	33,117	21.4%	2,878	95,325,288	46	0.0%
30	Newark	6,808,255	2.9%	5,822,002	2.7%	12,630,257	2.8%	4,664	3.0%	2,708	13,425,043	(794,786)	(6.3%)
31	Oakland	3,084,196	1.3%	2,841,998	1.3%	5,926,194	1.3%	2,035	1.3%	2,912	5,857,625	68,569	1.2%
32	Orange County	2,100,305	0.9%	1,710,454	0.8%	3,810,759	0.9%	1,405	0.9%	2,712	4,044,208	(233,449)	(6.1%)

Distribution of CARE Title I Year 08 Funds and HRSA Estimated Living Cases

Attachment I

	A	C	D	E	F	G	H	I	J	K	L	M	N
1	Eligible Metropolitan Area (EMA)	Formula Year 08		Supplement Year 08		Fiscal 1998		HRSA Estimated Living Cases (1988 - 1998)		Allocation per case	"Fair Share" (Cases Only)	Variance	
2													
33	Orlando	2,422,914	1.0%	2,186,925	1.0%	4,609,839	1.0%	1,784	1.2%	2,584	5,135,136	(525,297)	(11.4%)
34	Philadelphia	7,389,219	3.2%	6,692,554	3.1%	14,081,773	3.2%	5,355	3.5%	2,630	15,414,045	(1,332,272)	(9.5%)
35	Phoenix	1,803,130	0.8%	1,608,907	0.8%	3,412,037	0.8%	1,303	0.8%	2,619	3,750,607	(338,570)	(9.9%)
36	Ponce	1,190,039	0.5%	1,010,075	0.5%	2,200,114	0.5%	798	0.5%	2,757	2,296,995	(96,881)	(4.4%)
37	Portland	1,566,193	0.7%	1,491,273	0.7%	3,057,466	0.7%	1,008	0.7%	3,033	2,901,467	155,999	5.1%
38	Riverside / San Bernardino	2,939,624	1.3%	2,694,803	1.3%	5,634,427	1.3%	2,090	1.4%	2,696	6,015,939	(381,512)	(6.8%)
39	Sacramento	1,277,050	0.5%	1,112,320	0.5%	2,389,370	0.5%	865	0.6%	2,762	2,489,850	(100,480)	(4.2%)
40	San Antonio	1,670,606	0.7%	1,281,633	0.6%	2,952,239	0.7%	1,201	0.8%	2,458	3,457,006	(504,767)	(17.1%)
41	San Diego	4,296,991	1.9%	4,155,446	2.0%	8,452,437	1.9%	2,912	1.9%	2,903	8,382,016	70,421	0.8%
42	San Francisco	18,744,145	8.1%	17,650,769	8.3%	36,394,914	8.2%	6,079	3.9%	5,987	17,498,035	18,896,879	51.9%
43	San Jose	1,279,727	0.6%	1,165,753	0.5%	2,445,480	0.5%	820	0.5%	2,982	2,360,321	85,159	3.5%
44	San Juan	6,116,185	2.6%	5,542,727	2.6%	11,658,912	2.6%	4,478	2.9%	2,604	12,889,653	(1,230,741)	(10.6%)
45	Santa Rosa	629,154	0.3%	596,653	0.3%	1,225,807	0.3%	390	0.3%	3,143	1,122,591	103,216	8.4%
46	Seattle	2,608,983	1.1%	2,451,550	1.2%	5,060,533	1.1%	1,716	1.1%	2,949	4,939,403	121,130	2.4%
47	St. Louis	1,891,479	0.8%	1,670,371	0.8%	3,561,850	0.8%	1,277	0.8%	2,789	3,675,768	(113,918)	(3.2%)
48	Tampa - St Petersburg	3,289,005	1.4%	3,247,184	1.5%	6,536,189	1.5%	2,326	1.5%	2,810	6,695,251	(159,062)	(2.4%)
49	Vineland-Millville-Bridgeton	326,625	0.1%	267,376	0.1%	594,001	0.1%	220	0.1%	2,700	633,257	(39,256)	(6.6%)
50	Washington, D.C.	8,909,898	3.8%	7,800,828	3.7%	16,710,726	3.8%	6,387	4.1%	2,616	18,384,594	(1,673,868)	(10.0%)
51	West Palm Beach	3,133,725	1.3%	2,831,756	1.3%	5,965,481	1.3%	2,221	1.4%	2,686	6,393,015	(427,534)	(7.2%)
52													
53	Total	232,268,635	100.0%	212,907,972	100.0%	445,176,607	100.0%	154,659	100.0%		445,176,607	0	
54													
55	"Fair Share"									2,878			
56	Average									2,802			(4.5%)
57	Minimum									2,174			(32.4%)
58	Maximum									5,987			51.9%
59	Std deviation									498			10.9%

Distribution of CARE Title I Year 08 funds and CDC Estimated Living Cases

	A	C	D	E	F	G	H	I	J	K	L	M	N
1	Eligible Metropolitan Area (EMA)	Formula Year 08		Supplement Year 08		Fiscal 1998		CDC Estimated Living Cases (June 1998)		Allocation per case	"Fair Share" (Cases Only)	Variance	
2													
3	Atlanta	6,529,820	2.8%	5,491,634	2.6%	12,021,454	2.7%	6,330	3.1%	1,899	13,687,762	(1,666,308)	(13.9%)
4	Austin	1,496,584	0.6%	1,360,168	0.6%	2,856,752	0.6%	1,469	0.7%	1,945	3,176,512	(319,760)	(11.2%)
5	Baltimore	6,369,185	2.7%	5,815,296	2.7%	12,184,481	2.7%	5,939	2.9%	2,052	12,842,277	(657,796)	(5.4%)
6	Bergen Passaic	2,282,358	1.0%	2,071,933	1.0%	4,354,291	1.0%	1,828	0.9%	2,382	3,952,801	401,490	9.2%
7	Boston	5,159,067	2.2%	4,304,063	2.0%	9,463,130	2.1%	4,799	2.3%	1,972	10,377,183	(914,053)	(9.7%)
8	Caguas	757,663	0.3%	647,534	0.3%	1,405,197	0.3%	815	0.4%	1,724	1,762,326	(357,129)	(25.4%)
9	Chicago	8,193,733	3.5%	7,801,779	3.7%	15,995,512	3.6%	6,859	3.3%	4,886	14,831,652	1,163,860	7.3%
10	Cleveland	1,343,981	0.6%	1,115,462	0.5%	2,459,443	0.6%	1,321	0.6%	1,862	2,856,482	(397,039)	(16.1%)
11	Dallas	4,774,881	2.1%	4,307,336	2.0%	9,082,217	2.0%	4,886	2.4%	1,859	10,565,309	(1,483,092)	(16.3%)
12	Denver	2,163,221	0.9%	2,114,940	1.0%	4,278,161	1.0%	1,944	0.9%	2,201	4,203,635	74,526	1.7%
13	Detroit	2,994,508	1.3%	2,633,842	1.2%	5,628,350	1.3%	2,860	1.4%	1,968	6,184,360	(556,010)	(9.9%)
14	Dutchess County	467,181	0.2%	387,300	0.2%	854,481	0.2%	503	0.2%	1,699	1,087,669	(233,188)	(27.3%)
15	Fort Lauderdale	5,122,924	2.2%	5,005,707	2.4%	10,128,631	2.3%	4,787	2.3%	2,116	10,351,235	(222,604)	(2.2%)
16	Fort Worth	1,361,383	0.6%	1,257,248	0.6%	2,618,631	0.6%	1,387	0.7%	1,888	2,999,198	(380,567)	(14.5%)
17	Hartford	1,816,516	0.8%	1,796,513	0.8%	3,613,029	0.8%	1,947	0.9%	1,856	4,210,122	(597,093)	(16.5%)
18	Houston	6,990,308	3.0%	5,732,171	2.7%	12,722,479	2.9%	7,537	3.7%	1,688	16,297,734	(3,575,255)	(28.1%)
19	Jacksonville	1,783,051	0.8%	1,660,117	0.8%	3,443,168	0.8%	1,901	0.9%	1,811	4,110,653	(667,485)	(19.4%)
20	Jersey City	2,774,973	1.2%	2,545,327	1.2%	5,320,300	1.2%	2,161	1.0%	2,462	4,672,868	647,432	12.2%
21	Kansas City	1,445,717	0.6%	1,176,692	0.6%	2,622,409	0.6%	1,567	0.8%	1,674	3,388,424	(766,015)	(29.2%)
22	Los Angeles	16,562,826	7.1%	14,074,280	6.6%	30,637,106	6.9%	14,572	7.1%	2,102	31,509,962	(872,856)	(2.8%)
23	Miami	9,806,778	4.2%	8,665,375	4.1%	18,472,153	4.1%	9,201	4.5%	2,008	19,895,908	(1,423,755)	(7.7%)
24	Middlesex-Somerset-Hunterdon	1,338,627	0.6%	1,259,296	0.6%	2,597,923	0.6%	1,101	0.5%	2,360	2,380,762	217,161	8.4%
25	Minneapolis-St. Paul	1,285,081	0.6%	1,285,631	0.6%	2,570,712	0.6%	1,227	0.6%	2,095	2,653,220	(82,508)	(3.2%)
26	Nassau (Suffolk County)	2,670,560	1.1%	2,269,311	1.1%	4,939,871	1.1%	2,513	1.2%	1,966	5,434,020	(494,149)	(10.0%)
27	New Haven	2,874,031	1.2%	2,474,699	1.2%	5,348,730	1.2%	3,126	1.5%	1,711	6,759,549	(1,410,819)	(26.4%)
28	New Orleans	2,762,925	1.2%	2,158,932	1.0%	4,921,857	1.1%	2,528	1.2%	1,947	5,466,455	(544,598)	(11.1%)
29	New York	47,663,305	20.5%	47,662,029	22.4%	95,325,334	21.4%	41,241	20.0%	2,311	89,178,037	6,147,297	6.4%
30	Newark	6,808,255	2.9%	5,822,002	2.7%	12,630,257	2.8%	5,492	2.7%	2,300	11,875,701	754,556	6.0%
31	Oakland	3,084,196	1.3%	2,841,998	1.3%	5,926,194	1.3%	2,804	1.4%	2,113	6,063,268	(137,074)	(2.3%)
32	Orange County	2,100,305	0.9%	1,710,454	0.8%	3,810,759	0.9%	2,250	1.1%	1,694	4,865,318	(1,054,559)	(27.7%)

Distribution of CARE Title I Year 08 funds and CDC Estimated Living Cases

	A	C	D	E	F	G	H	I	J	K	L	M	N
1	Eligible Metropolitan Area (EMA)	Formula Year 08		Supplement Year 08		Fiscal 1998		CDC Estimated Living Cases (June 1998)		Allocation per case	"Fair Share" (Cases Only)	Variance	
2													
33	Orlando	2,422,914	1.0%	2,186,925	1.0%	4,609,839	1.0%	2,445	1.2%	1,885	5,286,979	(677,140)	(14.7%)
34	Philadelphia	7,389,219	3.2%	6,692,554	3.1%	14,081,773	3.2%	7,212	3.5%	1,953	15,594,966	(1,513,193)	(10.7%)
35	Phoenix	1,803,130	0.8%	1,608,907	0.8%	3,412,037	0.8%	1,838	0.9%	1,856	3,974,424	(562,387)	(16.5%)
36	Ponce	1,190,039	0.5%	1,010,075	0.5%	2,200,114	0.5%	1,052	0.5%	2,091	2,274,807	(74,693)	(3.4%)
37	Portland	1,566,193	0.7%	1,491,273	0.7%	3,057,466	0.7%	1,455	0.7%	2,101	3,146,239	(88,773)	(2.9%)
38	Riverside / San Bernardino	2,939,624	1.3%	2,694,803	1.3%	5,634,427	1.3%	2,934	1.4%	1,920	6,344,375	(709,948)	(12.6%)
39	Sacramento	1,277,050	0.5%	1,112,320	0.5%	2,389,370	0.5%	1,120	0.5%	2,133	2,421,847	(32,477)	(1.4%)
40	San Antonio	1,670,606	0.7%	1,281,633	0.6%	2,952,239	0.7%	1,703	0.8%	1,734	3,682,505	(730,266)	(24.7%)
41	San Diego	4,296,991	1.9%	4,155,446	2.0%	8,452,437	1.9%	4,008	1.9%	2,109	8,666,753	(214,316)	(2.5%)
42	San Francisco	18,744,145	8.1%	17,650,769	8.3%	36,394,914	8.2%	8,594	4.2%	4,235	18,583,353	17,811,561	48.9%
43	San Jose	1,279,727	0.6%	1,165,753	0.5%	2,445,480	0.5%	1,170	0.6%	2,090	2,529,965	(84,485)	(3.5%)
44	San Juan	6,116,185	2.6%	5,542,727	2.6%	11,658,912	2.6%	5,174	2.5%	2,253	11,188,069	470,843	4.0%
45	Santa Rosa	629,154	0.3%	596,653	0.3%	1,225,807	0.3%	585	0.3%	2,095	1,264,983	(39,176)	(3.2%)
46	Seattle	2,608,983	1.1%	2,451,550	1.2%	5,060,533	1.1%	2,521	1.2%	2,007	5,451,319	(390,786)	(7.7%)
47	St. Louis	1,891,479	0.8%	1,670,371	0.8%	3,561,850	0.8%	1,779	0.9%	2,002	3,846,845	(284,995)	(8.0%)
48	Tampa - St Petersburg	3,289,005	1.4%	3,247,184	1.5%	6,536,189	1.5%	3,281	1.6%	1,992	7,094,715	(558,526)	(8.5%)
49	Vineland-Millville Bridgeton	326,625	0.1%	267,376	0.1%	594,001	0.1%	265	0.1%	2,242	573,026	20,975	3.5%
50	Washington, D.C.	8,909,898	3.8%	7,800,828	3.7%	16,710,726	3.8%	8,854	4.3%	1,887	19,145,567	(2,434,841)	(14.6%)
51	West Palm Beach	3,133,725	1.3%	2,831,756	1.3%	5,965,481	1.3%	2,990	1.5%	1,995	6,465,467	(499,986)	(8.4%)
52													
53	**Total**	**232,268,635**	**100.0%**	**212,907,972**	**100.0%**	**445,176,607**	**100.0%**	**205,875**	**100.0%**		**445,176,607**	**(0)**	
54													
55	"Fair Share"									2,162			
56	Average									2,105			(7.6%)
57	Minimum									1,674			(29.2%)
58	Maximum									4,886			48.9%
59	Std deviation									550			13.4%

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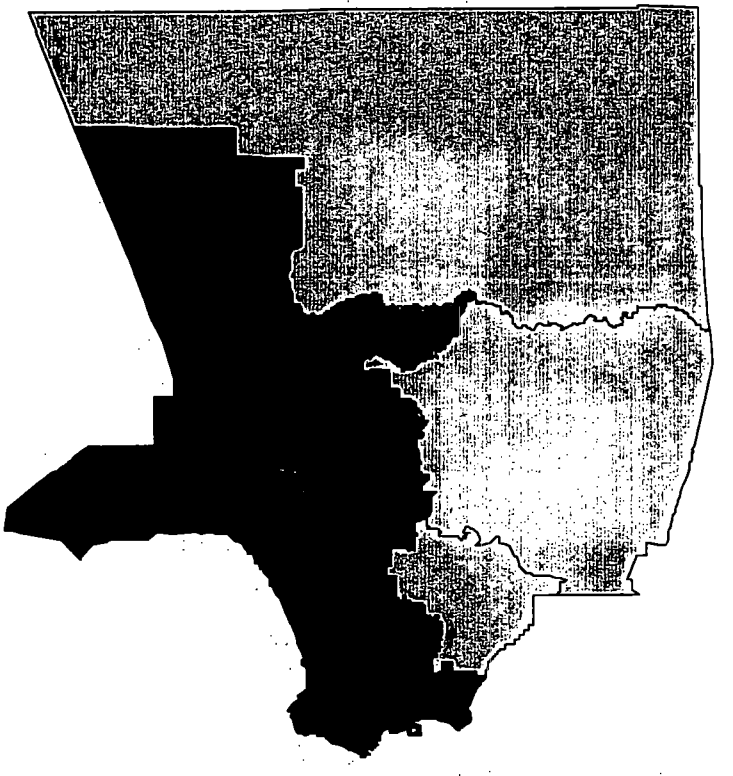
State of an Epidemic

HIV/AIDS in Los Angeles County

Trends and Future Directions



Los Angeles County Department of Health Services

Office of AIDS Programs and Policy

FACSIMILE COVER LETTER

Date: July 13, 1998

Number of Pages: 24
(including cover page)

1313 North Vine Street
Los Angeles, CA 90028
(213) 993 -1600
Fax (213) 993 -1592

To: Todd Summers **Fax Number:** 202.456.2438

From: John D'Amico **Telephone:** 213.993.1628

Department:

Messages/Comments: Per our conversation. I'll call you on Wednesday. john

AIDS Project Los Angeles'
Public Policy Department continues to play a leadership role

Summer 1998: New Priorities for the 21st Century

APLA looks forward to a countywide care system with centralized and accessible core services.

APLA is working to ensure a comprehensive set of services for all people with HIV -- including those who are benefiting from medications and those whose medications are failing them.

To receive a copy of APLA's white paper entitled "AIDS Services in Los Angeles County, Planning for the 21st Century," please call (213) 993-1628.

AIDS services in Los Angeles County must evolve.

Current HIV services in Los Angeles are based on an outdated planning model developed in 1994. Accurate AIDS service data from the county are missing or unavailable.

By June 1999, it is estimated that there will be over 15,500 people living with AIDS in Los Angeles County.

The continuum of services needed by people with HIV disease is expanding.

Many people with HIV will continue to need traditional support services while the need for housing and employment services may increase.

Planning for AIDS services in the 21st century must include how all these services will be funded and by whom.

APLA's white paper will facilitate a dialogue to assist all stakeholders -- people with HIV, service providers, and Los Angeles County officials -- to plan for the 21st century.

AIDS PROJECT LOS ANGELES

(213) 993-1600 www.apla.org

AIDS Services in Los Angeles County
Planning for the 21st Century

The Next Steps

June 1998

APLA's Public Policy Department

The Next Steps

AIDS Services in Los Angeles County - *Planning for the 21st Century* identifies a set of concerns to initiate a dialogue about AIDS services in Los Angeles County in the 21st Century. The Los Angeles County Commission on HIV Health Services has the opportunity to implement reform measures, before priorities are set, that will insure that the planning process moves forward and that the most necessary and vital CARE Act services are continued, uninterrupted to people with HIV disease in Los Angeles County.

The next twelve to eighteen months are a critical time as the national AIDS Community begins the work necessary to reauthorize the CARE Act in the year 2000. This is a transitional time and requires creating an atmosphere where changes in services and service providers can be explored to insure the very highest level of care for all people with HIV. The responsibility of AIDS services providers and government is not simply providing and contracting for services, but to assist in the development and protection of a dynamic, (not a static), environment, an environment in which a comprehensive system of care for people with HIV can thrive.

The Los Angeles County Office of AIDS Programs and Policy (OAPP) has the opportunity to make a new start with new leadership. The OAPP must help assist the Los Angeles County Commission on HIV Health Services in setting this year's priorities by providing data and information which facilitates sound, rational decision making. Though there have been significant staffing changes at the OAPP it is critical that the Commission not be rushed through this priority setting process.

The recent State of California audit of the OAPP examines the County's management of the CARE Act services in the past. Criticisms including mismanagement of funds and poorly supervised contracts should be a major concern for the Commission and the County government alike. The audit should serve as a warning bell for the larger HIV community.

Why Now?

APLA's whitepaper has generated a great deal of interest among community members and government officials in Los Angeles and across the nation. Much of the discussion has centered around a single question: why has APLA released this white paper in the middle of the priority setting process and what does APLA hope to gain?

The answer is simple. Neither the Commission nor the County OAPP has set aside time for strategic critical analysis and strategic thinking about the changes in the AIDS epidemic over the past 18-24 months and their impact on client utilization of services funded by the CARE Act. Neither the County nor the Commission has produced a single document acknowledging the changes brought about by new therapies and subsequent decline in AIDS case and death rates. An evaluation of how these changes impact existing CARE Act services and priorities for the coming year is not only prudent, but necessary. (APLA does not maintain that services were

"perfectly" delivered prior to the introduction of new anti-viral combination therapies and that the AIDS service community could not improve our service delivery systems, pre-protease inhibitor. However, we fear that the Commission and the County has gotten mired in planning for the recent relatively minor demographic and other changes that occurred in 1997-1998 and missed the sea change.)

APLA, following a move made by the City of Los Angeles AIDS Coordinator, determined that the status quo needed to be challenged. In light of protease inhibitors, in light of (a then forthcoming) OAPP audit by the State, in light of a new permanent OAPP Director, in light of declining death rates and rising infection rates, and most importantly in light of the needs of people with AIDS, changes needed to be discussed, considered, and implemented.

The hard work of the Priorities and Planning Committee (PaPC) is appreciated and should not be ignored; much work was done to prepare the Commission for Year 9 priority setting. However, substantial amounts of vital information/data are missing. Proceeding with the planning process without doing some of this work will result in a set of priorities which are not responsive to the HIV epidemic in Los Angeles County.

Many have said at recent public and private meetings that each year during the Commission priority setting process two issues consistently emerge: a lack of planning for future services and lack of data to evaluate past and current services. Rather than address these two significant issues, a pattern has emerged to do nothing because it is "too late in the process to do anything about it". If true, it is troubling that these issues have gone unaddressed year after year. We can no longer allow planning for future services and evaluation of existing services to be left out of the process. The Commission bears the burden of acting responsibly when the County does not.

Unless the Commission and the Community wishes to lose its voice in the process, the priority setting process is the time and the Commission meetings are the place for the discussion of these issues. Community and government must "think outside the box" in order to facilitate a set of changes which are truly responsive to the epidemic and the needs of people with HIV in Los Angeles.

In late 1997, at a PaPC meeting, a request was made by APLA that the County propose a set of priorities based on its projections for service utilization, service costs and client needs to which the community could react. The County declined to provide such projections and choose instead to allow the Commission to move forward unaided.

Recommendations

The following are a set of tasks the County and the Commission on HIV Services should put in place before the Year 9 priorities are established to ensure that the priorities are appropriate and responsive. This list is not intended to be comprehensive, but rather, a starting point for meaningful discussion of tasks and responsibilities. This will also insure that the priorities for Year 10 will be considered and implemented in an environment which has considered all available

sources of information and expertise. Completion of these tasks will initiate a chain of events that necessitate appropriate changes resulting in a more complete system of care for people with HIV disease in Los Angeles County.

Tasks for the Los Angeles County OAPP

- The County must collect, evaluate and deliver requested data to the Commission so that decisions regarding prioritization of services can be made. The following data (at a minimum) should be delivered within 90 days.
  - Number of clients enrolled (registered) for each service by category by provider
  - Number of units of service each client has received by category (reimbursed and unreimbursed)
  - Definition of units of service by category
  - Cost or reimbursement per unit of service by category
  - County financial contribution at County facilities (both direct and indirect including administration)
  - County Maintenance of Effort amount as mandated by HRSA//Ryan White
  - Estimated service utilization increase by category over the next 18-24 months

- The County needs to establish an equitable reimbursement structure which pays agencies equally for the level of service provided. Clients must be able to choose their providers. Only by linking services with reimbursement will that be accomplished. A good start might be to follow-through on the now 18 month old promise of fee-for-service for medical providers. Simultaneously, the County must begin to look at fee-for-service reimbursement for case management, food, mental health, women's services, etc. A transitional period could be implemented whereby providers would be cost reimbursed but reports would be made to the community each month of services provided and fees "earned."

- The County must begin the discussion of quality and standardized outcome measures for all services provided. Once standards are developed the County must provide to the Commission and community interim reports every three months on agency performance and client utilization.

Tasks for the Los Angeles County Commission on HIV Health Services

- Commission must develop a "wish list" of necessary data it needs OAPP to collect to complete a future priority setting process.

- Commission should set priorities only after the County has provided existing data and developed outcome measures. The Commission should set a schedule to reevaluate priorities for Year 9 after six months, once the County has delivered the requested data and the Commission has had the chance to evaluate again how best to fund services categories.

- Commission needs to involve all stakeholders in the discussions during this crucial period.

Joint Tasks for the Los Angeles County Commission on HIV Health Services and the Los Angeles County OAPP

- The Commission and the County need to decide what services are part of a core set of affordable AIDS services.

- The Commission and the County must determine if there are enough funds to pay for such services. Establish a sound reimbursement mechanism and equitable reimbursement rate for services provided with CARE Act funds.

- The Commission and the County must commit to building an infrastructure, which will provide an equal level of these CARE services to each planning region of the County.

Conclusion

This is a difficult time for people with HIV, agencies and the County OAPP. Each has a set of concerns which need appropriate consideration and attention in order for us to work together in establishing priorities for CARE Act funds in Los Angeles. The recommendations outlined above are a starting point for the Commission and the County OAPP to facilitate the changes necessary to provide services for people with HIV in the 21st Century.

AIDS Services in Los Angeles County
Planning for the 21st Century

Spring 1998

APLA's Public Policy Department

April 23, 1998

An open letter to the HIV community:

It is my hope that the following white paper on AIDS services in LA County will facilitate a dialogue which will help people with HIV, service providers and the local health department in Los Angeles County to plan for AIDS services in the 21st Century.

We have all seen the miracles brought about by the introduction of new, highly effective HIV medications and therapies. However, many of our friends and loved ones have not been so fortunate and have been let down by these same medications. One result is that the continuum of services needed by people with HIV is expanding while resources are diminishing.

This is a difficult and exciting time for people with HIV/AIDS and service providers. As AIDS service organizations have in the past we must again rise to the challenge of developing a system of care that leaves none behind, treats all with dignity, and provides the best and most appropriate level of service for those we serve.

This white paper is a starting point, a first draft, based on the best information we could gather. Please take the time to read this document and forward to me your reactions, concerns, points of agreement and points of disagreement. And more importantly use your reactions to assist the Los Angeles County Commission on HIV Health Services and the County Government to make the necessary changes to move our community to the next level.

Sincerely,

James Loyce, Jr.
Chief Executive Officer

Acknowledgments

APLA gratefully acknowledges the assistance of all who contributed to the writing of this paper, including our community and government partners.

Introduction

This document is a starting point to consider policy options to improve AIDS services in Los Angeles County. It is not an endorsement of any one particular system or set of systems for delivering AIDS services. Rather, it identifies a set of essential questions, gaps, planning goals and strategies which may assist in starting a dialogue.

The AIDS service arena in Los Angeles County and across the country maintains a dynamism unseen in any other healthcare or social service arena. People with HIV/AIDS struggle to maintain contact with the leading edges of HIV services and medical science/healthcare provision. This struggle has left many feeling overwhelmed as they try to work with their doctors and service providers to plan for the future. Likewise, many government and community-based organizations are left with little direction as they plan for and establish funding priorities for available federal, state and local grants to provide client services to those impacted by HIV.

In 1996, news from the 11th International Conference on AIDS in Vancouver stunned the world with reports of dramatic decreases in viral load following triple drug therapy including protease inhibitors. More important, during the first nine months of 1996 there were 19% fewer AIDS-related deaths in the United States than in a comparable period in 1995. By year's end the figure was 23%. Subsequent studies demonstrate the trend is holding.

Yet, for those who have little or limited access to the new treatment options the news is less than dazzling. At an estimated $12,000 per annum for combination drug therapy, treatment strategies are not an option for a substantial portion of people living with HIV/AIDS throughout the country. We are fortunate that in California the AIDS Drug Assistance Program (ADAP) provides full coverage for those who are uninsured, underinsured and unable to pay.

Treatment options continue to expand with new information regarding "combination therapy", "salvage therapies" and "treatment failures." Although most everyone in Los Angeles County has "access" to medications and services many still feel disconnected to HIV/AIDS medical advances,

lacking understanding or choosing not to participate in care. The community must continue to encourage persons at risk to be tested and when appropriate engaged in early intervention and primary HIV health care.

In turn, the struggle of people with HIV/AIDS to stay alive and healthy parallels the labors of service providers. Many AIDS service providers are struggling to sustain the level of service expected by the increasing number of people seeking medical care and social services. It is no surprise that as some clients are feeling better they are asking for new levels of service. At the same time, many of the "traditional" AIDS services are still necessary to serve people who have not benefited (or benefited fully) from contemporary advances in HIV medical therapy.

The recent success of drug therapies moreover, has had a chilling effect on public policy. Many elected officials, and it would seem the public at large, are under the false impression that the epidemic is over. The extension of which seems to be that AIDS is a chronic manageable disease and, therefore, the need for public funding, private donations, and programs and services for people with HIV/AIDS is no longer urgent.

As AIDS becomes more of a chronic disease that can be managed by drug therapies, the mainstreaming of HIV related healthcare and services seems eminent. The "AIDS exceptionalism" argument has been used against the HIV community to promote the "excesses" of CARE Act funding and highlight the lack of services to other disease groups.

In Los Angeles County, federal, state, and local government funds spent on AIDS care number in the tens of millions. There are also generous private charitable donations deployed each year in the fight against HIV/AIDS. Continued funding for a full range of HIV medical and social services is critical. Planning for AIDS services in the next century must consider how services will be funded and by whom (e.g. charitable contributions and local, state and federal government).

Money and planning alone will not solve the problems of an incomplete AIDS care system. Political buy-in from local government as well as community organizations and people with HIV/AIDS is required. The work of the HIV services planning bodies in Los Angeles is merely the beginning. After that work is finished (or at least substantive in direction) new levels of work must be completed by the HIV community, bureaucracy and elected official alike.

At the request of Mark Finucane, Director of Los Angeles County Department of Health Services (DHS), UCLA's School of Public Health recently conducted a review of the County's public health functions. In

January 1998, Mr. Finucane presented the findings and recommendations of that report and discussed the implications for Los Angeles County. The report identifies the mission of public health as "fulfilling society's interest in assuring conditions in which people can be healthy." [1] "To achieve this mission locally," the report continues, "numerous governmental, business, and voluntary organizations must work hand-in-hand, each implementing a piece of the overall task."

This white paper examines, the role of all stakeholders-- government, businesses, non-profit organizations, volunteer organizations and most importantly people with HIV -- in securing "conditions in which people can be healthy" with regards to HIV/AIDS. Further, this paper is intended to be a catalyst to help the community to work to guarantee for itself, as it moves into the next century, that "quality health services [needed for the protection and promotion of the public's health] are available and accessible to all persons [impacted by HIV]."[2]

AIDS and the Public Health Mission

A comprehensive, coordinated system of healthcare services which addresses unserved and underserved populations and regions in Los Angeles County does not exist. Though the county is moving towards what may be a more comprehensive system of preventative and personal health services the transition has not yet happened[3] .

Year-to-year healthcare planning tends to shift services and funding dollars from one planning region to another, or one service category to another, depending on the most pressing needs of the moment. This is true also within the AIDS arena. A thorough analysis would likely help to reduce short-term political decisions and promote longer term coordinated policy that helps slow the epidemic.

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[1] Report of Review of Public Health Programs and Services, Los Angeles County Department of Health Services by UCLA School of Public Health Technical Assistance Group, July, 1997, page 21.
[2] Ibid., page 24.
[3] The UCLA School of Public Health Report investigates the successes and shortcomings of LA County's public health system. One glaring concern for HIV/AIDS populations is the exclusion of AIDS programs from the report and its attendant long term planning. Since its publication the Department of Health Services has moved Office of AIDS Programs and Policy back into Public Health. It is unclear what the impact will be on public health and HIV/AIDS services alike. It would seem prudent for the Department of Health Services to release an addendum to this report outlining how the Office of AIDS Programs and Policy will once again fit into Public Health programs.

Absent from the HIV services planning process is a comprehensive set of longer term policies and strategies which respond to the following:

1. the implementation of a set of sound, effective and responsible health policies that would make funding available for HIV programs and services at levels necessary to assure all people have access to culturally sensitive quality care and medical services, in all regions and affected populations, and

2. the creation of a comprehensive integrated plan that would employ to maximum use social resources -- political and economic, private and public -- in supporting policies and funding strategies that would make a difference in the lives of people living with HIV/AIDS.

The County of Los Angeles

Los Angeles County is the largest urban county in the United States. The County's population consists of diverse ethnic and racial groups with a total population of over nine million. For planning purposes the Los Angeles County Department of Health Services (LACDHS) divides the County into eight specific planning regions and twenty-five health districts. The regions do not correspond to the five Supervisorial districts.

According to state law Los Angeles County is the mandated healthcare provider of last resort. This includes identifying and treating all communicable diseases such as TB, HIV and other STDs. In effect this means that the County is ultimately responsible for providing medical care to all indigent HIV positive persons in Los Angeles County.

LACDHS is currently in the middle of a multi-year, multi-million dollar restructuring of its public health programs. The main focus being a switch from hospital-based inpatient care to preventative outpatient-centered care. The 1115 waiver from the federal government helped to bail the county out of a major fiscal and healthcare crisis. This has resulted in the development of the public-private partnerships linking community and for-profit healthcare providers with county clinics and hospitals. Such partnerships are seemingly the perfect environment for HIV/AIDS outpatient care pilot programs and clinics to be established. Unfortunately, no such case study projects have been developed.

Additionally, the County government has begun to move MediCal populations into managed care systems. In Los Angeles County, this has meant that welfare and Temporary Assistance for Needy Families (TANF) populations have been required to choose from among two managed care providers, LA Care and Foundation Health. Persons with HIV have the ability to "opt out" of the two plan system though this is a complicated process and it has been reported that more than a few have fallen through the cracks.

The Los Angeles County Office of AIDS Programs and Policy (OAPP), a part of the LACDHS, is responsible for administering the federal Ryan White CARE Act program dollars and the additional general fund dollars the County contributes to HIV/AIDS care. The OAPP has experienced a series of difficult staffing situations since late in 1995. Though many at OAPP have worked very hard during this period the lack of consistent direction and a significant drop in full-time staff has left many OAPP departments gutted and without clear leadership, a critical gap in the age of protease inhibitors. The County has taken steps to correct this situation and in time may reach previous staffing levels.

The County government is required by the Ryan White CARE Act to establish a body, which represents the local HIV community, to set priorities for the allocation of all Title I and Title II Ryan White funding. This body is called the Los Angeles County Commission on HIV Health Services. Comprised of 49 members (plus 14 alternates), the Commission is required to reflect the AIDS epidemic in the local community. As mentioned, the Commission sets funding priorities, assumes responsibility for setting the standard of care for services to people with HIV/AIDS and evaluating the effectiveness of contracted interventions.

HIV/AIDS Data

In 1993, the Centers for Disease Control and Prevention (CDC) expanded the 1987 definition of AIDS to include persons with CD4+ t-Lymphocyte counts of fewer than 200 t-cells (14%), or one of three opportunistic diseases.[4] Many organizations and government institutions continue to use this case definition as a threshold for services and benefits. In the age of effective treatment for people with HIV the distinctions between HIV positive, HIV symptomatic and AIDS have become more fluid.

According to the Los Angeles County HIV Epidemiology program the HIV epidemic in Los Angeles County peaked by 1983 and the AIDS epidemic peaked about 9 years later in 1992. AIDS diagnosis rates declined dramatically from a high of 4,188 in 1992 to an estimated 2,463 in 1997. Death rates have dropped from 3,713 in 1991 to an estimated 1,057 in 1997. Currently, in Los Angeles County there are over 13,000 confirmed living AIDS cases with an additional 30,000 to 40,000 (estimated) people living with HIV.

Since 1996, AIDS incidence and mortality have decreased annually in the United States. This decrease reflects the impact of efficacious risk reduction efforts and the introduction of successful anti-HIV drug therapies. Fortunately, these trends are expected to continue for the near future.

Since the beginning of the epidemic the total number of people living with HIV has expanded each year. It is estimated that approximately 1,400 to 2,000 new infections are added annually to the number of persons living with HIV in Los Angeles County.[5] The recent reduction in AIDS deaths and the addition of new infections will mean that the number of people living

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[4] Los Angeles County Department of Health Services, HIV Epidemiology Program, LAC Cases Report. December, 31, 1995, Appendix 1, page 22.

[5] From a conversation with Walt Senterfitt, Epidemiologist, HIV Epidemiology Program re: New infections in Los Angeles County, April 15, 1998.

with HIV will continue to expand and the number of people with AIDS will grow by about 1,200 per year (estimated). In December, 1995 there were 10,716 people living with AIDS in Los Angeles County[6]. By June, 1999 there will be an estimated 15,533 people living with AIDS in the County.[7]

Table 1 below outlines the planning regions with the living and recently diagnosed cases of AIDS as of December 31, 1997[8]. The fourth planning region (Metro LA) has the highest number of living and recently diagnosed AIDS cases. The South Bay is second followed closely by the San Fernando Valley.

Table 1
Geographic Distribution of Living and Recent AIDS Cases

	Total Population	Living* AIDS Cases	Percent of AIDS Population	Recent** AIDS Cases	Percent of AIDS Population
One: Antelope Valley	282,439	142	1.08%	52	1.44%
Two: San Fernando Valley	1,860,233	1,718	13.10%	452	12.60%
Three: San Gabriel Valley	1,774,868	877	6.66%	243	6.74%
Four: Metro LA	1,280,630	5,080	38.73%	1,270	35.24%
Five: West Los Angeles	612,946	745	6.14%	164	4.55%
Six: South Los Angeles	989,088	1,175	9.29%	360	9.99%
Seven: East Los Angeles	1,266,128	783	6.13%	250	6.94%
Eight : South Bay	1,515,367	1,949	15.65%	545	15.12%
Other/Unknown		648	4.95%	266	7.38%
Total	9,581,699	13,116	100%	3,604	100%

* Reflects total Living AIDS cases by Race/Ethnicity
** Reflects total Recent AIDS Cases by Race/Ethnicity

The community has not had access to aggregate data regarding numbers of clients in services or service utilization data. Of the 13,116 people with AIDS and estimated 30,000 to 40,000 people with HIV in Los Angeles County there is no reliable number documenting how many are in medical care and other AIDS services. There are no reliable data documenting how many clients are in services paid for with Ryan White CARE Act dollars.

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[6] Los Angeles County Department of Health Services, HIV Epidemiology Program, LAC Cases Report. December, 31, 1995

[7] AIDS Project Los Angeles. (1998). "Direction of AIDS cases in Los Angeles County, 1987-1997 and APLA client population projections, 1998-1999" (Research report). Los Angeles, CA: prepared by Ronald Brooks.

[8] Geographic Distribution of AIDS Cases by Service Planning Region, CARE Act Title I/Title II Year 09 Priority Setting Manual, April, 1998, page 3.2.2

There are no data documenting how many clients are served at each agency, including level of client duplication. There are no data documenting what percentage of people with HIV from each health planning region are in services.

Federal, State and Local Funding Sources

According to *The CARE Act Title I/Title II Year 9 Priority Setting Manual*[9] distributed at the April, 1998 Commission meeting there are at least nine distinct funding streams that contribute to approximately $95 million in funding for AIDS services in Los Angeles County[10]. The table below outlines how much government money Los Angeles County receives through each funding stream. Additional information is available from the OAPP and the Commission on HIV Health Services which more carefully annotates which funding streams fund which services.

There are, however, large gaps in this information, given that a complete total of the costs involved in providing care at County outpatient and inpatient facilities has never been fully documented. The County required maintenance of effort contribution is currently not accounted for nor has the total cost of providing services to clients who also have MediCal been tallied.

Table 2
Sources of Funding
(total in millions)

	Title I	Title II	Title III	Title IV	Title V	State	MediCal	HOPWA	NCC
Federal	27.7	2.1	2.7	.46	3.0	-	?	5.7	-
State	-	-	-	-	-	46	?	-	-
Local	-	-	-	-	-	-	-	-	7.1 ?

Services and Servers

According to the OAPP, there are over 100 different community based organizations providing 30 separate Ryan White CARE Act funded services to people living with HIV/AIDS in Los Angeles County. Some additional

[9] Sources of Funding , The CARE Act Title I/Title II Year 09 Priority Setting Manual, April, 1998, page 3.3.2

[10] Table #1, Sources of Funding, page 3.3.2 reports a total of $95,184,601 and Table #3 Funding Allocations by Service Planning Region, page 3.5.2 reports a total of $98,937,741. The County regularly over allocates funds to account for fiscal year under spending by contractors.

services are provided without funding administered by OAPP. This patchwork of agencies includes large and small budgeted agencies, some which target specific populations or geographic regions and agencies with gender specific target groups and programs, among others.

The short and long term success of these agencies was once determined by the desire and need demonstrated by the community requesting services. Now, there are funding and competing interest concerns as well as political influence all weighing heavily on decisions which affect the distribution of HIV service resources.

Planning A Service Network

Currently, the priority setting process for the development and delivery of CARE Act funded AIDS services is conducted by the Los Angeles County Commission on HIV Health Services. Outreach to the HIV-infected community is used to assess service needs and concerns. Surprisingly absent from many recent priority setting discussions are longer term policy and planning strategies, and research into trends, outcome effectiveness evaluations and service delivery system coordination studies.

Such planning is difficult for a statutorily comprised "volunteer" organization such as the Los Angeles County Commission on HIV Health Services. Likewise, the OAPP has chosen not to propose a formal service network or system of care in order to allow the Commission (and by extension the HIV community) to set priorities. These absent planning events have left large gaps in the thoroughness of care, and in the equal distribution of services by target population and geographic region. At one time in the HIV epidemic such ad hoc planning may have been appropriate: targeting emergency services to clients in emergency situations. This is no longer an acceptable way to plan for HIV services in Los Angeles County.

Strategic planning has not driven the development of the matrix of HIV-related services. It has developed in large part by circumstance and chance. Funding decisions have been driven by activist pressures, political will, agency advocacy, and government directives limiting and defining services. Client need is an important part of the priority setting process, yet absent a meaningful planning structure, often remains secondary to the needs of individual constituents, elected officials and agencies.

This has left the Los Angeles County HIV/AIDS services community in a difficult position. With dwindling resources and rising numbers of people with HIV/AIDS needing care and treatment, many agencies are now in positions of financial difficulty with rising case loads. Throughout there has

been and remains a reluctance on behalf of some providers to collaborate on effective ways to mitigate service gaps and financial pressures.

Targeting Funds

A review of The *CARE Act Title I/Title II Year 9 Priority Setting Manual*[11] identifies many disparities in the assigning of funds to address the needs of people with HIV/AIDS in Los Angeles County. This is not a complete list. Rather this is the result of minimal investigation of available data distributed to the public. Listed below are examples of what has happened in a climate with little or no coordinated planning:

- When comparing funding allocations by region for medical and social services with the number of living cases of AIDS some great disparities are apparent. As the table 3 below shows Region Two receives only $2,395 per AIDS case while Region Five receives $4,107 per AIDS case. Region Six receives $5,260 per AIDS case, more than double the allocation given to region Two. The differences are perhaps warranted, but require some explanation as strategic planning looks to create systematic network of HIV/AIDS care and treatment.

- Among the eight planning districts, no two districts have the same set of services available to clients. Some planning regions provide as many as 18 services (Region Eight) while others have as few as 6 services (Region One). It is unclear how people with AIDS accommodate such disparity especially given that transportation dollars seem not to be equally distributed across regions.

[11] Funding Allocations by Service Planning Region and Distribution of Funds among Services within Service Planning Regions, The CARE Act Title I/Title II Year 09 Priority Setting Manual, April, 1998, page 3.5.1 to 3.7.2

Table 3
Average Dollars Per AIDS Case Based on Regional Distribution of Public Funds

Region	Living AIDS Cases through 12/97	Living AIDS Cases	Geographic Funding	Geographic Funds (not including **Countywide funds)	Average dollars per AIDS Case
One: Antelope Valley	1.08%	142	1.48%	$560,493	$3,947
Two: San Fernando Valley	13.10%	1,718	10.84%	$4,113,811	$2,395
Three: San Gabriel Valley	6.66%	874	6.57%	$2,494,554	$2,854
Four: Metro LA	38.73%	5,020	33.83%	$12,836,885	$2,557
Five: W LA	5.68%	745	8.06%	$3,059,669	$4,107
Six: S LA	8.96%	1,175	16.29%	$6,180,825	$5,260
Seven: E LA	5.97%	783	7.39%	$2,803,941	$3,581
Eight: South Bay	14.86%	1,949	15.53%	$5,891,864	$3,023
Unknown*	4.95%	649	-	-	-
	-	-	-	-	-
Regional Services	-	-	-	$37,942,043	-
Countywide Services**	-	-	-	$60,995,698	-
Total***	100.00 %	13,115	100.00%	$98,937,741	-

* Reflects cases which have not been distributed or where a residence within the county cannot be identified.

** Funds spent on countywide services including ADAP, Home Health, HOPWA, Special Needs, Training and Transportation. Including a percentage of Case Management, Community Consortium, Family and Child Support, Food, Legal, Mental Health, Substance Abuse and Treatment Advocacy

*** Total dollars does not include Medicaid/MediCal, AIDS waiver dollars, Home Health Medicaid waiver, County NCC in County clinics.

- Distribution of dollars and available services within regions differs as well. Table 4 below highlights the differences seen in regions two, six and eight.

Table 4
Services Distribution in Region 2, Region 6 and Region 8

	Region 2	Region 6	Region 8	County Average
Number of Services	15	13	18	12.6
Dollars Spent Per Region	4,113,811	6,180,825	5,891,864	4,742,755
Dollars Spent Per AIDS Case	2,395	5,260	3,023	2,902
Number of Living AIDS Cases	1,718	1,175	1,949	

- The County, as the California state mandated healthcare provider of last resort, has never identified the cost of providing outpatient medical services in its clinics. The OAPP allocates a substantial amount of CARE Act dollars each year to supplement County-run outpatient medical care clinics. Every dollar used for County outpatient medical care is one dollar less that the County has to spend from its own coffers and one dollar less that the Commission could have available to prioritize to non-County AIDS services. Why does the Commission choose to allow the County/OAPP to spend CARE Act dollars on County operated clinics?

- At the same time, the County is required to contribute to a maintenance of effort (MOE) to receive CARE Act dollars. And the CARE Act requires that all funds be used to supplement the local government's costs for delivering AIDS services, not to be used as a primary funding source. The County has access to many other funding streams and has used AIDS case data to justify the need in applying for such funds (i.e. 1115 waiver, disproportionate share dollars, MediCal waivers). The MOE amount has never been critically examined. It is time for the County to provide clear information on how much money is spent from which funding streams (including the MOE) on HIV/AIDS services.

Other funding concerns which do not bare themselves during the current priority setting process are the relative funding levels as compared to the numbers of cases within a given target population. Listed below are a few examples which highlight those concerns:

- The CARE Act mandates that a percentage of dollars equal to the number of cases of women be spent on women specific programs. Los Angeles County OAPP assures the Commission that they have met and exceeded funding level requirements for such programs. The County has never specifically identified which funds are used to satisfy these requirements. Instead the County identifies a set of women specific services and an estimate of the amount spent on women in outpatient medical care.

- Title IV of the CARE Act provides dollars for women and children infected and affected by HIV, funds over which the Commission does not have purview. The Commission has also provided additional moneys from Title I allocations to assist in providing these services. In Los Angeles County, during 1997, there were four new pediatric AIDS cases and of 48 children born to infected mothers one confirmed case of maternal-child HIV infection has been documented. Doctor Toni Frederics of Los Angeles County Epidemiology, reports that there are 51 living AIDS cases in persons under the age of 13 and 20 cases in

persons between the ages of 13 and 18.[12] There are an additional 421 identified persons with HIV under the age of 18 in the County.[13]

- In the substance abuse category, the LAC HIV Epidemiology Program Advanced HIV Disease (AIDS) Surveillance Summary reports the cumulative number of injection drug use cases to be over 2,500 or 7% of the total. And male-male sexual contact/IDU cases accounts for an additional 2,376 cases or 6% of the total. Drug use related AIDS cases accounts for over 13% of the cumulative AIDS cases in Los Angeles County. Recent drug related AIDS case rates in the African American populations are even higher. Meanwhile, funding for substance abuse programs from the Los Angeles County Alcohol and Drug system lags. Yet, Los Angeles County, with fewer drug related cases than the national average, spends more CARE Act money on substance abuse services than other Title I EMAs[14].

The need for a County-wide strategic plan to establish a comprehensive coordinated system of care has never been greater. Such assertions do not come without costs. Agencies across the County, as well as the OAPP, must review how services are provided and to whom and with what resources. Once done, agencies and providers will likely agree that the status quo, though easier to implement, is no solution to not having a comprehensive service network.

[12] From a conversation with Doctor Toni Frederics, Los Angeles County Pediatric HIV Surveillance and Epidemiology Program re: Adolescent infections in Los Angeles County as of April 15, 1998.
[13] LA County Pediatric Infection, Monthly Surveillance Report, December 31, 1997, page 3.
[14] Comparison of Year 08 Priorities to National Priorities, The CARE Act Title I/Title II Year 09 Priority Setting Manual, April, 1998, page 2.4.1.

Future Trends

Los Angeles County HIV service providers are not prepared to accommodate significant changes in the service matrix warranted in the coming months. Clients, agencies, government funders and regulatory agencies all acknowledge the need for a change in HIV services. It remains unclear which facets of service delivery demand initial modification. The merit of unilateral modifications and the potential impact on the service needs of specific populations remain unexplored.

The following is a set of recommendations which may assist in the priority setting process for client services across categories including geography, ethnicity, gender, race and risk factor.

- **Regionalization of Core Services** As core services become more available generally across districts, clients would be encouraged to use services and providers near their home. To accomplish this goal, the County would need to expand the matrix of services to meet client needs by region, Agencies would determine geographic boundaries and be compensated for serving clients who come from agreed upon areas. The current food distribution system is an example of this model. One likely outcome of this may mean that transportation costs will be reduced while some other costs may increase.

- **One Stop Shopping** The potential benefits of the "one stop shopping" service provision model have been identified by clients and providers from across the County as a preferred method of service delivery. When "one stop shopping" is available, clients tend to have more of their needs met on a consistent basis, reducing the likelihood that a need or set of needs will remain unattended.

- **Centralized Services** Geographic centralization of services (e.g., East Los Angeles, Lancaster, Long Beach) permits clients to travel from agency to agency for a separate service with limited difficulty. A critical mass of services for a defined regional population reduces duplication of services and facilitates coordination of transportation and care. This model is already in place within some regions which have a collection of services available to user populations.

- **Treatment and Medication Failures** For many agencies client case loads are beginning to break into two; those clients who respond to HIV medications and those clients whose medications fail them. Clients, AIDS service agencies, and the County need to consider how to deliver

categorized services to two distinct populations, based on acuity. The allocation of funds to case management, mental health, transportation, etc. should consider how services might be delivered to members of these two client populations. Additionally, as categories and services change to reflect the needs of clients who are feeling better, or never felt badly, long term utilization trends must be examined and forecast. For example housing, employment services and food use needs may be expanding while case management, transportation, hospice and home health care needs may be diminishing.

Strategies

Strategies for investigating these recommendations must include the following collaborative efforts and implementation activities. Currently, the planning process lacks some key activities and components. Listed below (in alphabetical order) are some examples:

- **Better Collaboration** New levels of collaborative effort on the part of community providers among themselves is essential. Additionally, Los Angeles City and County governments must provide the opportunity for community organizations who wish to accommodate changes in the epidemic through amendment of service provision contracts and/or new RFPs for new services.

- **Better Data** More complete sets of data from the Office of AIDS Programs and Policy. Such data would include agency caseloads and costs of service delivery, costs of providing care at county medical facilities, etc. It is important that the community more fully understand the cost of delivering service based on individual agency experience.

- **Better Surveillance** Increased levels of HIV surveillance to track and plan for trends in HIV infections and levels of services are needed.

- **Fee-For-Service** The County never managed to implement the proposed fee-for-service model for outpatient medical care. A fee-for-service billing structure for case management, mental health, food, substance abuse as well as outpatient medical care would immediately eliminate client duplication and help to further identify infrastructure deficits. It would seem the current cost reimbursement method is least effective in managing the quality and amount of services delivered.

- **Flexibility** The Los Angeles County community of HIV/AIDS care providers has no clear direction for addressing the changes in the HIV/AIDS epidemic. The County Office of AIDS Programs and Policy could assist in this effort by adopting more flexible standards for developing service delivery systems, more frequent review of the services provided and opportunities for agencies to assess (mid-contract) service delivery.

- **Program Evaluation** Program and contract evaluation remain critically absent from day to day, year to year service delivery systems. Better program evaluation will help correct any disparities in service delivery, service delivery costs and program administration costs. The critical absence of such evaluation may be the single greatest disincentive and damper for effective countywide program planning.

- **Standards of Care** The standards of Care Committee of the Commission recently approved a set of standards for HIV testing, care and treatment. The Commission should consider how to best provide dollars for the provision of services at the levels outlined. If funding is not available for service delivery that meets the minimum standards, then the County and consumers must determine acceptable standards and to what level the County is willing to fund such services. It is assumed that no client currently in service receives substandard care in any funded programs or facilities. However, numerous gaps in services (see table 4) across the county may result in de facto substandard care.

- **Uniform Definition of A Client** The OAPP has begun to tighten the definition of what constitutes a client for reporting and funding purposes for case management services. A comprehensive definition of who qualifies to receive services funded by the Ryan White CARE Act is necessary in order to realize a comprehensive set of standardized services.

Conclusion

The Ryan White CARE Act was created to assist large metropolitan areas in fighting the emergency that is AIDS at a time when there was little sympathy for the needs of people with AIDS and few resources. The services network in Los Angeles that has emerged from those initial days to our current system has assisted many thousands of people with HIV/AIDS to live longer, healthier lives and to die with dignity.