

Mayor Edward Koch Papers

Selected Documents Volume I: AIDS

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In Cooperation with The New York City Department of Records and Information Services/Municipal Archives, Brian G. Andersson, Commissioner

Introduction by Mayor Edward I. Koch December 12, 2007

Although recent evidence has documented the presence of the human immunodeficiency virus in the United States for close to forty years, 1981 is the date we accept as the beginning of the AIDS epidemic. Twenty six years ago, for the vast majority being given that diagnosis was the equivalent of a death sentence following a short debilitating, incapacitating illness.

The mere mention of the disease spread terror, not only in the groups that were its prime victims – first, homosexuals and then needle-using drug users – but also in the general population unsure of how the disease was spread. In a way, its effect on the public psyche with respect to contagion could be compared to that of leprosy of yesteryear, an uncontrolled irrational fear. Today, those with HIV or AIDS need not, and many will not, panic. During the past quarter of a century, drugs have been discovered that have converted the disease from terminal to chronic. With treatment, patients' lives are similar to those with many other illnesses that require continuing medical attention.

For many years testing for HIV/AIDS has required the written permission of the patient. Two salient reasons for this policy were the fact that there was little or no treatment available and as a result of the lack of information and abundant misinformation surrounding the diagnosis, prognosis and communicability of the disease there was a profound negative reaction on the part of most people towards those suspected of having the disease. Today meaningful treatment is available and, in the main, the irrational stigma associated with the diagnosis has been significantly reduced. Therefore, it is reasonable to review and perhaps revise this policy. A more rational formulation is "Can the simple oral assent of the patient be sufficient for testing for HIV/AIDS?" Many believe that neither written nor oral consent should be required since testing ordered by a physician for a host of diseases – using blood or other tests – does not require the patient's permission. Although there are of course still major privacy concerns, I believe allowing the patient's physician to decide on testing for HIV/AIDS is the appropriate response, if confidentiality can be assured.

One of the greatest successes of my administration with respect to government protection of the rights of those having the condition HIV/AIDS occurred when the City of New York in a proactive way maintained in a lawsuit that elementary school children with the condition or disease had a right to attend public school. We won that case in a courtroom in Queens County, in a case tried personally by the then Corporation Counsel, Fritz Schwarz, where a local school board had barred a student who had been diagnosed with HIV/AIDS.

The City of New York was fortunate in those early dark days to have as our Commissioner of Health Dr. David Sencer, succeeded by Dr. Stephen Joseph. We were fortunate throughout the 12 years to have as Corporation Counsel Allen Schwartz, Fritz Schwarz and Peter Zimroth. Public service, then and now, is the noblest of professions, when done honestly and done well. All of these public servants performed superbly.

RARE CANCER SEEN IN 41 HOMOSEXUALS

Outbreak Occurs Among Men in New York and California —8 Died Inside 2 Years

By LAWRENCE K. ALTMAN

Doctors in New York and California have diagnosed among homosexual men 41 cases of a rare and often rapidly fatal form of cancer. Eight of the victims died less than 24 months after the diagnosis was made.

The cause of the outbreak is unknown, The cause of the outbreak is unknown, and there is as yet no evidence of contagion. But the doctors who have made the diagnoses, mostly in New York City and the San Francisco Bay area, are alerting other physicians who treat large numbers of homosexual men to the problem in an effort to help identify more cases and to reduce the delay in offering chemotherapy treatment.

The sudden appearance of the cancer.

The sudden appearance of the cancer, called Kaposi's Sarcoma, has prompted a medical investigation that experts say could have as much scientific as public health importance because of what it may teach about determining the causes of more common types of cancer.

First Appears in Spots

Doctors have been taught in the past that the cancer usually appeared first in spots on the legs and that the disease took a slow course of up to 10 years. But these recent cases have shown that it appears in one or more violet colored spots. these recent cases have shown that it appears in one or more violet-colored spots anywhere on the body. The spots generally do not itch or cause other symptoms, often can be mistaken for bruises, sometimes appear as lumps and can turn brown after a period of time. The cancer often causes swollen lymph glands, and then kills by spreading throughout the body.

Doctors investigating the outbreak believe that many cases have gone undetected because of the rarity of the condition and the difficulty even dermatologists may have in diagnosing it.

condition and the difficulty even dermatologists may have in diagnosing it.

In a letter alerting other physicians to the problem, Dr. Alvin E. Friedman-Kien of New York University Medical Center, one of the investigators, described the appearance of the outbreak as "rather devastating."

Dr. Friedman-Kien said in an interview vesterday that he knew of 41 cases

Dr. Friedman-Kien said in an interview yesterday that he knew of 41 cases collated in the last five weeks, with the cases themselves dating to the past 30 months. The Federal Centers for Disease Control in Atlanta is expected to publish the first description of the outbreak in its weekly report today, according to a spokesman, Dr. James Curran. The report notes 26 of the cases — 20 in New York and six in California.

New York and six in California.

There is no national registry of cancer victims, but the nationwide incidence of

Kaposi's Sarcoma in the past had been estimated by the Centers for Disease Control to be less than six-one-hundredths of a case per 100,000 people annually, or about two cases in every three million people. However, the disease accounts for up to 9 percent of all cancers in a belt across equatorial Africa, where it commonly affects children and young adults.

In the United States, it has primarily affected men older than 50 years. But in the recent cases, doctors at nine medical centers in New York and seven hospitals in California have been diagnosing the condition among younger men, all of whom said in the course of standard diagnostic interviews that they were homosexual. Although the ages of the patients have ranged from 26 to 51 years, many have been under 40, with the mean at 39.

Nine of the 41 cases known to Dr. Friedman-Kien were diagnosed in California, and several of those victims reported that they had been in New York in the period preceding the diagnosis. Dr. Friedman-Kien said that his colleagues were checking on reports of two victims diagnosed in Copenhagen, one of whom had visited New York.

Viral Infections Indicated

No one medical investigator has yet interviewed all the victims, Dr. Curran said. According to Dr. Friedman-Kien, the reporting doctors said that most cases had involved homosexual men who have had multiple and frequent sexual encounters with different partners, as many as 10 sexual encounters each night up to four times a week.

Many of the patients have also been treated for viral infections such as herpes, cytomegalovirus and hepatitis B as well as parasitic infections such as amebiasis and giardiasis. Many patients also reported that they had used drugs such as amyl nitrite and LSD to heighten sexual pleasure

heighten sexual pleasure.

Cancer is not believed to be contagious, but conditions that might precipitate it, such as particular viruses or environmental factors, might account for an outbreak among a single group.

The medical investigators say some indirect evidence actually points away from contagion as a cause. None of the patients knew each other, although the theoretical possibility that some may have had sexual contact with a person with Kaposi's Sarcoma at some point in the past could not be excluded, Dr. Friedman-Kiensaid.

Dr. Curran said there was no apparent danger to nonhomosexuals from contagion. "The best evidence against contagion," he said, "is that no cases have been reported to date outside the homosexual community or in women."

homosexual community or in women."
Dr. Friedman-Kien said he had tested nine of the victims and found severe defects in their immunological systems. The patients had serious malfunctions of two types of cells called T and B cell lymphocytes, which have important roles in fighting infections and cancer.

But Dr. Friedman-Kien emphasized that the researchers did not know whether the immunological defects were the underlying problem or had de-

veloped secondarily to the infections or drug use.

The research team is testing various hypotheses, one of which is a possible link between past infection with cytomegalovirus and development of Kaposi's Sarcoma.

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THE CITY OF NEW YORK COMMISSIONER OF HEALTH David J. Sencer, M.D., M.P.H.



125 WORTH STREET NEW YORK, N.Y. 10013

February 3, 1982

TO: Hon. Nathan Leventhal, Deputy Mayor for Operations

FROM: David J. Sencer, M.D., Commissioner

SUBJECT: Report on Agency Activities: January 1982

i. DISEASE TRENDS

- 1. A hospital outbreak of hepatitis was investigated by the Health Department in cooperation with the Health & Hospital Corporation and the Centers for Disease Control. The outbreak was principally confined to the staff on one ward at Elmhurst Hospital. Adequate prophylaxis with gamma globulin and isolation procedures at the hospital appeared to have limited the outbreak.
- 2. Resistant strains of gonorrhea continue to assume greater importance in VD control activities. During the month of January over 120 cultures were positive for resistant organisms compared with 14 in a similar period of time last year. Intensive contact follow-up and treatment is underway in an attempt to limit spread.
- 3. The first case of botulism ever described as a result of infection following self injection by a drug user was diagnosed at New York Hospital. Laboratory confirmation was provided by the City's Bureau of Laboratory services.
- 4. A major investigation of lymph node enlargement thought to be due or to be a precursor of Kaposi's Syndrome is being launched by the Department of Health in collaboration with the Centers for Disease Control. This Syndrome (a previously rare malignant neoplasm) is assuming greater significance as investigations continue indicating that over 225 cases have been diagnosed in the United States, over half of which have occurred in New York City, principally occurring in homosexual males.
- 5. Another joint investigation by the Department of Health and the Centers for Disease Control is being instituted to determine pattern of spread, if any, of hepatitis among non-institutionalized mentally retarded individuals. The outcome of this study, which will take several months, will give indications for immunization policies for the nation.

Nathan Leventhal

11. MANAGEMENT ISSUES

- 1. The final transfer of the Methadone Maintenance Treatment Programs to the State was accomplished six months ahead of schedule.
- A new contract to provide health service to inmates in correctional institutions on Rikers Island was negotiated with Monteflore Hospital and approved by the Board of Estimate.

III. LEGAL ISSUES

- Activities related to regulations of mobile food vendors continue to be highly visible and time consuming. Demonstrations have been held at 125 Worth Street as well as City Hall protesting regulations which will bring vendors who process food in mobile equipment under the same degreee of control as a restaurant.
- The Department of Health will testify before Congressman Waxman and Scheuer on influenza immunization. The Department of Health will be supporting the concept that influenza immunization should be a reimbursable service under Medicare Part B.

cc: Hon. Edward I. Koch Hon. Robert F. Wagner, Jr.

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THE CITY OF NEW YORK
COMMISSIONER OF HEALTH
David J. Sencer, M.D., M.P.H.



125 WORTH STREET NEW YORK, N.Y. 10013

April 20, 1982,

TO: Hon. Nathan Leventhal, Deputy Mayor for Operations

FROM: David J. Sencer, M.D.; Commissioner

SUBJECT: Report on Agency Activities - March - April, 1982

HEALTH ISSUES

- The first meeting of investigators of Kaposi's sarcoma and other infections in New York City was held at the Health Department to discuss collaborative efforts. This group of diseases is reaching serious proportions in the homosexual male population, there are now over 125 cases. The fatality rate is 40%. The first meeting that was held was an unqualified success, in that it brought together all of the investigators in greater New York who are working on this problem. In the past they have been unwilling to discuss with each their research approaches but as a result of this meeting conversations are beginning and considerations of using common protocols' and reporting forms are underway. The Health Department will take primary., responsibility for gathering the epidemiologic information which will form the basis the work of other investigators. The Health Department will also act as a convener of meetings and disseminator of information both within in New York and also in collaboration with the United States Public Health Service. This to me is a unique role that the Health Department can provide with no budgetary impact upon our operations.
- The studies in collaboration with the Board of Education and Hepatitis B
 are proceeding with excellent cooperation from parent-teacher and Board of
 Education groups. The study should be completed on schedule in spite of
 minor road blocks that have come and gone.
- 3. Attached is a copy of testimony that was presented to the Environmental Protection Agency in Washington opposing their lifting the limits on tetraethyl lead in gasoline. The important point to be gained from this is the fact that we still, in spite of the work that has gone on for over ten years have over 1,200 cases of lead poisoning in children in New York that were identified through our screening programs last year. Unfortunately I can see no alternative other than continuing the screening activities since the cost of completely renovating the housing situation in the City would be astronomical.

4. An ad hoc working group of specialists in nuclear medicine and radiation protection is being brought together to begin to deal with the problem of disposal of very low level of radiation wastes such as those used in laboratory determinations in hospitals. As in so many of our environmental concerns the overlapping and intertwining of agencies makes it difficult to assign real responsibility for problems such as this. We will be involving the appropriate City agencies as well as the federal government in this effort.

Now that we have a Board of Health we plan to as a matter of policy askindividual members of the Board to sit on various groups such as this, hoping to involve them in substantive issues rather than merely in the formation and utilization of the health code.

5. The results of the program undertaken to control PPNG are mildly encouraging. The most recent summation of screening results is attached.

OTHER ISSUES

- A complete draft revision of day care facility regulations has been developed and after assuring that all of the parties within the Department of Health are in concurrence discussions with other interested groups, particularly your office will take place.
- 2. The absence of the Board of Health has delayed adoption of new day camp regulations which would put us in compliance with State regulations has been delayed but, we believe we will be able to meet the summer camping deadline by asking for comments on the regulations prior to the Board of Health meeting so that when the Board meets, comments will have been received and promulgation of the regulations can take place.

cc: Hon. Edward !. Koch Hon. Robert F. Wagner, Jr. Attachments: Volume 2, No. 11

March 16, 1983

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS): UPDATE

The New York City Department of Healt. continues to receive an average of one to two new report reports per day of Acquired Syndrome (AIDS). The total number of cases reported in New York City through March 9, 1983 is 585; this is 45 percent of the total reported cases in the nation (see Table 1). Kaposi's sarcoma (KS) continues to be diagnosed predominantly in homosexual or bisexual males. In heterosexuals, Pneumocystis pneumonia (PCP) and other serious carinii opportunistic infections (OI) account for more than 90 percent of the diagnoses. In addition to PCP, other opportunistic pathogens include cytomegalovirus (n=37), herpes simplex causing persistent ulcerative lesions (n=30), cryptococcus (n=36), toxoplasma affecting the central nervous system (n=21), cryptosporidium (n=20), and mycobacterium avium-intracellulare (n=26). Two cases of progressive multifocal leukoencephalopathy have been reported.

Table 2 is a breakdown of cases by mutually exclusive risk groups. No hemophiliac case has been reported to the Department of Health. New York City has a somewhat higher proportion (21 percent) of cases occurring in IV drug users than the nation as a whole (14 / names)

the nation as a whole (14.4 percent).

Included in the category "other" are cases who died prior to interview and whose risk factor status thus remains unknown. Seven women in this category have a history of sexual contact with a male member of an "at risk" group (IV drug user, bisexual man, etc.). Only one of thes contacts has had AIDS diagnosed; the health status of most of the other contacts is unknown.

New York City clinicians are urged to be alert for the occurrence of KS or OI, whether or not the patient is a member of a recognized risk group. New cases or updates on previously reported cases should be reported promptly to the AIDS Activity Office at 566-3630.

TABLE 1

AIDS CASES IN NEW YORK CITY THROUGH MARCH 9, 1983

Males	No. of Cases
KS	211
PCP Without KS	251
OI Without PCP or KS	82
Total Males	544
Females	
KS	3
PCP Without KS	24
OI Without PCP or KS	14
Total Females	41
Total Cases	585

TABLE 2

AIDS CASES BY RISK GROUP, MALES AND FEMALES, NEW YORK CITY, THROUGH MARCH 9, 1983

RISK GROUP	NUMBER	% OF TOTAL CASES	
Homosexual or bisexual	416		
IV Drug user (No history of homosexuality)	121	21	
Haitian (No history of homosexuality or IV drug use)	20	3	
Hemophilia	0	0	
Other	28	5	
Total	585	100	

As interest and concern about AIDS Q. Who seems to be affected? increase, the Department of Health, as well A. Currently, homosexual and bisexual males make up three-fourths of all reported cases. Cases have been identito the questions most often asked are presented below.

What is Acquired Immune Deficiency Syndrome or AIDS?

AIDS is the name given to a recently recognized medical condition. "Acquired" indicates that it is not inherited and not explained by an underlying illness. "Immune deficiency" is the factor common to all cases -- an inability of the body to defend itself against certain unusual tumors and/or infections. "Syndrome" refers to the variety of specific diseases which can occur; these are sometimes referred to as opportunistic cancers or opportunistic infections, as they take advantage of this loss of natural immunity against disease.

What are some of the specific diseases affecting AIDS patients? Many have had one or both of two rare diseases: (1) Kaposi's Sarcoma (KS), a type of cancer and (2) Pneumocystis carinii pneumonia (PCP), a parasitic infection of the lungs. In addition, severe life-threatening bacterial, yeast, or viral infections can occur. Herpes infections are seen in AIDS patients but are unusually severe and prolonged and are not the common "cold sore", routine genital herpes or "shingles".

What is known about these opportunistic diseases?

The opportunistic diseases seen with AIDS are not new. Kaposi's sarcoma (KS) was described over 100 years ago. Prior to 1980, KS primarily affected elderly men and was very seldom fatal, even 5 to 10 years after diagnosis.

Pneumocystis carinii pneumonia affects a
few hundred adults and children in the United States annually, but usually is seen only in patients with a severe underlying illness (such as leukemia) or in patients receiving intensive therapy with drugs known to suppress the immune system (such as kidney transplant patients, who receive such drugs to prevent organ rejection). Thus, while the diseases themselves are not new, they are affecting a new group of individuals--persons with no known cause for immune deficiency.

fied also in male and female intravenous drug users, a small number of Haitians residing in the United States and a few individuals with hemophilia . Approximately 5 percent of all cases do not belong to any of these recognized groups. About 95 percent are males in the age range of 25-44 years. races have been affected.

What specific risk factors have been identified?

AIDS does not appear to be a risk to the general public. Also, not all members of the groups affected can be considered at equal risk for AIDS. Studies of AIDS patients indicate that male homosexuals having multiple partners and drug abusers who share needles for intravenous heroin and cocaine injection are at higher risk. Other risk factors have not been identified at this time. .

What causes AIDS?

Investigators have not been able to find the cause or causes of this loss of immunity. The pattern of occurrence among the diverse groups suggests that an infectious agent or agents may in part be the cause of AIDS, but this has not been proven. Other contributing factors are being investigated.

Q. What is the geographical distribution of

reported cases?

Nearly half of the cases in the United States are reported from New York City and about 20 percent from California. AIDS cases have been reported from more than 30 states and from 16 foreign countries.

Can AIDS be transmitted from person to

person?

Although a cause for the syndrome has not been found, it appears that intimate, direct contact, such as sexual contact or injection into the blood is required. There is no evidence that AIDS is spread through the air or by other forms of casual contact that commonly occur in the workplace or school (sitting in the same room, shaking hands, sharing toilet facilities, etc.). AIDS does not appear to be a risk to the general public.

Can children get AIDS?

Many children's doctors and researchers are considering this question, but they have not as yet decided on the answer. Opportunistic infections are seen in very young children if they are born with an inherited immune problem. In New York City, opportunistic infections have been reported in a small number of children who do not appear to have either an inherited immune deficiency or another serious underlying illness, such as leukemia. Poor nutrition may have been a factor in at least some of these children. The Health Department is planning studies to look further at this difficult question.

How serious is AIDS? Q.

The fatality rate ranges from 20 percent to as high as 80 percent depending on the length of time the patient has had the syndrome and what specific opportunistic diseases have been diagnosed. Because normal immune function A. does not appear to return, individuals remain at risk of acquiring additional opportunistic diseases.

Are there any symptoms of AIDS?

There are no clearcut symptoms but many patients with AIDS have had enlarged lymph nodes (sometimes called "swollen glands") at several different sites in the body. Some have had un-explained diarrhea accompanied by a significant weight loss. These symptoms can occur over a period of months before a specific disease such as Kaposi's sarcoma or pneumocystis pneumonia is diagnosed. KS is a form of cancer that usually occurs in the skin. In early stages, it may look like a bruise or blue-violet or brownish spot which persists and may ulcerate. It may spread to other organs, including lymph nodes, causing them to enlarge. Pneumocystis pneumonia has symptoms similar to any other form of severe pneumonia, such as difficulty in breath-ing, severe cough, chest pain and fever. Some AIDS patients have had both KS and pneumocystis pneumonia at the same time.

Is there a laboratory test for AIDS? There is no specific test for diagnosing AIDS. The specific immune defect in AIDS has not been identified, but many patients show a decrease in the number and function of certain white blood cells called T-helper lymphocytes. Although

the function of these cells can be measured, these tests are not sensitive or specific enough to be used routinely and are not generally available. Other methods, the most important of which is a thorough physical examination, may assist the physician in establishing the diagnosis of AIDS and its associated diseases.

Is there any treatment or prevention for AIDS?

Because the cause for AIDS is not known, there is no currently accepted treatment for it. The opportunistic cancers and infections may be treated individually with varying success. Preventive measures for AIDS are also uncertain. There is no vaccine, serum or medicine which can protect someone from developing AIDS.

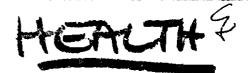
What is being done about the problem?

Government and other medical research groups are giving high priority to investigation of the problem and methods for control and prevention. Physicians, public health advisors, epidemiologists, statisticians, laboratory scientists, and others are working across the country.

What is being done in New York City? The Department of Health keeps count of all cases in the City to study disease trends. In November 1982 an active surveillance program was begun to seek out hospitalized cases of AIDS. The Department of Health sponsors a monthly meeting attended by clinical researchers at which current ideas and studies on AIDS are discussed. Health Department physicians and advisors continue to work jointly with the Centers for Disease Control and local researchers on a variety of AIDS-related studies. Department of Health representatives also work closely with concerned community groups. Recently, the Department of Health established an Office of Gay and Lesbian Health Concerns.

How can I tell if I have AIDS? If you have a question about your personal health, the best person to consult is a doctor. Ask your doctor if he/she is familiar with AIDS. If he/she is not, most Infectious Diseases Departments at major hospitals are. A diagnosis of AIDS cannot be made over the telephone.





THE CITY OF NEW YORK
OFFICE OF THE MAYOR
NEW YORK, N.Y. 10007

MEMORANDUM

To: David Sencer, M.D.

FROM: Edward I. Koch

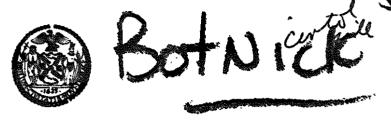
DATE: May 5, 1983

I am growing increasingly concerned about the number of AIDS cases that are being reported. It seems that we can expect a continual rise in the number of cases in the foreseeable future.

Although I believe that we have responded to this problem, I feel that we should be assuming a more aggressive posture as it relates to the medical policies implemented to deal with this disease. For example, I have been advised that all blood donated can be tested for infectious organisms for a small fee and the "bad" blood discarded. Should such testing be mandatory in the City? What precautions should be taken by medical personnel that might come into contact with AIDS victims? What provisions should be made to make certain that appropriate medical facilities i.e. ICU beds are available for AIDS patients? Should extra wards in certain hospitals be set aside for these patients?

These are all appropriate public policy questions. Therefore, I would like you to convene a meeting of the Board of Health to review how we have handled this matter to date, to consider the questions that I have raised as well as any others, and to promulgate regulations where appropriate. Please have the meeting convened within the next two weeks. Once the meeting is held I would like to meet with the Board to discuss their recommendations.

/am cc: Victor Botnick & Ka



THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

VICTOR BOTNICK Special Assistant to the Mayor Deputy Health Services Administrator

CONFIDENTIAL

TO:

Edward I. Koch

Mayor

Stanley Brezenoff

Deputy Mayor for Operations

FROM: Victor Both fety
Special Assistant to the Mayor
Deputy Health/Services Administrator

DATE: June 13, 1985

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AIDS INITIATIVES UPDATE

The following is a status report of the AIDS initiatives as of today. Also attached for your information is a chart comparing services and programs provided by New York City with those provided by San Francisco.

Housing

o Two buildings have been identified by the Department of Housing Preservation and Development as suitable housing for persons with AIDS. One building is in East Harlem and the other in Brooklyn. These sites were selected due to their proximity to Bellevue and Kings County Bospitals which have the largest AIDS patient census. recommend that the City renovate one of the buildings at an estimated cost of \$1 million. The other building will be turned over to the AIDS Resource Center (ARC) contingent upon ARC receiving State funding for renovation, pursuant to an RFP.

If this plan meets with your approval, an announcement can be made shortly. You may wish to give some consideration to announcing the housing program without naming a site, given the likely outcry of opposition from the communities involved. The alternative is to proceed with the project without an announcement.

You should know that the Brooklyn Borough President's Office has already told HFD that they are not in favor of the Brooklyn site because it is in a Hasidic community, and they know it will meet opposition. The City can choose to redevelop the Manhattan site and leave the Brooklyn site to ARC to renovate with State funding. However, there is no guarantee that the East Harlem community will object any less vehemently.

o Scattered Site Housing: The AIDS Resource Center (ARC) has submitted a proposal to HRA which is under discussion. A contract is expected to be in place by July and the program operational by September. The initial contract will be for five 2-person apartments. ARC will provide apartment maintenance, utilities, telephones, furniture and limited supervision. The cost per person is estimated at \$700 a month or less. Although this seems rather high, HRA reports that the cost of providing New York City shelters for individual men and women ranges from \$24.50 to \$37 per night. Purthermore, AIDS patients should be eligible for Level II Supplemental Security Income (SSI) payments for housing and supervision. These payments are double the normal monthly payments, at least \$600, and are mostly federal dollars. Alternatively, the program could be funded through Emergency Assistance to Adults, which is half state and half local.

HRA also has a small \$5,000 contract with ARC to provide a half-time worker to locate emergency housing in hotels. This will begin in the next few weeks. Since ARC will not have to pay for the rooms with public assistance checks, it is hoped that they will have an easier time securing rooms.

Assessments and Medical Care

Inpatient and Outpatient Services:

- o Interdisciplinary Health Care Teams: HHC has allocated \$1,445,000 for FY86. Funding authorization letters were sent on May 29, 1985 to Bellevue, Bronx Municipal, Harlem, Kings County, Lincoln, Metropolitan, North Central Bronx and Queens Hospitals. Recruitment for the teams is being facilitated through a corporate-wide advertisement which appeared in the New York Times. All that remains is for the institutions to select their candidates and file the PAR forms which is expected to be completed by July 1st.
- o <u>Bellevue Unit</u>: Space requiring minimal renovation has been identified for a 10-bed Adult AIDS Unit. Staff from HHC's Capital Programs have met with Bellevue Hospital Design staff to develop a scope of work, and establish responsibilities and a timetable for completion of design and construction. \$482,000 has been allocated for this unit. It is estimated that the space will be ready in forty-five days to two months.
- Nursing and OTPS Resources: Additional funding of \$1,436,000 for nursing resources, and \$605,000 for supplemental OTPS relief has been allocated. All facilities were notified that funding will be authorized effective July 1, 1985, based on updated AIDS census information.

Some supplementary information will be required before approval of final funding for each facility, especially in the area of case managed outpatient services. Meetings will be set up with Bellevue and Kings County, the two facilities with the largest AIDS populations, to discuss the development of models of impatient/outpatient case management.

- o <u>HHC Central Office Coordinator</u>: Funding of \$62,000 has been allocated for FY86. This covers a full-time coordinator and two half-time support staff. Two potential candidates have been identified and HHC plans to fill the position by June 15, 1985.
- o <u>Data Collection</u>: A second one-day AIDS Census was conducted on April 30, 1985 indicating an increase from the March 15, 1985 census of 20% (139 patients to 166). Five voluntary hospitals having a total of 42 cases participated in this survey. Regular data collection began May 6, 1985.

The first month's data will be analyzed and used as workload information in the July 1, 1985 distribution of resources. HHC is working to refine the data collection instrument, as well as assisting the Greater New York Hospital Association (GNYHA) in the collection of citywide data.

- o <u>Advisory Group</u>: An HHC AIDS Advisory Group meets monthly to discuss corporate—wide AIDS issues. The group consists of representatives from each of the hospitals and relevant Central Office staff from Finance, Corporate Affairs, Planning and Medical and Professional Affairs.
- o <u>Pediatric Day Care</u>: HHC staff is meeting with medical staff from Albert Einstein to discuss a pediatric day care program at HHHC. No dollars have yet been allocated. HHC will be meeting with HRA to discuss how much of the program would fall within day care guidelines and thus receive funding from HRA.

Extended Care Facilities:

o Comprehensive Home Care and Hospice Services: The draft RFP for the AIDS home care contract was completed June 6, 1985 and is now being circulated among the appropriate agencies for comment. The RFP should be finalized by June 20, 1985, and the target date for implementation is October, 1985. In order to meet this date, two issues need to be resolved with the State. These are: the establishment of a payment mechanism and a rate for all components of the comprehensive home care plan; and authorization for the certified home health care agency with whom HRA contracts to subcontract with other home care agencies so that services can be provided citywide. The latter is necessary since home care agencies are only certified to provide services within delimited catchment areas. HRA is scheduled to meet with representatives from the New York State Department of Health and the New York State Department of Social Services on Monday, June 17, 1985, to attempt to expedite the resolution of these issues.

ENA's initial estimate of the cost of the comprehensive home care program was between \$2.5 million - \$3.7 million. ONB used the lower number in their calculation of overall cost for the City's AIDS initiatives. Since their original estimate, ERA has reviewed the needs assessment performed by HHC and DOH and revised their estimate upward to \$4.3 million. This revised cost estimate covers services to approximately 190 persons with AIDS. The city tax levy contribution would be 12 percent or \$516,000. The program is structured to allow flexibility in shifting service needs to the demand for service. Payment will be on a per capita basis so that actual program costs will depend on the number of people served, the type of service and the specific length of time served.

As you know, RRA currently has a contract with the American Red Cross to provide home attendant services to AIDS patients. The Red Cross is currently seeing 61 patients. Pending the selection of a contractor for the new comprehensive home care program, the City will renew the contract with Red Cross for a six month period at a projected cost of \$472,000. This will ensure that some basic level of assistance with household and personal services will be provided to AIDS patients during the transition period. The new contract will provide the full scope of home care services, including certified home health agency services, nursing, personal care and skilled services.

With regard to hospice for AIDS patients, originally HHC was to contract with community agencies to provide home-based hospice services, bereavement counseling and support for AIDS patients and their families. These services were to be available to all AIDS patients regardless of payor status since a number of HHC's AIDS population is non-Medicaid. According to the latest one day census of April 30, 1985, 30 percent of HHC's AIDS patients were neither Medicaid nor pending Medicaid.

Subsequently, it was determined that the hospice program would be more appropriately handled by HRA. Since HRA was addressing all of the home care issues and had specifically included hospice in their comprehensive home care proposal, it did not make sense for HHC to operate a separate hospice program. The question remains whether hospice services will be made available to non-Medicaid patients. It would make sense to include this population since they represent a third of the AIDS patient census. The agency that is eventually awarded the home care contract could bill HRA for hospice services provided to non-paying patients.

I know that we were careful not to create a new entitlement program for home care since it would be very costly and we do not provide these services free of charge to any other group. However, the need for hospice services is unique to this group and would not be nearly as costly as home care since the number of patients are far fewer. This does not mean, however, that it would not be costly. HRA estimates that it would cost roughly \$2,272 per patient, per year, based on the experience of the Visiting Nurse Service; an that there are currently about five non-Medicaid patients who need hospice services.

- o Coler Long Term Care Program: A proposal for the assessment team and impatient unit was reviewed and is being revised. Based on that proposal, a funding authorization letter was sent on June 3, 1985 allocating \$331,000 for the inpatient unit and \$145,000 for the assessment team. Coler is currently reviewing resumes for the Infectious Disease physician and nurse epidemiologists, and has also placed an ad in this <u>Sunday's Times</u> for staffing. HHC patients currently pending LAC placement will be evaluated by Coler within the next two weeks. A clinical conference with staff on HBC acute care facilities who have experience with AIDS has been scheduled for the beginning of July to finalize clinical protocols, admission criteria, and environmental requirements. Based on this final program design, the vacant ward identified for the AIDS program will be renovated either into three bedrooms with bath and toilet, or single rooms with bath and toilet. If the patient assessment and clinical conference conclude that AIDS patients may be served in existing space with minimal or no physical alteration, patients may be admitted as soon as staff are on board.
- o <u>Meponsit Long Term Care Program</u>: Neponsit has allocated temporary space which can accommodate up to 10 HRF-level AIDS patients as soon as program design is completed and staff are hired. A program proposal will be received and reviewed by June 21, 1985; upon approval, \$171,000 will be allocated for the program. Vacant space has also been identified for long term use; as soon as the program design is approved (single vs. multi-person rooms) design and renovation will proceed. Neponsit will be able to admit HRF-level AIDS patients in the temporary space as soon as staff are on board and the State has lifted the general admission restriction on the facility.

Laboratories and Epidemological Support

- o <u>HTLV-III Laboratory</u>: Two technologists have been hired starting in June to help perform HTLV-III antibody tests. A total of 2,804 tests have been performed from March 20, 1985 to May 24, 1985. Protocols for test results are being revised, and protocols for data analysis are being developed. Interviews are in progress for the remaining professional and support personnel for the HTLV-III Lab. Some difficulty has arisen in obtaining qualified personnel, due to the perceived hazards of working with the HTLV-III virus. Therefore, the search is being expanded to the national level, delaying projected completion until September 1, 1985.
- o <u>Surveillance and Investigation Activities</u>: One Public Health Advisor will be added on June 17, 1985 and another in July.

As of May 20, 1985, 3,700 cases of AIDS have been reported in New York City representing an increase of 200 cases from the previous month. Hospital bed census of AIDS patients is monitored on a weekly basis. The pediatric surveillance reports a total of 63 cases, 4 new cases this month.

Protocols are being developed for presentation to the DOH Institutional Review Board for surveillance of family members of transfusion AIDS cases. Based on a pilot Tuberculosis (TB) study, a serosurvey of males (ages 25-44) for HTLV-III is currently being undertaken with the cooperation of the Bureau of TB.

A proposal to study transmission of HTLV-III virus from infected mothers to their infants is being developed for submission to the Centers for Disease Control (CDC) on June 24, 1985.

General Education and Support for Risk Reduction

o <u>HTLV-III Hotline</u>: The Hotline is in operation as scheduled. A total of 623 calls were received during the period of April 29, 1985 to May 24, 1985. 15 counselors have been trained, and a back-up counselor and physician have been named. An advertisement for community papers is in production and television stations are being approached about public service announcements. A Hotline protocol is constantly being revised according to the latest epidemiologic information.

An additional 5,000 HTLV-III flyers were printed and distributed to community organizations. Hotline staff have been meeting with social service providers, the New York State AIDS Institute, the New York Blood Center and the Hemophilia Foundation to coordinate resources for post-test counseling programs.

o <u>AIDS Education Unit</u>: An additional Health Educator and a Graphic Design Consultant were hired in May, 1985. HTLV-III AIDS wallet cards, an AIDS risk reduction brochure and an HTLV-III fact sheet are in production.

Commissioner Sencer chaired a meeting with substance abuse experts at DOH on how best to educate the substance abuse community about the risks of acquiring AIDS. A follow-up meeting with the New York State Association of Substance Abuse Agencies was held on May 16, 1985. Discussions are underway for seminars and conferences, and a planning committee will be formed by June 30, 1985.

The AIDS-related social, health care and community resource directory has been delayed due to typesetting and graphic design problems. July 1, 1985 is the projected completion date.

A Health Educator for professional and provider activities was hired on May 23, 1985. Outreach to professional care-givers is continuing, and 17 presentations were given from April 24 to May 29, 1985.

A contract to provide comprehensive education of high risk gay men and youth is being developed with GMEC. A proposal is due from GMEC by June 10, 1985.

Other Services to Persons with AIDS

o <u>Case Management Unit</u>: Recruitment efforts are continuing at HRA and six of the twelve staff persons are expected to start by June 15, 1985. This includes one Supervisor, one Community Coordinator, two Caseworkers and a Messenger. HRA staff has been meeting with HHC to determine the role that the Case Management Unit will play with regard to persons with AIDS who are hospitalized in City hospitals. HRA's services may be more extensive then previously planned.

If so, the head count will be adjusted accordingly. A meeting has been set for June 17, 1985 with voluntary hospitals to establish joint procedures for working with AIDS patients. HRA plans to discuss with the hospitals its request that City shelters not be considered an appropriate discharge plan for AIDS patients.

o <u>QMHC Contract</u>: A formal proposal from GMHC for counseling and assessment services has been received and a contract for submission to the June 20, 1985 Board of Estimate meeting is being prepared. The contract, which calls for GMHC to expand the number of cases for which they do case management, will cost approximately \$83,000, up from \$41,000 in FY85. GMHC has decided to hold off until FY86 on its plan to open borough offices in Bronx and Brooklyn until their expanded operation stabilizes.

Attached for your ready reference is a chart which compares the services provided to persons with AIDS in New York and San Francisco. Budgetary figures have been included where available. However, caution must be exercised in drawing conclusions about the level of service solely on the basis of budget information which is often incomplete at best. This is particularly true where AIDS related activities are not specifically broken down.

If you would like me to prepare information for the Press Office to write an article, please let me know.

COMPARISON OF NEW YORK AND SAN FRANCISCO RESPONSE TO ALDS

	NEW YORK (FY84-85) & NEW INITIATIVES SAN FRANCISCO (SP) (FY84-85)
I. LABS AND EPIDEMIOLOGICAL SUPPORT	o Monitoring; case finding; screening; o Monitoring; case finding; screening; epidemiologic studies (\$1.2M) epidemiologic studies (\$750,000)
II. ASSESSMENTS & MEDICAL CARE	o AIDS cases as of 2/85: 3,206 o AIDS cases as of 2/85: 932
A. Inpatient & Out- patient Services	o 10 bed AIDS Unit at Bellevue o 12 bed AIDS Unit at SF General (\$482,000)
	o 10 Interdisciplinary Patient o Combined AIDS/Oncology Clinic at Care Teams to manage and link SF General inpatient & outpatient care (\$1.4M)
	o 1 HHC Central Office Coordinator (\$62,000)
	o Patient Assessment Teams to select appropriate post-hospital care (\$145,000)
	o Additional nursing resources (\$1,346,000)
	o Supplemental OTPS budget (\$605,000)
	o Day hospital for pediatric AIDS patients (being discussed)
B. Extended Care Facilities	o Hospice RFP for 50-60 patients o AIDS Home Care Unit at Hospice of SF for 35 patients and a(\$474,622) public health nurse contract for home care services.
	o HRA contract with Red Cross to provide AIDS home care (\$472,000 for six-month contract)
	o 7-10 beds at Coler (\$331,000)
	o 10 beds at Neponsit Health Related Facility (\$171,000)

		NEW YORK (PY84-85) & NEW INITIATIVES	SAN FRANCISCO (SF) (FY84-85)
111.	Other Services For Persons With AIDS	o HRA 12-person needs case management unit (\$200,000)	o Three contracts for emotional and practical support and advocacy (\$679,643)
		o GMHC contract for counseling and assessment (\$83,450)	o Contract for Mental Health Support (\$395,000)
		o IRA Emergency Housing (\$300,000)	o Contract for short-term emergency housing for up to 6 people
		o Long term housing 2 in rem buildings, one to be renovated by the City for \$750,000 and one turned over to ARC for submission of an RFP to the State	
		o HRA RFP for scattered-site housing five two-person apartments (\$700 per person per month)	o Contract for 6 scattered-site houses
		o Substance abuse counseling	o Substance abuse counseling (\$51,818)
IV.	Professional Education	o Contract with Gay Men's Health Crisis for training for HHC housestaff (\$15,000)	o Contract for mental health education
		 O HHC employee training program, videotape, discussion guide and employee booklet 	o Contract for substance abuse
		o HHC/CDC developed protective guidelines for employees	o Enteric pathogens training
v.	General Education And Support For Risk Reduction	o Information, literature, public forums, outreach, etc. HTLV-III Hotline for counseling, information and referral (\$1M)	o Information, literature, public forums, outreach, etc. (\$551,074)



THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

MEMORANDUM

TO:

Victor Botnick

FROM:

Edward I. Koch

DATE:

August 8, 1985

I read your August 6 memo regarding AIDS Initiatives Update and it is superb.

I also had before me your July 31 memo on the RFP to be issued by the Human Resources Administration for the AIDS Comprehensive Home Care Program for Medicaid-eligible AIDS patients. I must leave to your and Stan Brezenoff's judgment as to whether all bases are covered.

I honestly don't understand the difference between hospice services which are being deleted and comprehensive home care which is being initiated. You and Stan will have to decide whether the RFP is adequate and your decision, whatever it is, is fine with me.

S

mg

cc: Stanley Brezenoff



THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

VICTOR BOTNICK Special Assistant to the Mayor Deputy Health Services Administrator

TO:

Bohard I. Koch

Mayor

Stanley Bresenoff

Deputy Mayor for Operations

FROM: Victor Botnick /
Special Assignant to the Mayor
Deputy Health Services Administrator

DATE: August 6, 1985

RE: AIDS INITIATIVES UPDATE

The following is a status report of the AIDS initiatives as of today.

<u> Bousing</u>

- o One in-rem building has been identified by the Department of Housing Preservation and Development (HPD) as suitable housing for persons with AIDS. The City plans to removate this building at an estimated cost of \$1 million. In addition, the City sent a letter of intent to transfer another vacant building with 15-25 units to the AIDS Resource Center (ARC) contingent upon ARC receiving State funding for renovation, pursuant to an RFP under the State Homeless Housing and Assistance Program round three. HPD has been in contact with both the Brooklyn Borough President and Manhattan Borough President's offices soliciting their support for the two projects. No response has been received thusfar, however, the Brooklyn Borough President indicated that a response would be sent this week.
- o Scattered Site Housing: The AIDS Resource Center (ARC) submitted a pilot housing proposal to HRA on June 21, 1985. The contract is under discussion and will be presented to the Board of Estimate on September 19, 1985. The program will be operational by late September or early October pending Board of Estimate approval. The initial contract is for five two-person apartments. ARC will provide apartment maintenance, utilities, telephones, furniture and limited supervision. The cost per person is estimated at \$700 a month or less to be funded jointly by HRA and the State. ARC will reserve all

ten beds for referrals from HRA, although they do have the right to refuse people they find inappropriate. AIDS patients should be eligible for Level II Supplemental Security Income (SSI) payments for housing and supervision and this is being explored with the State. Currently, SSI Level II is open only to programs serving the mentally disabled and the fragile elderly. However, the State is contemplating adapting the Enriched Housing Program (a supportive residential program for the fragile elderly which qualifies for the Level II reimbursement) to meet the needs of the non-elderly disabled which should include AIDS patients. Level II payments are double the normal monthly payments, at least \$600, and are mostly federal dollars. On July 1, 1985, the reimbursement level went up to \$710 a month. Alternatively, the program could be funded through Emergency Assistance to Adults, which is half state and half local.

Assessments and Medical Care

Impatient and Outpatient Services:

o Community-Based Asbulatory Care Clinic:

HHC is proceeding with the plan to provide community-based services for persons with AIDS. As you know, the clinic will scave as a satellite to the multi-disciplinary AIDS program at Bellevie using space that will be jointly operated by the Community Health Project (CHP). CHP is currently providing primarily AIDS screening and counseling services one evening a week on the Second Floor at 208 West 13th Street in Manhattam. Several options at the 13th Street location have been reviewed by BHC for the establishment of a community-based clinic.

An HHC workgroup identified a separate building detached from the main building and formerly used as a bakery as the most viable option for the location of a clinic. The bakery has sufficient space (4,100 square feet) to meet the minimum CHP space requirement of 2,800 square feet. It would provide access to the handicapped and adequate egress and services could be delivered there independent of the overall rehabilitation plans for the main building.

The initial review of design, bidding and construction needs indicates the following potential schedule for completion of the clinic space: six months for design and eight months for construction with bidding adding another three months. Since in-house work is not in the current schedule, it would have to be accomplished by authorization of overtime or by displacing other projects in the 1986 commitment plan.

Costs for construction (including furnishings) are estimated at \$100 per square foot or \$410,000 for 4,100 square feet of space. This estimate will be further refined once program needs are finalized and the adequacy of structural and service system requirements are determined. Since the building is not owned by the City, construction costs cannot be capitalized and will have to be treated as an expense item as was done at the Greenpoint Clinic and the Neptune Avenue Clinic.

The work group has also reviewed the possibility of renting elsewhere in the vicinity. An initial review by DGS indicates that comparable space in the neighborhood, a first-floor storefront of 2,800 square feet of raw space, would rent at \$25-\$30 per square foot or \$70,000-\$84,000 per year.

As far as programmatic issues at the clinic are concerned, the program model will involve an ATDS Assessment Program (AAP) to be provided five afternoons weekly onsite at CHP by a Bellevue Medical team as an extension of the Bellevue AIDS Frogram. The team will consist of two intermists, a nurse practitioner and a social worker who will conduct sessions both at CHP and Bellevue to ensure continuity of care and integration with the Bellevue ALDS Program. CHP will men the front desk and provide administrative support. Ongoing medical services for AIDS related cases and AIDS patients (pre-admission and post-discharge) will be provided by the same team. HHC was successful in obtaining National Health Service Corps designation for CHP. An Corps internist at Bellevue will be reassigned to CHP this week for one evening session weekly. Resumes for the other physician are being reviewed and a candidate for the murse practitioner has been identified. Day sessions will be phased in beginning in August pending staff recruitment and the negotiation of a smell interim contract with CHP in lieu of a larger annual contract which will require Board approval.

The draft of the service contract with CHP is being prepared by HHC's Legal Department and is due next week. By August 15, clinical sessions will be operating three days a week. HHC's Office of Ambulatory Care will provide technical assistance to Bellevue and coordinate the planning and implementation of the satellite clinic program. Negotiations will proceed on a weekly basis between Bellevue and CHP regarding professional oversight, organizational responsibilities, staffing patterns, space and equipment requirements, medical records Part I Application, and financial arrangements.

Billing will be handled from the start by Bellevue. CHP clients will be issued a Bellevue Clinic card entitling then to the full range of services. Negotiations are underway with the State regarding Article 28 certification. By mid-September, the Part I application will be submitted with the expectation that CHP will be approved on a temporary basis as an extension clinic of Bellevue pending completion of construction.

o Interdisciplinary Health Care Texass: HEC has allocated \$1,445,000 for FY86. Funding authorization letters were sent on May 29, 1985. All facilities have begun recruiting for the interdisciplinary texas and are in various stages of completion. At North Central Bronx, a team has been identified and will be on board September 1. Bronx Municipal Hospital Center and Metropolitan have only a nurse yet to recruit. One team is functioning at Bellevue. The other Bellevue team, except for a social worker, will be on board August 1. At Kings County, offers have been made to two physicians and a social worker and finalists for the nursing positions have been identified. Harlem is still in the process of recruiting a team. They have tentatively identified candidates in-house and will seek to backfill

these positions with initiative funding. Lincoln has hired a social worker, identified a physician and is finalizing the selection of the nurse. Queens Hospital has tentatively identified the physician and the nurse in-house and is finalizing the selection of the social worker.

- o <u>Bellevue Unit</u>: Space requiring minimal removation (Ward 12 East) has been identified for a 10-bed Adult AIDS Unit. The ward is currently partially occupied by housestaff and some administrative staff who will be moved to another area. The Unit will consist of 10 single bedded rooms. Minimal construction work is required. The Bellevue Hospital Design staff will submit a timetable for completion of design and construction on August 3, 1985. \$100,000 has been allocated for this unit. It is estimated that the space will be ready for occupancy by October 1, 1985.
- o <u>Nursing and OTPS Resources</u>: Additional funding of \$1,346,000 for nursing resources, and \$605,000 for supplemental OTPS relief has been allocated. All facilities were notified on July 24, 1985, of the funding allocations developed by the Office of Finance.

The allocations will be added to the bottom line of the facilities' budgets. To facilitate tracking the funds to ensure that they are actually spent on AIDS programs, RHC's Office of Planning has developed an expenditure plan form that each facility will be required to submit. The plan provides a specific breakdown of expenditures for Personal Services (PS), Affiliation and Other Than Personal Services (OTPS).

- o <u>HHC Central Office Coordinator</u>: The position of Aids Coordinator was filled on July 24, 1985. Funding of \$62,000 was allocated for FY86. This covers a full-time coordinator and two half-time support staff.
- o <u>Data Collection</u>: The first month's data (with the exception of Bellevue) is in and printouts have been generated for limited distribution to Central Office staff. Issues on scope and periodicity of data collection were discussed at a joint DOH/HHC meeting the week of July 1. The data collection instrument is being revised following feedback from the facilities. The new form will be condensed to streamline the monthly reporting process.
- o Advisory Group: An HHC AIDS Advisory Group meets monthly to discuss corporate wide AIDS issues. The group consists of representatives from each of the hospitals and relevant Central Office staff from Finance, Corporate Affairs, Planning and Medical and Professional Affairs. The agenda for the July 24th meeting included discussion of such topics as data collection, AIDS education and the RFP for the AIDS home care contract.
- o <u>Pediatric Day Care</u>: The planning for a pediatric day care resource center for children with AIDS is underway. Following the inclusion of monies for Pediatric AIDS in the final tudget package, (\$400,000) HHC staff have met with physicians from Einstein and requested a revised proposal. Underutilized space in the Van Etten Hospital has been identified. The center will accomposate 25 children between the ages of three months to seven years and staffing will include a pediatrician, nurse clinician, social worker, psychologist, physical therapist and an educator. Access to a dentist will also be available.

Extended Care Facilities:

o Comprehensive Bone Care and Bospice Services:

The Buman Resources Administration's Medical Assistance Program has issued a final draft of the revised RFP for the AIDS Comprehensive Home Care Program for Medicaid-eligible AIDS patients only. These patients would be eligible for home care under other HRA home care contracts, but this program will allow us to provide the service in a compassionate and expedited manner. The program is expected to serve between 348 and 364 persons by the end of the first year of operation. The draft RFP incorporates comments from the Health & Hospitals Corporation, the City Departments of Health & Mental Health and the State Departments of Social Services and Health. The RFP is ready for release, pending your approval.

The RFP includes the following key elements:

Hospice Services are deleted from the list of services that the contractor is required to provide. The decision to remove hospice was made because there is no certified home health agency (CHRA) in the City currently certified to provide community based hospice services and hospice is not a Medicaid reimbursement service. However, the certified home health agency selected will be able to provide "hospice like" services which include increased nursing visits and counseling for patients diagnosed as having less than six months to live. The CHRA will be able to obtain Medicaid reimbursement for these by claiming the costs under the category of medical social services which the RFP includes as a mandatory service.

The authorization process is modified to allow for a special review process if the cost associated with providing services to a particular patient exceeds an amount equal to 100 percent of the cost of caring for that patient in an skilled nursing facility (SNP). The initial authorization will include a monthly budget associated with the service plan so that the cost of care can be tracked on an on-going basis.

Occupational therapy, physical therapy and speech therapy are not included since the need for these services among AIDS patients is minimal and HRA felt that including them would set a costly precedent for future contacts.

Reimbursement will be set at the Medicaid rate for home health aide services, nursing services and professional visits. The rate for personal care services will be negotiated with the selected provider based on projected administrative costs. Only certified home health agencies will be eligible to apply.

o <u>Coler Long Term Care Program</u>: An interim assessment team will be in place by July 15, 1985. This team will consist of existing professional staff members at Coler, including the Director of Medicine. This team will continue to function until such time as the permanent team is on board. A permanent assessment team will be in place by September 1, 1985. This team will consist of professional staff members who will be recruited by Coler. The team will consist

of an infectious disease physician, a public health nurse, a nurse epidemiologist, and a social worker. Resumes are still being reviewed. Interim assessment team visits were scheduled during the week of July 8, 1985 and every week thereafter, when appropriate. Specific contacts have been made at Bellevue, Kings County and Metropolitan Hospitals. Six patient rooms with 18 beds have been identified for conversion to six rooms with 10 beds for AIDS patients. These rooms will be dispersed throughout the acute care portion of the facility. A design plan and construction schedule will be completed in three weeks. The adequacy of the existing water and sewer lines for additional plumbing fixtures is being assessed.

o Neponsit Long Term Care Program: On August 1, 1985 Neponsit will be prepared to accept their first AIDS patient via referral from Coler's assessment team. Additional staff will be required after August 1, 1985 depending on final program plans. Recruitment efforts to fill existing vacant lines are on-coing. Neponsit will be meeting with Bellevue and Kings County Hospital AIDS program representatives to coordinate educational programs for Neponsit staff and to determine and finalize professional staff needs at Neponsit. Neponsit will submit their AIDS program plan by July 25, 1985. This plan will be subject to change to accommodate new demands that become apparent. Neponsit requires some immediate minor construction within their selected unit. The unit will probably require additional construction as program plans for HRF patients are finalized.

Laboratories and Epidemological Support

- o <u>HTLV-III Laboratory</u>: Two technologists have been hired starting in June to help perform HTLV-III antibody tests. A total of 7,913 tests have been performed from March 20, 1985 to July 24, 1985. This represents a total of 1,275 specimens. Protocols for test results are being revised and protocols for data analysis are being developed. All additional staff except for a research scientist and an office associate have been hired. Some difficulty has arisen in obtaining qualified personnel, due to the perceived hazards of working with the HTLV-III virus. Therefore, the search has been expanded to the national level, delaying projected completion until September 1, 1985.
- o <u>Virology Lab</u>: Dr. Sencer is currently exploring with scientists from the Centers for Disease Control and across the country, whether or not it makes sense for the City to set up a virology lab to do AIDS virus isolation. The consensus thusfar is split. Many feel that since the test is so complicated and will likely be superceded by a simpler test, it would not make sense to fund something which would soon be outdated.

Also, the issue is not really a public health issue, but rather a research issue involving not only isolation of the virus, but also engaging in large scale studies leading to chemotherapy which would involve monitoring the activity of the virus. Dr. Sencer expects to meet with these various scientists by the end of June or early July and following this will make a decision about whether or not the City should be running a virology clinic.

o <u>Surveillance and Investigation Activities</u>: The Department of Sealth's AIDS Program in the Bureau of Spidemiological Services appointed an additional Public Health Advisor on June 17, 1985 and will add another in July for a total of eight.

As of July 22, 1985, 4,133 cases of AIDS have been reported in New York City representing an increase of 207 cases from the previous month. Hospital bed census of AIDS patients is monitored on a weekly basis. The pediatric surveillance as of July 22nd reports a total of 72 cases.

On June 27, 1985, the DOH Institutional Review Board approved protocols for surveillance of family members of transfusion AIDS cases.

Based on a pilot Tuberculosis (TB) study, a serosurvey of males (ages 25-44) for HTLV-III is currently being undertaken with the cooperation of the Bureau of TB.

A proposed multi-year study of transmission of HTLV-III virus between infected mothers and their newborns was submitted to the Centers for Disease Control (CDC) on June 24, 1985. The CDC gave verbal approval for this proposal, calling it the best grant application received in the country. DOH is currently negotiating a budget for the study.

The DOH has also submitted to and received verbal approval from the CDC for initiation of a validation study involving matching the surveillance data with death certificate information to assess adaquacy and completeness of reporting. Additionally, the DOH is now preparing a grant application for assessment of those individuals who are identified as HTLV-III positive by the New York Blood Center. Individuals will be interviewed to determine what, if any, risk factors they may have.

General Education and Support for Risk Reduction

o <u>HILV-III Hotline</u>: The Hotline is in operation as scheduled. A total of 741 calls were received during the period of April 29, 1985 to July 19, 1985, an increase of 100 percent over the previous month. 15 counselors have been trained, and a back-up counselor and physician have been named. An advertisement for community papers is in production and television stations are being approached about public service announcements. A Hotline protocol is constantly being revised according to the latest epidemiologic information.

An additional 5,000 HTLV-III flyers were printed and distributed to community organizations. Hotline staff have been meeting with social service providers, the New York State AIDS Institute, the New York Blood Center and the Hemophilia Foundation to coordinate resources for post-test counseling programs.

o AIDS Education Unit: An additional Health Educator and a Graphic Design Consultant were hired in May, 1985. 10,000 HTLV-III AIDS wallet cards have been printed with 2,500 distributed as of July 29th. 400,000 AIDS brochures have recently been printed and are ready for distribution.

Commissioner Sencer chaired a meeting with substance abuse experts at DOH on how best to educate the substance abuse community about the risks of acquiring AIDS. A follow-up meeting with the New York State Association of Substance Abuse Agencies was held on May 16, 1985. A training program for drug counselors has been developed and pilot tested. \$180,000 was approved in the budget for a contract or several contracts for education and outreach in the substance abuse field. An RFP is expected to be developed for this in the Fall. The Department of Health is also currently serving as a consultant on a video tape being developed by a drug counseling organization for training purposes.

The ADS-related social, health care and community resource directory typesetter and August 15, 1985 is the projected completion date.

A Health Educator for professional and provider activities was hired on May 23, 1985. Outreach to professional care-givers is continuing, and 41 presentations, attended by a total of 2595 people, were given from April 9 to July 31, 1985.

A contract to provide comprehensive education to high risk gay men and youth is being developed with GMBC. GMBC has submitted an outline which is currently under discussion and will be worked into a proposal. \$180,000 has been allocated in the budget for this contract. Under a co-operative arrangement with the CDC, the DOH can offer a \$30,000 federally financed, one-time contract for the revision and reproduction of the GMBC pamphlet, "Medical Answers About AIDS." A proposal has been submitted by GMBC and a contract is currently being developed.

Other Services to Persons with AIDS

o <u>Case Management Unit</u>: Recruitment efforts are continuing at HRA and six of the twelve staff persons are on board. This includes one Supervisor, one Community Coordinator, three Caseworkers and a Messenger. The Unit has an active caseload of 100 persons with 40 of these persons receiving intensive services and 60 receiving some form of housing assistance. More than 20 hospitals are being served. HRA staff has been meeting with HHC to determine the role that the Case Management Unit will play with regard to persons with AIDS who are hospitalized in City hospitals. HRA's services may be more extensive then previously planned. If so, the head count will be adjusted accordingly.

On June 17, 1985 met with several voluntary bospital representatives to discuss the unit and to establish joint procedures for working with AIDS patients. HRA discussed with the hospitals its request that City shelters not be considered an appropriate discharge plan for AIDS patients.

o GMEC Contract: A formal proposal from GMEC for counseling and assessment services was approved by the Board of Estimate and signed last month. The contract, which calls for GMEC to expand the number of cases for which they do case management, will cost \$83,000, up from \$41,000 in FY85.



THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

MEMORANDUM

TO:

Ken Conboy

FROM:

Edward I. Koch

DATE:

August 13, 1985

See the enclosed draft of the letter that I would like to send to the District Attorneys along with the underlying memo from David Sencer which would be enclosed with the letter.

I would appreciate your reworking the letter, if you thought it necessary, and providing me with a list of people to whom you think it should be sent in addition to the District Attorneys.

mg encl.

cc: Stan Brezenoff Fritz Schwarz Victor Botnick

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THE CITY OF NEW YORK COMMISSIONER OF HEALTH David J. Sencer, M.D., M.F.H.



August 13, 1985

TO:

Edward I. Koch, Mayor

FROM:

David t gentre donler comissioner

SUBJECT:

REUSE OF NEEDLES AND SYRINGES

The sharing of needles and syringes among drug abusers is the second most common manner in which the virus associated with AIDS is transmitted. Infected blood contaminates the needle and syringe of one user and is thus introduced into the next user. In this way the train of infection takes place.

An intravenous drug abuser is not addicted to the needle or syringe but to the material injected. Prevention and therapy of drug abuse should be directed to the addicting substance, not the mode of use.

Street surveillance indicates that addicts understand the risks associated with the sharing of needles and syringes. They have a desire to obtain sterile equipment. But they can't because:

1.) New York State restricts the sale of needles and syringes

except by a prescription from a physician (Sec. 3381 Public Health Law);

2) a physician is subject to disciplinary action by the State
Health Department if he knowingly writes a prescription for needles and syringes for a drug abuser;

 possession of needles and syringes is a misdemeanor (Sec. 220.45).

I believe it is time to reevaluate this aspect of society's approach to drug abuse, because by thus forcing addicts to use others' needles and syringes, we are condemning large numbers of addicts to death from AIDS. A live addict may be amenable to treatment of his drug abuse. An addict infected with HTLV-III virus continues the spread of AIDS not only to other addicts, but to their sex partners, and tragically to children born of such parents.

All of us are concerned over the magnitude of the drug abuse problem. None of us condone drug abuse, but as long as illicit materials are allowed to enter the country we will always be treating the tip of the iceberg. Interdiction, treatment and education must continue for, in New York City alone, it is estimated that 200,000 people are addicted to heroin, and only about 30,000 are under active treatment. Among this 200,000 over 1200 cases of AIDs have occurred, and about 100,000 are probably infected. The other 100,000 can benefit by prevention probably infected. The other 100,000 can benefit by prevention.

Under these circumstances shouldn't we attempt to practice preventive medicine and do something to interrupt the transmission of the virus? I think we should. What are the options open to us?

1) New York State is one of 11 states and the District of Columbia that restricts the sale of needles and syringes to prescribing physicians. Repeal of Sect.3381 of the Public Health Law could be proposed, bring New York Into consonance with the majority of the states.

2) A policy of nonarrest for possession of syringes and needles could be stated.

3) Drug abuse treatment sites could be allowed to trade sterile

for non-sterile equipment without threat of police surveillance.

4) The sale of non-sterile needles and syringes could be made a violation of the Health Code.

These actions stop short of the City actually providing the equipment.

Concurrent increase in educational activities aimed at the non-user would, of course, be essential.

I am sure that other City and State agencies will have suggestions both pro and con, and I urge that you begin the discussions because of the urgency of the AIDS problem. Dear ____:

I received the enclosed memorandum from Health Commissioner

David Sencer. It is self-explanatory and relates to his proposal to

reduce the risk that drug addicts have of contracting AIDS. It bears upon

law enforcement and is quite controversial.

I would be very appreciative if you would provide me with your thoughts on what you think my position should be in responding to his suggestion. It is a matter of urgency since the disease is spreading and the largest growing share of the patients are those who are drug abusers.

All the best.

Sincerely,

Edward I. Koch

enclosure



THE CITY OF NEW YORK OFFICE OF THE MAYOR COORDINATOR OF CRIMINAL JUSTICE 250 Broadway New York, New York 10007 (212) 566-0442

KENNETH CONBOY Coordinator

CONFIDENTIAL

PATRICK T. HOEY Deputy Coordinator

MEMORANDUM

To:

Honorable Edward I. Koch

From:

Kenneth Conboy

Date:

August 15, 1985

Subject: Sencer Proposal

With respect to your memorandum of August 13, 1985 on Dr. Sencer's suggestion relating to the legalization of needles and syringes for self-injection of heroin, and, implicitly, the distribution of such devices by the Government, I think the text of your proposed letter to the District Attorneys is precisely right. This is an enormously complex and sensitive public policy question. Most importantly, it represents a very difficult moral choice for Government to be confronted with.

As for a list of others in addition to the District Attorneys to whom the letter might be sent, I think the two Federal prosecutors in the City should also be written to. Although Federal law does not prohibit possession of non-medically prescribed needles and syringes, a broad Federal role in narcotics law enforcement warrants the solicitation of their views.

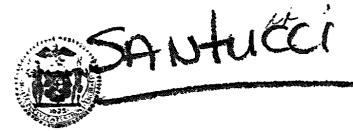
I don't think it appropriate at this time to raise the matter with the political leadership in the Legislature, but in keeping with the law enforcement emphasis, it might be appropriate to write to the Governor's Criminal Justice Director, Lawrence Kurlander, to secure his views. However, my instinct on this is not to involve the Governor's Office at this time because it might be interpreted as a political move designed to broaden burden sharing rather than solicit guidance.

I chatted with Victor about this matter and suggested that a similar letter should be sent to prominent medical professionals, including directors of major hospitals in the City, perhaps researchers directly involved in combatting the disease, and perhaps senior officials at the Center for Disease Control in Atlanta. Obviously we have here a classic Hobson's Choice in medical ethics. Victor said that you have asked Dr. Sencer to formulate a draft of a "medical grounds" letter.

Finally, since this is in the end principally a moral question, I think you should broach the matter privately with Cardinal O'Connor and other ranking spiritual leaders in the City. My sense is that this should be done by phone and not by letter. After you hear what they say, you can determine what public role, if any, they might be asked to play in this.

cc: Hon. Stanley Brezenoff Hon. F.A.O. Schwarz, Jr. Hon. Victor Botnick

KC/vc



THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

August 20, 1985

Hon. John J. Santucci District Attorney Criminal Courts Building 125-01 Queens Blvd. Kew Gardens, N.Y. 21415

Dear John:

I received the enclosed memorandum from Health Commissioner David Sencer. It is self-explanatory and relates to his proposal to reduce the risk that drug addicts have of contracting AIDS. It bears upon law enforcement and is quite controversial.

I would be very appreciative if you would provide me with your thoughts on what you think my position should be in responding to his suggestion. It is a matter of urgency since the disease is spreading and the largest growing share of the patients are those who are drug abusers.

All the best.

Sincerely,

dward I. Koch

Mayor

enclosure

JOHN J. SANTUCCI

DISTRICT ATTORNEY
125-01 QUEENS BOLLEVARD
KEW GARDENS, NEW YORK 11415-1568

September 3, 1985

Mayor Edward I. Koch City Hall New York, New York

Dear Mr. Mayor

I am pleased to respond to your kind request for my views in connection with Commissioner Sencer's recommendations concerning the availability of needles and syringes as it relates to preventing the spread of AIDs.

Although the Commissioner's recommendations are worthy of consideration, I believe it best to first consider the questions that arise and to explore other avenues.

I would point out that from the standpoint of our experience in Queens County, cases involving the possession of drug paraphernalia are generally processed through plea negotiation and there is rarely a jail sentence. The absence of such prosecutions would not in and of itself be troublesome to us. However, to make such possession lawful might well be perceived by the public as condoning or even promoting intravenous drug abuse. Recently in Los Angeles County a pamphlet was distributed aimed at halting the spread of AIDs among drug abusers. The publication, "Shooting Up and Your Health," was withdrawn from distribution after a public outcry and a statement by a county supervisor in which he said, "The entire pamphlet implies government approval of the use of drugs." However incorrect, such a public interpretation may arise from Sencer's proposal.

Additionally, the availability of needles and syringes could become counter-productive in that non-intravenous users may now feel safe and experiment accordingly. The Division of Substance Abuse Services estimates that the vast majority of the 250,000 narcotics abusers in this state are believed to be intravenous users. The numbers are inexact but the current figure represents a slight increase over those in prior years. Cocaine, the second leading drug after heroin, is readily available in our city and its intravenous use may increase as a result of the proposed procedures.

In view of the risk of public misperception and the possibility of increased drug abuse, we must consider whether the availability of drug paraphernalia through exchange in recognized facilities would prove inviting or useful to the addict. "Dirty" needles are most likely found in a "shooting gallery" setting. The drug culture is such that those who are second on the needle are anxious and preoccupied with getting "high" and have no time to be concerned with their concommittent health hazards which include hepatitis as well as AIDs. Methadone maintenance centers in New York indicate that there has been no significant recent increase in patients and claim absolutely no evidence to show that patients are seeking treatment in order to reduce the risk of contractng AIDs. There is no evidence that AIDs is, in fact, a deterrent to intravenous drug abuse and, according to authorities in New York and their counterparts in California, intravenous drug abusers have not decreased their drug use.

It should be noted, however, that two situations have been reported which indicate a trend toward the use of sterile needles. Division of Substance Abuse Services indicates information about a drug seller who provides a free sterile needle with a \$25.00 purchase and other drug sellers who sell sterile needles for \$2.00 each. There is no information as to the extent of this activity.

Needless to say I share your genuine concern for the AIDs victim as well as for the need to protect others from acquiring the disease. I feel at this time that rather than proceed with Commissioner Sencer's proposal, it would be more advisable to implement a dramatic educational campaign, hopefully avoiding the pitfalls of the California experience. The use of print and electronic media as well as billboards in getting out a very strong message could have the dual effect of fighting the spread of AIDs as well as reenforcing the war on drug abuse. Present and would-be drug abusers should be made to understand that drugs will take their minds and "dirty" needles might well take their lives.

While there is not necessarily a relationship between removal of legal restrictions regarding syringes and needles and drug abuse, this can occur and may in any event be subject to improper interpretation. An effective educational program must take this into account.

I sincerely hope that your efforts to fight this dreaded disease will be successful.

Respectfully

John J. Santucci



OFFICE OF THE District Attorney

KINGS COUNTY

MUNICIPAL BUILDING . BROOKLYN, NEW YORK 11201

718 802-2000

ELIZABETH HOLTZWAN

September 30, 1985

Honorable Edward I. Koch Mayor City Hall New York, New York 10007

Dear Ed:

Thank you for your recent inquiry concerning the sale of hypodermic instruments.

My staff's research reveals that approximately forty states and the District of Columbia have laws restricting in some form the sale of hypodermic instruments intended to be used to inject a controlled substance into a person.

The well-intentioned proposal to remove the restrictions on the sale and possession of such instruments will not adequately achieve its goal. The current expertise in this area suggests that the lawful and ready access to such instruments will encourage the spread of drug abuse and not curb the use of contaminated needles.

I would suggest that the City mount an educational program designed to reach anyone who regularly uses hypodermic needles of the dangers of spreading and receiving AIDS by the use of contaminated needles, and of the various methods available to disinfect a needle before use. Since many of those who use such needles to inject themselves with a controlled substance are among the prison population, including not only those arrested for drug use but also other offenders who use drugs, an intense educational campaign among inmates and detainees might be desirable.

With best wishes,

Sincerely,

Elizabeth Holytzman District Attorney

EH: WCD: yf



THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

MEMORANDUM

TO:

Kenneth Conboy

FROM:

Edward 1. Koch

DATE:

October 25, 1985

Yesterday Joyce Purnick asked that we clarify the difference of opinion between Dr. Sencer and Liz Holtzman with respect to the state jurisdictions allowing over-the-counter sale of hypodermic needles.

You will recall that they each reversed the figures used by the other. My recollection is that you said they were comparing apples and oranges and they were both correct. Could you provide me with a memo setting forth how each arrived at their respective numbers?

Joyce also asked if it would be possible to ascertain whether I.V. users in states allowing over-the-counter sale of hypodermics had less cases of AIDS than states like New York where prescriptions for these needles are required. Can you secure that information? The point being that if relevant information shows fewer cases of AIDS in states allowing over-the-counter sales than states where a prescription is required, and it can be stributable to the use of clean needles, we might be able to marshal opinion in Albony in support of Vr. Serger's original suggestion. Please give it some thought and see if we can respond to both questions.

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THE CITY OF NEW YORK OFFICE OF THE MAYOR COORDINATOR OF CRIMINAL JUSTICE 250 Broadway New York, New York 10007 (212) 566- 0442

KENNETH CONBOY

MEMORANDUM

PATRICK T. HOEY Deputy Coordinator

To:

Honorable Edward I. Koch

From:

Kenneth Conboy

Date:

November 25, 1985

Subject:

Sencer/Holtzman Disagreement on

Hypodermic Needles

In response to your memorandum of October 25, 1985 I have sought explanatory memoranda from Dr. Sencer and District Attorney Holtzman with respect to how they arrived at their respective positions. Neither office has yet provided me with its analysis. However, the letters of Dr. Sencer dated August 13, 1985 and District Attorney Holtzman dated September 30, 1985 suggest that each is referencing different aspects of laws that control accessibility to hypodermic needles. Dr. Sencer is referring to public health laws that control the distribution of hypodermic needles generally, by physicians. District Attorney Holtzman is making reference to penal statutes that control the dissemination by anyone of hypodermic needles with the intent that these instruments be used to inject dangerous drugs into a person.

Without having Dr. Sencer's underlying review of the public health law in the various States, I assume that he is correct that only eleven States specifically prohibit, except upon medical necessity on a license basis, the dissemination of such needles by physicians. The doctor makes reference to Section 3381 of New York State's Public Health Law which restricts the sale of needles and syringes except by a prescription from a physician. Under this law, a physician can sell or issue a hypodermic needle to an

individual only if he writes a prescription, and he must further file under Section 3372 with the State Commissioner of Health the names and addresses of drug addicts, which reports are available to law enforcement officials. What Dr. Sencer doesn't address, and what is the subject of District Attorney Holtzman's observation, are penal statutes in New York and the great majority of States, which punish the possession of hypodermic needles intended to be used for the injection of illegal drugs, and the offense of criminal facilitation of violations of the drug laws through the giving of hypodermic needles. These provisions apply to everyone and do not purport to exempt licensed physicians who, for example, without examining addicts or establishing a professional relationship, simply might make available or issue prescriptions indiscriminately to addicts for hypodermic needles for the purpose of maintaining a habit.

This distinction between licensing authority on the one hand and general prohibition on the other, is at the core of the disagreements between Dr. Sencer and District Attorney Holtzman. However, I am awaiting their respective research papers to confirm this. I thought you should have this interim report in the meantime.

With respect to the second point raised in your memorandum, you observed that Joyce Purnick asked if it would be possible to ascertain whether IV users in States allowing over-the-counter sales of hypodermic needles have fewer cases of AIDS than states like New York where prescriptions for such needles are required. I cannot begin to answer this question without the underlying data from Dr. Sencer and Elizabeth Holtzman, which would identify the States by name being referred to. I observe, however, that it is highly unlikely that any viable statistical conclusion can be reached since it is probably not possible to determine whether a case of AIDS afflicting an IV drug user was secured by a "legal" or illegal needle. Furthermore, I understand that the vast majority of drug related AIDS cases are concentrated in two or three States. Those States, I believe, are New York, California, and Texas. All three of these States do have penal law limitations on the unfettered dissemination of hypodermic needles for the purposes of injecting illegal drugs. Finally, the statistical incidence of any disease, and especially AIDS, about which so little is known, could not be shown related to the availability of over-the-counter needles, since such a review could not be controlled for other variables, thought, but not definitely known, to play a role in the dynamic of both infection and spread of the disease.

However, I want to suspend judgment on the viability of the approach implicit in Joyce Purnick's question until I receive the analyses of Dr. Sencer and District Attorney Holtzman.

Enclosures

KC/vc



THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

October 23, 1985

Honorable Ronald Reagan President of the United States 1600 Pennsylvania Avenue N.W. Washington, D.C. 20500

Dear Mr. President:

I am writing to you shout an issue of the utmost importance and concern to the City of New York and the United States. I am referring to the growing epidemic of Acquired Immune Deficiency Syndrome (AUCS), a presently incurable, fatal disease whose incidence is doubling every year.

Already, over 13,000 cases have been reported by the Centern for Disease Control nationwide, with 4,500 of those cases in New York City. In addition, it is estimated that at least one million Americans are carriars of the disease. It is unknown how many of these people will contract the illness or spread it to others. Although AIDS was unleard of only five years ago, it has already been responsible for the death of over 6,500 Americans. In New York City, AIDS is the leading cause of death among all man in their twenties and thirties, and the second leading cause of death among woman between the ages of thirty and thirty-four. AIDS clearly represents a public bealth emergency that is a growing threat nationwide.

As you indicated in your recent press conference, AIDS has become a major public health priority, to which simule assumes of federal, state and local funds have been devoted. On behalf of the City of New York, I wish to thank your Administration for its attention to the growing AIDS crisis. Unfortunately, however, there is still the strong likelihood that AIDS cases will continue to rise dramatically for the foresseable future.

The impact of the growing AIDS epidemic is two-fold. In addition to the disease's Gavastating effects on its victims, we must consider the financial impact AIDS has on providers of health care, whose viability is crucial to the medical needs of everybody. AIDS is a terminal illness whose progressively debilitating course results in the med for intensive medical and social services.

The cost of caring for AIDS patients is extremely high, due to their numerous hospital admissions, long lengths of stay, and intensity of care required. Preliminary estimates for New York City's Health and Hospitals Corporation (MMC) indicate that the average daily cost of treating AIDS patients is 50-70 percent higher than the average cost of caring for other patients. EMC, which operates the City's eleven public scare care hospitals, will spend over \$54 sillion on impatient care to AIDS patients, less than half of which will be reimbursed by third party payors. The serious fiscal implications for MMC, and other hospitals comprising the nation's public health safety net, are becoming more apparent as the number of AIDS cases continues to multiply.

Although the City of New York has accelerated its funding and expended services for those with AIDS, increased federal participation is clearly needed. Municipalities are unable to cope with the rapidly increasing costs of treatment and social services for AIDS patients without the assistance of the Federal Government. Preliminary estimates by the City's Health and Hospitals Corporation indicate that the City is spending over one million dollars per week on impatient care alone. Of this amount, less than half is reimbursed by third party payors. The samber of AIDS cases, however, is expected to double within the next year, with expenses rising accordingly. This problem is being compounded by the stigms and fear attached to the disease, which often results in loss of exployment and living accompositions for patients upon diagnosis. Again, as the incidence of AIDS continues to rise, local governments will become sore and more hard pressed to fund the services required. Innovative programs for treating AIDS patients in the community, such as a hespice without value or a case recognized program and education programs for drug abusers, must be emplored. The Medicare hospics program could be adapted for AIDS patients by easing current eligibility restrictions and by raising the reimburgement calling, which is too low to assure the amount of services needed by AIDS patients.

In addition, I ask your support for the following measures:

- o Establishment of Medicare eligibility upon disposis. Currently AIDS patients are not eligible for Medicare unless they have been certified as disabled for a two year period. One half of AIDS patients, however, die within two years of disposis. These patients are unually severely disabled, have exhausted their financial resources, lost their homes, and needed intensive medical one and social services.
- o Assignment of AIDS patients to a Diagnosis Related Group (DRC) that accurately reflects the cost of care for the disease. Ourrently, AIDS is reimbursed at a lower rate than the average patient, despite its significantly higher costs.
- o Development of a broader strategy of federal support for long term care, especially in catastrophic illness situations. There is a great and growing need for long term care services to meet the needs of AIDS patients who no longer require acuts care in the hospital setting, but need continuing care and support in the home or in a structured residential health care setting. Hadicare coverage for skilled nursing facility care and home health care is largely restricted to short term, post-scute care for the elderly.

This is insufficient to meet the chronic longer term care needs of the younger AIDS patients. Ourrently, Medicare does not provide for chronic care in the home; homemaker/personal care services are not covered; and home health aide coverege is too limited in terms of hours and duration of service to assure the amount of care necessary to serve the AIDS patient. There is a need to provide an integrated and coordinated service plan at home which combines skilled care including nursing, therapies and home health aides, and personal care/support services.

- o Increased use of waivers that allow Medicaid coverage of home and community based services. Federal Law allows State Medicaid programs to cover certain home and community based services for persons who would otherwise require treatment in a skilled nursing facility or intermediate care facility, so long as the cost of cutpatient care does not exceed the cost of institutional care. Increasing the availability of these waivers would enable states to provide long term care services to ATDS patients in a more cost-effective home or community setting, while at the same time allowing scarce long term care beds to be more approprizely utilized.
- o Allocation of additional funds to research the cause of AIDS and to first a cure. These funds should not be marely reprogrammed from other areas of health research. Such a practice would negatively affect other valuable projects, and would pit different areas of health research against each other in a battle for dollars.

The AIDS epidemic is not confined to certain areas of the country. The City of New York will continue to do its part in competting the disease and treating its victims—but the City and other localities cannot bear the burdsh alone. As the Mayor of the largest city in the country, a city which has recently survived a fiscal crisis, I clearly understand the constraints of a budget. The AIDS crisis, however, cannot be met by focusing on the bottom line. As with national defense, the effort made must match the external threat. In the case of AIDS, the threat is great and growing rapidly. Money spent now on research hastens the day when a cure or treatment can be found, and ultimately will save many times its expense by preventing further spread of the disease.

I appreciate the efforts that have been made to date, and applied the progress that has resulted. Unfortunately, however, much more is needed, and quickly. I ask your assistance in addressing this problem, and in ensuring the continued viability of many of the health care institutions upon which all Americans rely.

All the best.

edward I. Koch HAYOR



THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

November 7, 1985

Plato's Retreat 509 West 34th Street New York, N.Y. 10001

Dear Sir:

I am sure that you have known for some time that anal intercourse is a primary means by which the HTLV-III virus, which causes AIDS, is transmitted.

On October 25, 1985 the Public Health Council of the State of New York amended the New York Sanitary Code to define anal intercourse and fellatio as "high risk sexual activity". (I enclose a copy of the regulation and the resolution passed by the Public Health Council). That resolution provides that:

"No establishment shall make facilities available for the purpose of sexual activities in which facilities high risk sexual activity takes place. Such facilities shall constitute a public nuisance dangerous to the public health".

The Sanitary Code amendment also provides that various officials, including local health officers, may close any facilities or establishments which constitute a public nuisance—i.e., may close any facility or establishment in which anal intercourse or fellatio takes place.

You probably by now have also heard that, acting pursuant to those provisions, as well as numerous other provisions of law relating to public nuisances, the City obtained an order last night from the Supreme Court of the State of New York granting a temporary restraining order closing an establishment known as the Mine Shaft. We intend to continue to take such actions with respect to other establishments which constitute a public nuisance.

Nevertheless, if action with respect to saving lives can be achieved by prompt and clearly effective voluntary compliance, all concerned will benefit. We have no desire to close an establishment or to interfere with the activities which may occur in such an establishment unless it is necessary for the public health reasons previously referred to. In addition, we have no desire to enter into unnecessary litigation or to in any way harm the reputations of law abiding persons or establishments.

For all those reasons, I would like you to send me a report by November 14, 1985 which indicates, with specificity, precisely what steps you have already taken and what further steps you will take to assure that neither anal intercourse nor fellatio takes place in your establishment. In providing that answer, you should divide your response between steps with respect to (a) cubicles or other enclosed spaces and (b) larger and more open rooms in your establishment. Of course, if you have any other steps you intend to take, or comments you would like to provide, your response should indicate that. I intend to have these reports reviewed by the Corporation Counsel and he may be in touch with you for further information while I am away.

Sincerely,

Edward I. Koch

MAYOR

509 West 34th Street New York, New York 10001

November 14, 1985

Hon. Edward I. Koch Mayor, City of New York City Hall New York, New York 10007

Dear Mayor Koch:

We are in receipt of your letter of November 7, 1985 and we want you to know that even before receiving it we have started to take steps to alleviate the fears about AIDS which has been getting so much publicity lately.

We intend to immediately take the following steps, some of which have already been implemented:

- 1. Signs will be prominently displayed in the establishment prohibiting oral or anal sex.
- 2. We will provide adequate security in the Club to see that none of the regulations are violated.
- 3. Flyers will be distributed upon admission to the premises setting forth these rules.
- 4. Our ads will indicate that this is a couple's club and we will stress the social aspects thereof.

I have taken it upon myself to attend classes and lectures on AIDS; as a matter of fact, I attended a session last night sponsored by Roosevelt Hospital. The attached list of precautions, which I have taken from the booklet produced by the New York State Dept. of Health will be included in the flyers to be distributed by us.

We seek to co-operate with the authorities and if there is anything further of a reasonable nature that the City wishes us to do, we would be happy to discuss it.

Sincerely yours,

PLATO'S RETREAT

By Jamy Townson

Based on this information, there are precautions that can be taken by the general public and by persons in special risk groups to eliminate or reduce the risk of contracting AIDS:

- O DON'T HAVE SEXUAL CONTACT WITH ANY PERSON WHOSE PAST HISTORY AND CURRENT HEALTH STATUS IS NOT KNOWN.
- DON'T HAVE SEXUAL CONTACT WITH MULTIPLE PARTNERS OR WITH PERSONS WHO HAVE HAD MULTIPLE PARTNERS.
- O DON'T HAVE SEXUAL CONTACT WITH PERSONS KNOWN OR SUSPECTED OF HAVING AIDS.
- o DON'T ABUSE INTRAVENOUS (IV) DRUGS.
- DON'T SHARE NEEDLES OR SYRINGES (boiling does not guarantee sterility).
- O DON'T HAVE SEXUAL CONDUCT WITH PERSONS WHO ABUSE IV DRUGS.
- USE OF A CONDOM DURING SEXUAL INTERCOURSE MAY DECREASE THE RISK OF AIDS.
- O DON'T SHARE TOOTHBRUSHES, RAZORS OR OTHER PERSONAL IMPLEMENTS THAT COULD BECOME CONTAMINATED WITH BLOOD.
- O HEALTH WORKERS, LABORATORY PERSONNEL, FUNERAL DIRECTORS AND OTHERS WHOSE WORK MAY INVOLVE CONTACT WITH BODY FLUIDS SHOULD STRICTLY FOLLOW RECOMMENDED SAFETY PROCEDURES TO MINIMIZE EXPOSURE TO AIDS, HEPATITIS B AND OTHER DISEASES.
- O PERSONS WHO ARE AT INCREASED RISK FOR AIDS OR WHO HAVE POSITIVE HTLV-III ANTIBODY TEST RESULTS SHOULD NOT DONATE BLOOD, PLASMA, BODY ORGANS, SPERM OR OTHER TISSUE.

- -

- O PERSONS WITH POSITIVE HTLY-III ANTIBODY TEST RESULTS SHOULD HAVE REGULAR MEDICAL CHECKUPS, AND TAKE SPECIAL PRECAUTIONS AGAINST EXCHANGING BODY FLUIDS DURING SEXUAL ACTIVITY.
- O WOMEN WHO HAVE POSITIVE HTLV-III ANTIBODY TEST RESULTS SHOULD RECOGNIZE THAT IF THEY BECOME PREGNANT THEIR CHILDREN ARE AT INCREASED RISK OF GETTING AIDS.

November 14, 1985

BY HAND

The Honorable Edward I. Koch Mayor of the City of New York City Hall New York, New York 10007

Dear Mayor Koch:

This is in response to your letter of November 7, 1985, regarding the recent AIDS Amendment to the State Sanitary Code.

Obviously, the public health is of transcendent concern, but closing gay bathhouses will not be effective in combatting the spread of AIDS. A significant and overlooked fact about AIDS is that recent behavioral modifications by gay men already have resulted in a substantial decline in the rate of spread of the disease among them. Because of the long incubation period, current AIDS statistics have barely begun to reflect this. However, since rectal and pharyngeal gonorrhea in men are transmitted in the same manner as AIDS, it is relevant that a CDC Study of those diseases in men (almost exclusively homosexual) covering the years 1979 to 1983 shows, in Manhattan alone, a decline of 59 percent, and that New York City Health Department statistics show an 80 percent decline in such gonorrhea among homosexual males between 1980 and 1985. A comparison of these statistics with those of gonorrhea among heterosexuals shows that gay men have dramatically modified their sexual behavior to avoid practices which lead to the spread of AIDS. And recent statistics showing a significant drop in the proportion of gay AIDS victims to all AIDS victims verify this conclusion.

Obviously, then, the private programs undertaken by various community groups and establishments since 1982, including dissemination of educational materials at gay meeting places such as The New St. Marks Baths, have worked. And since most gay men already have made appropriate behavioral modifications, no public health purpose will be served by closing gay establishments; certainly the small number of compulsive gay men who still engage in unsafe sex will continue to do so whether or not bathhouses and bars remain open. If there ever was a time for Government intervention, it was in 1982 or before, not now. To put it colloquially, the Amendment is an attempt to close the barn door after the horse has escaped.

To make the case against bathhouse closure even more compelling, studies -- including the McKusick Study and City

Clinic Cohort Study in San Francisco -- show that closure will not reduce the spread of AIDS, even assuming that unsafe sexual conduct were occurring in the bathhouses. And that conclusion is shared by most psychologists, sociologists, sexologists and epidemiologists who have considered the issue, many of whom have concluded that closure, by removing an important situs for education about and peer pressure for safe sex, would be counterproductive.

As you know, your own Health Commissioner, Dr. Sensor, has recommended against closure, as have the Committee for Sexual Responsibility and the AIDS Advisory Council. Indeed, it was only recently that the State Health Commissioner, Dr. Axelrod, reversed his earlier stand against closure, on the ground that AIDS continues to spread in spite of educational efforts over the last year or so. The fallacy in that rationale is that it fails to account for the fact that current AIDS statistics reflect sexual conduct that occurred years ago.

The New St. Marks Baths has been a leader in the fight against AIDS. We already have contributed more than \$50,000 for AIDS research and prevention, and for care of AIDS victims. Also, we have taken the following steps on our premises to discourage sexual practices that might spread AIDS: conspicuous posting of signs that encourage safe practices and explicitly distinguish between safe and unsafe sex; distribution of hand-out literature to the same effect; elimination of public rooms for group sex; distribution of free condoms, each in an envelope advising that its contents "could save your life"; patrolling all open areas to assure that only safe sex is being practiced; and requiring each patron to sign a statement acknowledging that he has read, understands and will follow the Safe Sex Guidelines formulated by The New York Physicians For Human Rights. All this was done prior to expressions of concern by Government; after promulgation of the AIDS Amendment, we have posted signs advising patrons that the Amendment defines anal intercourse and fellatio as high risk sexual activity, we have included this same information in the statement that each patron must sign, and we have modified that statement so that it now contains the patron's agreement to refrain from any act that may be harmful either to himself or to others.

I am sure you will agree, therefore, that anyone engaging in sex on our premises has every motivation to make it safe. Unfortunately, the Amendment subjects us to closure even

if certain <u>safe sex</u> -- for example, anal intercourse with a condom -- takes place in a private room, and we believe that the Amendment is overbroad in this and other respects. Moreover, by failing to distinguish between safe and unsafe sex, the Amendment takes a step backward in the highly successful educational effort that we and other responsible establishments have undertaken.

It is worth noting that your recent characterization of bathhouse owners as "vile" and "merchants of death" (in the same manner as cigarette vendors, we suppose) evidences a regrettable lack of sensitivity to Constitutional rights here involved, and to the importance of not aggravating an already inflamed public opinion. Those Constitutional rights include the right of individuals to associate freely and to practice private sex, and the right to operate a lawful business. The opportunities for gay men to socialize in a supportive, non-hostile environment always have been limited, and never more so than today, when AIDS hysteria has elevated homophobia to an unprecedented height. Closing bathhouses and other gay establishments now will as a practical matter leave gay men with virtually no havens of assembly.

Finally, one unexpressed sentiment pervades this controversy, namely, the aversion that many heterosexuals feel towards homosexuals. Why, these heterosexuals would ask, do gay men even want to frequent establishments to participate in what most heterosexuals view as aberrant, promiscuous sex, whether safe or not? We will not answer that question here, because the answer is emphatically irrelevant. What is relevant is that the Constitutional rights of the gay community must prevail over political pressures for closing an establishment such as ours to create the appearance that something is being done about AIDS. And this is so quite apart from the ironic fact that AIDS amongst homosexuals — as opposed to drug addicts — poses virtually no threat to heterosexuals.

Rather than succumb to the hysterical voice of a frightened and ill-informed majority, this is a time for bold political leadership and initiative. The New Jersey Health Commissioner, Dr. Goldstein, recently stated that from a public health point of view all that is needed to combat the spread of AIDS is "a condom and a clean needle." Indeed, Dr. Sensor apparently still agrees with that view, but his courageous idea of distributing free, clean needles to addicts has not been implemented. Perhaps the concept of assisting addicts in their habit is offensive to powerful political constituencies. So too, unfortunately, are gay establishments and, indeed, homosexuals themselves.

The Commission on Wartime Relocation and Internment of Civilians recently concluded that the now infamous World War II decision to intern Japanese Americans was shaped by "prejudice, . . . hysteria and a failure of political leadership." In the present crisis, it is the responsibility of the political leadership to cull the facts from the prejudice and hysteria, and thus protect against yet another ignominious assault on the rights of an already oppressed minority and, indeed, on the Federal Constitution itself.

Very truly yours,

MARKS BATHS THE NEW ST.

Manager Mailman Brace

Judge Backs AIDS Policy Of Schools

By JOSEPH P. FRIED

A State Supreme Court justice ruled yesterday that children with AIDS cannot auto-

in New York City public schools.

He upheld the city's policy of deciding case by case whether such children should attend normal classes.

But the justice, Harold Hyman of Queens, But the justice, Harold Hyman of Queens, also declared in his 82-page ruling that city officials had developed their policy "behind the cloak of secrecy," and "perhaps unwittingly, let loose the forces of anxiety and fear." He also criticized unidentified "members of the medical community" he said had "exacerbated the fears and fueled the passions" by their "professionally irresponsible and baseless characterizations of this disease as a 'plague.'"

sponsible and baseless characterizations of this disease as a 'plague.'"

The city announced its policy just before the school year began in September. It also permitted an unidentified second grader then believed to have AIDS to remain in regular classes at an undisclosed location in the city. As a result, thousands of parents in two Queens school districts kept children out of school during the first week of out of school during the first week of classes

The districts, 27 and 29 in southern and eastern Queens, then filed a suit challenging the city's policy as unsafe. Justice Hyman held a five-week hearing on the matter in September and October

The city's chief lawyer, Corporation Counsel Frederick A. O. Schwarz Jr., who headed the legal team at the hearing, said he was "delighted" at the ruling and predicted it would "have both local and national significance." Regarding the judge's opinion that city officials had failed to be sufficiently open in fashioning the policy, Mr. Schwarz said, "They acted in a way that reflected the pressure of time." An attorney for the school boards, Robert

Sullivan, termed the ruling a "defeat for the people of Queens," but he found "no fault" with the ruling, which he called "legally correct."

A Violation of 'Equal Protection'

He said the judge was right in finding he could not overturn the city's policy inasmuch as the State Legislature had not classified AIDS, or acquired immune deficiency syndrome, as a "communicable disease." Mr. Sullivan said he had not yet de-

cided whether he would appeal.

Justice Hyman also held that automatic exclusion of children with the disease from normal classes would violate their rights "to equal protection of the laws."

boards of the Queens districts had argued that the city's approach of allowing at least some children with AIDS to be in

The myths on AIDS are separated from the facts. Personal Health, page C6.

normal classes was unsafe. "The experts unanimously agree," Justice Hyman said, "that the virus is not transmitted by casual interpersonal contact or airborne spread." After the hearing ended, it was determined that the child thought to have AIDS had been infected with the AIDS virus but actually had a related immune deficiency. No child with AIDS is currently known to be in the city's school system, health officials say. Under the city's policy, recommendations on whether such children should be in regular classes are to made by two panels, one of seven doctors and one of a doctor, a school official, a social worker and a parent.

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From:

VJD

Interviewee: Nathan Quinones

Session #1

Interviewer: Jonathan Soffer

Queens, New York

Date: May 17, 1995

[page 35]

Can you tell me a little about the contraception controversy, how it arose, and how you and,

I think, Bobby Wagner, were instrumental in handling it at that time?

Quinones: It took a number of -- It was like a prism. When I first took over the school system

was in the process of a curriculum on health education, sex education. My God, I was deluged with

-- against it, this was pornographic, we were going to induce children to have more sex -- and

particularly strong lobbying by the churches, particularly the Catholic church. So that was going on.

When the AIDS announcement, I guess particularly with Rock Hudson's death -- which to me was,

my God, this he-man has died of AIDS! -- that was a major revelation. The second year after I was

trying to push that sex-education curriculum, almost no mail against it. Now our concentration is

with AIDS so the sex-education curriculum has less importance. [end of page 35 - begin of page

36]

Simultaneously, I was pressing for health clinics in the schools, which some referred to as

sex clinics. In my view, then and now, health clinics have to be expanded and many of these things

are health issues, yes involved with education, but they certainly should be primarily in the hands of

health professionals and not a health teacher and not a social studies teacher, handing out condoms

in the classroom. That should be done in the context of an individual's total health, mental as well

as physical.

When the AIDS thing started to be of some concern my deputy, Chuck [Charles I.]

Schonhaut wrote the commissioner of health asking for the policy on AIDS. Now we didn't receive a response until almost the beginning of the opening of school year. The state also didn't come out with any guidelines. The hysteria on AIDS continued to escalate and apparently it was learned that we had some children with AIDS in our schools. We started organizing, and we were very clear that this is still primarily a health issue before it is an educational issue. We had a group of people we assembled under the Department of Health that included, I think, a pediatric physician with experience in AIDS, a pediatric social worker, a parent and a teacher, if I'm not mistaken, somebody with pedagogical background, to review those cases of children with AIDS and whether they should be in a school setting. That recommendation was then given -- and, by the way, anonymously; not the gender, not any other identifying feature -- and that was something that was then given to the Department of Health.

However, the hysteria on AIDS was escalating and some community [end of page 36 – being of page 37] school districts, particularly School District #27, I think it was, in Far Rockaway, started a movement for us to reveal the names of all children with AIDS. I refused to do that. They then got all the community school districts to boycott (there was a boycott of schools), and to bring a case against me and the board for us to reveal the names of all the children in schools. But, in fact, the resolutions passed by the respective school boards were that no child with AIDS should be in school, no person who had communicated with someone who had AIDS should be in school—There were three resolutions that would have made our schools empty if we had abided by those resolutions.

Koch was very silent. I thought I heard him coming out on two sides of the issue: Yes he supported it, no he did not. However, he remained fairly quiet but certainly gave the green light for the then corporation counsel, Fritz [Frederick A.G.] Schwartz, to handle the case himself. It was a long and arduous thing to sit through but we won, and we were fortunate enough to establish a standard that other districts throughout the country abided by, contrary to what some of the districts did to Ryan [], if you recall, and the burning of the homes of two children with AIDS, I think in Florida. But one of the districts even invited the superintendent who had excluded, I think, Ryan

from school to speak to them.

Q: Contraception -- Oh, we did talk --

We had the Harvey Milk School, also, which created -- It [end of page 37 - begin of Quinones: page 38] is a damning indictment of the media, the way they have exploited some of these things. They improved themselves by concentrating on AIDS and how it was contracted. I think we went through an educational period, both on television and the newspapers, as to how you contract AIDS, as opposed to how you salivate -- You sneeze on somebody and he's going to get AIDS, if that person is infected. But then we had some young people who were enrolled in a very small program, referred to as the Harvey Milk School, and that also -- I got a call, I think at 6:00 in the morning, somebody asked my wife whether I was aware that there was a high school for homosexuals and lesbians in New York City. She said, "What now? I didn't know about this," and she turns to me, "What are you doing now?" she asks me. I said, "My God, it's a small program." We had barely, I think, fifteen severely -- Well, these kids had been thrown out of their homes, beaten in many instances by their parents or by their fellow classmates in the high schools they had attended, and they were hustling their bodies over on the West Side. So they were at least in a program, getting some instruction, trying to get some counseling, and it was marvelous that they could be reintegrated into a school setting. But that was like -- I couldn't do any work in the office. I had to call for a press conference so I could handle all of them at once. To his credit, Jim Regan, who was the president of the board at the time, agreed to come with me. He volunteered, an Irish Catholic from Staten Island to accompany me.



THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

VICTOR BOTNICE Special Assistant to the Mayor Health Services Administrator

March 19, 1985

Dr. David Axelrod Commissioner of Health Empire State Plana Albany, New York 12237

Dear David:

I am writing to call your attention to a matter that I am growing increasingly concerned about, namely, the need for more effective coordination between the State and City in addressing the AIDS crisis.

A major problem is the fact that there is no lead agency or individual at the State level responsible for establishing an overall policy on AIDS. In addition, there has been little, if any, attempt by individual State agencies to coordinate AIDS-related activities with their counterparts in the City. This lack of interaction has proven to be a stumbling block to integrated planning and implementation of service programs for persons with AIDS.

Perhaps this problem is best highlighted by Mel Rosen's recent statement when testifying before the House Energy and Commerce Committee's Environment and Health Subcommittee. He basically stated that the New York City Department of Health was its own entity, and denied being aware of its activities on any regular basis. In fact, one Congressmen had to ask him if indeed, New York City was in New York State. This was not helpful to the City, or to the State, in attempting to attain Federal appropriations for AIDS related services.

Moreover, as a result of this confusion, the City has had to set funding priorities and make decisions about program developments in a vacuum, without being apprised of the State's priorities and programs. In some instances there has been a duplication of effort. For example, the City Department of Smalth co-sponsored an AIDS conference with the Department of Substance Abuse Services (DSAS) for staff members of substance programs, only to discover that DSAS had subsequently scheduled a conference on the same subject, for the same target audience, for approximately the same date.

Similarly, I was advised that at a recent National Health Policy Forum at the George Mashington University, Nel Rosen, who was one of the panel participants, asmounced that the State is planning to offer alternate site testing for drug abusers in Brooklyn, the Bronz, and Manhattan. He also advised that the State is setting up a mobile wan program to do outreach education in high drug abuse areas, and that an NFF will be issued in the next three weeks for a computer tracking system for AIDS patients that tracks particular types of services which AIDS patients are receiving, including the cost of these services.

The City has generally not been informed, or at best at the last minute, of the State's intentions to pursue AIDS initiatives. Though we wholeheartedly support these initiatives, the problem is that without joint planning, the City is seriously hampered in its ability to make rational decisions about AIDS programming and funding allocations that take into account the maximisation of available resources, the areas where services overlap and the opportunity for linkages. The one area where there has been some effort to communicate with the City by the State Department of Health, has been around the development of the RTP for AIDS Centers, and we believe that communication has been helpful in shaping a program that is better suited to the unique needs of New York City's hospitals.

The City has achieved notable success in its own efforts to improve interagency coordination through a formalized interagency planning structure. This system has ensured that any service gaps are readily identifiable, that service programs are not duplicated, and that the City's limited financial resources are being efficiently allocated. Unfortunately, the same level of coordination does not exist between the City and the State with respect to AIDS.

In order to alleviate this problem and to foster more efficient planning, I think it would be very useful for representatives from the State Department of Health to attend regular meetings with members of the City's AIDS Interagency Workgroup, to discuss current and future State plans as they relate to AIDS.

I look forward to discussing this with you, and would be interested in any suggestions that you might have on how we can better coordinate City and State efforts. As we discussed, we will certainly follow-up and periodically invite Florence Pracher to the AIDS Interagency Workgroup meetings, so that she can be kept abreast of the City's initiatives.

All the best.

Victor Botnick

cc: Stanley Brezenoff Ilene Margolin



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THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

VICTOR BOTNICK
Special Assistant to the Mayor
Health Services Administrator

TO:

Edwrd I. Koch

MAYOR

FROM:

Victor Botnick

Special Assistant to the Mayor Health Services Administrator

RE:

AIDS INITIATIVES

DATE:

March 24, 1986

Enclosed please find a status report on the City's AIDS Initiatives.

I am also enclosing, for your information, a copy of a recent letter I sent to the New York State Commissioner of Health, pavid Axelrod, MD, calling for more effective coordination between the planning efforts of the City and State in addressing the AIDS crisis.

The letter stresses the fact that without joint planning, the City is seriously hampered in its ability to make rational decisions about AIDS programming and funding allocations that take into account the maximization of available resources, the areas where services overlap and the opportunity for linkages.

I will keep you apprised of future developments.

/mip

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THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

VICTOR BOTNICK
Special Assistant to the Mayor
Health Services Administrator

TO:

Edward I. Koch

MAYOR

Stanley Brezenoff First Deputy Mayor

FROM:

Victor Botnick

Special Assistant to the Mayor Health Services Administrator

RE:

AIDS INITIATIVES UPDATE

DATE:

March 21, 1986

The following is a status report on the AIDS initiatives. Before describing the recent activities of the various City agencies, I wanted to mention that planning is underway for a City sponsored one-day conference on AIDS scheduled for June 10, 1986. We hope to attract 500 professionals from various voluntary agencies who provide direct services to AIDS patients.

The purpose of the conference is to provide a forum for these professionals to learn about what types of AIDS programs the City offers and how to access these services. It is hoped that the conference will create a greater awareness of the City's service program for AIDS patients, improve coordination between the activities of the voluntary sector and the City, and stimulate the sharing of ideas that will supplement the City's long range planning efforts.

In order to ensure that we are reaching a broad spectrum of providers, registration will be controlled so that all groups are equally represented (e.g., social workers, hospital workers, gay community, drug counsellors, etc.). Registration from any one agency will be limited to several members.

The tentative program will include: remarks by you announcing new money/initiatives; a broad overview of the public health, medical, social service and legal programs offered by the City with a detailed description of how those programs can be accessed; and a discussion of the City's long range plans for AIDS. Six pre-registered afternoon workshops will follow a lunch period, and allow for more selective and in-depth exploration of certain areas, e.g., substance abuse.

A consulting group will plan the conference with the Fund for the City of New York acting as fiscal agent. The press office will coordinate invitations to the press. I will keep you apprised of future developments as the planning for the conference proceeds.

Specific details regarding the status of the AIDS initiative activities are set forth below:

Laboratories and Epidemiologic Support

HTLV-III Laboratory: During January and February, the ELISA laboratory received 1500 specimens and performed a total of 3,784 assays. The cumulative total of specimens received from the start of this program is 5,112 and the total number of tests performed is 22,821. A total of 3,150 reports of HTLV-III results have been mailed out to participating doctors since October 11, 1985.

The Western Blot assay has been performed on a total of 3,254 samples for a total of 4,228 tests since March 20, 1985. During January and February, 844 samples were assayed by the Western Blot technique for a total of 1,236 tests (this includes repeats, controls, and experimental protocols).

Surveillance and Investigation Activities: As of February 18, 1986, New York City has had 5,646 cases of AIDS representing an increase of 228 cases from the previous month. CDC National Surveillance reports total U.S. cases as of 2/10/86 at 17,111.

The Pediatric Surveillance Report for February shows six (6) new cases for a cumulative total of 114. Sixty-six percent of these children have died and the mortality rate for adult cases is 55 percent.

On January 22, 1986, The Department of Health, represented by Dr. Stephen Schultz, participated in a meeting sponsored by the United States Conference of Local Health Officers Working Group on AIDS. The Working Group made the following recommendations to the United States Conference of Mayors: adherence to the strictest confidentiality protocols for any AIDS related health activity; opposition to the reporting of HTLV-III test results; rejection of calls for quarantine; development of risk reduction efforts, including the preparation of explicit materials where necessary and the exploration of innovative risk reduction efforts for the addict population; and increased federal funding for AIDS.

Preliminary data from the Department of Health's TB study supports the hypothesis that the increase in TB incidence in New York City is a function of AIDS-related immunosuppression. The study indicates that there is an ecological association between health districts with increasing TB rates among young males and risk factors for AIDS. Serosurveys for evidence of HTLV-III infection among male TB cases between the ages of 25 and 44 have been underway since July 1985. Twenty-one of 36 men (58%) with TB who have been interviewed and tested for HTLV-III have been positive for HTLV-III. Among those who are HTLV-III positive, 17 report being intravenous drug users, two report being homosexual, and two report being in no AIDS risk group.

General Education and Support for Risk Reduction

- total number of calls received at the AIDS Hotline was 6,348 (approximately 100 calls per day). (More current statistics are temporarily unavailable since the hotline data is presently being computerized.) The volume of calls has decreased from a high of around 1,000 calls a week in the months before November, 1985 to around 700 per week over the last several months. All hotlines in the area report a similar trend. Though the volume of calls has decreased, there has been an increase in calls from clearly at risk, symptomatic or diagnosed individuals. The Hotline has expanded its hours to include Saturday 9 a.m. to 9 p.m. During the period from November 20 to January 18, 1,158 medical referrals and 246 social service referrals were made.
- AIDS Education Unit: The AIDS Education Unit made 102 education and training presentations between November 18, 1985 and February 13, 1986. 5,367 people were reached through these efforts. During the same period, 61,621 copies of the general AIDS information brochures were forwarded to private citizens, physicians, schools and city and state agencies.

In addition, 10,954 Resource Guides, 26,571 Wallet Cards and 10,431 copies of ATDS - A Special Report on Acquired Immunodeficiency Syndrome were distributed. The general information brochure has been translated into Spanish and the first printing of 4,500 brochures was distributed, a second printing of 19,000 was run and 3,788 of these have been forwarded to private citizens, physicians, schools, and City and State agencies.

Patient Care Services

Inpatient and Outpatient Services:

- Interdisciplinary Health Care Teams: Staffing for the Interdisciplinary Health Care Teams is complete at Bronx Municipal, Metropolitan, North Central Bronx and Queens Hospitals. The Lincoln Hospital team is complete except for a physician who has been identified and will start in July, 1986 with interim coverage by existing hospital staff. Both teams at Kings County are complete except for one nurse clinician slot. At Harlem, a physician assistant is on board, the physician has been identified for a permanent role beginning July, 1986 and a social worker is being recruited. At Bellevue, one of the two teams is complete and the second team is lacking a physician though negotiations are currently underway with a candidate for this position.
- HHC AIDS Coordination Unit: The position of Physician Consultant has been filled and he will be on board March 17, 1986. Planning staff are interviewing candidates for a Systems Analyst. A half-time Systems Analyst and Central Office Coordinator have been on board since August. The Offices of Patient Relations and Risk Management report patient complaints and actions taken to the AIDS coordination staff monthly, or more often as needed, in order to ensure oversight and appropriate follow-up and resolution.
- Bellevue Hospital Inpatient AIDS Unit: The ten bed unit opened on January 13 as scheduled and is fully operational. Staffing has been completed, with the exception of a few non-essential roles. Orientation is ongoing. The Bellevue AIDS Unit census is regularly at its capacity of 10 patients.
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 HHC Data Collection: Inpatient data collection by RHC's Office of Planning is ongoing. The monthly demographic survey has been revised and all facilities provide a daily census and Alternate Level of Care (ALOC) breakdown each week. The Coler AIDS Longterm Care Assessment Team is provided with the ALOC

information to facilitate identification of potential patients. Following a holiday season decline, the Corporate Average Daily Inpatient Census for the month of February 1986, was 241, up from the prior month's 220.5.

The Office of Planning has received consultant reports on the provision of services relating to AIDS in Ambulatory Care and Dentistry and will develop these materials into proposals for services.

Nursing and OTPS Resources: Funding for nursing and OTPS enhancements, based on the increase in census, were approved by OMB in January. The Budget Office has allocated these funds to the facilities, based on the weekly census work load data collected by the Office of Planning. Additional resources are being requested on behalf of the facilities, as part of the FY '87 budget. Adherence to expenditure plans will be reviewed during facility site visits by a Central Office Team comprised of representatives from Planning, Budget and Ambulatory Care offices. These visits will begin as soon as the Physician Consultant is on board.

HHC AIDS Advisory Group: The HHC AIDS Advisory Group continues to hold monthly meetings. The next meeting is scheduled for March 21. Ad Hoc committees were convened to address special issues and resulted in the following:

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- A revised training film is in the process of being completed and is expected to be ready for distribution by the end of March.
- Companion revised printed educational and training materials incorporating subjects identified through an employee questionnaire on AIDS, are also being prepared;
- Following corporate review and comment, policy recommendations with regard to employees with AIDS, infection control and HTLV-III testing have been prepared for implementation by HHC. In addition, policy recommendations for employees with AIDS were submitted to the City-wide task force on employees with AIDS;
- A financial analysis of the cost of treating AIDS patients has been initiated using data from a representative sample of AIDS patients at Bellevue, Harlem, and North Central Bronx. Case reviews, using a survey instrument developed by the Finance Department, have been completed and cost analysis of the case reviews is proceeding. Completion of the study is expected in mid-March, 1986; and

A nursing utilization/cost study updating the previous 1983 data, was performed over a one-week period at Bellevue, Harlem and NCB. The study has been completed, and the findings will be included in the overall AIDS cost analysis.

In addition to the AIDS Advisory Group, an HHC Management Group meets weekly to oversee all aspects of the AIDS projects, facilitate progress and resolve any problems of the AIDS Initiatives. This group is also preparing a grant application for a \$2 million Robert Wood Johnson Foundation AIDS Health Services Program. The due date for letters of intent is March 17, 1986.

Pediatric Day Care: The proposed budget and staffing pattern for the Day Care Center was reviewed by HRA, Bronx Municipal, and HHC's Budget, Corporate Affairs, and Planning Offices. Budget is currently reviewing a revised budget and expenditure plan. HRA has provided a plan for potential reimbursement of Day Care costs and will assist with the licensing process.

Core Staff consisting of the physician, administrative teacher and secretarial staff was in place as of November 15. Core staff is completing program development, including medical protocols and selection criteria.

Although recruitment of remaining staff is largely complete, several critical roles remain vacant, because of a lack of qualified applicants. BMHC is using a variety of resources to identify candidates and anticipates completing its staff complement by March 15. HRA will assist with expediting the lengthy (6 week) State screening procedure required of all day care employees.

Construction began December 4 and was completed by February 15. Outfitting will be completed by March 23. All required outfitting items have been ordered. Central Office is expediting this schedule.

Following completion of construction and outfitting, the space is subject to inspection and approval by the Departments of Buildings, Fire and Sanitation. Final licensing of the facility is contingent on approval by these agencies, plus completed screening of the entire complement of the day care staff.

Community-based Ambulatory Care Clinic: As you know, AIDS outpatient services are available at every HHC acute facility. A proposal has been developed to provide expanded outpatient services, coordinated by

interdisciplinary teams and monitored by Central Office, for submission with the FY '87 budget package. Representatives from HHC's Planning, Ambulatory Care and Mental Hygiene Departments met with the City DMHMRAS on March 6, 1986, to discuss coordinated ambulatory care services targetted to the IV substance abuse risks groups.

In January, approval was granted to HHC by the State Office of Health Systems Management to provide part-time clinic services through the Community Health Project (CHP) in Greenwich Village. The State also approved the inclusion of Bellevue/CHF Glinic on the Bellevue operating certificate. The clinic continues to operate 15 hours per week at CHP and 10 hours per week at Bellevue for direct patient care.

A budget has been approved by the HHC Medical and Professional Affairs and Finance Committees, and by the HHC Board. This contract period will end June 30, 1986. The contract is in the process of being negotiated.

Submission of monthly utilization reports to Bellevue and Central Office will begin shortly. Current waiting time for a first-time non-urgent appointment is four weeks. Assessments are being performed by a team consisting of a physician, nurse practitioner, social worker and patient advocate. The program will be expanded to include a health educator, public health nurse and a coordinating manager.

Extended Care Services:

Patient Assessment Team at Coler Hospital: The physician assistant and social worker have been hired; Coler has given initial approval to an identified candidate for the role of Infectious Disease Physician. Recruitment efforts continue for a nurse epidemiologist. In the interim, the team is functioning using staff borrowed from other areas of the facility.

As of February 28, Coler had admitted a total of 11 patients. Four of these have expired, 1 was discharged home, 4 remain in-house. During January, 12 patients were referred, six accepted and three admitted. A letter offering the Coler and Goldwater services to all voluntary hospitals has been sent. The team assessed its first four voluntary patients at St. Vincent's. One patient was accepted, but the family declined admission. Referrals from other voluntaries are expected in March. These referrals will be made through the HRA AIDS Crisis Intervention Service.

<u>Coler Long Term Care Program:</u> All ten of the renovated beds have been completed. Transfers to Coler from HHC's acute care hospitals and from Coler back to the acute care setting are being closely monitored for adherence to corporate procedures with good communication between facilities to maintain continuity of care.

Goldwater Respital AIDS Unit: All construction for an eight bed unit has been completed and staff recruitment is complete except for an infectious disease physician. Goldwater has identified two patients for admission the week of March the 3rd. Pending completion of transfer evaluations at the sending facilities, the transfers will be completed.

Comprehensive Home Care Services: HRA's contract with the Visiting Nurse Service (VNS) for the operation of a comprehensive home care program for AIDS patients began on January 15. As of February 20, VNS received 115 referrals from HRA. 45 of these are receiving services (23 have home attendants; 22 have home health aides); 11 are not receiving services since they are hospitalized; 50 are closed cases (5 returned to hospital and remained for more than thirty days; 35 died; 8 refused service and 2 closed for other reasons); and 9 are awaiting service.

AIDS Case Management Unit: Following completion of construction, the Manhattan Unit has relocated to the Waverly Income Maintenance Center. The selection of sites and staffing for three additional units to be located in the Bronx, Queens and Brooklyn is nearly completed. These units will be phased in over the next three months beginning in Brooklyn.

The Manhattan Unit has served about 456 persons since its inception in June and as of March, about 328 are still receiving services. This number includes 16 women and 13 pediatric AIDS cases. Approximately 65 persons were receiving some sort of housing assistance and 11 persons were awaiting assessments. The following is an approximate breakdown of the kinds of housing assistance provided in January and February:

0	ARC Units	9
0	SRO Hotels/Furnished Rooms	35
0	Financial Assistance to Maintain a Home	75

In December, January and February, referrals were received from the following sources:

0	HHC Hospitals	74
0	Voluntary Hospitals	80
0	Veteran Hospitals	4
0	Corrections	7
0	Self-Referrals	1
0	HRA Homeless Shelters	4
0	Private Doctors	4

0

The AIDS Medicaid Helpline has been phased out and a new HRA AIDS Helpline that serves as an information and referral line for the entire range of social services provided by HRA to all persons with AIDS, is in operation and is also located at the Waverly Center. The HRA AIDS Helpline, 645-7070, has ten phone lines and is staffed by a supervisor and four caseworkers. Helpline staff are trained to screen for eligibility for entitlement programs, offer information on home care vendors if the caller is not Medicaid-eligible, counsel on Medicaid spend-down, and make referrals to the appropriate borough case management unit.

As of February, the Medical Assistance Program Field Services Unit, in cooperation with GMHC, has done 86 Medicaid eligibility interviews in the homes of persons with AIDS or in the offices of GMHC. Three of these interviews were conducted in February.

Supplementary At-Home Services for Persons with AIDS: HRA received three proposals in response to their RFP for the provision of a range of supplementary at-home services for persons with AIDS geared particularly to these patients without any type of insurance. These proposals are currently being reviewed and contract negotiations are underway.

Human Rights Activities: As you know, the Human Rights Commission received approval to hire four additional persons for the AIDS Discrimination Unit - one attorney, two human rights specialists and a principal administrative associate. All four staff members have been selected: one human rights specialist is on board, the remaining three appointments are being processed.

The Unit has compiled updated statistics on the number of cases of discrimination related to AIDS reported to the Commission during the period November 1983 to October 1985. 199 cases of discrimination were reported during this period. These cases involved 187 persons, the majority of whom (113) alleged discrimination on the basis of AIDS. The remainder (74) alleged discrimination on the basis of being perceived as having AIDS (e.g. identified as a member of one of the risk groups for AIDS).

The breakdown of the 199 cases is as follows:

Area of Discrimination	Number of Cases
Employment	35
Housing	21
Public Accommodation	97
Insurance	9
Prison	8
School	2
Bias/Violence	<u>27</u>
T ó Tàl	199

Additionally, 44 of the case reports involved systematic discrimination characterized by widespread discrimination applied to any and all persons with AIDS. Therefore, a far greater number of complaints would result from an individual tally of the people actually affected by such systematic discrimination.

With respect to pursuing major complaint actions against nursing homes, ambulances, ambulettes and funeral homes, the AIDS Discrimination Unit is continuing to engage in activities geared toward providing a concrete basis for complaint action: documenting cases; eliciting the future cooperation of social workers for the filing of supporting affidavits; and identifying potential expert witnesses. Once the enhanced staffing is on board, the Unit will be able to fast track these activities.

The response to your letter to the ambulance and ambulette companies alerting them to the serious repercussions that would result from denial of service to AIDS patients, has been positive. Numerous companies immediately informed the Unit of their non-discriminatory policies. This information was forwarded to GMHC and social workers so they can call on these firms to service their clients with AIDS. Since the letter went out, there have been far fewer reports of ambulance turndowns.

Only one complaint has come from a funeral parlor following your letter to Governor Cuomo and this was easily settled by threats of legal action. Nonetheless, since the AIDS cases are directed to cooperative funeral homes, the problem of discrimination is masked and continues. Corporation Counsel is looking into the possibility of a joint effort being undertaken on both City and State levels to solve the funeral home dilemma.



LAW DEPARTMENT

100 CHURCH STREET NEW YORK, N. Y. 10007

FREDERICK A. O. SCHWARZ, JR. Corporation Counsel

vinst openherie

(212) 566-

MEMORANDUM

TO:

EDWARD I. KOCH

Mayor

MARCELLA MAXWELL

Commissioner of Human Rights

STEPHEN C. JOSEPH Commissioner of Health

FROM:

FREDERICK A.O. SCHWARZ, JR.

Corporation Counsel

RE:

AIDS Related Discrimination

I enclose a memorandum prepared by my office dealing with issues of AIDS-related discrimination. The memorandum concludes that work-place discrimination against (i) persons suffering from AIDS, (ii) persons suffering from ARC, or (iii) asymptomatic individuals who test positive for the HTLV AIDS virus, or (iv) individuals falsely perceived as carrying the virus is illegal under Federal, State and City laws relating to handicap discrimination. Much of the memorandum is a critical dissection of the recent Department of Justice advisory opinion which concluded that federal law provides no protection against discrimination even when based upon a medically irrational view that the AIDS virus can be spread by casual contact.

I agree with the annexed memorandum and offer the following more general comments.

The primary professional obligation of the Department of 1. Justice is to provide a convincing and professional analysis of the law. In this basic task, it seems to me to have failed. As elaborated throughout the annexed memorandum, the Department's opinion ignores relevant cases, relies upon irrelevant cases, overlooks pertinent legislative history, departs from the interpretation of the law by the Federal agency initially responsible for its interpretation (the Department of Health and Human Services), rejects the legal reasoning of the wing of the Department of Justice itself responsible for court enforcement actions under the Federal law (the Civil Rights Division), strains to avoid the plain language of the statute itself, and runs counter to the well-established principle that remedial legislation should be "construed broadly" to effectuate its purposes. (At the same time, It mistated the views of the only medical authority cited in favor of the suggestion that the AIDS virus is transmissible through casual contact).

Aside from analyzing the rigor and accuracy of its professional legal analysis, it is noteworthy and relevant to comment also on the likely effects of the Department of Justice's memorandum.

2. Last Fall, I personally tried the <u>District 27 (Queens)</u> case involving the child infected with the AIDS virus whose presence in achool was successfully defended by the City. I know from involvement in that case how powerful are the emotions, fears and prejudices surrounding AIDS and how many misconceptions as to transmissibility exist among many elements of the general public. I also know from that experience that the processes of the law can be used to teach, to calm and ultimately to help move from prejudice based upon misconceptions to the law can based upon facts.

In the Queens case, we used the educating function of the law and its adversary system to convince an initially hostile judge to uphold the courageous position taken by you, David Sencer and Nat Quinones. Justice Hyman wrote by far the most comprehensive judicial opinion in existence on the medical and epidemiological facts and the legal implications of AIDS and the AIDS virus. The understandably concerned Queens parents who sat through the trial every day acquired a reasonable sense of security. Most importantly, I believe that the patient and lengthy exposition of the facts at the trial and the court's detailed opinion, as reported by the media, helped to calm the general public.

Judged in terms of its effects, the Justice Department memorandum moves strongly in the opposite direction and exacerbates, rather than calms fears.

- 3. In addition, the Department of Justice's widely publicized memorandum, unless authoritatively discredited and disavowed, will have the effect of injuring the public health. In that memorandum, the Justice Department has announced that employers are free under Federal law to discharge persons because of a fear-even when irrational-that casual contact can spread the AIDS virus. As we proved in the Queens case, this will naturally and inevitably create pressures on carriers and potential carriers of the AIDS virus, deterring them from cooperating with public health authorities in providing epidemiological information and in obtaining health care advice.
- 4. Moreover, having stated that the effects of a legal view not the starting point for a professional legal analysis, is not to

say that effects are irrelevant to analysis of the meaning of a statute. The ultimate issue, after all, is what Congress shall be presumed to have meant when it passed the law. The Department's opinion encourages and rewards irrational beliefs, unfounded in medical evidence, concerning the spread of AIDS. The impact of discrimination based upon such irrationality is to harm a vulnerable class of individuals on account of their medical condition. But the very purpose of Congress in passing Section 504 of the Rehabilitation Act in 1974 was to prevent unequal treatment based upon prejudice, stereotype or irrational fear arising from, among other things, a physical impairment, or the perception thereof. The single greatest flaw in the Department's analysis is its utter failure to attempt to square its analysis with those broad remedial purposes of the Congress.

5. As you know, the Department of Justice's opinion is not a binding interpretation of Federal law. Moreover, by definition, it does not control the interpretation of either State or City law. Accordingly, we do not believe that the Department's interpretation should be followed by City agencies in administering programs covered by the Federal law and the Human Rights Commission should continue to enforce the City Human Rights Law on the basis that AIDS-related discrimination is covered.



LAW DEPARTMENT

100 CHURCH STREET NEW YORK, N. Y. 10007

FREDERICK A. O. SCHWARZ, JR. Corporation Counsel

MEMORANDUM

TO: FREDERICK A. O. SCHWARZ, JR.

Corporation Counsel

VIA: PAUL REPHEN

Chief, Division of Legal Counsel

JOAN SCHAFRANN

Assistant Chief, Division of Legal Counsel

PROM: STEVEN GOULDEN

Assistant Corporation Counsel

ABBY NOTTERMAN

Assistant Corporation Counsel

Examination of U.S. Department of Justice Memorandum on

AIDS-Related Discrimination

DATE: JULY 25, 1986

This memorandum is intended to assist the New York City

Miman Rights Commission in responding to complaints of discrimination

and on Acquired Immune Deficiency Syndrome ("AIDS") and related

menditions. Such complaints have been brought by individuals with

AIDS-related complex ("ARC"), asymptomatic individuals who

led positive for the antibody to the AIDS virus ("seropositive"

dividuals) and persons who are perceived as seropositive or as

faring from AIDS or ARC. Although the Human Rights Commission

the charged with enforcing the City Human Rights Law, an analysis of relevant federal and state law, in addition to that at the local level, is useful.

On June 20, 1986, Charles J. Cooper, Assistant Attorney General, United States Department of Justice ("DOJ"), issued a memorandum concerning whether \$504 of the Rehabilitation Act of 1973, 29 U.S.C. §794, prohibits AIDS-related discrimination. In that memorandum, DOJ interprets the statute narrowly to conclude that 1504 prohibits discrimination based on the "disabling effects that AIDS and related conditions may have on their victims," but that "an Individual's (real or perceived) ability to transmit the disease to others is not a handicap within the meaning of the statute and, therefore, that discrimination on this basis does not fall within section 104." DOJ Memo at 1. The term "handicap", as interpreted by DOJ, encompasses only the disabling effects of AIDS, or in some cases the disabling effects of ARC, but not the condition of being infected with the AIDS virus. DOJ asserts that since communicability is not itself handicap within the meaning of §504, nothing contained in the Act prohibits discrimination against persons with AIDS (and perhaps ARC) If the basis for the discrimination is fear of contagion, regardless of whether that fear has any rational basis.

^{*}DOJ reaches the same conclusions with respect to all remmunicable diseases in an amicus curiae brief ("DOJ brief") filed (Footnote Continued)



THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

August 29, 1986

Otis Bowen, M.D.
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Bowen:

I enjoyed our lunch during your recent visit to New York, and I'm glad we had the opportunity to discuss certain issues face-to-face. I know of your deep interest in drug abuse programs and I look forward to working with you to strengthen the Federal commitment in this area. I am writing to give you more information on two other issues I raised with you which are of great concern to New York City and the nation.

The first is AIDS. This disease will be one of the top ten killers in America within five years. An increasing percentage of the victims will be from places other than New York and San Francisco; there will also be more heterosexuals, more women, and more children falling victim to AIDS. We are facing a national crisis which requires a national response. Without increased Federal assistance, health care delivery systems across the country will be overwhelmed by the rising caseload in the next few years.

Attached is a letter I sent last year to President Reagan, outlining certain proposals which would help states and localities cope with the costs of AIDS care. Among these proposals are the establishment of Medicare eligibility on diagnosis and the assignment of AIDS patients to a DRG that accurately reflects the costs of care. The Federal government has yet to adopt any of the proposals described in my letter. I hope that with your leadership, we can begin to move on them.

The second issue of concern to me is two-party checks, which are an important tool in our efforts to prevent eviction and homelessness as well as the abuse of funds. I am pleased to report that we now expect New York State to issue regulations giving the City the authority to broaden the criteria for putting welfare tenants on rent restriction. These regulations, as you know, were made possible by your recent action empowering the states to give localities this authority. Your assistance is much appreciated. I will keep you advised as to how the situation works out.

I appreciate your consideration of the AIDS issues described above, and I look forward to hearing from you. Please let me know when you plan to be in the City again so that we can get together.

All the best.

Sincerely,

Edward I. Koch



THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

March 25, 1987

Ms. Dorcas R. Hardy Commissioner of Social Security 900 Altmeyer Building 6401 Security Boulevard Baltimore, Maryland 21235

Dear Commissioner Hardy:

The City of New York recently contracted with the AIDS Resource Center (ARC), a private organization, to operate a residence called Bailey House for persons with AIDS. Regional officials of your agency have ruled that Bailey House should be classified as a public institution, thus substantially depriving its residents of their SSI benefits. I am writing to urge your agency to treat this facility as a private institution, not a public one, and to allow residents to continue collecting full SSI benefits.

I need not detail the horrors of AIDS, the alarming rate of its growth, and the burdens that it places on all levels of government. Much work needs to be done, not only to find a cure for this disease, but to alleviate the suffering it will cause while the search for a cure continues. Toward that end, New York City and ARC began discussions almost a year ago about establishing a program to help persons with AIDS who had no place to live and who would find themselves with everincreasing needs for a variety of services. As a result of these talks, ARC established the Bailey House residence in the former River Hotel as a facility for over 40 homeless men and women with AIDS.

Public health officials from all levels of government have been warning us of the difficult fight society faces in grappling with the consequences of AIDS. Bailey House is an important effort by this City to provide an appropriate environment in which people with AIDS can receive housing and basic services. Without SSI benefits, clients cannot contribute to the operation of the facility. A determination that Bailey House is a public institution would place an additional obstacle in the path of future development of facilities like it and would cause concern over the role the federal government will be willing to play in future endeavors of this kind.

The Human Resources Administration (HRA), the City agency which holds the contract with ARC, has already presented your New York office with an extensive explanation of why Bailey House should not be classified as a public institution. I attach a copy of HRA's letter for your information. After reviewing the documents submitted and the appropriate legal criteria, I am sure you will agree that this facility is a private one.

This facility, like so many others which receive significant government funding, is operated and staffed by a totally independent private corporation. While the City subsidizes the cost of the residents' care, its powers under the contract with ARC are designed for accountability, not day-to-day programmatic or fiscal control. Government must be able to ensure that public funds are being appropriately spent. That type of government involvement should not be viewed as making a facility like Bailey House into a public institution.

I look forward to a prompt and favorable determination on the status of Bailey House. Please feel free to contact HRA Administrator William Grinker if you need additional information or assistance from the City before SSA makes its ruling.

All the best.

Edward I. Koch M A Y O R

EIK:11 Attach. 3421ao

cc: William Grinker, HRA Administrator
Peter Disturco, Regional Commissioner of Social Security

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

125 Worth Street • New York, New York 10013

(212)566-6038

Jo tvey Boufford, M.D. President

MENORANDUM

TO:

Executive Directors

Chiefs of Service

FROM:

Jo Ivey Mufford, M.D.

DATE:

August 4, 1987

SUBJECT:

Treatment of AIDS Patients

The attached policy statement on physician refusal to treat AIDS patients should be widely circulated and implemented immediately.

JIB/mfs treatmntaids:a:002 cc: Lilliam Barrios-Paoli Robert L. Cohen, M.D.

Physician Refusal To Treat Patients With HIV Related Disease or Presumed To Have HIV Related Disease

Policy Statement: The best available medical knowledge about Acquired Immune Deficiency Syndrome (AIDS) indicates that the risk of transmission of the Human Immunodeficiency Virus (HIV) from one individual to another is extremely small. Even in the health care setting, risk is minimal if proper infection control procedures are followed; therefore:

- That a patient is infected or presumed to be infected by HIV shall not be accepted as justification for the failure of any HHC physician to provide necessary services.
- Any physician refusing patient care shall be referred to his/her Chief of Service for counseling and education regarding HIV transmission.
- 3. If the physician still refuses to render patient care, this shall be grounds for termination.

FROM

AO

Session 1

Interviewee: Jo Ivey Boufford

President, New York City Health and Hospitals Corporation (1985-1989)

Interviewer: Sharon Zane, New York, New York

Date: May 14, 2992

[page 25]

I think the AIDS epidemic was the health issue that was always was like the subtext, you know, from '84. It was natural that most of his energy would go towards AIDS. So that I think it got –if there was one health issue that had to be addressed, it was AIDS, and if there was one health related issue that had to be addressed, it was the health care of the homeless. Both sort of got played out in other health policy issues, rather than specific to the Corporation.

[page 41]

Q: Now you mentioned AIDS again. AIDS policy is not set by HHC, is it? [end page 41-begin page 42]

Boufford: No, it's really health commissioner. Department of Health.

Q: Department of Health. But still, obviously, you know, the whole issue of AIDS has and had, while you were there, an enormous impact on what you were delivering.

Boufford: Yes. It was a big – I mean, it was – there was sort of good news and bad news about AIDS. The good news, I think was that we did a lot of good stuff with the workforce, I think, on education, and I think we were actually one of the early ones that sort of set the pattern for a lot of voluntary hospitals. Our staff and the unions were really good, by and large, about it. There were relatively few AIDS patients in voluntary hospitals. With a few exceptions like St. Vincents, did not provide the extensive service that HHC employees and doctors and nurses did right there at the beginning, you know, sort of setting the pattern really for the city and the state around not being – you know,

sort of toughing it out before people really knew what was going on. They really helped develop policies, training programs, and other things that other people used. The AIDS center approach. We were doing that – at the very beginning, '86, '87, '88. I mean, it was really interestingly ironic later when the states developed AIDS centers and because of capital regulations the Corporation hospitals couldn't qualify to be AIDS centers even though we had – early on, even though we had the necessary teams, we had [end of page42- begin page43] the case management with the toughest patients in the city. All the drug addicts were in HHC, not the gay patients. The gay patients were in the private hospitals. So that was the good part. We did well. And we got a lot of money. We got new money for AIDS activities.

The bad news was that the focus on AIDS became the only thing you could get new money for, and so what we tried to do was design programs that would take some of the load off of the infrastructure, rather than isolating the AIDS programs. But basically it began to drain all of the new money. I mean, everything that was new was AIDS. And so you couldn't expand primary care services. You couldn't expand attending supervision. You couldn't do a lot that you knew you should be doing. It was an enormous problem, but in the great scheme of things, you know, it was 2,000 out of 8,500 acute beds. And ideally we would have wanted to do case management and interdisciplinary collaboration on the diabetics, the hypertensives, the people – you know, the bulk of the patients, wouldn't it be wonderful. So it created a lot of tension in the system, because we knew we should be doing that for everybody. But there was a little bit of spin-off in terms of people seeing those models really working. But I think the Corporation was a real success story and really – if it hadn't been for HHC I don't think AIDS would be being taken care as well in the city because the Corporation really, I think, along with Steve [Steven] Joseph, the health commissioner, really spoke out and really made demands on the service side, and didn't let the voluntary hospitals off the hook. So I think that was a real contribution. But it was just unfortunate that it ended up taking resources from the larger system. [end of page 43-begin page 44]

Q: Well, which I imagine is a situation that basically continues.

Boufford: Yes, I think so, too. Yep. I'm sure it does. I'm sure it's still the major focus for new money in any budget discussion.

Q: Do you think it's also the major issue facing the health care industry now?

Boufford: Not sure. I can't tell. I mean, I've only been back a few days (was in Europe 1989-93), I'm surprised to see the bed numbers are still going up, because the notion was that care would move much more into ambulatory setting, even for the addicts, and much more into long term care, and I'm now hearing that that's not happening. So, the long term care demand is not materializing in the way we thought it would, in terms of needing AIDS nursing homes and those kinds of things. I'm not up on exactly what's going on clinically, now, but I'm sure it's still draining the system.



THE CITY OF NEW YORK OFFICE OF THE MAYOR COORDINATOR OF CRIMINAL JUSTICE 250 Broadway New York, New York 10007 (212) 566-

KEVIN B. FRAWLEY

Charles J. Heffernan, jr. Deputy Coordinator

MEMORANDUM

TO:

Edward I. Koch

FROM: Kevin B. Frawley

RE:

Testing of Alleged Rapists for Aids Virus

DATE: October 15, 1987

In response to your memo of September 18th, we have researched the issue and consulted with experts in Health and Victims rights. My advice is that requiring an alleged rapist to be tested for AIDS is not a good idea and should not be pursued as a legislative proposal.

Attached is a memorandum discussing the reasons for my conclusion, together with a copy of an affidavit submitted by Steve Joseph in a Queens criminal case in which this issue was raised.

These are the key points involved:

- 1. Dr. Joseph strongly opposes this testing. The test only shows if the body is producing antibodies to the BIV virus; it is not a test for AIDS. More important, the incubation period may be as long as one year and thus testing may produce negative results even though infection has occurred.
- 2. Victims' advocates believe that counselling of the victims and testing of the victims provided there is informed consent is the proper course to pursue since testing of the defendant does not necessarily yield the information sought.

3. Finally, while one state, Illinois, passed a law requiring such testing, it was limited to convicted sexual offenders and, even in that form, it was recently vetoed by the Governor. To our knowledge, there is now no state with a law mandating AIDS testing of alleged or convicted offenders.



THE CITY OF NEW YORK OFFICE OF THE MAYOR COORDINATOR OF CRIMINAL JUSTICE 250 Broadway New York, New York 10007 (212) 566-

KEVIN B. FRAWLEY Coordinator

CHARLES J. HEFFERNAN, Jr. Deputy Coordinator

MEMORANDUM

TO: Kevin Frawley

FROM: Ruth Pickholz

.....

RE: Proposed AIDS Legislation

DATE: October 15, 1987

Background

Legislation has been proposed which would authorize mandatory testing of "alleged rapists" upon request of the victim.

II. Positic of Dr. Steven Joseph - Commissioner Department of Health. <u>People v. Emanuel Santana</u>.

Dr. Joseph submitted an affidavit (see attached) in response to a motion brought by the Queens District Attorney for an order compelling the City of New York to analyze the blood specimen of a criminal defendant for the intended purpose of ascertaining the presence of HIV antibodies, the agent which causes AIDS. Dr. Joseph gives a compelling argument against such an order. In substance, he argued the following:

- A. Testing does not identify persons with AIDS but only those with antibodies to HIV. The test is therefore neither a test for AIDS nor a test for the virus; rather it is a test for the antibodies produced by the body in response to HIV.
- B. There may be an absence of antibodies during an incubation period of up to 6 months (new research indicates that period may be as long as 1 year). A test administered

during this period may produce a negative result even though a person may have been infected.

- C. Public dissemination of a positive result could prove harmful to victims of rapes. Dr. Joseph does not believe that confidentiality can be maintained.
- D. Positive test results conveyed without adequate explanation of their meaning and implications could have disastrous consequences for individuals, for example, suicide or clinical depression.
- E. A positive test result for the defendant would not necessarily indicate that the victim has been infected. It is likely that the woman's anxiety over her condition would increase if she were to learn of such result.
- F. Dr. Joseph suggests that, should victims request it, they be tested free of charge by the Department of Health with full pre and post-test counselling.

III. Victims' Position

Sheri Price, herself a rape victim and now regional director of the Sunny von Bulow Victim Advocacy Center, is against the proposal. She feels it would cause additional anxiety to victim since a positive finding for the defendant would not necessarrily mean that the AIDS virus has been transmitted. The victim would then have to be tested over a lengthy period of time which would add to the trauma already being suffered. Likewise, a negative finding would not necessary mean the victim is safe since the HIV antibodies could still show up in the defendant at a later point.

Lucy Friedman, Executive Director of the Victim Services Agency, agrees with Ms. Price's position, but adds that the victim should be given as much counselling as possible.

IV. Legislation in other jurisdictions:

The Illinois Legislature recently passed a law which has since been vetced by the Governor which provided that, whenever a defendant is convicted of a sexual offense, the defendant shall be tested for infection with HIV. The results shall be kept strictly confidential and must be personally delivered to the judge in a sealed envelope. Acting in accordance with the best interest of the victims and public, the judge shall have the discretion to determine to whom, if anyone, the results of the testing may be revealed. It is not yet clear if the Legislature will seek to override the Governor's veto.

V. Conclusion - It should be noted that AIDS is unlike any other sexually transmitted disease. In cases such as syphilis or gonorrhea, a positive finding is proof of the existence of the disease. A course of treatment can then be prescribed to cure the disease. Of course, there is no cure for AIDS as yet and the testing does not provide the patient with a positive finding of the disease itself. Thus, testing a defendant may be counter-productive. Victims may wish to be tested, but should have full-counselling before undergoing any test and additional counselling after the results are disclosed.

SUPREME COURT OF THE STATE OF NEW YORK COUNTY OF QUEENS

THE PEOPLE OF THE STATE OF NEW YORK

AFFIDAVIT

- against -

Indictment No. 4419/83

EMANUEL SANTANA AKA MANUEL SANTANA

Defendant.

STATE OF NEW YORK)
COUNTY OF NEW YORK)

STEPHEN C. JOSEPH, M.D., being duly sworn, deposes and says:

- I am the Commissioner of the Department of Health of the City of New York (the "Department") and have held this position since May of 1986.
- 2. Pursuant to Chapter 22 of the New York City Charter, the Department is the City agency with primary responsibility in the field of public health. I have the jurisdiction, except as otherwise provided by law, to "regulate all matters affecting health in the City of New York and to perform all those functions and operations performed by the City that relate to the health of the people of the City..." Charter Section 556.
- 3. I submit this affidavit in response to the motion, brought by the Office of the District Attorney of the County of

Queens, for an order to compel the City of New York to analyze the blood specimen of a criminal defendant for the intended purpose of ascertaining the presence of antibodies for the human immunodeficiency virus (HIV), the agent which causes Acquired Immune Deficiency Syndrome ("AIDS"). I am concerned with any order which would undermine the integrity of the City's AIDS prevention program, and specifically the City's program for antibody testing. For that reason, and consistent with my duties, I believe that prior to exercising its discretion on the application now before it, the Court should be aware of the Department's current procedures for HIV antibody testing, the social and public health considerations which led to the implementation of these procedures, and the facts relating to the effectiveness of the test itself.

Background

defenses of individuals and is caused by the human immunodeficiency virus (HIV). The first report identifying AIDS was published in 1981. As of July 1987, 10,954 people have been diagnosed with AIDS in New York City. Nearly half a million people in the City are estimated to be presently infected with the HIV virus. The consequences of the AIDS epidemic are catastrophic in terms of loss of life and human suffering. There is no known cure for the disease and, to date, the fatality rate for all adults who have been diagnosed with AIDS in New York City is 58 percent. AIDS is now the leading cause of death in the City for men 25 to 44 years of age, and women 25 to 34 years of age. More than 300 new cases are reported in the

City each month and the current epidemic curve appears to be a steady linear case increase.

- 5. The virus has been isolated in virtually all body fluids. Therefore, precautions should be taken when exposures to any body fluid are likely. It has been found to be transmitted by exposure to blood, semen and vaginal secretions. Behaviors most associated with risk for acquisition of the virus, and hence AIDS, are sharing of needles and syringes for intravenous drug use, and sexual intercourse with persons at risk. Those at risk are intravenous drug users, homosexual and bisexual men, and persons who have intercourse with such partners (although barrier protection significantly lowers such risk).
- human behavior, sexuality and drug use. Given this fact, and the unfounded fears of some members of the public over a disease which has received widespread media attention, a pattern of discrimination and harassment against people associated with AIDS has emerged. Discrimination has been reported in the areas of employment, education, housing and health care services. Illegal job dismissals, unwarranted evictions, and loss of health insurance are just some of the results of misinformation concerning the disease. Members of the prison population who are known to be infected with the HIV virus are particularly vulnerable to harassment, and even acts of violence, from other inmates.
- 7. In response to the extraordinary health and social impact of the disease, a wide range of programs have been initiated

by different City agencies. Their purpose is to understand the causes and patterns of the infection, to control the spread of the HIV virus, to protect individuals and families from AIDS-related discrimination and harassment, and to provide those who are ill with appropriate medical treatment and psychosocial support

- 8. In addition to monitoring the trends of the AIDS epidemic, the Department focuses its activities on AIDS prevention. Its programs include community education and professional training programs, the development and distribution of educational materials on AIDS, and a full range of counseling services, including antibody testing.
- 9. Because there is no effective vaccine for AIDS, the only currently feasible approach to prevention is to alter the course of the epidemic through education of both the public and professionals on its transmission and prevention. A vital task of prevention is to reach individuals who are at risk by virtue of specific behavior, and persons concerned about possible exposure to or infection by the virus. A critical aspect of this program is to provide all persons counseled or tested with personal risk counseling, including antibody testing. The goal is to alert all individuals as to their status and to help them implement and maintain risk reduction practices. The Department's hope is that knowledge and counseling will motivate persons to alter their behavior and thereby reduce the spread of AIDS.
- 10. It has been the Department's experience that if persons are protected from the social and economic consequences of

dissemination of the test results, they will submit to testing and seek the counseling vital to AIDS prevention. If these protections are not available, they will not cooperate with testing and counseling. As a result, both the State and the City have adopted regulations on antibody testing which require: (a) voluntary and informed consent, (b) pre- and post-test counseling, and (c) confidentiality. New York City Department of Health Commissioner's Regulations, HIV/HTLV-III/LAV Antibody Testing, September 3, 1986.1 These protections encourage the voluntary cooperation of those with the virus and offer the greatest hope to stop the spread of AIDS. Failure to adhere to the safeguards provided by the regulations might drive HIV-infected persons underground, thus subverting public health goals.

and test sites in the City which provide full commseling and anonymous antibody testing. The State of New York has also established four test sites within the City of New York. The New York City public Health Laboratories, several medical school affiliated hospitals, and blood banks are the only laboratories authorized in the City to analyze blood samples to determine whether antibodies are present that would indicate exposure to HIV. All samples to first tested using the ELISA HIV Antibody Test, with confirmation of

86.83 86.83

The Department of Health Regulations on antibody testing are virtually identical to those on testing adopted by New York State as an Emergency Action on January 5, 1987. Public Health Regulations, 10 NYCRR Section 58-1.1.

positive results by a separate test called the Western Blot. The Public Health Laboratories receive blood specimens from a number of sources, including private physicians, public or non-profit hospitals, and the City and State Anonymous Counseling and Testing Sites.

- 12. Extraordinary steps are taken to ensure anonymity and confidentiality because of the potentially devastating impact the results may have on the individual. Specimens and individuals are identified by code number alone through all stages of testing and counseling. Even the pre-test consent forms are acknowledged with a non-identifying statement rather than a patient's signature.
- the Department's program and serves functions in addition to prevention and risk reduction. Pre-test counseling is used to evaluate an individual's need to undergo the test in the first instance. Sources and types of exposure must be considered to assess the likelihood of infection. Recommendations are made based on the information supplied by a patient to a counselor with knowledge of how the HIV virus is transmitted. Counseling is important at this stage since testing without counseling may pose a risk of psychological trauma; many assume it is performed only on members of high-risk groups who carry the virus in any event. The Department's policy, however, is to provide testing to all who seek it, regardless of a counselor's professional assessment, since persons may omit pertinent information out of embarrassment or fear.
- 14. It should be emphasized that testing does not identify persons with AIDS, but identifies only those with antibodies to HIV.

The ELISA test was originally developed not as a diagnostic tool for the detection of AIDS in particular individuals, but as a method of screening denated blood. When used for diagnostic purposes (as distinguished from blood bank screening), the ELISA procedure is always used in conjunction with a confirmatory test. Together, these texts provide a highly reliable indicator of exposure to the virus. The tests, it should be emphasized, are neither a test for AIDS nor a test for the virus; rather, they are a test for the antibodies produced by the body in response to the introduction of HIV. A probability, however slight, of felse positives, or felse negatives, does exist. Furthermore, because there may be an absence of antibodies during an incubation period generally accepted to be six months (although in some cases periodic testing may be recommended for as long as a year after the exposure), a test administered during this period may produce a negative result even though the person tested has in fact been infected with the virus.

15. Counseling is therefore important to inform an individual of the usefulness of the test and to provide an accurate assessment of their results. A positive test result, conveyed without adequate explanation of its meaning and implications, could have potentially disastrous consequences to an individual. Serious clinical depression and suicide have occurred following the communication of positive test results. Trained counselors are available at the post-test stage to provide emotional support and to direct individuals to a broad range of support services for the ill and infected. These

include housing services, family case management, foster care, crisis intervention services, and long-term and out-patient medical care.

- program. It is unlikely that infected persons will have the motivation to integrate and sustain risk-reduction techniques in their lives if long term support is unavailable to help them cope with both stress and the wide range of their care needs.
- to analyze a blood specimen obtained through nonconsensual, non-informed testing, and for a purpose unrelated to medical care, raises troubling ethical and policy questions. In particular, where the results of the test are intended for eventual use in the judicial system, it is unlikely that confidentiality can be maintained. If positive test results become public, the privacy of the defendant may be intruded upon in a highly significant manner. If he is ordered to take the test, the defendant may be subjected to harassment from other inmates. Public dissemination of a positive result could likewise prove harmful to the victims of the rapes, in that members of the public may wrongly assume that since these victims have had sexual contact with the defendant, they have necessarily been infected with the virus.
- 18. Testing in the absence of consent may also have harmful consequences for the AIDS antibody testing program. A precedent established by coercive, non-anonymous testing could undermine the City's efforts to assure individuals of its commitment to confidentiality. The anxiety which currently surrounds the issue of

confidentiality could be compounded and might intimidate infected persons and deter them from seeking critical help. Such a result is clearly harmful to the goal of AIDS prevention.

The Case at Hand

- 19. Based on the facts of this case that have been provided to me through Corporation Counsel's discussions with the District Attorney's office and the defendant's attorney. I believe that an order compelling the defendant to submit to HIV testing would be particularly unwarranted. If, as the District Attorney indicates, the purpose of the requested testing is to allay the anxieties of the victims about whether they have been exposed to the virus, a far more sensible solution would be to counsel, and if appropriate, to test, the women themselves.
- Attorney addresses the option of having the women tested, but asserts that such tests would not provide the information necessary to give the women the reassurance to which they are entitled. The District Attorney asserts that only a test of the defendant can conclusively confirm that the women have not been exposed to the virus. The District Attorney's position rests on a fundamental misunderstanding of the nature and limitations of the HIV testing procedure.
- 21. The District Attorney's contention that a negative test result of the women would be inconclusive is based on the District Attorney's notion that for a period of time after exposure to the virus, a person may test negative on the antibody test even though

she has in fact contracted the virus. This proposition is correct. However, the District Attorney has grossly misstated the length of this period. It is widely agreed in the medical community that this period is no more than approximately six to nine months, and may be as short as a few weeks. In the case at hand, it has been nearly four years since the rapes took place. Thus, if the women take the test and obtain a negative result, they can be confident that the defendant did not transmit the virus to them.

- 22. The District Attorney's misunderstanding of the length of the period during which the antibody test may be inaccurate appears to be based on a confusion between that period and the period of time between exposure and the onset of symptoms of the disease itself. As noted in the District Attorney's papers, the period between exposure to the virus and the development of symptoms of the disease may often be many years. This fact, however, in no way indicates that an antibody test administered at anytime during this period is unreliable. Thus, the fact that the defendant and these women have apparently not developed symptoms of AIDS does not indicate that an antibody test administered to these women now, some four years after the possible exposure, would be unreliable.
- 23. Furthermore, administering the HIV antibody test to the defendant may needlessly alarm these women, rather than calming them. If the defendant tests positive at this time for the antibodies, it cannot be assumed that the defendant was infected with the virus four years ago, when the rapes occurred. A positive test result in a test of the defendant could also be the product of the defendant's

having been infected at some point after his sexual contact with these women. In addition, even if the defendant was infected with the virus at the time of the rapes, he may not have transmitted the virus to these women. Nevertheless, despite the possibility that a positive test result for the defendant does not necessarily indicate that the women have been infected, it is likely that the women's anxiety over their condition would increase if they were to learn of such a result.

- 24. The Department of Health is prepared to administer the test to these women, should they request it, free of charge, under the complete confidentiality protections established by the City and State regulations, and with full pre- and post-test counseling. These procedures could be performed immediately.
- 25. The procedure that I have suggested would provide the most reliable information as to whether these women have been exposed to the HIV virus, while at the same time preserving the principles of voluntariness, informed consent, and confidentiality on which the success of the City's HIV-testing program depends.

In conclusion, I request the Court to weigh the social and medical implications raised by the District Attorney's motion, and ask that all feasible attempts be pursued to resolve the legal issues being

presented in a manner consistent with the goals and policies of the AIDS antibody testing program.

Dated:

New York, New York September 3, 1987

STEPHEN C. JOSEPH, M.D., M.P.H. COMMISSIONER OF HEALTH.

Swore to before me

This 3rd day of Sliptember, 1987

Solver J. Feldian

Notarkhibila, Standol New York

No. 21-470327

Qualified in Plan York County

Commission Expires thereb 13:18.

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Senator Helms's Callousness Toward AIDS Victims By Edward I. Koch

New York Times (1857-Current file); Nov 7, 1987; ProQuest Historical Newspapers The New York Times (1851 - 2004)

Senator Helms's Callousness Toward AIDS Victims

By Edward I. Koch

partments of Labor, Health and Human Services, and Education, "and a perverted human being a per-verted human being," fronte, com-ments, indeed, given the profound "We have got to call a spade a spade," said Senator Jesse Helms in offering an amendment to the fiscal perversity of the policy his amend-ment advances.

programs that "promote, encourage or condone homosexual activities." The Senate passed it, 86 to 2. Only 47 House members had the good sense It prohibits the Federal Centers for Disease Control from funding AIDS Edward I. Kach is Mayor of New

and "a foolish exercise." Then why did he vote to make it the law of the land, particularly since it ignores the proved effectiveness of AIDS education efforts and severely impedes our ability to expand them? and common decency to resist homo-phobic hysteria and oppose the he's upset with the New York's Gay Men's Health Crisis. The organization has established a brilliant reputation Mr. Helms introduced it because

AIDS cases reported; of these, 6,605 have died. Of the total cases, 55 percent are homosexual or bisexual men. Crisis and city educational efforts have helped contribute to a decline in one year and found them not infected with the AIDS virus, there's only a 1 percent chance that samples from the same men would be infected the To date, New York has had 11,513 Among these, the Gay Men's Health annually. In nonscientific terms, this means that if you took blood samples from homosexual or bisexual men the seroconversion rate to 1 percent "perverts" — because they re a pri-mery ALDS risk group. Cays com-prise about 10 percent of the United States' adult population, or 20 million people. If only half are made, 10 mil-lion men are at risk and in need of education and counseling on how to cut the risk. That's why the Gay Mer's Health Crisis and organizain caring for and counseling those with AIDS and in educating others on It serves gay men - Mr. Helms's tions like it around the country exist.
The amendment, protests Senator
Edward M. Kennedy, is "toothless". how to prevent the spread of AIDS.

Among intravenous drug users

rate. Obviously, education changes behavior among those whose facul-uses aren't impaired and enslaved by there's an 8 percent seroconversion Gay Men's Health Crisis materials

aren't innocents who'll be shocked by such iterature. They already practice sex; they want to know how to practice it more safely. The organization tells them and thereby helps save words and sexually graphic illustra-tion that "perpetuate the AIDS prob-lem." But those the materials reach complains Sexator Helms, use blunt

If we're shy with one risk group, we'll probably make the same mistake with others. Today, AIDS is gage in homosexual or bisexual practices or intravenous drug abuse. By 1991, some 40,800 people in New York found principally among men who en-

innocent infants.

drug users — are the sons and daughters of families who love them. They too deserve protection against the for the amendment should remember that homosexuals — and intravenous Schator Helms may not like homosexuals. But he and those who voted gravest public health threat our na-

Regrettably, lousy politics over-whelmed good public health policy.

and 270,000 nationally may have AIDS. Some will be heterosexuals who've had intercourse with a bisexual man or a drug user. If they don't know how to protect themselves, how will they? Cutting off Federal funds to organizations like the Gay Men's Health Crisis may only help spread the disease, causing the deaths of not only homosexuals but heterosexuals of both sexes and, most tragic of all,

Apparently fearing an adverse reaction that a homophobic demaggage might inflame in their home states or districts, members of Congress gave in to koncophobic hysteria. Only a tew had the courage to vote against this foolish amendment. I commend Senators Daniel Parick Moyanihan and Lowell Weicker and members of New York's House delegation who joined the homor roll: Gary L. Ackerman, Bill Green, Major R. Owens, James H. Scheurer and Fed Weiss. They hold the moral high ground.
The amendment is a fait accompli.

porting programs and policies that have proved so effective in fighting this tragic disease. that future Congressional action on AIDS ignores the homophobes by sup-The blot on the Congress can't be erased. But what can't be undone can be uncovered. That alone may insure

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THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

November 13, 1987

Henorable Mario Cuome Governor The Executive Chamber State Capitol Albany, New York 12224

Dear Mario:

I am writing to seek your support in addressing the urgent problem of HIV transmission among IV drug users in New York City. As you know, needle sharing among IV drug users is one of the primary means of transmitting the HIV virus. Recent Health Department research now indicates that 53 percent of HIV-related mortality results from IV drug use. We project that by 1991 as many as 59 percent of AIDS related deaths will be directly or indirectly (via transmission to sex partners of IV drug users) linked to drug use. We must act immediately to expand the availability of drug treatment in New York City if we are to stem the spread of this disease.

Although your recent designation of 5,000-8,000 drug treatment slots in New York State goes a long way to address this problem, I am concerned about the speed with which these slots can become operational, and whether these slots alone are enough to address the magnitude of the problem. I know you share my view that every addict who seeks drug treatment should receive it, and that especially in light of the current AIDS crisis, we cannot be in a position of turning people away. I want to do my part to help the State succeed in providing these essential services.

Therefore, I am proposing a series of actions that we in the City are prepared to take to assist the State in expediting the expansion of drug treatment slots if additional State dollars were available.

 The Realth and Hospitals Corporation could extend the hours of its 10 existing drug treatment clinics from 4:00 to 8:00 pm. HHC estimates that this will roughly increase the numbers of clients served by as many as 1,500; their total treatment slots could be increased to a maximum of 4,500 from 3,000. These slots would be gradually phased in to insure that the programs can actually accommodate these numbers.

In addition, HHC proposes to, where appropriate, initiate methadons maintenance to patients while they are still in the hospital where appropriate. These patients would then be linked to community programs upon discharge.

Both parts of this program would require additional resources from the State and waivers from Federal and State regulations (primarily in the area of the ratio of drug counselors to clients).

2. The Department of Health could extend the hours in eleven of its District Health Centers from 5:30 to 8:00 pm to allow private methadone maintenance providers to give treatment. The programs would operate, in "off-hours", out of the Department's sexually transmitted disease clinics, which are suited for this purpose because they are located in many of the high drug-using areas of the City, and because their physical lay-out is consistent with the needs of a drug treatment program.

DCH estimates that as many as 1,650 slots could be added in this way. As with the HHC proposal, patients would be phased-in gradually to reach a maximum of 1,650 slots. Likewise, Federal waivers would be necessary to reduce the ratio of drug counselors required to staff the program.

3. We believe the process that has already been established between the Department of Substance Abuse Services, the Department of Housing Preservation and Development and my Office of the Criminal Justice Coordinator has worked very well to date in identifying City-owned buildings as sites for drug treatment programs. Kevin Frawley and Paul Crotty are fully committed to continuing this process on an on-going basis to identify additional buildings for this purpose.

In sum, I am prepared to begin phasing in additional drug treatment slots immediately at HHC and DOH. I ask that the State fully fund the cost of these slots, fund HHC's inpatient costs for providing methadone treatment, and fund whatever renovation and additional security costs may be incurred. We estimate that the cost for the treatment slots, alone, would be close to \$5 million, but we believe a sizeable portion of the total would be eligible for Medicaid reimbursement. About 71 percent of HHC's current methadone maintenance clients are Medicaid eligible, although the full cost of their treatment is not reimbursed.

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I expect that we will hear loud and clearly from the communities, which will be asked to absorb these new clinics or to accept the expansion of existing ones. I want you to know that I am prepared to stand with you in resisting these community pressures and believe that, together, we will prevail.

I am eager to discuss this with you. I have designated Dr. Jo Ivey Boufford and Dr. Stephen Joseph to take the lead on this for me and ask that you designate someone from your staff to begin working with us immediately.

All the best.

Sincerely,

Edward I. Koch

EIK:pm

DRAFT I

December 7, 1987

Letter to the Editor The Village Voice New York, N.Y.

To the Editor:

It has been my practice not to reply to <u>Village Voice</u> articles, but your disgraceful December 8th editorial on "street-corner dissidents" sets a new low in journalism, even for the <u>Voice</u>. The record must be set straight.

Your use of the terms "dissidents" and "refuseniks" to describe mentally disabled homeless persons is a heartless attempt to ignore the plight of these people by trying to pretend that the symptoms of their illness are really a kind of independent lifestyle. If you tried to falsely describe AIDS victims as people who are practicing their right to come in contact with whatever viruses they wish, you would be rightly denounced for your cruelty in making a catastrophe appear to be a choice. But because homeless mentally disabled people are isolated and alone, you feel free to make them a target of your ideological fantasies.

The facts are these: Project HELP, which was begun in 1982, is engaged in a new initiative to bring care and assistance to mentally disabled homeless people throughout Manhattan, which is where most of this population lives. Every person entering the program is provided with legal representation. Their rights are scrupulously protected. The Voice incorrectly states that no new psychiatric beds have been created. The fact is that New York City has added 28 acute care beds for this program, and the State is providing another 50 intermediate and long-term care beds. Also, the City has set up 40 specialized shelter beds for men and women discharged from Bellevue who are not in need of institutional care, or who are not appropriate for, or accepted by, a community residence. No person now receiving care in an institution will be shunted aside to make way for persons being admitted under Project HELP. Over the last 18 months, the City has added 197 acute psychiatric care beds to two HHC hospitals, and 162 more beds are in the pipeline.

Since last July, New York City Community Support Services programs have successfully placed more than 300 mentally ill individuals in alternative residential settings, such as single room occupancy (with ongoing services provided), adult homes, and community residences. If the housing shortage were solved tomorrow, mentally disabled people would still require assistance. They need more than just a place to live. If anyone doubts the serious nature of the illnesses which afflict these unfortunates, read the front page story in the December 7th New York Times.

Is Jeyce Brown better off now than she was while living in harsh conditions on the street? That question is more than a legal exercise. It is a test of our ability to feel compassion. Joyce Brown is now receiving medical care. She is back in touch with members of her family, who are pleading with the City to continue treatment. She has been offered shelter in a supportive residence. The Voice says her attorneys found this residence for her. I'm glad to hear it. But what were these attorneys doing before Project HELP intervened?

Many forms of cruelty exist in this world. Those who deliberately ignore the desperate needs of others are surely among the most callous. But those who imitate the <u>Voice</u> editorial and ignore the needs of others in the name of human rights, are even worse. They are beneath contempt.

Sincerely,

Edward I. Roch



THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

December 9, 1987

Hon. Timothy E. Wirth United States Senate 237 Senate Russell Office Building Washington, D.C. 20510

Dear Senator:

I am writing to urge you to join several of your Senate colleagues who are taking leadership roles to implement an effective, rational federal response to the AIDS epidemic.

The Comprehensive AIDS Research, Information and Care Act (\$1220), introduced by Senator Kennedy, provides the framework for an appropriate federal policy for coping with this deadly disease. It creates a coordinated national AIDS research effort, provides resources for the care and treatment of people with AIDS, and mandates a program of training and awareness for health care workers.

Most importantly, S.1220 authorizes an extensive federal, state and local effort to educate the public on the most effective methods to prevent the spread of the disease. Virtually all public health experts, including the Surgeon General and the Centers for Disease Control, agree that frank, comprehensive and accurate education on modes of transmission of the AIDS virus is the only way individuals can protect themselves from becoming infected.

Finally, I am sure that many of you are aware of the mean-spirited efforts of some of your colleagues to shift this debate from the arena of public health to one of legislating a moral point of view. Mandatory testing, quarantine and punitive actions against people with AIDS will not provide a cure or prevent the spread of the disease; education and research will. AIDS is a disease, not a crime; it is a public health problem, not a political problem. I hope you will assist in derailing these misguided efforts in whatever form they may be presented.

In fact, I understand that some of these amendments may be offered during Senate floor consideration of the Continuing Resolution in the next few days. For your information, I have attached a memo from the New York City Health Commissioner, Dr. Stephen Joseph, that outlines in detail our objections to these amendments.

I urge you to support \$.1220, and to oppose amendments that only serve to undermine public health programs and policies that have proven effective in fighting this tragic disease.

All the best.

Edward I. Koch

Enclosure

THE CITY OF NEW YORK COMMISSIONER OF HEALTH Stephen C. Joseph, M.D., M.P.H.



125 WORTH STREET NEW YORK, N.Y. 10013

TO: Edward I. Koch, Mayor

FROM: Stephen C. Joseph, M.D., M.P.H.

Commissioner of Health

DATE: December 9, 1987

SUBJECT: Potential HIV-related Amendments to Federal Legislation by Senator

Helms

I understand that Senator Jesse Helms will propose a number of amendments to Federal legislation this week pertaining to the control and prevention of AIDS. In many important ways, these amendments are directly counter to near-universal convictions within the public health community. These amendments seek to:

- o expand mandatory testing to include marriage license applicants, anyone admitted to a VÁ hospital, and food handlers;
- o require reporting to a central Federal source of names of all persons testing HIV positive;
- o institute mandatory tracing and testing of contacts of HIV positive individuals;
- o weaken existing antidiscrimination laws;
- o increase certain federal criminal sanctions (which will have little impact on infection control);
- o require federally-funded family planning providers to counsel <u>only</u> the virtues of abstinence and the ineffectiveness of condoms;
- o remove prohibitions from use of HIV test for health insurance purposes without viable afternatives available.

Similar to Senator Helm's earlier, and unfortunately successful, amendments mandating HIV testing of immigrants and federal prisoners, and interfering with funding for necessarily explicit educational activities, these current amendments contradict near-unanimous expert public health opinion regarding the best methods for disease control.

These amendments, if adopted, would act as severe disincentives to individuals in seeking counseling, testing, and related services, undermining the enormous public health efforts being made in New York City and across the country. The result would wreck havoc on state and local prevention activities by making AIDS funding contingent upon implementation of these destructive approaches. Linking compliance with funding is particularly onerous at a time when need is so great and existing resources so strained.

The overall goal of AICS-related public health programs is to change the behavior of large numbers of people through broad educational efforts and targeted programs of risk reduction counseling and testing. Both confidential and anonymous HIV testing are critical components of this infection control strategy. Confidentiality, which guards against HIV-related discrimination, is absolutely essential to encourage those most at risk to participate in voluntary education, counseling and testing programs.

New York City agencies are engaged in an aggressive program of education and voluntary counseling and testing to reach those people most likely to place themselves and others at risk for HIV infection. We continue to oppose mandatory reporting, testing and/or contact tracing because these strategies drive underground the very people we need most to reach with effective risk reduction counseling and services.

It is clearly more effective to provide a wide variety of tailored public education programs, to encourage those who may be at risk to seek confidential and/or anonymous testing, and to offer those who are HIV+ confidential assistance in notifying their contacts; this is now being done by the New York City Health Department and most other public health agencies across the country. This is a more cost-effective way of identifying infected individuals than widescale mandatory screening. In screening large numbers in low-risk groups, such as marriage license applicants, a significant percentage will be falsely identified as positive ("false positives"), causing unnecessary anguish and disruption of lives, while contributing little to our fight against AIDS.

One particular amendment seeks to overrule the Supreme Court's <u>Arline</u> decision. This would <u>weaken</u> civil rights protections for people with contagious diseases. In contrast, the City has consistently supported <u>strengthening</u> anti-discrimination measures to protect individuals with HIV infection, ARC or AIDS, and we believe the <u>Arline</u> decision is an important safeguard against discrimination in employment. In addition, your recent Municipal Conference on AIDS, attended by a broad cross-section of U.S. mayors and other public officials, specifically endorsed the idea of <u>strengthening</u> federal protection against HIV-related discrimination.

Certain other amendments involving blood, semen and organ donations would seek to create new categories of federal crimes. The COC recommendations concerning these matters are excellent and, to the best of my knowledge, have been widely accepted and instituted. Similarly, existing state and local laws provide adequate remedies for the unusual case in which a HIV positive individual intentionally seeks to infect others.

Concerning information provided by federally funded family planning programs, government should not interfere with the privileged relationship of clients and their physicians; a client seeking health services or counseling has a right to receive, and the doctor an obligation to provide, all relevant medical information in order to make informed choices. Since the vast majority of family planning clinic clients are already sexually active, it is imperative that they receive sufficient information about risk avoidance, including safer sex practices.

Finally, regulation of the insurance industry has historically been a state responsibility. Whether HIV antibody testing should be required of applicants for health or life insurance is a complex and controversial issue that should be left to the states, or in the case of Washington, D.C., to the local legislature to decide. The significant advantages and disadvantages of making any changes, particularly as related to medical care coverage, must be carefully weighed before decisions are made which may disenfranchise those most in need of care.

Given the very short time available to analyze these proposed amendments, I hope the above makes clear their potentially disruptive consequences to existing disease control programs and policies in New York City. It is important to avoid measures that contribute to unrealistic public fear or stigmatize citizens unfairly. Our efforts and resources to contain this epidemic must remain focused on the most significant risks and effective measures. A more detailed analysis of each of the amendments and their implications for New York City will be provided to you shortly.

SCJ:SS:da 6969E

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QUICK SUMMARY OF POTENTIAL HELMS AMENDMENTS

- 1. Seeks to overturn the U.S. Supreme Court's Arline decision. This decision held that a person with a contagious disaese may be a handicapped individual under saction 504 of the Rehabiliation Act of 1973. Such designation allows for protection against discrimination if otherwise qualified.
- 2. Seeks to prohibit employment of HIV (+) individuals as food handlers with in the federal government, or in federally funded programs.
- 3. Prohibits use of federal funds for AIDS educational materials which are seen to encourage or promote homosexuality and requires all such material emphasize abstinence and monogomy within matriage.
- 4. Requires all Title X Family Planning Programs to inform recipients of services of the virtues of abstinence and the limited effectiveness of particular contracaptive methods.
- 5. Directs state health departments to collect names of Individuals who tested HIV (+) as a condition of AIDS funding and requires that such information be conveyed to the CDC.
- 6. Requires that states implement mandatory testing and reporting of HIV (+) marriage license applicante as a condition of AIDS funding.
- Requires that, as a condition of federal financial assistance, states establish a program to trace and test the sex and needle-aharing pertners of individuals who are HIV (+).
- 8. Mandates testing and reporting in federal prisons upon entry and every 12 months thereafter. Segregation/isolation of thosa who test HIV (+) where possible.
- 9. Handstes teating and reporting upon entry into any VA hospital, St. Elizabeth's Hospital, and other mental health facilities. Also attempts to demonstrate that mandatory testing is the will of the Congress through a Sense of the Seneta.
- 10. Directs the President, pursuant to the Immigration and Naturalization Act, to add AIDS to the list of dangerous contagious diseases within 90 days of enactment.

- 11. Hakes it a federal offense for an individual to donate blood, semen, or organs if: he/she is knowingly HIV (+); or has had homosexual relations, been an IV drug user, emigrated from Heiti or Central Africa, received clotting fector concentration as a hemophilise, or has had sexual intercourse with any of the aforementioned parsons at anytime since January, 1977.
- 12. Makes it a federal offense for federal employees or those on federal grounds, who know they are HIV (+) or have AIDS, to engage in high-risk behavior.
- 13. Requires the Surgeon General close all homosexual bathhouses within 180 days of enactment.
- 14. Repeals the District of Columbia law which created a 5 year moratorium on the use of the HIV antibody test by health and insurance providers.

ABRIDGED REMARKS

OF

THE HONORABLE EDWARD I. KOCH

MAYOR

CITY OF NEW YORK

PRESENTED TO THE

PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC

DECEMBER 17, 1987
WASHINGTON, D.C.

I appreciate this opportunity to appear before the Presidential Commission on the Human Immunodeficiency Virus Epidemic.

I am here representing the United States Conference of Mayors, as well as the City of New York. For your record I submit the comprehensive AIDS resolution that I co-sponsored at the Conference of Mayors' Annual Conference in Nashville in June, as well as the resolutions that came out of the Municipal Conference on AIDS held in New York City in October for mayors and county officials.

This Commission's Preliminary Report correctly identified IV drug abuse as one of four critical areas of its further work. I believe that IV drug abuse is the most critical area for vigorous action to stop the further spread of HIV infection among addicts, women, children, and minorities.

The HIV-infected IV drug user is the main source of infection to other addicts, women, and children. We must launch a national program to stop HIV transmission among IV drug users and from IV drug users to their sex partners and unborn children. The future of the epidemic depends upon this.

To reach IV drug users, AIDS prevention efforts must be linked to drug treatment programs. In New York State, drug treatment programs are the State's responsibility. Yet thousands of New York City heroin addicts remain outside of the

treatment network because of a lack of treatment slots. I have begun important and direct steps to phase in more drug treatment, including proposing in a letter to Governor Cuomo ways to increase the number of treatment slots available for State funding. Increases in federal funding must allow the State to fund more slots (a sizable portion of which would be eligible for Medicaid reimbursement), and federal waivers must reduce the ratio of drug counselors to clients.

While substance abuse treatment has been a State responsibility since 1977, New York City will not shirk its duty to address the full range of needs of those sick from AIDS or AIDS-related illness. We have done more than any other city in the country to put expanding medical, social service, and public health AIDS programs in place.

Yet AIDS is a national concern that demands national action. New York City once accounted for almost half of the country's AIDS cases; it now has 27 percent as the disease has spread throughout the nation, and will have only 15 percent in 1991. We need more action such as Senator Kennedy's Comprehensive AIDS Research, Information, and Care Act, and Congressman Rangel's bill to establish grant programs to prevent HIV transmission among IV drug abusers.

However, Congress, which in the continued absence of firm direction from the Administration has been our strongest hope for a national AIDS policy, has also been the source of our

biggest disappointments in its repeated embrace of Senator Helms' amendments. These threaten the AIDS education and prevention programs that have helped reduce the seroconversion rate among gay men to 1 percent. I have asked every Senator to reject these amendments in favor of an effective, rational federal response to AIDS.

The federal administration has not responded to our needs in New York City, nor to the country's need for vigorous, effective leadership on the national level. We need the following commitments from Washington:

It must increase federal assistance to give IV drug users more access to drug treatment programs and public health education programs. It must increase federal assistance for residential and ambulatory drug treatment programs geared to the needs of women with children, not just single male addicts. It must increase federal support for more public health education risk reduction efforts, including more confidential, voluntary risk reduction counseling and HIV antibody testing. It must increase federal support for services to keep families together and independent without turning to drugs. It must accelerate the federal review process for experimental drug testing. It must revise the AIDS DRG reimbursement methodology to reflect more closely the actual cost of treatment.

Finally, it must correct a number of Medicare issues.

First, the "80/20 rule" requires that no more than 20 percent of hospice care may be provided in an institution, and that the remaining 80 percent of Medicare-reimburseable days be spent outside an institution. This restricts the range of care that can be provided under hospice regulations for AIDS patients, who spend a much greater proportion of their treatment time receiving institutional care than the 20 percent allowed under hospice reimbursement. Substance abusers, especially, do not have family or community support services, and must receive institutional care.

Second, we must see enactment of legislation that exempts people with AIDS from the two-year waiting period for Medicare eligibility. People with AIDS are immediately eligible for Social Security Disability Insurance payments, and meet the requirement of disability for Medicare eligibility. A second Medicare requirement, however, imposes a 24-month waiting period from the time of declaration of disability until the time of coverage. At least half of all people with AIDS die within two years. The federal government currently exempts persons suffering from end-stage renal disease from the 24-month waiting period; legislation must make a similar exemption for people with AIDS.

I offer these needs on behalf of everyone throughout this country who has fallen before the relentless onslaughts of AIDS and IV drug abuse. The real fight is against these dual scourges. With your vigorous support, may we be successful.



THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

April 25, 1988

Honorable Fernando Perrer President of the Borough of the Bronx 851 Grand Concourse Bronx, New York 19451

Dear Fred:

Over the next several years, we are going to have to substantially expand facilities that care for AIDS patients who have no homes in New York City.

AIDS is a tragic disease which has affected thousands of young men, women and children. The number of people with AIDS is continuing to rise and increasingly the population consists of IV drug abusers, women and children. I am committed to do whatever is necessary to make sure that people with AIDS are cared for in appropriate settings.

We have been working with the State and have recently received draft regulations for facilities for people with AIDS. These regulations provide reimbursement for health related facilities (HRFs) and skilled nursing facilities (SNFs). There will also be a need to develop some housing for people with AIDS who are not medically eligible for HRFs and SNFs. We are actively pursuing the development of facilities that will meet all levels of care, and will be working with the State to hopefully modify the draft regulations to ensure that they provide sufficient flexibility to meet the needs of as many people with AIDS who have no homes as possible.

You probably know that we now provide housing assistance to hundreds of people with AIDS. Our highest priority is to keep people in their own homes. We have been doing this by supplementing rents and by providing home care services. In February 1986, 40 individuals were receiving financial

assistance to help pay their rents; in February 1988, 596 people were receiving such assistance. As for home care services, in February 1986, we were serving 38 individuals; by February 1988, 316 people were being provided with home care services.

There are people, however, who do not have homes or are not able to return to their homes after a stay in the hospital. For these people, we have been providing scatter site apartments, rooms at Bailey House and SROs, if necessary. In February 1986, we were providing direct housing services to 25 people; that number grew to 191 people in February 1988.

New York City is also one of the few providers of long term care beds for AIDS patients. HHC is now providing care to about 40 individuals at Coler and Goldwater Hospitals, with plans to substantially expand this number over the next two years.

We have been coordinating with City agencies the identification of sites to care for people with AIDS. We have identified a number of facilities and we intend to move forward to ULURP three of them. They include 1680 Lexington Avenue in Manhattan, 1024 Fulton Street in Brooklyn and 727 Throggs Neck Expressway in the Bronx. A decision to go forward with Throggs Neck is contingent on our evaluation of the costs of rehabilitating the facility.

In addition, there are a number of other sites ws are actively working on that are not currently under the City's jurisdiction. We are working to finalize negotiations on these facilities as quickly as possible -- some we are seeking to acquire directly and others religious and/or not-for-profit groups are seeking to acquire with our assistance. As soon as these properties are firmed up, we will get back to you.

I should also mention that we are moving ahead to expand beds at Bailey House. HRA is working closely with the State and Bailey House on plans for a small expansion of beds in the facility next door.

As our experience in recent years with siting shelters in this City demonstrates, facilities of this sort rarely enjoy community support and, often, spark community opposition. AIDS will only heighten the prospect of this. But-this is not an issue we can ignore or a need that will go away, particularly in the absence of a cure or vaccine. We must act now and, I hope, we will act together. We can take the politically easy course of doing nothing or the politically responsible course of beginning now to select and approve sites that will permit us to continue expanding our efforts to help and care for those who have the misfortune to suffer from this most tragic disease.

Page Three

I need your support as we move forward to establish facilities in various communities throughout the City. We need to stand up and do what is right -- provide this much needed housing for people with AIDS.

Of course, if you know of additional facilities that might be appropriate, we would be interested in pursuing them. I look forward to hearing from you.

All the best.

Edward I. Koch

EIK:pm



PRESIDENT OF THE BOROUGH OF BROOKLYN

HOWARD GOLDEN

May 23, 1988

Edward I. Koch Mayor City of New York City Hall New York, New York 10007

Dear Mayor Koch:

I received your letter dated April 25, 1988 announcing your intention to utilize 1024 Fulton Street as part of an overall plan to provide shelter to AIDS clients.

I share your concerns that people with AIDS have access to suitable housing to meet their medical and social service needs.

As you know, 1024 Fulton Street was recently rejected by the Board of Estimate as a proposed site to serve the dual purpose of housing homeless women with infants and providing emergency assistance services to all borough residents.

The site was rejected due to its inaccessability to public transportation, the serious drug traficking in the area, and the general decay of the surrounding community. These conditions present the same problems to an AIDS population - a population no less vulnerable than young mothers.

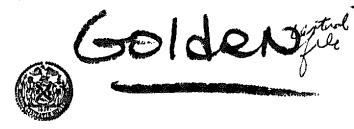
I trust these issues will be re-examined by your agencies as they re-consider this site.

Reviewing individusl sites in the absence of the City-wide plan you are proposing is at best difficult.

I look forward to hearing from you on the balance of your AIDS housing initiative. Upon receipt I will'be pleased to share my views with you.

Howard Golden

BOROUGH HALL, 209 JORALEMON STREET, BROOKLYN, N.Y. 11201 1-718 '643-2051



THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

June 2, 1988

Hon. Howard Golden Brooklyn Borough President 16 Court Street - 14th Floor Brooklyn, NY 11241

Dear Howard:

I am forwarding, for your information, a copy of New York's Plan for responding to the AIDS epidemic through 1991. This Plan, which covers the epidemiology of AIDS in New York City and details coordinated plans across seven City agencies, was prepared by the Interagency Task Force on AIDS. It is a sensible, but sobering document, reinforcing the perception that the AIDS epidemic is the principal public health crisis of this generation.

The demands for prevention, clinical care, housing and social services projected in the Plan are both ambitious and conservative. Yet, even to meet these needs, City, State, Federal and private resources will have to be committed far beyond current levels. And, since AIDS presents unique problems as a disease, it is evident that some entirely new regulations and funding will have to be developed in order to support programs that will serve those who are sick. For FY 1989 alone, the City has budgeted \$25 million in capital funds for AIDS housing and extended care facilities, and we have budgeted more than \$333 million in operating funds (City, State and Federal) for services and programs described in the Plan.

While currently centered in a handful of urban areas, the AIDS epidemic is clearly one we must face as a nation. The City will be working in the coming months to implement the programs outlined in the Plan and to develop new initiatives that respond to the epidemic here. Full cooperation across all levels of government and between public and private institutions is essential, if we are to be effective in dealing with this disease.

epidemic here. Full cooperation across all levels of government and between public and private institutions is essential, if we are to be effective in dealing with this disease.

I welcome your comments on this Plan and look forward to working with you to address the many crucial issues this plan lays out in caring for people with AIDS.

All the best.

Sincerely,

Edward I. Koch

Enclosure



PRESIDENT OF THE BOROUGH OF BROOKLYN

HOWARD GOLDEN PRESIDENT

October 7, 1988

Edward I. Koch Mayor City of New York City Hall New York, New York 10007

Dear Mayor Koch:

In May, after receiving your letter which stated your intention to use 1024 Fulton Street as one site in an overall plan to shelter AIDS clients, I wrote to you asking for details of your AIDS housing plan.

To date, I have received no response and have not been informed of whether this plan has been developed.

My concern over the housing needs of AIDS patients grows, as hospital beds continue to be used as the alternative to adequate and appropriate housing for this population.

I, therefore, would appreciate receiving a response on this issue at your earliest convenience.

A HOWARD COLDER

Attachment



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THE CITY OF NEW YORK
OFFICE OF THE MAYOR
NEW YORK, N Y. 10007

STANLEY BREZENOFF First Deputy Mayor

October 19, 1988

Howard Golden President of the Borough of Brooklyn Borough Hall 209 Joralemon Street Brooklyn, NY 11201

Dear Howard:

Mayor Koch has shared with me your letters regarding AIDS housing in the City. If you recall, in the Spring, the City released a multi-year AIDS plan that extensively discussed, among other issues, the needs and plans for both supportive housing and long term care for People with AIDS. We assumed that this document, which was shared with you, served as the response to your last letter.

We are in the process of identifying a number of sites around the City to be used as facilities for People with AIDS. We have done an extensive search of City-owned property and have also advertised in the newspapers about our interest in acquiring new space. As you can imagine, it has not been an easy process.

We are getting close to finalizing a set of sites that will be recommended to the Board of Estimate for use as either supportive housing or health-related facilities for People with AIDS. We are also working with religious and not-for-profit groups who have identified sites on their own or are interested in acquiring and/or operating City-owned facilities. I anticipate that we will be in a position to make some final decisions shortly and you can be assured that your office will be advised.

Sincerely,

Stanley Brezenoff



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THE CITY OF NEW YORK
OFFICE OF THE MATOR
NEW YORK, NY 10007

Caryn A. Schwah Special Advisor to the Mayor

MEMORANDUM

TO:

Edward I, Koch

FROM:

Caryn Schward

DATE:

July 8, 1988

I thought you'd be interested in the attached Letter to the Editor from Steve Joseph regarding the Times iltorial on the needle exchange demonstration.

Peter Benitez, Peter Zimroth and Steve met with Sterling Johnson and John Fried from Morgenthau's office yesterday. While I understand that Johnson continued to strongly object, Morganthau's person offered some cause for optimism.

It was agreed that Johnson would talk with Morgenthau and that they would get back to us next week. Peter Zimroth is also calling him.

cc: Stan Brezenoff

Company of the contract

NICHOLAS WADE

New York Times (1857-Current file); Jul 6, 1988; ProQuest Historical Newspapers The New York Times (1851 - 2004) pg. A22

The Editorial Notebook

For Addicts: A Death Penalty

Few people would advocate solving the drug problem by killing addicts. Yet that's the effect of the drug policy now pursued by Mayor Koch and Governor Cuomo. By re-

Why Deprive Users Of Clean Needles?

change increases drug abuse. On the contrary; Amsterdam's experience suggests that it does not. outweighs the hypothetical risks of

The heavy toll of AIDS by now

sisting measures to halt transmission of the AIDS virus among addicts, they are letting the infection spread. That does not eliminate drug abuse, only drug abusers

does not eliminate drug abuse, only drug abusers.

New York City has about 200,000 addicts, some 60 percent of whom now carry the AIDS virus. Among the rest, some 6 percent become infected each year — about 5,000 people. Many acquire the virus through sharing needles and syringes, a practice encouraged by the New York State law that prohibits sale of such equipment.

Many of these 5,000 might be protected if they could exchange used needles and syringes for sterile ones. In the Netherlands, more than 70 percent of Amsterdam's addicts are participating in a needle-exchange program. Among addicts in a Swedish program, the rate of new infections has dropped close to zero. Needle exchanges are a unique way of reaching and counseling addicts, many of whom would not seek treatment even if it were available.

New York refuses to offer clean needles to addicts because of vociferous resistance from officials responsible for combating drugs. They abhor giving any kind of sanction to drug abuse and argue that making needles available would enhance it. These are reasonable objections in theory. But there's no empirical evidence that needle ex-

a clean-needle program. In neglecting an opportunity to halt transmission, New York's authorities assume a heavy burden of consequences. Apart from keeping addicts alive, clean needles could spare the innocents whom the addicts infect — their partners and children. The addicts and their partners are also a source from which AIDS may spread to the wider population.

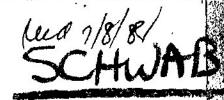
Other cities have taken some first steps. The District of Columbia is providing addicts with vials of bleach to sterilize needles. This month, Oregon began a pilot project to give needles to 125 addicts in Portland. But through the inaction of Mayor Koch and Governor Cuomo, New York has done almost nothing. David Sencer, then the city's Health Commissioner, proposed in August 1985 that addicts be given a clean needle for each dirty one turned in. Three years later, a small-scale exchange experiment has been approved, in principle, but has still not begun.

Even if the pilot project gets under way, it will take months before opponents can be placated and a citywide program put into effect. Stephen Joseph, the city's Health Commissioner, offers a grim summary: "We have lost so much time, and an enormous number of lives."

NICHOLAS WADE

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THE CITY OF NEW YORK
COMMISSIONER OF HEALTH
Stephen C. Joseph, M.D., M.P.H.





125 WORTH STREET NEW YORK, N.Y. 10013

July 7, 1988

Letters to the Editor New York Times 229 West 43 Street New York NY 10036

To the Editor:

I must correct two critical inaccuracies that mar Nicholas Wade's call for stepped-up efforts to prevent the spread of HIV among addicts ("For Addicts: A Death Penalty." Editorial Notebook, July 6, 1988).

First, Mr. Wade incorrectly identifies Mayor Koch as a source of resistance to a pilot clean needle exchange program. The Mayor has consistently supported. since 1985 when the idea of needle exchange was first proposed by then Health commissioner Dr. David Sencer, a clean needle exchange trial as a vitally important study. State Health Commissioner Dr. David Axelrod's recent publication and promulgation of the regulations that would allow us to undertake our small pilot study indicate that the State now supports the City's position.

It must be clear that the obstacles to a clean needle exchange program in New York City now reside in the prosecutorial and law enforcement communities. In particular, the vigorous opposition of Special Prosecutor for Narcotics Sterling Johnson exemplifies these concerns.

Second, Mr. Wade wrongly asserts that New York City has done "almost nothing" for the past two years to support and educate addicts about the dangers of needle sharing. In addition to this Department's vigorous program of AIDS education to addicts and their sex partners, New York City has for the past two years supported the nation's largest outreach effort to addicts, including bleach distribution and addict education on clean needles, through contracts with the Association for Drug Abuse Prevention and Treatment (ADAPT). In Fiscal 1989, the Mayor's new Executive Budget will triple (from Fiscal 1987 levels) the number of outreach workers bringing AIDS prevention messages to addicts and their sex partners in neighborhoods where IV drug use is rampent.

New York Times Page 2

Mayor Koch and I have been among the strongest voices in the country drawing attention to the AIBS/IV drug connection, and advocating a broad and rapid range of response, from interdiction at the international level, to more vigorous law enforcement at all levels, to more credible and effective drug education programs, increased and liberalized methadone maintenance and rapid and massive detoxification programs for those already addicted, and availability of clean needle exchange.

Sincerely,

Stephen C. Joseph, M.D., M.P.H.

Commissioner of Health

SCJ:del 0849p The City of New York

Office of the Mayor

Office of Manager Strand Support



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July 8, 1988

MEMORANDOM

To:

Elinor Bachrach

Special Deputy Comptroller

From:

Diana Portuna

Deputy Director \
Office of Management and Budget

Stephen Schultz, M.D. Deputy Commissioner / Department of Health

Ray Baxter, Ph. Vice President

Health and Hospitals Corporation

Subject: Comments on 6/30/88 Draft of "The Growing AIDS Crisis in New York City: Issues of Cost and Strategic Planning"

We have reviewed your latest draft on Acquired Immune Deficiency Syndrome (AIDS) and its financial and programmatic impact upon the City. One year after the Office of the Special Deputy Comptroller (OSDC) released its initial report on AIDS, little has changed in the analysis. OSDC's analysis remains predicated upon a model developed by Dr. Michael H. Alderman and his colleagues at Montefiore Hospital. In this model gross estimates of the number of BIV infected individuals are used as the basis to project active AIDS prevalence by applying estimates of the time between infection and onset of disease to the population base. The OSDC applies the tenets of this model using overly simplified statistical logic to project cumulative cases in 1992 that exceed the City's 1991 estimates by nearly 300 percent and the City's 1992 inpatient census estimates by over 100 percent.

The City bases its AIDS case projections on a mathematical amodel of the existing epidemic (referred to in the draft as the historical model). The basic tenets of this model are

accepted by both the State Department of Health and the Centers for Disease Control. We continue to believe that this is likely to prove the most accurate projection method, as it is based on observations of actual events (specifically, diagnosed cases of CDC-defined AIDS) and projects an observed and increasing phenomenon into the future. The existing epidemic is the best illustration of the effect of all underlying biological parameters. As the epidemic evolves, these projections must be continuously repeated and reevaluated.

So far actual cases will most likely come in below original projections. We can estimate from case surveillance that the number of cases reported so far for 1987 diagnoses (3,714), represents 94% of cases that we will ultimately have (3,950). This is nearly 600 cases less than the original predicted value of 4,542 new cases.

We have studied the epidemiologic model (discussed, for example, in the New York State Medical Bulletin) and consider it to be flawed by the overwhelming uncertainty of the data applied to the model. Rates of infection used are taken from a cohort of homosexual men in San Francisco and may not be applicable to women and intravenous drug users. The estimated number of persons infected, 400,000, is already suspected by us as being too high. For example, that estimate includes approximately 50,000 women. Recent City and State serosurveys of women in New York City suggest that only half that many women are infected. From a comparison of the rate of HIV infection and AIDS in gay men in San Francisco, the suggestion has been made that the number of gay men at risk in New York City may actually be less than the range of 250,000-500,000 we originally used. For these reasons, epidemiologists in the AIDS program are reexamining the estimates for men, in order to more accuately define the scope of infection.

At the current rate of new cases, about 330 per month for 1987, with steady increases, we can expect to reach the cumulative 43,000 predicted by 1991. If the "epidemiologic" model is correct in predicting a cumulative 144,000 by 1991, an average of 3,583 cases per month must be diagnosed and reported: 10 times the current number of about 330 per month in 1987. No such drastic increase is evident. Further, a drastic increase is unlikely, as AIDS has a long incubation period and similar "slow" virus outbreaks have not shown marked increase in rates over time. A drastic upturning of cases has not been observed in any of the cohorts of HIV infected persons under study.

Regarding the comment that New York City is increasing its number of predicted cases over time, this is not entirely

securate. Our first projection in 1986 of 40,000 used a different mathematical method than the 1987 projection of 43,000.

The fact that the epidemic for 1987 has remained under the predicted number suggests that the 1988 projections will be similar to the 1987 ones, and certainly no higher. Considering the importance of these data to health care planners, it seems prudent to use the sound and conservative method of mathematical modeling based on existing case rates, while maintaining a diligent watch on disease trends, and an ongoing validation of case counts.

The City clearly recognizes there are limits to any analysis of this type, and incorporates a range of possible estimates around the projectiona, but as previously discussed, these do not approach the levels OSDC predicts. Despite detailed responses from the City, inpatient projections that have come in exceedingly close to actuals (in fiscal year 1987 HHC's actual AIDS average daily census was 307, while the projected budgeted census was 350), and the decreasing likelihood that there could be an explosion in AIDS cases of the magnitude needed to yield the projections contained in your report, your office refuses to modify its caseload estimates, not even to say they could represent the high side, or a range of possibilities. What is most disturbing is that the existence of new data has not lead to a modification in OSDC's position.

Beyond the caseload projections, there are several other issues raised in your report to which I will respond below:

1. Caseload split between voluntary and municipal hospitals

The OSDC report assumes that NHC will have to bear more than 33 percent of the citywide AIDS caseload because of the increase in IVDU cases. As stated in the plan, HHC already bears a disproportionate burden of the City's AIDS workload. While we are not forecasting a decrease in HHC's share, continuance of the current share is not desirable. The State must respond to the stress AIDS has placed on the health care system, and insure that sufficient bed capacity is available throughout the City to serve all acute care needs.

In addition, as was explained to your staff, the 29 percent HBC share of inpatient caseload reflected in the Financial Plan is purely the result of a technical inconsistency on the part of OMB and in no way reflects any policy or analysis on the part of the City that predicts or dictates a

specific decreased share of AIDS patients in municipal hospitals. Although this was communicated to your office, it is described in your draft as an adopted City policy, which it is not.

2. Inpatient care projections

The report questions a valid assumption that AIT and other therapeutic modalities will prolong life, and cause an increase in ambulatory service demand. Though difficult to quantify, it has been reported by clinical staff that patients on AIT have fewer inpatient stays. Many of their clinical meeds, such as blood transfusions, can be handled on an ambulatory basis as well. Patients on AIT, and PCP prophylaxis, even have mild cases of PCP handled on an outpatient basis. As patients are diagnosed earlier in the course of their disease, and are offered management and treatment, the focus of the disease will begin to shift to ambulatory management.

3. Inpatient care costs

Beyond the issue of caseload, your report implies that ONB's cost estimates are too low because the estimate of cost per day may not include all services consumed by AIDS patients, and a loss in revenue may be incurred due to outlier and alternate level of care days under DRG per case reimbursement. The data used by OMB is the best available information at this time that can yield the most reliable estimates of cost. As new data is evaluated, OMB's analysis of AIDS costs will continue to be refined and updated.

Your report implies that your office has been able to review a higher State estimate of AIDS inpatient costs, and has concluded that these are more accurate than the City's estimate. OMB has not seen the State's analysis, but would welcome the opportunity to review the material OSDC has reviewed.

4. Insufficent documentation was supplied to OSDC by City officials

Detailed documentation has been forwarded to your office that describes in depth the assumptions and methodologies used to arrive at the City's estimates of service need. Your office has asked for information that goes beyond evaluating the reasonableness of the City's assumptions, but rather seeks to replicate entire analyses. The City does

not understand the need to reproduce the work of the AIDS Interagency Task Force.

5. Contingency plans

Throughout the report OSDC states that "contingency plans" | should be made in case the actual AIDS caseload far exceeds City estimates. What OSDC refers to as "prudence" implicitly means setting up large reserves of funds in the Financial Plan for the City to assume full responsibility for the AIDS crisis at the levels predicted by the Montefiore model. At one point the report makes the alarming statement that the City should be prepared to assume the burden for AIDS treatment and prevention without regard to funding sources! The burden of the AIDS crisis must also be borne by the Federal and State government and ,by the voluntary health sector. Your office should be assured that the City will continue to pursue an aggressive policy to increase the involvement and support of these sectors. No matter what level of services need to be provided, OSDC can not make a credible recommendation that the City be prepared to act as the sole financier of additional resources for AIDS. OSDC, understanding the potential magnitude of the AIDS crisis, should join the City's efforts and recommend increased support for AIDS services by Federal, State and voluntary providers.

cc: C. Schwab

- P. Dickstein
 - B. Eng
- L. Fagnani
- R. Blake
- J. Boufford
- P. Moore
- K. Morrison
- S. Joseph
- P. Clarke
- M. Baker



THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

August 15, 1988

Dr. C. Everett Koop Surgeon General & Director Office of International Health Health and Human Services Department 200 Independence Avenue, S.W. Washington, D.C. 20201

Dear Dr. Koop:

I recently saw you on a cable television show speaking about AIDS. I believe that one of the statistics you gave in responding to questions was that 90 percent of all I.V. heroin users in New York City had the AIDS virus. I mentioned that figure to Dr. Stephen Joseph, and he believes the figure is somewhere between 40 and 60 percent. Did I misunderstand you? Is Dr. Joseph's figure closer to the truth as horrendous as it is?

The Q&A portion of the show you were on was superb. Is it possible for you to furnish me with a video tape of that show? I am going to ask Richard Green, Chancellor of the New York City Board of Education, to watch it and consider using it as a teaching mechanism in our school curriculum. Do you have any other video tapes on the subject of AIDS which could be used as teaching tools? If you do, I would appreciate your sending those on to me as well.

Now to a second subject regarding drugs which I know you have a great interest in. As you will see by the enclosed letter that I sent to Lauro Cavazos, Education Secretary Designee, I viewed the videos used in our school system to educate our students on the dangers of using drugs. I found those tapes to be totally inadequate. I have suggested that the Department of Education consider authorizing the production of videos, and I would like to suggest that you do

the same. Indeed, the best video that I can think of would be one of you discussing the subject. Do please give this some thought. In any event, if you agree that the Federal Government has a role to play in producing these videos, perhaps you could work with Secretary Designee Cavazos on the issue.

The next time you plan on coming to New York City, please give me a call. I would love to have lunch or dinner with you again. You are terrific!

All the best.

II. Koch Mayor

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THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

Caryn A. Schwab Special Advisor to the Mayor

MEMORANDUM

TO:

Edward I. Roch

FROM:

Caryn Schriff

DATE:

September 27, 1988

I have attached some talking points for you to use in the first meeting of the City and Voluntary Task Force on AICS. This group, chaired by Dr. David Rogers, will meet at 8:00 a.m. on this Wednesday, September 28. This is a follow up to the Gracie Mausion breakfast from the summer and is the first working session of the Task Force. I'll be bringing Dr. Rogers in at 7:45 a.m. to meet with you.

Also attached is a full list of the members of the Task Force.

CAS:pm Attach. cc: Stanley Brezenoff

EDWARD I. KOCH REMARKS TO THE FIRST MEETING OF THE MAYOR'S CITY AND VOLUMTARY HOSPITAL TASK FORCE ON AIDS SKPTHMBER 28, 1988

- I am delighted that you are all here this morning to convene this important AIDS Task Force. You know firsthand the impact of AIDS on this City. You also know that not the City, nor the Health and Hospitals Corporation, nor the private hospitals in New York can face this problem alone. What is needed now more than ever is a combined planning effort by the public and private sectors. This is why I have created this mayoral Task Force.
- pronouncements or make predictions. Instead, its duty is down-to-earth. This group must come up with pragmatic and workable plans which can be implemented quickly, combining the resources of the municipal and voluntary health care facilities to best serve the growing AIDS population.
- I wrote to each of you describing the threefold nature of the problem we are facing.

- -- First, more acute care beds are needed, at least 1,200 more before 1991. While we are meeting the current level of acute care need just now, the City's hospitals are overcrowded and this affects all patients. Access to these facilities in the immediate future is in grave jeopardy.
- -- Second, the responsibility for this acute care must be shared among all providers. Currently, ten hospitals with only 25% of the medical/ surgical beds in this City treat more than half of the AIDS patients. Every hospital in the City must participate.
- -- Finally, we need far more non-acute care resources, including nursing home beds, supportive housing, home care and primary care that treats proactively to minimize hospitalization.
- I am confident that Dr. Rogers' leadership and the combined expertise of the officials assembled here will produce the kinds of answers we need. I know these answers will not come easily. I have asked Dr. Rogers for a report in 90 days -- for this most urgent problem, there is no time for deley.

CITY/VOLUNTARY AIDS TASK FORCE

David Rogers, M.D. Professor of Medicine Cornell University Medical College 1300 York Avenue Room A-127 New York, NY 10021

Dr. Spencer Foreman President Montefiore Medical Center 111 East 210th Street Bronx, NY 10467

Mr. Angel Quinones Executive Director Lincoln Medical and Mental Health Center 234 East 149th Street Bronx, NY 10451

Mr. Alan Channing Executive Director City Hospital Center at Elmhurst 79-01 Broadway Elmhurst, NY 11373

Mr. Jeffrey Frerichs Executive Vice President Cabrini Medical Center 227 East 19th Street New York, NY 10003

Patricia Cahill, J.D. Executive Director Alliance for Catholic Health Care Archdiocese of New york 1011 First Avenue New York, NY 10622

Richard I. Beattie, Esq. Simpson Thatcher & Bartlett 1 Battery Park Plaza 33rd Floor New York, Ny 10004

Mr. Kenneth Raske President Greater New York Hospital Association 61 West 62nd Street New York, NY 10023 Bruce C. Vladeck, Ph.D. President United Hospital Fund 55 Fifth Avenue 16th Floor New York, NY 10003

Thomas Q. Morris, M.D. President Columbia Presbyterian Hospital 622 168th Street New York, NY 10032

Robert G. Newman, M.D. President Beth Israel Medical Center First Avenue and 16th Street New York, NY 10003

Caryn A. Schwab Special Advisor to the Mayor The Office of the Mayor City Hall New York, NY 10007

Jo Ivey Boufford, M.D. President Health & Mospitals Corporation 125 Worth Street New York, NY 10013

Stephen Joseph, M.D. Commissioner The Department of Health 125 Worth Street New York, NY 10013

Raymond Baxter, M.D. Senior Vice President Health & Hospitals Corporation 346 Broadway Room 518 New York, Ny 10013

Saul Farber, M.D. Chairman, Department of Medicine New York University Medical Center 550 First Avenue New York, NY 10016



gke

THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

MENORANDUM

TO: Stanley Brezenoff

FROM: Edward I. Koch

DATE: Occober 28, 1988

I just want to acknowledge Caryn Schwab's October 26 memo to you regarding AIDS facilities. I am in total accord with her plan.

We have taken many actions in the past to deal with a very difficult situation -- namely, providing apartments or other accommodations for AIDS patients. The need for such apartments for those in hospitals, regrettably, is not restricted to any one group of sufferers and includes many who have other forms of cancer and illnesses, some terminal, some not. Rowever, I think most people would agree that because of the special situations involving AIDS patients -- their youth, the nature of their suffering, the isolation from families -- they deserve special attention. Caryn's proposals do exactly that, and I am for them. She should immediately sit down with OMB and take the necessary measures to commence condemnation or purchase negotiations, whichever is cheaper.

Every elected official in the city government, particularly the Board of Estimate which will have to vote in the ULURP process, should be briefed as soon as possible. I am sure that they will help us to site these facilities and acquire them, notwithstanding the community pressures that will, regrettably, resist. We asked each of the members of the Board of Estimate in April of this year to suggest AIDS facilities either denovo or as alternatives to those we submitted to them. Since they have come forward with no alternative sites and there is a compelling need for us to move forward, I believe it is prudent for us to implement this plan as quickly as possible.

mgl



THE COUNCIL OF THE CITY OF NEW YORK CITY HALL

October 27, 1988

Honorable Edward I. Koch Mayor City of New York New York, New York 10007

Dear Mr. Mayor:

We, the members of the City Council Black and Hispanic Caucus, are writing you on behalf of our constituents and on behalf of all New Yorkers, who fear the drug scourge on our city, to stop the ill-conceived needle exchange program which your Health Commissioner is about to begin.

We Caucus members see daily reminders of drug affliction and our communities are hardest hit by this plague. Believe us, we would do anything to help eradicate the AIDS epidemic. However, this needle exchange program would do nothing to alleviate the spread of AIDS and is inconceivable in light of your efforts and the Council's efforts to fight drugs. As you must know, many medical professionals and others at the forefront in fighting drug abuse and counseling drug addicts, oppose this program.

We agree with yesterday's Daily News editorial: "To hand out free needles bespeaks the grossest insensitivity to the realities of life in New York." It is beyond all human reason and common sense for the city to hand out needles to drug addicts at a time when our police officers and our citizens have become casualties in the drug war.

Mr. Mayor, we urge you to reconsider this program and we hope that some sound second thoughts will convince you to cancel it. Please know, however, that we represent taxpayers, homeowners and concerned community groups who do not want this program in their neighborhood, or in any neighborhood. Their concerns must, and will, be heard.

All New Yorkers want a strong city fight against drugs. Let's not have any city program, however well intentioned, detract from this all important battle.

Sincerely,

The Members of the Black and Hispanic Caucus

Members:

Hilton Clark
Rafael Castaneira Colon
Rev. Wendell Foster
Mary Pinkett
Jose Rivera
Victor Robles
Archie Spigner
Enoch Williams (chair)
Priscilla Wooten



THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

October 31, 1988

Honorable Enoch Williams
Member of the City Council
Chair, Black and Hispanic Caucus
City Hall
New York, New York 10007

Dear Enoch:

I have your recent letter on behalf of the members of the Black and Hispanic Caucus and I must disagree in the strongest terms with your characterization of the needle exchange study and its role in the protection of the health of New Yorkers.

We are at only the beginning of the worst epidemic in memory. AIDS is already the number-one killer of New York City men aged 25 to 44 and women aged 25 to 39. Almost 100 infants infected with the AIDS virus are born each month in this City. The AIDS virus has already infected half of the City's 200,000 intravenous drug users. It is apreading, virtually unabated, to the other half, and to their sex partners and their unborn children. If we do not slow its spread, it will ravage the City's poorest, drug-ridden communities, and strike down not just IV drug users but whole families on an almost unimaginable scale.

I must face squarely what lies ahead. The decision to allow an investigation of needle exchange as a supportive bridge to drug treatment and AIDS prevention is not one that I take lightly or come to easily. Certainly, it is not the measure of highest urgency; the rapid expansion of drug treatment program capacity is, and I have urged the State, where responsibility for drug treatment is lodged, for over a year to provide the authorization and resources for a rapid expansion of drug treatment in this City.

But I must face facts. Without enough treatment slots to give every addict treatment on demand, tens of thousands, currently hundreds of thousands, of IV drug addicts will remain outside of treatment.

Needle exchange may help. Your letter claims that "this needle exchange program would do nothing to alleviate the spread of AIDS." The best available public health evidence suggests the contrary. Needle exchange has been tried elsewhere, with some success. No one knows if it would work here; it merits a trial in this time of crisis. I have said before that I don't believe it will work, but it is my obligation to do everything in my power to discover its possible worth to protect the health of the public, particularly the increasing numbers of minority women and children who are being infected through exposure to drug use.

The study has been extensively debated, approved by State Health Commissioner Axelrod, and widely adjudged to be scientifically sound. Those who have either supported this needle exchange trial here or endorsed it in principle include the Surgeon General of the United States, the National Academy of Sciences Institute of Medicine Task Force on AIDS, the American Public Health Association, the New York County Medical Society, the Committee on Medicine and Law of the New York City Bar Association, the World Health Organization, and a number of the nation's leading drug treatment and public health experts.

No less an expert than the Surgeon General has said, "If a needle and/or syringe program could contain in any way the spread of HIV who could possibly be against it?"

I regret that as leaders of communities that are being devastated by the AIDS epidemic, you have chosen to align yourselves, not with this attempt to find another weapon to slow the spread of AIDS, but with those whose misplaced concern or mistaken reasoning have allowed this issue to become bitterly divisive.

What will the people who do not want this study in their neighborhoods — this trial, which involves only 200 people, less than one-half of one percent of the City's IV drug users — do in the years ahead when they are faced with the incalculably greater tragedy of thousands of AIDS deaths tearing apart their entire communities? Will they not then turn to you and demand, with justifiable anger, "Why didn't we try everything possible to stop this disease when we had the chance?"

Page Three

I must allow every available reasonable measure to arrest the rampaging AIDS virus. Based on a review of the evidence before me, I believe this study reasonable.

You will be interested in the enclosed letters that I received commenting on and approving of the Needle Exchange Program. One is from the New York County Medical Society and the other is from the Association of the Bar.

All the best.

Sincerely,

Edward I. Koch

EIK:np

cc: Hilton Clark
Rafael Castaneira Colon
Rev. Wendell Foster
Mary Pinkett
Jose Rivera
Victor Robles
Archie Spigner
Priscilla Wooten

Needle Exchange Angers Many Minorities By MICHEL MARRIOTT

New York Times (1857-Current file); Nov 7, 1988; ProQuest Historical Newspapers The New York Times (1851 - 2004)

Needle Exchange Angers Many Minorities

By MICHEL MARRIOTT

accept the surge of freshly cooked heroin. may help a fellow addict find a vein able to provide a used hypodermic syringe and he will reach inside his rumpled jacket and tor" each day. For a fee of drugs or dollars late 30's, sets up his practice as a "hit docshooting gallery, Roberto, an addict in his Behind the broken bricks of a Brooklyn

sharing needles is frequently subordinated of intravenous drug use remains one where to the need to get high. the danger of spreading the AIDS virus by Even in the noon sun, the shadowy world

"People know they are taking chances when they share needles," said Roberto,

used by as many as 10 addicts because "there is such a need." who said he has seen one uncleaned needle

spread of AIDS. whether such an exchange can reduce the cials plan to begin distributing new needles dicts buy and inject heroin, city health offifor old ones today, in an experiment to learn leries, the abandoned buildings where ad-Far from New York City's shooting gal-

Charges of a Genocide Campaign

medical and political leadership and that versy that has deeply divided the city's troubles criminal justice officials. More however, has ignited a firestorm of contro-The announcement of the needle program,

> panic city officials. vehomently denounced by black and Hisspecifically, the needle exchange has been

of Harlem recently accused the New York neighborhoods. So intense are the sentiand insensitive. What is needed, many of of the city's addicts are black or Hispanic cialists, contend that because the majority City Health Commissioner, Dr. Stephen C. them say, is more drug-prevention educapeople, the needle program is misguided ments that City Councilman Hilton B. Clark loseph, of using the free needle program to They, joined by many drug treatment spe-

Continued on Page B8

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Needle Plan Stirs Anger Of Minorities

Continued From Page B1

conduct a genocidal campaign against black and Hispanic people. Mr. Clark said that the needles, even

if distributed for a limited period of six to nine months, will encourage drug use rather than contain AIDS.

Even the city's Police Commissioner, Benjamin Ward, last week joined the debate. Some drug treatment experts suggest that debate illustrates more about the failure of the city's black and Hispanic leadership to effectively combet. tively combat AIDS in their communi-ties than about the alleged insensitivity of City Hall to minorities.

Denounced by Ward

On a television call-in program Mr. Ward, who is black, called the exchange a "bad idea" and said he opposed it as a law-enforcement official and as a black man.

"As a black person we have a particular sensitivity to doctors conducting experiments, and they too frequently seem to be conducted against blacks,"

In a letter to Mayor Koch dated Oct. 27, the City Council's Black and Hispanic Caucus said, "It is beyond all human reason and common sense for the city to hand out needles to drug addicts at a time when our police officers and citizens have become casualties in the drug war."

The Koch administration, nonethe-

The Koch administration, nonemeless, supports the experiment, which is thought to be the first government-sponsored needle exchange program in the country and has taken more than two years to win the approval of the New York State Health Commissioner, Dr. David Axelrod.

Hard Look at Possible Help

More than half of the city's more than 200,000 heroin addicts are infected with the fatal AIDS virus, Dr. Joseph said, adding that the virus is making its way into the larger society through addicts' sexual partners, some of whom

"We feel that the crisis of the epidemic, the pressure of the numbers, the inability for any other short-term solution to offer relief, forces us to take a good hard honest look at this possibility for "he said"

Last week, after the principal of an elementary school in Chelsea complained that one of the two sites designated. nated for the exchange of needles was next door to his school, the Koch administration quickly re-examined its plan. City health officials said the needle exchange will operate only from the Health Department's headquarters at 125 Worth Street in lower Manhattan

while other sites are explored.

"On Monday we will begin with a small number of people," Dr. Joseph said. "In fact it might be later in the



dles are often recovered and used by other addicts to inject heroin.

Used hypodermic needles strewn among other debris in the yard of a house in Brooklyn believed to be used as a shooting gallery. Such nee-

'Why must we again be the guinea pigs in this genocidal mentality?'

week before we have any sizable num-ber at all."

The experiment plans to include 400 intravenous drug users who, after applying for methadone drug treatment, may volunteer for the study. The group will be randomly divided in half. Two will be randomly divided in half. Two hundred drug users will receive AIDS and drug counseling and an opportunity to exchange their dirty needles for clean ones, and the other 200 will receive only the counseling. ceive only the counseling.

ceive only the counseling.

Yolanda Serrano, executive director of a grass-roots drug prevention program in Brooklyn, said she and other proponents of the needle exchange will demonstrate today in front of the Health Department headquarters to support the city's plan "only because it is a first step."

Spaces in Treatment Programs

Although her support seems less than enthusiastic, Ms. Serrano, who helped found Adapt, the Association for helped found Adapt, the Association for Drug Abuse Prevention and Treatment, assailed black and Hispanic leaders who have recently criticized the plan. "Where were they for the last eight years?" she asked. "It's genocide now while blacks and Latinos are dying in the streets from AIDS."

But Dr. Beny J. Primm, a widely regarded drug treatment expert and director of the Booklyn-based Addiction

Research and Treatment Corporation, said he is "totally opposed" to the experiment. Although foreign countries like England and Sweden have distributed clean needles to addicts for years, Dr. Primm said, no medical evidence has been found linking the practice to slowing the spread of AIDS.

Dr. Primm, who is black, said he would rather see city health officials create a central clearinghouse to monitor and assign openings in city drug treatment programs to addicts who want help. Despite all the talk of waiting lists, he said, there are openings.

But Dr. Robert G. Newman, president of Beth Israel Medical Center in Manhatian, said there are far too few

Manhattan, said there are far too few treatment slots for all the addicts who seeks help.

At Park Avenue and 128th Street, in a festering corridor of drugs and poverty in East Harlem, the Rev. Reginald Williams operates the Addicts Rehabilation Center, a residential treatment center. Every day, he said, he sees the ravages of drugs and the very real threat of AIDS in his neighborhood. "But there will never be a needle exchange program here," he pledged. "I think the communities and neighborhoods would rise up in opposition. "They tell me this is what we must try?" he asked. "Why must we again be the guinea pigs in this genocidal mentality?"

In a recent tour of a Brooklyn shoot-At Park Avenue and 128th Street, in a

In a recent tour of a Brooklyn shoot-ing gallery, Ms. Serrano suggested the answer in the dead gaze of a 22-yearold addict.

Known by his Spanish nickname of Negro, he said nothing mattered more to him more than shooting heroin. As he bought a used syringe from Roberto, he said that if he had no other choice, 'I'd pick a needle up off the floor and use it.'

Back up



THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

November 2, 1988

Honorable Fernando Ferrer President of the Borough of the Bronx 851 Grand Concourse Bronx, New York 10451

Dear Fred:

I was somewhat surprised to read the reaction in the newspapers on the AIDS residences and Health Related Facilities (HRF) that my administration has identified. Most of the sites will go through the ULURP process and will ultimately come to the Board of Estimte for a final decision.

Follow-up stories reported the comments of several members of the Board of Estimate either opposing the shelters or decrying the process in identifying them. I want to acknowledge David Dinkins' response, which I thought was both compassionate and responsible. There were also comments from advocates of the gay community and I.V. drug users stating that we are not doing enough. They claim that the over 800 beds identified, which are the projections arrived at by those who engaged in the New York City Strategic Plan for AIDS under Commissioner Stephen Joseph, are inadequate. So, you're damned if you do and damned if you don't.

The two proposed sites in the Bronx are the Woodycrest Mansion and Roe Avenue. I should note that neither of these sites requires ULURP. The Mansion is being acquired privately through a non-profit organization, Housing and Services Inc., with the help of a City loan through HPD. The Hoe Avenue site was already under HRA's jurisdiction and had been used for a similar use previously, the housing of homeless families. In addition, the renovation work was relatively minor.

As you know, I wrote to every member of the Board of Estimate on April 25, 1988, a copy of which is enclosed, requesting suggestions on alternative sites to the ones we were considering at that time. To the best of my knowledge, no one has offered alternative specific sites in their respective boroughs. That offer still stands. If you have an alternative site that you want us to consider, it will be accepted as long as it meets the criteria that the task force which I established has set. We need to hear from you soon about the Woodycrest site, however, since we are ready to schedule the closing.

However, absent an acceptable alternative, I do hope that you will support moving ahead on these facilities. If we do not move on these sites or alternative ones expeditiously, we will not be able to meet needs by 1991 of the growing number of people with AIDS who will be homeless. In addition, given the lead time to develop facilities, we need to be planning for additional sites now for 1991 and beyond.

If you would like to discuss this matter further and go over criteria or the sites themselves, have your staff contact Caryn Schwab immediately at 566-4180. She will provide you with whatever information you request. If you would like to meet with her and Stanley Brezenoff to discuss the issue, they will be happy to do so at your earliest convenience.

All the best.

Edward I. Koch

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PRESIDENT OF THE BOROUGH OF THE BRONX BRONX COUNTY BUILDING BRONX, N. Y. 10451

PERNANDO FERRER

November 4, 1988

SB

The Honorable
Edward I. Koch
Mayor of the City of New York
City Hall
New York, New York 10007

Dear Mayor Kock

This is in response to your letter of November 2, 1988, in which you express surprise at newspaper accounts of the reaction of Board of Estimate members to the imposition of AIDS shelter sites in their jurisdictions.

When I received your prior correspondence (4/25/88) soliciting my support as you moved forward to establish facilities in various communities. I did not understand that your statement. "as soon as properties are firmed up, we will get back to you," meant that you intended to use the New York Times to convey your message. Since there seems to be an engoing communication problem. I am pleased to be given this opportunity to state my position and that of my constituents.

The people of The Bronx are not unwilling to take care of their own. We are committed to working cooperatively to appropriately shelter and care for our PWA neighbors. We are also best qualified to judge the means whereby that can be accomplished, in a manner that respects the rights and concerns of all Bronx citizens.

PWAs in The Bronx want to be accepted and supported by their neighbors. To accomplish this, it is vitally important that consensus and support is developed within the immediate community. Although the two shelters announced for The Bronx last week do not require ULURP, it is ultimately fastest and easiest to involve neighborhood leaders in the planning process. Such consensus building was, in fact, in the process of occurring—at least until the location of these sites was precipitously announced without prior information to, or coordination with, my staff.

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PRESIDENT OF THE BOROUGH OF THE BRONK

Mayor Koch 11/4/88

Page 2

Regarding your request for advice on the proposed sites, it is my understanding that the Woodycrest site plan has not met with major community opposition but that the announcement has complicated negotiations for the purchase of the building. Ms. Eileen Grigg, my Deputy Director of Health and Human Services, has arranged to attend the Community Board 3 meeting of November 15th, at which the Hoe Avenue plan is to be presented. She has also contacted Ms. Schwab to set up a meeting to determine your further suggestions. In the future, this office expects to be a participant rather than a bystander in the decisions regarding the fate of its people.

Singerely,

FERNANDO FERRER

FF/eg/ac



THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 1000?

December 2, 1988

Hon. Fernando Ferrer Borough President of the Bronx 851 Grand Concourse Bronx, NY 10451

Dear Fred:

I have your recent letter concerning the proposed AIDS sites.

As the attached two memos demonstrate, our intent regarding AIDS sites was to discuss these sites fully with elected officials and community groups. In fact, we have shared much information on the Bronx sites with the community.

In September, HRA's External Affairs Office alerted your office about Hoe Avenue. This was followed by an October 11 letter (attached) from Bill Grinker describing HRA's plans for the facility. On October 18, hRA wrote to the Chairman of Community Board 3, David Reid, and on November 9, a presentation was made to the Executive Committee. I understand that further meetings are scheduled, and we look forward to the participation of your office.

As for the Woodycrest site, as you know, the City is assisting Housing and Services, Inc. in the acquisition of this facility. We are not directly involved in the purchase negotiations. Housing and Services, Inc. has been working jointly with Brother Ed Phalen of the Eighbridge Community Life Center, Inc. Brother Phalen sits on the Health Committee of Community Board 4 and briefed the Committee on this project last Spring. The project was subsequently referred to the full Board, where it was decided that no vote was required since this

Page Two

was a private sequisition and ULURP was not necessary. I am told, however, that the tone of the meeting was generally supportive of the project. In addition, Brother Phalen reported virtually every month on this project to the Bronx AIDS Task force.

I know that Caryn Schwab met with your staff last week and provided you with the information you needed. We hope that your office will support these projects as they move forward. We also would consider proposals for appropriate alternative sites that you identify.

All the best.

Koch

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THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

Caryn A. Schwab Special Advisor to the Mayor

MEMORANDUM

TO:

Edward I. Koch

FROM:

Caryn Schwar

DATE:

January 20, 1989

I have attached an AIDS article which ran in the New York Native several months ago, as well as another piece we sent to them recently, which they have not yet printed. You had wanted another column based on my recent memo to you following Bruce Lambert's New York Times' story. The Press office suggests holding off on a third, basicially repetitive piece at this time. Instead, they'd like to keep trying to get the Native to print the piece it now has.

If it's okay with you, I'll hold off for a few weeks. If the column doesn't get printed, we can go ahead and do another one.

COLUMN FOR THE NATIVE by Mayor Edward I. Koch Copyright by Edward I. Koch, 1988

By any measure, the City of New York is making an aggressive, coordinated effort to deal with the AIDS epidemic. Whether you consider expenditures or the array of services, it is safe to say that no other city has responded with more seriousness of purpose and forceful action.

Our interagency task force's strategic plan on AIDS of May 1988 reviews the work of various city agencies involved in public health and social services over the last several years, and it presents perhaps the first comprehensive overview of the needs of the growing AIDS population.

Each of these agencies is already providing a range of services which considerably stretches its resources. For example, the average daily census of AIDS patients in our city hospitals is now well over 500 -- it was about 200 two years ago. The case management unit of the Human Resources Administration, which is the intake point for city-sponsored health and social services for AIDS patients, now serves more than 2,000 people, up from just over 1,000 a year ago.

The Department of Health continues to open new anonymous counseling and testing sites, to offer educational sessions to 4,000 prisoners and 7,000 other people a month, and to operate an AIDS Hotline which receives almost 5,000 calls a month. While these few examples barely indicate the range and quantity of services currently available, clearly, the city is putting a lot of effort and money into its AIDS programs.

Our primary goal is to keep people with AIDS in their own homes. City services include the following:

- -- HRA is providing rent assistance to 885 people with AIDS, up from 462 a year ago. We anticipate increasing this number to 1,400 by 1991.
- -- HRA is currently providing home care to 337 people through the visiting nurse service and has provided home care services to more than 1,000 people sinca July 1987.

But, although everyone's praference is to have AIDS patients remain in their own homes or apartments and the city is prepared to help with the rent, there are many who don't have their own places to live, and the city is doing the following:

- -- There are 44 people with AIDS in Bailey House, which is at full capacity. Plans are now being made to expand this facility by nine beds in an adjacent building.
- -- There are 20 people with AIDS in scatter-site apartments and HRA has contractual commitments for 20 more. The fiscal 1989 budget calls for 80 more, or 120 apartments altogether.
- -- HRA has placed 342 people with AIDS in SRO hotels, up from 87 a year ago.

At Coler and Goldwater Hospitals, facilities with special long-term care units, there are 52 chronic care beds. They're full. These are the only such beds in New York City and among the first in the nation. Although HHC will add about 30 more such beds at these facilities in January, and will have a total of 110 by the end of this fiscal year, there are simply not enough. Acute-care hospitals, public and private, are filled with AIDS patients awaiting discharge. One way to ease this problem would be to require nursing homes to accept AIDS natients.

There are, right now, about 50 patients in Health and Hospitals Corporation hospitals who no longer require acute care in the facility they are in but have nowhere else to go. A variety of potential barriers exist which may hamper our efforts to solve this problem.

Among its projections and recommendations, the interagency strategic plan called for the creation of 784 residential or health-related facility (HRF) beds by 1991. And we've decided to raise this to 838 beds. This is an absolutely vital component of the plan's approach to housing and providing alternative levels of care to AIDS patients, and remember, it's only one component of the 2,700 plus AIDS patients who will either be receiving assistance with their rent or a new place to live.

The residential or HRF facilities are a new area of expansion for the city, one which will serve a very needy subgroup of AIDS patients -- the homeless. My budget sets eside \$25 million to get this new housing initiative off the ground.

For the past nine months we have been working to identify appropriate sites for residential and HRF purposes. At the beginning of this process, I asked the Board of Estimate for recommendations on sites. None have been forthcoming.

Nevertheless, we have identified a number of sites after an extended search, and we are now poised to move through the Uniform Land Use Review Procedure, where required, on eight.

We believe many patients leaving the hospital will require some level of medical care on discharge, and we want to maximize reimbursement to the city for these facilities. We are anticipating that full state support will be available to finance their acquisition, renovation and operating costs.

It is our hope that \$25 million in city funds, which we will use to kick this program off, will be largely reimbursed so it can continue to serve as a revolving housing fund to initiate more AIDS facilities.

Critics of the city's plan have expressed the familiar "not in my backyard" opposition to the creation of these facilities and some neighborhoods may try to block them.

Some others say that 838 beds are not enough. This number is based on an estimate by the same experts who have accurately projected the AIDS caseload citywide for several years. We can point to the formulas used to derive it. But some people have bandied about figures as high as 5,000. Where do these figures come from? No one has been able to tell us.

The issue here is not a matter of estimates. We must concentrate on getting started. We cannot expand a program before we have a program. Of course, we are aware that the number will grow as more people become sick, and we must begin to identify additional sites beyond those already being planned. That's why we need state reimbursement funds to "revolve" the city's resources for future expansion.

Some say the facilities we have planned are too large, but it has been difficult to find smaller buildings to use, partly since many do not have elevators, which are absolutely necessary. We would welcome suggestions for additional sites.

In facing an unprecedented public health crisis, one which is compounded and intensified by its spread through sexual contact and intravenous drug use, we are seeking new ideas to deal with the problems created by the AIDS tragedy.

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by By Edward I. Noch, Mayer of the City of New York

September 8, 1988

the recent controversy over the new estimate of HIV-infected persons in New York City is missing the forest by disputing the tree count. Questions about the reliability of the particular methodology used to arrive at this estimate and the fact that there has been a recent downward revision by the City's Department of Health must not be allowed to deflect attention from the real and ongoing needs of PWAs and HIV. infected persons. There are some who argue that the estimates should be much higher and others who would cite lower estimates. The Health Department's estimates fall somewhere in between.

Estimates and their revisions will continue to be disputed. What is important, however, are the facts about the City's commitment to dealing with its most serious public health crisis. Fact: the projection of 43,000 AIDS cases in New York City by 1991, the number which is used as the basis for planning AIDS services, is unaffected by the revised estimate of HIV-infected persons, as the former is based on projections from the actual number of diagnosed cases in New York City: Fact: the City added \$115 million to its I'Y 1969 budget, including \$25 million in capital funds for AIDS housing and health related facilities, upping the total funds allocated for AIDS expenditures to more than \$333 million. Fact: the City's Interagency Task Force on AIDS has outlined in its May 1988 Strategic Plan specific programs to add long-term care facilities, to provide supparted housing, to expand targeted AIDS education and prevention programs, to improve anti-discrimination efforts, and to offer more testing and counselling serviers to at-risk New Yorkers.

SPACE AVAILABLE

These several facts clearly point to one central fact: as the demand for AIDS corvices rises, so too will the City's response. The past three years have established notable precedents: for example, the average daily AIDS inpatient census at municipal hospitals is now nearly 590, or double the census in 1986. Although these hospitals have only 16 percent of the med-surg beds in New York, they provide approximately one third of the City's inpatient care for PWAs. As another example of continually increasing aid, in April 1988, 167 individuals vere receiving financial assistance to help pay their rents; in July 1988, 811 people were receiving such assistance. In the area of home care services, the City has more than tripled its services since 1986, now reaching 371 persons.

In no way does the revised estimate, which has drawn so much attention, decrease New York City's ongoing efforts on behalf of PWAs, those infected and those at risk. The examples above are already recorded history; for the immediate future, we have plans to develop a number of supportive housing and

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health related facilities. In addition, under the FY 1989 budget, the Health and Hospitals Corporation will add 70 long-term care beds to the 40 beds now in place at Coler and Goldwater Hospitals.

But these efforts are not enough. The City's FY 1989 budget gives top priority to making sure New Yorkers get the help they need; however, our ability to provide additional essential services is determined by available resources. If we are, for example, to add police officers, reduce the caseloads of child protective workers. and rehabilitate our in rem housing stock, as well as expand services for people with AIDS, there will have to be full cooperation and shared responsibility for functing ALDS services between City, State and Federal agencies and more. The Interagency Plan for AIDS is exceedingly ambitious, requiring both government and private resources.

An important area where this kind of cooperation must take place is the acute care beds of the City. As I mentioned earlier, the City, through the Health and Hospitals Corporation, now provides a disproportionate share of these beds given HHC's percentage of such beds Citywide Dr. David Axelrod, the State Health Commissioner, has approved nearly 500 new AIDS beds for New York City and we hope that these beds come on board quickly. However, even more beds are needed. In an effort to ensure that the City is adequately prepared to meet the increasing numbers of AIDS patients. I have established a task force of City, private and voluntary hospital representatives, chaired by Dr. David Rogers, to review the actions that must be taken to make sure that we are in a position to meet the needs.

Because drug abuse is increasingly tied to the spread of AIDS, we have continued to call on the State to expand drug treatment programs and have offered our assistance to expedite the development of more than 4,000 treatment alots in a number of ways, by providing in rembuildings for these programs, by offering to expand hours in HHC drug treatment clinics and by making available Department of Health sites in the evening hours to establish new programs.

The City's Interagency AIDS plan offers a thorough and sober analysis of the needs of people with AIDS and the actions required to meet those needs over the next several years. As Mayor, I succeed that the committed to meeting the needs that the City will face, however, it's clear that we cannot do it alone. AIDS is a local, a statewide, and a national health crists. Toward this cod, all levels of government, along with the voluntary sector, must participate fully in the bettle against this generation's most severe health crists.

CKOUNDATELLY

REMARKS BY MAYOR EDWARD I. KOCH AT NEW YORK UNIVERSITY'S AIDS AWARENESS WEEK LOEB STUDENT CENTER, 566 LAGUARDIA PLACE - 5TH FLOOR TUESDAY, FEBRUARY 14, 1989 AT 5:00 P.M.

THANK YOU, DR. MANUELL.

ON BEHALF OF ALL NEW YORKERS, I COMMEND N.Y.U. FOR SPONSORING THIS WEEK-LONG SERIES OF EVENTS ON AIDS, OUR CITY'S MOST SERIOUS HEALTH CRISIS.

I ESPECIALLY COMMEND ALL OF YOU HERE TODAY FOR YOUR INTEREST, YOUR CONCERN, AND, MOST OF ALL, YOUR CARING.

"THE POWER OF CARING" IS, AFTER ALL, THE THEME OF AIDS
AWARENESS WEEK. THE WEEK'S CALENDAR WILL EXPLORE WAYS WE CAN
REACH OUT TO THOSE STRICKEN WITH AIDS AND TO THEIR FRIENDS AND
LOVED ONES, AND HELP US LEARN MORE ABOUT THE RISK OF H.I.V.
INFECTION.

OF REPORTED AIDS CASES IN THE NATION. BUT OUR CITY HAS UNITED

IN A FIGHT STOP AIDS AND IN THE EFFORT CARE FOR THOSE WHO

SUFFER FROM THIS TERRIBLE AFFLICTION.

AIDS HAS BECOME A PART OF THE DAILY LIVES OF NEW YORKERS IN WAYS THAT ARE IMPOSSIBLE TO IGNORE. AS OF THE END OF JANUARY, 18,500 CASES OF AIDS HAVE BEEN REPORTED IN NEW YORK CITY.

CLOSE TO 10,000 PEOPLE HAVE DIED FROM AIDS, MOST OF THEM IN THE PRIME OF THEIR LIVES. AIDS IS NOW THE LEADING CAUSE OF DEATH AMONG NEW YORK MEN AGES 25 TO 44, AND AMONG WOMEN AGES 25 TO 34.

SOMETIMES PEOPLE FORGET THAT MORE THAN 2,200 WOMEN AND ALMOST 400 CHILDREN HAVE BEEN DIAGNOSED WITH AIDS HERE. SOME 200,000 NEW YORKERS ARE INFECTED WITH H.I.V., THE VIRUS THAT CAUSES AIDS. THIS FIGURE INCLUDES UP TO 60 PERCENT OF THE ESTIMATED 200,000 INTRAVENOUS DRUG USERS IN THE CITY. TENS OF THOUSANDS OF OTHERS, PRIMARILY WOMEN AND UNBORN CHILDREN, ARE AT RISK THROUGH SEXUAL CONTACT WITH I.V. DRUG USERS. ROUGHLY 100 INFANTS INFECTED WITH H.I.V. ARE BORN EACH MONTH IN NEW YORK CITY.

MUCH AS WE ALL HOPE OTHERWISE, THE AIDS EPIDEMIC IN NEW YORK CITY WILL GET WORSE IN THE NEXT FEW YEARS AS MANY OF THE PEOPLE WHO HAVE ALREADY BEEN INFECTED WITH H.I.V. BECOME ILL. AS THE EPIDEMIC CONTINUES TO FOCUS ON I.V. DRUG USE, THE OUTLOOK IS GRIM FOR ADDICTS, THEIR SEX PARTNERS, AND THEIR CHILDREN, THE OVERWHELMING MAJORITY OF WHOM ARE MINORITIES. THE SAD FACT IS, AIDS IS DEADLY THREAT TO MINORITIES AND THE POOR.

(MORF)

BY 1991, THE CITY'S HEALTH DEPARTMENT PROJECTS THAT MORE
THAN 43,000 PEOPLE WILL HAVE DEVELOPED AIDS IN NEW YORK CITY;
32,000 PEOPLE WILL HAVE DIED. IF WE COUNTED THE ADDICTS WHO ARE
SICK AND DYING FROM TUBERCULOSIS AND OTHER DISEASES RELATED TO
H.I.V. INFECTION BUT NOT OFFICIALLY CLASSIFIED AS AIDS, OUR
PROJECTIONS WOULD BE CONSIDERABLY HIGHER.

EVEN THOUGH NEW YORK CITY IS SUFFERING TERRIBLY, WE ARE

ALSO WORKING HARD TO FIND THE ANSWERS WE NEED. NOWHERE ELSE IN

THE COUNTRY ARE THE IMMENSE CHALLENGES OF AIDS BEING FOUGHT ON AS

MANY FRONTS AS IN NEW YORK CITY. IN RESPONSE TO THE EPIDEMIC,

THE CITY HAS COME FORWARD WITH THE MOST WIDE-RANGING AND

COMPASSIONATE PROGRAMS AND SERVICES TO BE FOUND ANYWHERE.

NEW YORK HAS LED THE WAY IN EVERY IMPORTANT EDUCATION, PREVENTION, AND SERVICE AREA ON THE AIDS FRONT, INCLUDING:

- -- PENDORMING STUDIES TO COUNT CASES WITH THE CENTERS FOR DISEASE CONTROL:
- -- MOUNTING NATIONALLY RENOWNED MASS MEDIA AND STREET-LEVEL EDUCATION CAMPAIGNS;
 - -- DEVELOPING PEDIATRIC AIDS PROGRAMS;

/MODE \

- -- PROVIDING A.Z.T. TREATMENT TO 1,000 NEW YORKERS;
- -- ESTABLISHING A NETWORK OF CONFIDENTIAL AIDS-PREVENTION COUNSELING AND TESTING SITES;
- -- PERFORMING H.I.V.-ANTIBODY TESTS ON OVER 170,000 SPECIMENS TO DATE IN THE PUBLIC HEALTH LABORATORY;
- -- AND PUSHING FOR THE NATION'S FIRST VITALLY IMPORTANT STUDY OF NEEDLE EXCHANGE.

MANY OF THE EXCELLENT CONCLUSIONS OF THE PRESIDENTIAL

COMMISSION ABOUT THE H.I.V. EPIDEMIC AND THE MOST EFFECTIVE WAYS

TO FIGHT IT CAME FROM INFORMATION AND PROGRAMS THAT ORIGINATED IN

THE CITY'S INITIATIVES IN EDUCATION, PREVENTION, TREATMENT, AND

RESEARCH.

EVEN THOUGH THE FEDERAL GOVERNMENT, WHICH FORMED THE COMMISSION, HAS ALL BUT IGNORED ITS RECOMMENDATIONS, I TAKE GREAT PRIDE IN NEW YORK CITY'S LEADERSHIP ROLE. MY PRIDE EXTENDS TO THOSE NEW YORKERS IN AND OUT OF GOVERNMENT WHO HAVE JOINED THE PUBLIC-PRIVATE PARTNERSHIP THAT HAS BROUGHT US THIS FAR.

BUT WE STILL HAVE A LONG WAY TO GO. WE WILL NOT REST UNTIL AIDS, LIKE SMALLPOX, HAS BEEN ERADICATED FROM THE EARTH.

REGRETTABLY, EVEN THE MOST OPTIMISTIC EXPERTS AGREE THAT WE ARE YEARS, MAYBE EVEN DECADES, FROM A CURE OR AN EFFECTIVE VACCINE AGAINST AIDS. UNTIL THEN, THE CITY OF NEW YORK WILL DO ALL IT CAN TO CARE FOR THOSE WHO SUFFER FROM AIDS AND TO PROTECT THOSE WHO DO NOT. BUT, AS I HAVE SAID MANY TIMES, AND AS I WILL REPEAT AS OFTEN AS I MUST, WE CAN'T DO IT ALONE.

THERE ARE A NUMBER OF CRITICAL AREAS OVER WHICH NEW YORK
CITY HAS LIMITED OR NO RESPONSIBILITY.

PERHAPS THE MOST CRITICAL OF THESE AREAS IS SUBSTANCE ABUSE.

WE HAVE PUT MANY PROGRAMS INTO EFFECT TO BRING THE AIDS

PREVENTION MESSAGE DIRECTLY INTO THE STREETS AND NEIGHBORHOODS

WHERE I.V. DRUG USE IS RAMPANT. THE CITY CONTRACTS WITH MANY

COMMUNITY-BASED ORGANIZATIONS TO FUND STREET-LEVEL SUBSTANCE

ABUSE COUNSELING AND EDUCATION. WE ARE WORKING EVEN HARDER TO

OPEN NEW DIRECT TREATMENT SLOTS IN THE CITY. BUT THE

RESPONSIBILITY FOR FUNDING AND OPENING ADDITIONAL SLOTS IN DRUG

TREATMENT PROGRAMS RESTS WITH THE STATE. THE BUCK REALLY STOPS

IN WASHINGTON, WHERE MORE FEDERAL MONEY FOR DRUG TREATMENT MUST

BE THE NUMBER ONE PRIORITY FOR WINNING THE WAR ON DRUGS.

THE FEDERAL LEVEL IF WE ARE TO TURN DEFEAT INTO VICTORY. WHEN I WAS IN WASHINGTON LAST WEEK, THESE WERE SOME OF THE SUGGESTIONS I MADE TO THE LAWMAKERS I SPOKE WITH. THE ARMED FORCES MUST TAKE A MORE ACTIVE ROLE IN STOPPING DRUGS AT THE BORDERS. THE COURTS HAVE TO BECOME MORE EFFICIENT IN PROCESSING THE DRUG CRIMINALS PICKED UP BY THE POLICE. FEDERAL FUNDS SHOULD BE USED TO UNDERWRITE RESEARCH TO DEVELOP A CHEMICAL THAT COULD BLOCK A COCAINE ADDICT'S CRAVING FOR THAT DRUG.

ANOTHER AREA WHERE NEW YORK CITY HAS LIMITED AUTHORITY IS IN THE EXPANSION OF ACUTE-CARE HOSPITAL BEDS IN THE CITY. IT IS ESTIMATED THAT AN ADDITIONAL 1,500 ACUTE-CARE BEDS WILL BE REQUIRED IN THE CITY TO MEET THE NEEDS OF PATIENTS WITH H.I.V. DISEASE IN THE NEXT FIVE YEARS. THE STATE MUST SPEED UP THE PLANNING AND APPROVAL PROCESS IF WE ARE TO HAVE THE BEDS WE WILL NEED.

INDEED, THE PRIME CHALLENGE TO THE ENTIRE HEALTH CARE
INDUSTRY IN THE COMING YEARS IN NEW YORK CITY WILL BE THE SHEER
SIZE OF THE CLINICAL SERVICE NEEDS RELATED TO AIDS.

THE WAVE OF DEMANDS FOR SERVICES IS ALREADY BEGINNING TO BATTER OUR HOSPITAL SYSTEM. WE HAVE SEEN THIS WAVE COMING, AND AS IT CRESTS, ITS EFFECTS WILL BE FELT IN EVERY AREA OF HEALTH CARE -- IN INCREASED DEMANDS ON OUR AMBULATORY, ACUTE-CARE, AND LONG-TERM-CARE SYSTEMS, IN STAFF BURN-OUT, AND IN APPROPRIATE PATTERNS OF STAFFING.

AS OUR HEALTH CARE AND SOCIAL SERVICE COMMUNITIES CONTINUE

TO EXPAND THE SERVICES PROVIDED TO NEW YORKERS WITH AIDS, WE WILL

INCREASINGLY TURN TO ALBANY AND WASHINGTON FOR HELP IN PROVIDING

THE FINANCIAL ASSISTANCE AND REGULATORY FRAMEWORK WE NEED TO CARE

FOR THOSE AFFECTED BY THE EPIDEMIC.

EVEN WITH STATE AND FEDERAL HELP, WE CANNOT CARRY THE BURDEN OF THE AIDS EPIDEMIC WITHOUT YOUR HELP.

ON THE ONE HAND, WE NEED YOUR HELP IN PREVENTING THE SPREAD OF INFECTION. MOST OF THE AIDS CASES THAT WILL BE DIAGNOSED IN THE YEAR 2000 WILL BE AMONG PEOPLE WHO ARE NOW IN THEIR TEENS OR EARLY TWENTIES. AND WE KNOW HOW TO PREVENT THOSE CASES -- BY AVOIDING THE TYPES OF BEHAVIOR WHICH SPREAD THE VIRUS.

THIS MEANS EACH PERSON HAS TO TAKE RESPONSIBILITY FOR WHAT HE OR SHE DOES. PEOPLE MUST TAKE RESPONSIBILITY FOR EDUCATING THEMSELVES ABOUT AIDS. AND FOR NOT DOING THINGS THAT PUT THEMSELVES AND OTHERS AT RISK.

BUT AIDS IS A SPIRITUAL AND EMOTIONAL CRISIS AS WELL AS A MEDICAL ONE. THE EPIDEMIC CHALLENGES US TO CALL UPON ALL OF OUR COMPASSION AND FAITH. IT CHALLENGES US TO GET INVOLVED. TO JOIN THE BATTLE AGAINST THIS DISEASE AT EVERY OPPORTUNITY.

WHETHER BY EDUCATING YOURSELF TO COUNTER THE IGNORANCE AND DISCRIMINATION THAT SURROUNDS THE DISEASE, OR BY REACHING OUT TO HELP DELIVER FOOD OR ARRANGE HOUSING AND SOCIAL SERVICES FOR PEOPLE WITH AIDS AND H.I.V. ILLNESS, WE MUST ALL GET INVOLVED.

IN SHORT, AIDS CHALLENGES US TO CARE FOR OUR FELLOW NEW YORKERS IN WAYS THAT WE MIGHT NOT HAVE THOUGHT OF BEFORE. IF YOU DO -- AND I'M HERE TO TELL YOU TODAY THAT YOU MUST, BECAUSE NEW YORK NO LONGER HAS THE LUXURY OF A CHOICE ABOUT WHETHER OR NOT TO GET INVOLVED IN THE FIGHT AGAINST AIDS -- WE WILL ALL OF US SEE THIS CRISIS THROUGH. I AM CONFIDENT THAT WE WILL.

AGAIN, I WELCOME YOU TO THIS SERIES ON AIDS, AND TO THE GOOD WORKS THIS WEEK WILL PRODUCE.

THANK YOU, AND GOD BLESS.

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Edit NATOS

Three Plagues

Modern America's Three Plagues blight the South Bronx: poverty, drug addiction and AIDS. The population is now widely infected with a disease that slowly drains the body of control, sight, mind and life. When the administrations of Mayor Edward Kech and Gov. Mario Cuomo are long forgotten, history will surely note that the New York of their era left the poor to rot, in unparalleled numbers, from the cruelest of diseases

Now there is vivid evidence of just how punishing the AIDS plague has become. Among emergency room patients tested at Bronx-Lebanon Medical Center, 23 percent were found to be infected with the AIDS virus, Bruce Lambert reported recently in The Times. That doesn't necessarily mean a quar-

ter of the South Bronx is infected. Emergency room patients are sicker than the population at large. But it's a horrifying warning.

The people of the South Bronx are mostly black or Hispanic, and poor. Poverty and drug addiction go together. Unable to buy clean needles, heroin addicts share them, thus spreading the blood-corne AIDS virus. Crack houses, where sex is often exchanged for

drugs, spur the spread of other diseases, which in turn promote the spread of AIDS. Addicts then infect their partners. In one South Bronx district, 1 of every 25 women giving birth now carries the virus, and nearly half of these infect their babies.

As if the Three Plagues weren't deadly enough, they are magnified by a larger malady indifference. The poor of the South Bronx do not speak loudly in the councils of state. Other critzens readily see them, if at all, as an underclass, an unregenerate source of addiction and crime.

Society has not, surely, chosen a deliberate policy to let them die. But if it had, the present out-come would not be very different. Governor Cuomo,

announcing his tive-year plan for combating AIDS, declared last week, "I want to say as clearly as I can, I am not putting into this plan this year nearly enough money to meet these goals realistically."

There is no public health plan to stem the spread of AIDS in the South Brook, just a grab bag of half-hearted initiatives. It society really cared about the Three Plagues, in every South Brook across the country, many measures might have been tried long ago:

CI Drug treatment would be made available on demand, and centers set up where addicts congregate, conquering local opposition.

Instead of having to send addicts back on the street when no drug treatment was available,

clinics would be allowed to supply them with clean needles. This would help keep an addict coming back until a treatment slot was ready, meanwhile protecting against infection.

O'Addicts would be urged to avoid sharing needles, to recrilize their works with bleach and to enroll in dirty-for-clean needle exchange programs while awaiting

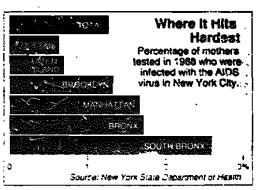
treatment.

□ Each severely af-

signed a health worker charged with insuring that every resident understood how to protect himself against contracting AIDS.

Once the victims of AIDS are dying, with only months to live, public expenditure soars, often reaching \$190,000 per case. Were a fraction of the same money available for prevention, many lives would be saved.

Without a serious preventive effort, the incidence of AIDS in the South Bronx will soon approach that in African cities with minimal standards of public health. And the levels in other inner cities won't be far behind, to the enduring shame of all New York and of all America.





THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

March 3, 1989

Jack Rosenthal Editorial Page Editor The New York Times 229 West 43rd Street New York, New York 10036

To the Editor:

The Times editorial headlined "Three Plagues" is correct in expressing outrage and indignation at the three new "Horsemen of the Apocalypse": poverty, drug addiction and AIDS. But The Times is absolutely wrong to suggest that the City of New York is sitting idly by and is not aggressively responding.

What is it that we are doing? New York City has led the way in every important education, prevention and service area on the AIDS front. We have mounted nationally renowned mass media and outreach campaigns and we have taken our campaigns to the streets of New York, especially the South Bronx and other hard-hit communities.

In the last two years, we have funded 34 community-based organizations to carry out AIDS education and prevention programs at the grass-roots level.

We have established seven anonymous AIDS testing and counselling sites -- including one in the South Bronx. Our public health laboratories have tested well over 175,900

Page Two

specimens for antibodies to the AIDS virus. We have championed the right, for the last two years, to be allowed to establish a pilot needle exchange program, which is now operating in lower Manhattan. We are looking for expansion sites elsewhere.

In the South Bronx, we are making space available to Bronx Lebanon Hospital to assist them in developing a continuum of services that spans outreach and education efforts, counselling and testing programs and primary care and social support services.

We offered the State space in the Department of Health clinics to encourage them to expand drug treatment funds. If funds are made available, we are also prepared to expand HHC drug treatment programs. We have also extended our offer of space to current providers of methadone maintenance treatment, and some have expressed interest. We hope more will come forward.

We are making enormous investments in high-risk communities; however, educating drug abusers is tough. We are investing millions of dollars in efforts to reach this population and prevent the spread of this deadly disease.

On the enforcement front, we have committed \$116 million to the Tactical Marcotics Teams (TNT), a program that combats drug trafficking in neighborhoods around the city.

More than 500 of the 1,500 AIDS patients in New York City are being cared for in municipal hospitals; more than 1,000 people with AIDS are being treated in municipal hospitals with AZT, even those unable to pay; nearly 1200 people with AIDS are being provided with rent assistance to allow them to remain in their own homes; over 350 people are being provided home care; 84 long-term care AIDS patients are being cared for at Coler and Goldwater Hospitals, and we are developing special housing and health-related facilities. And we are doing much more.

Yes, more resources are needed. But \$335 million is being spent this year on AIDS in the city budget that wasn't being spent five years ago. Another \$116 million is going toward the TNT initiative. Where is it coming from? It's

Page Three

coming from sanitation, fire, transportation and a whole host of other essential services. And of course, we are prepared to do more. But we can't do it alone. We need more help, especially from the federal government.

The AIDS and drug epidemics are national emergencies. The fact that the federal government has failed to respond adequately is a national disgrace. If there were an earthquake or a tornado, the federal government would be there. AIDS and drug abuse should be treated no differently.

Sincerely,

Edward I. Koch M A Y O R





Compl

March 13, 1989

Honorable Edward I. Koch Mayor City Hall New York, New York 10007

Dear Ed:

The AIDS epidemic threatens to overwhelm our health care system. Over 19,000 cases have been diagnosed in the City; more than half of those have already died.

In your preliminary Financial Plan, issued last month, you describe enhanced services for the Health and Hospitals Corporation; yet your proposals seem weefully inadequate for the onslaught of new AIDS patients. The Plan speaks of five additional beds for AIDS patients, as well as more funding for AZT treatment. We must do more in the coming fiscal year.

The need for primary care for People with AIDS is essential. Comprehensive care for HIV+ individuals reduces the extent to which we must otherwise provide them acute care. Fiscally speaking, that is prudent management. Futhermore, early intervention and treatment have been shown to prolong lives.

In addition, we must seek to reduce the number of homeless people with AIDS in New York City. The scatter site housing program for people with AIDS is cost effective; it also maintains the dignity of AIDS patients. I urge you to expand it dramatically in the next fiscal year.

We must also mandate thoughtful, comprehensive sex education in our public schools, especially in the secondary grades. Over 20% of people with AIDS are in their 20s. That substantiates the extent to which HIV is transmitted

890322

Honorable Edward I. Roch March 13, 1989 Page 2 during the teen years. We are sentencing our young people to possible disease and death by our inaction. sincerely.



THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

April 3, 1989

Hon. Harrison J. Goldin Comptroller City of New York 530 Municipal Building New York, NY 10007

Dear Jay:

I have your letter of March 13 regarding AIDS. As you know, the financial plan is a preliminary budget; the final budget for HMC, as for all other agencies, is still open to revision and refinement. Therefore, no final_determinations have been made. Of course, what is really needed to bolster our services is much greater financial participation from the State, which also has the only authority to create new beds, and the Federal government, which is lagging far behind the AIDS crisis in its response thus far.

Presently, primary care for AIDS patients is provided at all 11 HHC hospitals and Meighborhood Family Care Centers. In addition, HHC has created three special community-based AIDS Assessment Centers (Belvis, Bushwick, and Bellevue -- one each in the Bronx, Brooklyn and Manhattan), and plans to open a fourth this year.

At this time, HRA is working vigorously to expand the scatter-site apartment program. With 20 apartments operational and 20 more under contract to Volunteers of America, HRA recently released an RFP for 100 more apartments to 185 potential managing agencies. Thus far, six organizations have responded, and HRA is reviewing those responses.

The Board of Education (BOE) initiatives in the area of AIDS education are numerous and continuing to expand. The Office of Health, Physical Education, and Substance Abuse has been working in close collaboration with the Department of Health on policy issues, education and outreach related to AIDS. In compliance with a BOE goal from the May 1988 Interagency Strategic Plan on AIDS, a Citywide AIDS Education Advisory Committee has met

to review curriculum and educational materials and advise on programming. Each school district is also forming its own advisory committee, usually in conjunction with existing Family Living/Sex Education advisory committees.

In the schools themselves, the State Education Department's AIDS Health Syllabus is currently being used as part of BOE's AIDS staff development module for grades K-6. Six AIDS lessons for grades 7-12 are also included as a supplement to their Family Living/Sex Education curriculum. Finally, in an effort to assess our school children's present knowledge about AIDS, as well as their attitudes and behavioral patterns, baseline data on all of these categories have been collected by the State Education Department, and phase two of their study is proceeding.

In all, I believe we are well aware of the magnitude of the AIDS epidemic, and we are making every effort to address it comprehensively and effectively.

All the best.

Edward. Koch

EIK:pdh

REMARKS BY MAYOR EDWARD I. KOCH GAY & LESBIAN COMMUNITY SERVICES CENTER 208 WEST 13TH STREET TUESDAY, MAY 30, 1989 9:30 P.M.

THANK YOU, GINNY APUZZO.

MEMBERS AND FRIENDS OF THE GAY AND LESBIAN COMMUNITIES.

GOOD EVENING.

WE ARE NOW IN THE MIDST OF ONE OF GREATEST CRISES IN
HISTORY. THE AIDS EPIDEMIC IS A KNIFE AT THE THROAT OF
CIVILIZATION ITSELF. THE GAY COMMUNITY IS SUFFERING
TREMENDOUSLY, AND AT THE SAME TIME IS LEADING THE FIGHT TO CARE
FOR PERSONS WITH AIDS AND -- MOST IMPORTANTLY -- TO FIND A CURE.
WHEN THE HISTORY OF THIS ERA IS WRITTEN, I BELIEVE IT WILL SHOW
THAT THE EVENTUAL VICTORY OVER AIDS WAS MADE POSSIBLE BY HEROES
IN THE GAY AND LESBIAN COMMUNITIES WHO LED THE BATTLE.

WE'RE STILL A LONG WAY FROM THAT GOAL, BUT LONG JOURNEYS ARE NOTHING NEW. WE'VE ALREADY COME A LONG WAY SINCE THE STONEWALL REBELLION 20 YEARS AGO. VERY FEW PEOPLE IN 1969 WOULD HAVE BELIEVED IT WAS POSSIBLE TO ACHIEVE THE EXTRAORDINARY PROGRESS IN CIVIL RIGHTS FOR GAYS AND LESBIANS THAT EXISTS TODAY. THERE IS MUCH MORE TO BE DONE -- ESPECIALLY IN FIGHTING AIDS AND IN PREVENTING AIDS-RELATED DISCRIMINATION -- AND WE WILL DO IT.

MODE

DURING MY CAREER IN PUBLIC SERVICE I HAVE WORKED TOGETHER
WITH LEADERS AND MEMBERS OF THE GAY AND LESBIAN COMMUNITIES TO
HELP PASS THE GAY RIGHTS BILL, TO HELP SHAPE THE CITY'S INCREASED
RESPONSE TO THE AIDS CRISIS, TO MEET THE NEEDS OF GAY SENIORS,
MINORITIES, AND DISABLED. I WILL CONTINUE TO REACH OUT TO YOU,
WITH THE HELP OF MY NEW OFFICE FOR THE LESBIAN AND GAY COMMUNITY.
THIS OFFICE IS UNDER THE ABLE GUIDANCE OF MY ASSISTANT, LEE
HUDSON. THIS OFFICE, I AM PROUD TO SAY, IS THE FIRST OF ITS KIND
IN THE NATION.

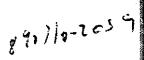
IN CLOSING, I WANT TO SAY THAT I AM ALSO PROUD THAT I HAVE NOT FAILED TO SPEAK OUT ON ANY MAJOR ISSUE FACING THIS COMMUNITY.

- -- I ANSWERED THE HATEFUL ASSAULTS OF JESSE HELMS.
- -- I ATTACKED THE COWARDLY INACTION OF THE STATE
 LEGISLATURE THAT HAS FAILED TO INACT A STATE BIAS CRIME BILL
 WHICH INCLUDES ATTACKS AGAINST GAY PEOPLE.
- -- I SUPPORTED KAREN THOMPSON, WHO WAS DENIED VISITATION
 RIGHTS FOR OVER THREE YEARS AFTER HER LIFE PARTNER WAS CRITICALLY
 INJURED IN AN AUTOMOBILE ACCIDENT.

- -- AS A CONGRESSMAN IN THE '70S, I SPOKE OUT AGAINST THE MILITARY'S POLICY OF EXCLUDING HOMOSEXUALS. I HAD A SERIES OF LETTERS ENTERED INTO THE FEDERAL REGISTER ON BEHALF OF SEVERAL SERVICEMEN.
- -- I RAISED MY VOICE AGAINST THE INJUSTICE OF THE 1986
 SUPREME COURT "HARDWICK" DECISION DENYING HOMOSEXUALS ANY RIGHTS
 OF PRIVACY UNDER THE CONSTITUTION.

I HAVE NEVER FAILED TO SPEAK OUT. I WILL CONTINUE TO JOIN
WITH YOU IN BREAKING NEW GROUND, AND IN DEFENDING THE PROGRESS WE
HAVE ALREADY MADE. I WILL NEVER LET YOU DOWN.

THANK YOU.





THE CITY OF NEW YORK

DEPARTMENT OF EMPLOYMENT 220 CHURCH STREET MEMADWE # A 10512

LILLIAM BARRIOS-PAOLI Commissioner

MEMORANDUM

July 6, 1989

TO:

FROM:

RE:

Lilliam Barrios-Paoli filliam
Nulitasking Su--

As you requested, I have prepared a brief article for you regarding the recent opening of our demonstration employment program for people with AIDS. The opening was covered by the Daily News and WINS radic.

Please let me know if I can be of additional assistance.

TD/rmg Attachment

cc: Stanley Brezenoff Clifford Chanin

MULTITASKING SESTEMS OF REM YORK, INC.

Several days ago I announced the opening of a new employment demonstration program for men and women suffering from AIDS and the AIDS related complex. The program, sponsored by the New York City Department of Employment (DOE) and developed in conjunction with Multitasking Systems of New York, Inc. (MTS), will train people with AIDS to operate a business service center that will provide word processing, facsimile transmittion, xeroxing and other related services to local companies.

Several months before the announcement, Michael Weisberg, executive director of MTS, described the concept to Lilliam Barrios-Paoli, my DOE Commissioner. MTS was founded in 1966 by several doctors at New York University Medical Center, he told her, to address the employment needs of people with AIDS. The founders believed that many people with AIDS could remain employed and self-sufficient if they had flexible hours with time off as needed for medical treatment — and a compassionate, supportive atmosphere. MTS had already obtained some corporate and foundation funds for the center; it could provide the facilities and recruit the workers. Could the city help?

The Commissioner said yes. DOE staff, working with Mr. Weisberg, devised a program in which the city would fund the training of 30 people over the course of one year. MTS would provide the teachers, and DOE would contribute up to \$3.50 per hour to each trainee's salary. After several weeks of training, MTS would match the City's \$3.50, resulting in \$7.00 per hour for each trainee. After six months, MTS will hire the trainees and pay unsubsidized wages of \$7.00 per hour. During and after training, workers will receive counselling from the New York State Office of Vocational Rehabilitation.

As I was walking into MTS's pleasantly designed offices to announce the start of the program, I saw workers and trainees already stationed at word processers and computers. The founders of MTS and many of its supports attended the ceremony. While pleased that their concept had become reality, they realized that their next task was to generate enough business to keep the business center operating.

I was extremely pleased that representatives from my administration, the private sector and those dedicated to improving the quality of life of people with AIDS could be brought together to develop this innovative program. The cost of \$115,000 to the city is far outweighed by the savings in public assistance costs if these people were unable to work. But even more important is the added esteem felt by the program participants who remain employed.



THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

July 24, 1989

Hon. David N. Dinkins
The City of New York
Office of the President
of the Borough of Manhattan
Municipal Building
New York, New York 10007

Dear David:

On last Sunday's Newsmakers show, you charged that in New York City, minorities die on average 28 weeks after being diagnosed with AIDS, while whites survive on average two years.

That is not true. A 1987 Health Department study showed that whites died, on average, 12 months after diagnosis; recently this has increased to 15 months. As for minorities, their average survival, after diagnosis, was between 9 and 10 months.

It is an oversimplification to deduce from this a lower quality of care for minorities with AIDS. The sad truth is that most minority persons with AIDS are intravenous drug users. Because they are intravenous drug users, they are likely to be in a generally poorer state of health to begin with, and once infected with HIV, many do not take advantage of the health care system. Unfortunately, too many wait too long to come to the hospital; oftentimes only after they are acutely ill. It's at that point that they are diagnosed with AIDS. Thus, it's not surprising — since many of the intravenous drug users wait longer than the gay population to be diagnosed — that minorities would appear to have a shorter life span after diagnosis.

Additionally, many gay white men, especially early in the epidemic, had Kaposi's Sarcoma as their major manifestation, and we now know that KS is associated with longer survival.

David, you have supported the City's efforts to upgrade the quality of health care through the Health and Hospitals Corporation, both in general and for AIDS patients. We are currently providing an enormous array of services to people who are HIV ill or have AIDS. More needs to be done, especially in light of the Centers for Disease Control announcement that we can now prevent the onset of PCP pneumonia by early intervention. I look forward to continuing to work with you to ensure that every person who suffers from this terrible disease has access to early and appropriate treatment.

All the best.

Sincerely,

Edward I. Koch MAYOR



THE CITY OF NEW YORK OFFICE OF THE PRESIDENT OF THE BOROUGH OF MANHATTAN

KS

MUNICIPAL BUILDING NEW YORK, N.Y. 10007 (212) 668-6300

DAVID N. DSAKINS BOROUGH PRESIDENT

July 26, 1989

Hon. Edward I Koch The City of New York Office of the Mayor City Hall New York, New York 10007

Dear Mr. Mayor:

Your letter of July 24, 1989 incorrectly describes my response to questions on AIDS. For several years I have referred to studies which demonstrate that in the <u>United States</u> while the average life span of a white person with AIDS after diagnosis is two years, the average minority person with AIDS lives only 28 weeks after diagnosis. I refer you to the report prepared by the Human Services Subcommittee and The Governor's Advisory Committee For Black Affairs (November, 1987) entitled, "Falling Behind," which gives the average life span for a minority person with AIDS as only 19 weeks.

It is absolutely not an "oversimplification" to state that a disparity in the quality of health care has an effect on a person's ability to survive disease. Numerous studies have shown the relationship of access, availability and quality of services to the health status of particular populations, i.e. minorities, uninsured, working poor. Indeed, the call to improve access to quality, comprehensive health services has been articulated by several of your own appointed Commissions. In the soon to be released report, "The Future of Child Health in New York City," this point is clearly stated.

With regard to intravenous drug users with AIDS, whom you describe as "not taking advantage of the health care system," I remind you that our City cannot offer a treatment slot to every addict who wants one, without confronting long waiting lists. To overlook the attitudes that prevail in our society toward drug addicts as well as the lack of comprehensive treatment services available to them, is to ignore the obstacles faced daily by the hundreds of health experts who for decades have been looking for ways to combat drug abuse.

Finally, as you note in your letter, my commitment to health promotion and preventive measures of care are a longstanding part of my record. The recent expansion of ambulatory services within the Health and Hospitals Corporation to people who are HIV ill or have AIDS, has been eagerly sweited, and I applaud this effort. Yes, I agree, more needs to be done and I will contine to work toward the goal of ensuring that early access to quality health care will be available to all people who are HIV ill or have AIDS.

Sincerely,

David N. Dinkins

DND/cvr



THE CITY OF NEW YORK OFFICE OF THE MAYOR NEW YORK, N.Y. 10007

MEMORANDUM

TO:

Paul Dickstein

FROM:

Edward I. Koch

DATE:

September 8, 1989

See the attached memo that I received from Tony Shorris regarding the funding of an assigned risk pool for persons with AIDS.

I think his proposal regarding the insurance tax is a good one. Can we fit it in?

mg encl.

cc: Stanley Brezenoff



ANTHONY E. SHORRIS Commissioner of Finance The City of New York Department of Finance Municipal Building New York, N.Y. 10007 Telephone: (212) 659-4555

September 6, 1989 '

M R M O R A M D U K

TO:

Mayor Edward I. Koch

FROM:

Tony Shorria

RE:

Funding an Assigned Risk Pool for Persons

with AIDS

I understand you have met with OMB to discuss a proposal for the purchasing of Blue Cross hospital insurance for persons with AIDS. Jo Boufford has also sent some comments reviewing the issue of high risk pools and the status in other states. Assessing the needs of the population and the health care policy implications of the risk pool are outside my expertise, so I want to limit my comments to the tax policy implications of these ideas.

If we expand coverage for any medical benefits to those not currently covered, someone will pay. Assigned risk pools do not break even. Purchasing insurance costs somebody money. Higher costs for Blue Cross or private insurers get passed along to employers. In the best case, we can try to do what OMB has proposed: develop a strategy that draws down Federal and State funds and offers us budget relief in the process. However, if such a strategy requires the involvement of too many parties —Blue Cross and the private insurers, the voluntary and public hospitals State-wide affected by the BDCCP, the State and the Federal government — the odds of passage may be reduced. Further, even with substantial Federal participation, insurers, employers, the State or the City will still be paying two-thirds of the cost. There may be advantages to "hidden taxes" sometimes, but at least we need to understand who's going to foot the bill.

The burdens associated with any of these schemes can be compared to those of a new tax. Who should bear the cost: employers, insurers or individuals? For simplicity's sake, there are at least three tax options worth considering that are closely related to the issue of health insurance for this population.

Making Employers Pay: Adding Back Insurance Costs
If we think that business should cover the costs of the
program, the tax proposal that most directly addresses
the issue would be one that eliminates employers'
ability to expense insurance contributions above a
certain level. This would be simple to administer, and
by targeting only high benefit levels, would not
discourage provision of basic health insurance. The
change would not stand out, so its effect on our
competitive position would be limited. In fact, by
limiting the add-back only to high benefit levels (or
high income employees), the tax could be progressive.
If we only taxed those benefits that are above the
average level (\$1,500 per employee), revenues would be
\$25 - 40 million.

Making Insurers Pay: Bringing Back the Insurance Tax
We eliminated the City insurance tax in 1974.
Insurance companies are the only business in the City
not to pay any tax to us. They pay \$450 million a year
to the State. If we impose a tax on them, this tax
will be an expense for those firms operating here and
elsewhere; other states may lose money if they allow
credits for out-of-state taxes and they could raise
their taxes in response. It is possible that a full
cycle of responses could eventually reduce the yield to
us, but this does not seem reason enough not to do it
at all. Otherwise, the tax is relatively easy to
administer, conforms with State practice, and would
treat insurance companies just like other businesses.
A City tax comparable to the State's would raise over
\$150 million a year.

Making Individuals Pay: Taxing High Levels of Benefits Companies here and abroad have been turning more and more to paying people through non-salary benefits to avoid taxes. Some of these benefits are already treated as income, such as use of a company car or employer-provided life insurance coverage. We could propose that health insurance benefits over a certain level (again, so as not to discourage the provision of basic coverage for anyone) would be treated as income for income tax purposes. This would be progressive and have relatively little competitive effect. It could also raise about \$25 million a year in revenue.

Of course, each of these has issues associated with them, but they have also have some clear advantages. They directly confront the issue of coming up with the money for the need, rather than imposing hidden taxes. They are politically simpler, since they do not involve half a dozen separate constituencies. They are taxes directly related to the insurance and health care issue. They leave open a further option in terms of the much larger question of coverage for the uninsured: taxing those employers who do not offer health care coverage to their employees. And any of them can be combined with some elements of the OMB plan to provide substantial City budget relief by increasing HHC revenues.

Once we have agreed on the needs of the population involved, we can compare the advantages of what is, in effect, a back-door tax increase with those of an up-front one. Of course, if we can obtain the same benefits without new taxes through another approach, this course should be pursued. Federal and State funding that we can obtain without legislative action is always a goal. But sooner or later, somebody will end up footing the bill for this extension of coverage and, sooner or later, that somebody will figure it out.

I recommend we look at all the options -- whether they involve new taxes or not -- together in terms of who will be paying for the initiative, what opposition they may offer to bearing the cost, and where our odds are best of making it work.

cc: Stan Brezenoff Stan Grayson Paul Dickstein

PROPOSALS FOR A NATIONAL RESPONSE TO AIDS

City of New York



September 27, 1989

REMARKS BY EDWARD I. KOCH CONGRESSIONAL DELEGATION LUNCHEON SEPTEMBER 27, 1989

OUR CITIES HAVE BECOME THE FRONT LINES FOR FIGHTING THE WARS AGAINST DRUGS AND AIDS. UNFORTUNATELY, THE PROBLEMS ARE GROWING, AND UNLESS THE FEDERAL GOVERNMENT IS PREPARED TO SEND IN ITS RESOURCES, THE WARS WILL BE LOST.

WE'VE TALKED ON MANY OCCASIONS ABOUT THE NEED FOR A STRONG FEDERAL RESPONSE TO THE PROBLEM OF DRUGS. AND YOU KNOW MY VIEWS ON PRESIDENT BUSH'S RECENT PLAN. BUT TODAY, I WOULD LIKE TO TALK WITH YOU ABOUT A RELATED, EQUALLY PRESSING PROBLEM -- AIDS.

IT THREATENS SOME OF THE LARGEST CITIES IN THIS COUNTRY

-- SAN FRANCISCO, LOS ANGELES, MIAMI, HOUSTON AND OF COURSE

NEW YORK -- AND IT THREATENS SOME OF THE FINEST MEDICAL

INSTITUTIONS. OUR HOSPITALS ARE IN TROUBLE. FOR THE FIRST

TIME, IN AS LONG AS I CAN REMEMBER, IT MAY NOT BE POSSIBLE

TO GET A HOSPITAL BED WHEN YOU NEED ONE IN NEW YORK CITY.

AND OUR PROBLEMS ARE ONLY GOING TO GET WORSE. THE NUMBERS

ARE GROWING. SO FAR, IN NEW YORK CITY OVER 20,000 CASES OF

AIDS HAVE BEEN DIAGNOSED. THAT NUMBER WILL GROW TO 43,000

BY 1991; 31,000 WILL HAVE DIED.

EXPERTS PREDICT THAT IN NEW YORK CITY, THE NUMBER OF ACUTE CARE BEDS NEEDED TO CARE FOR THE AIDS POPULATION WILL HAVE TO DOUBLE FROM ABOUT 2,000 TODAY TO ABOUT 4,000 IN 1993. THROUGHOUT THE CITY, THERE ARE OVER 21,000 MEDICAL/SURGICAL BEDS. THUS, AIDS CASES MAKE UP ABOUT 10 PERCENT OF THE MEDICAL/SURGICAL BEDS CITYWIDE AND WILL GROW TO 20 PERCENT, IF THE TOTAL NUMBER OF SUCH BEDS DO NOT EXPAND. BUT SOME HOSPITALS BEAR A DISPROPORTIONATE BURDEN. TEN HOSPITALS IN THE CITY (SIX VOLUNTARY HOSPITALS AND FOUR MUNICIPAL HOSPITALS), REPRESENTING 22 PERCENT OF THE TOTAL MEDICAL/SURGICAL BEDS, CARE FOR MORE THAN HALF OF ALL THE AIDS CASES. I SHOULD ADD THAT ON TOP OF ACUTE CARE BEDS, THOUSANDS OF LONG TERM CARE AND RESIDENTIAL BEDS WILL NEED TO BE CREATED.

THE BREAKTHROUGHS ON DRUG THERAPIES SUCH AS AZT,
AEROSOLIZED PENTAMIDINE AND BACTRIM BRING NEW HOPE. BUT
WITH THE NEW HOPE COMES THE GRIM REALITY OF THE LIMITATIONS
OF OUR HEALTH CARE SYSTEM AND LOCAL GOVERNMENTS TO RESPOND.
WE ARE NO LONGER FACING AN EPIDEMIC THAT HAS HIT 20,000
INDIVIDUALS IN NEW YORK CITY; VIRTUALLY OVERNIGHT, WE NOW
FIND OURSELVES FIGHTING AN EPIDEMIC THAT AFFECTS 200,000
INDIVIDUALS BELIEVED TO BE INFECTED WITH THE AIDS VIRUS.
EFFECTIVE DRUG TREATMENTS NOW MEAN THAT EARLY INTERVENTION
AND CARE MIGHT MAKE A DIFFERENCE IN EXTENDING PEOPLE'S
LIVES.

PAGE THREE

IN THIS CONTEXT, I URGE THAT A FEDERAL ARBITRATION
BOARD BE ESTABLISHED TO SET FAIR AND REASONABLE PRICES ON
LIFE EXTENDING DRUGS, SUCH AS AZT, WHERE FEDERAL DOLLARS
HAVE PLAYED A PART IN THE RESEARCH AND DEVELOPMENT. OBVIOUSLY,
WE NEED TO MAKE SURE THAT COMPANIES ARE ABLE TO RECOUP THEIR
COSTS, WITH SOME MARGIN OF PROFIT, IF WE ARE TO ENCOURAGE
THEM TO DO THIS VERY EXPENSIVE RESEARCH. ON THE OTHER HAND,
WE NEED TO MAKE CERTAIN THAT LIFE-EXTENDING DRUGS ARE MADE
AVAILABLE AND AFFORDABLE TO THOSE WHO NEED THEM.

TODAY NEW YORK CITY IS SPENDING OVER \$230 MILLION ON AIDS IN CITY FUNDS; ABOUT \$1 BILLION IN ALL FUNDS, INCLUDING CITY, STATE, FEDERAL AND COMMERCIAL INSURERS, SUCH AS BLUE CROSS/BLUE SHIELD, ARE BEING SPENT.

WE'RE DOING A TREMENDOUS AMOUNT. BUT THE DEMANDS ARE ENORMOUS. A RECENT NEW YORK CITY AIDS TASK FORCE REPORT ESTIMATES THAT OVER THE NEXT FIVE YEARS, OVER \$7 BILLION WILL NEED TO BE SPENT IN NEW YORK CITY TO CARE FOR THOSE WHO ARE ILL, INCLUDING HEALTH, SOCIAL SERVICES AND HOUSING. WE ARE ALREADY FULLY COMMITTED TO OUR SHARE OF THESE COSTS, ABOUT 17 PERCENT, BUT WE CANNOT DO IT ALONE.

PAGE FOUR

OUR HOSPITALS ARE OVERCROWDED; CRITICALLY ILL PATIENTS WAIT HOURS AND SOMETIMES DAYS FOR A BED; STAFF SHORTAGES THREATEN OUR ABILITY TO DELIVER EXISTING SERVICES -- NO LESS TO EXPAND AND MEET THE GROWING NUMBERS; AND THE FINANCIAL PRESSURES ON BOTH MUNICIPAL AND VOLUNTARY HOSPITALS ARE FORMIDABLE. ALTOGETHER, THE CITY OF NEW YORK IS SPENDING \$2.3 BILLION FOR HEALTH CARE INCLUDING FUNDS FOR THE HEALTH AND MENTAL HEALTH DEPARTMENTS, THE HEALTH AND HOSPITALS CORPORATION, AS WELL AS THE CITY'S SHARE OF MEDICAID.

WE DON'T HAVE ALL THE ANSWERS. WE KNOW THAT THE FEDERAL GOVERNMENT, LIKE STATE AND LOCAL GOVERNMENTS, IS FACING BUDGETARY PRESSURES. BUT WE NEED THE FEDERAL GOVERNMENT TO RECOGNIZE, AT A MINIMUM, THAT IT IS A PARTNER IN THE EFFORT TO PROVIDE CARE TO THOSE WITH AIDS AND WHO ARE HIV ILL. IT NEEDS TO BECOME A MUCH FULLER PARTNER. AND IT NEEDS TO DO SO NOW.

BY THAT WE MEAN THAT MEDICAID COVERAGE SHOULD BE EXTENDED TO ANYONE WHO MEETS THE FINANCIAL REQUIREMENTS AND IS HIV ILL, AND THAT FUNDS ARE PROVIDED TO HELP FINANCE THOSE WHO ARE MEDICALLY INDIGENT AND ARE NOT ELIGIBLE FOR MEDICAID. CURRENTLY, MEDICAID RESTRICTS ELIGIBILITY TO THOSE WHO HAVE CDC-DEFINED AIDS. I WOULD ALSO URGE, AS I

HAVE IN THE PAST, THAT CONGRESS ELIMINATE THE TWO-YEAR WAITING PERIOD FOR MEDICARE ELIGIBILITY. SINCE MANY INDIVIDUALS WHO ARE DIAGNOSED WITH CDC-DEFINED AIDS DO NOT SURVIVE THE TWO-YEAR WAITING PERIOD, THIS POLICY CLEARLY MAKES NO SENSE.

OTHER PROPOSALS I SUPPORT, AND HOPE YOU WILL AS WELL, INCLUDE EXPANDING CURRENT FEDERAL REQUIREMENTS FOR MEDICAID DISPROPORTIONATE SHARE FUNDS TO UNCOMPENSATED AIDS CARE; MANDATING STATES TO DEVELOP PLANS TO EQUITABLY DISTRIBUTE THE BURDEN OF CARING FOR AIDS PATIENTS AMONG ALL HOSPITALS; DEVELOPING A FUNDING MECHANISM FOR AIDS SUPPORTED HOUSING FOR THOSE WHO ARE HOMELESS; EXPANDING DRUG TREATMENT FUNDS; REVITALIZING AND REDIRECTING THE NATIONAL SERVICE CORPS TO ASSIST CITIES IN FILLING CRUCIAL POSITIONS SUCH AS PHYSICIANS AND NURSES; ENACTING A DISASTER RELIEF FUND FOR CITIES WITH HIGH CONCENTRATIONS OF HIV ILL; AND MOVING FORWARD TO EXTEND AND EXPAND THE FUNDS FOR AZT AND OTHER DRUGS. FINALLY, AND VERY IMPORTANTLY, CONGRESS SHOULD MOVE AHEAD QUICKLY TO ADOPT A NATIONAL ANTI-DISCRIMINATION BILL FOR PEOPLE WITH AIDS.

THE FEDERAL GOVERNMENT HAS A RESPONSIBILITY TO RESPOND TO THIS NATIONAL PUBLIC HEALTH EPIDEMIC. OTHERWISE STATE

AND LOCAL GOVERNMENTS WILL BE OVERWHELMED AND PEOPLE WITH AIDS WILL BE UNDERSERVED AT A TIME WHEN THEY ARE MOST IN NEED OF HELP. THIS WOULD BE A GREAT NATIONAL TRAGEDY FOR ALL OF US.

AT TODAY'S DISCUSSION, WE WILL DESCRIBE IN MORE DETAIL
FOR YOU THE DIMENSIONS OF THE PROBLEM, WHAT WE ARE DOING
ABOUT IT AND HOW YOU CAN HELP. WE WILL BE DESCRIBING, IN
MORE DETAIL, THE DIFFERENT APPROACHES I MENTIONED ABOVE THAT
THE CONGRESS CAN ADOPT TO ASSIST CITIES IN FIGHTING THIS
EPIDEMIC. WE NEED TO BEGIN THIS PROCESS NOW, SO THAT THE
RESOURCES ARE IN PLACE AS RAPIDLY AS POSSIBLE. ATTACHED TO
MY REMARKS ARE THE TEN PROPOSALS THAT WE BELIEVE PROVIDE A
COMPREHENSIVE NATIONAL RESPONSE TO THE PROBLEM OF AIDS. I
HOPE YOU WILL GIVE THEM YOUR FULL SUPPORT.