



Little Hoover Commission

1303 J Street, Suite 270 • Sacramento, CA 95814 • (916) 445-2125

CALIFORNIA'S COORDINATION OF AIDS SERVICES

MAY 1990



Little Hoover Commission

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May 11, 1990

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The Honorable David Roberti
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The Honorable Willie L. Brown, Jr.
Speaker of the Assembly
and Members of the Assembly

The Honorable Kenneth L. Maddy
Senate Minority Floor Leader

The Honorable Ross Johnson
Assembly Minority Floor Leader

Dear Governor and Members of the Legislature:

With the second largest number of AIDS cases in the nation, California has been at the forefront of the battle against this fatal disease for almost a decade. But is the State effectively using its resources to provide services to AIDS patients and to forestall the spread of the deadly virus? To answer that question, the Little Hoover Commission has conducted an investigation of the role of the State in coordinating anti-AIDS efforts.

The Commission has found that while the State has committed substantial resources to dealing with AIDS--more than \$128 million this year--there is no coordinated effort to maximize the effect of those dollars. In addition, the Commission has noted that a lack of firm leadership, commitment and sense of direction at the State level has meant that the State's steps toward coordination have been tentative, halting and, in general, unsuccessful.

As a result of its study, the Little Hoover Commission believes the State should move to strengthen its coordinating efforts and to provide the leadership needed to create county and regional networks throughout the State that will ensure services are provided without gaps or overlaps.

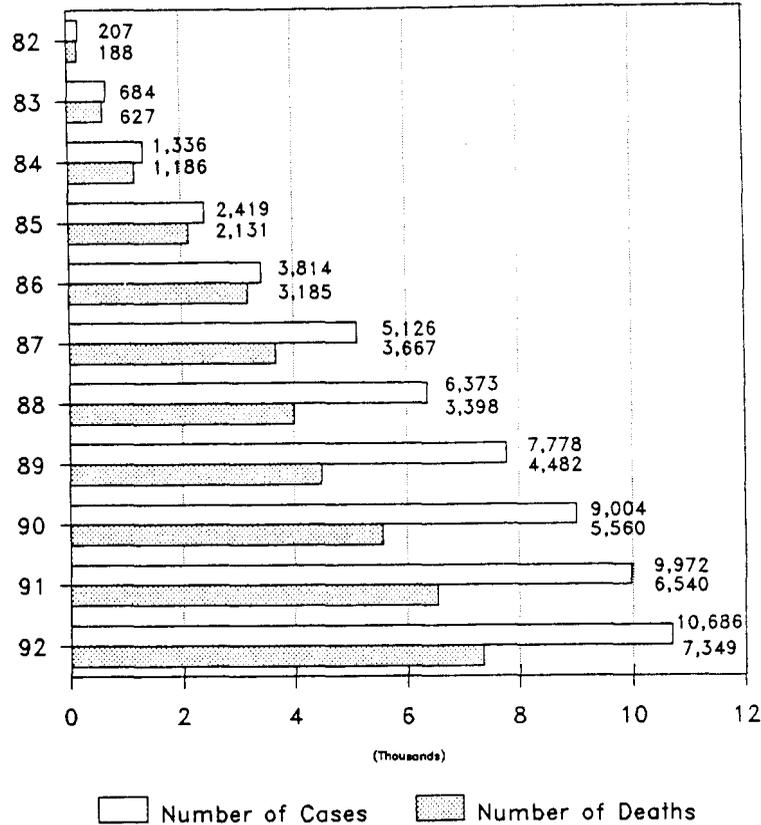
Background

Acquired Immune Deficiency Syndrome (AIDS) was first described in medical literature in 1981 and soon after experts began predicting that, if no cure or vaccine were found, AIDS would become the worst infectious disease epidemic of all time.

During the eight years that AIDS diagnoses have been reported and tracked, California, which has more than 10 percent of the nation's population, has consistently accounted for more than 20 percent of the cases in the country. Chart A below shows AIDS cases and deaths since 1982, estimated through 1992.

CHART A

State AIDS Cases and Deaths



Source: State Office of AIDS

1988-92 figures are projections

The chart shows year by year totals. Cumulatively, as of March 31, 1990, 25,658 cases of AIDS had been reported in California, with 16,534 (64.4 percent) having died. Thirty-nine percent of the cases have been reported from Los Angeles County and 31 percent from San Francisco. By the end of 1992, almost 60,000 cumulative cases statewide are expected to be reported.

Although less easy to pinpoint statistically, the number of people in California who are infected with the human immunodeficiency virus (HIV) that causes AIDS but who have not yet shown disease symptoms (a condition known as "HIV-positive") is estimated to be about 300,000. Because of the long time delay that can occur between infection and onset of the disease, scientists have yet to determine whether everyone who is HIV-positive will eventually develop AIDS, just as they are uncertain that everyone with AIDS will die if a cure is not found. But the average AIDS patient dies less than two years after a diagnosis is made. (January 1990 California AIDS Update)

The California experience has **not** been similar to the rest of the nation's. For the past six years, approximately 90 percent of the cases in this state have been among homosexual or bisexual men and 4 percent among intravenous drug users. In comparison, intravenous (IV) drug users have accounted for 19 percent of the cases nationwide. The higher incidence of AIDS among IV drug users is also linked to a much higher rate of pediatric AIDS nationwide, as female IV drug users or women affiliated with male IV drug users pass on the disease during pregnancy.

AIDS experts agree, however, that in California the disease is increasing most rapidly among children and among IV drug users, while the rate of new infections among homosexual men has declined dramatically. One San Francisco study shows the rate of infection dropping from 18 percent a year between 1982 and 1984 to .7 percent during the last six months of 1987. This sharp decline is attributed to effective and widespread education efforts in the homosexual community.

The general consensus among those who follow the AIDS situation is that the primary epidemic of AIDS in California was among homosexuals, the secondary epidemic will be among IV drug users and a third potential epidemic looms over college-age heterosexuals (who may be inclined to experiment with both unprotected sex and drugs).

The State moved to meet the challenge of this disease by creating a special AIDS program in 1983, which became the separate State Office of AIDS in the Department of Health Services in 1986. In 1983, the office began with two workers borrowed from other agencies and the state spent about \$3.4 million on AIDS. This year (1989-90), about 140 people staff the office and about \$128.5 million is budgeted in the five areas that the State has targeted: epidemiologic surveillance, preventive education, services to AIDS patients, disease research and long-range planning.

Chart B below shows that the \$128.5 million budgeted for AIDS programs this fiscal year is spread among seven state entities.

CHART B

CALIFORNIA AIDS FUNDING (\$ In Thousands)

	<u>1983-84</u>	<u>1984-85</u>	<u>1985-86</u>	<u>1986-87</u>	<u>1987-88</u>	<u>1988-89</u>	<u>1989-90</u>
Dept. of Health Services	\$ 500	\$ 1,040	\$ 7,621	\$16,217	\$47,830	\$71,298	\$94,573
Dept. of Alcohol and Durg Programs	--	--	--	--	2,555	11,253	18,422
University of California	2,900	3,094	7,597	9,618	9,857	9,357	9,357
Dept. of Corrections	--	--	--	622	2,840	3,000	3,868
Dept. of Mental Health	--	--	600	--	700	1,500	1,500
Youth Authority	--	--	--	--	200	200	200
Dept. of Social Services	--	--	--	--	--	63	125
All Funds	\$ 3,400	\$ 4,134	\$15,818	\$26,457	\$63,982	\$97,171	\$128,545
General Funds	3,400	4,134	15,818	24,505	50,699	71,788	78,967
Federal Funds	0	0	0	1,952	13,283	25,383	49,578

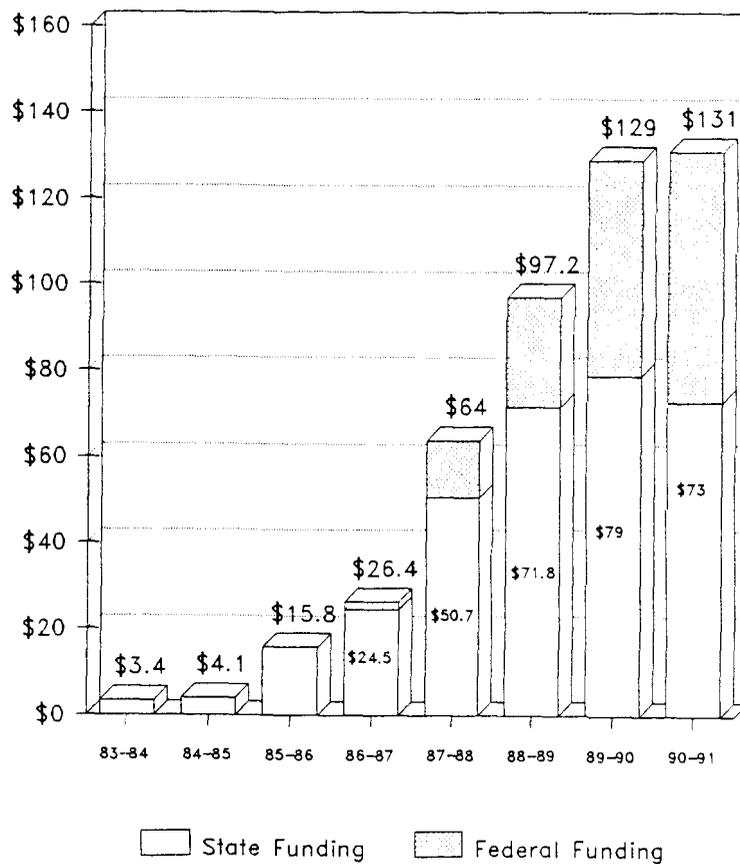
Source: State Office of AIDS January 1990

As the chart shows, the bulk of AIDS funding, \$94.6 million, is under the control of the Department of Health Services. The Department of Alcohol and Drug Programs controls \$18.4 million and the University of California, which conducts AIDS research, has \$9.9 million. Other smaller amounts are funneled through the Department of Mental Health, Department of Corrections, Department of Social Services and the California Youth Authority.

As the chart also indicates, California has consistently budgeted more General Fund dollars to tackle AIDS than the amounts sent directly to the state by the federal government to combat the disease. Chart C below shows the total combined state and federal funding in California that is under the direction of the state.

CHART C
State-Controlled AIDS Funding

(Dollars in Millions)



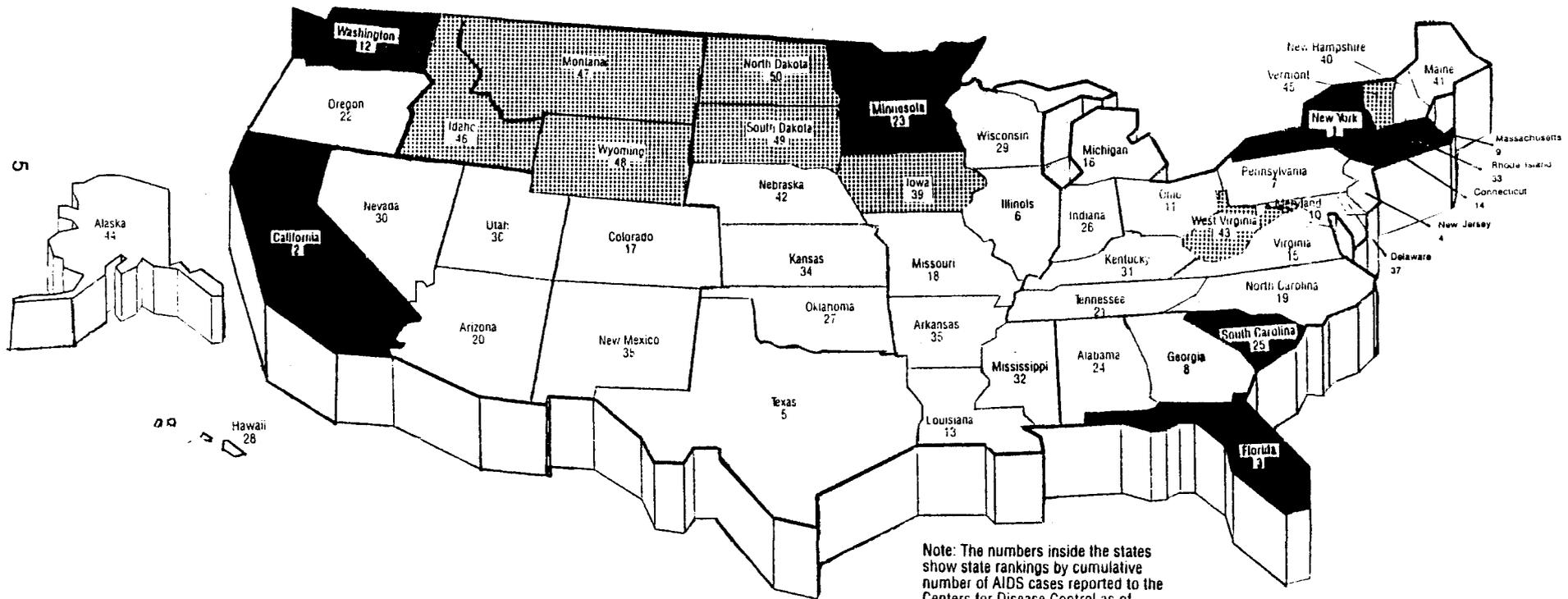
Source: State Office of AIDS 1990-91 figures are projections from Governor's Budget

The federal government also sends funds directly to San Francisco and Los Angeles, on beyond the block grant reflected in Chart C above that it gives to California to direct to the other areas of the state. In addition, some federal funds go directly to community-based organizations providing AIDS services. The State Office of AIDS has indicated, however, that it has no way of knowing the total of amount of federal funding coming into the state.

The map on the next page indicates the ranking of each state in the country by number of reported AIDS cases and each state's response in terms of spending.

1989 Funding For AIDS Programs

State Ranking by Number of AIDS Cases



Note: The numbers inside the states show state rankings by cumulative number of AIDS cases reported to the Centers for Disease Control as of November 1988.

- State Spends More
- Federal Spends More
- No State Funding

California, with the second largest AIDS caseload in the country, is one of nine states where state AIDS funding exceeds federal spending, as the map on the preceding page shows. But for the bulk of the nation, federal dollars are the key to AIDS services, education and treatment. There are seven states that spend none of their own funds on AIDS.

In addition, California is one of only 10 states that funds its own AIDS research rather than relying on federal efforts to understand and combat this disease. In fact, California is conducting its own clinical drug and vaccine tests rather than waiting for the federal Food and Drug Administration to complete its arduous approval processes.

The charts and the map are indications that California has taken AIDS seriously and is committed to meeting the challenges of the disease. And the challenges are growing:

- * The rate of HIV infection among intravenous drug users is increasing (although more slowly than in eastern states like New York and New Jersey where "shooting galleries" and sharing needles are more popular). Since the IV drug using population has proven tougher to reach with education and preventive measures than the homosexual community (which, by and large, is better educated and more thoroughly tied into social networks that can be used for communication), the implication is that more resources will be needed to head off this second stage of the epidemic.

- * The proportion of AIDS patients whose care is paid for by Medi-Cal is growing. According to a December 1988 Department of Health Services report, Medi-Cal paid for care for 19 percent of AIDS patients in 1983, 27 percent in 1986 and 33 percent in 1988. Medi-Cal AIDS-related expenditures for fiscal year 1989-90 were expected to total \$56.4 million. This compares to total AIDS-related treatment expenditures in California, including Medi-Cal, of \$420.8 million for fiscal year 1989-90.

The one bright note in the 1988 report is the notation that the average monthly treatment expenditure for an AIDS patient dropped from \$2,985 in 1984-85 to \$1,986 in 1987-88 as more emphasis was placed on programs to help patients avoid long hospital stays. But this improved fiscal sign may be more than offset in the future by the recent discovery that the expensive drug AZT can help HIV-positive people long before they develop AIDS symptoms, thus greatly expanding the pool of people who will seek this subsidized drug treatment.

- * Finally, because of the long incubation period of the virus (scientists believe people may test positive for HIV as much as 10 years before they develop AIDS), even if a vaccine were developed tomorrow, California faces a long-term future of caring for some 300,000 people who it is believed are already infected.

While the State of California has signaled its willingness to address AIDS through its budget decisions, it is imperative that the state's approach be as effective and efficient as possible to maximize the use of its resources as the problems relating to the deadly disease continue to grow.

Findings

FINDING #1: The State Office of AIDS lacks the authority to act as a lead agency for the State on all matters relating to AIDS.

Although the existence of a separate State Office of AIDS implies a centralized State mechanism for coping with the disease, the Office of AIDS has no control over \$34 million, or more than 26 percent, of the \$128.5 million budgeted in 1989-90 for AIDS programs.

Just as the effect of AIDS spreads on beyond the individuals infected with the disease, state programs and services dealing with AIDS reach beyond the State Office of AIDS. Appendix A indexes the AIDS programs run in seven departments under the Health and Welfare Agency, two departments under the Youth and Adult Correctional Agency, the Department of Education and the Department of Insurance (Business, Transportation and Housing Agency).

Both the Legislative Analyst's Office (LAO) and advocates for AIDS programs have been critical of the State for lacking a coordinated approach to all the many programs involved. In its "1988-89 Budget: Perspectives and Issues," the Legislative Analyst recommended that the Department of Alcohol and Drug Programs and the Office of AIDS "advise the Legislature how they plan to coordinate the use of their funds to prevent the spread of AIDS among intravenous drug abusers."

Noting that the State's budget provided funds for drug abusers' AIDS prevention under both entities, the Legislative Analyst said little evidence of coordination between the two could be found:

"For example, last year the departments informed the Legislature during budget hearings that they would sign a detailed Memorandum of Understanding in the near future to ensure coordination. However, as of January 1988 no such memorandum had been finalized. Moreover, the departments do not work together on identifying needs or making funding decisions, nor are they informed of efforts to coordinate at the county level. For example, the Office of AIDS could not tell us how the county drug programs (that receive funds from [the Department of Alcohol and Drug Programs]) interact with the Office of AIDS' intravenous drug abuser education and prevention contractors."

Although the Memorandum of Understanding mentioned above eventually was signed, the LAO continues to be concerned about coordination of AIDS programs. An LAO analyst has said there appears to be some duplication of effort in education and prevention programs by the Department of Corrections and the Office of AIDS. The analyst described it as a turf battle that could be the result of the state not defining clearly who is in charge as the lead agency on AIDS issues.

AIDS program advocates have echoed the same complaint and have maintained this lack of coordination makes the state difficult to deal with because requirements are not standardized across the departments and agencies. Educational pamphlets are developed separately by the Department of Corrections and the Office of AIDS, with differing guidelines on the approaches that may be taken. And while the Office of AIDS officially endorses the belief that HIV-infected persons do not casually transmit the disease, the Department of Corrections has followed a policy of segregating HIV-positive inmates regardless of their symptom status.

One AIDS spokesman has noted that when people who are HIV-positive leave the control or jurisdiction of the Department of Corrections, there is no program to hook them into other sources of support, such as case management.

William K. Smith, executive director of the Desert AIDS Project in Palm Springs, testified about this problem at a May 26, 1989, hearing conducted by the Department of Health Services about the State's efforts to create a strategic AIDS plan:

"Let me tell you some experiences we've had. As I understand it, those persons who are paroled go back to the origin in which they committed the crime.... We are finding that people are being paroled from the State penal system that are HIV-positive that are coming to our community without any prior planning. What...the correctional institution constitutes as prior planning is simply notifying the parole officer that Joe Doakes will be in town on a certain date, maybe, and he's to report to such and such a place on a certain date...."

"They arrive on our door, no money, no clothes, no primary health care. They tell us they were having AZT treatment in prison. There's no prescription. There's no medical plan or anything. So at the eleventh hour we are trying to run around and find housing, working with the parole officer. They don't know anything about it; they are overworked....We find very quickly these are people that we think are not only at risk themselves, but the community's at risk for having them there. We do not go on record as saying they should be penalized and not be paroled to the community. We just simply say that contained in this strategy of how to get from here to there, there ought to be some careful consideration about when you parole someone who's HIV positive and that all necessary steps be taken to ensure that at least their period of parole has one chance in a hundred of succeeding."

None of the above should be seen as an indication that the Office of AIDS works in a vacuum. The California AIDS Leadership Committee, with a membership of about 35 and an advisory group of some 200, meets monthly to go over issues and was the primary agent for forming the 1989 "California's Continuing Response to HIV Disease: A Strategic Plan."

But advocates for AIDS programs charge that the committee "overrepresents the bureaucracy and underrepresents Community-Based Organizations and affected populations," a contention the director of the Office of AIDS¹ has said she agrees with. Further, the AIDS program advocates maintain many of those who are supposed to be on the committee don't show up, particularly departments that could benefit from coordination.

Nonetheless, even were the AIDS Leadership Committee working in top form, the State would still lack a strong focal point for coordination unless one entity, such as the Office of AIDS, is designated as the lead agency and given authority--both budgetary and policy--over AIDS issues.

¹ Thelma Frazier, director of the State Office of AIDS since May 1987, is quoted throughout the report. She left that position on April 2, 1990; as this report is written, no permanent replacement has been named.

FINDING #2: The State Office of AIDS fails to exert the leadership required to act as a clearinghouse for statewide AIDS information.

Just as the Office of AIDS has failed to be the focal point for state activities, it has not served as a central organization to guide local governments and local service groups. Funding for AIDS programs comes from diverse, uncoordinated sources and the programs are, for the most part, operated by independent community-based organizations (CBOs). While acknowledging the need for better coordination of both funding and programs, the State Office of AIDS has not cast itself in the role of either enforcing coordination from above or acting as a clearinghouse and information exchange center for local entities.

No organization or entity contacted during the course of this study was able to estimate the amount of money spent in California on the battle against AIDS. Funding comes in from private sources, local entities, state government and the federal government, but there is no single point through which all the money filters and is accounted for.

The federal government adds to the lack of coordination by distributing its California funds in three segments: directly to San Francisco, directly to Los Angeles and the rest to the State to service the remainder of California. The director of the State Office of AIDS has said her office doesn't even know the amounts that are distributed to San Francisco and Los Angeles and does not feel responsible for tracking the funds.

The lack of coordination of funding becomes a problem when CBOs apply to both the state government and the federal government for funding for a specific program. There is no obligation for the organization to tell either level of government about the duplicated grant applications, and because each level of government has a different fiscal year (July 1 through June 30 for the state and October 1 through September 30 for the federal government) grant approvals are often out of sync.

In addition to problems with funding coordination, the programs themselves also are not well coordinated. The director of the State Office of AIDS has said that dozens of the 200 applications the office received in 1989 for education program grants would have offered duplicative services, in some cities within blocks of each other. She said her conversations with many of these grant applicants showed that they were unaware of what services already were being offered or were being planned by other agencies in their own area. The State Office of AIDS also is officially unaware of what programs are being undertaken throughout the state except through the mechanism of its own grant applications.

In its "Strategic Plan," the State at one point says those who provide AIDS educational material have problems keeping up with current information. "A need for expanded clearinghouse capabilities has been identified by a variety of sources...Rather than developing several specialized clearinghouses in the state, one multi-purpose clearinghouse should be maintained to meet specialized needs." The document goes on to recommend that a centralized AIDS educational materials clearinghouse should be funded and maintained by the State of California. There is no position stated in the Strategic Plan on whether the State Office of AIDS could act in such a capacity under its current authority and budget.

Although the Strategic Plan appears to give the State Office of AIDS little consideration as a candidate for the State's chief coordinating mechanism, the State makes it clear that coordination of funding and programs is a high priority. The Strategic Plan's executive summary lists first among 12 priority recommendations: "Coordinated state-local, public-private HIV disease planning

should be implemented throughout California; this should be undertaken along the lines specified in the California Department of Health Services' AIDS Prevention and Treatment: A Framework for Local Planning."

The framework encourages county by county plans that would meet overall state goals of providing prevention and testing programs, treatment and support services and coordination. The framework stresses to the counties the importance of coordinating financing:

"Insofar as public funds may originate from multiple local, state and federal agencies, it is essential that a mechanism exist for coordinating the various financing mechanisms. Likewise, a means needs to exist whereby funds can be rapidly distributed to local entities while maintaining the requisite programmatic and fiscal accountability. In the same vein, a means to evaluate the cost-effectiveness of the various HIV disease prevention and treatment components is essential to ensure continued support of these programs."

While these goals are laudatory, the State does not carve out for itself any aggressive leadership role in assuring that the described coordination at the local level is accomplished, nor does it express any interest in developing mechanisms to track funding statewide. It is difficult to escape the conclusion that these would be natural roles for the State Office of AIDS if the State were interested in assuming a leadership, rather than advisory, role.

The State Office of AIDS has made some tentative steps in the direction of encouraging county-level planning. The state now funnels funds directly to counties for five AIDS-related areas: a local block grant, sexually transmitted disease programs, counseling, drugs (AZT) and alternative test sites. But historically the State has given grants for a sixth area, AIDS prevention and education, directly to community-based organizations (CBOs).

The State is in the midst of moving toward adding the sixth area to the other county grants, with the goal of having county health officials coordinate education and prevention funding at the local level. The State offered this "subvention funding" plan to counties for the 1989-90 fiscal year, with the requirement that any interested county complete an overall plan that would reflect input from all interested parties, including current grant-receiving CBOs. The director of the Office of AIDS said four or five counties attempted to win the funding, but that the State concluded CBOs had been left out of their planning efforts.

The State then made more intensive efforts to educate counties about what was required and worked with the statewide organization of county health officers. The Office of AIDS director estimates that the coming fiscal year will see a dozen counties enter the program (Sacramento, Contra Costa, Placer, Monterey, Napa, Nevada, San Joaquin, San Bernardino, Santa Barbara, Tulare and Yolo, as well as the City of Long Beach).

From the State's viewpoint, funneling funds through the county health offices allows more efficient administrative costs, especially since many CBOs are small and have unsophisticated approaches to grants, both in applying for them and in monitoring them.

From the county health officers' perspective, controlling the funds allows better coordination of the complete range of AIDS services at the local level where the needs are best known.

But from the CBOs' viewpoint, the move to subvention funding is seen as a process that may freeze them out and allow county health departments to slice off chunks of grant money to cover administration costs. In addition, they fear that differing political climates from county to

county will mean that some areas will receive very little AIDS services since county health departments are subject to the control of boards of supervisors. They also fear that county health departments, which have suffered funding cutbacks ever since property tax revenues were trimmed, will begin creating their own programs to keep all the state money in-house.

The director of the Office of AIDS, however, says the state requirements that counties work with CBOs are designed to ease those fears, although CBOs would not have a veto power over county decisions. In addition, the director has set a limit of 5 percent of the total grant for administrative costs so that funds are not needlessly diverted from programs. These conditions, however, are Office of AIDS internal policy rather than regulations or state statute.

The positive aspect of the switch to subvention funding is that both dollars and services will be open to better coordination and tracking, if the State institutes proper mechanisms for reporting. But the voluntary aspect of subvention funding acts to self-select counties that already are moving in the direction of coordinating AIDS services, leaving a continuing coordination void in many areas of the state.

In the absence of State direction or incentives, however, there are local and regional efforts to coordinate AIDS services. For instance, the Coachella Valley AIDS Consortium in Southern California draws together 19 organizations in a public-private partnership to coordinate funding and plan AIDS services. San Francisco has long been a proven leader in weaving together public and private efforts to fight AIDS. And in its five-year plan for AIDS services (April 1988), Los Angeles County acknowledged the need for "a consortium of private and public agencies" to raise funds, coordinate services and create networks of communication.

On a much wider scale, The Sierra Foundation has worked to bring together AIDS activities in 26 Northern California counties, from Stanislaus, Tuolumne and Mono Counties on the south to the Oregon border and from the Nevada border on the west to the eastern edge of the Bay Area, excluding the redwood coastal counties. An independent private foundation committed to supporting health activities in Northern California, The Sierra Foundation began its Northern California AIDS Initiative in June 1988.

In addition to producing a standard protocol for dealing with AIDS patients, The Sierra Foundation AIDS Initiative has surveyed the available resources and services in 26 counties. In a February 1989 report on its AIDS Funding Survey, the Foundation reported that State Department of Health Services funds in the 26 counties totalled \$4,189,018, with an additional \$1,323,185 coming from federal, other State and private sources.

The Sierra Foundation survey also noted scattered efforts at coordination in many of these largely rural counties, but found "a need for comprehensive county-by-county accounting of AIDS programs, services and funding." The Foundation currently underwrites eight model case management and coordination programs that include all but five of the 26 counties in its territory.

The Sierra Foundation also has been active in tracking nationwide efforts to coordinate programs and funding. Among the states it has noted are moving forward with comprehensive planning efforts are:

- * Washington, where a 1988 law required the Department of Social and Health Services to establish a statewide system of regional AIDS service networks. The largest county in each region takes the lead, developing an organizational and service plan to deliver required services.

- * New York, where the AIDS Institute has been placed in charge of establishing an eight-region planning system. Each region is headed by its own AIDS planning coordinator and develops annual plans to be incorporated into a statewide plan.
- * Florida, where in 1987 a state law authorized the development of AIDS Patient Care Networks in various regions with high AIDS caseloads. Seventeen networks have been formed, serving 92 percent of the state's AIDS cases. The law also required the state's 11 local health councils to conduct needs assessments for those with HIV infection.
- * Missouri, where four regionalized coordinating networks were created in 1989 to deliver case management services to AIDS patients and to develop data for long-range planning.

Through its grants and research efforts, The Sierra Foundation has sought to emulate, develop and perfect techniques of coordinating AIDS services within the Northern California area covered by the Foundation. In addition, it has shared information whenever possible with other areas of the state to encourage coordination efforts throughout California.

Such private and local efforts are attempting to fill the void, on a piecemeal basis, left by the lack of state leadership in coordinating services and funding.

FINDING #3: The State has crafted an updated comprehensive plan for addressing AIDS but has sent mixed signals about its intentions for implementing the plan.

The Department of Health Services has made numerous efforts over the past decade to comprehensively plan its attack on AIDS, including a 1986 document entitled "Acquired Immune Deficiency Syndrome in California: A Prescription for Meeting the Needs of 1990." But its latest planning document, "California's Continuing Response to HIV Disease: A Strategic Plan," has stirred controversy and has been left to drift without a clear future.

The California AIDS Leadership Committee, a group of about 35 AIDS experts appointed by Department of Health Services Director Ken Kizer, issued a draft of the Strategic Plan in May 1989 and originally expected the report to be approved by the Governor's Office shortly after.

Several of the recommendations, however, proved controversial: studying the concept of exchanging clean needles for used ones with drug addicts; issuing condoms in prison; and instituting mandatory AIDS education in all schools. A campaign to have the report rejected in its entirety was embarked upon at one point. Ken Kizer, director of the Department of Health Services, recognized the controversy in his letter transmitting the draft report to the Governor's Office:

"The plan contains a total of 113 recommendations, many of which affirm existing policies and programs and which have essentially universal support from persons knowledgeable in the area. The plan also contains some controversial recommendations, which is not surprising in view of the controversy inherent to the AIDS issue...."

"The California AIDS Leadership Committee recognizes that a handful of recommendations (e.g., pilot programs to evaluate the effectiveness of paraphernalia exchange for drug addicts and condom distribution in prisons) are quite controversial and are at variance with positions historically espoused by the Deukmejian Administration....However, after carefully reviewing available data, a majority of the [Committee] felt that these recommendations

needed to be advanced so that they might be more fully evaluated and debated by the Legislature and others, taking into consideration the broad range of public policy concerns which they raise....[The Committee] felt these were issues warranting careful study or evaluation via appropriately constructed scientific queries, as well as broad public debate based on reliable and reproducible data."

Eventually, the plan was released by the Governor's Office on September 29, 1989, although there was no formal endorsement of the plan's 113 recommendations.

In addition to the proposals listed above, the plan backs voluntary (as opposed to mandatory) AIDS testing, updated blood bank procedures, explicit AIDS prevention materials, anti-discrimination legislation, the establishment of standards for procedures, interpretation and reporting of test results, and prohibition of AIDS testing for health insurance eligibility.

The director of the Office of AIDS has said that the Office of AIDS is now going through the plan to see what is already being done and to determine what recommendations can be implemented at the administrative level. With the California AIDS Leadership Committee meeting monthly, she has said she expects to take implementation plans on various segments of the report as they are developed by the Committee for approval.

AIDS program activists, however, are leery of a process that they believe has taken too much time with too little results. One said that when the process began everyone felt the resulting plan would be "an operational and budget" plan that would say "do this by that date for this much money." But instead a strategic plan that he described as very global in approach is the outcome—a plan that he believes would have been more appropriate in 1985 when the state first started addressing the AIDS issue. He and others expressed the fear that the California AIDS Leadership Committee will be used as an excuse and a forum to drag out the timeline for any improvements in State procedures that are eventually made.

Supporting evidence for these critics' fears can be seen in the recent inactivity of the Leadership Committee: The report was issued in September 1989. In January 1990, at the Little Hoover Commission public hearing on AIDS, the Committee co-chair testified that he had been told the Committee's next task would be a county-by-county assessment of funding, programs and needs, a process he estimated would take three or four months. As April 1990 began, the Committee had not begun its work.

With no clear direction, it is uncertain how the "Strategic Plan" will be used, how much of it will be implemented and what kind of timeline will be followed.

FINDING #4: The Office of AIDS appears to be unable to administer its grant programs in a timely and efficient manner.

A wide variety of sources, including community-based organizations, the California Conference of Local Health Officers, and the Legislative Analyst's Office, have noted that the Office of AIDS grant procedure is cumbersome, complex and costly. But perhaps the most telling testimony on this point is that of the director of the Office of AIDS, who concedes that the office's Request-for-Proposal (RFP) process is a problem.

Testifying to the Little Hoover Commission, representatives of the California Conference of Local Health Officers spoke of contracts averaging 50 to 60 pages in length, with one example of a 260-page contract: "The RFP/contracting process has been very cumbersome at both the state

and the local levels. The Office of AIDS has had tremendous problems moving their multitude of contracts through the State's system. Office of AIDS contracts have consistently been delayed, with County Boards of Supervisors receiving contracts for signature six to eight months into the contract year."

The complexity makes Office of AIDS funds extremely expensive to administer, according to the statewide local health officers' group. A survey conducted by the Association of Bay Area Health Officials found that local health jurisdictions estimated that to administer Office of AIDS grants takes between one-half and one full-time person. Specific examples included: Santa Clara County with \$1.5 million in grants uses 5.34 full-time-equivalent employees to administer the funds. Monterey County with \$575,000 in grants estimates it costs between \$200,000 and \$250,000 to administer the funds. And the City of Berkeley, which receives \$490,000, says administering the funds takes four to five times as much work as any other type of state grant.

The California Conference of Local Health Officers identified nine problem areas that contribute to the expense of administering Office of AIDS grants:

1. Each grant operates under a separate memorandum of understanding, even if the same group has several grants.
2. The memoranda of understanding, meant to replace previous complicated RFP contracts, are equal in length and detail, and therefore are not an improvement over the RFP process.
3. Grants operate under separate time frames, discouraging coordination and disrupting cash flow.
4. Each grant is overseen by a different Office of AIDS contract monitor and separate fiscal monitor, meaning that jurisdictions with multiple grants interact with a multitude of Office of AIDS employees.
5. Contracts, documents, etc., are invariably late and sometimes are delayed until the second or third fiscal quarter.
6. Frequent staff turnover in the Office of AIDS and changing of contract and fiscal monitors makes it difficult for local entities to consistently interact with the state.
7. Clear and consistent direction from the Office of AIDS is lacking, which results in documents being redrafted several times.
8. Official documents arrive incomplete from the Office of AIDS, leading to further processing delays.
9. Protocols and policies are developed at the state level without input from local agencies, often leading to rigidity that fails to take into account local needs and practices.

Finally, the Association of Bay Area Health Officials said that few local health jurisdictions had completed their agreements with the Office of AIDS by December 1989, five months into the fiscal year. On a similar note, the Legislative Analyst's Office noted that midway through the budget year the Office of AIDS was still working on contracts for early intervention programs

fiscal year. On a similar note, the Legislative Analyst's Office noted that midway through the budget year the Office of AIDS was still working on contracts for early intervention programs authorized last year by the Legislature.

Concern on the part of the Legislative Analyst over the functioning of the State Office of AIDS was indicated even more so when the office's assessment of the governor's budget proposal was released in February 1990. Because the State Office of AIDS was unable to supply a budget breakdown, justification for its program changes and staffing levels and other standard information that is usually collected from each state entity, the Legislative Analyst withheld making any recommendations to the Legislature on office's \$50.9 million budget proposal.

Adding to the litany of criticism was testimony in May 1989 to the Department of Health Services from representatives of community-based organizations, who said small organizations in particular have difficulty competing for state grants because of the detailed and cumbersome RFP procedures. Some complained that funds end up being diverted to cover the cost of grant proposal writing and grant administration rather than being spent directly on services to AIDS patients or education efforts.

At the Little Hoover Commission's January 1990 AIDS hearing, the director of the Office of AIDS denied none of the criticisms directed at the Office's grant procedures. She said she has urged her staff to simplify the RFP process and to particularly concentrate on limiting the tedious detail now required of an entity to describe and document its planned scope of work. But the director, who subsequently left the Office of AIDS in early April 1990, apparently was unable to set the stage for a streamlined RFP process during her three-year tenure running the office.

While the State has a very real interest in ensuring that funds it grants to organizations are used appropriately, it would seem to be counterproductive to have such rigid and demanding policies that the cost of administering a grant takes up a significant portion of the grant funding itself.

Recommendations

- 1. The Governor and the Legislature should give the Office of AIDS authority as the state's lead agency on AIDS and further should designate the Office of AIDS as the source of funding for all state programs dealing with AIDS.**

The Office of AIDS needs to be at the forefront of coordinating all state programs, regardless of the agency or department involved, to ensure there is no duplication of effort, that the state speaks with a unified policy voice and that maximum effect is achieved for each dollar spent.

- 2. The Governor and the Legislature should require counties on their own or in regional groupings to produce AIDS services plans, in consultation with community-based organizations, identifying resources from all levels of government and private sources, cataloguing local needs and coordinating funds and services. The Office of AIDS should serve as a technical adviser in the production of the plans, as a monitor to ensure plans cover all aspects of AIDS problems and incorporate all organizations in each area, and as a clearinghouse for gathering statistics on a statewide level based on the plans.**

While the current Office of AIDS move toward subvention funding envisions counties moving towards coordinated planning, the process will be slow and uneven throughout the state. The need for coordination of funds and services, in order to maximize the use of scarce funding, is immediate throughout the state.

- 3. The Governor and the Legislature should direct the Office of AIDS to streamline its grant procedures in order to reduce administrative costs (both at the state and local levels). If these goals are not achieved in a timely manner, the auditor general should be directed to examine the Office of AIDS and make recommendations for any necessary new procedures.**

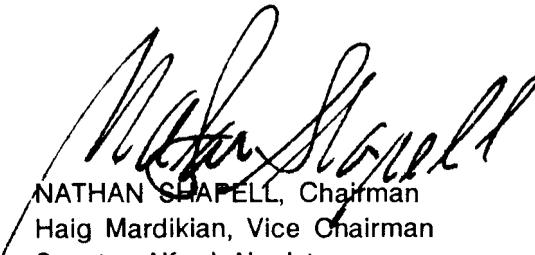
The Office of AIDS could look to the Centers for Disease Control's Cooperative Agreements and Grants as a model for more efficient and flexible means of distributing funds. In addition, Office of AIDS project monitors should, as much as possible, be assigned to the same projects and provide continuity through familiarity with the local entities and programs. Finally, the Office of AIDS should develop an advisory committee of AIDS service providers to consult with the Office of AIDS on protocols, contracts and procedures as they are developed and modified.

- 4. The Department of Health Services should formulate and report to the Legislature a timeline and budget requirements for those recommendations in the state AIDS Strategic Plan it intends to implement; the Department further should produce a list of goals and a timeline for the future activities of the California AIDS Leadership Committee.**

While the existence of a strategic plan is a key to coordinating services and maximizing benefits from funding, such a plan is of little value if it is not implemented. The State should clearly delineate which portions of the Strategic Plan are, in fact, State policy that will be pursued.

The Little Hoover Commission believes the above steps, if implemented, will greatly enhance the State's ability to cope with AIDS and the devastating effect the disease has on individuals and society as a whole.

Sincerely,



NATHAN SHAPELL, Chairman
Haig Mardikian, Vice Chairman
Senator Alfred Alquist
Mary Anne Chalker
Albert Gersten
Senator Milton Marks
Assemblywoman Gwen Moore
George Paras
Abraham Spiegel
Barbara Stone
Richard Terzian
Assemblyman Phillip Wyman

APPENDIX A

The following state agencies and departments provide AIDS services:

1. Health and Welfare Agency

A. Department of Health Services

Office of AIDS:

Epidemiologic surveillance, education and prevention, testing and counseling, treatment and research

Family Health Division:

Treatment through California Children Services Program, testing through Office of Family Planning and education through Maternal and Child Health

Rural and Community Health Division:

Coordination of services in rural areas and testing in health clinics

Preventive Medical Services Division:

Education through the Immunization Unit, the Sexually Transmitted Disease Section and the Tuberculosis Control and Refugee Health Programs Unit

Laboratory Services Division:

Testing, training and research through the Viral and Rickettsial Disease Laboratory, the Microbial Disease Laboratory and Laboratory Field Services

Food and Drug Branch:

Research and testing of drugs

Licensing and Certification Division:

Licensing of facilities for AIDS patients

Medi-Cal:

Treatment and the health insurance premium payment program

B. Department of Alcohol and Drug Programs

Education, training and outreach to drug users

C. Department of Mental Health

Testing, education, training and care for mentally ill persons with AIDS

D. Department of Social Services

Adult Services:

In-Home Supportive Services provides services for the ill at home

Family and Children Services Branch:

Recruits foster care for HIV-infected children

Foster Care and Adoptions Program:

Testing and screening of children

Community Care Licensing:

Licensing of non-medical homes for those with AIDS

E. Department of Developmental Services

Education and prevention for those with developmental handicaps

F. Department of Aging

Education for senior network

G. Department of Rehabilitation

Training for those with HIV infection

H. Emergency Medical Services Authority

Education for public safety workers

2. Youth and Adult Correctional Agency

A. Department of Corrections

Education, testing, treatment and other services for inmates

B. Department of the Youth Authority

Education, testing, treatment and other services for inmates

3. Business, Transportation and Housing Agency

A. Department of Insurance

Education and regulation of health and life insurance

4. Department of Education

Education and development of policies regarding infection control