REPORT #2

of

THE GOVERNOR'S TASK FORCE ON AIDS

(Acquired Immune Deficiency Syndrome)

December 14, 1986
Tallahassee, Florida

112361

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The Florida AIDS Hotline provides information to the public about AIDS, including methods of transmission and the availability of testing programs and local experts and speakers. It can be reached toll-free by calling 1-800-FLA-AIDS.

MEMBERS OF THE TASK FORCE

Chariman: Robert A. Good, M.D., M.P.H.
Professor of Medical Microbiology and Immunology,
University of South Florida
Physician-in-Chief, All Children's Hospital
St. Petersburg

E. Joan Barice, M.D.
Private Practice Physician
Palm Beach Gardens

Fred J. Cowell
President, Public Health Trust
Jackson Memorial Hospital
Miami

David G. Droller, M.D.
Private Practice Physician
Ft. Lauderdale

Margaret A. Fischl, M.D.
Director of AIDS Clinical Research Unit
Special Immunology and AIDS Clinics
University of Miami School of Medicine/
Jackson Memorial Hospital
Miami

James T. Howell, M.D., M.P.H.
Director, Palm Beach County Public Health Unit
West Palm Beach

Charles Konigsberg, M.D., M.P.H.
Health Program Supervisor, District 10
Department of Health and Rehabilitative Services
Ft. Lauderdale

Donald S. Kwalick, M.D., M.P.H.
Director, Hillsborough County Public Health Unit
Tampa

Lionel Resnick, M.D.
Chief of Retrovirology Laboratories
Mount Sinai Medical Center
Miami

Bealer T. Rogers, Jr., M.D.
Assistant Secretary for Health Services
Department of Corrections
Tallahassee

Gerold L. Schiebler, M.D.
Associate Vice President for Health Affairs
University of Florida
Gainesville

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THE GOVERNOR'S TASK FORCE ON AIDS

I. SUMMARY

More than 28,000 Americans have been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS). The reported cases nationwide are approximately doubling every 12 months. Many thousands more than that number have a related, but less lethal, form of the disease known as AIDS Related Complex (ARC). The Centers for Disease Control in Atlanta estimates that as many as two million individuals in the United States are infected with the virus known to cause the disease, the Human Immunodeficiency Virus (HIV).

Florida has recorded 1,918 cumulative cases of AIDS as of December 2, 1986. By December 1987, the number is expected to be 3,800, 7,600 by December 1988, 15,200 by December 1989, and 30,400 by December 1990. The number of persons with AIDS Related Complex (ARC) and the number of individuals infected with the AIDS virus are expected to increase similarly.

There is no vaccine to prevent spread of the AIDS virus. Treatment modalities are in their infancy. Research has established cause of the disease and suggested possible preventions and cures; much additional research remains to be accomplished.

"It is estimated that by 1991, 54,000 people will die from AIDS. At this moment, many of them are not infected with the AIDS virus. With proper information, as many as 12,000 to 14,000 people could be saved in 1991 from death by AIDS" (United States Surgeon General's Report on Acquired Immune Deficiency Syndrome).

Governor Bob Graham appointed the Task Force on AIDS in October 1985. The mission of the Task Force is to develop and apply medical, public health, educational, and governmental expertise to the identification, analysis, and resulution of policy issues relating to AIDS. The Task Force provides advice and recommendations to the executive and legislative branches of state government.

The first report of the Task Force was released on January 6, 1986. The report included recommendations on five public health issues, six public educational concerns, three patient service needs, and three research and epidemiology projects. Budget recommendations for the 1986-87 fiscal year totaled $14,503,000 including state and federal funds.

Significant additional state resources are needed for patient care, research, education, counseling/testing, surveillance, and special community studies to combat AIDS. The report summarizes recent actions and policy recommendations of the Task Force and 1987-88 fiscal year budget recommendations.

A. Budget Recommendations

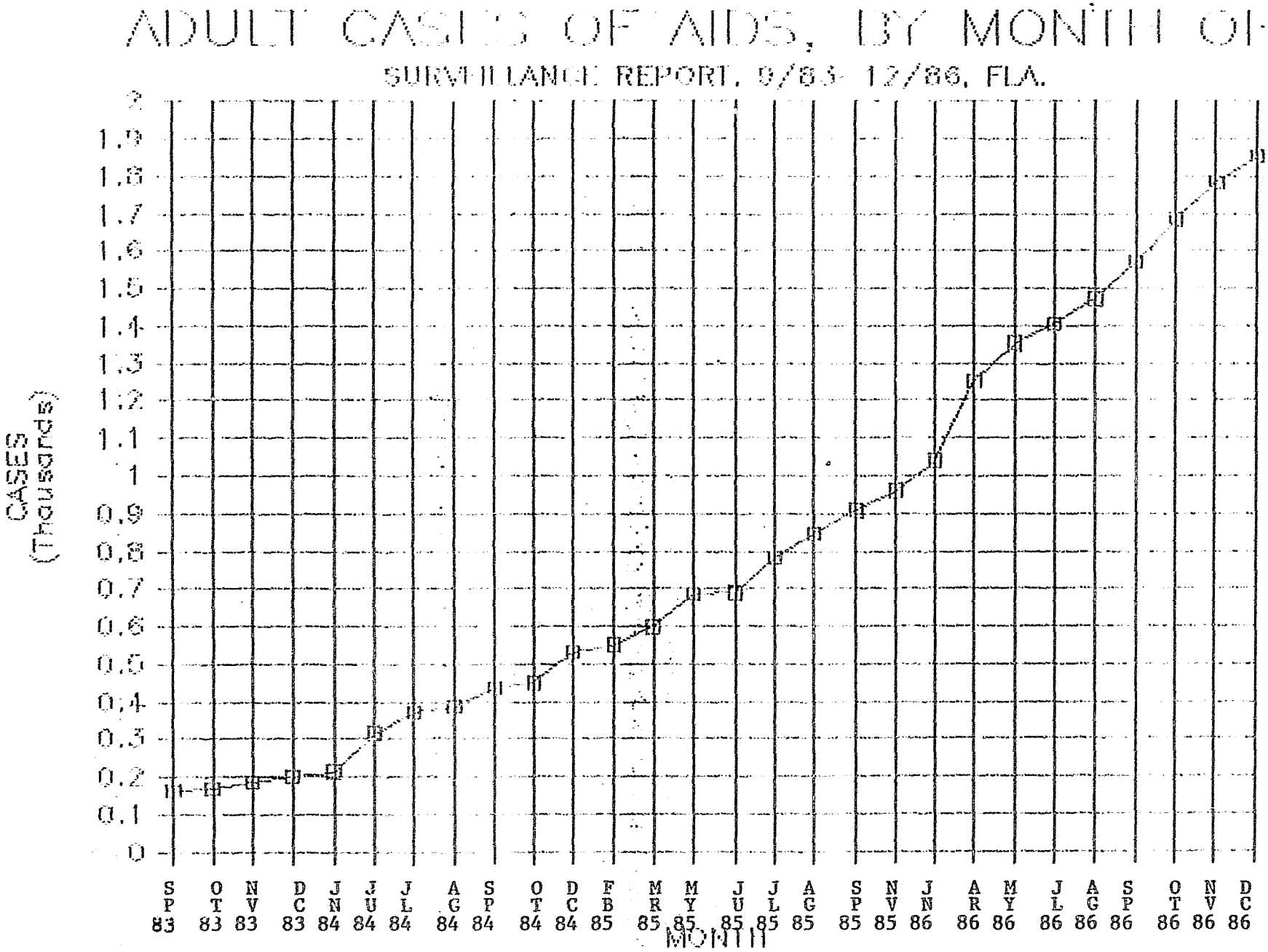
1987-88

Task Force Recommendations

General Revenue Appropriations*

Item	Actual 1986-1987 GR Funding	1987-88 GR Recommendations	Narrative Page No.
Dade County Patient Care Network	$4,218,344	$6,500,000	6
Other County Patient Care Networks	700,000	5,000,000	6
Information and Education	189,000	3,000,000	7
AIDS Research Network	-0-	3,000,000	9
Virology Laboratory Enhancements	450,000	1,200,000	10
Counseling and Testing	-0-	1,000,000	11
Surveillance	-0-	600,000	12
Special Community Studies	-0-	600,000	12
TOTALS:	$5,557,344	$20,900,000	

* These recommendations do not include routine operations budgets for the state office, state laboratories, and district coordinators.


ADULT CASES OF AIDS, BY MONTH OF
SURVEILLANCE REPORT, 9/83- 12/86, FLA.
CASES (THOUSANDS)
2
1.9
1.8
1.7
1.6
1.5
1.4
1.3
1.2
1.1
1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
SP 83
OT 83
NV 83
DC 83
JN 84
JU 84
JL 84
AG 84
SP 84
OT 84
DC 84
FB 85
MR 85
MY 85
JU 85
JL 85
AG 85
SP 85
NV 85
JN 86
AR 86
MY 86
JL 86
AG 86
SP 86
OT 86
NV 86
DC 86
MONTH

Current AIDS Funding Summary

ITEM	FY 1986-87 State Funds*	Federal Funds	Federal Funding Cycle***
Dade County Patient Care Network	$4,218,344	-0-	
Jackson Memorial Hospital Renovations	$1,245,000**	-0-	
Other County Patient Care Networks	$ 700,000	-0-	
Operations (State Office, District Coordinators, and State Laboratories)	$ 469,382	-0-	
Virology Laboratory Improvements	$ 450,000	-0-	
Counseling and Testing	-0-	$672,281	09-01-86/ 08-31-87
Health Education/Risk Reduction	-0-	$439,890	02-15-86/ 04-30-87
Surveillance	-0-	$316,708	12-01-86/ 11-30-87
Belle Glade Study****	-0-	207,520	02-01-86/ 01-31-87
Prostitute Study****	-0-	$113,093	09-27-86/ 08-26-87
TOTAL:	$7,082,726	$1,749,492	

* General Revenue Funds
** These funds were appropriated by the 1986 Legislature from 1985-86 revenue sources and released prior to June 30, 1986.
*** The dates are the current federal funding cycle for each co-operative agreement.
**** The study is described in more detail in Section III.

National data on state expenditures for AIDS are available. The George Washington University published "An Overview of Specific State Funding for AIDS Programs and Activities," dated July 23, 1986 (Appendix A). The report shows 1986-87 state funding for AIDS as follows:

STATE	FUNDING
New York	$10,500,000
California	$29,384,751
Florida	$ 6,153,000
New Jersey	$ 3,800,000

New York has the greatest cumulative number of AIDS cases; California, Florida, and New Jersey have the second, third, and fourth greatest number of cumulative cases of AIDS. California has spent or obligated $21 million for AIDS research.

Patient Care Services

Patient care resources continue to be a pressing need with AIDS. This disease is expected to affect as many people during 1987 as the total number affected in the 6 years since discovery of the disease. As knowledge of the disease increases, the need also increases to treat the disease more cost-effectively and prolong the lives of the patients. Although AIDS is a fatal disease, more people will be living longer and will need a greater scope of care than ever before.

An AIDS patient care network has been established in Dade County with a $4.2 million state appropriation by the 1986 Legislature. Similar to a very successful San Fransisco network, the program is described in detail in Section III of this report (page 31).

Patient care networks have also been initiated in Broward, Palm Beach, Monroe, Orange, and Hillsborough Counties with

$700,000 appropriated by the 1986 Legislature. The networks will assure basic health care services to indigent persons with AIDS or ARC (AIDS Related Complex).

The number of persons with AIDS and the number of persons with ARC are expected to double every 12 months in Florida. Consequently, more than a 100 percent increase in state appropriations is requested for AIDS patient care services.

Information and Education

United States Surgeon General, Dr. C. Everett Koop, recently released a forceful report on Acquired Immune Deficiency Syndrome. The report emphasizes information and education as the primary preventive measures available today to control spread of AIDS.

The public must be made aware of the known modes of transmission, signs and symptoms, and risk factors involved with AIDS. An informed public will also have a more rational approach to AIDS, reducing unwarranted discrimination and unfounded fears.

The task force recommends a comprehensive educational program to inform public and health profession groups, high risk populations, legal groups, schools, detention centers, and prison personnel about AIDS, its methods of transmission, and ways to control the spread of this deadly disease.

A study in San Francisco demonstrated that increasing public awareness of the transmission and risk factors associated with AIDS helped to decrease the incidence of some sexually transmitted diseases by 74 percent, and altered the sexual habits of homosexual men in that city. A nation-wide decrease in the incidence of anal gonorrhea also may be attributed to the public awareness and concern about AIDS. Despite this encouraging news, a successful public education program must overcome several dif-

ficult barriers. Because AIDS is primarily a sexually transmitted disease, sexual habits and lifestyles must be changed in order to reduce transmission of the virus. These changes relate not only to homosexuals, but also to prostitutes and promiscuous heterosexuals. Most people view their sexual habits as very private. Such personal choices are not easily swayed by public education, health advisories, and religious teachings. In addition, many individuals in high risk groups may have a fatalistic attitude about AIDS and refuse to take necessary precautions.

Another risk group even more difficult to reach and influcence is intravenous (IV) drug users. In Florida there has been a steady increase in the number of intravenous drug users who have AIDS, ARC, or HIV infected. The virus is transmitted when an infectious person uses a needle and shares the blood-contaminated needle with others. To complicate the problem, many I.V. drug users are also prostitutes, further increasing their chances of exposure to HIV.

Educational programs in Florida need to address these groups through both mass media and individual counseling. Specific programs that reach these high risk groups should be increased.

Medical and other health care professionals, and other workers in hospitals, nursing homes, other health care facilities, schools, detention centers and prisons should be provided with continuous and updated educational programs about AIDS and how to care for AIDS patients. Most health care facilities provide routine in-service training programs for their staff to educate them concerning sanitary precautions and treatment procedures. This training should include appropriate management of patients with HIV infection. To ensure consistent and safe care, each health care facility in Florida should have a copy of HRS pamphlet 150-3, which provides complete instructions on handling AIDS patients.

The legal profession will have an increasing role in determining how people with AIDS are managed in Florida. There is a need for judges and attorneys to understand how HIV is transmitted. Information should be available to all judges and prosecuting and defending attorneys that explains how the HIV is transmitted, the latency period of the infection, what diagnostic tests are available and how these tests are interpreted. These groups should be provided new information on developments in AIDS technology and Florida Statutes dealing with AIDS.

A total of $3,000,000 is requestd for statewide information and education services.

AIDS Research Network

AIDS is caused by a newly-recognized human virus belonging to the family of retroviruses. The discovery of the virus has allowed researchers to gain a better understanding of how the disease spreads and evolves. Of monumental importance, AIDS researchers have developed a blood test that detects a person's exposure to the virus. This blood test has successfully led to a decontamination of our nation's blood supply, thereby saving countless lives. Despite significant strides in AIDS research, a protective vaccine and an effective treatment for AIDS do not exist. As the AIDS epidemic continues to increase, our only ultimate solution to the AIDS problem lies with our research efforts.

Florida has unique problems of major importance concerning AIDS. The heterogeneity of our population, with its large mixture of different ethnic groups, make Floridians prime candidates for the rapid increase in the heterosexual transmission of AIDS. The potential for the continued spread of AIDS and the significant expense that is needed to provide for patient care makes it imperative that we do not delay in our formation of an AIDS Florida research network. The comprehensive AIDS research net-

work would focus on the specific topics of epidemiology, virology, immunology, etc..

Research projects could include: 1) the methods and rates of transmission of AIDS among Floridians; 2) the biologic behavior and differences among the viral strains; 3) the host immune response to viral infection; 4) the psychoneurologic sequelae of AIDS; 5) pediatric AIDS. The State of Florida AIDS Research Network would also give Florida a competitive edge in obtaining Federal AIDS research grant dollars.

The task force recommends appropriation of $3,000,000 of state funds to establish a Florida AIDS research network at six sites: Tampa, St. Petersburg, Gainesville, Jacksonville, Jackson Memorial Regional Medical Center, and Mount Sinai Medical Center. Half of the appropriation would be distributed equally among the six sites. The remaining funds would be allocated to the six sites on a competitive basis through review of proposals by a statewide scientific committee. A coordinated and organized AIDS research network among the major universities in the State of Florida will allow different investigators to apply different approaches to solving Florida's AIDS problems.

Virology Laboratory Enhancements

To accomplish research into the virology of HIV including investigation of new anti-viral compounds to inhibit HIV *in vitro*, several additional P-3 (protection level 3) laboratories must be established. A P-3 level laboratory is constructed to provide the highest level of protection against viral or bacterial contamination, accidents, or leakage outside of the laboratory. An existing laboratory may be converted into a P-3 laboratory for a cost of $50,000 to $150,000 or more, depending on the current design of the facility. Such laboratories are recommended by the National Institutes of Health to perform research with high concentrations of retroviruses, such as HIV. At least

three additional P-3 laboratories are recommended by the Task Force in order for Florida to effectively compete for Federal funds for AIDS virological research.

A total of $450,000 are recommended to establish an additional three P-3 level laboratories in Florida research facilities the 1987-88 fiscal year. A total of $450,000 ($150,000 each) are requested to support viral research projects in three existing P-3 level laboratories created by 1986 legislative funding. A total of $300,000 are recommended to upgrade state laboratory facilities in Jacksonville, Tampa, and Miami. A grand total of $1,200,000 is recommended for all three virology laboratory enhancement projects.

Counseling and Testing

The Counseling and Testing (Alternate Sites) Program offers HIV antibody tests to individuals who suspect exposure to the virus. The purpose of the program is to both divert potential high risk donors away from blood banks to "alternate sites" to test their blood for the HIV antibody and to counsel them to reduce their risk behavior.

Testing, counseling, and referral are carried out through 19 county public health units, chosen for equitable geographic distribution and number of AIDS cases. Actual testing of the blood is performed by HRS laboratories in Jacksonville, Tampa and Miami.

Client counseling about lifestyle changes is as important as the testing. In addition, clients at the alternate sites are assured of anonymity. The program has expanded activities to include community education and prevention work. Approximately 12,000 persons have been counseled and tested since the sites were established in June 1985. The program is described in detail in Section III of this report (page 20).

The counseling and testing (Alternate Site) program was established with federal funds in the amount of $967,000 the 1985-86 year. Federal funds for the 1986-87 year were reduced to $672,281. Federal support of the services are not anticipated beyond the current state fiscal year.

A total of $1,000,000 of state funds for the 1987-88 fiscal year are requested to maintain the sites at county public health units at the current level of services.

Surveillance

Florida would benefit greatly from enhanced epidemiological studies and increased surveillance of HIV. Florida's heterogenous demographic characteristics require specific inquiries to determine if unique factors contribute to the high number of cases in the state. In addition, with as many cases expected next year as in the previous five years cumulatively, additional assistance will be needed at the county public health unit level for investigation and follow-up, especially of individuals who are in no known risk groups.

A total of $600,000 are recommended for statewide surveillance activities. Surveillance services are explained in more detail in section III (page 18).

Special Community Studies

Certain groups of the AIDS cases are unique and require special surveillance studies to understand prevalence of HIV infection within the group, mode of transmission of the virus, and other factors. The State Health Office/Centers for Disease Control have two such studies in progress now: The Belle Glade Study and the Miami Prostitute Study. The studies are necessary to design intervention strategies to control or halt spread of

the virus. The need for these special studies will continue and accelerate in the next two to five years.

Specifically, AIDS among inner city IV drug users is expected to increase sharply in the nation and in Florida by FY 1987. IV drug users, in turn, are expected to spread the AIDS virus into the heterosexual population rapidly. AIDS cases now are largely confined to urban areas; these developments will likely spread the disease to less populated areas.

Creation of a surveillance and study team is proposed to assist county public health units to respond to predictable crisis that require specialized and intensive investigation and study. Two trained epidemiologists, a statistician, and one support person are requested for the intervention team. No less than three special studies like the Belle Glade and Miami Prostitute Studies would be completed each year in cooperation with county public health units. Initial studies will focus on IV drug and heterosexual transmission of AIDS.

Cost for the studies include Career Service employees, OPS salaries, medical supplies, equipment, laboratory cost, and other incidental expenditures. The State Health Office and county public health units will continue to provide significant in-kind costs to these special studies.

A total of $600,000 is requested for special community studies during the 1987-88 fiscal year.

B. Task Force Actions

Actions of the Governor's Task Force on AIDS since the first report on January 6, 1986, include the following:

1. Assisted in development and endorsed a policy on AIDS of the Board of Regents that govern nine Florida public

universities. The policy prohibits discrimination against students or employees based upon Human Immunodeficiency Virus antibody status, ARC, or AIDS illness. The policy also provides for counseling and other services for these students (see Appendix B).

2. Recommended that drug rehabilitation facilities provide services to potential clients regardless of the applicant's HIV antibody status. Some facilities in Florida are, apparently, testing applicants and denying services to seropositive persons.

3. Reviewed and endorsed proposed rules for the "new" comprehensive Sexually Transmissible Disease Act (see Appendix C).

4. Reviewed and endorsed guidelines for a revision in Florida Statutes, An Act Relating to Prostitution (see Appendix D).

5. Advised the Governor and the state legislature on AIDS related issues.

6. Reviewed and made recommendations on proposed legislation.

7. Assisted the Governor and the Department of Health and Rehabilitative Services shape an AIDS program for Florida.

8. Served as a resource group for the media for timely and accurate information.

9. Reviewed and approved federal grant proposals.

II. SURVEILLANCE OVERVIEW

A. AIDS in the United States

Acquired immune deficiency syndrome (AIDS), a disease which only a short time ago became recognized as a distinct clinical entity, has resulted in considerable morbidity and mortality in the United States in the past five years. During the next five years AIDS will become an even more serious public health problem. An estimated 74,000 new cases are expected to occur in 1991 alone, with almost the same number diagnosed in previous years requiring care and treatment during 1991 (Morgan and Curran, 1986[1]).

AIDS is a medical disorder that results in the loss of cell-mediated immunity in affected persons. It is caused by a retrovirus known as human immunodeficiency virus or HIV. The disease is transmitted by intimate sexual contact, contaminated needles, exposure to infected blood or blood products, or perinatally from infected women to their newborns before, during, or perhaps shortly after birth.

Cases have occurred in every state in the nation. By December 8, 1986, 28,098 cases of AIDS were reported to the Centers for Disease Control (CDC). Of these 15,757 (57%) are known to have died. Most adult cases are white males (63%) between the ages of 20 and 49 years (90%). The majority of adult cases acquired the disease through homosexual or bisexual contact (66%). Intravenous (IV) drug use is the second major risk factor associated with the disease, accounting for 17 per cent of the cases nationwide. To date a total of 394 children (≤ 13 years of age) have been reported to the CDC. Perinatal transmission accounts for 79 per cent of the pediatric cases.

[1]Morgan,WM and Curran, JW: Acquired Immunodeficiency Syndrome: Current and Future Trends: Public Health Reports, 101:459-465, 1986.

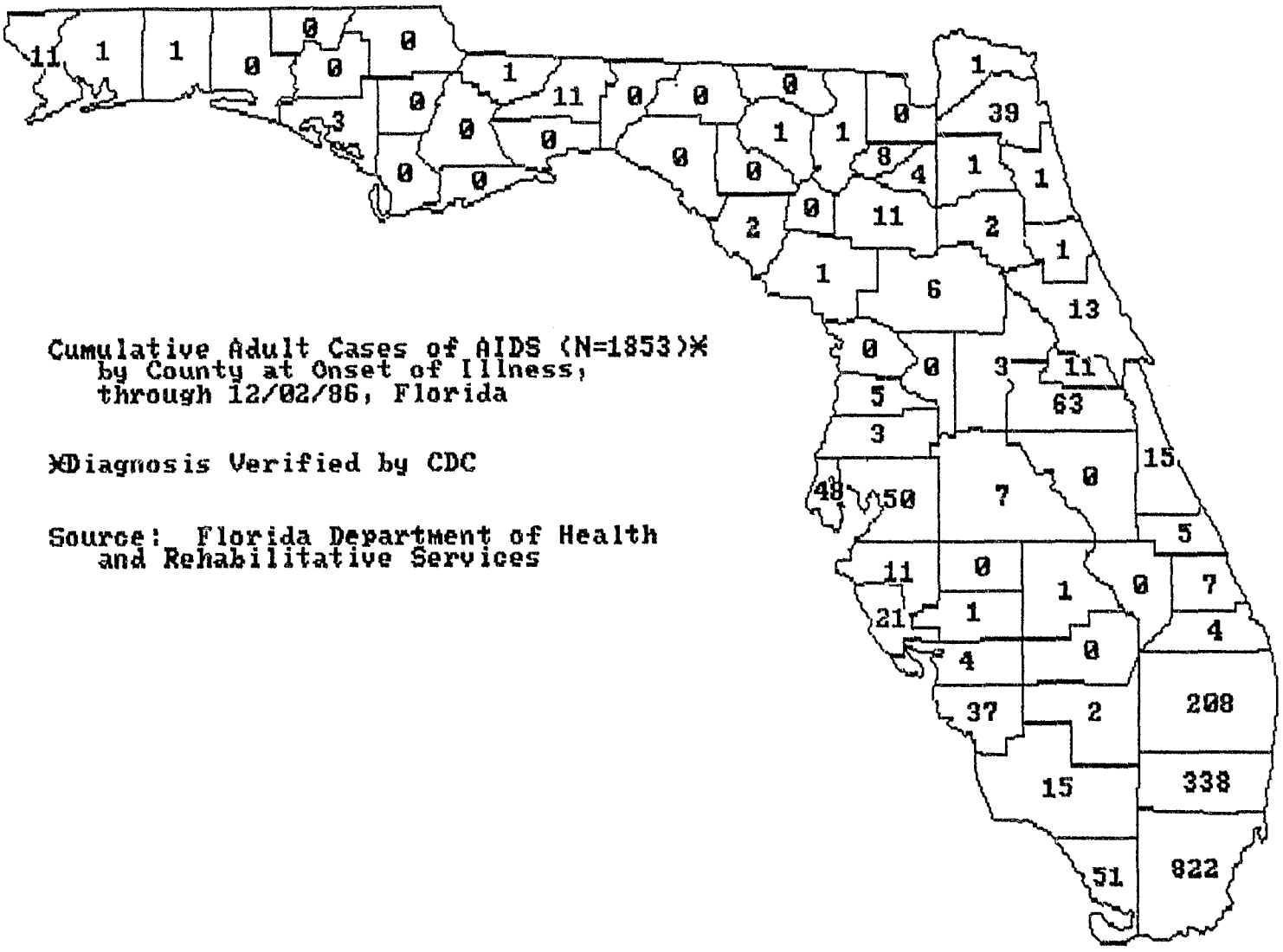
Persons infected with HIV may present with a variety of manifestations ranging from asymptomatic infection to severe immunodeficiency and life-threatening secondary infectious diseases or cancers. Pneumocystis carinii pneumonia and Kaposi's sarcoma are the commonest diseases associated with AIDS. Nationally, 58 and 43 per cent respectively of the cases have been diagnosed with these diseases.

B. AIDS in Florida

Throughout the course of the epidemic, Florida has consistently ranked third in the nation in the number of reported cases, accounting for almost seven per cent of the national morbidity. When children are examined separately, almost 17 per cent of the reported cases are from Florida, one of the highest incidence areas for pediatric AIDS. By December 2, 1986, Florida reported 1,863 cases of AIDS in adults and 55 pediatric cases for a total of 1,918. Sixty percent of these persons have died.

Miami, the most populous city in the state, ranks fifth in total number of reported cases after New York City, San Francisco, Los Angeles, and Houston, when national metropolitan areas are compared. Dade County, which incorporates the city of Miami, has reported a total of 790 adult cases accounting for over 44 per cent of the cases in the state. Further, the southeastern region of the state (encompassing the counties of Dade, Broward, Palm Beach, and Monroe) accounts for approximately 76 per cent of Florida reported cases.

Similar to the nation as a whole, a marked increase in the number of cases has occurred over the five-year period from 1981 through 1986 in Florida. The current cumulative number of reported cases is almost twice the number of cases reported a year ago which totaled 992 by November 21, 1985. Florida will no doubt continue to play a significant role in the projected increase in AIDS morbidity facing the nation by 1991.



Cumulative Adult Cases of AIDS (N=1853)*
by County at Onset of Illness,
through 12/02/86, Florida

*Diagnosis Verified by CDC

Source: Florida Department of Health
and Rehabilitative Services

III. THE FLORIDA AIDS PROGRAM

A. Surveillance

Reporting in Florida

AIDS surveillance involves the identification and reporting of cases of AIDS. The purpose of surveillance is to 1) monitor trends in morbidity and mortality; 2) identify rapidly and precisely the risk of AIDS for different groups; and 3) develop more precise descriptive epidemiologic and clinical information about AIDS cases. The goal is ultimately to understand the occurrence and distribution of the disease for the purpose of controlling its spread.

Cases of AIDS in Florida have been reported to the CDC since 1981; it was not until 1983, however, that a formal program for surveillance was established in the state with the first year of a three year cooperative agreement with the CDC. At that time AIDS was made a reportable disease under the direction of the State Health Officer. All practicing physicians in the state were notified and mailed a copy of the case definition and requested to report cases of AIDS meeting this definition. Notification of the 1985 revision of the definition was carried out as well.

AIDS surveillance in Florida was initially conducted by a Federal Public Health Advisor assigned by the CDC to identify and report cases. In 1984, a state employee was hired to help with the surveillance effort. Both positions were based in Miami where the majority of cases were occurring. The original approach to surveillance was a personal commitment on the part of these individuals to establish contact with physicians, hospitals, infection control practitioners, and medical examiners throughout the state. Case information was then obtained by mail, over the phone, or by routine visits to selected hospitals and county public health units (CPHU). The surveillance team

would then collect or complete case reports, assign state numbers to the cases, and forward the reports to the CDC.

Prior to 1985, the majority of case reports were completed by the surveillance team members. As the number of AIDS cases began to increase, especially during 1985, CPHU personnel were encouraged to collect or complete forms when cases were reported. At the same time the state office began to distribute the revised AIDS case report form (CDC 50.42 - Rev. 3-85) to physicians and CPHU personnel statewide (see Appendix E). County public health units have now assumed primary responsibility for AIDS surveillance work.

By 1986, written guidelines for conducting AIDS surveillance were distributed to all CPHU personnel. These guidelines have been updated and expanded and are incorporated into a department manual (HRSM 150-30). Also, in 1986, specific individuals in each CPHU were designated to conduct AIDS surveillance in their respective counties. Follow-up investigations for selected cases are carried out by these individuals as well.

All completed case report forms are now sent directly to the state office in Tallahassee from the CPHUs, where the computerized registry is maintained. All cases are reviewed for completeness and accuracy, checked against the registry for duplicates, assigned a state identification number, and entered on the computer. Approximately twice a month, data is forwarded to the CDC electronically. Patient names are deleted in the process. Extensive measures have been taken, both at the local and state level, to protect the confidentiality of sensitive case data. All files are kept secure under lock and key with limited access.

Currently, there are five state positions responsible for AIDS surveillance. Two professional positions are located in Tallahassee, where overall direction for the program is maintained. Two professional positions and one clerical position are

based in Dade County. To maintain and expand the present system of reporting and follow-up, additional state positions have been requested with the new surveillance proposal recently submitted to the CDC.

In June 1986, new state legislation was developed which specifies reporting of AIDS and AIDS-Related Complex (ARC) as defined by the CDC, replacing the existing statute. With respect to reporting in Florida, however, no immediate changes will occur. Physicians will be required to report cases of AIDS, as before, but ARC reporting will not be mandated on a statewide level at this time. Certain locales may be asked to report HIV associated disease other than AIDS as part of the 1986-87 cooperative agreement which was recently established for the surveillance unit of the Florida AIDS program. It is hoped that this effort will help determine the actual amount of infection in a population which may be representative of other areas in Florida.

B. Counseling and Testing

Testing and counseling services were initiated at 16 CPHUs in June, 1985, funded by a cooperative agreement with the Centers for Disease Control (CDC) for over $967,000. The primary purpose of the "alternate testing" sites was to provide an opportunity for high risk persons to be tested for the HIV antibody rather than go to blood banks to receive this information. The sites were designed to help keep the blood supply free from contamination by HIV. Counseling for risk behavior reduction was also recognized as an important component in the control of HIV transmission.

Extensive efforts were made to reach out to the homosexual community to encourage homosexuals or bisexuals to be informed of their infection status and take appropriate health care precautions. Of the 12,000 persons that have been tested and counseled at the anonymous sites, 45% noted homosexuality as a risk factor.

The clinics have become an accepted service to provide confidential and accurate information on HIV testing and AIDS, as well as serve as a referral source for medical care and psychological support.

Intravenous drug abusers and heterosexual contacts are a major concern in the spread of HIV. Increased efforts are underway to provide focused education to these groups and counseling on altering behavior and attitudes. Over 61% of the clients at the anonymous sites report sexual contact with a high risk sex partner and 19% report IV drug use as a risk factor. Although the ratio of men to women accessing the clinics has remained constant (4:1), an increase in couples wanting to know their infection status before they develop a relationship has been noted in the clinics.

HIV seropositivity is not a reportable condition in the state of Florida, nor is it a required screening procedure in any place other than the United States Armed Services and for blood bank donors. For these reasons, all tests are voluntarily done on individuals who are at a perceived risk for acquiring HIV. The table below is a summary of data from the anonymous clinics from June 1985 to November 1986. This data indicates that persons at risk for HIV infection are aware of transmission factors and that they are accessing the clinics. Although this is the original purpose of the clinics, the focus for the testing and counseling program now is to identify and educate persons who may not be aware that they are at risk for HIV infection and offer testing and counseling services to them and their contacts.

Table 1. HIV antibody prevalence, by sex and risk status, HRS Testing/Counseling clinics, June 1985 - December 1986 - Florida

	Number Positive/Number Tested (% Positive)		
	Total	Male	Female
High Risk	1903/8853(21%)	1796/7556(24%)	134/1297(10%)
Low Risk	180/2404(7%)	129/1511(9%)	51/893(6%)
Unknown	169/840(20%)	150/661(23%)	19/179(11%)
Total	2252/12,509(19%)	9728/2075(21%)	204/2369(9%)

The Centers for Disease Control (CDC) awarded a cooperative agreement to the HRS AIDS Program for $672,281 for September 1986 through August 1987, to conduct testing and counseling services. Testing on an anonymous basis will continue in the 16 original CPHUs, as well as adding three additional sites in Brevard, Volusia and Columbia Counties.

All clients at maternity, family planning and sexually transmissible disease clinics will be interviewed as to their risk status for contacting HIV. Those persons found at risk will be offered the HIV antibody tests and appropriate counseling on risk reduction. All testing will be voluntary with prior written consent and all test results will be strictly confidential. All personnel involved with counseling will receive training prior to implementation of the program in the three public health services.

Through the expansion of HIV testing and counseling into the three clinics, persons who may unknowingly be infected will be identified and offered assistance. Many of the clients are followed on a regular basis in the clinics, therefore, better understanding of the progression of HIV infection will be available, as well as more timely medical care, especially prenatal and new born care. Outreach and education into the heterosexual and IV drug using communitees will also be increased through client contact referrals.

The testing and counseling program will begin a pilot project in January, 1987, with the Drug and Alcohol Health Care Services,Inc., a drug rehabilitation program in Tampa. The project will involve interviews, testing and counseling of all clients at risk at the center during a six month period. In addition to the initial interviews, all clients will be evaluated as to signs and symptoms of AIDS or AIDS-Related-Complex during the intake history and physical. The information derived from the project will provide data on HIV infection rates among IV drug users; meaningful counseling techniques on risk reduction; and progression of symptomatology among seropositive IV drug users.

C. Information and Education

In February, 1985, the Centers for Disease Control (CDC) awarded a cooperative agreement to DHRS for Information and Education about AIDS. The cooperative agreement was renewed in February 1986, and consolidated with the Health Education/Risk Reduction award in September 1986. The purpose of the project is to increase knowledge and awareness about AIDS for members of high risk groups, health care professionals, and the general public.

Staff for the project include a program manager and administrative secretary in Tallahassee, and a program specialist in the Southeastern part of the state.

Accurate and timely information and education about AIDS for the general public is critical to prevent the spread of HIV infection and to offset misinformation. Efforts to provide current information to the general public have consisted of responding to requests for speakers for presentations and written materials and media requests for radio and television interviews. Flyers, pamphlets and posters have been disseminated statewide with encouragement to groups to distribute materials to their member-

ship. The statewide AIDS Hotline (1-800-FLA-AIDS) has provided callers with a personal response to general questions about AIDS, crisis counseling and referral services.

Activities directed toward individuals whose behavior places them at high risk for AIDS are designed to increase knowledge and to enable them to take action to prevent infection and reduce transmission of the virus. Contracts with community groups in Dade and Monroe Counties provide funding for education through presentations, literature distribution, and counseling and referral services.

Health care professionals need accurate and current information about AIDS and infection control practices which are followed for clients with HIV infection. The AIDS Program provides technical assistance, consultation and training for HRS personnel. Key persons in each district and county public health unit have been identified as the contact person for AIDS and HIV information. A copy of the HRS pamphlet 150-3, "Information and Procedural Guidelines for Providing Health and Social Services to Persons With AIDS," has been distributed statewide to hospitals, nursing homes, primary care centers, renal dialysis centers, and HRS Program staff. Flyers, pamphlets and posters have also been distributed to health care workers, primarily on a response-to-request basis.

A thirty minute video entitled "AIDS: Understanding the Challenge" was produced and distributed through the Office of Public Information (PI). Three hundred copies of this have been sent, primarily on a response-to-request basis, to health care facilities.

The 1986-87 General Revenue Appropriation for Information and Education provides funding for the AIDS Hotline, distribution of the HRS/PI videotape, printing of a variety of flyers and pam-

phlets, and development, reproduction and distribution of radio public service announcements in English, Spanish and Creole.

D. Health Education and Risk Reduction

The AIDS Program has been awarded a federal grant to conduct Health Education/Risk Reduction (HE/RR) activities for up to five years in Broward, Dade, Monroe and Palm Beach Counties, which collectively have reported 75% of the state's AIDS cases. In the absence of a vaccine and effective treatment, infection and disease control depends on information, education, and prevention campaigns.

With input and assistance from the community, HE/RR Project staff intend to develop health education strategies to reduce the occurrence of personal behaviors associated with HIV infection and AIDS. Systematic evaluation is essential: Interventions that can be documented as effective will be given the greatest attention. Project impact will be estimated through outcome assessment, evaluation of risk factors, and trend analysis of indicators/sentinel events correlated with HIV infection (e.g., sexually transmitted diseases, hepatitis B, etc.).

A self-administered questionnaire has been developed to assess knowledge, attitudes and behaviors concerning AIDS. It will be distributed to a large number of persons in high risk groups, as well as to targeted low risk groups, in the four-county area. Respondents will remain anonymous. Data analysis of this initial survey will help provide a basis for designing HE/RR strategies to meet community needs. Subsequent surveys during the five-year project will periodically attempt to determine if favorable changes have occurred with regard to reducing the chances of HIV transmission in similar groups.

Available HIV seroprevalence data will be collected and interpreted (e.g., alternate sites, prostitute studies, military

recruit screening, Belle Glade studies). Subsequent studies will be designed and conducted to determine HIV prevalence in groups at risk and the general population. Based on questionnaire survey and seroprevalence data, additional health education programs will be developed and implemented, including written and audiovisual materials on AIDS, prevention guidelines and community resources; activities aimed at increasing awareness of AIDS risk situations and providing support for prevention measures; and programs to counsel seropositives and assure referral of recent sex partners for testing and counseling, and counsel high risk seronegatives. Repeat studies will document changes in the understanding of AIDS risk factors and associated behaviors. Repeat serosurveys will monitor changes in prevalence of HIV antibody in groups at risk.

In the general population, surveys will be developed to measure AIDS related knowledge and attitudes. Specific, measurable educational objectives will be derived from the findings. For example, if a decline in blood donations appears to be attributable to misconceptions ("you can get AIDS from donating blood"), a "speaker's bureau" could be established at local chapters of the American Red Cross by HE/RR staff. The key indicator here would be a resultant increase in blood donations.

E. Belle Glade Study

Through September 15, 1986, 76 adult and three pediatric AIDS cases were reported from western Palm Beach County (Belle Glade, Pahokee, and South Bay). The high cumulative incidence in this area -- comparable to that of San Francisco and Manhattan -- is mainly the effect of high rates of AIDS among IV drug abusers and their sexual partners, as shown by ongoing surveillance. Among the adult cases, 13 (17%) had no identifiable risk factor (NIR) for AIDS, an NIR rate which significantly exceeds that in the balance of the state (5%); however, 10 of the 13 adult cases had died before comprehensive information on risk factors could

be obtained. Based on national surveillance data, it is suggested that many of those cases initially reported as NIR would have been reclassified into a risk group had they been available for follow-up.

Of the total 79 AIDS cases from Western Palm Beach, the majority (N=62) were residents of Belle Glade at the time of diagnosis. Cases were concentrated in the central part of town. To evaluate the occurrence of infections due to the AIDS virus (human immunodeficiency virus (HIV)) in Belle Glade, the AIDS Program (HRS) and CDC conducted a community-wide study of HIV seroprevalence and risk factors for infection from February through September 1986. The sampling scheme was designed so as to randomly select 75% of the participants from the central part of town and 25% from the surrounding neighborhoods.

Preliminary findings indicate that 30 (3.1%) of 959 study participants tested had antibodies to HIV by both enzyme immunoassay (EIA) and Western-blot methods. Among the first 736 persons (including 26 with HIV antibodies) for whom data entry has been completed, a high prevalence of HIV infection (8.9% or 14/157) was found among both males and females ages 18-29 years, with generally declining rates in older age groups through 59 years of age. No evidence of HIV infection was found in 94 adults over 60 years of age nor in 121 children ages 2-10 years. The proportion of seropositive adults ages 18-49 years in the study (88%) was similar to the proportion of AIDS cases in the United States in that age group (90%). HIV antibodies were detected in 26 (4.2%) of 616 black participants, including 13 (8.7%) of 150 who were born in Haiti. None of 42 Hispanic and none of 60 white-non-Hispanic participants was seropositive. There was no evidence of household transmission of HIV infection to non-sexual household contacts. Testing of serologic specimens in the study for antibody to five mosquito-borne arboviruses indicated that HIV infection was not associated with arbovirus in-

fection, a finding consistent with that of the CDC/HRS Belle Glade pilot study in 1985.

In Belle Glade, HIV transmission appears to be the result predominantly of sexual contact and the sharing of contaminated needles for intravenous drug use. The AIDS surveillance data, age-specific rates of HIV infection, arbovirus studies, and other epidemiologic evidence do not suggest that mosquitoes are playing a role in transmission. Programs to promote the reduction of behaviors associated with the spread of HIV are being planned by the HE/RR AIDS Program currently. In view of the high cumulative incidence of AIDS in this area, and the high prevalence of HIV infection, a proposal for a fully funded risk-reduction project specific to Belle Glade community needs is also being prepared by AIDS Program and Palm Beach County Public Health Unit staff, with the encouragement of CDC advisors. Forthcoming analysis of the Belle Glade study data for risk factors will provide a further basis for developing intervention strategies.

A preliminary report on the Belle Glade Study was published recently (MMWR, October 3, 1986, Vol. 35, No. 39, pp. 609-612). A copy of the article is included in Appendix F.

F. Prostitute Study

History

Since 1980, the number of AIDS cases in Florida has increased dramatically. The state now ranks third in the nation behind New York and California in both cases and deaths from AIDS. As of December 2, 1986, Florida had a total of 1,918 Centers for Disease Control (CDC) confirmed cases of AIDS. A significant portion of the cases in women (35%) attribute their risk to intravenous drug use. Few admit to being prostitutes, but there are indications that at least some of these women supported their drug habit through prostitution.

A seroprevalence study conducted by the University of Miami showed a 40% positivity rate in 25 prostitutes tested at an AIDS screening clinic. Eight of the 10 (80%) used IV drugs. It is very difficult to speculate how effectively female prostitutes, once infected might transmit HIV through sexual contact. Still, it is generally believed that prostitutes have the potential for widespread transmission of this virus to the population at large.

In June, 1985, HRS applied for funds to study the seroprevalence of HIV infection in prostitutes from Miami. Notice of a CDC Cooperative Agreement for the study of transmission of HIV among prostitutes was received on October 7, 1985. The total award for the YEAR 01 budget was $92,999.

Project staff were recruited and employed early in January 1986, in anticipation of project implementation later that month. However, a series of delays related to approval of the human subjects aspect of this particular project by HRS and CDC Institutional Review Boards (IRB) and the Federal Office for Protection from Research Risks (OPRR) postponed the official release of funds.

Between January and June, project staff established liaison and essential communication linkages with collaborating agencies, tested protocols, developed working relationships with key individuals involved in various aspects of the project and improved operational policies and procedures as appropriate. The most significant achievement was completion of a pilot study that screened 438 prostitutes for antibodies to HIV, Syphilis and Gonorrhea.

Over one-half (52%) of the pilot study group was black and over two-thirds (68%) were between the ages of 20 and 29. Most (87%) identified the USA as their country of birth with 8% from Caribbean Islands and 2% from South America. Seventy-six (17%) were seropositive for HIV by EIA. Of these, 55 were also tested

by Western Blot with 82% found positive. Eighty-nine (22%) of the 404 tested for syphilis antibodies were reactive in VDRL tests and N. gonorrhea was isolated from 40 (12%) of the 356 participants tested.

The formal project was initiated on July 17, 1986. On September 30, 1986, HRS received notice of a YEAR 02 award of $113,093 for continuation of the project through September 26, 1987.

Study Design

The goal of this project is to determine the prevalence of HIV infection in a defined population of prostitutes from Miami, and provide for the monitoring of selected individuals to detect changes in health status over time.

Women participating in this study are currently being recruited for enrollment from the Dade County Women's Detention Center and the Dade CPHU Sexually Transmitted Disease (STD) Clinics. All prostitutes recruited are processed according to the approved CDC project protocol. Prospective participants are initially presented with a brief description of the project and its purpose, then asked to provide informed consent at enrollment. Upon agreeing to participate, each woman is interviewed, examined, provided pre-test counseling information on AIDS transmission and finally, scheduled for post-test counseling and review of test results. Confidentiality is assured during the entire process via the use of assigned patient numbers for all specimens, records, etc.

The prevalence study will continue through YEAR 02 with the expectation of obtaining appropriate serum samples from approximately 2,200 individual prostitutes.

Data Collection

Information on medical, pregnancy, drug use, sexual history and activities, as well as clinical findings from a brief physical examination and serologic tests for HIV, syphillis and hepatitis is being computerized and analyzed by DHRS and the Centers for Disease Control (CDC). Test results are provided to participants along with post-test counseling by scheduled appointment at the University of Miami.

Between initiation of the project on June 17, 1986, and November 15, 1986, staff have recruited and processed 166 participants according to the CDC approved protocol. About half (45%) were black, the majority (96%) were between the ages of 20 and 39. More detailed findings will be released jointly by the DHRS and the CDC in the future.

Future

Staff changes and the initiation of new recruitment procedures at both the Women's Detention Center and Dade CPHU STD clinic should increase the recruitment rate. This mid-course adjustment will at least double the number of participants enlisted in the project. The CDC has scheduled a meeting for all project investigators in Atlanta on December 12 and 13, 1986, to discuss progress to date and presentation of project findings at the Third International Conference on AIDS in Washington D.C., June 1-5, 1987.

G. County Patient Care Services

Dade County Network

The 1986 Florida Legislature appropriated $4.2 million of general revenue funds to establish a Dade County patient care network for persons with AIDS and persons with AIDS Related Com-

plex (ARC) during the 1986-87 state fiscal year. The objective of the network is to provide a continuum of quality health care services at a minimum cost per patient.

Jackson Memorial Regional Medical Center is the primary network contractor with the Department of Health and Rehabilitative Services. Jackson Memorial will provide a core of inpatient and outpatient network services and purchase additional services from the following:

1. Health Crises Network (Community Support Group).
2. Visiting Nurses Association.
3. Residential Care Facilities.
4. Dade County Human Resources Health Center (Nursing Home).
5. Physicians through the University of Miami.
6. Alcohol, Drug Abuse, and Mental Health Program of the Department of Health and Rehabilitative Services.
7. Hospice, Inc., of Dade County.

Specific services to be provided to patients of the network are:

1. Hospital inpatient services.
2. Non-emergency hospital outpatient services.
3. Emergency services.
4. Physician services.
5. Home health services.
6. Home health aid services.
7. Home health high technological services.
8. Homemaker services.
9. Dental services.
10. Hospice care.

11. Nursing home care, including skilled nursing care.
12. Residential care for adults and children.
13. Psychosocial counseling services.
14. Social work services.
15. Transportation.
16. Educational services.
17. Prescribed drugs; IV solutions; anti-biotic therapy.
18. Mental health services.
19. Substance abuse services.
20. Medical equipment.

Services provided by the network are at the medicaid rate unless otherwise approved by the Department of Health and Rehabilitative Services. Jackson Memorial will provide monthly reports to the department including cost per unit of service, the numbers of units of service provided in several categories, and the total cost per patient. The department will make a special report to the Legislature on the project in April 1987.

The District 11 State Health Office provides a departmental contract manager for the project. State Health Office staff provide direction and technical support to the contract manager.

Dade County Patient Care Network services are also supported with Robert Wood Johnson Foundation funds and Health Resources and Services Administration funds described later in this section.

Other County Networks

The 1986 Florida Legislature also appropriated $700,000 of general revenue funds for AIDS patient care networks in counties

other than Dade. The funds were distributed by the State Health Office as follows:

COUNTY	ALLOCATION
Broward	$275,000
Palm Beach	$200,000
Monroe	$ 75,000
Orange	$ 75,000
Hillsborough	$ 75,000
TOTAL:	$700,000

The allocations were made utilizing Florida AIDS Case Registry data as of July 1, 1986. The county cumulative case count in the registry was used as an index of prevalence of the disease and, therefore, an index of need for patient care services in each county.

The objective of the developing networks in each of the five counties is the same as the more comprehensive network of services in Dade County. The Dade network will serve as a model for fully establishing networks in these counties over a two to five year period.

Robert Wood Johnson Foundation
AIDS Health Services Program

The Robert Wood Johnson Foundation has awarded $17.2 million to ten eligible metropolitan areas with the largest AIDS case loads. The awards address the need for more specialized and less costly health services for AIDS/ARC patients.

Three South Florida cities will receive funding over four years: Miami ($1.2 million); Fort Lauderdale ($1.6 million); and West Palm Beach ($1.6 million). The Program will support the de-

velopment of city-wide AIDS health services projects providing specialized care from the hospital to the home. These projects will emphasize in-home and community-based care.

The aim of the Program is to help bring many needed medical and supportive services to AIDS patients, demonstrate that care can be provided at reduced costs, and help relieve the burden which caring for AIDS patients has placed on many urban hospitals in the absence of alternative, community-based care. One major goal of the Program is to encourage health professionals and health care institutions, public agencies, voluntary organizations and others involved in the provision of services to AIDS patients to work together in support of coordinated, effective systems of care.

AIDS Service Demonstration Project
Health Resources and Services Administration

Effective October 1, 1986, the Department of Health and Human Services, Health Resources and Services Administration (HRSA), awarded the Public Health Trust of Dade County Florida, Jackson Memorial Hospital, $1,360,000.00 to develop an AIDS Service Demonstration Project. These funds will be allocated over a three year period of time with an annual appropriation of about $450,000.00.

Miami is one of four standard metropolitan statistical areas (SMSA) in the United States that reports the highest incidence of AIDS. The AIDS Service Demonstration Program is intended to ad-

dress the service delivery aspects of the AIDS problem. Specifically, it is intended to demonstrate the most cost effective ways of providing treatment and support for patients with AIDS and AIDS related disorders in the four SMSAs with the highest concentration of persons with AIDS by emphasizing the development of comprehensive ambulatory and community-based systems of care.

There is a need for more innovative, compassionate, alternative approaches to managing patients with AIDS, which emphasize service delivery in outpatient and community settings and reduce the amount of time spent in hospital settings. The Service demonstration projects to be carried out under section 301 of the Public Health Service Act are intended to serve as models for other communities with significant numbers of persons with AIDS.

Within the Dade County area the HRSA funds will be used to build a framework for the network of services which will be provided to this patient population. Funding will support such items as an advisory committee, community psychosocial services, hot-line services, patient advocates, nursing personnel and an administrative component. It is through the administrative component that a comprehensive centralized registry of patients and services will be provided.

IV. FUTURE OF THE TASK FORCE

AIDS is a major public health problem for Florida and the nation. The cumulative number of cases continue to increase rapidly; likewise, problems associated with the epidemic continue to grow rapidly. Consequently, the Governor's Task Force on AIDS recommends the following:

1. That the existing Task Force on AIDS continue as a scientific/ medical advisory group to the Department of Health and Rehabilitative Services, the Governor and the Legislature.

2. That membership of the Task Force on AIDS be expanded to include an infection control practitioner and the medical director of a blood bank.

3. That non-medical/non-scientific issues related to AIDS be referred to the Department of Health and Rehabilitative Services for appropriate actions by the Statewide Human Rights Advocacy Committee, the statewide Health Planning Council, special community-based study groups, etc.

The Governor's Task Force on AIDS will address the following important issues in the near future:

1. Contact tracing with appropriate counseling services.
2. Non-complaint carriers such as prostitutes.
3. State role in treatment therapies.
4. Pediatric AIDS and maternity testing.
5. IV drug users and AIDS.
6. Impact of AIDS on the family.
7. State role in AIDS research.
8. A state AIDS research network.
9. Specific AIDS research needed in Florida.
10. Specific recommendations for AIDS education and counseling services.

11. Blood bank concerns.
12. An AIDS policy for management of departmental clients.
13. Advisability of mandatory reporting of positive HIV antibody test results.
14. Advisability of mandating premarital HIV antibody testing.
15. Advisability of mandating the reporting of ARC cases.

APPENDIX A

AN OVERVIEW OF SPECIFIC STATE FUNDING FOR AIDS PROGRAMS AND ACTIVITIES

by

THE INTERGOVERNMENTAL HEALTH POLICY PROJECT

at

THE GEORGE WASHINGTON UNIVERSITY

July 23, 1986

STATE FUNDING FOR AIDS PROGRAMS AND ACTIVITIES

	FY 83-84	FY 84-85	FY 85-86	FY 86-87	Total
ALABAMA			98,605		98,605
ALASKA			17,500	48,000	65,500
ARIZONA			30,000	400,000	430,000
ARKANSAS			3/4 FTE[1]		30,000[2]
CALIFORNIA	3,400,000	4,094,000	18,800,000	29,384,751	55,678,751
COLORADO	2FTEs[1]	3FTEs[1]	267,000	203,000[3]	670,000
CONNECTICUT			140,000	140,000	280,000
DELAWARE				33,000	33,000
FLORIDA	25,000	32,000	1,821,000	6,153,000	8,031,000
GEORGIA				406,000	406,000
HAWAII				270,000	270,000
IDAHO					0,000
ILLINOIS				2,352,000	2,352,000
INDIANA			220,000		220,000
IOWA					0,000
KANSAS				40,000	40,000
KENTUCKY				90,000	90,000
LOUISIANA					0,000
MAINE				90,850	90,850
MARYLAND				625,123	625,123
MASSACHUSETTS		1,500,000	1,800,000	4,073,514	7,373,514
MICHIGAN			325,000	1,215,000	1,540,000
MINNESOTA			397,000	900,000	1,297,000
MISSISSIPPI			43,771		43,771
MISSOURI			1FTE[1]	156,261	196,261
MONTANA					0,000
NEBRASKA					0,000
NEVADA					0,000
NEW HAMPSHIRE			55,000	55,000	110,000
NEW JERSEY	530,000	920,000	2,200,000	3,800,000	7,450,000
NEW MEXICO			100,000	100,000	200,000
NEW YORK	5,250,000	2,800,000	4,900,000	10,500,000	23,450,000
NORTH CAROLINA			40,000	40,000	80,000
NORTH DAKOTA		5,000	5,000		10,000
OHIO			50,000	70,000	120,000
OKLAHOMA					0,000
OREGON			200,000	200,000	400,000
PENNSYLVANIA				150,000	150,000
RHODE ISLAND			60,000		60,000
SOUTH CAROLINA			171,500	171,500	343,000
SOUTH DAKOTA			15,000	15,000	30,000
TENNESSEE					0,000
TEXAS		2FTEs[1]	2FTEs[1]		160,000
UTAH				85,000	85,000
VERMONT					0,000
VIRGINIA			175,000	543,000	718,000
WASHINGTON			225,000	625,000	850,000
WEST VIRGINIA				50,000	50,000
WISCONSIN			176,400	331,700	508,100
WYOMING					0,000
D.C.		42,500	889,000	1,859,500	2,791,000
TOTAL	$9,285,000	$9,593,500	$33,461,776	$65,046,199	$117,426,475

[1] One FTE = approximately $40,000

[2] Department has requested $500,000 for FY 86-87. Legislature does not convene until January 1987.

[3] Additional supplemental request expected.

Intergovernmental Health Policy Project
Suite 616, Joseph Henry Building
2100 Pennsylvania Avenue, N.W.
Washington, DC 20037

HIGHLIGHTS OF STATE AIDS EXPENDITURES

- Since July 1, 1983, state governments have spent or have committed to spend a total of $117.3 million for AIDS-related programs and activities. (This figure is exclusive of the millions of dollars states are contributing for direct inpatient hospital care and long-term care services under Medicaid. It also does not include the millions contributed for patient care and support services by several county and municipal governments throughout the nation.)

- State funding commitments have shown marked increases over the past three fiscal years -- $9.6 million in FY 84-85, $33 million in FY 85-86, and proposed spending of about $65 million in FY 86-87 (which began July 1 of this year for most states).

- Of the total $117.3 million spent or currently obligated, the state of California accounts for almost 48 percent or $55.6 million. New York state is the second largest contributor, with $23.5 million or 20 percent. Florida is third, with $8 million, accounting for about 7 percent. New Jersey and Massachusetts account for about 6.5 percent each with spending of $7.5 million and $7.4 million respectively.

- Hence, California and New York account for two of every three dollars spent or committed by states for AIDS programs. Eighty-five percent of all state funding to date has been concentrated in only five states.

- In addition to California, New York, Florida, New Jersey and Massachusetts, Michigan, Minnesota and the District of Columbia have each spent or obligated more than one million dollars for AIDS programs. Four other states account for between $500,000 to $1 million.

- Of the $117.3 million total, $110.2 million or 94% has come through specific line item appropriations from 21 state legislatures and the District of Columbia.

- Most of the balance of state monies -- $5.2 million or 4%, -- came from redirecting or reallocating existing resources within state health department budgets, frequently within the offices of communicable or sexually-transmitted diseases. (In many instances, two or three full-time equivalents (FTE's) or a percentage of an FTE were shifted to these new responsibilities).

- For FY 87, twenty-one state legislatures plus the District of Columbia appropriated a total of $62 million compared with a total of $30 million appropriated by only 10 legislatures and D.C. in FY 86.

- Additional specific appropriations may occur early in 1987, as five legislatures that did not convene in 1986 meet early next year.

ANALYSIS OF FIVE STATES

CALIFORNIA

California's $55.6 million contribution ($29 million of which is available during the 1986-87 fiscal year) eclipses all other states' expenditures for AIDS-related programs. In fact, California accounts for almost one of every two state dollars spent or obligated for AIDS programs.

California leads the way with regard to total state dollars devoted to AIDS research with $21 million already spent or committed. During FY 85-86 more than sixty research grants were awarded by the state covering the following areas: virology, infectious disease, clinical epidemology, clinical trials and descriptions of new clinical entities. A large part of the University of California's efforts has been on the development of clinical trial centers. These centers are responsible for conducting innovative testing of new antiviral, antibacterial and antifungal chemotherapeutic agents and prospective vaccines.

At the present time, four university laboratories (University of California at San Francisco, University of California at Davis, University of California at Los Angeles, and the University of Southern California), and the California Department of Health Services are at various stages of setting up viral culture capabilities. Since the endpoint of antiviral drug intervention is inhibition and/or eradication of the virus, the presence of viral culture capability is necessary for both monitoring drug therapy and for staging individuals to properly qualify them for drug trials. State and federal support is being given to foster the development and increased availability of these virology and immunology services, and the state laboratory is expanding its capacity.

The California AIDS Task Force is supporting the establishment of a career development program for new AIDS investigators. The program would fund from ten to fifty career development awards annually, at $50,000 per investigator. The monies would go for salaries to provide the investigators with protected time to conduct AIDS-related research.

The second highest priority in state funding has been community education. To date, about $6.6 million have gone for preventive education and outreach efforts aimed at high-risk population groups, the general population and occupation target groups such as health care workers, public safety personnel and teachers and school administrators.

Funding for these activities has increased from an initial $1 million in FY 85 to $5.1 million in FY 86; and $7.1 million has been budgeted for FY 87.

Funds also support an AIDS Information Center that can supply information on current trends in AIDS research to assist in state program development and the development of educational materials such as videos and public service announcements, with wide applicability to the public.

Expanded funds for community education purposes in FY 87 are expected to focus on the particular educational needs of IV drug users and HTLV III negative individuals in high-risk groups, as well as on the development of a statewide educational campaign for the general public.

California is one of the few states that has dedicated state monies for the development and maintenance of alternative test sites, i.e., alternative locations to blood banks where those who are at increased risk for infection by the AIDS virus can discover whether or not they have been exposed to antibodies to the HTLV III virus. The state has authorized $5 million to be applied for the continuation of alternative sites once federal funds have been exhausted. (According to the California Department of Health Services, about 32,000 people had been tested at one of the ATS, with about 20 percent of the completed tests positive for antibody to the AIDS virus).

A relatively small amount of state funds have been spent for general surveillance of the AIDS virus infection in the population. This activity has consisted mostly of collecting data on AIDS patients. However, since clinical AIDS represents only a small percentage of all those infected by the HTLV III virus, the department intends undertake a more proactive and comprehensive surveillance effort. Counties are expected to provide additional support to assist the state in AIDS surveillance and control activities. The department also proposes to monitor the prevalence of infection in blood donors, in sexually transmitted disease clinics and in drug abuse treatment clinics. Moreover, it is proposing to develop programs to identify and test women who are at increased risk of exposure to the AIDS virus and to provide information to them regarding risks to their fetus if they become pregnant.

So far, California is the only state that has placed an emphasis on addressing the mental health aspects of AIDS. The legislature appropriated $600,000 in FY 86 with the funds to be divided among three key programs: $300,000 for a media campaign emphasizing the relationship between stress and the immune system, the use of support groups, and means of dealing with grief; $200,000 for education and training programs for mental health personnel; and $100,000 to study AIDS-related mental health needs. Future mental health needs will be delineated by the current needs assessment survey, which should be completed by the spring of 1987, and unmet needs will be addressed as discovered.

The legislature recently proposed increasing the $26.7 million base budget as recommended by the governor for AIDS programs by $22.4 million in FY 87, but the governor vetoed all but $2.1 million of the proposed augmentation. The $2.1 million is to go for two specific activities: (1) $600,000 for six pilot projects for the treatment and counseling of underserved minority populations with AIDS; and (2) $1.5 million for the first phase of a $10 million project to add two floors to San Francisco General Hospital to establish an interdisciplinary AIDS research center.

NEW YORK

New York State has the highest incidence of AIDS in the country--more than 6,000 diagnosed cases, or about 33 percent of the total cases nationwide. Between 1983 and the end of 1985, the AIDS Institute -- created by state legislation with responsibility for meeting the needs presented by the epidemic -- distributed about $12.5 million for research and educational programs. The Institute awarded forty-three research grants totalling $7.8 million. So far, the state's funds have supported research into such epidemiological issues as localized clusters of the disease, drug use habits and the significance of "risk groups" and the infections that strike them. Moreover, research monies have gone for the support of a whole range of clinical investigations such as potential risk factors associated with AIDS cases among hemophiliacs and the development of a serological test for pneumocystis carinii -- a frequently detected opportunistic infection in AIDS victims -- to provide early warnings of impending illness, thus allowing therapeutic intervention. The state is also supporting epidemiologic investigations of AIDS within its prison system.

The next largest share of New York's funds has gone for the development of the Community Services Program (CSP). The CSP is a referral system for individuals with AIDS and also provides counseling to those who have tested positive for the antibody or who are seeking advice. The CSP consists of seven regional AIDS task forces, each comprised of individuals from the community representing public agencies, the medical profession and not-for-profit community organizations. Each task force is responsible for operating a hotline manned by trained counselors and for conducting educational programs.

Another early priority was to maintain and enhance the HTLV III Antibody Testing and Counseling Program. The state supports the placement of regional counselors at alternate test sites to provide counseling, information and referral, and health education. These counselors are also charged with maintaining a resource/referral network consisting of local health, mental health and crisis intervention organizations so that sero-positive individuals can be linked to appropriate follow-up care providers.

In response to the increased demand for more resources, New York's governor and state legislature agreed to a $9.5 million AIDS expenditure plan for FY 87, representing a 110 percent increase over the FY 86 funding level. The increase will permit the AIDS Institute to continue current programs at a level that can more adequately meet rapidly rising needs while at the same time to embark on initiatives targeted on identified service and educational gaps for high risk groups, particularly I.V. drug users. The state projects that that rate of increase in AIDS cases among I.V. drug users will be greater than any other risk group in the state. Moreover, I.V. drug users who contract AIDS represent a significant fiscal consequence to the state, as very few of them are covered under private health insurance and many are on public assistance.

To address the growing problems presented by this high risk group the state proposes to spend approximately $2 million on the following activities:

A sub-allocation of funding to the research arm of the State Division of Substance Abuse Services to establish storefront AIDS

education centers within high drug-use communities in New York City; to maintain mobile vans and street-worker teams to provide outreach services; and to conduct follow-up research on the effects of education, counseling and HTLV III testing on drug users.

Creation of HTLV III Counseling and Testing Centers in New York City in high drug abuse areas.

The establishment of three additional task forces to serve the Bronx, Brooklyn and Queens with geographically proximate and culturally appropriate services.

The intensification of a targeted educational and informational campaign aimed at current and potential drug abusers and their sexual partners.

The strengthening of the AIDS Institute's in-house coordination of programs and services for the I.V. drug abusing population.

New York's other initiative consists of the designation of certain hospitals to serve as centers for the care of AIDS patients. The objective is to increase access by those with AIDS to essential health care and community resources and to address patient needs not being served by the extisting health care and social services delivery systems. It is also designed to either provide for or arrange a full continuum of services that may be required by an AIDS patient, including inpatient services, housing, home health and hospice services, if appropriate. Under the plan, designated AIDS Centers will qualify for a higher reimbursement rate for providing or brokering a broad range of comprehensive services.

An AIDS Intervention Management System (AIMS) will be implemented to monitor and evaluate the quality and appropriateness of care of patients provided by the AIDS Centers. The AIMS program will serve to facilitate access to services, control costs, identify unmet needs, reduce inappropriate utilization, and develop data for further planning requirements.

FLORIDA

Funding for AIDS activities in Florida increased about 240 percent--from $1.8 million in FY 85-86 to $6.2 million during the current fiscal year. Two-thirds of the state's funds in FY 85-86 were devoted to support specific renovations for the creation of an AIDS patient care wing at Jackson Memorial Hospital in Dade County (Miami), where 46 percent of AIDS cases in the state have been identified. The remaining third was divided among such activities as general surveillance, testing and counseling, and public education and outreach.

For FY 86-87, the preponderance of state monies will be dedicated for the support of the care and treatment of AIDS patients. More than $4 million will go to Jackson Memorial Regional Medical Center for the development of an AIDS patient care network in Dade County. Jackson Memorial is expected to provide approximately $2 million in direct inpatient and outpatient services and to subcontract another $2 million for the provision of essential home health, hospice, psychosocial and transportation services. The Legislative Appropriations Act specifically requires that all services provided for AIDS patients that are supported by state appropriations shall be reimbursed at the state Medicaid rate. The legislature intends the Jackson Memorial AIDS Network to serve as a model for other counties. Moreover, the legislature has mandated an accountability report by April 7, 1987, of all dollars expended on AIDS patients by the FY 86-87 appropriations. The report must include at a minimum: the number of clients served; the type and cost of all services provided for each client; the specific identification of each provider funded along with the number of clients; the number of services per client; the total amount funded from the state; and the rate per day for each service provided.

In addition to the $4.2 million that will flow to Dade County, the department intends to divide about $700,00 for AIDS patient care among the five other counties with the highest incidences of AIDS.

It also plans to divide $450,00 equally among three university teaching hospital laboratories for the purpose of upgrading their facilities to so-called P-3 status. This will enable the laboratories to conduct viral isolation studies, thus placing them in a position to attract federal research money.

The department's Health Program Office will receive about $189,000 in new funds for statewide information and educational services. Part of the total -- $75,000 -- will go to preserving the statewide AIDS hotline, which was previously supported by federal funds. An additional $614,000 was appropriated to continue activities begun during FY 85-86 such as: administration of the state's AIDS program office; support for five district AIDS coordinators; and provision of state laboratory services.

NEW JERSEY

New Jersey -- with the fourth highest incidence of AIDS cases -- has contributed or obligated about $7.5 million in state funds to AIDS-related activities. During FY 85-86 the Health Department received a $2 million supplemental appropriation to help bolster its surveillance and epidemiologic investigations of AIDS cases. About one-fourth of these funds were used to provide appropriate laboratory support to clinicians and health care providers treating AIDS patients and their families, as well as to blood banks and blood products processing centers. Education materials and disease prevention programs were developed and made available to individuals at risk and to the general public. Personnel were hired to disseminate risk reduction information in the drug treatment facilities and in their surrounding areas, and minimal social support services were enhanced slightly by the hiring of a second social worker.

Approximately $350,000 was allocated for contracts with agencies and health care facilities to provide ambulatory care services to AIDS patients after discharge from the hospital. Another $265,000 was targeted on ambulatory care, counseling, education and testing of drug abusers.

Recently, an additional $1.6 million for AIDS activities was approved by the legislature and agreed to by the governor. The new funds will be used in FY 86-87 principally for the following purposes:

Post-hospitalization care, rehabilitative services and other community-based support services for AIDS patients and their families;

Post-hospitalization care and services for children with AIDS and children of parents with AIDS, which will include placement in foster homes, provision of rehabilitative services and educational programs for homebound children; and

Counseling services to individuals who are reactive to HTLV III antibody, especially blood donors.

MASSACHUSETTS

During fiscal years 1984-85 and 1985-86, Massachusetts spent about $3.3 million in state funds in two major areas: AIDS research and an education and prevention campaign for high-risk groups and the general public.

For FY 1986-87 the legislature has increased the amount of funds available for AIDS programs to slightly more than $4 million. Research will remain a key priority, consuming about $1 million of the total. However, a large share of the increase is intended for the provision of a range of medical and support services for those stricken with the disease. More specifically, in response to projections that AIDS will increase dramatically among the drug-abusing population and the homeless, state resources are slated for aggressive education campaigns, certain specialized care and social services unique to their needs. For example, emphasis will be placed on the provision of specialized shelter services for the homeless following hospital discharge. For those unable to comply with shelter rules, the state intends to provide a comprehensive special shelter solely for patients with AIDS or AIDS-related conditions(ARC). This shelter will consist of a full range of medical and social service, including a guardianship program.

Moreover, the state proposes to establish, in conjunction with the Boston Department of Health and Hospitals, a coordinated, comprehensive ambulatory/-inpatient care unit which can serve the special medical needs of the homeless and drug abusers. The FY 86-87 Appropriations Act specifically requires the department to obligate at least $200,000 for new outpatient methadone maintenance programs.

The provision of a residential facility for children with AIDS whose families are unable to care for them and for whom no other placement is available is another state priority for FY 87. In addition, the Department of Public Health's Western Massachusetts Hospital will provide a multi-service residential care program, including skilled nursing services and chronic care, for AIDS patients, as a state-wide resource.

Finally, the state intends to expand both the availability and accessibility of home care services for people with AIDS living in the community. In conjunction with this expansion, it will develop specialized hospice services for individuals with AIDS who choose not to be hospitalized during the terminal phase of their illness.

ciated with arbovirus infection, suggesting that HTLV-III/LAV-infected persons were not more likely than persons without HTLV-III/LAV infection to have been exposed to mosquitoes. Thus, the hypothesis that arthropods have transmitted HTLV-III/LAV in Belle Glade is not supported by AIDS surveillance data, age-specific rates of HTLV-III/LAV infection, and the arbovirus serologic studies.

The available epidemiologic evidence suggests that HTLV-III/LAV infection in Belle Glade results predominantly from sexual transmission and the use of contaminated needles for injecting drugs intravenously. The U.S. Public Health Service has published guidelines to prevent sexual and drug-abuse-related transmission of HTLV-III/LAV (7). In this setting of a high cumulative rate of AIDS and a high prevalence of HTLV-III/LAV infection, programs to promote risk-reduction practices must be expanded and adopted. Additionally, voluntary serologic testing combined with health education and counseling should continue to be available to enhance reduction of HTLV-III/LAV transmission.

The ongoing analyses of the community-wide DHRS/CDC study should further clarify specific risk factors for HTLV-III/LAV infection in Belle Glade and provide a basis for additional public health recommendations for the prevention of infection with this virus.

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Arthropods have been hypothesized as a mode of HTLV-III/LAV transmission in Belle Glade (*4*). As a measure of exposure to different mosquito vectors and antibody prevalence, samples obtained during the serosurvey were tested by the serum dilution-plaque reduction neutralization method in the Division of Vector-Borne Viral Diseases, CDC, for antibodies to five arboviruses (Tensaw, Maguari, Keystone, Saint Louis encephalitis, and dengue-2) prevalent in South Florida or the Caribbean (Table 2). There was no significant difference in prevalence of antibodies to these arboviruses between HTLV-III/LAV-infected and -noninfected persons. The lack of association between detection of antibodies to HTLV-III/LAV and antibodies to these arboviruses extends the findings of an earlier pilot study that included these and four other arboviruses (Pahayokee, Shark River, Gumbo Limbo, and Mahogany Hammock) indigenous to South Florida (*5*).

Reported by M Roberts, RN, Glades General Hospital, R Young, MD, Glades Health Center, J Howell, MD, MPH, Palm Beach County Public Health Unit, M Wilder, MD, Acting State Epidemiologist, Florida Dept of Health and Rehabilitative Svcs; Division of Vector-Borne Viral Diseases, AIDS Program Office, Center for Infectious Diseases, CDC.

Editorial Note: The high rate of AIDS in western Palm Beach County has focused national attention on this area. The cumulative AIDS incidence in this area (295/100,000 population) is comparable to that of the City of San Francisco (316/100,000) and the borough of Manhattan (270/100,000)—areas with the highest incidence of AIDS in the United States. In western Palm Beach County, the high cumulative rate is largely the result of high rates of AIDS among IV drug abusers and their sexual partners.

Thirteen (17.1%) of 76 adult patients in western Palm Beach County with AIDS had no reported risk factors. Although this proportion is significantly higher than in other areas in Florida, 10 of the 13 case-patients died before they could be comprehensively interviewed to obtain additional epidemiologic information on risk factors. Nationally, 72.9% of AIDS case-patients who were initially reported as persons without known risk factors, and who were available for follow-up, have been reclassified (*6*). AIDS cases are not categorized as resulting from heterosexual transmission unless the index partner of the AIDS patient is known a) to be infected with HTLV-III/LAV, b) to have AIDS, or c) to belong to another risk group. Therefore, if no such information is available concerning the relevant sexual partners, a case is characterized as having no risk factors.

Thus far, findings of the community-based study demonstrate a high prevalence of HTLV-III/LAV infection among younger adults of both sexes (i.e., 18-29 years of age), while no children and no adults over age 60 have had evidence of infection with HTLV-III/LAV. Additionally, serologic findings for household members of HTLV-III/LAV-infected persons did not show any evidence of viral transmission through casual contact. Infection with HTLV-III/LAV was not asso-

TABLE 2. Results of testing* for antibody to five arboviruses, by HTLV-III/LAV antibody status, community survey, Belle Glade, Florida, 1986

HTLV-III/LAV antibody status	Number of persons positive for antibody to arbovirus				
	Tensaw	Maguari	Keystone	St. Louis encephalitis	Dengue-2†
Positive (n=27)	1 (3.7%)	3 (11.1%)	1 (3.7%)	3 (11.1%)	8 (29.6%)
Negative (n=603)	81 (13.4%)	106 (17.6%)	79 (13.1%)	79 (13.1%)	91 (15.1%)

*Serum dilution-plaque reduction neutralization technique.

†This difference is not statistically significant by the Cochran-Mantel-Haenszel test for association between HTLV-III/LAV and dengue-2, after controlling for previous residence in Haiti, where dengue viruses are endemic.

Table 1. AIDS cases in western Palm Beach County, Florida, by patient characteristics, city of residence, and sex, September 15, 1986

Characteristics	Belle Glade		Pahokee/South Bay		Total (%)
	Male	Female	Male	Female	
Adult patients					
Homosexual/bisexual	9	0	1	0	10 (12.7)
Heterosexual IV drug abuser	10	4	8	2	24 (30.4)
Transfusion-associated	0	2	0	0	2 (2.5)
Heterosexual patient*	23	3	1	0	27 (34.2)
None of the above	7	1	4	1	13 (16.5)
Pediatric patients					
Mother with AIDS	1	2	0	0	3 (3.8)
Total	**50**	**12**	**14**	**3**	**79(~100.0)**

*Includes 10 persons who had heterosexual contact with a person with AIDS or at increased risk of AIDS, and 17 persons born in Haiti, where heterosexual transmission is believed to play a major role.

Detailed information is available for the 62 case-patients from Belle Glade. Most of the AIDS patients lived in an area in the central part of town, comprising a population of 7,207 persons (1980 Decennial Census, Neighborhood Statistics Program). This area of Belle Glade is characterized by high rates of IV drug abuse and sexually transmitted diseases (*3*). Investigations in May 1985, May 1986, and August 1986 revealed that 19 adults with AIDS in Belle Glade could be directly linked to at least one other reported AIDS case by sexual contact, by sharing of needles during IV drug abuse, or both. These linked patients account for 32.2% of the 59 adult AIDS case-patients reported from Belle Glade between February 1982 and August 1986. Five of the 10 adult women reported as having AIDS during this time were prostitutes; four of the five were also IV drug abusers.

To evaluate the prevalence of and risk factors for HTLV-III/LAV infection in Belle Glade, a community-wide study was conducted from February through September 1986 by the Florida Department of Health and Rehabilitative Services (DHRS) and CDC. The town was divided into neighborhoods as determined by the 1980 decennial census. A proportionate-sampling scheme was used to interview and test persons living in and around the neighborhoods in which most of the AIDS patients resided. Preliminary results of this study indicate that 30 (3.1%) of 959 persons tested had detectable antibodies to HTLV-III/LAV by both enzyme immunoassay and Western-blot methods. One of the 30 persons had been diagnosed as having AIDS.

Sex-, age-, and race-specific seroprevalence rates have been calculated for the first 736 persons for whom data entry has been completed. Fourteen (3.7%) of 378 males and 12 (3.4%) of 358 females had antibodies to HTLV-III/LAV. None of 121 children ages 2-10 years had antibodies to HTLV-III/LAV. Other HTLV-III/LAV-antibody prevalence rates by age group were as follow: 14 (8.9%) of 157 persons ages 18-29; seven (4.4%) of 160 persons ages 30-39; two (1.8%) of 113 persons ages 40-49; three (3.2%) of 91 persons ages 50-59; and none of 94 persons over 60 years of age. Eighty-eight percent of seropositive adults were ages 18-49 years; 90% of adult AIDS case-patients reported in the United States are in that same age group. Twenty-six (4.2%) of 616 black-not-Hispanic persons tested had antibodies to HTLV-III/LAV, including 13 (8.7%) of 150 persons born in Haiti. None of 42 Hispanic persons and none of 60 white-not-Hispanic persons were seropositive. There was no clustering of persons infected with HTLV-III/LAV within households, except for four instances of infection involving two pairs of sexual partners. Further analyses are in progress to determine specific risk factors for infection.

Reprinted by the
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE

from MMWR, October 3, 1986, Vol. 35, No. 39, pp. 609–612

Acquired Immunodeficiency Syndrome (AIDS) in Western Palm Beach County, Florida

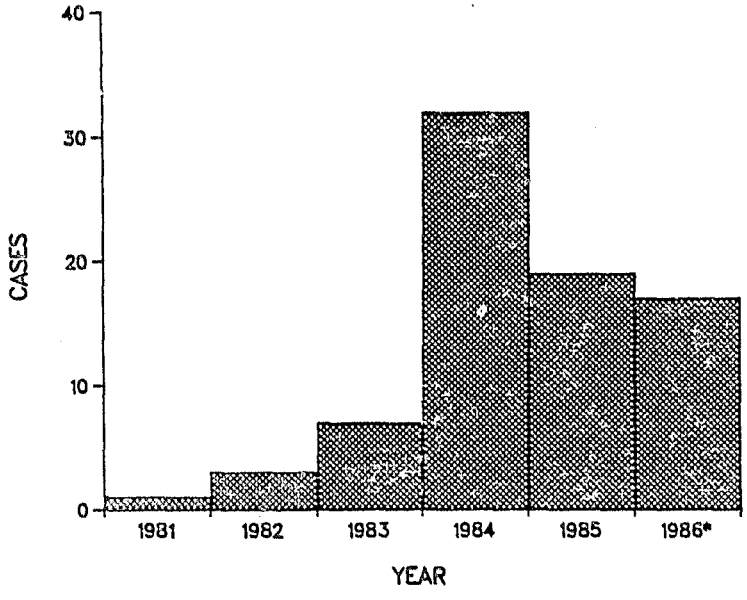
From July 1982 through September 15, 1986, 79 persons meeting the surveillance case definition for acquired immunodeficiency syndrome (AIDS) were reported from western Palm Beach County, Florida. These patients were residents of the towns of Belle Glade (62 case-patients), Pahokee (seven case-patients), and South Bay (10 case-patients) at the time of onset of their illnesses. The number of cases is shown by year of diagnosis in Figure 1. Based upon 1980 census data, the calculated cumulative incidence for AIDS in these three towns is 295/100,000 population. In comparison, the overall cumulative incidence for AIDS in the United States is 10.8/100,000.

Selected characteristics of these 79 AIDS patients are listed in Table 1. Sixty-four patients were male; all but three of the patients were at least 13 years of age. The three pediatric patients were born to mothers infected with human lymphotropic virus type-III/lymphadenopathy-associated virus (HTLV-III/LAV), the virus that causes AIDS.* Of the 76 adult patients, 63 (82.8%) were members of population groups known to be at increased risk for HTLV-III/LAV infection or were born in Haiti, a country in which heterosexual contact plays a major role in transmission of HTLV-III/LAV (*1,2*). The remaining 13 (11 men, two women) adult patients had no reported risk factors for AIDS, but 10 of these 13 died before epidemiologic investigations could be completed.

Compared with other adult AIDS case-patients reported from Florida in the period, adult AIDS patients from western Palm Beach County were more likely to be reported as heterosexual intravenous (IV) drug abusers (31.6% vs. 13.1%, $p < 0.05$), as sex partners of persons at increased risk of having AIDS (35.5% vs. 18.5%, $p < 0.01$), or as persons with no reported risk factors for AIDS (17.1% vs. 4.8%, $p < 0.01$).

*The designation "human immunodeficiency virus" (HIV) has been accepted by a subcommittee of the International Committee for the Taxonomy of Viruses as the appropriate name for the retrovirus that has been implicated as the causative agent of AIDS (Science 1986;232:697).

FIGURE 1. Acquired immunodeficiency syndrome cases, by year of diagnosis — western Palm Beach County, Florida, 1981-1986



*Cases reported through September 15, 1986.

APPENDIX B

STATE UNIVERSITY SYSTEM

AIDS Policy

It is the policy of the State University System (SUS) to balance the rights of Acquired Immune Deficiency Syndrome (AIDS) victims to an education and employment against the rights of students and university employees to an environment in which they are protected from contracting the disease. In the belief that education can exercise some control over the spread of the disease, and help the public to respond in a reasoned manner, the SUS is committed to providing the university communities and communities at large with education on the nature and transmission of the disease and the legal rights of AIDS victims.

Each university will be flexible in its response to incidents of the disease on campus, evaluating each occurrence in light of its general policy and the latest information available. A university Committee consisting of appropriate representatives shall be responsible for acting upon and administering the SUS Policy on AIDS in specific cases, and coordinating the university's efforts in educating the university community on the nature of the AIDS disease. Pursuant to these responsibilities, the Committee will meet regularly to monitor the university efforts at educating the university community on AIDS. The Committee will meet on an "as needed" basis to consider individual occurrences of the disease and recommend appropriate action.

The university Committee on AIDS will designate an AIDS counselor available to the student body and employees on a request basis to answer questions and provide counseling with regard to the disease. Contact with the AIDS counselor will be confidential. The location of the AIDS counselor and the hours the counselor will be available will be posted prominently throughout the university and included in the AIDS Policy which will be distributed to students at registration and to all employees.

EDUCATION

Each university will make available to its students and employees information about the transmissibility of the disease and precautions that may be taken by AIDS victims and non-victims to prevent the spread of the disease. Coordination of this educational effort will be the responsibility of the university Committee on AIDS.

GENERAL GUIDELINES

There is no evidence to indicate that AIDS can be spread by casual contact. The evidence demonstrates that the AIDS virus (HTLV-III/LAV) requires direct passage through body fluids to cause infection. The greatest risk, therefore, lies in the use of contaminated syringes or exposure via intimate contact with an infected partner.

Recent developments in the law in Florida and the nation in general indicate that AIDS is included in the definition of a handicap for purposes of state law prohibiting discrimination in employment on the basis of handicap, and the federal Rehabilitation Act of 1973 which prohibits discrimination against qualified individuals by employers and by those who provide services with the assistance of federal funding (§ 503 and § 504). Under federal law the university as an employer and a provider of educational services must make reasonable accommodations for AIDS-handicapped individuals.

The SUS will be guided in its actions by the most recent medical evidence, the federal regulations implementing § 503 and § 504 of the Rehabilitation Act, the guidelines suggested by the Centers for Disease Control (CDC), the Public Health Service, the American College Health Association, the Department of Health and Rehabilitative Services, and the Governor's Task Force on AIDS.

MEDICAL BACKGROUND

AIDS was first reported in the medical literature in 1981. A significant number of homosexual men in California had developed rare opportunistic infections seen only in cases in which the individual's immune system had been destroyed. Healthy individuals with functioning immune systems do not develop opportunistic infections. The underlying pathology in AIDS is a breakdown of the body's immune defenses caused by a virus known as HTLV-III/LAV.

The virus attacks specific cells of the immune system responsible for controlling the immune system's ability to destroy microorganisms and the cells they infect. Specifically, the AIDS virus destroys lymphocyte "T-Helper" cells. These cells recognize invading microorganisms and activate the immune system which in turn destroys the invading microorganisms. The immune system is rendered inactive by HTLV-III/LAV, and therefore the body is opened to infections by pathogens that would otherwise be harmless. Anyone infected with this virus, whether or not they have symptoms, is presumed infectious.

The CDC has identified a discrete number of groups in which there is high incidence of AIDS. These include homosexual and bisexual men, intravenous drug abusers, hemophiliacs, recipients of blood transfusions, sexual partners of persons infected with HTLV-III/LAV, and infants born to mothers who are infected with HTLV-III/LAV at the time of birth.

A cumulative total of 18,405 cases have been reported to the CDC in Atlanta as of February 1986. Florida has confirmed 1,224 cases for the same time period. Seventy-five percent of the Florida cases are reported from Monroe, Dade, Broward and Palm Beach counties. Currently, the only effective means of limiting the continued transmission of AIDS is through education regarding risk factors, mechanisms of disease transmission and means for prevention.

LEGAL BACKGROUND

The Rehabilitation Act of 1973 prohibits discrimination against qualified handicapped individuals by institutions which receive federal financial assistance or which have contracted with the federal government. The SUS receives federal funds; therefore, each university must comply with the provisions of the Rehabilitation Act. Under the Rehabilitation Act a university may not discriminate against any employee or student who has a physical or mental impairment which substantially limits one or more major life activities, who has a record of such an impairment, or who is regarded as having such an impairment. Although there are no reported court decisions in which an individual has alleged discrimination on the basis of handicap because of AIDS, it is generally believed AIDS is a handicap under the Rehabilitation Act.

In an analogous case, Arlines v. School Board of Nassau County, the Eleventh Circuit of the United States Court of Appeals held that the language of the Rehabilitation Act in every respect supports a conclusion that persons with contagious diseases are within the coverage of the Rehabilitation Act. Although the plaintiff in Arlines had tuberculosis, the decision may apply to any contagious disease which "substantially limits major life activity." AIDS is a contagious disease which substantially limits major life activity.

The Court in Arlines also stated that an employer may not arbitrarily determine that an individual's handicap prevents the individual from performing

required duties. The employer must make a "well informed judgment grounded in a careful and open-minded weighing of the risks and alternatives..." (Arlines, 772 F.2d 765 (1985 at 765)).

Section 504 of the Rehabilitation Act of 1973 states that:

> " No otherwise qualified handicapped individual in the United States...shall, solely by reason of handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity conducted by an Executive agency..."

The Department of Health and Human Services enforces the Rehabilitation Act and has issued rules that must be followed by any institution receiving federal funds. Under those regulations a university may not deny an AIDS victim admission to the university because the individual has AIDS. Furthermore, the university may not ask students applying for admission whether they have AIDS or require a seriologic test for infection with HTLV-III/LAV (45 C.F.R. § 84.42(b)(4) and (c)). If students with AIDS require special accommodations due to their illness, the university may inquire about the disease after the student has been admitted. Records gathered by the university about a student's disease are confidential, as provided by federal regulations.

The university must offer students with AIDS the same opportunities and benefits offered non-handicapped students. This requirement includes access to educational programs, counseling, health insurance, housing, employment opportunities, transportation, health care, and financial assistance.

The university may not impose any rules upon enrolled AIDS victims that have the effect of limiting the student's participation in the university's educational programs or activities.

A recipient of federal funds is also prohibited from engaging in employment discrimination against handicapped individuals under the Rehabilitation Act. As a recipient of federal funds, the university may not discriminate against infected applicants or employees by action which adversely affects their opportunities or status unless the handicap substantially intereferes with the employee's ability to perform job duties. Thus, the university must use the same criteria to evaluate applicants or employees with AIDS as it uses to evaluate non-handicapped applicants or employees.

Under the regulations adopted by Health and Human Services, the university may not require applicants to submit to a medical examination as a condition of employment. The university may ask an applicant about his or her ability to perform a job, but may not ask an applicant about his or her physical disabilities. University records regarding an employee's handicap condition are confidential, as provided by federal regulations.

Under the Rehabilitation Act, the university is required to reasonably accommodate the special needs of students and employees with AIDS unless the university can show that accommodation causes undue hardship. Generally, the accommodation does not produce an undue hardship unless funds must be expended to accommodate the handicapped individual.

Each university must also comply with state law prohibiting employment discrimination against handicapped individuals. The state agency responsible for enforcing the anti-discrimination statute, Chapter 760 of Florida Statutes, is the Commission on Human Relations. Recently, the Commission on Human Relations decided that there was cause to believe that Broward County had illegally discriminated against an employee who was terminated solely because he had AIDS, finding that the disease is a handicap under state law and that the county therefore must make reasonable accommodation.

Chapter 760 of the Florida Statutes prohibits employment discrimination against handicapped individuals by employers with more than fifteen employees. The university may not "discharge or fail to hire or otherwise discriminate with respect to compensation, conditions, or privileges of employment" because the individual has AIDS. (Fla. Stat. § 760.10(1)(a)). In addition, the university may not segregate or classify a handicapped individual in any way which would deprive or tend to deprive any individual of employment opportunities. Furthermore, it is unlawful to adversely affect any individual's status as an employee because of "...handicap." (Fla. Stat.

§ 760.10(1)(b)). An AIDS victim may not be isolated by the university unless the individual poses a scientifically proven risk to co-workers or students. The language of Chapter 760 protects handicapped employees and, therefore, AIDS victims from arbitrary dismissal, discrimination in hiring, promotion, and compensation decisions, and any other actions an employer may take that adversely affect an employee's status.

ACTION GUIDELINES

Definition

For the purpose of these guidelines, an infected individual means:

(a) an individual who is diagnosed as having AIDS;

(b) an individual who is disgnosed as having AIDS Related Complex (ARC); or

(c) an individual who is determined to be HTLV-III/LAV antibody positive but has not yet developed the symptoms of AIDS or ARC.

ACTION GUIDELINES FOR STUDENTS

Student Admissions

Admission will not be denied to a qualified student solely on the ground that the student is an infected individual.

STUDENT SUSPENSIONS, LEAVES OF ABSENCE, WITHDRAWALS

No student will be required to cease attending the university solely on the basis of a diagnosis of infection. Such decisions will be made only after reasonable accommodations have been made and an examination of the facts demonstrates that the student can no longer perform as required, or that the student presents a health risk to himself or the university community.

Recent information indicates that the central nervous system may become infected by the HTL-III/LAV virus. This infection may lead to progressive neurological and cognitive dysfunction and consequent inability of the student to maintain his scholastic performance. Decisions regarding remedial or disciplinary action in such cases should take these facts into consideration.

STUDENTS LIVING IN THE DORMITORIES

1. A student shall not be denied the opportunity to live in the dormitory solely on the basis of a diagnosis of infection.

2. Students will not be moved within or removed from the dormitory solely on the basis of a diagnosis of infection. Changes in room, or removal from the dormitory will be made on a case-by-case examination in which it is determined that

   (a) the student has communicable opportunistic infections or is showing other symptoms of illness and requires care which cannot reasonably be provided in the dormitory setting;

   (b) the student is demonstrating symptoms, needs or behaviors which are inappropriate in a dormitory and cannot reasonably be accommodated; or

   (c) the student presents a risk to himself or the other residents of the dormitory.

STUDENTS OF THE HEALTH OCCUPATIONS DOING HEALTH CARE WORK

The risk of contracting Hepatitis B is greater than the risk of contracting AIDS. Therefore, recommendations for the control of Hepatitis B infection will effectively prevent the spread of AIDS. All such recommendations are therefore incorporated herein.

1. Sharp items (needles, scalpel, blades, and other sharp instruments) should be considered as potentially infective and be handled with extraordinary care to prevent accidental injuries.

2. Disposable syringes and needles, scalpel blades and other sharp items should be placed in puncture resistant containers located as close as practical to the area in which they were used. To prevent needle stick injuries, needles should not be recapped, purposely bent, broken, removed from disposable syringes, or otherwise manipulated by hand.

3. When the possibility of exposure to blood or other body fluid exists, routinely recommended precautions should be followed. The anticipated exposure may require gloves alone, as in handling items soiled with blood or other body fluids, or may also require gowns, masks and eye coverings when performing procedures or post-mortem examinations. Hands should be washed thoroughly and immediately if they accidentally become contaminated with blood.

4. To minimize the need for emergency mouth-to-mouth resuscitation, mouthpieces, resuscitation bags, or other ventilation devices should be located and available for use in areas where the need for resuscitation is predictable.

5. Pregnant health occupation students or students engaged in health care are not known to be at greater risk of contracting the AIDS virus than students who are not pregnant. However, if a student develops infection with the AIDS virus during pregnancy, the infant has an increased risk of infection through prenatal or perinatal transmission. Because of this risk, pregnant students should be especially familiar with precautions for preventing the transmission or acquisition of AIDS virus.

6. Health occupation students or students engaged in health care who have AIDS who are not involved in invasive procedures need not be restricted from work unless they have some other illness for which any health care worker would be restricted.

7. For health occupation students or students engaged in health care who have AIDS, there is an increased danger from infection due to diseases they may come in contact with at class or in the work place. Students with AIDS, who have defective immunity, are at risk of acquiring or experiencing serious complication of such diseases. Of particular concern is the risk of severe infection following exposure to patients with infectious diseases that are easily transmitted if appropriate precautions are not taken (e.g. tuberculosis or chicken pox). Students with AIDS should be counseled about potential risk associated with exposure to or taking care of patients with transmissible infections and should continue to follow existing recommendations for infection control to minimize their risk of exposure to other infectious agents.

8. The health occupation student's physician and/or the university's student health physician in conjunction with the university faculty and AIDS Committee should determine on an individual basis whether the student with AIDS or ARC can adequately and safely perform patient care duties and suggest changes in work assignments if indicated.

9. Infected neurologically handicapped students who cannot control bodily secretions and students who have uncoverable oozing lesions should not be permitted to participate in health care services. The determination of whether an infected student should be excluded from providing health care shall be made on a case-by-case basis by a team composed of the student's physician, the appropriate university faculty, and the university Committee on AIDS.

ACTION GUIDELINES FOR UNIVERSITY EMPLOYEES

Employees

1. An infected employee will be treated in the same manner as any employee diagnosed as having any other illness, injury or disability.

2. In instances where an infected employee is unable to fulfill his/her regular responsiblities, or portions of these responsibilities, but is able and desires to continue working in a less physically demanding capacity, the university will make a reasonable effort, if requested, to accommodate the employee's physical handicap.

3. As in the case of any other illness, injury or disability, a supervisor who believes than an infected employee is unable to perform assigned duties due to the illness, may recommend to the Personnel Department that the employee be required to submit to a medical examination by a physician named and paid by the university. Based upon the medical opinion, appropriate action as provided in applicable procedures will be applied.

4. Any employee who informs the university that he/she is infected will be accorded confidentiality regarding disclosure of the medical condition. Records will be maintained by the designated AIDS counselor.

5. Any infected employee shall be eligible to use accrued sick or annual leave as needed. A university Sick Leave Pool member shall be eligible to request use of leave hours through the Pool.

6. University employees, while performing their university duties, will be required to conform to the university policy on AIDS and these guidelines in dealing with infected students or employees.

UNIVERSITY DEPARTMENT OF PUBLIC SAFETY EMPLOYEES

1. All police officers shall be trained to use and be issued an appropriate oral airway for use in providing an individual cardiopulmonary resuscitation. This will avoid direct mouth contact with any infected person and will further serve to protect police officers from any other disease or infection that might be transmitted orally.

2. All police officers shall be issued disposable plastic gloves for use when assisting or restraining any individual who is bleeding from any injury. This will avoid direct contact with the blood of any infected persons, as well as protect police officers from any other blood-borne disease or infection.

EMPLOYEES PROVIDING HEALTH CARE

See Students of Health Occupations, #1-9.

CUSTODIAL AND PHYSICAL PLANT WORKERS

1. All university employees who have responsibility for cleaning or repairing university restrooms shall wear plastic gloves when working in restrooms. This will ensure that these employees are protected from risk of infection through cuts on their hands.

2. In cleaning restrooms, custodial workers shall use an appropriate disinfectant in cleaning the facilities to ensure that any contaminated surfaces are fully cleaned.

3. Custodial workers will receive instruction about modes of transmission or acquisition of HTLV-III/LAV. The importance of hand washing after handling potentially contaminated objects will be emphasized.

PCB/jm
4/23/86

APPENDIX C

and no chairperson shall serve as chairperson for more than two consecutive terms.

(5) Members of the council shall receive no compensation, but shall be reimbursed for per diem and travel expenses by the department in accordance with the provisions of s. 112.061, Florida Statutes, while engaged in the performance of their duties.

(6) The responsibilities of the council shall be to recommend to the department indications for adult and pediatric organ transplants. The council shall also formulate guidelines and standards for organ transplants and for the development of End Stage Organ Disease and Tissue/Organ Transplant programs.

(7) The council shall meet at least annually or upon the call of the chairperson or the Secretary of Health and Rehabilitative Services.

Section 89. Section 113 of this act is repealed on October 1, 1996, and the technical Organ Transplant Advisory Council shall be reviewed by the Legislature pursuant to s. 11.611, Florida Statutes.

Section 90. Sections 384.21, 384.22, 384.23, 384.24, 384.25, 384.26, 384.27, 384.28, 384.29, 384.30, 384.31, 384.32, 384.33, and 384.34, Florida Statutes, are created to read:

384.21 Short title.--This chapter may be cited as the Control of Sexually Transmissible Disease Act.

384.22 Findings; intent.--The Legislature finds and declares that sexually transmissible diseases constitute a serious and sometimes fatal threat to the public and individual health and welfare of the people of the state and visitors to the state. The Legislature finds that the

incidence of sexually transmissible diseases is rising at an alarming rate and that these diseases result in significant social, health, and economic costs, including infant and maternal mortality, temporary and lifelong disability, and premature death. The Legislature finds that sexually transmissible diseases, by their nature, involve sensitive issues of privacy, and it is the intent of the Legislature that all programs designed to deal with these diseases afford patients privacy, confidentiality, and dignity. The Legislature finds that medical knowledge and information about sexually transmissible diseases are rapidly changing. The Legislature intends to provide a program that is sufficiently flexible to meet emerging needs, deals efficiently and effectively with reducing the incidence of sexually transmissible diseases, and provides patients with a secure knowledge that information they provide will remain private and confidential.

384.23 Definitions.--

(1) "Department" means the Department of Health and Rehabilitative Services.

(2) "County public health unit" means agencies and entities as designated in chapter 154.

(3) "Sexually transmissible disease" means a bacterial, viral, fungal, or parasitic disease, determined by rule of the department to be sexually transmissible, to be a threat to the public health and welfare, and to be a disease for which a legitimate public interest will be served by providing for regulation and treatment. In considering which diseases are to be designated as sexually transmissible diseases, the department shall consider such diseases as chancroid, gonorrhea, granuloma inguinale, lymphogranuloma

venereum, genital herpes simplex, chlamydia, nongonococcal urethritis (NGU), pelvic inflammatory disease (PID)/Acute Salpingitis, syphilis, and human T-lymphotropic virus type III (HTLV-III) infection for designation, and shall consider the recommendations and classifications of the centers for disease control and other nationally recognized medical authorities. Not all diseases that are sexually transmissible need be designated for purposes of this act.

384.24 Unlawful acts.--It is unlawful for any person who has chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum, genital herpes simplex, chlamydia, nongonococcal urethritis (NGU), pelvic inflammatory disease (PID)/Acute Salpingitis, syphilis, or human T-lymphotropic virus type III (HTLV-III) infection, when such person knows he is infected with one or more of these diseases and when such person has been informed that he may communicate this disease to another person through sexual intercourse, to have sexual intercourse with any other person, unless such other person has been informed of the presence of the sexually transmissible disease.

384.25 Reporting required.--

(1) Each person who makes a diagnosis of or treats a person with a sexually transmissible disease and each laboratory that performs a test for a sexually transmissible disease which concludes with a positive result shall report such facts as may be required by the department by rule, within a time period as specified by rule of the department, but in no case to exceed two weeks.

(2) The department shall adopt rules specifying the information required in reporting a sexually transmissible disease and specifying a minimum time period for reporting.

CODING: Words in ~~struck through~~ type are deletions from existing law; words <u>underlined</u> are additions.

In adopting such rules, the department shall consider the need for information, protections for the privacy and confidentiality of the patient, and the practical ability of persons and laboratories to report in a reasonable fashion. Rules pursuant to reporting of HTLV III infection shall be limited to physician reporting and shall include only physician diagnosed cases of Acquired Immune Deficiency Syndrome (AIDS) and AIDS Related Complex based upon diagnostic criteria from the Centers for Disease Control of the United States Public Health Service.

(3) Each person who violates the provisions of this section or the rules adopted hereunder may be fined by the department up to $500 for each offense. The department shall report each violation of this section to the regulatory agency responsible for licensing each health care professional and each laboratory to which these provisions apply.

384.26 Contact investigation.--

(1) The department and its authorized representatives may interview, or cause to be interviewed, all persons infected or suspected of being infected with a sexually transmissible disease for the purpose of investigating the source and spread of the disease and for the purpose of ordering a person to submit to examination and treatment as necessary.

(2) All information gathered in the course of contact investigation shall be considered confidential and subject to the provisions of s. 384.29. Such information is exempt from ss. 119.01 and 119.07(1). This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(3) No person who is infected with a sexually transmissible disease, or suspected of an infection, who reveals the name or names of sexual contacts during the course of an investigation shall be held liable in a civil action for such revelation, unless the revelation is made falsely or with reckless disregard for the truth.

384.27 Physical examination and treatment.--

(1) Subject to the provisions of subsection (3), the department and its authorized representatives may examine or cause to be examined persons suspected of being infected with or exposed to a sexually transmissible disease.

(2) Subject to the provisions of subsection (3), persons with a sexually transmissible disease shall report for complete treatment to a physician licensed under the provisions of chapter 458 or chapter 459, or shall submit to treatment at a county public health unit or other public facility, until the disease is noncommunicable.

(3) No person shall be apprehended, examined or treated for a sexually transmissible disease against his will, except upon the presentation of a warrant duly authorized by a court of competent jurisdiction. In requesting the issuance of such a warrant, the department shall show by a preponderance of evidence that a threat to the public's health and welfare exists unless such warrant is issued and shall show that all other reasonable means of obtaining compliance have been exhausted and that no other less restrictive alternative is available.

384.28 Quarantine and isolation.--

(1) Subject to the provisions of subsection (2), the department may order a person to be isolated or a place to be quarantined and made off limits to the public as a result of

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the probable spread of a sexually transmissible disease, until such time as the condition can be corrected or the threat to the public's health eliminated or reduced in such a manner that a substantial threat to the public's health no longer exists.

(2) No person may be ordered to be isolated, and no place may be ordered to be quarantined, except upon the order of a court of competent jurisdiction and upon proof by the department, by clear and convincing evidence, that the public's health and welfare are significantly endangered by a person with a sexually transmissible disease or by a place where there is a significant amount of sexual activity likely to spread a sexually transmissible disease, and upon proof that all other reasonable means of correcting the problem have been exhausted and no less restrictive alternative exists.

(3) This section shall be considered supplemental to the existing authorities and powers of the department, and shall not be construed to restrain or restrict the department in protecting the public health under other sections of law.

384.29 Confidentiality.--

(1) All information and records held by the department and its authorized representatives relating to known or suspected cases of sexually transmissible diseases shall be strictly confidential and exempt from ss. 119.01 and 119.07(1). This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14. Such information shall not be released or made public by the department or its authorized representatives, or by a court or parties to a lawsuit upon revelation by subpoena, except that release may be made under the following circumstances:

CODING: Words in ~~struck through~~ type are deletions from existing law; words <u>underlined</u> are additions.

(a) When made with the consent of all persons to which the information applies;

(b) When made for statistical purposes, medical or epidemiologic information is summarized so that no person can be identified and no names are revealed;

(c) When made to medical personnel, appropriate state agencies, or courts of appropriate jurisdiction, to enforce the provisions of this chapter and related rules;

(d) When made in a medical emergency, but only to the extent necessary to protect the health or life of a named party; or

(e) When made to the proper authorities as required by chapter 415.

(2) When disclosure is made pursuant to a subpoena, such information shall be sealed by the court from further disclosure, except as deemed necessary by the court to reach a decision, unless otherwise agreed to by all parties.

(3) No employee of the department or its authorized representatives shall be examined in a civil, criminal, special, or other proceeding as to the existence or contents of pertinent records of a person examined or treated for a sexually transmissible disease by the department or its authorized representatives, or of the existence or contents of such reports received from a private physician or private health facility, without the consent of the person examined and treated for such diseases, except in proceedings under ss. 384.27 and 384.28.

384.30 Minors' consent to treatment.--

(1) The department and its authorized representatives, each physician licensed to practice medicine under the provisions of chapter 458 or chapter 459, each health care

professional licensed under the provisions of chapter 464 who is acting pursuant to the scope of his license, and each public or private hospital, clinic, or other health facility may examine and provide treatment for sexually transmissible diseases to any minor, if the physician, health care professional, or facility is qualified to provide such treatment. The consent of the parents or guardians of a minor is not a prerequisite for an examination or treatment.

(2) The fact of consultation, examination, and treatment of a minor for a sexually transmissible disease is confidential and shall not be divulged in any direct or indirect manner, such as sending a bill for services rendered to a parent or guardian, except as provided in s. 384.29. Such information is exempt from ss. 119.01 and 119.07(1). This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

384.31 Serological testing of pregnant women; duty of the attendant.--Every person, including every physician licensed under chapter 458 or chapter 459 or midwife licensed under chapter 464 or chapter 467, attending a pregnant woman for conditions relating to pregnancy during the period of gestation and delivery shall take or cause to be taken a sample of venous blood at a time or times specified by the department. Each sample of blood shall be tested by a laboratory approved for such purposes under part I of chapter 483 for sexually transmissible diseases as required by rule of the department.

384.32 Prisoners.--

(1) The department and its authorized representatives may, at its discretion, enter any state, county, or municipal detention facility to interview, examine, and treat any

prisoner for a sexually transmissible disease. Any such state, county, or municipal detention facility shall cooperate with the department and its authorized representatives to provide such space as is necessary for the examination and treatment of all prisoners suffering from or suspected of having a sexually transmissible disease.

(2) Nothing in this section shall be construed as relieving the Department of Corrections, counties, or municipalities of their primary responsibility for providing medical treatment for prisoners, including treatment for sexually transmissible diseases.

384.33 Rules.--The department may adopt rules to carry out the provisions of this chapter.

384.34 Penalties.--

(1) Any person who violates the provisions of s. 384.24, s. 384.26, or s. 384.29 is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(2) Any person who maliciously disseminates any false information or report concerning the existence of any sexually transmissible disease is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(3) Any person who violates the provisions of the department's rules pertaining to sexually transmissible diseases may be punished by a fine not to exceed $500 for each violation. Any penalties enforced under this subsection shall be in addition to other penalties provided by this act.

Section 91. Sections 383.08, 383.09, 384.01, 384.02, 384.03, 384.04, 384.05, 384.06, 384.061, 384.07, 384.08, 384.09, 384.10, 384.11, 384.12, 384.13, 384.14, 384.15,

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State of Florida

Department of Health and Rehabilitative Services

Control of Sexually Transmissible Diseases

Creating 10D-3.94 through 10D-4.02

10D-3.94 Control of Sexually Transmissible Disease - General. This rule prescribes prevention and control measures relating to the designation of diseases as sexually transmissible diseases, reporting, contact investigation, blood testing of pregnant women and enforcement and penalties.

Specific Authority: 381.031(1)(g)1, 384.21, FS

Law Implemented: 384.21, FS

History: New

10D-3.95 Definitions. For the purposes of this chapter, the following words and phrases shall have the meanings indicated:

(1) Acquired Immunodeficiency Syndrome (AIDS) - A reliably diagnosed disease that is at least moderately indicative of an underlying cellular immunodeficiency in the absence of an identifiable cause of cellular immunodeficiency, other than human immunodeficiency virus, or of increased susceptibility to that disease, as defined by the Centers for Disease Control of the United States Public Health Service.

(2) Approved Laboratory - A laboratory approved by the Department of Health and Rehabilitative Services under Part I of Chapter 483.

(3) Authorized Representative - A person officially named by a County Public Health Unit Director or the State Health Officer to represent or carry out the functions of the department with regard to the control of sexually transmissible diseases.

(4) Chancroid - An acute, localized, genital infection characterized clinically by single or multiple painful ulcers at the site of infection, frequently accompanied by swelling of the lymph nodes as described in the International Classification of Diseases.

(5) Confidentiality - The protection of private and sensitive information held by the department and its authorized representatives.

(6) Contact Investigation - Interviewing, counseling, education, and investigation activities, conducted by authorized representatives of the department, of persons who are infected or suspected of being infected with a sexually transmissible disease.

(7) County Public Health Unit - Agencies designated in Chapter 154, FS, for the delivery of public health services.

(8) Department - The Department of Health and Rehabilitative Services.

(9) Gestation - The carrying of the fetus in the uterus.

(10) Gonorrhea - A sexually transmitted disease caused by the infectious agent called Neisseria gonorrhoeae, as described in the International Classification of Diseases.

(11) Granuloma Inguinale - A mildly communicable, nonfatal, chronic and progressive bacterial disease of the skin and mucous membranes of the external genitalia, inguinale and anal region, as described in the International Classification of Diseases.

(12) Human Immunodeficiency Virus Infection - Is evidenced by the presence of Human T-lymphotropic virus type III (HTLV-III)/Human Immunodeficiency Virus (HIV) antibodies in a blood sample or virus culture of blood, tissue or secretion as determined by laboratory analysis.

(13) Lymphogranuloma Venereum - A sexually transmitted infection beginning with a small painless erosion, papule, nodule or lesion on the penis or vulva, frequently unnoticed, as described in the International Classification of Diseases.

(14) Midwife - A person, licensed under Chapter 464, FS, or Chapter 467, FS, who assists women in childbirth.

(15) Physician - A medical doctor or doctor of osteopathy licensed under the provisions of Chapter 458, FS, or Chapter 459, FS.

(16) Source of Disease - The person from whom an infectious agent passes to another person.

(17) Syphilis - A sexually transmitted disease characterized by a primary lesion, a secondary eruption involving skin and mucous membranes, long periods of latency, and late lesions of the skin, bone, viscera and the central nervous and cardiovascular systems as described in the International Classification of Diseases.

(18) Venous Blood - Blood drawn from the veins.

(19) Working Days - Means Monday through Friday excluding weekends or official holidays observed by the State of Florida.

Specific Authority: 381.031(1)(g)1, 384.23, FS

Law Implemented: 384.23, FS

History: New

10D-3.96 Diseases Designated as Sexually Transmissible Diseases

(1) The following diseases are designated as sexually transmissible diseases for the purposes of Chapter 384, FS, and this rule.

a. Acquired Immunodeficiency Syndrome

b. Chancroid

c. Gonorrhea

d. Granuloma Inguinale

e. Human Immunodeficiency Virus Infection

f. Lymphogranuloma Venereum

g. Syphilis

(2) The department finds that the diseases designated in paragraph (1) are sexually transmissible and constitute a threat to the public health and welfare of residents and visitors to the state. The provision of regulation for these diseases will serve a legitimate public interest by allowing the department and its county public health units to monitor the incidence of disease and provide appropriate disease intervention activities that will result in treatment,the interruption of disease transmission, and reduction of the incidence of disease-related complications.

Specific Authority: 381.031(1)(g)1, 384.23, FS

Law Implemented: 384.23, FS

History: New

10D-3.97 Reporting Required by Physicians

(1) Each physician who is licensed under Chapter 458, FS, or 459, FS, and makes a diagnosis of a sexually transmissible disease excluding Human Immunodeficiency Virus (HIV) infection shall report such diagnosis to the Department.

(2) The form (HRS 720) upon which the case will be reported shall be furnished by the department or the local county public health unit. Identifying information required on the report form is: patient's name, address, telephone number, date of birth, sex, race and disease, type and amount of treatment provided as well as the name and address of the physician submitting the report.

(3) The time within which the report must be submitted shall be two working days from diagnosis. Reports shall be submitted to the Sexually Transmitted Disease Control Program office of the department's district office having jurisdiction for the area wherein is located the office of the reporting physician. If the physician has offices or is affiliated with hospitals located in different department districts, the report shall go to the district office with jurisdiction for the facility within which the patient was diagnosed.

(4) The mailing address and telephone number of the department's district Sexually Transmitted Disease Control Program office shall be made available to all physicians licensed under Chapter 458 or 459, FS.

(5) Any report of the diagnosis of a sexually transmissible disease shall be submitted in an envelope sealed with tape which is plainly marked "Confidential".

Specified Authority: 381.031(1)(g)1, 381.231, 384.25, FS.

Law Implemented: 384.25, FS.

History: New

10D-3.98 Reporting Required for AIDS

(1) Reporting of cases of AIDS is required only by physicians licensed under Chapter 458 or 459, F.S. who make a diagnosis or treat a case of AIDS.

(2) The form (CDC 50.42 Rev. 3-85) upon which the AIDS case will be reported shall be furnished by the department or the

local county public health unit. Identifying information required on the form is: patient's name, address, telephone number, date of birth, current vital status, sex, race, residence at onset of illness, diagnosing hospital, disease, method of diagnosis, other underlying diseases, known causes of reduced resistance, social and risk factors, and laboratory data, as well as the name and address of the physician submitting the report.

(3) The time within which the report must be submitted shall be within two weeks after diagnosis. Reports shall be submitted to the local county public health unit who, in turn, shall submit case reports within two weeks to the department.

(4) Any report of the diagnosis of AIDS shall be submitted in an envelope sealed with tape which is plainly marked "Confidential".

Specific Authority: 381.031(1)(g)1, 381.231, 384.25, FS

Law Implemented: 384.25, FS

History: New

10D-3.99 Reporting Required by Laboratories

(1) Each person who is in charge of a clinical or hospital laboratory, blood bank, mobile unit, or other facility in which a laboratory examination of any specimen derived from a human body yields evidence suggestive of a sexually transmissible disease excluding AIDS, shall notify of its findings the Sexually Transmitted Disease Control Program office of the department's district having jurisdiction for the area wherein the facility is located. Notification shall be submitted within two working days.

(2) The department will consider notification from clinical laboratories only as indicators of a sexually transmissible disease until a physician licensed under Chapter 458 or 459, FS, reports a sexually transmissible disease. In every case where contact investigation is initiated on the basis of a laboratory report, the authorized representative of the Department shall first attempt, by telephonic or other means, to consult with the physician who submitted the specimen.

(3) Identifying information required on the report is: tests performed and results, including titer when quantitative

procedures are performed, the name, date of birth, race, sex, address and telephone number of the persons from whom the specimen was obtained, the reason for the test, the name and address of the submitting physician and that of the processing clinical laboratory. The form upon which the information will be reported shall be furnished by the laboratory.

(4) Each laboratory shall be notified by the department's district Sexually Transmitted Disease Control Program office as to the address and telephone number for the reporting of information required on tests performed and results.

(5) Any report of laboratory findings suggestive of a sexually transmissible disease shall be submitted in an envelope with tape which is plainly marked "Confidential."

Specific Authority: 381.031(1)(g)1, 381.231, 384.25, FS

Law Implemented: 384.25, FS

History: New

10D-4.00 Contact Investigation

(1) The department and its authorized representatives may interview, or cause to be interviewed, all persons infected or suspected of being infected with a sexually transmissible disease.

(2) All information gathered in the course of contact investigation shall be considered confidential and subject to the provisions of 384.29, FS.

(3) In every case where contact investigation is initiated, the authorized representative of the department shall first attempt, by telephonic or other means, to consult with the physician submitting the report of a sexually transmissible disease before initiating steps to interview the patient or cause the patient to be interviewed.

Authority: 154.01(2)(a), 381.031(1)(g)1, 384.26, FS

Law Implemented: 384.26, FS

History: New

10D-4.01 - Blood Testing of Pregnant Women

(1) Each physician licensed under Chapter 458, FS, or 459, FS, or midwife licensed under Chapter 464 or 467, FS, who attends a pregnant woman for conditions relating to pregnancy during

the period of gestation and delivery, shall take or cause to be taken a sample of venous blood, and shall submit the sample to an approved laboratory for a standard blood test for syphilis.

(2) The samples of blood shall be taken at the time of the first examination relating to the current pregnancy and a second specimen at thirty to thirty-two weeks.

(3) A blood sample shall be taken for testing on pregnant women who appear at delivery with no record of a blood test for syphilis during pregnancy or pregnant women who had a serologic test for syphilis during pregnancy that was reactive, regardless or whether subsequent tests were non-reactive.

(4) Physicians required by law to report births and stillbirths shall record on such report the date or approximate date a blood test for syphilis was made on the woman who bore the child or state the reason for not making the test if none was made. In no case shall the result of the test be recorded on the birth certificate.

(5) The physician submitting the blood sample for such test shall state that this is a blood test for syphilis on a pregnant woman. The laboratory report shall be made on a form provided by the department.

(6) The department is authorized to use the information from pregnancy blood tests for such follow-up procedures as required by law or deemed necessary by the department for the protection of public health.

(7) Form Availability - The form to be used to report results of a blood test for syphilis in a pregnant woman is:

Form #HRS 552

Effective Date - (July 86)

Title - Serology Syphilis

Availability - Local County Public Health Units

Specific Authority: 383.09, 384.31, FS

Law Implemented: 384.31, FS

History: New

10D-4.02 Enforcement and Penalties

(1) Any person who does not comply as required by

subsection 10D-3.97, 3.98, and 3.99 of this rule may be fined by the Department up to $500 for each offense.

(2) In determining the amount of fine to be levied for a violation as provided in paragraph (1), the following factors shall be considered:

a. A history of late, infrequent, or non-reporting by each physician or midwife who makes a diagnosis of or treats a person with a sexually transmissible disease and each laboratory that performs a test for a sexually transmissible disease which concludes with a positive test.

b. The severity of the violation, including the probability that transmission of the disease will be spread to other persons or serious harm to the health of any person will result or has resulted.

c. Actions taken by the physician licensed under Chapter 458 or 459 , F.S., or midwife licensed under Chapter 464 or 467, F.S., and each laboratory, to correct the violation or to remedy the complaints.

d. Any previous violations of the physician, midwife or laboratory.

e. All amounts collected pursuant to this section shall be deposited in the County Public Health Unit Trust Fund.

Specific Authority: 381.411, 384.34, FS

Law Implemented: 384.34, FS

History: New

APPENDIX D

ENROLLED

CS for SB 576 First Engrossed

A bill to be entitled

An act relating to prostitution; amending s. 796.07, F.S.; defining "sexual activity" for purposes of the prohibition against prostitution; deleting obsolete language; redefining the elements of prostitution; creating s. 796.08, F.S.; providing for screening for sexually transmissible diseases for persons arrested for or convicted of prostitution; making it unlawful for persons tested positive for certain sexually transmissible diseases to engage in prostitution; providing for screening of persons or inmates who injure a law enforcement or correctional officer or firefighter or paramedic acting within scope of employment; providing penalties; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 796.07, Florida Statutes, is amended to read:

796.07 [illegible] prostitution etc.; evidence; penalties; definitions.--

(1) As used in this section, ~~unless the context clearly requires otherwise:~~

(a) ~~The term~~ "Prostitution" means ~~shall be construed to include~~ the giving or receiving of the body for sexual activity ~~intercourse~~ for hire, ~~and shall also be construed to~~

CODING: Words stricken are deletions; words underlined are additions.

~~include-the-giving-or-receiving-of-the-body-for-licentious sexual-intercourse-without-hire.~~

(b) ~~The-term~~ "Lewdness" means ~~shall-be-construed-to~~ ~~include~~ any indecent or obscene act.

(c) ~~The-term~~ "Assignation" means ~~shall-be-construed-to~~ ~~include~~ the making of any appointment or engagement for prostitution or lewdness or any act in furtherance of such appointment or engagement.

(d) ~~The-term~~ "Prostitution" as used in paragraph (a) shall be construed so as to exclude sexual activity ~~intercourse~~ between a husband and his wife.

(e) "Sexual activity" means oral, anal, or vaginal penetration by, or union with, the sexual organ of another or the anal or vaginal penetration of another by any other object, or the handling or fondling of the sexual organ of another for the purpose of masturbation; however, the term does not include acts done for bona fide medical purposes.

(2) ~~After-May-1,-1943,~~ It is ~~shall-be~~ unlawful in the state:

(a) To keep, set up, maintain, or operate any place, structure, building, or conveyance for the purpose of lewdness, assignation, or prostitution.

(b) To offer, or to offer or agree to secure, another for the purpose of prostitution, or for any other lewd or indecent act.

(c) To receive, or to offer or agree to receive, any person into any place, structure, building, or conveyance for the purpose of prostitution, lewdness, or assignation, or to permit any person to remain there for such purpose.

(d) To direct, take, or transport, or to offer or agree to take or transport, any person to any place,

structure, or building, or to any other person, with knowledge or reasonable cause to believe that the purpose of such directing, taking, or transporting is prostitution, lewdness, or assignation.

(3) It is also ~~shall further be~~ unlawful in the state:

(a) To offer to commit, or to commit, or to engage in, prostitution, lewdness, or assignation.

(b) To solicit, induce, entice, or procure another to commit prostitution, lewdness, or assignation with himself or herself.

(c) To reside in, enter, or remain in, any place, structure, or building, or to enter or remain in any conveyance, for the purpose of prostitution, lewdness, or assignation.

(d) To aid, abet, or participate in the doing of any of the acts or things enumerated in subsections (2) and (3) of this section.

(e) To purchase the services of any person engaged in prostitution.

(4) In the trial of any persons charged with the violation of any of the provisions of this section, testimony concerning the reputation of any place, structure, building, or conveyance involved in said charge, and of the person or persons who reside in, operate, or frequent the same, and of the defendant, shall be admissible in evidence in support of the charge.

(5) Any person who violates any provision of this section is ~~shall be deemed~~ guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

Section 2. Section 796.08, Florida Statutes, is created to read:

796.08 Screening for sexually transmissible diseases; providing penalties.--

(1) Any person arrested under s. 796.07 may request screening for a sexually transmissible disease under direction of the Department of Health and Rehabilitative Services and, if infected, shall submit to appropriate treatment and counseling.

(2) Any person convicted of prostitution under the provisions of s. 796.07, shall be required to undergo screening for a sexually transmissible disease under direction of the Department of Health and Rehabilitative Services and, if infected, shall submit to treatment and counseling as a condition of release from probation, community control or incarceration. For the purposes of this section, "sexually transmissible disease" means a bacterial, viral, fungal or parasitic disease, determined by rule of the department to be sexually transmissible, a threat to the public health and welfare, and a disease for which a legitimate public interest will be served by providing for regulation and treatment. In considering which diseases are to be designated as sexually transmissible diseases, the department shall consider such diseases as chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum, genital herpes simplex, chlamydia, nongonococcal urethritis (NGU), pelvic inflammatory disease (PID)/Acute Salpingitis, syphilis, and human T-lymphotropic virus type III (HTLV-III) infection for designation, and shall consider the recommendations and classifications of the Centers for Disease Control and other nationally recognized

CODING: Words stricken are deletions; words underlined are additions.

authorities. Not all diseases that are sexually transmissible need be designated for purposes of this statute.

(3) Any person who commits prostitution and who, prior to the commission of such crime, had tested positive for a sexually transmissible disease and knew or had been informed that he had tested positive for a sexually transmissible disease and that he could possibly communicate such disease to another person through sexual activity is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.083, s. 775.083, or s. 775.084. A person may be convicted and sentenced separately for a violation of this subsection and for the underlying crime of prostitution.

(4) The department or its authorized representatives may examine or cause to be examined any person or inmate who injures a law enforcement or correctional officer, or a firefighter or paramedic acting within the scope of employment. Evidence of injury and a statement by a licensed physician that the nature of the injury is such as to result in the transmission of a disease covered by this act shall constitute probable cause for issuance of a warrant duly authorized by a court of competent jurisdiction.

Section 3. This act shall take effect October 1, 1986.

Signed by Governor
6/24/86

CODING: Words stricken are deletions; words underlined are additions.

APPENDIX E

Guidelines for the Medical Screening of Convicted Prostitutes for Sexually Transmitted Diseases

I. Screening of Prostitutes

A. Legislation (CS for SB 576) requires that all persons convicted of prostitution, be screened for sexually transmitted diseases (STDs), counseled and treated as necessary.

B. All persons who are charged or arraigned for prostitution should be counseled and offered STD screening at that time.

II. Sexually Transmitted Diseases Designated for Screening

A. AIDS (HTLV-III/HIV infection)

B. Syphilis

C. Gonorrhea

D. Chlamydia trachomatis

III. Methods and Materials

A. The standard laboratory test for AIDS is the Human Immunodeficiency Virus (HIV) antibody test and for syphilis the VDRL, a nontreponemal test.

B. Laboratory tests for the HIV antibody screening and syphilis screening requires the drawing of blood. For both tests a minimum of 2 ml. of serum is required.

C. Screening for gonorrhea will require accurate history taking to identify all potential sites of infection for specimen collection and inoculation on selective media. The "Guide for the Diagnosis of Gonorrhea: Using Culture and Gram Stain" should be used (Attachment A).

D. The laboratory test for Chlamydia is <u>either</u> flourescent

antibody (FA) examination of a direct smear or an enzyme immunoassay test (EIA), as described in Chlamydia trachomatis Infections: Policy Guidelines for Prevention and Control (Attachment B).

When the test will be required infrequently (e.g. 1-2 per day) and a highly skilled technician is available, the FA is recommended.

When large numbers (e.g. 20) tests are required, the EIA will be more economical.

E. Although local detention facilities may not have the capability to screen for all STDs, it is critical that the patient receive a basic physical examination as outlined in the "Quality Assurance Guidelines for STD Clinics 1986", pages 8 and 9 (Attachment C).

IV. Counseling

A. HRS District STD Control Programs will provide staff to conduct a limited number of counseling/interviews. These will include all patients diagnosed with early syphilis, penicillin-resistant gonorrhea and complicated gonorrhea. Referrals for counseling should be made to the District STD Program Manager (Attachment D).

B. All other STD patients should be counseled by detention facility medical staff. Counseling should include medical compliance, return for post treatment testing, assured examination of sexual partners, risk reduction and response to disease suspicion.

C. Counseling of those with positive HIV infection should conform with current HRS protocols (Attachment E).

V. Treatment Protocols

A. Detention medical facilities should adhere to the recommended "1985 STD Treatment Guidelines" (Attachment F).

B. In view of the high incidence of penicillin-resistant gonorrhea in Florida, special attention should be given to page 10 of the "Treatment Guidelines."

C. Currently, there are no antimicrobials available for the treatment of HIV infections.

VI. Reporting

A. STDs including full-blown cases of AIDS, but excluding HIV infection, shall be reported by any attending practitioner or superintendent or manager of any penal institution.

B. Reports shall be submitted to the STD Control Program Office of the HRS district office having jurisdiction for the area wherein the detention center is located. (Attachment D).

C. Aggregate reporting of EIA test results, number tested and number positive for HIV infection will be reported monthly to the AIDS Program in the local County Public Health Unit.

APPENDIX F

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)
CONFIDENTIAL CASE REPORT
CDC 50.42 REV. 12-84

Introduction and Purpose

The "Acquired Immunodeficiency Syndrome (AIDS) Confidential Case Report" is a 3-part, snap-out form, which when folded in half will fit in standard files. The form is designed to collect in a confidential manner information that will lead to a better understanding of and ability to control the spread of AIDS.

The completed form should be sent to the appropriate State or local health agency. The white copy, without patient or physician identifier information, will be submitted by the health agency to the Surveillance and Statistics Section, AIDS Branch, Division of Viral Diseases, Center for Infectious Diseases, Centers for Disease Control, Atlanta, Georgia 30333. The other copies, with patient or health care provider identifier information, are to be retained by the State and local health agencies.

The phonetic alphanumeric code (Soundex), used in conjunction with the date of birth, and the State or city/county number will be used in place of the patient's name to facilitate communication between health agencies, minimize duplicate reporting of cases, and allow timely feedback of information to reporting agencies.

"Instructions for Completing the AIDS Case Report Form" are provided below on items that may require clarification. While all the items on this form are important, those in *Italics* are critical for classifying, processing, and reporting each case.

Date Form Completed — The date the patient information was entered onto the case report form.

***Soundex Name Code** — The patient's surname is to be converted to the phonetic alphanumeric code by the State or local health department before the form is sent to CDC. Assistance in determining the Soundex code may be obtained from the Surveillance and Statistics Section, AIDS Branch, CDC, (404) 329-3472, FTS 236-3472.*

Status of this Report — Check "New Case" if information about the patient has not been previously reported. Check "Update Report" to reflect a change in the condition or status of a patient whose case has already been reported to CDC.

Reporting Health Department — State, city, or county agency reporting the case to CDC.

Section I. ***Basic Patient Information***

CDC Patient Number — To be assigned by CDC.

State or City/County Number — To be assigned at the State or local level before sending the case to CDC.

Residence at Onset of Illness Suggestive of AIDS — Patient's city and State of residence at the time of onset of AIDS related illness (including prodromal symptoms, *not* necessarily the residence at the time of diagnosis, hospitalization, or report.

Hospital Where Diagnosis of AIDS Established — Enter name and location. If the patient was not hospitalized, but the diagnosis was made from a specimen submitted to a hospital laboratory, enter the name and location of that hospital. If no hospital was involved, leave blank.

Section II. ***Diseases at Least Moderately Indicative of Cellular Immunodeficiency and AIDS***

Check all diseases that apply. Note the month and year of diagnosis (or date of specimen collection, if it preceded diagnosis by a month or more).

For classification under the surveillance definition of AIDS, only cases in which the diseases were diagnosed by sufficiently reliable methods (those listed in the left-hand column under "Methods of Diagnosis") will be accepted.

Section III. ***Other Opportunistic or Underlying Diseases** — Other diseases that might result from immunodeficiency or diseases that might cause reduced resistance.*

(Continued on opposite page)

ASSURANCE OF CONFIDENTIALITY FOR AIDS SURVEILLANCE
CENTERS FOR DISEASE CONTROL

The national surveillance program for the acquired immunodeficiency syndrome (AIDS) is being coordinated by the Centers for Disease Control (CDC), an agency of the U.S. Public Health Service (USPHS). The surveillance information requested by CDC consists of reports of persons with suspected or confirmed AIDS or related conditions. The data are used for statistical summaries and research by USPHS scientists and cooperating state and local health officials to help understand and control the spread of AIDS.

Information in the surveillance system that would permit identification of any individual or establishment is collected with a guarantee that it will be held in confidence, will be used only for purposes stated in this assurance, and will not otherwise be disclosed or released without the consent of the individual or the establishment in accordance with Sections 306 and 308(d) of the Public Health Service Act (42 U.S.C. 242k and 242m).

Information you provide that could be used to identify an individual will be kept confidential. Full names, addresses, social security numbers, and telephone numbers will not be collected about cases reported to this surveillance system. Medical, personal and lifestyle information about the case, the birthdate, and an alpha numeric code based on surname will be collected.

Surveillance information reported to the CDC will be used without identifiers primarily for statistical and analytic summaries in which no individual can be identified and, secondarily, for special investigations of the natural history and epidemiology of AIDS. When necessary for confirming surveillance information or in the interest of public health and disease prevention, the CDC may confirm information contained in case reports or may notify other medical personnel or health officials of such information; in each instance, only the minimum information necessary will be disclosed.

Collaborative research efforts with an important public health purpose will require approval by the Director of CDC pursuant to strict conditions. If disclosure of identifying information to the collaborating researchers is essential to conduct of the research, a written certificate will be required that identifying information obtained from CDC will be managed as confidential and will not be released or redisclosed.

No CDC AIDS surveillance information that could be used to identify individuals, either directly or indirectly, will be made available to anyone for nonpublic health purposes. In particular, such information will not be disclosed to the public, parties involved in civil, criminal, or administrative litigation, or non-health agencies of the federal, state, or local government.

Instructions *(continued from opposite page)*

Section IV. ***Known Causes of Reduced Resistance***

Did this patient have any other medical condition which may cause immunodeficiency? Answer yes or no. If yes, specify.

MEDICAL CONDITIONS WHICH MAY CAUSE IMMUNODEFICIENCY:

1. *Cancer of lymphoid or histiocytic tissue, such as lymphoma (except for lymphoma localized to the brain), Hodgkin's disease, lymphocytic leukemia, multiple myeloma, or angioimmunoblastic lymphadenopathy.*
2. *An immunodeficiency atypical of AIDS, such as one involving hypogammaglobulinemia, or an immunodeficiency whose cause appears to be a genetic or developmental defect.*
3. *Exogenous malnutrition (starvation).*

Receive systemic corticosteriod therapy within 1 month before diagnosis of the earliest opportunistic disease? Answer yes or no.

Receive other systemic immunosuppressive or cytotoxic therapy within 1 year before diagnosis of the above opportunistic disease? Answer yes or no.

If the answer is yes to either of the above two questions, did symptoms specifically related to the opportunistic disease precede the immunosuppressive therapy? Answer yes or no.

Section V. Social and Risk Factors

IF THE PATIENT HAS DONATED BLOOD OR PLASMA SINCE JANUARY 1, 1978, enter the exact name and location of the blood/plasma center(s) and approximate month/day/year of each donation. (Use additional sheets if necessary). Donor information is shared with the U.S. Food and Drug Administration, which has the responsibility for the follow-up of all commercial blood/plasma products donated by AIDS patients.

Section VI. Laboratory Data

The laboratory tests listed are not required as part of the case definition used in the surveillance of AIDS. Serologic and virus isolation tests for AIDS may be required only after reliable tests become readily available.

Section VII. Additional Information or Comments

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)
CONFIDENTIAL CASE REPORT
CDC 50.42 REV. 12-84

Introduction and Purpose

The "Acquired Immunodeficiency Syndrome (AIDS) Confidential Case Report" is a 3-part, snap-out form, which when folded in half will fit in standard files. The form is designed to collect in a confidential manner information that will lead to a better understanding of and ability to control the spread of AIDS.

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Status of this Report — Check "New Case" if information about the patient has not been previously reported. Check "Update Report" to reflect a change in the condition or status of a patient whose case has already been reported to CDC.

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Information in the surveillance system that would permit identification of any individual or establishment is collected with a guarantee that it will be held in confidence, will be used only for purposes stated in this assurance, and will not otherwise be disclosed or released without the consent of the individual or the establishment in accordance with Sections 306 and 308(d) of the Public Health Service Act (42 U.S.C. 242k and 242m).

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Collaborative research efforts with an important public health purpose will require approval by the Director of CDC pursuant to strict conditions. If disclosure of identifying information to the collaborating researchers is essential to conduct of the research, a written certificate will be required that identifying information obtained from CDC will be managed as confidential and will not be released or redisclosed.

No CDC AIDS surveillance information that could be used to identify individuals, either directly or indirectly, will be made available to anyone for non-public health purposes. In particular, such information will not be disclosed to the public, parties involved in civil, criminal, or administrative litigation, or non-health agencies of the federal, state, or local government.

Instructions (continued from opposite page)

Section IV. ***Known Causes of Reduced Resistance***

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MEDICAL CONDITIONS WHICH MAY CAUSE IMMUNODEFICIENCY:

1. *Cancer of lymphoid or histiocytic tissue, such as lymphoma (except for lymphoma localized to the brain), Hodgkin's disease, lymphocytic leukemia, multiple myeloma, or angioimmunoblastic lymphadenopathy.*
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3. *Exogenous malnutrition (starvation).*

Receive systemic corticosteroid therapy within 1 month before diagnosis of the earliest opportunistic disease? Answer yes or no.

Receive other systemic immunosuppressive or cytotoxic therapy within 1 year before diagnosis of the above opportunistic disease? Answer yes or no.

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The laboratory tests listed are not required as part of the case definition used in the surveillance of AIDS. Serologic and virus tion tests for AIDS may be required only after reliable tests become readily available.

Section VII. Additional Information or Comments

Patient's Name _____ Telephone No.: _____

Address _____

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)
CONFIDENTIAL CASE REPORT

Physician's Name: _____ Telephone No.: _____

Hospital: _____ Medical Record No.: _____

Person Completing Form: _____ Telephone No.: _____

AIDS BRANCH
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL
ATLANTA, GEORGIA 30333

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)
CONFIDENTIAL CASE REPORT

FORM APPROVED
OMB NO. 0920-0009

This report is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of AIDS. Information in the surveillance system that would permit identification of any individual or establishment is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on the reverse of the form, and will not otherwise be disclosed or released without the consent of the individual or the establishment in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

DATE FORM COMPLETED: Mo. Day Year

SOUNDEX NAME CODE

HEALTH DEPARTMENT USE ONLY
STATUS OF THIS REPORT: [1] New Case [2] Update Report
REPORTING HEALTH DEPARTMENT: State _____ City/County _____

CDC USE

I. BASIC PATIENT INFORMATION

Date of Birth: Mo. Day Year
Age at Diagnosis of AIDS: Years
Current Status: [1] Alive [2] Dead [9] Unknown
Date of Death: Mo. Day Year

CDC PATIENT NUMBER
STATE PATIENT NUMBER
CITY/COUNTY PATIENT NUMBER

Sex: [1] Male [2] Female

Race/Ethnicity: [1] White (not Hispanic) [2] Black (not Hispanic) [3] Hispanic [4] Asian/Pacific Islander [5] American Indian/Alaskan Native [9] Not Specified

RESIDENCE AT ONSET OF ILLNESS SUGGESTIVE OF AIDS:
City _____ Zip Code _____
County _____ State/Country _____

CDC USE: CITY COUNTY STATE

HOSPITAL WHERE DIAGNOSIS OF AIDS ESTABLISHED:
Name _____
City _____ State _____

HOSPITAL: CITY STATE

II. DISEASES AT LEAST MODERATELY INDICATIVE OF CELLULAR IMMUNODEFICIENCY AND AIDS

DISEASE *(Check all that apply)* — Date of Specimen or Diagnosis: Mo. Year — Method of Diagnosis (Check One): Microscopy (Histology Cytology) / Other

- [1] Kaposi's sarcoma — [1] / [0]
- [1] *Pneumocystis carinii* pneumonia — [1] / [0]
- [1] Toxoplasmosis (exclude if only in liver, spleen, muscle, or lymph nodes) [1] Brain/CNS [8] Other Site — [1] / [0]
- [1] Cryptosporidiosis with diarrhea persisting > 1 mo. — [1] / [0]
- [1] Cytomegalovirus infection histopathologically documented (exclude if only in liver, nodes, or mononucleosis syndrome, or diagnosis by serology or culture alone) — [1] / [0]
- [1] Primary lymphoma of brain — [1] / [0]
- [1] Progressive multifocal leukoencephalopathy (Papovavirus infection, brain) — [1] / [0]

Endoscopy/Autopsy with culture, microscopic, or gross exam of esophagus

- [1] Candida esophagitis — [1] / [0]
- [1] Atypical (non tuberculous) mycobacterial infection, disseminated, e.g. bone marrow or multiple organ involvement (exclude if only pulmonary and/or lymph node infection) — Culture [1] / Other [0]

Species: [1] *M. avium intracellulare* [8] Other, (Specify): _____

Microscopy, Culture, or Antigen

- [1] Cryptococcal infection (exclude pulmonary only) [1] Meningitis [2] Other internal organ [3] Blood — [1] / [0]
- [1] Chronic mucocutaneous herpes simplex infection persisting > 1 mo. — [1] / [0]

CDC USE SPECIES

III. OTHER OPPORTUNISTIC OR UNDERLYING DISEASES

PATHOGEN/DISEASE	ANATOMIC SITE	DATE OF SPECIMEN OR DIAGNOSIS Mo. Yr.	CDC USE PATHOGEN/DISEASE	CDC USE ANATOMIC SITE

IV. KNOWN CAUSES OF REDUCED RESISTANCE

Did this patient — Yes / No

Have any other medical condition which may cause immunodeficiency? (See Section IV of instructions on back of form) [1] / [0]
If yes, specify: _____

Receive systemic corticosteroid therapy within 1 month before diagnosis of the earliest opportunistic disease? [1] / [0]

Receive other systemic immunosuppressive or cytotoxic therapy within 1 year before diagnosis of the earliest opportunistic disease? [1] / [0]

If the answer is Yes to either of the above two questions, did symptoms specifically related to the opportunistic disease precede the immunosuppressive therapy? [1] / [0]

V. SOCIAL AND RISK FACTORS

Was patient born in U.S. (50 states, Washington, D.C.)? Yes [1] No [0] Unk [9] If no, date of arrival in U.S.: Mo. Yr.

CDC USE COUNTRY

If patient was born outside U.S., what was country/territory of birth? [1] Canada [3] Dominican Republic [4] Haiti [5] Mexico [6] Puerto Rico [8] Other (Specify country/territory) _____

What is the sexual orientation of the patient? [1] Heterosexual [2] Homosexual [3] Bisexual [4] None [9] Unknown

Did the patient ever use needles for self injection of drugs not prescribed by a physician? [1] Yes [0] No [9] Unk

FOR WOMEN: Has the patient delivered a live-born infant since 1978? [1] Yes [0] No [9] Unk Is patient currently pregnant? [1] Yes [0] No [9] Unk

SINCE 1978 AND PRECEDING THE DIAGNOSIS OF AIDS, DID THIS PATIENT:

CDC USE OCCUPATION

Work in a health care or clinical laboratory setting? [1] Yes [0] No [8] Unk If yes, specify occupation: _____

Receive any blood products (i.e. Factor VIII or IX, cryoprecipitate, or fibrinogen) for the treatment of a coagulation disorder? [1] Yes [0] No [8] Unk

If yes, specify disorder [1] Hemophilia A (Factor VIII) [2] Hemophilia B (Factor IX) [8] Other, specify _____

	Yes	No	Unk
Have sexual relations with a male partner?	1	0	9
Have sexual relations with a female partner?	1	0	9
Have heterosexual relations with a person with a risk factor for AIDS?	1	0	9

	Yes	No	Unk
Receive hepatitis B vaccine?	1	0	9
Receive hepatitis B immune globulin (HBIG)?	1	0	9
Receive other immune globulin?	1	0	9
Receive blood or blood components e.g. packed red cells, platelets or plasma?	1	0	9

Since 1978, has patient donated blood or plasma? [1] Yes [0] No [9] Unk If yes, complete next section.

Blood/plasma center(s) of most recent donation(s): Name of Center / City / State / Approximate Date(s) of Donation Mo. Day Yr.

VI. LABORATORY DATA

T-HELPER/T-SUPPRESSOR (T_H/T_S) RATIO: _____

INTERPRETATION OF T_H/T_S RATIO FOR THIS PATIENT IS: [1] Normal [2] High [3] Low

DATE OF T – LYMPHOCYTE RATIO TEST: Mo. Day Yr.

SEROLOGIC TEST FOR AIDS — Specify Type of Test: — Result Pos. Neg. — Date Mo. Day Yr.

VIRUS ISOLATION — Specify Source of Specimen (Blood, Semen, Saliva, etc.): — Result Pos. Neg. — Date Mo. Day Yr.

CDC USE

VII. ADDITIONAL INFORMATION OR COMMENTS

CDC USE: Form Reviewer _____ Date of Form Review Mo. Day Yr. _____ Case Classification _____ Other _____