Governor's Advisory Council on AIDS

REPORT ON AIDS IN COLORADO: Impact, Implications and Recommendations

April, 1988

"We are fighting a deadly disease. We are not fighting the people who have that disease."

C. Everett Koop
United States Surgeon General

STATE OF COLORADO

EXECUTIVE CHAMBERS
136 State Capitol
Denver, Colorado 80203-1792
Phone (303) 866-2471

Roy Romer
Governor

April 25, 1988

The Honorable Roy Romer, Governor
State of Colorado
State Capitol, Room 136
Denver, Colorado 80203

Dear Governor Romer:

It is with pride and relief that the Colorado Governor's Advisory Council on AIDS presents you with our "Report on AIDS in Colorado: Impact, Implications, and Recommendations".

We are proud because in spite of diverse backgrounds and often conflicting perspectives, we have reached agreement on a blueprint for you as Governor and for the State of Colorado in dealing with the AIDS epidemic. The proposed actions build on the outstanding work already in progress within the voluntary, public, and private sectors of the State.

We are relieved because we have completed our work nearly within our self-imposed deadline, the result of hundreds of hours of volunteer time from the Council members working in their work groups and on the draft report itself. In my experience, I have seldom seen such dedication and persistence, such willingness to study the issues, prepare reports, and debate successive drafts, and such consistency in doing all of this with humor, sensitivity, and urgency about the task itself.

Thank you for the opportunity to serve on your Council. It has been a unique privilege indeed. We look forward to working with you to implement those elements of the report with which we might be able to assist.

Sincerely,

David Lawrence, M.D.
Chairman
Colorado Governor's Advisory Council on AIDS

DL:djm

TABLE OF CONTENTS

APPENDICES

Council Information

Consulting Agencies and Experts

ACKNOWLEDGEMENTS

The Governor's Advisory Council on AIDS wishes to acknowledge the contributions of members, consultants, staff and funders for the time, expertise and support committed to completion of this report.

Special recognition is due to the Colorado Trust and Kaiser Permanente for grant and in-kind support, and to Joyce Davis and MeriLou Johnson for clerical and staff support.

We also wish to recognize the contributions of the members of commissions, task forces, special study groups, etc. from around the country who generously shared their reports and experiences with us, enabling us to build on the excellent work done elsewhere.

Particular thanks is due to the Intergovernmental Health Policy Project for publication of their three-volume guide, AIDS: A Public Health Challenge, which has been an invaluable resource in focusing our efforts. With permission, we have made use of material from the guide.

EXECUTIVE SUMMARY

The AIDS epidemic will continue to impact Colorado citizens into the 21st Century, not only because of continuing spread of the infection itself, but also because of social and financial costs of dealing with those who become ill as a result of the HIV virus. Until a vaccine is developed or until definitive treatment is introduced, the major tools for responding will continue to be education, disease surveillance and life-prolonging and terminal care. Current expenditure levels and support systems are inadequate to meet the demands we anticipate in the near future, much less into the next decade. The implications for the state are serious and must be addressed now.

The Council proposes a ten-point action plan for the Governor's consideration, as summarized below.

Recommendation #1: Articulate an explicit position on the impact of AIDS in Colorado and the role of government in responding to it.

Recommendation #2: Monitor the following areas to ensure objectivity and fairness, and to identify possible interventions required of the Governor:

1. State Auditor's analysis and evaluation of regulatory provisions for Implementation of C.R.S. 25-4-14.
2. Development of AIDS policies and programs within the state corrections system.
3. Experiments to better reach the population of IV drug users in the general community.

Recommendation #3: Support and adequately fund an ongoing body or bodies to oversee statewide efforts in responding to the AIDS epidemic.

Recommendation #4: Document AIDS health care costs to facilitate assessment and planning for care delivery needs in the state.

Recommendation #5: Actively support a comprehensive health education curriculum with human sexuality and substance abuse components that include AIDS education and prevention in Colorado's middle and secondary schools.

Recommendation #6: Select and promote a model workplace program for addressing the AIDS epidemic.

Recommendation #7: Provide state funding for targeted education programs of community based AIDS projects.

Recommendation #8: Lead efforts to develop state funding for education, prevention and treatment of AIDS, including:

1. Creation of a medically uninsurable risk pool;
2. Development of financial protections for health insurers experiencing prolonged adverse selection against AIDS;
3. Review of state tax codes for possible incentives to promote education and prevention efforts;
4. Modification of Medicaid to cover AZT and to encourage development of lower cost care alternatives;
5. Development of alternatives for improving the state's Medicaid program;
6. Assessment of potential demand for and provision of intermediate, hospice, homecare and assisted living care systems in the state.
7. Advocate for changes in federal policies that are impeding effective state response to the AIDS epidemic, including modification of ERISA protections of self-insured programs, and Medicaid and Medicare guidelines for home-based care.

Recommendation #9: Request that the State Division of Housing, Colorado Housing Authority and the Health Care Financing Authority work together to develop a range of program and resource options available to meet the growing housing needs of persons with AIDS.

Recommendation #10: Lead statewide efforts to eliminate civil rights violations against people with HIV infection and AIDS, and people perceived to be at risk for HIV infection, through:

1. Review of existing protections against AIDS-related discrimination;
2. Study of such problems that have occurred within the state during the epidemic; and
3. Consistent articulation of legal and moral bases for non-discrimination.

Ethics

The magnitude and cost of the AIDS epidemic creates major financial, social and political dilemmas for our state. The epidemic also forces us to confront several fundamental ethical dilemmas which must receive thorough consideration. It is our view that the public policy response must be firmly rooted in these ethical considerations.

Three ethical issues of particular importance are: the manner in which we as a society choose to respond to those with AIDS or at

risk of developing AIDS; the framework within which we make decisions about allocation of scarce resources, both public and private; and the dilemma posed by forced choices between conflicting moral positions.

The difficult issues raised by the AIDS epidemic cannot and should not be avoided. Maintaining a consistent perspective that recognizes the deadly, costly and elusive nature of the disease will enable the Governor to chart a course through the controversies, conflicting moral views and competing options raised by AIDS. Clear identification of the realities about the virus and the infection must guide the policy-making process. Using this approach will help avoid inaction or an overly political resolution of the public health and health care financing problems raised by AIDS.

INTRODUCTION

The Governor's Advisory Council on AIDS, which is broadly representative of a wide range of AIDS-related concerns, was appointed in June, 1987 in response to the Governor's wish to better understand the current and anticipated effects of the AIDS epidemic in Colorado. The increasing number of people dying from and developing AIDS and the impact of their illness and loss on their loved ones, their friends, their community and our state lends urgency to the task of the Council. In his charge to the Council, Governor Romer said:

> "Formulation of a statewide policy to reduce the spread of AIDS and address the personal tragedies and social and medical problems associated with this deadly disease is critical. The Council will advise us on not only how to control this disease but on how to best be caring and compassionate to those who are its victims. I expect this Council to help this state weave its path through a policy of firmness in terms of control and fairness in terms of care of individuals."

By the time the Council was created, a rich body of information about AIDS had been developed in the country, and a complex system of disease control and care for AIDS had developed within the state.

The focus of most state task forces and commissions has been to develop detailed recommendations for procedurally addressing control and treatment of the AIDS disease. Ours is not such a report. Nor is it an extensive review of the impact of AIDS on Colorado, either from a human or an epidemiological point of view. Our report identifies what we believe are the key issues facing the Governor and the state as a result of the AIDS epidemic. It also recommends actions we consider most important for Governor Romer to take in response to the identified issues.

The Council, which has met regularly since June, 1987, divided into five work groups representing the areas in which investigation and recommendations are most needed; these were: Care Delivery, Disease Control, Education and Public Information, Financing and Legal/Discrimination. In addition to meetings of the Council, the work groups established their own meeting schedules, identified key contacts and resources, and developed recommendations for review by the full Council.

Throughout our deliberations we have attempted to adhere to the following process: first, the critical policy questions were identified; next, the options for addressing the questions were developed; third, the advantages and disadvantages of the various

options were evaluated; and finally, where consensus could be reached, one of the options was selected as the recommended response to the policy question. Because of the emotional and political tensions surrounding many AIDS-related issues and the advantage of having a broadly representative Council, we believe this approach has enabled us to identify and objectively evaluate the various perspectives of these issues.

Because our report is intended to lead to action, we have summarized Council recommendations in this document. The reader is encouraged to explore research materials and work group drafts on file in the Governor's Office of Policy and Research for detailed background information.

The perspective section of the report describes the impact AIDS has had and is projected to have on Colorado. Data are provided for: infection, death and seroconversion rates; care costs and expenditure levels; and comparisons of Colorado expenditure patterns with other states. We have concluded this section with a presentation of several major ethical dilemmas that the AIDS epidemic has forced us to confront.

Next, we offer an action program for the Governor. The program represents the most critical of the Council's findings and recommendations. The Action Program is a synthesis of work group research and recommendations and public testimony from community organizations and interests uniquely affected by the AIDS epidemic.

The remaining sections include summary findings and recommendations of the work groups, followed by appendices containing information about: the composition of the Advisory Council and work groups; a list of resources used for consultation and education; a glossary of terms commonly used in discussing AIDS; and the "Code of Conduct" adopted by the Council. The code defines the operating framework within which Council members agreed to manage discussions of this sensitive subject of AIDS. The final appendix item is a copy of the Colorado AIDS statute.

We present our findings, confident that we have responded to the charge originally set forth by Governor Romer. Having completed the background work necessary to carry out that challenge, now more than ever, we offer this report with a sense of compassion and concern and, most importantly, with a sense of urgency to get on with the difficult tasks that face the State as a result of the epidemic.

PERSPECTIVE ON AIDS IN COLORADO

Definition

Acquired Immune Deficiency Syndrome (AIDS) is an immune system disorder presently assumed to be caused by a blood-borne virus called Human Immunodeficiency Virus (HIV). The virus attacks a particular type of immune system cell, crippling the body's disease resistance capacity and leaving it vulnerable to life-threatening infections and cancers. AIDS is a new and complex disease about which knowledge changes rapidly, for which there is no known vaccine or cure, and which is most often ultimately fatal. It is global in distribution and is having a significant impact on the state of Colorado.

Epidemiology

- Colorado accounts for between 1-1.3% of the more than 53,000 AIDS cases reported nationwide. As of April 25, 1988, 648 clinically diagnosed cases of AIDS had been reported from Colorado; of that number 387 have died. At least 65 cases diagnosed out of state also are being followed in Colorado.

- In March, 1988, more AIDS cases were diagnosed and reported in Colorado than in any month since the first case was diagnosed in 1982.

- Over 84% of Colorado cases are in the Denver area.

- As of February 1988, Colorado ranked 11th nationwide in number of cases per 100,000 residents and 17th in absolute numbers of cases reported. Colorado ranks 26th in population.

- There are 18,000 to 30,000 HIV infected persons in Colorado, most asymptomatic, and all capable of infecting others. Symptoms may not occur for ten years or more after infection.

- By the end of 1991, the estimated cumulative number of AIDS cases in Colorado will be 3345, 962 of which will be diagnosed in 1991 alone. While we know that new infections will continue to occur, it is difficult to project the rate or number increase through 1991 because the epidemiology of the disease may be changing.

- The annual rate of increase in clinically diagnosed AIDS cases in Colorado declined between 1982 and 1987, but experts remain cautious about predictions that the epidemic is coming under control because of the large numbers of infected, asymptomatic persons in the population.

- Men who have sex with men account for 75% of the state's AIDS cases; another 5% report IV drug use as the risk behavior; and an additional 12% fall into a category combining the two previous groups. Approximately 30-40% of gay men, 2-5% of IV drug users and 50% of hemophiliacs tested in Denver have been seropositive for HIV.

- The incidence of AIDS in Colorado among racial groups is: Whites, 82%; Blacks, 6%, and Latinos, 11%. A few cases have been reported among American Indians. The case distribution is consistent with the racial/ethnic composition of the general state population: Whites, 82.9%; Blacks, 3.5%; and Latinos, 11.8%, American Indian, 1% The distribution of those seeking AIDS antibody testing shows a slightly higher proportion of Blacks (8%), and a slightly lower proportion of Latinos (7.7%), while the proportion of Whites reflects that of the general population (81.3%).

Costs

- There is no good mechanism for determining the cost of caring for someone with AIDS. In addition to inpatient and outpatient medical and support service costs, the fiscal impact of illness on employment and productivity can be significant but is difficult to quantify.

- In Colorado, current medical care charges for AIDS are approximately $35,400 per case per year, a figure at the low end of national studies. Using this figure and assuming no changes in treatment methods between now and the end of 1991, the minimum statewide charge for medical care only of new AIDS cases will be just under $100 million. The added costs of ongoing and outpatient care of symptomatic HIV patients are difficult to estimate but may equal the medical costs for AIDS.

- Denver General Hospital, which treats over 30% of AIDS cases in the state and which realizes a collection rate of 18% on inpatient AIDS treatment costs, projects a loss of approximately $2 million in AIDS-related care in 1988 alone. This is based on 109 projected new cases and an assumption of a one year life expectancy per patient.

Expenditures

- Colorado reports a state-only (exclusive of Medicaid, Social Security , federal funds or city/municipality funds) level of spending on all AIDS activities equal to $830 per diagnosed AIDS case and $.13 per capita. National averages are $3,323 and $.65 respectively.

- In 1987, over $1.3 million and $1.4 million were spent on AIDS activities by Denver Public Health and The Colorado Department of Health, respectively. Not included are the costs incurred for treating those with HIV infections outside of Denver Public Health Clinics, or the costs of AIDS-related activities to other local Colorado health departments and voluntary organizations.

- Of 37 states that report spending on AIDS, Colorado ranks 29th in per case spending, and of the total amount spent, only 35% is actually appropriated by the state for AIDS-related activities. The balance represents resources shifted from other areas and subsidies provided at the expense of other programs.

- As more people have become ill with AIDS or related conditions, there have been increasing demands for a growing range of services. Among the more critical shortages are housing, dental care, access to drug therapies and more extensive counseling for patients, and their families, lovers, friends and those who deliver health care to persons with AIDS.

Future Impact

Based on the data just presented, several conclusions emerge that form the basis for the Action Program that follows.

1. Though the epidemic may not spread as widely through the population of Colorado as originally feared, the threat of continued transmission of HIV remains, not only in high risk populations of men who have sex with men and their sexual contacts, IV drug users and their sexual contacts, and sexual contacts of blood recipients, but in lower risk heterosexual populations as well.

2. Until a vaccine is found, the main tools available to control the spread of HIV are: education about the disease and its prevention; vigilance in disease surveillance; and screening the blood supply and other tissue sources.

3. The major impact of the epidemic will continue to be in urban centers, specifically the Denver and Colorado Springs areas where the largest numbers of high risk individuals reside.

4. Although the minority (Latino, Black) populations have not been disproportionately affected by the epidemic in Colorado, experience in other parts of the country raises concern that this could occur because of the disproportionate prevalence of IV drug abuse within these

groups. Potential for HIV infection spread also exists among American Indians whose isolation and cultural mores place them at high risk for infection.

5. Because the number of infected individuals will remain high in selected populations and new individuals will continue to be infected, and because a portion of seropositive individuals will develop symptomatic HIV infection including AIDS, the significant human, social and financial burdens of the AIDS epidemic will continue into the next century.

6. Public and private financing, social support networks and care delivery systems are inadequate to deal with the numbers of Colorado citizens expected to develop disease in the remaining years of the century. This unfunded liability will increase significantly throughout the course of the epidemic.

7. Estimates of costs of caring for Colorado's AIDS patients only from time of diagnosis to death are expected to be $.3-.5 billion between now and the year 2000. This does not include costs of caring for those with symptomatic HIV infection (the precursor to AIDS), or for those who test positive for HIV antibody. Moreover, and perhaps more significantly, the estimate does not include the costs of lost productivity or employment, or of the extensive support system necessary to provide non-hospital care.

Ethical Dilemmas

The magnitude and cost of the AIDS epidemic creates major financial, social and political dilemmas. More important perhaps, the epidemic forces us to confront several fundamental ethical dilemmas. Beyond the decisions patients, families and clinicians face daily as they deal with issues of confidentiality, duty to inform, death and dying, or others that are part of the disease process are the ethical concerns that underlie public policy issues and that have been forced to the surface by the AIDS epidemic. The public policy response must be firmly rooted in these considerations.

Three such issues are of particular importance. First is the manner in which society chooses to respond to those with AIDS or at risk of developing AIDS. Second is the framework used to make decisions about allocation of scarce resources, both public and private. Third is the dilemma posed by forced choices among conflicting moral positions.

The predominance of AIDS among homosexual and bisexual men and racial and ethnic minorities, groups that traditionally have not benefited from full participation in society, raises the

disturbing possibility of further excluding them from daily life of the larger community, i.e., employment, insurance, housing, health care, support systems. Built into America's legal system, if not into the social fabric, has been the basic ethical tenet of tolerance for a wide range of people, ethnic groups and beliefs. Yet the veneer of tolerance is a thin one; witness the fire bombings of homes of families with children with AIDS, or the exclusion of children with AIDS from school, or adoption of legislation that discriminates on the basis of sexual orientation. Great care must be taken to protect those affected by the AIDS epidemic from any efforts to reverse the long years of struggle toward greater participation in society.

The manner in which resources are allocated across society has major ethical implications and may even be done through explicit ethical discussion. From the outset of our deliberations the Council has recognized the conflicting demands on the state at a time when resources are constrained. We encourage state leaders to adopt a position of support for those affected by the AIDS epidemic that is consistent with support for others in crisis--nothing more, but certainly nothing less.

Finally, the AIDS epidemic forces definition of a path through conflicting moral choices and significant controversy. As the epidemic runs its course, society will confront questions about the role of the State and educational institutions in providing explicit human sexuality education and AIDS prevention education in the high schools and middle schools. Society must chart a course that balances duty to protect the health of the general public with maintenance of civil rights of individuals specifically affected by AIDS. There will be difficult choices concerning effective interventions with IV drug users...does the State promote programs that teach IV drug users safer use of illegal paraphernalia to protect themselves, their sexual contacts and their offspring from AIDS?

These are examples of difficult issues forced to the surface by the AIDS epidemic: they cannot be avoided. Planning a direction through the controversies, conflicting moral views and competing options will be a challenging task for the Governor. While each issue will demand a solution appropriate to the situation, we recommend that the Governor be guided in these decisions by a consistent perspective that acknowledges the inherent nature of the AIDS epidemic. AIDS is dangerous. AIDS kills. AIDS is spreading indiscriminately. Care of those with AIDS or HIV infection is costly to society. AIDS is transmitted through activities that have for centuries eluded social, political or legal sanctions.

AIDS itself is not a moral issue, but each time a "solution" to a particular issue is proposed, moral positions will be taken. Each of us, as members of society and as citizens of this State, must remind ourselves that we are fighting a disease, not those individuals who have that disease.

ACTION PROGRAM FOR THE GOVERNOR

The Action Program contains recommendations focused within critical arenas in which the Governor can most effectively lead the state in responding to the AIDS epidemic. Areas covered include: general leadership activities; ongoing data collection, coordination and oversight activities; the role of education; support service needs of persons with AIDS; the state's role in financing AIDS activities; and discrimination protections.

I. General Leadership Activities

RECOMMENDATION #1. Articulate an Explicit Position on the Impact of AIDS in Colorado and the Role of Government in Responding to It.

At a minimum, the position should incorporate the data provided in this report, the implications as discussed, and awareness of the ethical concerns raised. It should also recognize:

a) the extensive state infrastructure and expertise related to AIDS, the dedication of members of this complex system to responding to the epidemic, and the inadequacy of the structure to meet the future demands of the AIDS epidemic.

b) the limited but critical coordinating role state government can play in building on what is in place and in remedying gaps in the system that create problems for those with AIDS; friends, lovers, family members or professionals caring for affected persons; or employers dealing with either the fear or reality of AIDS in the workplace.

In order to facilitate ongoing government response to the epidemic, we suggest development of a clearly defined administrative process within the Governor's office for evaluating and deciding AIDS-related matters.

RECOMMENDATION #2. Monitor the Following Areas:

1. State Auditor's Analysis and Evaluation of the Regulatory Provisions Adopted to Implement C.R.S. 25-4-14. Prior to the C.R.S. 25-4-14 sunset date, the state auditor is required to carry out an evaluation of the regulatory provisions of the bill. Of particular importance will be assessment of mandatory named reporting of individuals testing HIV antibody positive, one of the most controversial aspects of the legislation. It is imperative to monitor the evaluation process to ensure its fairness and completeness prior

to assuming a position on subsequent legislation. Because the epidemic will continue to affect the state into the next century, the Governor can anticipate further action by the General Assembly and therefore a need to respond to subsequent legislative initiatives on HIV control.

2. Development of Policies and Programs Within the State Corrections System. The prevalence of HIV antibody positive individuals is high in the corrections system. The IV drug abuser population is disproportionately represented within the corrections system, and that system involves unique civil liberties sensitivities. For these reasons, we urge the Governor to carefully monitor the development of policies and procedures for responding to the epidemic within the corrections system. Specific emphasis on education, segregation, confidentiality, transfer of medical information, personnel management and inmate movement within the system and back into the community will be particularly important.

3. Experiments to Better Reach the Population of IV Drug Users in the General Community. There are an estimated 12,000 IV drug users in the state of Colorado. As the prevalence of AIDS and HIV infection grows within this population, their sexual contacts and offspring, so too does the urgency with which we need to respond. Unfortunately, the avenues for reaching this population are poorly understood. Colorado alcohol and drug abuse treatment programs appear to have adequate slots for alcohol and IV heroin abusers who choose or are ordered to get treatment. However, we cannot assume that this population represents the majority of those in need.

A number of experiments in health education are already underway in the state and additional work is being done in other states to alter unsafe practices that increase the likelihood of HIV infection among IV drug users. Many of the proposals are controversial, i.e., needle distribution programs, needle sterilization education programs, etc. While we believe it is premature for the state to take specific positions in this area (with the exception of support for health education and drug rehabilitation efforts) we do feel it is imperative for the Governor to:

a) examine the adequacy of existing drug abuse prevention and treatment programs;
b) encourage the Drug and Alcohol Division of the State Health Department to pursue experimental methods of aggressive outreach and to focus any additional treatment slots on high risk populations;
c) promote private and philanthropic community support for alternative approaches to preventing spread of IV drug transmitted HIV; and
d) advocate for incorporation of proven approaches into the ongoing programs supported by the State.

II. Ongoing Information Gathering and Coordination

RECOMMENDATION #3. Support and Adequately Fund an Ongoing Body or Bodies to Oversee Statewide Efforts in Responding to the AIDS Epidemic.

The AIDS epidemic will continue into the next century. Its impact on treatment systems, support systems, and most importantly, on individuals and their loved ones is difficult to comprehend. At a number of levels within the state, responsive treatment, education and prevention are evolving rapidly, suggesting that a permanent (through the course of the epidemic) entity or entities needs to be created to oversee that response. The critical activities of such a body or bodies would include:

a. oversight of and advice on state AIDS policies and state government responses to the epidemic;
b. clearinghouse for information and resources;
c. coordination among public and private agencies;
d. advocacy for AIDS funding, legislation and programs;
e. advocacy on behalf of individuals affected by the AIDS epidemic.

Because state response needs to be broad and far-reaching, a variety of capabilities and interests must be integrated for greatest effectiveness. Among the configurations to be considered, either alone or in combination, are:

a. an influential, high level community based steering committee including members representing business, government and philanthropic constituencies appointed jointly by the Governor and legislative leadership.
b. a small AIDS Commission appointed by the Governor, paid by the state and subject to legislative approval.
c. a broadly representative voluntary Council appointed by the Governor, i.e., a continuation of the present Council structure.
d. a legislative oversight committee appointed and funded by the Legislature.
e. an expansion of the charter of the State Board of Health to include the above responsibilities.
f. an informal response that encourages the development of an independent, "grass roots" coalition that assumes the listed responsibilities without official status.

We urge the creation of a paid state staff, including an AIDS coordinator, to support the ongoing effort.

RECOMMENDATION #4. Using Statewide Health Care Costs Data Systems Under Development by The Colorado Health Data Commission, Document AIDS Health Care Costs to Facilitate Assessment and Planning for Care Delivery Needs in the State.

Although the Health Data Commission efforts are just beginning, it is timely to request that some resources be concentrated on the development of data about the cost of HIV infection-related care in Colorado. Information is needed on both hospital and non-hospital, medical and non-medical components of care to understand current and projected needs within the system. With proper design, the data could be produced without compromising patient confidentiality.

III. Education and Prevention Efforts

RECOMMENDATION #5. Actively Support a Comprehensive Health Education Program With Human Sexuality and Substance Abuse Components That Include AIDS Education and Prevention in Colorado's Secondary Schools.

Through past legislative actions, the Colorado General Assembly has emphasized the importance of having a comprehensive health care curriculum in the public schools and of providing information on alcohol and controlled substances to students. Previously, state dollars have been appropriated for assistance in developing curriculum materials, and school districts have been held accountable for teaching these subjects. Conformity has been variable, however, with some districts adopting exceptional programs and others doing an inadequate job. Legislative attention to these programs has waned dramatically.

The Council concurs that a comprehensive health curriculum is an important component of public education, and further believes that information about AIDS (and relevant to AIDS) must be integrated into this curriculum. The need to provide information about AIDS to this vulnerable population is so urgent that AIDS education should proceed in the absence of comprehensive health care curricula where necessary.

The reasons for this recommendation are compelling. Based on knowledge of epidemiology of HIV infections, many individuals diagnosed with AIDS probably contracted the virus during adolescence. The adolescent population is at particular risk for spread AIDS due to experimentation with high-risk behaviors associated with transmission of AIDS. Colorado already experiences one of the highest rates of teen pregnancies in the nation. Now, because of HIV infection, the consequences of unsafe sexual practices carry added burdens for the children themselves and their offspring, as well as for society as a whole.

Equally important is drug abuse prevention education, particularly IV drug abuse prevention. Again, teenagers are a population with documented needs in this area. Adding the risks of HIV infection to the already established risks and costs associated with drug abuse make the case for aggressive prevention education even more compelling.

To accomplish this task, we suggest the Governor advocate with the Legislature and the Department of Education for:

1. Renewed attention to and emphasis on the importance of comprehensive health care education, including AIDS information.
2. Education and training of school personnel, including board members, administrators, teachers, counselors and support personnel, to both inform them about AIDS and to enable them to carry out effective and age appropriate education and prevention.
3. Definition of minimum content requirements and curriculum parameters for AIDS education, either within existing statutes or through enactment of new legislation.
4. Adaptation of existing curriculum materials to local needs rather than allocation of resources to time consuming and expensive curriculum development.

RECOMMENDATION #6. Select and Promote a Model Workplace Program for Addressing the AIDS Epidemic.

In addition to the schools, the workplace can be a critical avenue for reaching the public with AIDS prevention and general educational information. The workplace can also serve as a model for policies, attitudes and responses--including continued employment--to infected individuals, whether symptomatic or not. The Council expects this recommendation to be achievable within a short term because several excellent programs already exist across the country. We specifically recommend that the Governor:

a. create a coalition of state and business leaders to:
(i) develop or adopt and implement model worksite programs in both a state agency (or agencies) and a private business (or businesses);
(ii) disseminate the results of the programs throughout the state using channels already available.

b. maintain a high profile in holding state department and office directors accountable for following the guidelines established in the model program(s).

RECOMMENDATION #7. Provide State Funding for Targeted Education Programs of Community Based AIDS Projects.

As early as 1983, private voluntary organizations were formed in Colorado, the first to respond to the AIDS epidemic. These organizations have multiplied and expanded in an effort to meet the growing needs of those affected by AIDS. Still staffed, supported and primarily funded by private citizens, they struggle financially to continue providing targeted, cost-effective prevention and support services.

Community based programs, which have achieved credibility and have demonstrated effectiveness in reaching and successfully influencing people engaged in high risk behaviors, offer the best alternative for providing education that will reduce spread of the disease. Because of the extensive support of volunteers and access to affected populations, they also have the potential to save government entities hundreds of thousands of dollars.

We strongly recommend that these organizations receive ongoing state financial support (other than federal pass-throughs) at a level that will enable them to gain stability, and sustain programs. The total 1988 budget for all community-based AIDS service organizations statewide is approximately $550,000. The state should guarantee availability of a $250,000 annual fund to be drawn on by these agencies for targeted education of groups at high risk for spread of AIDS. There are models in the state for management of such a fund. This fund would not only assure provision of essential education, but would also enable programs to attract other funds for provision of support services such as housing, food, furnishings, grants to buy medications, counseling, advocacy for benefits, etc.

IV. Funding

RECOMMENDATION #8. Lead Efforts to Develop State Funding for Education, Prevention and Treatment of AIDS.

It is imperative to confront head on the difficult issue of state support for AIDS treatment. We recommend actions in several areas, some of which are likely to be revenue neutral, some of which must wait for a better financial environment, and some of which are sufficiently important to require immediate attention in spite of their costs.

1. Create a Medically Uninsurable Pool. Work with legislative leaders and the insurance industry to create an insurance pool for the medically uninsurable, as 15 states have now done. With the problems of the medically uninsurable and underinsured well documented, the threat of AIDS lends added urgency to the

task of creating a state-sponsored pool for the uninsurable. A number of funding mechanisms exist, among them gross premiums taxes on health insurance premiums. However, we would strongly argue that such taxes are inappropriate until such time as the ERISA protections are removed to allow for full participation by employers who sponsor their own self-insurance plans. Alternative funding sources may include: hospital bed-day taxes, ambulatory visit taxes, hospital bed taxes, employer taxes on a per-employee basis, etc. **(Requires significant new funds)**

2. Explore Financial Protections for Health Insurers Providing Coverage to Persons with AIDS. Most financing for AIDS-related health care is provided by the private insurance sector through employer sponsored group health insurance. If this system is closed to AIDS patients through discriminatory underwriting practices or becomes prohibitively expensive to maintain, the burden for financing will shift to the state and federal governments. Moreover, if specific health insurers become over-represented with AIDS patients relative to their competitors because of clinical excellence, benefit coverage or marketing history, the selection bias can adversely impact their competitive positions and ultimately their financial viability.

While adverse selection is technically difficult to demonstrate, the issue is of such potential concern that immediate exploratory steps are in order. We specifically recommend that the Governor ask the Insurance Commissioner to work with the health insurance industry to explore funding and administrative options for creating financial protections against the impact of long term adverse selection. Two alternatives to consider are: a public-private sponsored stop-loss pool and state subsidies for a portion of AIDS care costs borne by insurers. **(Revenue Impact Undetermined)**

3. Undertake a Comprehensive Review of State Tax Codes to Identify Potential Incentives in the Tax Structure that may be Utilized to Promote AIDS Education, Prevention and Care. It is possible that such an approach could be structured as revenue neutral. Currently the impact of employment and health insurance decisions for HIV positive and HIV symptomatic individuals as well as AIDS patients can result in reduced productivity, loss of jobs and transfer of costs of care to local, state or federal funding sources. Properly structured, tax incentives could move employers and individual providers toward decisions that result in continued employment and insurance coverage. The incentives could result in more aggressive employer-sponsored education and prevention efforts in the workplace. Similar incentives could apply to other taxable entities that can assist with controlling the epidemic such as media, voluntary agencies, health delivery organizations, etc. **(Revenue Impact Undetermined)**

4. Modify Medicaid Guidelines and/or Obtain Appropriate Waivers to: a) allow for extension of AZT and lower cost care benefits to eligible patients with HIV infections; and b) permit selective experimentation in structuring reimbursement incentives that encourage development of lower cost care alternatives. At present AZT is the only life-extending drug in common clinical use for the treatment of HIV infection, especially AIDS. Yet it is being provided on a limited basis in Colorado to Medicaid eligible patients through a federal grant that expires November, 1988. State support is necessary to continue providing AZT coverage for Medicaid eligible individuals, a cost estimated at $300,000 per year. There are an additional 30-50% of individuals requiring AZT who "fall through the cracks" of Medicaid eligibility but who are nonetheless medically indigent or who are not eligible for other third party reimbursement for medication. It is important, however, that funds for AZT not be shifted from other important health care programs.

Often Medicaid guidelines inhibit use of nursing home, hospice or home health care because of reimbursement levels, referral constraints, etc. The benefits of care delivered through these alternatives coupled with their reduced economic impact makes them important components of a comprehensive care financing and delivery strategy.

Finally, we have much to learn about how to most effectively organize and deliver care to those with AIDS. To the extent the Medicaid program (and the Medically Uninsurable Pool mentioned above) can be flexibly structured to encourage experimentation, the search for better, less expensive methods of care for AIDS patients can occur. **(New Revenue Required for AZT; Revenue Neutral or Positive for Other Components)**

5. Develop Alternatives for Improving the State Medicaid Program to Provide Those with Chronic Illness, Including AIDS, with More Dependable Benefits. This effort should focus on:

a) broadening coverage (up to New York or California level benefits) to include a "medically needy category;
b) improving incentives for self-sufficiency;
c) decreasing operational hurdles for the recipient;
d) purchasing care through prepaid systems;
e) modifying restrictions on moving in and out of Medicaid;

We suggest that the Center for Health Policy Analysis and Medical Ethics at the University of Colorado-Denver or another similar entity be commissioned to carry out the study. Funding should be sought from local foundations interested in the field. **(Study Probably Revenue Neutral; Expanded Medicaid Program Cost Negative)**

6. Undertake a Study of Intermediate (Skilled Nursing Facility, Intermediate Care Facility), Hospice, Home-based Care Systems in Colorado for people with AIDS. The questions to be asked, at a minimum, regard:

a) adequacy of existing resources for the demand;
b) incentives and disincentives for use of such resources;
c) incentives and disincentives for development of such resources; and
d) recommended actions by the state and local jurisdictions to address the problems.

It is our conclusion that current resources in this area are inadequate, either because too few resources are in existence or because availability is restricted by barriers to use. A critical component of the long term care delivery strategy will be the existence of adequate and accessible lower cost alternatives for meeting the acute and chronic care burdens on individuals and society imposed by the AIDS epidemic. As with #5 above, funding for the study may be obtained through local foundations, and the study should be conducted by an appropriate public interest group such as the Center for Health Policy Analysis and Medical Ethics at the University of Colorado. **(Until the Study is Completed, the Cost Impacts on the State are Difficult to Determine)**

7. Advocate Changes in Federal Policies that are Impeding Effective State Response to the Epidemic. At this time, specific attention needs to be paid to: a) modification of ERISA guidelines that now remove employer sponsored self-insured health plans from required participation in AIDS care or financing of uninsurable medical pools and medically indigent pools at the state level; and b) modification of Medicare and Medicaid guidelines for alternative care that affect reimbursement or patient placements.

V. Support Services

RECOMMENDATION #9. Request that the State Division of Housing, the Colorado Housing Authority and the Health Care Financing Authority Develop a Range of Program and Resource Options Available to Meet the Growing Housing Needs of Persons With AIDS.

Housing is among the most critical emerging needs of persons with AIDS. States affected earliest by the AIDS epidemic provide evidence of this fact and are now in the process of addressing housing issues. It is a need that will continue to grow as absolute numbers of persons with AIDS increase. Housing needs exist for

both: short-term care for individuals too ill to be self-sufficient, but not critical enough to require hospital care; and for long-term independent living for those who are indigent or who have become unable to maintain previous living arrangements. We recommend that a group be formed with representation from the three identified agencies to work in consultation with the Colorado AIDS Project, which expects to have completed a housing needs assessment in April 1988.

VI. Civil Rights Protections

RECOMMENDATION #10. Lead Statewide Efforts to Eliminate Human Rights Violations Against People with HIV Infection or AIDS, and People Perceived to be At-risk for HIV Infection.

Specific actions would include:

1. Request that the State Attorney General and the Colorado Civil Rights Division Director Review Existing State and Federal Protections from AIDS-related Discrimination. Additionally the review should include legal protections established in other state jurisdictions. Conclusions and recommendations should be made to the Governor within six months regarding:

a) the adequacy of protections;
b) necessary changes in the law to enhance protection, and
c) weaknesses in protections that will require ongoing vigilance or clarification through legal action.

2. Concurrently ask the state AIDS coordinating/oversight body to undertake a study of AIDS-related discrimination problems that have occured within the state during the epidemic. We recommend that this activity be the first task of the oversight body and that the study focus especially on current discrimination experiences.

3. In the leadership position described in Recommendation #1, as well as at every subsequent opportunity, articulate the legal and moral bases for non-discrimination.

WORK GROUP SUMMARIES

Care Delivery Work Group

Background

- Local government and community-based organizations were the first to respond to the AIDS epidemic, offering creative approaches and essential services in an effort to meet the wide range of needs of persons affected by HIV infection. This challenge was met in the face of limited resources, resistance and ignorance about AIDS.

- The initial focus of the care delivery response to AIDS was in the area of health care, the most readily acknowledged need. Subsequent attention has focused on counseling support, helping secure benefits, meeting needs for companionship, housing, transportation, etc.

- Most agencies that have put procedures into place have followed CDC guidelines.

- Care delivery remains fairly fragmented with patchwork funding, a situation which produces both duplication of effort and gaps in service.

- Many services are either in short supply or not available at all, owing to lack of information, possession of misinformation or pre-existing system barriers. Inadequate resources restrict the ability of potential care providers to develop and deliver needed programs and services.

- Operating with limited resources, the Colorado Department of Health, whose primary role has been disease control, and Denver Public Health, which provides treatment and disease control, have also provided extensive consultation and education to service providers.

Policy Issues/Questions

- What system of medical and social support services will best serve people with HIV infection?

- Who should determine what policies direct delivery of care to persons with HIV infection?

- How should the problems of barriers to accessing services be addressed?

- Should the care response to persons infected with HIV vary from response to any other serious contagious/infectious illness?

- What are the responsibilities of providers in care delivery settings for ensuring the well-being of service users?

Assumptions

- AIDS is a complex disease that requires a comprehensive and well-coordinated care delivery system for appropriate response.

- Among the components of the continuum of care are: inpatient and outpatient medical treatment; counseling of persons with HIV infection, friends and family members; housing; transportation; meal delivery; dental care; mental health services; and hospice care and final arrangements.

- The care delivery system must respond to those requiring HIV infection-related care, and it must operate at maximum efficiency to make best use of scarce resources.

- It is the duty of care providers to ensure safe environments, including protection of employees, patients and other workers from inadvertent exposure to HIV.

- There are many systemic, attitudinal and moral barriers which interfere with the ability of persons with HIV infection to secure needed services.

- Constraints on access to health, life and disability insurance place tremendous obstacles in the path of persons with AIDS in obtaining adequate care.

- The nature of the infection has contributed to the less than aggressive response to AIDS, i.e., the relatively long time span between infection and seroconversion, and more so between seroconversion and symptomology.

- Care for AIDS must be specifically and adequately funded, not supported through diversion of funds from other essential health care needs.

- Due to the large numbers of HIV infected individuals in the population, most of whom will eventually develop ARC or AIDS, demands on the care delivery system will escalate significantly through the end of the century.

- There are resources available statewide which have not as yet been drawn on but which may be tapped through an organized effort to assist persons with HIV infection.

- We should consider a new long-term view of HIV infection, treating it not as a terminal disease, but as a chronic infection which may be treated preventively to delay or eliminate symptomology.

- Definition of care delivery policy must be a cooperative effort between health care and support service agencies, affected individuals and state and local government.

Recommendations

- There should be a statewide coordinating mechanism for efficiency in care delivery to persons with AIDS. The coordinating role may include the following functions:

  - develop a continuum of care model for the state
  - identify and document all services statewide
  - identify service gaps
  - identify barriers to service access and correct
  - serve as a resource to case managers
  - review and advise on funding availability and application

- Those responsible for providing care to persons with HIV infection should adopt a case management approach to service delivery, working within a network of integrated services and planning for the entire continuum of care required.

- Service providers, especially those in health care delivery systems, who have HIV infection risk factors, should assume responsibility for being tested and monitoring their health, and should follow procedures established by their work place.

- Care providers should be familiar with mechanisms for discharging "duty to warn" responsibilities in the event they gain knowledge of another's unknowing exposure to HIV.

- Relevant parties should be convened to assess and plan a response for removal of barriers to access to care. Such barriers include exclusive eligibility criteria, zoning and building code obstacles and shortage of adequate and alternative care.

- No patient should be denied care, provided a lesser level of care, or be given a lesser level of accessibility to care based upon the existence of HIV infection in that patient. Further, there should be continued full funding of free public HIV testing, counseling and outreach education programs.

- The state should establish a program of Health Care Recognition Awards to recognize those individuals and

agencies that contribute in an exemplary fashion to the care and treatment of persons with AIDS, their families and significant others.

- The state should investigate the possibility of designing a guaranteed insurance premium payment system, which in our view, would be cost-effective over the long term.

Disease Control Work Group

Background

- The first AIDS case was reported in Colorado in 1982.
- Formal AIDS disease control practices in Colorado have developed consistently since 1983.
- Colorado ias one of nine states that require named reporting of HIV infected individuals.
- To date, epidemiological surveillance has guided disease control efforts including: education, testing and counseling, contact tracing, and blood and tissue product screening.

Policy Issues/Questions

- What are the most effective methods for preventing the spread of AIDS?
- What should be the priorities in AIDS disease control in Colorado?
- What policies should govern decisions about disclosure of HIV status information?

Assumptions

- Education directed to modification of risk behavior is a critically important mechanism for disease control.
- The purpose of disease control strategies is to reduce the number of individuals who become infected with the AIDS virus.
- HIV infection results from risks in behavior which intimately expose individuals to infected body fluids. Greatest risks in behavior include unprotected sexual intercourse, birth from an infected mother, and receipt of contaminated blood or blood products by transfusion or shared needles.
- Sexual and drug use behaviors which place persons at high risk for contracting the AIDS virus are strongly motivated and are therefore very difficult to change.
- Adolescents are at increased risk for HIV infection because of experimentation with drug use and sexual behaviors.

- The greatest threat of spread of HIV infection to the larger heterosexual population is from heterosexual and bisexual IV drug users. The at-risk IV drug user population is estimated to number 12,000 in Colorado.

- We believe that Colorado has a reasonable program of access to sterile needles and syringes which, without contributing to increasing the problem of drug abuse, assures that those who are so motivated may obtain clean implements. This reduces the probability of transmission of AIDS and insures greater effectiveness of education efforts. However, in the past, pharmacists have been reluctant to sell syringes to persons appearing to be IV drug abusers.

- Disease control efforts and resources should be focused on the most at-risk groups, including: gay and bisexual men; IV drug users; pre-1985 recipients of blood and blood products; adolescents, especially street youth; and sexual partners and offspring of persons in all the previously mentioned groups.

- HIV antibody screening of low risk populations is not currently a cost effective method of disease control and is recommended only for purposes of disease surveillance or blood and tissue product safety.

- A positive test for HIV antibody means that an individual is and will continue to be infected with HIV and will be infectious to others by the recognized routes of transmission.

- Knowledge of one's HIV antibody status can: result in modified behavior; emphasize the importance of avoiding infection or reinfection; enable a person to take advantage of treatments to slow the development of the disease; and help in tracing sexual, needle and blood contacts.

- Safety of patients and health care workers alike are equally important. CDC guidelines for universal precautions in handling blood and other body fluids represent the best disease control methods presently available to protect health care and other workers and patients.

- The disclosure of individual HIV status can be very damaging. Protection of the confidentiality of that information must be assured as the first course of action in any policy decision.

Recommendations

- The number and location of test sites should be reviewed to be sure they are adequate, accessible and acceptable to the variety

of group cultures to be served. These sites should be located in care delivery facilities already used by at-risk groups.

- All testing facilities must provide culturally sensitive education which includes pre- and post-testing counseling and ready access to support services for the infected individual. Individuals with negative HIV antibody test results should receive AIDS awareness and prevention education.

- Education in an explicit manner for modifying risk behaviors and to avoid further transmission of infection should take place at sites of highest risk activity.

- Sex, needle and blood contacts of infected persons should be notified of their potential exposure and should receive HIV antibody testing and counceling.

- Schools are an extremely important focus of AIDS education and such programs should be offered on an ongoing basis.

- Those whose occupations may expose them to fluids infected with HIV should be educated about risk and provided with means to comply with universal precautions.

- Individuals who are exposed to HIV contaminated body fluids in an occupational setting should immediately receive a baseline HIV antibody status test, and follow-up testing in a timely fashion. Institutions should develop policies to manage personnel under such circumstances, keeping in mind a responsibility to both protect their clients and minimally disrupt the workplace.

- Testing for HIV should include provision for an appropriate supplementary test to evaluate a repeatedly reactive ELISA test.

- Compliance with C.R.S. 25-4-14 regarding mandatory reporting of HIV antibody test results should be limited to reporting those persons who have a repeatedly highly reactive ELISA tests or who do not have a negative supplementary test reported soon after the ELISA test is done.

- The State Department of Health should undertake a study to determine in what circumstances contact tracing is most effective as a disease control measure.

Education /Public Information Work Group

Background

- Denver Public Health and the Colorado Department of Health spent over $500,000 on education and public information activities in 1987.
- CDC grants to the Colorado Department of Health, Colorado Department of Education and Denver Public Schools are the primary source of funds for state educational efforts.
- The AIDS Coalition for Education (ACE) formed to respond in the most efficient way to the high volume of requests for AIDS education and information across the state.
- Volunteers have played a critical role in providing AIDS education throughout the state.
- AIDS Awareness Month has been an important vehicle for carrying out AIDS education statewide.
- Media reports on AIDS, many from national sources, focus on scientific/epidemiologic findings and organizational response and policy development, including legislation. Media coverage is variable, depending on news source, and may have misleading headlines.
- Men who have sex with men and those who seek testing have been the primary target groups of AIDS education efforts.

Policy Issues/Questions

- What priority should AIDS education be given relative to other AIDS epidemic related activities?
- Within the area of education, how should priorities for allocation of scarce resources be determined and by whom?
- Should the state mandate inclusion of AIDS education in the public school curriculum? How and by whom should content be determined?
- How extensive should the state role be in defining and monitoring AIDS education?
- Should the state monitor media reporting of AIDS-related information and actively respond to misinformation?

- What is the most effective setting for conducting AIDS education (testing sites, public forums, media, school, workplace,etc.)?

Assumptions

- The purpose of AIDS education is twofold--to prevent spread of the disease and to prevent discrimination, thereby ensuring service availability to HIV-positive individuals.
- Until a vaccine or cure becomes available, education, testing and counseling are considered the best means of epidemic control.
- To be effective, educational program goals must be clear and the message must be comprehensive, consistent, factual, understandable, direct, ongoing, culturally relevant to the target population and delivered by a credible source. Addressing emotional concerns and fears associated with the subject of AIDS is important.
- Funding, implementation and content of education efforts must be a shared responsibility on the part of state and local jurisdictions, professional associations, community groups and social institutions from public, private and non-profit sectors.
- Designing and implementing educational programs is complicated by personal morality biases of leaders and decision-makers, the effect of which has been to impede progress in carrying out important educational activities.
- Due to extensive coverage of the AIDS epidemic during the past two years, most members of the general public, both in high and low risk groups, are aware of AIDS.
- Substantial resource investment has been made in reaching the high risk gay/bisexual male population with education programs with success. However, spread of HIV infection among IV drug users remains a poorly controlled problem.
- Volunteerism plays a critical role in responding to the impact of AIDS.

Recommendations

- Establish an AIDS information clearinghouse and central coordination office for AIDS education, consultation and technical assistance. This clearinghouse should be used as a primary source of information and rumor control by the media.

- Amend existing legislation or enact new legislation setting forth the minimum acceptable level of public school AIDS education statewide, including process, content and target groups.

- Ensure coordination and cooperation between various entities administering federally funded education programs for consistency and maximum efficiency in utilization of resources.

- Prepare and distribute a media packet containing information on: the Governor's position and state policies on responding to the AIDS epidemic; updated state epidemiologic data; an overview of statewide activities; and names of state designated, credible information sources. Arrangements should be made, on a regular basis for the state AIDS coordinating entity to hold periodic press briefings to update the media on the current status of the epidemic.

- Because most complaints about press coverage of the epidemic relate to headlines rather than story selection or coverage, workplace briefings on the epidemic should be conducted with upper editorial management and copy desk staff who write headlines at the major dailies.

- Enlist the support of various media trade associations to address workplace education and certain difficult public information issues relating to the epidemic. For example, the Denver Advertising Federation and the Colorado chapter of the Public Relations Society of America might offer valuable insight into methods of communicating with hard to reach groups such as IV drug users.

- Focus educational outreach on IV drug users and their sexual partners, ethnic minorities and disenfranchised youth, i.e., runaway, throwaway adolescents, dropouts.

- Recommend that studies or research be conducted to determine the most effective educational methods for reaching difficult to reach risk groups.

- Discussion should be held with the Colorado broadcast and cable television community about how to best use available public service announcements concerning AIDS prevention. In particular, the electronic media should be made aware of programs in other states or nations that have shown demonstrable success. Planning must include use of mono- or bilingual announcements where appropriate.

Finance Work Group

Background

- AIDS-related costs are incurred for education, surveillance and control, treatment, support services and research.
- 1987 costs for AIDS activities for Denver Public Health and the Colorado Department of Health were $2,796,000, of which at least three-quarters was federally funded. This figure does not include costs of treatment of HIV infections incurred outside of Denver public health clinics nor the costs of AIDS related activities to other local Colorado health departments and voluntary organizations.
- Colorado reports a state-only (exclusive of Medicaid, Social Security, federal funds or city/municipality funds) level of spending on all AIDS activities that equals $830 per diagnosed AIDS case and $.13 per capita. National averages are $3,323 and $.65 respectively. This disparity indicates an inadequate state response to the AIDS epidemic. Either services are not being provided, or they are made available at the expense of other need areas from which funds are diverted to meet the necessary costs of AIDS.
- Colorado was one of only five states that did not include AZT in its Medicaid benefit program. The State Department of Social Services will add AZT as a benefit of the Medicaid program for persons with AIDS effective October 1, 1988
- In 1987 insurance regulations were adopted which permit private insurers operating in Colorado to use HIV testing for underwriting decisions, thus potentially eliminating private insurance financing of AIDS costs for many HIV infected individuals.
- There are state policy and procedural barriers to low cost alternative care for persons with AIDS.
- Local philanthropic response to the AIDS crisis has been slow in developing.
- Currently there are no new AIDS appropriations bills pending in the Colorado State Legislature, but the previous year's AIDS appropriation for disease surveillance, $146,000, has been recommended for continuation.
- State and local health care/treatment programs have responded to the AIDS epidemic with limited resources, often shifted from other areas. These resources are severely strained.

- The Colorado AIDS Project estimates that for each $1 it spends, it saves a state, county or municipal agency $10.

- Community action groups and voluntary non-profit organizations have played a critical role in the state response to AIDS, but have had to limit their activities due to understaffing and underfunding.

- The indirect costs of lost or reduced productivity and premature exit from the labor force by persons with AIDS, and the often subsequent dependence on public welfare, have begun to impact the state economy.

Policy Issues/Questions

- What may we expect the cost impact of AIDS to be on Colorado and how will responsibility for meeting those costs be distributed?

- What are the implications of AIDS to state health care financing mechanisms such as Medicaid and private insurance?

- What are the most effective and efficient mechanisms for meeting the costs of the AIDS epidemic?

- To what extent can the state continue to rely on federal funding to meet AIDS costs?

Assumptions

- AIDS has forced us to revisit many health care financing problems already present in the state and private health care system, and responses to AIDS should be considered to have applicability to all catastrophic illnesses and indigent health care issues.

- Responding to the AIDS impact on Colorado will require cooperative effort on the part of public, private and non-profit sectors.

- It is unlikely that the Colorado Legislature will appropriate significant new funds to pay for AIDS education, treatment or research in the immediate future.

- Exclusive of Medicaid funds, Colorado will receive approximately $2 million in federal AIDS funding in 1988 for prevention and disease control.

- The existing AIDS-related service delivery infrastructure in Colorado is inadequate to meet the projected incidence of AIDS in the coming years.
- The private corporate and philanthropic sectors must be called upon to help meet the costs of AIDS in Colorado.
- In responding to AIDS, a higher priority for state funding should be treatment and the extensive continuum of care.
- The effect of discriminatory insurance underwriting and employment practices can be unavailability of health insurance coverage for many and consequent dependence on public assistance.
- The current public assistance, indigent care and health care delivery systems contain many barriers to access for individuals experiencing serious illness, including AIDS.
- Employers can play an important role in helping their employees with AIDS avoid becoming medically indigent or enrolling in Medicaid by creating flexible approaches to keeping them employed.
- Moral judgments about persons primarily affected by AIDS and predominant modes of disease transmission have contributed to the fact that many sectors have been slow to respond in appropriate ways to the impact of the epidemic.
- There is a clear negative economic impact that results from failure to retain otherwise qualified and capable workers who are HIV infected which includes: increased costs of operating; erosion of the tax base; and requisite state support of the unemployed and ultimately indigent ill.

Recommendations

- The state should enter into cooperative, jointly funded AIDS education efforts with the private sector.
- The Governor should convene a Business Roundtable to develop employee-sponsored AIDS education, AIDS policies and procedures for the workplace, and incentives to maintaining employment of HIV+ individuals.
- The state should set as its highest AIDS funding priorities appropriation of funds for treatment and care of persons with AIDS, including: expansion of the Medicaid formulary to include AZT; and direct state funding allocation to state AIDS projects.

- Colorado should develop a statewide system for tracking and analyzing the costs and expenditures of AIDS.

- The Medicaid program is substantially underfunded. The State Department of Social Services should conduct an evaluation of Medicaid eligibility requirements and benefits to remove barriers to services and to provide low-cost, effective care to persons with AIDS.

- The Colorado Department of Social Services and county health departments should provide directories of health and support services within the state.

- Colorado foundations should take a leadership role in examining the financing of catastrophic and medically indigent care in the state. This activity could be linked to the University of Colorado-Denver Health Policy and Medical Ethics Center.

- The state Insurance Commissioner should establish a medical advisory board to advise him on AIDS-related insurance regulations. In the future, proposed regulations may cover such issues as thresholds, support services and cost-effective methods of service delivery. They should be developed and reviewed based on current solid medical information. The regulations will have a significant impact on the size of the uninsurable pool that will look to the state for support.

- The state should underwrite the costs of competing for grants that would help Colorado develop an integrated patient care model of service delivery which emphasizes inpatient and outpatient case management and home care.

Legal/Discrimination Work Group

Background

- Colorado has no specific directive in the form of executive order, legislation or civil rights commission declaration prohibiting discrimination based on a diagnosis of HIV infection or perception of risk for HIV infection.

- In March, 1986, the Colorado Civil Rights Commission declared that AIDS fits within the definition of a physical handicap, thereby extending protections from discrimination in employment, housing and access to public accommodations to persons with AIDS. Subsequently, the Commission also decided to treat ARC in the same manner as AIDS.

- Effective January 1988, the Colorado State Insurance Commission adopted a regulation which purpose was to "establish standards to assure non-discriminatory treatment with respect to AIDS and HIV related illness in underwriting practices, policy forms and benefit provisions." The standards prohibit questions on sexual lifestyle and "redlining" in health and life insurance underwriting practices. HIV antibody testing is permitted.

- Colorado Department of Health disease control regulations for AIDS place emphasis on rigid confidentiality provisions for managing HIV antibody test status information.

- State AIDS projects and other organizations have documented evidence of discrimination against persons with AIDS in the areas of employment, housing, insurance, access to public accommodations, health and dental care and education.

- An informal survey of organizations concerned about discrimination and legal problems arising from the AIDS epidemic (including ACLU, the Colorado Civil Rights Commission, CAP, etc.), reveals that by early 1988, 43 reports of discrimination had been registered covering a variety of employment, insurance, housing and access to service situations.

Policy Issues/Questions

- What policy position most properly balances the concerns for the well-being of the general population with the civil rights protections of individuals?

- Are existing non-discrimination provisions, protections and enforcement adequate to ensure non-discriminatory behavior toward individuals diagnosed with HIV, ARC or AIDS, or presumed at risk for contracting HIV infection and related illnesses?

- Should the State adopt legal or administrative measures or take other explicit action to address potential or actual discrimination against persons with HIV infection, ARC or AIDS?

- How should the State determine the most equitable, effective and appropriately responsive methods to address unique AIDS-related issues of discrimination in special settings such as corrections, residential care and public health care delivery programs?

- What are the most probable areas of litigation and causes of action the state may face over the course of the AIDS epidemic?

Assumptions

- Persons at highest risk for AIDS, who already must struggle for equitable participation in society, are now confronted with increased vulnerability due to fear of and misinformation about AIDS.

- Fear of AIDS, combined with pre-existing social biases and moral judgments, has exacerbated problems of discrimination experienced by those at highest risk of falling victim to the AIDS virus. The possibility of discrimination imposes a major obstacle to successful public health strategies to manage the AIDS epidemic.

- While we may introduce policies in an effort to discourage and negatively sanction discriminatory behavior, we must also use education to address the prejudice that leads to discrimination.

- Increase in the number of persons with HIV infection, ARC and AIDS demanding services will heighten the civil rights-public health debate and increase the potential for litigation of AIDS-related issues.

- Confidence in civil rights protections will promote participation in testing and counseling by high risk groups.

- Due to the potentially disastrous impact of disclosure, protection of confidentiality of HIV status information must become and remain a high priority in AIDS policy and decision making.

- New case law is being born of the AIDS crisis, revolving around the regulatory actions and service provision roles of state government. Most likely causes of action against public officials and agencies may include: discrimination; breach of confidentiality; duty to warn; and negligence. Areas of litigation may include: handicap discrimination; testing/screening practices; collection and dissemination of patient or employee information; harassment; and labor laws and safety of work conditions/environment.

Recommendations

- Join the Council in issuing a strong statement condemning discrimination based on a diagnosis of AIDS, and advocate for legislative enactment of an anti-discriminatory law protecting people with HIV infection.

- Order a review of existing state civil rights protections for those that are inclusive of AIDS-related issues by the Attorney General, Civil Rights Commission and other appropriate bodies.

- Once protective provisions are passed and/or identified, issue an executive order alerting the public to anti-discrimination laws and their interpretation.

- Direct the Civil Rights Commission to review AIDS-related complaints within a reasonable time frame that recognizes the often relatively swift effect of the disease.

- Recommend inclusion of sanctions for discrimination in regulatory codes for professionals licensed by the state of Colorado.

APPENDICES

STATE OF COLORADO

EXECUTIVE CHAMBERS
136 State Capitol
Denver, Colorado 80203-1792
Phone (303) 866-2471

Roy Romer
Governor

D 007 87

EXECUTIVE ORDER

CREATION OF THE GOVERNOR'S ADVISORY COUNCIL ON AIDS

WHEREAS, Acquired Immune Deficiency Syndrome ("AIDS") has become one of the most serious threats to the health of the people of the State of Colorado and this nation; and

WHEREAS, more than 20,000 citizens throughout the United States and more than 200 citizens in Colorado have died from AIDS or AIDS-related complications since the disease was discovered; and

WHEREAS, formulation of a statewide policy to reduce the spread of AIDS and address the personal tragedies and social and medical problems associated with this deadly disease is critical;

NOW, THEREFORE, I, Roy Romer, Governor of Colorado, by virtue of the authority vested in me under the laws of Colorado, DO HEREBY ORDER THAT:

1. The Governor's Advisory Council on AIDS is created, which will consist of members representing affected populations and experts in relevant fields. All members shall be appointed by the Governor and serve at his pleasure. Members shall serve without compensation.

2. The council shall have the following duties:

   a. Develop and maintain policy and procedures for the council's operation.

   b. Develop and present recommendations to the executive branch and the Legislature on the following issues:

      - public education and training;
      - public health protection;
      - patient care, advocacy and service delivery;
      - legal and discrimination implications;
      - treatment costs; and
      - other public policy issues.

E 007 87

3. The council shall meet at times and in places designated by the chairman. The council shall submit periodic reports of its work and recommendations to the Governor.

Given under my hand and the Executive Seal of the State of Colorado, this 8th day of June, 1987

Roy Romer
Governor

Governor's Advisory Council on AIDS

MEMBERSHIP LIST

David M. Lawrence, M.D.,
Vice President/Regional Manager
Kaiser Permanente
Council Chairperson

Ms. Patricia M. Annison
Legal/Discrimination Work Group

Ms. Elaine Gantz-Berman
Program Officer
The Piton Foundation
Finance Work Group

Ms. Carol Bujwit
Medical Technician, Research Associate
AIDS Prevention Program, Denver Public Health
Disease Control Work Group, Co-Chairperson

Robert G. Chapman, M.D.
Director
Belle Bonfils Memorial Blood Center
Disease Control Work Group, Co-Chairperson

Mr. Jack Clark
Employee Relations Specialist
Mountain States Employers Council
Legal/Discriminaiton Work Group

Mr. David E. Greenberg
Senior Partner
Greenberg, Baron & Associates, Public Relations
Education/ Public Information Work Group, Co-Chairperson

Richard Hoffman, M.D.
State Epidemiologist, Chief, Communicable Disease Control
Colorado Department of Health
Disease Control Work Group

Ms. Carol Hunt
Director
Denver Office of Citizen Response
Finance Work Group

Mr. Richard Hunter
Legal/Discrimination Work Group

Donald Johnson,Ph.D.
Professor, Colorado University
President, Boulder County AIDS Project
Care Delivery Work Group

Franklyn N. Judson. M.D.
Director, Denver Public Health Department
Professor, Departments of Medicine and Preventive Medicine,
University of Colorado
Care Delivery Work Group, Co-Chairperson

The Honorable Jerry Kopel
State Representative
Legal/Discrimination Work Group

Ms. Mary Leisring
Assistant Program Administrator
Colorado Board of Medical Examiners
Education/Public Information Work Group, Co-Chairperson

Ms. Elinor Kirby Lewallen
National President
Parents and Friends of Lesbians and Gays
Education/Public Information Work Group

Mr. Chris Lines
Policy Analyst
Colorado Student Loan Program
Legal/Discrimination Work Group

Ms. Jan McClure
Legislative Director, El Paso County Medical Society
Public Affairs Director, Colorado Psychiatric Society
Education/Public Information Work Group

Ms. Barbara O'Brien
Director of Campus Affairs
University of Colorado at Denver
Finance Work Group, Chairperson

Jon O'Neal, M.D.
Flight Surgeon, Peterson AFB
Founder, Southern Colorado AIDS Project
Disease Control Work Group

Ms. Marjorie Pierson
Director of Education and Training
Affiliated Banks Service Company
Finance Work Group

Mr. Bill Reynard
Law Partner
Reynard & Booms, P.C.
Legal/Discrimination Work Group

The Reverend Julian Rush
Executive Director
Colorado AIDS Project
Legal/Discrimination Work Group, Chairperson

Ms. Julia Schluger
AIDS Coordinator
Mountain States Regional Hemophilia Center
Care Delivery Work Group

Mr. Carlos Trujillo
Translator/Medical Secretary
St. Anthony's Hospital Systems
Education/Public Information Work Group

The Honorable Dottie Wham
State Senator

Harry Wilson, M.D.
Pathologist
The Children's Hospital
Care Delivery Work Group, Co-Chairperson

Resignations:

The Honorable Martha Ezzard (9/87)
State Senator

Ms. Elizabeth Getto (9/87)

Staff:

Ms. MeriLou Johnson, MSW, MPA

Governor's Advisory Council on AIDS

CODE OF CONDUCT

I. Procedural Issues:

A. In the event of strongly divided issues, a minority report should be prepared. The feasibility of such a report shall be determined by the Chairperson of the Council.

B. Discretion regarding all Council deliberations shall be observed at all times. Visitors to any Council or Work Group meetings should be expected to exercise confidentiality as well.

II. Behavioral Issues:

A. Regular attendance at all Council and Work Group meetings should be expected.

B. Punctuality at all meetings should be expected.

C. All opinions expressed in meetings should be accorded full attention and respect.

D. Each Council member should be free to speak on any given issue without interruption, except by the Chairperson for the sake of time limitations.

III. Public Relations Issues:

A. All statements to the press with regard to Council deliberations or recommendations should be made only by designated spokespersons. The Council Chairperson will fulfill this function or appoint a designated representative when necessary.

B. All other Council members should speak only as individuals, and so designate to the press.

Task Force: Julian Rush, Elizabeth Getto, Patricia Annison

Accepted: September 17, 1987

Community Resources to the Council

Provided Testimony at January 14, 1988 Hearing

Ms. Linda Barley, Administrator
Hospice of St. John's

Mr. Lou Ceci, Public Information and Education Coordinator
Boulder County AIDS Project

Ms. Debora Sandau-Christopher, Senior Consultant
Colorado Department of Education

David L. Cohn, M.D., Director
Disease Control Service, Denver Department of Health and Hospitals

Dr. Estevan Flores, Acting Co-Chairperson
Dr. Marta Lopez-Garza
Northwest Denver AIDS Coalition

Ms. Roxanne Gonzalez, private citizen

Mr. Harvey Hersh, Director
Denver Office of Employee Assistance
Association of Alcohol and Drug Abuse Programs

Dr. Carolyn Jass, President
Colorado Nurses' Association

Mr. John Jay, Board Chairperson
Colorado AIDS Project

Mr. Charles Johnston, Chief
Lakewood, Colorado Police Department

James L. Kurowski, M.D., Chairperson
Colorado Medical Society Task Force on AIDS

Ms. Donna Megeath, Chairperson
Colorado Department of Social Services AIDS Task Force

Mr. Robert Moore, MPA, R.Ph., Chairperson
Colorado Department of Corrections AIDS Task Force

Dr. Martha Pearse, Chairperson
Colorado Psychological Association AIDS Committee

Ms. Carolyn Phillips
Black AIDS Project-at-Large

Mr. David Platt
PWA (Persons With AIDS) Coalition - Colorado
Colorado AIDS Resource Exchange

Mr. Arthur Powers, Interim Director
Coalition for Political Responsibility

Ms. Glenda Schneider, Chairperson
Weld County AIDS Coalition

Ms. Ellen Stein, Director
Colorado Medical Society Division of Socio-Economics and Public Health

Mr. Pat Sullivan, Sheriff
Arapahoe County Sheriff's Department

Mr. Jeff Thompson, Executive Director
Colorado Dental Association

Additional Expert Resources

Richard Bedell, M.D., President
Colorado Medical Society

Mr. Dennis Brinn
Coalition for Political Responsibility

Ms. Anna Chavez, Health Care Analyst
Denver Department of Health and Hospitals

Mr. Robert Doyle, R. Ph., Pharmacy Compliance Officer
Colorado Department of Social Services

Ms. Jean Finn, Disease Control Specialist
Colorado Department of Health

Ms. Rashida Hassan, Director
Blacks Educating Blacks About Sexual Health Issues
Philadelphia, PA

Ms. Irene Ibarra, Executive Director
Colorado Department of Social Services

Mr. Walter "Kip" Kautzky, Executive Director
Colorado Department of Corrections

Mr. John Kezer, Commissioner of Insurance
Colorado State Division of Insurance

Mr. Joel Kohn, Director
Colorado Governor's Office of Policy and Research

Mr. John Maxwell, Legislative Aide
Pennsylvania State Senate, Senator James R. Kelly

Northwest AIDS Foundation
Seattle, Washington

Ms. Darlene Ortega, Co-Chairperson
Northwest Denver AIDS Coalition

Ms. Mary Peterson, Chairperson
AIDS Coalition for Education

Mr. George Rivera, Co-Chairperson
Northwest Denver AIDS Coalition

Mr. Bruce Rockwell, Executive Director
The Colorado Trust

Ms. Mona Rowe, Policy Analyst/Researcher
Intergovernmental Health Policy Project
Washington, D.C.

Ms. Nancy Spencer, Disease Control Specialist
Colorado Department of Health

Mr. Lee Stolberg, Supervising Analyst
Colorado Division of Insurance, Life and Health Section

George Thomasson, M.D., Chairperson
Colorado Medical Society Council on Community Health Issues

Mr. Garry Toerber, Director of Medical Services
Colorado Department of Social Services

Thomas Vernon, M.D., Executive Director
Colorado Department of Health

Mr. David West, Director, Division of Programs
Colorado Department of Social Services

Mr. Timothy Westmoreland, Congressional Aide
U.S. Subcommitte on Health

Ms. Barbara Yondorf, Director
Research and Program Development
National Conference of State Legislatures

GLOSSARY

Acquired Immune Deficiency Syndrome (AIDS) - the ultimate manifestation of a serious viral disease characterized by loss of the body's natural defenses, making it unable to resist many types of life-threatening infections and cancers which do not normally attack a healthy body. This impaired immune system condition is thought to be caused by the Human Immunodeficiency Virus (HIV). A national case definition of AIDS is used by the Centers for Disease Control (CDC) for surveillance, official diagnosis and reporting of AIDS. Of persons officially diagnosed as having AIDS for three or more years, over 80% have died.

AIDS-Related Complex (ARC) - a condition less severe than AIDS but caused by the same virus that causes AIDS. Symptoms may include swollen glands, chronic fatigue, recurrent diarrhea, weight loss, persistent fevers, night sweats and yeast infections. ARC may last for years without progressing to AIDS or may lead to the rare types of cancer and pneumonia that typify "full-blown" AIDS.

Antibody - a protein substance found in the blood which is produced by the body in response to invasion by infectious agents or toxins, such as virus or bacteria. Presence of a particular antibody is evidence of exposure to a specific infectious agent and this is the basis for "HIV testing."

Asymptomatic infection - having an infectious organism within the body but having no complaints of disease. Asymptomatic HIV infected people may eventually develop AIDS (10-40%), ARC (25%) or remain without disease symptoms, but remain infectious to others.

AZT (azidothymidine: brand name "Retrovir") - currently the only FDA approved drug for treating AIDS, it prevents the AIDS virus from multiplying, thereby limiting further destruction of the immune system and perhaps allowing other natural or immune building processes to occur. It is not a cure for the disease. Much remains unknown about its effectiveness and use, though there are indications that beginning AZT treatment before onset of serious infections may expand treatment options, reduce side effects and prolong life. Demand for AZT exceeds supply and cost of the drug is approximately $25 per day.

Contact tracing - when public officials: 1) actively seek the names or trace the identity of persons who have come in contact with or have been exposed to a disease, and 2) actively notify these contacts about their possible exposure to the disease.

ELISA (Enzyme-Linked Immunosorbent Assay) test - a sensitive test for the presence of HIV antibodies in the blood licensed by the FDA for screening the blood supply only. It is not designed to be a diagnostic test for AIDS. Because "false positive" and some "false negative" results may occur, ELISA tests are repeated if positive and, if repeatedly positive, also followed by a Western Blot or other supplementary test for confirmation.

Epidemic - the occurrence of an event, i.e., disease, within a population, community or region that affects many individuals at the same time, or the product of sudden, rapid spread or development of a disease.

Epidemiology - the branch of medical/public health science that deals with the spread and distribution of disease, the scientific basis for disease control strategy, and the evaluation of disease control program effectiveness.

False positive - in the case of HIV antibody tests, the indication that the tested blood contains HIV antibodies when none are present.

Hepatitis B - an infectious liver disease caused by the Hepatitis B virus. Because transmission routes, affected populations, and precautions and other prevention methods are very similar to AIDS, information about Hepatitis B may be applied to AIDS disease control. However, Hepatitis B is more contagious and more prevalent than AIDS.

Hemophilia - a hereditary blood disorder characterized by excessive, sometimes spontaneous bleeding and treated by infusion of pooled blood clotting factors. While hemophiliacs are potentially at risk for receiving HIV contaminated blood products, this risk is currently very low due to careful screening of donors and special treating of blood products since 1985.

Human Immunodeficiency Virus (HIV) - the most commonly used name for the specific retrovirus which is presumed to cause AIDS and related diseases. HIV is transmitted via blood and semen through unprotected sexual intercourse and needle sharing with infected persons, from an infected woman to her fetus or infant, and through receipt of contaminated blood or blood products. Previously called HTLV-III or LAV.

Immune system - a complex network of organs and cells whose functions and interactions enable the body to defend itself against infection and substances which are foreign to it.

Incidence - the number of new cases of a disease over a specified period of time.

Infected - the state of the body when a part of it has been invaded by a disease-causing organism that usually multiplies and causes harmful effects.

Intravenous (IV) drug user - one whose drugs are injected by needle directly into the vein, sometimes with shared equipment.

Kaposi's Sarcoma (KS) - a rare form of cancer that is one of the more common opportunistic diseases occurring in people with AIDS.

Opportunistic infection - a variety of diseases, caused by agents commonly found in our bodies and environment, which occur in individuals whose natural resistance to disease has been damaged, i.e. whose immune systems are not healthy.

Pediatric AIDS - AIDS in children under 13.

Pneumocystis carinii Pneumonia (PCP) - a form of pneumonia which is the most common life-threatening opportunistic infection found among persons with AIDS.

Retrovirus - a special family of viruses, characterized by the unusual way genetic material is reproduced and known to cause a variety of diseases in animals. HIV is a retrovirus.

Screening - the process of identifying undetected disease by using tests, examinations or other procedures, and as applied to AIDS, is testing for the HIV antibody.

Seroconvert - a blood status change from seronegative to seropositive, or the point at which antibodies are detectable. Following infection with the AIDS virus, this may take anywhere from three weeks to six months.

Seropositive - producing a positive reaction to a blood test for HIV antibodies, generally determined by the combination of two positive ELISA and one Western Blot test.

Seroprevalence - measurement of the number of persons in a population with a disease or infection in a given period of time by testing for antibodies in blood specimens collected from the population.

Surveillance - when referring to disease, involves collection, analysis and interpretaion of public health data in a systematic and ongoing basis to determine how disease occurs and spreads through the population.

Symptomatic - having complaints of disease.

T_4-cell - a type of white blood cell (lymphocyte) that orchestrates immune system function.

Universal Blood/body fluid precautions - infection control procedures applied to all patients regardless of whether HIV antibody status in known. The procedures are designed to minimize or prevent the transmisison of infections when in direct contact with blood and other body fluids.

Virus - a microorganism that: may cause infectious disease; is capable of multiplication and growth only within a living cell; and which may destroy the living cells it invades.

Western Blot test - a highly specific blood test used for identifying presence of HIV antibody. Though more expensive than the ELISA, it is less likely to produce false positive results and is used to supplement the ELISA for HIV detection.

1987

An Act

HOUSE BILL NO. 1177.

BY REPRESENTATIVES Wham, Allison, Bond, Grampsas, Swenson, Anderson, Bowen, Chlouber, Entz, Epps, Fagan, Fish, Grant, Groff, Jenkins, Lawson, Masson, Owens, Reeser, Rupert, Taylor-Little, and S. Williams;
also SENATORS Allard, Bird, DeNier, Fowler, Lee, McCormick, Strickland, Traylor, and Trujillo.

CONCERNING THE DECLARATION OF HIV INFECTION, THE VIRUS WHICH CAUSES ACQUIRED IMMUNE DEFICIENCY SYNDROME, AS A COMMUNICABLE DISEASE, AND, IN CONNECTION THEREWITH, ESTABLISHING PROCEDURES FOR THE CONTROL OF THE DISEASE.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Article 4 of title 25, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW PART to read:

PART 14
HIV INFECTION AND ACQUIRED IMMUNE DEFICIENCY SYNDROME

25-4-1401. Legislative declaration. The general assembly hereby declares that infection with human immunodeficiency virus, the virus which causes acquired immune deficiency syndrome (AIDS), referred to in this part 14 as "HIV", is an infectious and communicable disease that endangers the population of this state. The general assembly further declares that reporting of HIV infection to public health officials is essential to enable a better understanding of the disease, the scope of exposure, the impact on the community, and the means of control and that efforts to control the disease should include public education, counseling, and voluntary testing and that restrictive enforcement measures should be used only when necessary to protect the public health. The general assembly further declares that the purpose of this part 14 is to protect the

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

public health and prevent the spread of said disease.

25-4-1402. Reports of HIV infection. (1) Every attending physician in this state shall make a report in writing to the state or local department of health, in a form designated by the state department of health, on every individual known by said physician to have a diagnosis of AIDS or HIV related illness, including death from HIV infection, within twenty-four hours after such fact comes to the knowledge of said physician.

(2) All other persons treating a case of HIV infection in hospitals, clinics, sanitariums, penal institutions, and other private or public institutions shall make a report to the state or local department of health, in a form designated by the state department of health, on every individual having a diagnosis of AIDS or HIV related illness, including death from HIV infection, within twenty-four hours after such fact comes to the knowledge of said person.

(3) Only one report shall be required for each individual having HIV infection.

(4) The reports required to be made under the provisions of subsections (1) and (2) of this section shall contain the name, date of birth, sex, and address of the individual reported on and the name and address of the physician or other person making the report.

(5) Good faith reporting or disclosure pursuant to this section or section 25-4-1403 shall not constitute libel or slander or a violation of the right of privacy or privileged communication.

(6) Any person who in good faith complies completely with this part 14 shall be immune from civil and criminal liability for any action taken in compliance with the provisions of this part 14. Compliance by a physician with the reporting requirements of this part 14 and with any regulations promulgated by the state department of health relating thereto shall fulfill any duty of such physician to a third party.

25-4-1403. Reports of HIV infection by laboratories. All clinical laboratories rendering diagnostic service shall report to the state department of health or appropriate local department of health, within twenty-four hours after diagnosis, the name, date of birth, sex, and address of any individual whose specimen submitted for examination tests positive for HIV antibody or virus. Such report shall include the test results and the name and address of the attending physician and any other person or agency referring such

positive specimen for clinical diagnosis.

25-4-1404. Use of reports. (1) The reports required to be submitted by sections 25-4-1402, 25-4-1403, and 25-4-1405 (8) and held by the state or local department of health or a health care provider or facility, third-party payor, physician, clinic, laboratory, blood bank, or other agency shall be strictly confidential medical information. Such information shall not be released, shared with any agency or institution, or made public, upon subpoena, search warrant, discovery proceedings, or otherwise, except under any of the following circumstances:

(a) Release may be made of medical or epidemiologic information for statistical purposes in a manner such that no individual person can be identified.

(b) Release may be made of medical or epidemiological information to the extent necessary to enforce the provisions of this part 14 and related rules and regulations concerning the treatment, control, and investigation of HIV infection by public health officials.

(c) Release may be made of medical or epidemiological information to medical personnel in a medical emergency to the extent necessary to protect the health or life of the named party.

(2) No officer or employee of the state or local department of health shall be examined in any judicial, executive, legislative, or other proceeding as to the existence or content of any individual's report retained by such department pursuant to this part 14 or as to the existence of the contents of reports received pursuant to sections 25-4-1402 and 25-4-1403 or the results of investigations in section 25-4-1405. This provision shall not apply to individuals who are under restrictive actions pursuant to section 25-4-1406 or 25-4-1407.

25-4-1405. Disease control by state and local health departments. (1) It is the duty of state and local health officers to investigate sources of HIV infection and to use every proper means to prevent the spread of the disease.

(2) It is the duty of state and local health officers, as part of disease control efforts, to provide public information, risk reduction education, confidential voluntary testing and counseling, educational materials for use in schools, and professional education to health care providers.

(3) The state department of health shall:

(a) Prepare and disseminate to health care providers circulars of information and presentations describing the epidemiology, testing, diagnosis, treatment, medical, counseling, and other aspects of HIV infection;

(b) Provide consultation to agencies and organizations regarding appropriate policies for testing, education, confidentiality, and infection control;

(c) Conduct health information programs to inform the general public of the medical and psychosocial aspects of HIV infection, including updated information on how infection is transmitted and can be prevented. The department shall prepare for free distribution among the residents of the state printed information and instructions concerning the dangers from HIV infection, its prevention, and the necessity for testing.

(d) Prepare and update an educational program on HIV infection in the workplace for use by employers;

(e) Develop and implement HIV education risk-reduction programs for specific populations at higher risk for infection; and

(f) Develop and update a medically correct AIDS prevention curriculum for use at the discretion of secondary and middle schools.

(4) School districts are urged to provide every secondary school student, with parental consent, education on HIV infection and AIDS and its prevention.

(5) It is the duty of every physician who, during the course of an examination, discovers the existence of HIV infection or who treats a patient for HIV infection to inform the patient of the interpretation of laboratory results and measures for preventing the infection of others.

(6) Any local health department, state institution or facility, medical practitioner, or public or private hospital or clinic may examine and provide treatment for HIV infection for any minor if such physician or facility is qualified to provide such examination and treatment. The consent of the parent or guardian of such minor shall not be a prerequisite to such examination and treatment. The physician in charge or other appropriate authority of the facility or the licensed physician concerned shall prescribe an appropriate course of treatment for such minor. The fact of consultation, examination, and treatment of such a minor under the provisions of this section shall be absolutely confidential and shall not be divulged by the facility or physician to any

person other than the minor except for purposes of a report required under sections 25-4-1402, 25-4-1403, and 25-4-1405 (8) and a report containing the name and medical information of the minor made to the appropriate authorities if required by the "Child Protection Act of 1975", article 10 of title 19, C.R.S. If the minor is less than sixteen years of age or not emancipated, the minor's parents or legal guardians may be informed by the facility or physician of the consultation, examination, and treatment. The physician or other health care provider shall counsel the minor on the importance of bringing parents or guardians into the minor's confidence about the consultation, examination, or treatment.

(7) When investigating HIV infection, state and local health departments, within their respective jurisdictions, may inspect and have access to medical and laboratory records relevant to the investigation of HIV infection.

(8) (a) No physician, health worker, or any other person and no hospital, clinic, sanitarium, laboratory, or any other private or public institution shall test, or shall cause by any means to have tested, any specimen of any patient for HIV infection without the knowledge and consent of the patient; except that knowledge and consent need not be given:

(I) Where the health of a health care provider or a custodial employee of the department of corrections or the department of institutions is immediately threatened by exposure to HIV in blood or other bodily fluids;

(II) When a patient's medical condition is such that knowledge and consent cannot be obtained;

(III) When the testing is done as part of seroprevalence surveys if all personal identifiers are removed from the specimens prior to the laboratory testing;

(IV) When the patient to be tested is sentenced to and in the custody of the department of corrections or is committed to the Colorado state hospital and confined to the forensic ward or the minimum or maximum security ward of such hospital.

(b) Any patient tested for HIV infection pursuant to this subsection (8) without his knowledge and consent shall be given notice promptly, personally, and confidentially that a test sample was taken and that the results of such test may be obtained upon his request.

25-4-1406. Public health procedures for persons with HIV infection. (1) Orders directed to individuals with HIV infection or restrictive measures on individuals with HIV

infection, as described in this part 14, shall be used as the last resort when other measures to protect the public health have failed, including all reasonable efforts, which shall be documented, to obtain the voluntary cooperation of the individual who may be subject to such an order. The orders and measures shall be applied serially with the least intrusive measures used first. The burden of proof shall be on the state or local health department to show that specified grounds exist for the issuance of the orders or restrictive measures and that the terms and conditions imposed are no more restrictive than necessary to protect the public health.

(2) When the executive director of the state department of health or the director of the local department of health, within his respective jurisdiction, knows or has reason to believe, because of medical or epidemiological information, that a person has HIV infection and is a danger to the public health, he may issue an order to:

(a) Require a person to be examined and tested to determine whether he has HIV infection;

(b) Require a person with HIV infection to report to a qualified physician or health worker for counseling on the disease and for information on how to avoid infecting others;

(c) Direct a person with HIV infection to cease and desist from specified conduct which endangers the health of others, but only if the executive director or director has determined that clear and convincing evidence exists to believe that such person has been ordered to report for counseling as provided in paragraph (b) of this subsection (2) and continues to demonstrate behavior which endangers the health of others.

(3) If a person violates a cease and desist order issued pursuant to paragraph (c) of subsection (2) of this section and it is shown that the person is a danger to others, the executive director of the state department of health or the director of the local department of health may enforce the cease and desist order by imposing such restrictions upon the person as are necessary to prevent the specific conduct which endangers the health of others. Any restriction shall be in writing, setting forth the name of the person to be restricted and the initial period of time, not to exceed three months, during which the order shall remain effective, the terms of the restrictions, and such other conditions as may be necessary to protect the public health. Restrictions shall be imposed in the least restrictive manner necessary to protect the public health. The executive director or the director issuing an order pursuant to this subsection (3) shall review petitions for reconsideration from the person affected by the

order. Restriction orders issued by directors of local departments of health shall be submitted for review and approval of the executive director of the state department of health.

(4) (a) Upon the issuance of any order by the state or local department of health pursuant to subsection (2) or (3) of this section, such department of health shall give notice promptly, personally, and confidentially to the person who is the subject of the order stating the grounds and provisions of the order and notifying the person who is the subject of the order that he has a right to refuse to comply with such order and a right to be present at a judicial hearing in the district court to review the order and that he may have an attorney appear on his behalf in said hearing. If the person who is the subject of the order refuses to comply with such order and refuses to cooperate voluntarily with the executive director of the state department of health or the director of the local department of health, the executive director or local director may petition the district court for an order of compliance with such order. The executive director or local director shall request the district attorney to file such petition in the district court, but, if the district attorney refuses to act, the executive director or local director may file such petition and be represented by the attorney general. If an order of compliance is requested, the court shall hear the matter within ten days after the request. Notice of the place, date, and time of the court hearing shall be made by personal service or, if the person is not available, shall be mailed to the person who is the subject of the order by prepaid certified mail, return receipt requested, at his last-known address. Proof of mailing by the state or local department of health shall be sufficient notice under this section. The burden of proof shall be on the state or local department of health to show by clear and convincing evidence that the specified grounds exist for the issuance of the order and for the need for compliance and that the terms and conditions imposed therein are no more restrictive than necessary to protect the public health. Upon conclusion of the hearing, the court shall issue appropriate orders affirming, modifying, or dismissing the order.

(b) If the executive director or local director does not petition the district court for an order of compliance within thirty days after the person who is the subject of the order refuses to comply, such person may petition the court for dismissal of the order. If the district court dismisses the order, the fact that such order was issued shall be expunged from the records of the state or local department of health.

(5) Any hearing conducted pursuant to this section shall be closed and confidential, and any transcripts or records

relating thereto shall also be confidential.

25-4-1407. Emergency public health procedures. (1) When the procedures of section 25-4-1406 have been exhausted or cannot be satisfied as a result of threatened criminal behavior and the executive director of the state department of health or the director of a local department of health, within his respective jurisdiction, knows or has reason to believe, because of medical information, that a person has HIV infection and that such person presents an imminent danger to the public health, the executive director or local director may bring an action in district court, pursuant to rule 65 of the Colorado rules of civil procedure, to enjoin such person from engaging in or continuing to engage in specific conduct which endangers the public health. The executive director or local director shall request the district attorney to file such action in the district court, but, if the district attorney refuses to act, the executive director or local director may file such action and be represented by the attorney general.

(2) Under the circumstances outlined in subsection (1) of this section, in addition to the injunction order, the district court may issue other appropriate court orders including, but not limited to, an order to take such person into custody, for a period not to exceed seventy-two hours, and place him in a facility designated or approved by the executive director. A custody order issued for the purpose of counseling and testing to determine whether such person has HIV infection shall provide for the immediate release from custody and from the facility of any person who tests negative and may provide for counseling or other appropriate measures to be imposed on any person who tests positive. The person who is the subject of the order shall be given notice of the order promptly, personally, and confidentially stating the grounds and provisions of the order and notifying such person that he has a right to refuse to comply with such order and a right to be present at a hearing to review the order and that he may have an attorney appear on his behalf in said hearing. If such person contests testing or treatment, no invasive medical procedures shall be carried out prior to a hearing being held pursuant to subsection (3) of this section.

(3) Any order issued by the district court pursuant to subsection (2) of this section shall be subject to review in a court hearing. Notice of the place, date, and time of the court hearing shall be given promptly, personally, and confidentially to the person who is the subject of the court order. Such hearing shall be conducted by the court no later than forty-eight hours after the issuance of the order. Such person has a right to be present at the hearing and may have an attorney appear on his behalf in said hearing. Upon

conclusion of the hearing, the court shall issue appropriate orders affirming, modifying, or dismissing the order.

(4) The burden of proof shall be on the state or local department of health to show by clear and convincing evidence that grounds exist for the issuance of any court order pursuant to subsection (1) or (2) of this section.

(5) Any hearing conducted by the district court pursuant to subsection (1) or (2) of this section shall be closed and confidential, and any transcripts or records relating thereto shall also be confidential.

(6) Any order entered by the district court pursuant to subsection (1) or (2) of this section shall impose terms and conditions no more restrictive than necessary to protect the public health.

25-4-1408. Rules and regulations. The state board of health may adopt such rules and regulations as are in its judgment necessary to carry out the provisions of this part 14.

25-4-1409. Penalties. (1) Any attending physician or other health care provider required to make a report pursuant to section 25-4-1402, or any clinical laboratory required to make a report pursuant to section 25-4-1403, who fails to make such a report commits a class 2 petty offense and, upon conviction thereof, shall be punished by a fine of not more than three hundred dollars.

(2) Any physician or other health care provider, any officer or employee of the state department or local departments of health, or any person, firm, or corporation which violates section 25-4-1404 by releasing or making public confidential medical information or by otherwise breaching the confidentiality requirements of said section is guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not less than five hundred dollars nor more than five thousand dollars or by imprisonment in the county jail for not less than six months nor more than twenty-four months, or by both such fine and imprisonment.

25-4-1410. Repeal of part. (1) This part 14 shall be repealed, effective July 1, 1990, unless the general assembly, acting by bill, continues said part 14.

(2) As part of his other department of health reviews to be done in 1989, the state auditor shall conduct an analysis and evaluation of the regulatory provisions of this part 14. Such analysis and evaluation shall be completed by January 1, 1990, and a written report based upon the analysis and

evaluation, along with such supporting materials as may be requested, shall be submitted by the state auditor to the general assembly no later than January 15, 1990.

SECTION 2. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Carl B. Bledsoe
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Ted L. Strickland
PRESIDENT OF
THE SENATE

Lee C. Bahrych
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

Marjorie L. Nielson
SECRETARY OF
THE SENATE

APPROVED June 8, 1987 at 2:11 PM

Roy Romer
GOVERNOR OF THE STATE OF COLORADO