
Building a Community-Based Consortium for AIDS Patient Services

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Synopsis

The authors describe a 3-year effort by a public health care system in a large metropolitan area to obtain Federal funds for treating patients with

acquired immunodeficiency syndrome (AIDS). During that process, program planners moved incrementally from proposing an exclusively medical model to one emphasizing the activities of a coalition of community based organizations (CBO). Successive proposals for Federal funding reflected increasing understanding of the nature and functioning of CBOs in providing case management and other support services. The third application proposed devoting 34.5 percent of the budget to CBO activities. That application, which was successfully funded, provided leverage and momentum for the concept of the interdisciplinary, broadly based services consortium which has evolved in Denver since 1989. The consortium has been instrumental in the 55.9 percent reduction in the cost of medical care for AIDS patients that has occurred.

PUBLIC HEALTH RESOURCES in the City of Denver since the mid-1980s have been severely stressed by the human immunodeficiency virus (HIV) epidemic.

Funds provided by the Centers for Disease Control and Prevention, and the Colorado State Department of Health, have helped the City and County of Denver Department of Health and Hospitals (DHH) to provide HIV-related epidemiologic studies, outreach services, prevention efforts, counseling and testing, and partner notification. However, funds prior to 1989 have been generally unavailable for treatment.

As a result, growing numbers of patients with acquired immunodeficiency syndrome (AIDS) received treatment from DHH, the agency responsible for the health care of low-income and medically indigent citizens. The numbers of AIDS patients seen at the DHH Infectious Diseases (ID) Clinic increased from 8 cases in 1982 to 110 per year in 1987, which was 41 percent of the city's 268 confirmed AIDS patients that year, when there were no other dedicated facilities in the State for AIDS outpatient care.

In 1987, AIDS, in many respects, had not yet come out of the closet. The consequences for the patient of an AIDS diagnosis also could include social ostracism, denial of insurance benefits, and loss of employment. In Denver that year, 91 percent of the 244 AIDS cases were among gay or bisexual men, compared with 71 percent nationally (1). A diagnosis of AIDS meant being identified with the gay com-

munity. Because many patients tried to conceal the nature of their condition, and because virtually no dedicated facilities existed for primary care for those with HIV infection, few openly sought routine or preventive care. Instead, most delayed seeking treatment until they were forced to by the progression of the disease.

When they required urgent or emergent care, they usually went to the ID-AIDS clinic; to such specialty clinics as those for dermatology, oncology, or nonemergency care; to the DHH walk-in clinic; or the emergency room. Delays in seeking care usually resulted in higher acuity of illnesses, inpatient admissions, and prolonged lengths of stay (2). Continuity of care virtually was unavailable.

The ID-AIDS clinic occupied a small space borrowed from another clinic. There were long waiting periods for appointments, and it was not unusual for patients to be lined up on gurneys in the hall, waiting to see a physician, or receiving intravenous therapy. It was not unusual for a patient's first contact with the health care delivery system to be the last. AIDS patients occupying medical beds at Denver General Hospital often were those with end-stage disease who had only recently sought emergency care.

Once a patient was discharged, no formal case management system was in place in the community. There was but one hospice that accepted AIDS

patients. Home health and hospice care were rarely available, owing to a lack of reimbursement for those services. As a result, social workers at Denver General Hospital often were reluctant for patients to be discharged. The situation contributed to an average length of stay for AIDS patients of 11.3 days in 1986, compared with 5.5 days for the hospital overall. By comparison, systems tied to a strong network of home care resources can reduce average lengths of stay for AIDS patients by 60 percent (3).

A 1987 study of billing records by DHH Management Services showed that only 21 percent of AIDS patients admitted to Denver General Hospital had third party coverage. Reimbursement for those services was calculated at 18 percent of charges, which in 1986 averaged \$23,940 (4). The report forecast a significant increase by 1991 in HIV-infected patients in Denver, then an area of moderate seroprevalence, and estimated that at least half those patients, most of whom would be uninsured, would seek care in the DHH system. Clearly, the public health system needed to prepare for the expected influx. In its efforts to control costs while trying to minimize suffering, DHH needed to establish integrated systems of care which would address the range of complex and varied needs of patients with HIV infection from diagnosis to death.

Socioeconomic Environment

By 1987, when Denver's public health officials began to recognize more fully the impact that AIDS would have on the health care system, the recession of the 1980s was most severe in the local economy. While the city had covered 25 percent of the DHH budget in 1985, it supported only 11 percent in 1986, owing to an eroding tax base. The hospital operated in the red that year, with a year-end deficit of more than \$16 million. Contributing to the deficit was the cost of caring for uninsured AIDS patients, estimated at \$31,180 per inpatient and outpatient per year, excluding pharmaceutical charges.

At that time, few health care providers treated patients with HIV infection. No hospital in the area wished to become known as an "AIDS hospital," a reputation that might discourage private patient admission and attract uninsured AIDS patients from the region. The general public concern and confusion about the epidemic infiltrated the legislative and medical arenas, the workplace, law enforcement agencies, the insurance industry, and various educational and religious institutions. With the exception of churches, which tended to maintain a hands-off posture, virtually all facets of Denver society

struggled to develop policies that would balance the perceived interests of their constituents with the needs and rights of those HIV-infected.

Most policy development went forward in a highly public way, with daily press reports on controversial issues: potential quarantine of AIDS "victims" (5), mandatory testing of rape suspects (6) and marriage license applicants (7), isolation of prisoners with HIV (8), and the propriety of advertising condoms on television (9). The American Civil Liberties Union, the Denver Civil Rights Commission, and an array of gay rights activists lobbied strongly for the rights of the HIV-infected, as well as for research and treatment funds. In particular, they lobbied against any reporting laws which would identify seropositive persons by name (10). That requirement was established by the Colorado legislature in June 1987 and signed by the Governor (11). Gay rights activists protested that it would drive the epidemic underground. State health officials countered that using names would make it possible to reach persons exposed to the disease. The Colorado Department of Health and the legislature had chosen to treat the AIDS epidemic like any other reportable disease.

During that time, prominent attorneys advised businesses to delay discrimination suits brought against them by AIDS patients and to wait for the patient to die (12). Bath houses were shut down in Denver by the department of public health. Sit-ins were held at DHH Administration by gay rights activists demanding more funds for treatment and more humane care.

Community organization, however, practically was nonexistent, and little attention was paid to the growing numbers nationally of women, members of minority groups, and children who were infected with HIV. One major community-based organization, the Colorado AIDS Project (CAP), had evolved in response to the epidemic. Founded in 1982 by gay men, it was largely a volunteer operation and strongly identified with the gay community.

Available Services

In this environment, treatment issues were assumed to be the province of the medical community, whose wisdom was seldom questioned. DHH was joined by the Visiting Nurses Association (VNA), one hospice, and one half-way house, in being among the few agencies caring for AIDS patients. The Colorado Department of Health, the Department of Public Health (a division of DHH), and a number of local health departments responded to the crisis by establishing a number of counseling and testing sites.

In addition, the Department of Public Health implemented a sophisticated epidemiologic tracking system, as well as a Centers for Disease Control and Prevention-funded demonstration program to test the effectiveness of various risk reduction strategies among a cohort of 500 gay males.

The medical community led HIV prevention efforts with a range of HIV prevention, awareness, and education activities. In 1987, to provide an umbrella organization and to avoid duplication of services, 27 agencies involved in AIDS prevention and education formed the AIDS Coalition for Education. Only two of the charter members were nonmedical organizations (the Denver Department of Social Services and CAP).

By the mid-1980s, CAP had become widely recognized for its efforts to promote AIDS awareness and education. The agency quickly found, however, that with awareness and education came expectations for services. By 1987, CAP had opened a food bank and begun to provide advocacy, assistance with daily living needs, crisis intervention, individual and group counseling, support groups, and referrals to community resources. However, with but five paid staff members, professional social work and case management services could be provided for only about 5 to 10 new patients per month with fully symptomatic AIDS, which was a small portion of the 268 diagnosed AIDS cases in Denver. Remaining clients took advantage of group counseling and support offered by the agency or by the volunteer buddy program, which provided transportation to various community resources and appointments, assistance with daily living, advocacy in obtaining benefits and housing, and emotional support.

At this time, CAP was in its infancy and would require a large infusion of funds before it could extend professional services to patients with AIDS-related complex (ARC) symptoms or those who were HIV-seropositive and asymptomatic. CAP also would need additional resources to better organize and manage its services delivery, as it was becoming known to the public as an inefficient agency of well-intentioned volunteers.

In short, there were tremendous gaps in Denver's AIDS services delivery system. Among its three major players, DHH was able to provide inpatient, specialty, and emergency care to fewer than half of Denver's 268 AIDS patients; CAP was limited to providing professional social work services to 10 new clients per month or less; and VNA provided home health care to about 30 patients per year. Thus, it was a logical next step for CAP and VNA to join DHH in seeking Federal funds for treatment.

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First Grant Application

The Public Health Service's Health Resources and Services Administration (HRSA) began its AIDS Service Demonstration Projects in 1986, with grants to New York, San Francisco, Los Angeles, and Miami, all areas with high prevalence of HIV infection. In 1987, the Denver-Boulder Standard Metropolitan Statistical Area (SMSA) became eligible to compete for program funds.

HRSA's 1987 program announcement called for "projects demonstrating a comprehensive, cost-effective, ambulatory, and community-based health and support system for persons with AIDS, AIDS-related conditions/complex (ARC), and HIV infection" (13). Applicants were expected to demonstrate "a thorough understanding of the incidence of AIDS, ARC, and HIV infection, the need and demand for services, and a realistic plan for providing the most needed services, including education and prevention services."

The most pressing need for AIDS patients, as far as public health department physicians were concerned, was medical care. They based their conclusion on their experience in treating AIDS patients within the DHH system, where patient waits were long; clinic space was lacking; specialty services, particularly the ID, oncology, and neuropsychiatric clinics, were understaffed; and no system was in place for HIV primary care or patient case management. The limited perspective was reinforced by the local chapter of ACT UP, a radical gay rights group, which openly demonstrated for enhanced medical services for patients with AIDS.

During the development of the first proposal, VNA and CAP were consulted on arrangements for sub-contracts and on soliciting letters of support. Those two agencies were not instrumental in program development, nor did they question the preeminence

Organizations of the Metro Denver AIDS Services Consortium

Black AIDS Project-at-Large (B-A-PAL/CARE). Provides culturally sensitive services to African American HIV-AIDS patients. Services include intake, assessment, case management, counseling, support, and substance abuse counseling and referral.

Boulder County AIDS Project (BCAP). An independent, nonprofit agency with a staff of 28 persons who provide services for Boulder County residents with or affected by HIV/AIDS. Primary services include case management, support groups, a food bank, a buddy program, emergency assistance, pro bono professional services, and referrals to community-based organizations and other resource groups.

Colorado AIDS Project (CAP). A private, nonprofit agency that provides services to HIV-AIDS clients, families, and friends. Services include intake and assessment, case management, and emotional and practical support. Provides a food bank, durable medical equipment, emergency financial assistance, a buddy program, support groups, referrals for medical and psychiatric care, legal services, housing assistance, and related services.

Denver Health and Hospitals. An agency of the City and County of Denver. Provides a fully integrated system of HIV-AIDS inpatient and specialty care to Denver residents. Currently servicing 1,160 patients.

Empowerment. A private, nonprofit organization offering HIV risk reduction counseling and direct HIV-AIDS case management services to female juveniles and adults at risk for or with past or present involvement with the criminal justice system.

Hospice of Metro Denver. A private, nonprofit

agency providing services to the terminally ill and their families. Services include case management, nursing care, mental health, nutrition, rehabilitation (physical, occupational, and speech), individual and group counseling, bereavement support, personal care, spiritual counseling, 24-hour on-call, and volunteer support.

Hospice of Peace. Offers a team concept of assistance to terminally ill AIDS patients. Team members include registered nurses, home health aides, social workers, and pastoral counselors to patients and family. An affiliate of Catholic Social Services.

Latino AIDS Community Network (Latino Network). A collaborative effort of Latino organizations to provide HIV-related services such as direct services, outreach, case management, education and prevention, treatment information, transportation, and counseling.

People of Color Consortium Against AIDS (POC-CAA). Part of a multi-State, private, nonprofit agency using community resource developers to strengthen the availability of HIV-AIDS services. Cultivates volunteers and provides direct services, including intake and assessment, referral, and case management.

People with AIDS (PWA) Coalition. Local chapter provides information, advocacy, and referral services. Publishes *Resolute*, a newsletter dedicated to HIV survival.

Visiting Nurses Association (VNA). Affiliate of the national, private, nonprofit agency that provides such services as physical assessment, home maker, home health, care giver, and case management.

of DHH in its informal, medically biased assessment of the needs of HIV-infected patients. Prior to the submission of the proposal, five other agencies were invited to participate in the proposed consortium. They were the University of Colorado Health Sciences Center, the Hospice of St. John, Denver Medical Society, Colorado Department of Health, and Jesser House, a halfway house.

The lack of a formal, broad-based needs assessment caused the proposal planners to overlook HRSA's emphasis on developing "community-based systems of care." In DHH's first proposal, we concentrated almost exclusively on defining the need and demand for medical services. Resources to

provide primary care for mildly symptomatic and asymptomatic patients were critically needed, as were funds for drug therapy, home health care, neuropsychiatric care, and additional staff persons for the existing DHH hematology-oncology and ID-AIDS clinics and the clinical social work department. Accordingly, we proposed to implement three interdisciplinary primary care teams at three different sites in the DHH Neighborhood Health Program (funded under Section 330 of the Public Health Service Act). That would cover the continuum of care from diagnosis to death.

While the proposed services consortium would include an array of community-based organizations

Proposed annual expenditures for Denver Health and Hospitals' (DHH) successive grant applications for AIDS service demonstration projects, by budget category

Category	1987		1988		1989	
	Amount	Percent	Amount	Percent	Amount	Percent
Total	807,659	100	595,497	100	1,087,175	100
DHH:						
Personnel and benefits.....	583,341	72.2	350,914	58.9	474,406	43.6
Equipment.....	21,020	2.6	...	...	30,000	2.8
Supplies.....	35,000	4.3	9,000	1.5	47,000	4.4
Travel and other.....	25,000	3.1	2,000	0.4	2,100	0.2
Indirect costs.....	98,298	12.2	121,583	20.4	157,769	14.5
Subtotal.....	762,659	94.4	483,497	81.2	712,175	65.5
Community-based organizations:						
CAP.....	35,000	4.3	40,000	6.7	250,000	23.0
VNA.....	10,000	1.3	48,068	8.1	75,000	6.9
Other.....	...	...	23,932	4.0	50,000	4.6
Subtotal.....	45,000	5.6	112,000	18.8	375,000	34.5

NOTE: CAP = Colorado AIDS Project. VNA = Visiting Nurses Association.

(CBOs) and public and private providers, its role as envisioned in the proposal would be largely advisory and political. The consortium was intended to help plan and coordinate services, reduce duplication, fill service gaps, and marshall public and private sector support for the project. The organization chart for the proposed Denver AIDS Service Consortium showed the primary care team at the center, surrounded by medical providers. The accompanying box lists and describes the currently participating organizations. CAP and Jesser House, the only nonmedical community service agencies involved in the project, were relegated largely to responsibilities for outreach and education.

The amount requested for the first year of the proposed program was \$807,659. Of this amount, 5.6 percent (\$45,000) was for CAP and VNA for case management and home health care (see table), and did not constitute a "community-based" project. CAP had campaigned aggressively, but unsuccessfully, for more funds. As a result, CAP and other CBOs began to distrust DHH's controlling approach. HRSA did not fund the first grant application. The reason given for rejection was that the proposed program was perceived not as a community-based demonstration, but as an expansion of DHH's existing services.

Second Grant Application

Apparently, other applicants interpreted the 1987 HRSA notice in much the same way that Denver did. In the 1988 program announcement for AIDS Service Demonstration Project funding, HRSA refined its

program objectives to include "demonstration of community-based systems of care which ... provide appropriate alternatives to inpatient hospital care" (14). The first evaluation criterion was the ability to "coalesce broad-based community support among appropriate agencies and programs"

A representative of the DHH grant writing team sent to a HRSA technical assistance workshop in Washington returned with three clear messages. First, HRSA intended to fund consortia that actually managed funded projects; second, HRSA wanted proposals that described comprehensive service plans directly tied to identified service gaps; and third, HRSA wanted well-developed case management components.

With that in mind, DHH convened a planning team, which for the first time, included representatives of several CBOs. By 1988, new agencies had emerged that were devoted to prevention and education in Denver's minority community. Additionally, a number of existing agencies already serving various minorities and other populations, such as the homeless, runaways, youth, the disabled, intravenous drug users, and others, had begun addressing HIV-related concerns as they affected their clients, primarily prevention and education activities. A total of 58 agencies were invited to join the "Denver Metropolitan Council on AIDS-Related Disorders," which was convened by DHH, and representatives attended a formal meeting prior to preparing the 1988 application. Of the total number, five agencies offered in-kind support to the project and six were proposed as subcontractors. Those agencies attended one or more informal grant writing

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meetings or made arrangements with DHH principals on the proposed project to provide services under the auspices of the grant.

Moreover, the project was no longer housed within Denver Public Health; instead, the Department of Ambulatory Care Services, which encompasses the community-based health stations comprising the Neighborhood Health Program, took up the task. Greater care was taken to identify and quantify specific service gaps and to address them in the proposal's objectives and comprehensive service plan.

Despite those improvements, the planning team was still heavily weighted in favor of DHH. From within the agency, the team included representatives of neuropsychiatry, oncology, clinical social work, public health, nutrition services, and ambulatory care services, whose collective experience with AIDS patients tended to overwhelm the smaller, struggling, and financially needy CBOs. Not surprisingly, during its handful of meetings, the grant writing team arrived at the conclusion that outreach, prevention, and education programs in Denver, precisely those provided by most CBOs, were adequate. The strongest expressed need was for a community-based system of outpatient care, case management services, neuropsychiatric diagnosis and treatment, housing and nutrition assistance, transportation, day care, surrogate care giver and respite care, job training and placement, and long-term care.

The goals of the second proposal's service plan reflected, however, an expanded awareness brought about by the inclusion of CBOs in the planning process. The proposal described the mobilization of a services coalition, comprehensive and coordinated outreach, prevention and education, early identification and treatment, and case management, as well as medical care. Plans for a community-based coalition were more clearly defined and included forming an executive committee to coordinate directly with the DHH project management team.

Like the first application, the second effort said that the coalition would serve in an advisory capacity. Although the project goals clearly addressed the importance of community involvement, the money would go largely to DHH for medical services.

Specifically, the project budget for a year came to \$595,497. Of that, 18.8 percent (\$112,000) was to be contracted to CAP, VNA, and other CBOs. They were Servicios de la Raza, an established provider of mental health and social services to Denver's Hispanic population; the Minority AIDS Coalition and the Black AIDS Project-at-Large, new groups dedicated to prevention and education; BCAP, CAP's Boulder-based counterpart; and other CBOs to be identified later.

The 1988 proposed budget reflected the planners' growing recognition of the importance of expanding social work services to include HIV-infected patients. However, DHH maintained that it could meet that need by supplementing its own resources. Of the \$595,497 allocated to DHH, 35.6 percent (\$212,137) was to be used to hire additional clinical social work staff members to provide medical case management, emphasizing efforts to coordinate activities of the medical and local communities and to provide individual and group counseling efforts and discharge planning. CAP was to receive only 6.7 percent (\$40,000) of the budget for community case management that emphasized access to community resources and meeting the daily living needs of clients for transportation, homemaking services, food, shelter, and other services. Again, DHH was proposing to spend more than 80 percent of the grant dollars. While the agency had made concessions in the name of coalition-building, it had not yet come to terms with what was intended for community involvement.

Third Grant Application

By 1989, the financial and political pressures on DHH brought on by the AIDS epidemic were mounting. There were 939 confirmed cases of AIDS in Denver, and another 1,880 were predicted during the next 3 years. Several of the CBOs struggling to survive in 1987 and 1988 had an established presence in the community, and others were being formed to fill service gaps in minority outreach and psychosocial support services. CAP had been aggressive in seeking funds, and now had an annual budget in excess of \$600,000. Thirteen counseling and testing sites were in operation in the SMSA. Two outpatient-based hospices now accepted AIDS patients, and many systems in the private sector, such as Kaiser Permanente and a few private physicians, had developed clinical programs for those with HIV infection. The DHH Dental and Oral Surgery Clinics had begun to treat seropositive patients, and had identified needs for dedicated equipment and additional personnel. Similarly, DHH Substance Treat-

ment Services was treating several intravenous drug users diagnosed with HIV and surmised that there were others among its caseload.

Rudimentary linkages had been forged among public and private sector providers. The University of Colorado had received a HRSA Educational Training Center grant to educate health care workers about HIV infection and drew expertise from Denver Public Health. A neurologist at DHH was available to consult with specialists throughout the region on neuropsychiatric implications of AIDS. DHH staff members collaborated with the University of Colorado and the Department of Veterans Affairs to establish the Nursing Project on Human Caring, which provided intravenous therapy and respite care to HIV-positive persons and support for family members. The Governor started the Advisory Council on AIDS, which included several DHH staff members.

In 1989, a series of informal meetings was held by program planners and proposed subcontractors, including CAP, VNA, BCAP, and the People of Color Consortium Against AIDS (POCCAA), a regional organization representing 11 CBOs that focused on culturally appropriate education and prevention efforts for minority group communities, with HRSA's technical assistance.

During planning meetings, resentment toward DHH's role was expressed by representatives of local CBOs. In some meetings, hostile remarks were made as leaders in the community pressed for funds for their agencies. With months and years of experience, local CBOs had acquired political support, strength in their convictions, and sophistication about the non-medical needs of HIV-infected people. DHH personnel did not yet understand the level of expertise that the CBOs had attained.

In the third application, while the service gaps identified by the planning group paralleled those articulated in the second application, the proposed solutions took on a different shape. While DHH would hold final accountability for the grant and the proposed coalition would continue to operate in an advisory capacity, funding for medical case management internal to DHH, at a proposed \$150,088, would be half the \$305,767 allocated to community case management by CAP and BCAP.

Of the total requested first-year budget of \$1,087,175, 34.5 percent (\$375,000) would go to CBOs. DHH would be able to install needed interdisciplinary primary care teams, establish a neuropsychiatric service dedicated to AIDS patients, and expand staffing for nutritional, dental, and hematology-oncology and ID services. CAP would

receive \$250,000 for community case management and related services. Additionally, VNA would receive \$75,000 for three-quarters of the time of a nurse facilitator and for home-based care, and would let contracts with local hospices for home hospice care. The BCAP would receive \$30,000 to hire a case manager, while POCCAA would be given \$20,000 to expand its outreach and prevention services among minority populations.

HRSA made a conditional award of \$880,000, stating that support for CBOs should remain in the budget, but that DHH would need to reduce its proposed budget by 29 percent (\$207,175). Thus, 43 percent of the total budget would ultimately go to CBOs, again reinforcing their importance in the overall scheme of AIDS services.

The conditional award also required the project to define better the consortium and its decision-making capabilities and to clarify the relationship between CAP and the DHH Clinical Social Work Department. We responded that the coalition would include the DHH management team and 21 CBOs. An executive committee of the coalition would be comprised of representatives of DHH and the four funded CBOs, a person with AIDS, and a member of the Governor's Advisory Council on AIDS. While DHH would retain fiscal and programmatic control of the project, the executive committee would be "integrally involved in the actual execution of the project."

Experience Gained

During the 3 years, DHH learned by trial and error, reinforced by encouragement from HRSA and political pressures in the community, to fully enfranchise CBOs in its plans to serve patients with HIV. During the period, the agency progressed from allocating 5.6 percent to 18.8 percent to 34.5 percent of proposed grant funds to CBOs, attesting to its growing recognition of the role that CBOs would play in the provision of services. In the final and successful grant application, DHH proposed a demonstration program that would vitally involve CBOs in services delivery while giving them the financial leverage to continue, if not expand, their efforts on behalf of patients with HIV. The five agencies funded by the grant, DHH and four core CBOs, were now poised to build a functioning AIDS services coalition from the many splintered and competitive groups in the community.

1989 to 1993

In its fourth year of operation, the Metro Denver AIDS Services Consortium has achieved an efficient

continuum of care, jointly managed by nine CBOs and DHH. With continued funding from HRSA under the Ryan White CARE Act, new grants from HRSA's Bureau of Primary Health Care, and a supplemental allocation from the City and County of Denver, DHH has established and continues to operate three neighborhood-based, outpatient, HIV early intervention clinics, a neuropsychiatric resource center, and two weekly hematology-oncology clinics for patients with AIDS.

HRSA funding for those services has shrunk over the years, partly as a result of the Federal formula under the Ryan White CARE Act for funding allocations to States, and partly by majority vote of the consortium, which has, in each successive year, devoted an increasing proportion of grant funds to CBOs. In the most recent award, for 1993—94, DHH received 34.9 percent of the funding awarded the consortium, far from the original conception of how Federal AIDS funds would flow into Denver.

The consortium membership has evolved, as some CBOs failed to thrive and others came forward. In addition to the five original members of the consortium (DHH, CAP, BCAP, VNA, and POC-CAA), the organization now provides case management services for Hispanics through the Latino Network, for blacks through B-A-PAL/CARE, and for women through the Empowerment Program. The Hospice of Metro Denver offers supplemental caregiver support, and the Hospice of Peace provides home hospice care.

In the program year ending March 1, 1993, the consortium served 1,100 patients. From its inception, the consortium proved highly effective in controlling the cost of care for patients with AIDS. In 1990, because of the coordinated continuum of medical and psychosocial services, inpatient and outpatient charges per AIDS patient served by DHH were contained at \$17,765 (15), which was 55.9 percent of the \$31,180 spent in 1986. The average length of stay for inpatient care was 8.2 days compared with 11.3 days in 1986.

The value of a true, community-based collaboration in providing support services to HIV-infected persons has been clearly established. We plan to describe the mechanisms the consortium used to achieve its present level of functioning in a later publication.

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