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HOUSING ISSUES AND THE HIV EPIDEMIC

VOLUME II

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P R O C E E D I N G S

CHAIRMAN OSBORN: We're a little behind schedule, and we have an important morning session of testimony. Thank you for your patience. We're getting ourselves a bit reorganized. Mayor Flynn unexpectedly, as such things happen, had a funeral that he needed to be at so that we're going to reschedule a little bit and let me tell you a bit so your planning is clear. We'll start right in with Anna Kondratas, whom we welcome, and I'll get back there in a second, and have a brief chance for questions with her, but then go on to the three panelists following, and get a chance to hear all the presentations.

We'll break at about 10:30 at the latest, I should think, perhaps a little before that, so that at 10:45 we could reconvene with Mayor Flynn, assuming that his schedule holds as it now is. Public comment is at 11:30, and the public comment sign-up sheet is on the registration table outside for those who wish to make very brief remarks, two minutes. You should be signed up in order to keep that as an orderly process as we do.

So that's the way we will proceed in the morning. As was the case yesterday, our schedule doesn't have much

flexibility because we have again the opportunity to do some visits to housing sites in the afternoon, and that puts some constraints on things. Before we start, I would like on the behalf of the commission, I guess, to take the liberty to ask all of us just for a moment to think silently about our absent Commissioner Scott Allen, whose wife died, and her funeral was yesterday. When we talked with him about whether one of us or several of us -- many of us would like to have been there, all of us would -- he said, no. He thought what he and what she would have liked and what he would like is that we work hard on housing. So we are here in memory of Lydia in a certain sense, and I wondered if we could just be silent about that for a moment.

(Moment of silence.)

CHAIRMAN OSBORN: Thank you. Some of you may not know that Lydia created Bryan's House in Dallas and was a very major person in her community and in the national community in leading to greater expression of concern about HIV and AIDS, an important loss along with many, many other important losses.

I also want to, on a very pleasant, excited note, tell you that we are, the commission is going to have more

wonderful fresh input. I'm pleased to say that Mary Fisher has agreed to be a consultant to the commission in the area of awareness on a dollar a year basis so that it's official, and Mary is here, I think. There she is. And so we officially welcome Mary as a partner in crime and a consultant and thank you for being willing to work with us, Mary.

(Applause.)

CHAIRMAN OSBORN: Did the kids go back already? Can't introduce them? All right. Well, welcome to Anna Kondratas, Assistant Secretary for Community Planning and Development of the Department of Housing and Urban Development in Washington, D.C. I think you heard the testimony yesterday.

MS. KONDRATAS: Yes.

CHAIRMAN OSBORN: And we're very eager to hear from you and have some chance to interact.

MS. KONDRATAS: I'm very pleased to be here today to represent Secretary Kemp in presenting information on the department's programs to the National Commission on AIDS. I'll be discussing the department's current and planned efforts in addressing the housing needs of persons with AIDS in the context of our overall mission to create conditions

for individuals and families to have decent and affordable housing, to ensure equal housing opportunity for all, and to strengthen and enrich our nation's communities.

The department operates a variety of programs to promote affordable housing. As you well know, persons with AIDS and their families are part of every community in our nation. They may well benefit from the programs and services offered by this department even when those programs are not targeted to persons with AIDS. It's a fundamental principle that these programs not discriminate on the basis of a person's HIV infection status.

The department does recognize, however, that persons with AIDS are facing unique challenges in meeting their housing needs. Many individuals have lost their source of income and their residences and face intermittent health crises that require inpatient care and additional home health care services and treatments. These challenges require a targeted response by housing providers supported by government at all levels. For the purposes of this hearing, I would like to describe the department's AIDS related programs as well as several major mainstream programs which offer the flexibility to states and local governments to respond to the

needs of persons with AIDS by tailoring programs to their unique housing needs.

The department also requires comprehensive planning by state and local governments and the linking of housing assistance to the needed supportive services that enhance an individual's ability to continue independent living. The department is cooperating with other federal agencies including the Department of Health and Human Services to help ensure overall coordination of federal efforts. Under the National Affordable Housing Act of 1990, states and local governments are required to create Comprehensive Housing Affordability Strategies, CHAS for short, to receive assistance from HUD. The CHAS describes the jurisdiction's housing needs including the needs of low income persons and persons with AIDS as well as strategies for addressing those needs.

I recommend that AIDS housing providers and advocates participate in this level of community planning to help ensure that their concerns and needs are addressed in the strategies that will direct ensuing state and local efforts. Again, these plans have to be submitted to the federal government before they can get any HUD assistance.

Many jurisdictions are continuing to draft and refine their original CHAS reports now and all are required to provide annual updates to HUD. The department recognizes that providing housing assistance is only one part of the challenge in addressing the special needs of targeted populations.

As with our homeless programs, HUD has adopted a philosophy that shelter alone is not enough to meet the needs of certain vulnerable persons and groups and that a substantial part of the solution must be found in providing appropriate supportive services. The programs that I will detail today are sufficiently flexible to allow providers to incorporate supportive service components in their housing projects. Some of these authorized funding for such components while others seek to leverage federal, state, local and private resources including related HHS funding for health services under the Ryan White Comprehensive AIDS Resources Emergency Act.

The National Affordable Housing Act of 1990 established the Housing Opportunities for Persons with AIDS Program, and I know the commission has asked me about this specifically. The Act appropriated $50 million for the current fiscal year. At HUD, the Office of Special Needs

Assistance Programs, which is under my jurisdiction, is preparing the program's guidelines. The guidelines will be issued as an interim rule in the coming months under an expedited process in recognition of the urgency of the housing needs of persons with AIDS.

The entitlement awards, because it is an entitlement program 90 percent of the program's funds will go to those states and eligible metropolitan areas that have the greatest number of cases of persons with AIDS. Grantees will be able to use funds to assist all forms of housing including emergency housing, apartments, single room occupancy dwellings, and community residences. Funds may also be used to provide services and, in fact, the program requires the provision of appropriate supportive services including intensive care when needed as part of the housing assistance.

We anticipate that formula entitlement funds will be available to eligible applicants by June of 1992. HUD expects to approve these applications within 30 days of their receipt. Due to the large variety of activities that are authorized, the department does not at this time have an estimate of the number of persons that might benefit from the program. For the competitive grants that focus on projects

of national significance, we expect that funds will be available this fall, and these projects will be evaluated for their effectiveness and potential for replication.

The National Affordable Housing Act also created the new Section 811 program that authorizes supportive housing for persons with disabilities including persons disabled as a result of HIV infection. Congress established a set-aside in this program, which will provide 500 new units for persons with AIDS at an approximate cost of 32 million. Persons with AIDS and groups representing them are also eligible to apply for the rest of the program so this is a set-aside specifically for persons with AIDS but the rest of the program is also an eligible source of revenue.

These projects will expand the supply of supportive housing for persons with AIDS through the acquisition, construction or rehabilitation of housing units and the provision of a project based rental assistance. The 500 new permanent housing units will become available under a 20 year commitment in independent apartment complexes or group homes. The notice of award for these grants were announced last week. 12 communities were selected. There are two projects that were selected in the Boston area.

Because of the lack of sufficient fundable applications, all of the money available was not awarded so another solicitation will be made in the very near future for the remaining $18 million plus. This program requires the establishment of a supportive services plan to provide appropriate services based on each individual's need. This one year program will be used to augment on a long-term basis the housing stock that is available and targeted to address AIDS housing needs. The remainder of the Section 811 program is also available as I mentioned for PWA housing and providing housing to persons with disabilities.

For fiscal year 1993, the president has requested $144 million for this program. The department is also implementing a new program Shelter Plus Care that focuses on the most vulnerable homeless groups, persons with disabilities including the seriously mentally ill, chronic substance abusers, and persons with AIDS and related diseases. This program was developed by the administration to address the housing and service needs of disabled homeless persons, needs not sufficiently addressed by the Stewart B. McKinney Homeless Assistance Act.

This year $110 million was appropriated for the

program, well below the president's request of $258. Applications for projects were due last Friday, February 28, for this first year of the Shelter Plus Care Program. This year's program offers two types of housing assistance for persons with disabilities: a ten year assistance program which is renewable under an expanded Section 8 moderate rehabilitation of SRO dwellings and a five year sponsor-based rental assistance program. A third component of Shelter Plus Care, tenant based assistance, which you heard about yesterday, was not provided an appropriation by the Congress. Tenant based assistance represents perhaps the most flexible type of rental assistance. HUD requires state and local grantees to match these housing assistance funds with supportive services that meet the unique needs of these persons as appropriate including health care, substance and alcohol abuse services, case management, and other services essential for achieving and maintaining independent living.

The program is designed to be flexible in allowing a variety of housing choices with a range of supportive services. Our expectation is that applicants will include discrete projects for persons with AIDS and projects that serve persons with AIDS and other disabled homeless persons

together. Awards are expected to be announced in the coming months. The Shelter Plus Care Program is the focal point for the administration's request for AIDS-related housing programs in fiscal year 1993.

The overall program request now pending congressional approval is $266 million for Shelter Plus Care. Overall, the administration is requesting $537 million for HUD's homeless programs in 1993. The expanded Shelter Plus Care Program will help address housing needs for the most needy including persons with AIDS, and maintain the link to the necessary supportive services for these individuals. In 1992, the Supportive Housing Demonstration Program, one of the McKinney Act programs, provided $150 million to grantees who are serving a large variety of client populations among the homeless including persons with AIDS, the mentally ill, developmentally disabled, substance abusers, and families with children.

The program has provided grants to units of government and private nonprofit organizations to defray the cost of acquiring, rehabilitating and operating existing buildings to provide both permanent and transitional housing and supportive services for homeless persons. An initial

telephone survey was undertaken as part of an evaluation of the program's effectiveness. That survey reported that of the 738 active grantees including pre-1992 awarded grants, 120 or 16 percent are providing some form of assistance to persons with AIDS including two projects that target services to persons with AIDS alone.

A continuing evaluation of the program's effectiveness is underway including the monitoring of the program's components that apply to persons with AIDS. The president has requested that the Supportive Housing Demonstration Program to be renamed the Transitional Housing Program be expanded in fiscal year 1993 to $204 million, a $54 million increase over the 1992 level.

As with the previous two programs, the Section 8 homeless program has been used by HUD applicants to serve the emerging housing needs of persons with AIDS. In the past year, the Section 8 SRO moderate rehabilitation program has supported projects for homeless individuals with an appropriation of $105 million for rental assistance. While not AIDS specific, the program does offer opportunities for providing an effective housing alternative for the single homeless at affordable rents. For 1993, the administration has requested

$24.3 billion to fund housing programs in the department as a whole.

I'm moving now from the targeted programs to our mainstream programs which might also be of assistance. I think these mainstream programs might best help address additional housing needs as administered by state and local governments. Again, the sums of money in targeted programs, and that holds true for homelessness as well as programs targeted to persons with AIDS, cannot solve the entire range of the problem, but the $24 billion that the department is requesting this year has a wide variety of housing services for which persons with AIDS ought to be eligible and that when targeted to state and local governments, state and local governments should be using to help meet the needs of persons with AIDS.

The Community Development Block Grant Program with the 1993 budget request of 3 billion, nearly 3 billion, has had nearly 30 percent of its prior funds used for housing purposes by local decision. The block grant has also been used to improve public facilities including health care facilities. The New Home Investment Partnership Grant Programs with a 1993 request of 950 million will provide

funds for rental assistance, acquisition and rehabilitation to increase the affordability and availability of housing and home ownership for low income persons. Requested increases in the Section 8 rental certificate and rental voucher programs have also been made for 1993 under a total allocation of $8.5 billion for assisted housing.

This includes $2.7 billion for 87,281 incremental vouchers for initiatives related to expanding affordable housing opportunities. The local public housing authorities can demonstrate flexibility in using the Section 8 certificates and voucher programs in providing rental assistance to eligible low income households in ways that address the needs of homeless families and individuals including those with disabilities or HIV infection. These and other mainstream programs offer the largest federal source of funding for local housing efforts and by far exceed the amounts provided for by the targeted homeless and AIDS programs that I've described today.

These mainstream programs are available for innovative use in addressing local needs including those of persons with AIDS. In fact, I will be happy to address later in the question and answer session any questions you might

have about federal planning. In the area of homeless programs, the federal government does have a plan, and it includes extensive use of mainstream program to address those needs and that same model might be one we would want to follow in trying to address the housing needs of persons with AIDS.

In conclusion, I hope that I've assisted the commission in gaining some understanding of this department's current programs and plans. Again, to sum up, the targeted programs seek to assist the most needy individuals and tie appropriate supportive services to the housing that is provided. In our mainstream programs, the department seeks to provide flexibility to state and local governments and nonprofit organizations to design programs based on local evaluation of housing needs. The department is committed to ensuring that our programs are effective and operate in a manner that will be serve those who are intended to benefit from them. Thank you for this opportunity to share experience. I look forward to working with you to try to address this problem.

CHAIRMAN OSBORN: I think if it's all right with you, Secretary Kondratas, we will perhaps have a few moments

for questions now, but I understand that you'll be able to join up here later --

MS. KONDRATAS: Yes.

CHAIRMAN OSBORN: -- for later questions as well when the other panel has presented. So maybe for the moment, questions of clarification, and then a little bit later on, we can get into discussion. Eunice and Harlon to start with.

MS. DIAZ: Thank you very much for your testimony today because it has clarified a number of points that I wanted to ask about. But still it's not clear in my mind, the new projects that you just awarded, the 12 projects, do you have a list there in addition to Boston what those others might be because I don't know?

MS. KONDRATAS: I do. I mean I have a list there.

MS. DIAZ: Could you just go through that very briefly?

MS. KONDRATAS: In the Boston projects?

MS. DIAZ: No, not Boston. You said in the Boston area but outside of Boston, what were the other projects, the other locations?

MS. KONDRATAS: I don't remember offhand all of them. I know there were some in Seattle because somebody

asked me about them yesterday. There's one in Cambridge, one in Boston, one in Patterson, New Jersey, Key West, Florida, Charlotte, North Carolina, Chicago, Illinois, Minneapolis, Minnesota, Summit County, Ohio, Madison, Wisconsin, St. Louis, Missouri, Phoenix, Arizona and Seattle, Washington.

MS. DIAZ: Those particular projects, were they awarded to applicants who had demonstrated that their particular needs were tied into the Ryan White planning process or was is it devoid of that? I'm just concerned, looking at what's happening at the local levels with a great deal of energy and time put into assessing total AIDS needs, particularly in housing and transportation and other issues, that that local effort really come forth when an application is sent for federal money so that it ties into a very well defined and credible planning environment and process.

MS. KONDRATAS: The criteria for funding, the criteria that are used by HUD, are always set forth in the notice of funding ability, and the evaluation is always done by professional career evaluation staff. It is never a political appointee that interferes in the selection process. In other words, I can't tell you specifically because this particular program is not under Community Planning and

Development, my jurisdiction, but under the Assistant Secretary for Housing, and I don't, I did not read the no fund. I don't remember the exact selection criteria, but I can assure that whatever selection criteria that were listed there is exactly the basis on which these awards were granted.

It's entirely a merit process. And it's a merit process, and I might add we said yesterday there isn't sufficient money to meet the need. On the other hand, it isn't just a question of money because clearly there were insufficient fundable applications which means that they were incomplete in substantial ways. They did not comply with all federal laws and requirements, and therefore we could not even award all the money that we have. So I think that we will need to work together to make sure that our housing policy is such that not only is money available, but that we are able to encourage and assist the development of local capacity to utilize these federal funds.

MS. DIAZ: Yeah. I think I'm not doubting the credibility of the internal process whereby the monies were allocated, but mainly I'm concerned that if, in fact, this is not coordinated locally within a regional or local planning process, the very best of applications could sometimes not

reflect --

MS. KONDRATAS: Yes.

MS. DIAZ: -- the need. And in proportion to the particular monies that we are going to allocate if, in fact, they are tied to some planning process that is already established, and within the AIDS field we do have a planning process called Ryan White Planning Councils? And I would just urge that perhaps at the very highest levels, at the federal level, that there needs to be a greater coordination of HRSA related activities with CDC related activities, with HUD activities and priorities, in meeting the needs of HIV populations in an area. It just cannot be done by one agency regardless of how credible the process is within that agency.

MS. KONDRATAS: Right. I think that your suggestion is a very, very good one, and as I said, I was going to discuss later what the Interagency Council on the Homeless, for example, has done to coordinate efforts on homeless programs for the federal government. We are also required, once we've got our own act together in coordinating our own efforts and meeting quite regularly and creating task forces for specific problems and developing policy together, we do require that local applicant be required to either inform or

touch base with, if it's a housing application, with social services providers.

In fact, that's one of the reasons we've begun developing programs for which states and local governments are applicants that provide housing assistance from HUD because our housing dollars are scarce, and housing development is very expensive with social services dollars, whether from the federal agencies or at the state or local agencies that provide services, because that will force at the state and local level human services organizations to have to cooperate and coordinate with housing agencies. We're trying to do that at the federal level. You're absolutely right. It's required. We may not have gone far enough in that with addressing the AIDS problem. We've certainly accepted it as it overlaps with the homeless problem because as I said we do have a federal plan to end homelessness which does require not only that kind of coordination at the federal level but ties federal funding to that kind of coordination at the local and state level.

MS. DIAZ: Thank you.

CHAIRMAN OSBORN: I have a number of commissioners already indicating interest in interacting now. So I think

we will keep this going for a little while.

MS. KONDRATAS: All right.

CHAIRMAN OSBORN: If that's all right with you. Harlon Dalton, David Rogers, Larry Kessler and Roy Widdus has a question. Don Goldman.

MS. KONDRATAS: Sounds like we'll be going quite awhile.

CHAIRMAN OSBORN: You've activated everybody's interest.

MR. DALTON: I appreciate your trying to pack a lot of information in a short period of time. I rarely meets somebody who talks as fast as I do, and probably faster than I think. So I'm a little confused about a couple of things. Two questions: one has to do with rental assistance programs and the other has to do with the Housing Opportunities for Persons with AIDS Program.

With respect to rental assistance, I thought I heard you mention at least three times in the context of a Shelter Plus Care Program. If I heard you correctly, you indicated that there is in that program some sponsor-based five year rental assistance program. I think you said that, I guess, in FY '92, there was proposed tenant based mobile

rental assistance which was not funded. So one question, I guess, in fiscal 1993 are you asking for money for tenant based as well as sponsor-based rental assistance under the Shelter Plus Care Program?

I thought I also heard you mention rental assistance in the context, I think you said Section 8 housing program, and you talked about rental assistance, and then when you talked about mainstream programs you again talked about Section 8 rental assistance. And so I'm trying to understand are there three different rental assistance programs, one of which is disability specific, one of which is homeless specific, and one of which is general, or something else?

I mean how many different rental assistance programs are there? To what extent are they available to people living with HIV and how do they differ from one another?

MS. KONDRATAS: I would hesitate to say the exact number, but the rental assistance program vouchers and certificates, which is a mainstream program -- everybody is eligible for it including persons with HIV infection. However, as you know, there are waiting lists and it's difficult to get that assistance, and there are also targeted

programs. There are targeted programs --

MR. DALTON: I was going to say with respect to the mainstream programs is there a priority given to people who are disabled or people who have --

MS. KONDRATAS: Yes.

MR. DALTON: -- terminal illnesses or people with HIV?

MS. KONDRATAS: There are priorities, federal priorities, set including for the homeless and persons with disabilities, but these priorities are handled differently at the local level. The local public housing authorities have a great deal of discretion in how they address those priorities. They're not an absolute priority, and sometimes that makes it difficult in the absence of sufficient funding for all the persons on the waiting list, to really address and meet the needs of the most vulnerable populations.

We are proposing this year, the Bush administration is proposing this year for the first time to have an absolute requirement that these certificates and vouchers be provided for persons exiting from HUD sponsored transitional housing. We have often heard complaints that when we have a transitional housing project that we fund and the person is able to be

stabilized and would be able to live in the community and is ready to leave, they have no money and no housing assistance when they leave. So we are trying to address that problem by proposing to the Congress an absolute set-aside for persons exiting from transitional housing. But other than that, it's simply a preference. It's not an absolute preference. It's a preference that can be handled differently at the local level by PHAs.

MR. DALTON: And when you say that you're proposing that to Congress, does that mean that HUD cannot set an absolute preference or does it mean that -- that is if HUD chose to set an absolute preference for people coming out of transitional housing, let's say, single-family, single room occupancy or whatever, could HUD do that or is that something that Congress has to do?

MS. KONDRATAS: I believe we have to change the law. That's why it was proposed. I mean because we raised it as an issue. My office raised that as a proposal. If we had been able to do it, I'm sure the lawyers wouldn't have put it into our legislative proposals for the Congress.

MR. DALTON: And so I take it, then, that with respect to your general rental assistance programs, you could

also propose an absolute preference for people with terminal illness as well?

MS. KONDRATAS: We could propose that.

MR. DALTON: Right.

MS. KONDRATAS: Now the problem with absolute preferences, of course, in the absence of sufficient vouchers and certificates to cover the entire eligible population is because then it becomes a game of set-asides in a way. If everybody gets a set-aside for a specific vulnerable group, then there isn't enough to cover the needs of the low income population that isn't targeted. And I think that's the fear that there be some equity and fairness in the way housing assistance is distributed since it's a scarce resource.

MR. DALTON: All right. That's the general kind of program -- rental assistance program; right?

MS. KONDRATAS: Right.

MR. DALTON: And roughly how many units are we talking about nationally under the general rental assistance programs?

MS. KONDRATAS: I believe, well, with both public housing and rental assistance, we are assisting, I believe, 4.5 million families nationwide, something like that.

MR. DALTON: And do you know what proportion of that is rental assistance rather than public housing?

MS. KONDRATAS: No, I don't know offhand because neither of those are my areas. I can certainly submit that to you for the record.

MR. DALTON: Now with respect to targeted programs, you talked about, I believe, rental assistance for the homeless and you also talked about the Shelter Plus Care Program. Can you explain those rental assistance programs?

MS. KONDRATAS: The Shelter Plus Care Program has three components, as I mentioned, and one is the SRO component and one is the sponsor-based/project-based component, and the other was the tenant-based assistance, which was a new type of rental assistance. So rather than targeting the vouchers and certificates, we wanted to create a new type of rental assistance that would be targeted to the most vulnerable homeless persons, actually the ones with mental illness, substance abuse problems, and persons with AIDS.

MR. DALTON: And that's the program where tenants who get the certificate would pay 30 percent of their income for rent; is that what was talked about yesterday?

MS. KONDRATAS: Actually I think we had worked it

out a little bit more flexibly. As we said, we were creating a new program. We were trying to meet the needs of vulnerable populations. We tried to make it flexible even from year to year as to what part of the award went to rent. The key feature of that was that the person could use that rental assistance in a project or a group home, but then when they were ready to leave, they could take the rental assistance with them and live independently. In other words, the rental assistance would stay with them, which we felt was a need.

I might add that the reason this component was not funded was not because there wasn't wide bipartisan agreement that it's a necessary component and a necessary part of Shelter Plus Care. We had the support of the National Coalition for the Homeless and about 38 other organizations that signed on to support full funding for the entire Shelter Plus Care Program. But in the budget game, sometimes funny things happen in the late night hours when priorities get shifted and for some reason I think because everybody was, there was no opposition to this program, even though it was a new program, everybody was confident that it would get funded and the organizations that were most interested in seeing it funded did not spend particular time lobbying for it.

They are more aware of the need for that this year, and I have every confidence in the world that we will get full funding for Shelter Plus Care this year.

MR. DALTON: I'll save my other question for later.

CHAIRMAN OSBORN: Thanks, Harlon, for clarifying something that is important. David.

DR. ROGERS: Ms. Kondratas, I have a fairly simple question. Yesterday we heard, as you did, some pretty distressing commentaries on the unresponsiveness of HUD from Mr. Greenwald. We had in the packet that was given to us before on housing and the epidemic a chart of HUD funding for low income housing, which would include people with AIDS, and I can't reproduce the chart, but you're young, and your eyes are probably pretty good.

(Laughter.)

DR. ROGERS: It looks like this.

MS. KONDRATAS: Yes.

DR. ROGERS: And this is 1978 in which it looks to me as though HUD were putting $32 billion into housing. This is 1988 in which they're putting three, 32 and three. That was a pretty appalling commentary --

MS. KONDRATAS: I'm sorry. What was the last year

of the chart?

DR. ROGERS: '88.

MS. KONDRATAS: 1988, okay.

DR. ROGERS: What's happened since '88?

MS. KONDRATAS: Well, first of all, I'm not certain. I think the lowest budget authority figure that I've ever seen is seven billion so I don't know what the four billion comes from, but your point is the same regardless. I might add that '78 and '79 are very odd starting points since budget authority was never that high in any year before that nor in any year following that. The confusion there is really budget authority versus appropriated funds and budget outlays.

DR. ROGERS: I guess my question is when the problems of homelessness and AIDS and so on has moved up so strikingly, have we really moved from 32 billion to seven to three or what have you?

MS. KONDRATAS: Our budget requests for budget authority over the next five years, because that's when we submit a budget, we submit it for a five year projection, is all in the $25 billion range for each and every year.

DR. ROGERS: Per year?

MS. KONDRATAS: Per year.

DR. ROGERS: And what do you have to spend this year just simplistically?

MS. KONDRATAS: What do I, my office or HUD as a whole?

DR. ROGERS: Yeah. How much are you putting into low income housing overall?

MS. KONDRATAS: I'm not familiar with the outlay figures because, as I said, what we spend every year is not what is appropriated every year. In fact, there is such a lag, there are 20 year programs, 40 year programs. There are --

DR. ROGERS: I was just wondering what roughly are you spending a year for low income housing?

MS. KONDRATAS: I just don't have the outlay figures, but the outlay figures have always been a great deal higher than those budget authority figures that you cited. In fact, I'd like to point out that from 1980 to 1990, in 1980 at those very high authority levels, we were assisting only 3.5 million families. At the end of the '80s, in 1988, we were assisting over 4 million families because the things that HUD, housing programs take a long time to get acted

through, and I'm not saying this is a credit to the Reagan years in terms of the amount of money that was put in.

But, in fact, the amount of money that was being spent because of what had been authorized in '78, '79 and '80 was growing every single year of the Reagan years -- the actual expenditures.

DR. ROGERS: I guess it would be very helpful for us to -- I realize you don't have them -- but to have those figures because this is what the commission is left with, a tenfold drop during a time of enormous crisis in housing.

MS. KONDRATAS: As I said, the drop is very misleading because in actual fact the amount of federal money spent every year, laid out, actually spent, has risen every single year during the '80s. And so you'd have to juxtapose that particular chart for budget authority with the budget outlay chart.

DR. ROGERS: Maybe you could give us those figures.

MS. KONDRATAS: Yes, I sure will because we do have them. Thank you.

DR. ROGERS: Thank you.

CHAIRMAN OSBORN: The list grows longer. Larry Kessler, Roy Widdus, Don Goldman, and Earvin Johnson.

MR. KESSLER: Secretary Kondratas, I'm concerned, and I want to get a clarification here. You said that $18 million was not distributed in the recent round because of insufficient proposals or proposals that failed to meet the criteria, and as Dr. Rogers has said, you know, the need and the gravity of the situation requires that we move this money as fast as possible.

MS. KONDRATAS: Yes.

MR. KESSLER: I would like to suggest, and perhaps you've already done this, but if you haven't done it, it seems appropriate that HUD have a technical assistance conference and that they use some of the expertise that exists. It's no accident that you made grants to Boston, Seattle and some of those other cities. But yet the need is great nationwide.

MS. KONDRATAS: Yes.

MR. KESSLER: And I think it's time for a partnership here between the community-based groups that have had a success record between those housing corporations that want to do something around AIDS housing so that more people can get into the game here and that more players can have successful proposals. To not have successful enough proposals

to have to revert $18 million is just unacceptable in light of this epidemic and in light of the epidemic of need. And I think your office, and I think the community groups across the country that can help you make sure that that money is spent.

I guess another way to say this is we're all aware on the commission that many people have not wanted to do AIDS housing, but there are other groups who do want to do it, who are capable of doing it, and if we can have a user friendly system that's designed to enable them to put together fundable proposals, then I think we're all going to be better off. Applying 40 years of bureaucracy to this new issue probably is not the interest of the people with AIDS who need housing today. We don't have the luxury of trying to spend the next three years trying to figure out the regs so that a sufficiently good proposal can be submitted.

MS. KONDRATAS: Well, I quite agree with you, and I can assure you that we will be trying to spend that money just as fast as possible. On the other hand, I'd like to point out that sometimes even when we get the money out, there are other barriers that, as I said, we need to address together, namely, for example, in our Emergency Shelter Grant

Program, which is for emergency shelter for the homeless, when we distributed it, New York City, for example, has not spent any of their 1992 appropriation, almost none of their 1991 appropriation, and they haven't completed spending their 1990 appropriation.

We have had to unfortunately collect back from New York City $7 million that we had awarded to nonprofits in the transitional housing program because those nonprofits were not able to get through the New York City bureaucracy to get site control that is required by law, not our regulations, by law, to take place within one year of award. So I agree with you that we need to do a lot in providing technical assistance to persons who receive our money, but as I said, we do need to work together to make sure that the whole system works.

The system has three levels of government, and it also involves the nonprofits at the local level. We need to make sure that all parts of the system work very well.

MR. KESSLER: I think that's a very excellent point because we would all probably agree that the problem doesn't rest solely at the federal level and sometimes it's with the states and sometimes with the counties and sometimes with the cities. But as we go around the country, if we're aware of

that, then we can sometimes talk to some of those mayors as well and say lighten up and get with the program because we hear them whining all the time as well.

MS. KONDRATAS: On the technical assistance issue, I agree that that's the way to raise capacity. In fact, I'm very glad that you invited me here for this hearing because I was able to network, as it were, yesterday and I think I have talked to several people who do have the capacity to provide some technical assistance, and I think a good idea might be since we have a structure at the Interagency Council on the Homeless to provide technical assistance in various regional conferences. That we might have a panel on AIDS-related housing since clearly it is an overlapping issue. I think that would be very useful, and we've identified a few people who would be able to do that. Thank you.

CHAIRMAN OSBORN: I think I'll ask Roy and Don and Earvin to ask their questions, and then I'm very pleased that you can stay with us later so that we can continue. I don't want to cut people off, but I also don't want us to get to the point where we can't interact with everybody. Roy is going to pass. Don.

MR. GOLDMAN: Thank you. I really have two

separate questions, if I may. The first question is yesterday we heard of numerous instances in which it appeared that HUD had taken what some people might suggest are unusual positions on certain issues regarding discrimination and disability. You had indicated before, I thought, that in fact under certain programs local prioritization for persons with disabilities was appropriate, and yet there have been instances in the past in which HUD has determined that people with AIDS are not disabled.

MS. KONDRATAS: I don't, I don't recall that HUD has determined in any program application that people with AIDS are not disabled, no.

MR. GOLDMAN: Well, I have some correspondence here from various regional administrators and saying that persons, the statutory criteria of handicapped require an impairment which is expected to be of long-lasting duration.

MS. KONDRATAS: What's the date of the --

MR. GOLDMAN: This is 1989.

MS. KONDRATAS: Okay.

MR. GOLDMAN: I have another letter also from back from, I think, '89 suggests two things. It says that you have to be disabled, on one hand, and if you're so disabled

then you can't live independently, and if you're disabled enough to be disabled, then you are too disabled to live independently, and therefore persons with AIDS are not eligible. And even more recently here in Massachusetts where the state of Massachusetts attempted to provide some set-asides, some 20 Section 8 existing certificates, the director of the management division of the Office of Public Housing found that, I guess, that the city of Boston or the state of Massachusetts was improperly setting aside that because they weren't fulfilling the obligation to maintain those units for the disabled.

And even more recently, in 1991, a provision saying that trying to set aside units for persons with AIDS or HIV infection would violate Section 504. And yet on the other hand, you said here before --

MS. KONDRATAS: Well, we have funded projects for persons with AIDS. I do know that.

MR. GOLDMAN: So, I mean, well, I guess has there been a change in HUD's position since these letters ranging, the letters I have date from, I guess, September '88 to September of '91, of that three year period? Has there been in the past six months a change in HUD's position regarding

this?

MS. KONDRATAS: Now I don't know whether we have an official position that has been ruled on by the General Counsel that is either of those or any other that is a change or not a change or an interpretation. I do know that significant legislation has been passed since 1989. Not only the Americans with Disabilities Act, but the Fair Housing Act, and I think that did cause the General Counsel's Office to review the requirements and the definitions for handicapped. Now I'm not an attorney, and the technicalities I don't get into. But I will be happy to try to get you what the current HUD position is. I do know that we're not being, in the program offices we're not being hindered or hampered for trying to provide housing for persons with AIDS.

CHAIRMAN OSBORN: Don, this is an important point, and we should get back to it, but I don't want to pursue it too deeply right now if we could proceed.

MR. GOLDMAN: Okay. The last question, the second question that I had, had to do with a different issue and had to do with your recognition earlier that persons with HIV face unique challenges and deserve a targeted response. But that that response, like in the shelter program, requires the

need of overall coordination, supportive services, as well as housing services, and my question to you is this commission has called for a national plan so that the efforts of the different departments regarding issues directed towards AIDS and HIV infection can, in fact, be coordinated so that, for example, your offices at HUD -- and you indicated to me that you have one section. There's another Assistant Secretary for Housing Programs which also provides significant services available for persons with AIDS and HIV infection who is not here.

Justice in dealing with the implementation of the ADA and other areas as well as Health and Human Services. We don't see very much of a national coordination of efforts, and I was wondering if you could describe the extent to which that coordination has existed or if it doesn't whether or not you agree with us that it should exist?

MS. KONDRATAS: Let me answer the last part first. I agree with you that it would be very useful and it should exist, and the plan would be very good. However, I feel a little bit on the spot for being asked to respond for the entire federal government when I represent HUD when you have three federal agencies sitting on your commission as to why

there isn't the coordination necessary at the federal level.

So I think I would certainly support such an effort. I think it could yield fruitful results. As I said, we will try to use the Interagency Council on the Homeless to a certain degree until such time as we're able to do that to try to address some of these issues because some of the issues are cross-cutting.

CHAIRMAN OSBORN: Earvin, I'll give you the last question for this round.

MR. JOHNSON: I have two questions. I'm trying to understand the difference between, you keep mentioning homeless; right? And I guess a big part of your budget it seems like it's going to the homeless, and I'm trying to understand the difference between AIDS homeless person and just a homeless person because I don't think you understand that people with AIDS are homeless, too.

And so I'm trying to -- you keep mentioning the homeless and you're giving a lot of your money to them, but it seems like you're leaving out homeless AIDS patients. I'm trying to get the difference, but I mean people are people who are homeless.

MS. KONDRATAS: Right. Well --

MR. JOHNSON: So can you tell me the difference there?

MS. KONDRATAS: First of all, we don't perceive the homeless as a single, undifferentiated group in any case. I think that was one of the problems with federal policy several years ago that everybody talked about the homeless assumed you needed housing only and didn't look at the very different need that homeless families have, that homeless individuals have who are just homeless for economic reasons, that homeless individuals have who may have severe mental illness, that homeless individuals may have if that have AIDS, and so on down the line.

All of our homeless programs we are trying to target to the needs of specific groups among the homeless, and in our Shelter Plus Care Program, persons with AIDS are targeted as one of those most vulnerable groups among the homeless. We don't have general homeless programs other than the Emergency Shelter Grant Program which goes to state and local governments and they can use in many ways. Furthermore, we recognize that the only way to end homelessness, and our federal plan is called the Federal Plan to End Homelessness, is to address all the inadequacies of the mainstream welfare

programs and social service programs that allow people to become homeless in the first place.

And prevention is something that we are very interested. Prevention of homelessness, I heard a lot about that yesterday. I think that definitely would be an integral component of any attempt to deal with the housing for persons with AIDS issue because I heard again yesterday something that is very similar to the homeless problem. You need a continuum of shelter options and services and a continuum of different opportunities for people to enter at whatever stage they might need assistance before they get to the most severe need. And the federal plan to end homelessness does propose reforms for SSI and AFDC and other programs, mental health and health programs, which might help to prevent people from becoming homeless.

So I think we see the difference, and not everybody with AIDS is homeless or will be homeless. Not everybody homeless has or will contract AIDS. So we are very aware of that, but we're trying to meet the needs of the people. It's hard to talk, we talk about categories because we're bureaucrats. We have to have programs. You don't have an open-ended kind of continuum, but we do recognize that society

isn't like that and people aren't like that.

MR. JOHNSON: My second question is that you awarded cities grants. And if minorities make up 53 percent, whether hispanics, blacks -- well, blacks make up 53, 54, and where there's children. I don't really see too many minority cities getting those grants or cities that have a large minority population. Now I heard a lot of suburbs of different cities that got those grants, but Los Angeles, you can go on, New York, on and on and on, cities that have a high population of minorities that should get those grants that didn't even get grants.

MS. KONDRATAS: The grants that I mentioned were competitive grants that anybody in the country can apply for.

MR. JOHNSON: I understand. I don't want to cut you off, but see what you're about to do -- I understand the process.

MS. KONDRATAS: Right.

MR. JOHNSON: But the numbers say something different than what you're about to tell me so what I'm trying to say is that minorities make up more than half of all the AIDS cases, okay, so that's where we're at now. Now you're about to tell me the process, but the process is not

what I'm talking about. I'm talking about people who have AIDS cases, minorities make up more than half, and cities that have a large number of minorities need those grants.

MS. KONDRATAS: Yes.

MR. JOHNSON: You see what I'm saying?

MS. KONDRATAS: I see exactly what you're saying, and I agree with you, but I don't, of the projects that I read to you, I wouldn't jump to the conclusion that those are not serving minorities. I'd have to look into it to see who they are serving. Beyond that, the Community Development Block Grant Program is distributed to cities and states on the basis of poverty and need only. I mean there are housing components and others, but it's a formula. And the big cities with minorities --

MR. JOHNSON: Minorities still make up --

MS. KONDRATAS: But they get more money from us for that reason.

MR. JOHNSON: See minorities are in the poverty situation. So we make up that high end, too, you see.

MS. KONDRATAS: Yes.

MR. JOHNSON: So we're in that high end and we're in high end of AIDS cases so you got both. So when you talk

about poverty, you're talking about minorities. So we need those grants to go to those particular cities. And it doesn't make any sense. I mean I don't want to pull out the charts on you but, just like Dr. Rogers did, but if that's what if you need for me to make you understand what I'm trying to say here. So everything you just said, minorities still make up that, too. So --

MS. KONDRATAS: I agree with you there. And as I said, all of the federal programs that are targeted to cities and states are distributed on the basis of poverty and other housing needs. To the extent that the minority populations are disproportionately represented in the poverty population, those cities do get larger amounts of federal money, and we certainly, the competitive programs, I have to tell you, HUD has gotten into enough trouble for running competitive programs noncompetitively. We do have to follow the law and the criteria that we set forth in the register.

MR. JOHNSON: Well, I'm going to let you take a break from me because I still have some more questions because I want you to think about that 500 housing which isn't enough, but I want you to think about it until 9:30, and then also the $7 million that you took back.

MS. KONDRATAS: We're redistributing it to people who can use it faster. We always redistribute the money. We take it back because the law tells us we have to take it back.

MR. JOHNSON: Those Section 8 -- I'm going to tell you where you can use it real fast.

(Laughter.)

MR. JOHNSON: Okay? Those Section 8, we need more of --

MS. KONDRATAS: It's not Section 8 we took back. We don't take that back.

MR. JOHNSON: No, no. What I'm saying is -- hold on one second -- Section 8 -- right? That's housing -- am I right? Am I getting this right?

MS. KONDRATAS: Rental assistance, yes.

MR. JOHNSON: Okay. What is it that you get that you can get into a house? A certificate. You can put it right there because there are a lot of people waiting to get into housing that don't have the certificate. They need the certificates so you can put it right there for these people can get in housing. But we'll be back. We'll talk about it later.

MS. KONDRATAS: Okay.

CHAIRMAN OSBORN: You really have been very good to have a long session of questioning right now, and perhaps we can regroup after the next group of three people talks with us and we give you a little bit of a break.

MS. KONDRATAS: Thank you.

MR. JOHNSON: Thank you for your patience.

MS. KONDRATAS: Thank you for yours.

CHAIRMAN OSBORN: Let's proceed to the next panel. Let me ask Barbara Ann Chinn, Leo Teachout and Virginia Shubert to come and join us at the table, and while they're doing so I'll introduce them and then ask them to speak in that sequence to us. As I mentioned earlier, after you have a chance to make your presentations, we'll probably break then and after we've heard from the mayor after the break then get back to a general round of questioning which again would include Secretary Kondratas.

Barbara Ann Chinn is director of Schwartz Housing Services for the Whitman Walker Clinic, Incorporated, in Washington, D.C. Leo Teachout is director of GROW, a Community Service Corporation in Wilmington, North Carolina, and Virginia Shubert is director of Advocacy and Public Policy, Housing Works, Incorporated, New York, New York. I

want to thank the three of you for joining us, and we're looking forward to your presentations and please proceed.

MS. CHINN: Good morning.

CHAIRMAN OSBORN: I need to warn you these are mikes that you almost have to bite to get heard.

MS. CHINN: Good morning.

DR. ROGERS: June, might I also say one welcome, too.

MS. CHINN: Thank you.

DR. ROGERS: I'm delighted that we have your written testimony. I would suggest that each of you take about ten minutes to make your major points so that we can break at 10:30, and then we'll have a chance to interact with you on questions.

MS. CHINN: All right. My name is Barbara Chinn, and I am the director of Schwartz Housing Services of the Whitman Walker Clinic in Washington, D.C. On behalf of the staff and the volunteers of Whitman Walker, and most importantly, the people we serve, thank you for this opportunity to appear before you, the commission, to discuss issues surrounding housing for people with AIDS.

When we think of housing, we think of shelter, a

place to live and to stay warm. Shelter is the easiest part of what we do. Securing funding, finding a house, getting it in shape, and keeping it that way is hard work. It takes a lot of time and energy, but there is a formula. There are few unknowns. That part of my job is quite similar to my past career in property management. As a housing director, I have to know how to locate appropriate properties, negotiate rental agreements and decide what needs to be repaired and when.

In many ways, our housing program is a small property management firm but with a whole other dimension, and that, of course, is the residents. Now it's not the property that's of ultimate importance. It's the people. That's a much greater and more satisfying challenge. A housing program for people with AIDS, as I'm sure you well know, is so much more than a roof and four walls. We provide shelter to sick people who are often rapidly getting sicker. Because we do provide their home, we are very often their primary source of care and support, even for individuals who have case managers and in most cases volunteer buddies.

We are first and foremost in the business of crisis management. We primarily operate group homes with four to

five residents, each with a private bedroom but sharing common living areas. There is no live-in staff. This type of program brings together people of different backgrounds. In one house, we might have a middle class professional who has lost his home because of medical costs, a formerly homeless woman who moved in from a shelter and a recovering substance abuser.

Often the only thing our residents have in common is their disease. Many are angry having been abandoned by family, friends, and the health care system. Often HIV is one of several complicating factors. These can be very needy people. Our goal is to work with these people to create a home that addresses their physical and emotional needs. Certainly, the group house setting encourages interaction with others, both residents and volunteers. That helps prevent isolation and withdrawal. Through weekly house meetings with a volunteer house coordinator, we try to build community.

Our residents celebrate holidays and take trips to the mountains and the beach. Even with that effort, it can be hard to create a sense of unity. There are tensions as in any group home: noisy visitors, dirty dishes, too much time

in the bathroom. Those differences are often exaggerated by the varied backgrounds, worsening medical conditions, anger, fear, racism, classism and so on. But we find that when one of the residents becomes very ill that the house, residents and volunteers, often pull together. Sometimes the residents do distance themselves because they perceive that person's illness as their own future. But in most cases, it's those times that bring a house together.

Yet we are reminded almost daily that each resident has unique needs. Our task as a department is to manage the lives of the residents without infringing upon their integrity and self-esteem. We help them access services, whether at the clinic or elsewhere. We get them into drug treatment programs. We make sure they get to the doctor's office or the hospital. We track down their visiting nurse when the home health aide doesn't show up. We help them deal with their families. The greatest set of challenges I faced as housing director was opening a home for women with HIV and their families.

One of the first lessons we learned as we began to interview prospective residents was that these women were where many of the gay men were ten years ago. They knew very

little, if anything, about the disease. They were completely isolated. They didn't know anyone who was sick and really had no idea what to expect. They thought there was no one else like them. Some of these women had not explained their illness to their kids or other family members. And, of course, there were other issues, some new, like child care, others not so new like working with folks in recovery.

We worked especially hard to create a strong relevant support system, and as a result built a very different type of service to address the special needs of this population. Unlike our other facilities, this residence, which includes eight apartments, has a resident manager, a family services coordinator who is a social worker on site part-time along with a volunteer coordinator. We included an on-site community room. The resident manager and volunteers provide day care and respite care and tutoring to the children.

We offer HIV/AIDS education, nutritional education, mental health counseling and hold weekly pizza nights with videos. We also have to develop plans for the care of the children if the mother becomes too ill to care for them or die. One of the real benefits of the house was that it

allowed the women to realize that there were part of a larger group. There were other women in this same position, HIV positive, and trying to raise kids who could understand what they were facing. The kids too benefit from this small community. All of them are facing the prospect of one sick parent and in some cases a sibling who is also HIV infected and perhaps symptomatic.

They also live in an apartment building where others, both adults and children, are sick and may die. We have had to develop programs or locate resources for the kids to deal with these very difficult issues. We were able to create this level of service and care because a city contract for the house included funding for the support positions in addition to operational expenses. Without those positions, we would be unable to operate a home for women and children. It's important that funding sources that provide money for housing don't just fund the building but also the many support services that are inherent in any housing program whether for individuals or families.

For instance, we've received funding that allows us to purchase two residences giving us monthly payments less than the rent. While those funds are very helpful, we still

have to locate other money for utilities, insurance, trash collection, furniture and upkeep as well as support staff. Funding sources need to understand that housing programs need to be funded at levels that allow them to adequately address the needs of the residents. One place where we all need more assistance is dealing with alcohol and substance abuse issues It is certainly our greatest challenge. Every person with HIV/AIDS entering our program must have an alcohol and drug abuse assessment, and if a problem is determined, they must agree to enter treatment, entertain a certain amount of clean time as a condition of entering our homes.

The more residents I work with, though, the more I am reminded that relapse is a part of recovery. We know that much of the relapse can be attributed to the fact that our residents are facing a life-threatening disease and may be watching their housemates die as their own health deteriorates. Often they feel like I'm going to die anyway so why shouldn't I drink. The relapsing abuser not only harms himself or herself but threatens the whole house. Substance abuse is certainly the greatest cause of tension among our residents. It can completely disrupt the dynamics of a house. We have a very clear policy that repeated abuse will

result in removal from the housing program. Sometimes it is very difficult to draw the line.

One dramatic example can be found in the McKinney House for Women and Families. In one of the apartments we have a family unit including a mother, father, and three children. Both the mother and father are HIV infected, and the youngest child has full-blown AIDS. The father is in recovery and has relapsed on several occasions. He has entered treatment programs we've identified but hasn't been able to maintain his sobriety and continues to use/abuse sporadically.

How do we cope with that? He is a very important part of that family unit. De we lock him out with the knowledge that it will severely disrupt the lives of the children and his wife? If he does leave, would he take the family with him? Then we end up threatening the welfare of his wife and kids for his actions. Addressing substance abuse issues is the toughest part of my job, and it is even more complicated when a whole family is involved. We have made some important progress in addressing substance abuse in the program. Previously housing residents were scattered throughout Whitman Walker's case management system. Now all

housing residents are handled by one case manager, a simple step that has made a tremendous difference.

It's helped us identify instances of substance abuse because there is one central source of information who hears stories from all sides. That case manager also runs a daytime recovery support group for housing residents in conjunction with the clinic's alcohol and substance abuse services program. It is clear to me that one of the most critical needs in the housing continuum is specialized housing for individuals in recovery. These residences should have 24 hour on-site staff with training in substance abuse counseling. The houses should also have on-site support group or AA and NA meetings. If we are serious about keeping people clean and sober as they face one of life's most profound challenges, we've got to give them an intensive level of support.

We're missing another crucial element in the continuum of care. Everyone accepted into our housing program has to be capable of independent living at the time they move in. They are guaranteed a home for life. One of the most critical issues we face is how to care for people as they get sicker. One solution we've developed was opening a

licensed interim care facility which offers around the clock care. The staff includes a director who is a physician's assistant, a cook, housekeeper and a resident assistant as well as numerous volunteers.

There are only seven beds with the first priority given to Schwartz Housing residents. Residents and non-residents come here ideally with two or three months to regain their strength after a hospital stay and then return to their own home or to one of our homes. In some cases, they do go back to the hospital or to hospice or die in the house. This house has proved a vital link in our care network. But it is far too limited to meet the needs in the District. Again, we are able to offer this kind of care because we received local government funding specifically for the project which includes money to pay for the specialized staff. One reason we need this type of facility are the problems we have with home health care aides assigned to care for residents in the houses.

Their wages are so low that it is difficult to attract and maintain qualified, dedicated workers leading to problems for the residents. We have one resident now with a colostomy bag that he is unable to change himself. We

sometimes receive frantic calls from his buddy because the home health aide has not shown up and the bag is about to overflow. He resisted going into the interim care facility because he wanted to stay in his residence and be more independent but is beginning to realize that he may not have any other option.

We have other residents who are not quite as sick but still need a higher level of care than can easily be provided in the house. Those needs will largely be addressed by the clinic's recently completed day treatment and care center. A hub of services, it provides medical care including transfusions, intravenous therapies, and medication monitoring, meals, support groups, massage and whirlpool therapy, and is directly connected to our other medical and dental clinics, food bank and case management services.

Linked to our houses by a new transportation program,, the center will address many of the residents' needs while allowing them to maintain a sense of independence in our homes. As one of my coworkers says, we're really in the business of security, companionship and self-worth. We appreciate your continued support of our work. Thank you.

CHAIRMAN OSBORN: Thank you very much, Ms. Chinn.

MR. TEACHOUT: My name is Leo Teachout, and I'm the executive director of GROW, A Community Service Corporation, in Wilmington, North Carolina. I realize you're up against some time constraints so I'm going to keep it very brief and just paint a brief picture of what we do, where our issues are and some recommendations that I have that may be helpful to us. GROW is an organization that started in 1979 but got involved with HIV in 1982. We have six interrelated projects that deal with HIV infection in our seven county regional area. We provide transportation, case management, resource management, benefit advocacy. We have a buddy program. We offer assistance with food. We have emergency financial assistance.

Most of what we do has been patterned after our good friends here at AIDS Action in Boston, at Whitman Walker Clinic in Washington, D.C., and after Gay Men's Health Crisis in New York. In the early days, '82 through '85, we relied on them heavily for technical assistance and it's my pleasure to be sitting here amid some of these people today. We are currently working with 172 patients in the seven counties in southeastern North Carolina which, as Mr. Johnson may know, is the hometown of his good friend Michael Jordan. And we're

very proud of that.

We also know that our caseload will double in the next 12 months just as it doubled over the last 12 months. And as the person who has been doing the case management, who's been coordinating the transportation, who has been purchasing the vehicles to carry people 150 miles to their primary medical care, I frankly am worried and concerned and fearful of how we're going to continue to be able to that over the next 12 months without some outside assistance. And at the same time we find ourselves so tied up in providing the services and in the day to day case management that we don't really have time to do planning.

We don't have the luxury of having a strategy. So when I come here and hear those terms over and over again, it's interesting, but I'm a little nonplused because I know that that right now is not an option for me as I sit behind my desk in my chair with my word processor. I just don't have the time to do it. Where we see housing differences from our area as compared to an area like Boston, as we heard about yesterday, is in the amount of money that is required to rent. So we have rentals that are readily available to folks in our area for 250 to $275 a month that are not grand

and glorious, but they're adequate and they're safe and they're appropriate for most people who are ill.

So the average person there who is getting a disability check of $525 to $575 can afford to have independent living, and as long as the other resources, as far as his medical care are concerned and buddy support and psychosocial support are put in place, he can maintain independent living. Where we have the greatest problem are at the very beginning of the housing continuum and at the very end. The middle part is pretty much taken care of so far. At the very beginning while people are waiting for resources to come into place, that time when they have applied for Social Security disability and SSI and Medicaid, there's going to be a period of six weeks to three months in which they have no income at all.

Regardless of, even if they're family, they will have no income at all. We up until this time have been able to continue with their rent through using our own emergency funds, our own fund-raisers that raise that money, and lately through using funds that are available under the Ryan White program. The funds that are available for our Ryan White program only cover three of the seven counties that we work

with. So most of our own funds go to those four counties that are not covered by Ryan White. They're not covered by Ryan White simply because the agencies within those counties did not get involved in the process. And the state is holding money. The state of North Carolina is holding aside federal money that could help those people.

It's sitting in a bank in Raleigh. It could help those people except that the agencies, the health department, the DSS, did not get involved in the process. We hope to change that the coming year. We hope to change that and get them involved. One of those issues since some of the commissioners have raised repeatedly the issue of Ryan White, and I'm glad they did, one of the issues for HUD, for example, is even though we had this routine contact this year about what can we do for HIV folks, and we have to have this in our planning for the coming year, and we have to put a priority on it, we were asked, we gave our input, and we were thanked very much, and we've never heard from those folks.

Our local HUD office should be involved in our Ryan White consortium. It should be involved, visibly, openly, and without apology, but right now they don't see this as a big issue frankly. And the only reason they called us and

asked the question is because the Washington office told them to. That's the only reason, and we don't expect to see much out of it. The other part of the continuum that is a major problem is at the very end when the person is coming home from the hospital probably for the last time, has been able to achieve independent living with the support services that are available up until that time, and now he needs to rely on either family, and if family is not there he needs to rely on volunteers and hospice and home health.

Hospice cannot come in unless he has a primary care provider who spends 24 hours a day with him. Home health will not come in, cannot come in, and you can understand why, unless there is somebody in the house who is going to be looking after him when home health or hospice are not there. What happens to that person? One would think that normally under most circumstances with somebody in that position, they would be able to go to a nursing home. We do not have a nursing home in my part of the state or anywhere in North Carolina that I'm aware of that will accept an HIV patient.

They will tell you we do not deny access to our nursing home on the basis of your HIV antibody status, but I'm here to tell you they don't have one. They do not have

one and have never had one. Nursing homes are permitted to pick and choose who they want to have as residents of their nursing home facility. And they pick and choose, not just around HIV patients. We've heard of nursing homes who have refused to take somebody because they're obese, because they don't want that kind of struggle.

And it seems to me that nursing homes which are dependent upon Medicaid and Medicare that is a system that is for everyone, that is paid for by everyone, that they should not have the luxury to pick and choose. That patients should be taken on a first come/first serve basis. And I don't see any reason why that policy change can't be made tonight. It could solve that problem immediately.

While I have been here -- and I'll just a tell a brief story and then I'll let you go because I think I've indicated what our problems are.

DR. ROGERS: We need to finish up fairly soon.

MR. TEACHOUT: Okay.

DR. ROGERS: That's very powerful. But give us your recommendations so we can hear.

MR. TEACHOUT: Okay. My recommendations are full funding of the Ryan White program and insistence that local

agencies involved in HIV care visibly participate in those consortiums. Right now we have to beg them to come to a meeting. A stronger federal mandate to local housing agencies, especially HUD, to participate fully in those consortiums. That is going to be a major problem, and as I said, the changes under the Medicaid/Medicare regulations which would mandate that nursing homes wherever they are take whatever patients regardless of whatever disease. Thank you.

CHAIRMAN OSBORN: Thank you. That's very helpful recommendations. Jenny Shubert. We still remember our good visit with you sometime ago, and it's nice to have you with us.

MS. SHUBERT: Good. I hope you never forget it. I'm sure you won't. My name is Virginia Shubert, and I thank you for the opportunity to be here. I have written copies of my testimony as well as a description of Housing Works which is the program that I helped to found and has been in existence about a year now. I'm the director of Advocacy and Public Policy for Housing Works. We are a community-based, minority controlled, not for profit corporation that was formed in 1990 to provide housing, support services and advocacy for homeless persons with HIV and AIDS in New York

City.

Just a brief word about who we are. We are a membership organization, and we operate as a partnership of residents and clients, paid and volunteer staff, and our board of directors. A majority of our board and staff are African-American and/or Latino-Latina, and a majority of our board and staff are also persons living with AIDS and HIV. In addition, a majority of our staff are persons who have experienced homelessness and/or persons in recovery from chemical addiction. In all of our programs and in all of our organizational structures, we are dedicated to the principle of empowerment of our clients and to remaining responsive to their expressed needs.

We're also dedicated to maintaining their right to privacy and independence and to providing them the resources necessary to reassert control over their own lives. Our organization grew out of our frustration as advocates for homeless persons with HIV and AIDS. Before joining Housing Works, I founded and directed the AIDS Project of the Coalition for the Homeless. Our clients were repeatedly denied housing services, either because they could not establish a Centers for Disease Control diagnosis of AIDS,

that's routinely used as an eligibility requirement for AIDS entitlements, or because of the reluctance or the outright refusal of existing housing programs to serve persons who are mentally ill, persons who are chemically addicted and/or persons who lack basic living skills.

As a consequence of these exclusions, as many of the commissioners know from visiting us in New York City, thousands of homeless persons living with HIV and AIDS in New York City are confined to city streets, subway tunnels, or violent and decision-ridden mass shelters. We have 13,000 homeless people living with AIDS in New York City today.

It's the priority of all of our programs to serve persons not well served by existing organizations including people who are chemically addicted, mentally ill, people recently released from incarceration, adults with dependent children, families of choice, and lesbians and gay men. We're the only organization in New York City that specifically provides services to homeless people and people at risk of homelessness who are living with HIV and AIDS. And I think we may be the only supportive housing program in the country that houses active users.

We opened our first direct service office a little

over a year ago in April of 1991. To date, we've served over 500 clients. Over 90 percent of our clients are African-American and Latino-Latina. One-third are women, approximately 65 percent of whom are mothers of minor children. About 40 percent of our clients manifest symptoms of chronic mental illness. The overwhelming majority of our clients who are not chronically mental ill demonstrate situational disorder related to the desocialization inherent in homelessness. About 50 percent of our clients have a history of IV drugs, and 20 percent are currently using IV drugs. 80 percent of our clients have a history of crack or cocaine use and/or alcohol dependence, and 40 percent are still actively using crack cocaine, and about ten percent are actively dependent on alcohol.

Now, it's clear that the large majority of our clients could be classified as the type of difficult to serve persons who are routinely relegated to shelters and other substandard institutional settings. Yet I am proud to say our experience to date has demonstrated that about 75 percent of these persons can be housed independently in their own communities, provided that they are afforded real access to necessary services. Supportive housing programs create

caring environments sometimes for the first time in our clients' lives, where their psychosocial and medical needs can be met, and through the provision of case management, medical monitoring, and mental health services our clients have been able to live independently, to reunite with their family members, or other care givers, and to gain control again of their own lives.

The first step in this is our intake program which screens clients, assesses their eligibility for entitlements, helps them get those entitlements and provides emergency relief. At that point, we start to build a relationship with a client where the client defines their own housing and service needs, and we work with them to meet them. We started in April. We now house over 100 clients in 52 units of scattered site housing including 14 families with 24 children. In the next six months with some luck, we'll add another 90 units of housing and we'll serve over 180 additional residential clients. Our government funded housing program is available unfortunately only to those persons qualifying with the CDC AIDS diagnosis.

We have a separate, privately funded independent living program that provides independent housing and support

services for the many homeless people with HIV related illness who do not have a CDC diagnosis. Both of these programs utilize private apartments -- we locate on the open market -- and support services that are provided either through our offices or with home visits.

Now I just want to outline a few support services that are absolutely essential for our clients in order that this not just become another set up for failure or rejection because most of our clients do have a previous history of homelessness.

DR. ROGERS: Ms. Shubert.

MS. SHUBERT: Yes.

DR. ROGERS: Could you do that in about two or three minutes? I'm sorry that we're pushing you --

MS. SHUBERT: I think so. That's fine.

DR. ROGERS: And I'm glad we have your testimony before us. We'll all read it carefully. Fire away.

MS. SHUBERT: Sure. The most important thing that I have to mention is harm reduction and drug treatment. As I've already said, the overwhelming majority of programs operating housing stock attempt to maintain drug free environments, deliberately excluding active chemically

dependent applicants who do not have a clear and convincing commitment to maintaining a clean and sober lifestyle. Now I want to be clear that we believe in a clean and sober life style for our clients, and we hope that everyone of our clients will achieve that goal. However, I don't believe that a person's drug use should be a barrier to safe housing, enough food to eat, support services, or medical care.

We've adopted a harm reduction model that focuses on reducing the harmful behaviors related to drug use, especially as it relates to maintaining housing and maintaining good health. We're in the process of developing a harm reduction treatment program that will, for clients that either have no initial interest in abstinence or who have a high probability of failure in traditional programs, the program will focus on harm reduction, use reduction and readiness for treatment through abstinence. And we believe that this is the most important program, harm reduction, for our clients.

I'll just list the other ones. We have a program of linkages to mental health services for our clients with histories of chronic mental health problems. This is working well so far. However, we are going to go for our own mental

health licensure because many problems can or won't deal with people who are chemically addicted or people who have an HIV diagnosis. Family intervention was mentioned. It's tremendously important. Many of our clients have been able to reunite with their families which provides them more support than we could ever hope to. Living skill training for people that have experienced the desocialization of homelessness is essential. Health care coordination in a city like New York where it takes active advocacy to establish and maintain a relationship with primary health care provider.

I just want to mention the recent fears surrounding tuberculosis present the latest brief for inappropriate institutionalization or even detention of homeless persons with HIV, and we're committed to developing our own program of TB monitoring and directly observe therapy in independent living situations to avoid this kind of institutionalization because of fear.

Finally, education, training and job readiness is really essential for our clients. Once their lives become stabilized, they develop an interest in getting more out of their lives. Unfortunately, the strict income restraints on entitlement programs make it virtually impossible for them to

do job training or even reenter the workforce without jeopardizing their health benefits. Just briefly, about 20 percent of our clients aren't able to live independently with these supports. They need on-site support services because of medical frailty or mental health problems. We're trying to develop a residence. There's very little or nothing available in New York City for these folks.

And then finally it's true that about five percent of our clients require intensive 24 hour supervision and medical care. However, I want to note that's five percent of our clients. 95 percent of our clients can pursue their independent lives. And unfortunately, there is absolutely nothing in New York City today for HIV positive persons who need this kind of support. The result is that the clients that we see that have the greatest need are often left on the streets to fend for themselves. Thank you.

CHAIRMAN OSBORN: Thank you very much.

MR. KESSLER: What we're going to do now is because people are probably in need of a stretching break is take a break, and then we would ask the three panelists to come back and be joined by Secretary Kondratas and Mr. Greenwald to have a discussion about some of these issues with the

commissioners. Before we do that, I would like to call on Representative Alvin Thompson and the Executive Director of the Massachusetts Black Legislative Caucus, Betty Robinson. They will both be introduced by Ron Brown from --

MR. BROWN: Good morning. We'd like to take this opportunity to recognize the efforts of the total commission and the commitment that you've made to get this issue of awareness regarding AIDS, and so to that extent the Massachusetts Legislative Black Caucus wanted to pay special recognition. And there will be two presentations. The first one will be made by State Representative Alvin Thompson who hails from the city of Cambridge, Massachusetts, who also is the vice chair of the Public Service Committee on Housing. Whereas, you all are doing a great public service, we thought that it was fitting that Representative Thompson who's vice chair of the Public Service Committee, make the first presentation on behalf of the Massachusetts Legislative Black Caucus. Representative Thompson.

MR. THOMPSON: Good morning. Dr. June Osborn. Good morning. This recognition this morning is on behalf of the National Commission on AIDS which we you are chairman of. Your dedication and efforts in conducting hearings across the

country with particular focus on housing, raising the awareness of HIV/AIDS education and prevention, honor to you this day March 3, Charles Flaherty, Speaker of the House, offered by the Massachusetts Black Legislative Caucus.

(Applause.)

MR. BROWN: Our next presentation will be presented by Betty Robinson who is the Executive Director the Massachusetts Legislative Black Caucus, and the Black Caucus wanted to pay special recognition and tribute to Magic Johnson for his agreeing to serve on this commission and to assist all of you to get in the mission of educating the world how important it is that we all should be aware on AIDS. So Magic, would you come forth and Betty.

(Applause.)

MS. ROBINSON: The Commonwealth of Massachusetts, the House of Representatives, be it hereby known to all that the Massachusetts House of Representatives offers its sincerest congratulations to Earvin Magic Johnson in recognition of your initiative and commitment in teaching all individuals across the country how the promise of a brighter economic future, how pride in ownership, and how economic empowerment can begin a chain of improvement that permeates

every segment of a neighborhood. The entire membership extends its very best wishes and expresses the hope for future good fortune and continued success in all endeavors.

Given this third day of March 1992 at the State House, Boston, Mass. by Charles Flaherty, Speaker of the House, offered by the Massachusetts Black Legislative Caucus.

(Applause.)

MR. KESSLER: Thank you very, very much. And I think June is going to speak.

CHAIRMAN OSBORN: On behalf of the commission, I am really quite delighted that you've taken the trouble to be with us and to give us such a nice honor. It's very inspiring to know that we are helpful because it's hard sometimes to feel that way. So your efforts today and in arranging for these awards are very much appreciated. Thank you.

(Applause.)

MR. KESSLER: We will now take a -- I'm sorry. I'm sorry. How could I miss him?

MR. JOHNSON: I was hoping you would do that.

(Laughter.)

MR. JOHNSON: On behalf of my colleagues on the commission as well as we have a couple other minorities on

the board, Eunice and Harlon, I really appreciate this. I'm just going to try to do whatever I can to continue to fight and continue to make people aware what's going on with HIV and AIDS and that's it. And hopefully HUD will do more; right?

(Laughter and applause.)

MR. KESSLER: We will now take a ten minute break, and we will reconvene at quarter to 11.

(Whereupon, a short break was taken.)

CHAIRMAN OSBORN: Let me ask everybody in the back of the room to take their seats. We are very pleased to welcome, Mayor Flynn. We've had some memorable times together. The first time we met, I think, was in the introduction of the Ryan White CARE Act, and very recently Mayor Flynn represented the U.S. Conference of Mayors when the commission presented sort of a celebration of the production of our two year comprehensive report. So we've gotten to feel like you're part of us. We're very pleased to be in Boston and to have you with us. Thanks for being here.

MAYOR FLYNN: Thank you, Doctor. Thank you very much. And I would like to sincerely thank the members of the National Commission on AIDS for the work that you are doing

to educate the public and the federal government about the variety of issues which flows from the AIDS epidemic. Unfortunately, we live in a nation which has not yet seen fit to assure that all citizens get proper health care in housing. For this reason, we must make the strongest argument possible for decent health care and supported housing for people with AIDS without compromising the principle that no American should be denied these basic rights. And I want to thank the commission for their hard work that they have already demonstrated to the people of this city and to the people of this country in moving around the city and seeing firsthand some of the efforts that are being made by people across the neighborhoods of Boston in trying to provide creative housing for people living with AIDS and I'm very, very proud of them. It's really they that deserve all the credit.

People sometimes point the accolades at political leaders, but I want to assure you that it's the people of the neighborhoods of the city that deserve this real credit for achieving what they've been able to achieve. It's a positive step in the right direction. It's no total solution to the problem. As long as we have people like Larry Kessler around

the city and other people who are committed to our housing for people living with AIDS, we're very, very proud and we'll continue to make strides.

Before I continue with my testimony, again for the members of the commission, I'm Raymond Flynn, Mayor of Boston, president of the United States Conference of Mayors. Next to me is Dr. Larry Barrett, who's my special adviser, advisor to the mayor, to the city government, on the AIDS issue. Maybe Larry could introduce himself.

DR. BARRETT: Hello. I'm Lawrence Barrett, and I'm a physician, and I'm also a person with HIV and I've been in this position for about four months.

MAYOR FLYNN: Thank you, Dr. Osborn. We are honored that the commission has selected Boston as the site of your discussions on housing for people with AIDS. We are all working together so that persons with AIDS can live with dignity and as independently as possible without relying on unnecessary or on expensive hospital care or falling into homelessness. Frankly, we had hoped to be preparing for an even larger event this May, the Eighth Annual International Conference on AIDS. The failure of the United States Justice Department to respect international standards by imposing

unreasonable travel and immigration restrictions made it necessary for us to cancel Boston as the site of this prestigious conference, and I'm sure you understand.

I am pleased that the conference will go forward this summer in Amsterdam, but I am still angry that there are those who played to the fears of others by supporting discriminatory practices. In Boston, we have tried to stay ahead of the relentless course the AIDS epidemic is cutting through our society. While President Reagan was debating whether to send out the Surgeon General's Report on AIDS, we acquired the text, printed the report, and mailed it out to every household in Boston. We established the first residential facility for children with AIDS at the Boston City Hospital, and we are now constructing a new home for this program in our Mattapan neighborhood.

Working with AIDS service organizations and the good people of our Mission Hill neighborhood, we sited one of the nation's first community based hospices for people with AIDS. In 1988 we recommended a pilot needle exchange program to cope with the spread of HIV through the sharing of dirty needles. The Boston City Council became the first legislative body in the country to approve such a measure. Though the

needle exchange initiative was defeated at the State House, we went on to establish Project Trust, a confidential counseling and testing service, which reaches out to addicts with bleach as well as AIDS and drug treatment information.

And now at long last, our state leaders appear ready to pass legislation which will allow a pilot needle exchange program to go forward in Boston as one component of our comprehensive effort. And as we build a new Boston City Hospital, this historic institution continues to treat persons with AIDS regardless of their ability to pay. This means staying out in front on treatment issues. A few years ago, I approved an expenditure of over a million dollars so that our patients, both acute and ambulatory, would have access to aerosol treatment for AIDS related lung problems. And now we are facing the fact of adolescent AIDS by considering a proposal from our Health and Hospitals Commissioner, Judith Kurland, to pursue comprehensive health education in all our public schools and establish adolescent health services in our public high schools.

But AIDS is not just a local issue. It is a national and international crisis. The federal government responded with a solid piece of legislation, the Ryan White

Act. Locally, we have a coalition structure which will use these federal funds as effectively and as innovatively as possible, but as we all know, even the best vehicle needs fuel. We must all demand full funding of the Ryan White Act as the first modest step necessary to allow local communities to struggle with the AIDS epidemic on their turf and on their terms.

And finally, as you are moving through the city on the various site visits, we are creating supported housing opportunities for people with AIDS. At Amory Street and Jamaica Plain, vacant public housing is a development for senior citizens which has been transformed into a congregate housing community within the community. And we are coping with the many needs of homeless persons with AIDS at the Safe Harbors Program alongside our Long Island Shelter. And we are committed to developing 501 units of housing for persons with AIDS in Boston by 1994.

We chose the number 501 in May of last year in response to the federal administration's minimal 1991 commitment of 500 units of housing nationwide. At this point, we have 23 developments in motion representing 237 units, 61 of which are either completed or are in construc-

tion. Though we are firm in our resolve to reach our goal of 501 units of supported housing, the federal government continues to create obstacles to success at a time when it should offer full and aggressive partnership. The Community Development Block Grant Program continues to be cut in Boston and all across this country. And recent increases in federal housing funding are token when compared to the wholesale cuts enacted in the '80s.

The Federal Housing For People With AIDS Program is funded, but HUD has repeatedly delayed the disbursal of these funds, and despite the supportive work of our HUD regional director, John Mastapietro (phonetic), we are constantly working around HUD's refusal to acknowledge AIDS as a disability. Various federal agencies are falling short in their mandates when it comes to the AIDS issue. For example, the Veterans Administration which provides such a life line for veterans with substance abuse problems has yet to take on the growing problem of AIDS among its ranks.

In Boston, we are using scarce Ryan White Act money to fund a case worker for veterans with AIDS. And finally, at both the state and federal level, there is a refusal to acknowledge the ongoing need to fund support services for

housing, even though such services save the government substantially in housing costs through entitlement programs such as Medicaid. The federal government could pay for the supportive care if they are willing to expand the list of services which Medicaid now reimburses. And state cooperation is also critical. When the state government program cuts programs like general relief, it forces persons with AIDS and others out of independent living and into a state of despair and complete dependence on emergency shelters and public hospitals.

Members of the commission, this is not only morally wrong, it makes no financial sense whatever either. In the heart of this crisis, it is the failure of the federal government in the various agencies to develop a coordinated and comprehensive approach to meet the housing needs of people living with AIDS. It is imperative that the federal government begin to respond aggressively and compassionately now. I want to make it clear that HIV and AIDS is becoming a very personal issue for all of us. For me, it was the first visit to the Children With AIDS Program at Boston City Hospital in 1988.

For others, it will be a friend or a family member.

As we overcome our fears, we are able to confront not only the challenges of AIDS but also the inadequacies of our entire health and housing system in our country in an otherwise proud and prosperous nation. I am pleased that there is such a thing as a National Commission on AIDS, and I wish you well as you take your mission to other cities across America. Again, I want to make it very clear that I am pleased that the commission came to Boston because you have an opportunity to see what people of goodwill can do when they really put their hearts and minds in doing it. I want to be the first to acknowledge, and I say this with the highest degree of humility, the people in back of me, the people in the neighborhoods of the city, are as determined, are as committed, are as compassionate, as anyplace in this country.

And so I want the rest of the nation to look to Boston, as you have looked to Boston here, and seeing what is being done on housing for people with AIDS as an example of how community and government can come together, working together and meet their responsibility to the people living with AIDS in our city and our country. So if they're looking for an example of where a program can work with the community,

let them come to Boston, as you have.

Lastly, let me thank the commission. It is an honor to welcome you to our city. We are very, very pleased of the two days of hard work, of the on-site visits, that you have already made. You are demonstrating that this is a hands on commission, not only to hear testimony but to actually go out into the communities and meet with people and get firsthand observations and understand the feeling of support that we have in our city. So let me again welcome you and thank you very, very much. Keep up the wonderful work that you're doing. It's critical. It's critical to all of us, and we're depending on you to take this message to the federal government, and we stand with you. Thank you.

(Applause.)

CHAIRMAN OSBORN: Thank you very much, Mayor Flynn.

MAYOR FLYNN: Thank you.

MR. KESSLER: Thank you, Mayor Flynn. We're going to, I think, accept your comments for the record and thank you for coming in terms of your busy schedule. We won't do a question period at this point because we're beginning to run a little late. But again thanks for your hospitality and thank you for the work that Larry Barrett has done in

supporting this visit as well as other members of your staff. Thank you.

DR. ROGERS: Larry, would you permit me one comment?

MR. KESSLER: Sure. I always have to permit the vice chair here. Dr. Rogers.

DR. ROGERS: Mayor Flynn, I wish we could clone you across the country. Many of us have said if in leadership positions people would speak out as eloquently as you have, we'd have vastly less of a problem, and we're all grateful to you.

MAYOR FLYNN: Well, thank you, Dr. Rogers. I appreciate that.

(Applause.)

MAYOR FLYNN: You could do something for me, Dr. Rogers, and that's make sure that Patrick Ewing does not beat the Boston Celtics for first place in the Eastern Division. We have the best basketball team in America, the Boston Celtics.

DR. ROGERS: We've got our team right here.

MAYOR FLYNN: Does he play basketball, that fellow?

MR. JOHNSON: I used to.

MAYOR FLYNN: We're very proud of Magic Johnson.

Thank you, sir, for coming to our city. Thank you.

MR. KESSLER: Thank you.

MR. JOHNSON: Thank you.

MR. KESSLER: Before we convene our panel, I also would like to take this opportunity to welcome Lt. Governor Paul Saluchi. Gratefully, his schedule also cleared late this morning, and he has come to bring greetings to the commission, and it's important for me to say that the Lieutenant Governor is the former Senator Saluchi, who has been absolutely excellent in terms of human service issues and in particular AIDS and understanding that, and his commitment to helping us resolve some of the problems that we've had with the federal government and HUD and so on has been appreciated and should be noted. Thank you.

MR. SALUCHI: Thank you very much, Larry, and I, too would like to welcome the members of the commission on behalf of Governor Weld and our administration to the Commonwealth of Massachusetts, and both the governor and I appreciate the opportunity to participate in this hearing on the issue of providing housing for people with AIDS. Here in the Commonwealth, we are aggressively taking on the challenge of developing housing and community based services for people

with special needs in the Commonwealth. People with special needs are some of our most vulnerable citizens, and supporting the development of special needs housing is a significant part of our administration's commitment providing affordable housing opportunities in our state.

We fully support the findings of this distinguished commission that many people with HIV in the early stages of their illness would be better off and less expensive in a more appropriate setting. Residential housing for people with AIDS is more cost effective and often more humane than forcing a person in the early stages of AIDS to languish in a hospital bed simply because there is no place to go. This is one of the basic principles that we have been enunciating in our efforts to control the escalation of health care costs, and that is that we must reduce our dependence on high cost institutions. We must provide care in the appropriate and less costly setting.

And I think the differences in cost are rather staggering. Someone who could be cared for with some housing, someone in the early stages of AIDS where it might cost $15 a day for that housing, that same person in a hospital bed would be costing $1000 per day. So the dif-

ferences in cost are rather staggering.

Our Executive Office of Communities and Development has created a model affordable AIDS housing program with its Section 8 project based assistance program. Appropriate support services, funded by the State Department of Public Health, will be provided to each resident who participates in the program. To proceed with this unique initiative, our administration and the AIDS advocacy community spent weeks challenging HUD's strict interpretation of Section 504 of the Rehabilitation Act of 1973, an interpretation which almost caused the initiatives to fail. Fortunately, with the cooperation of HUD's regional administrator, John Mastapietro, here in Boston, we were able to move forward, and we are now in the process of developing a total of 52 units in Boston and Springfield.

We believe this model of developing long-term, affordable housing could easily be imitated by housing agencies throughout the country. And, in fact, we expect a linkage of community-based services in affordable housing to be a national model. It's a paradigm that makes sense because it successfully addresses the critical housing issues facing people who have lost the ability to generate a regular

income because of their illness. Moreover, this model does not require additional HUD funds, and as I noted earlier is far more cost effective than the alternative of relying on high cost institutions. So today we would like to take this opportunity to recommend that both regulatory and, if need be, legislative action be taken to clarify that Section 504 was not intended to prevent the use of federal funds for AIDS housing.

This action will ensure that housing agencies can request and receive HUD permission to set aside a percentage of their already existing units for this purpose. And finally, let me also point out that in Massachusetts we have set aside 20 state funded 707 tenant based units for people with AIDS in Boston. We believe setting aside a percentage of units from non-federally funded affordable housing programs should be encouraged. Even small set-asides, if done nationwide, will have an enormous impact on addressing this critical housing need. I again would like to thank the members of the commission for being here in Boston for this opportunity to participate. We believe that linking affordable housing and community-based services recognizes that people with special needs can live independent and fulfilling

lives if given the opportunity.

We look forward to working with you on a coordinated effort with federal and the local governments to do all that we can here in the Commonwealth to provide that opportunity. Thank you.

CHAIRMAN OSBORN: Thank you very much, Lt. Governor Saluchi. We're really very pleased that you had time to join us. I know your schedule is very crowded, but we appreciate the welcome, and we have found this a most rewarding visit already, and we still have some more to do. So thank you for your time.

MR. SALUCHI: Very good. Okay. Thank you, all.

(Applause.)

MR. PERNICK: June, if I may have a word?

CHAIRMAN OSBORN: Yes.

MR. PERNICK: I didn't want to appear rude when the Mayor was here, but I think that when he made some passing references of a disparaging nature to the work of the Department of Veterans Affairs, he may have been speaking in ignorance, and I personally would invite either the mayor or Dr. Barrett or any member of his administration to visit our program at our Hospital Jamaica Plain or our smaller support

programs in Brockton and West Roxbury or at the VA outpatient client in downtown Boston. Thank you.

CHAIRMAN OSBORN: Thanks very much. As some of you may not know, Irwin Pernick represents the Department of Veterans Affairs as one of most wonderfully loyal and helpful members of the commission. So we have good communication and are pleased to have your comment. I'd like the people who talked to us this morning to join us again at the table, and I believe Mr. Greenwald was going to join us as well from yesterday in order to have a discussion. Thank you for your patience. We've had some very distinguished additions to the program this morning, but we're very eager now to follow through with some of your presentations.

Let me say that we have constraints on our time. I don't know if there is much leeway at all. There is a press conference briefly that's scheduled at noon. Perhaps a couple minutes give there but not much. We have quite a number of people who have taken advantage of the sign-up sheet who would like to make public comment. So we're going to have to be pretty focused on what we bring out here. Eunice.

MS. DIAZ: Mr. Teachout, I was very interested in

some of the barriers to getting the job done in smaller communities. I guess some of my questions yesterday really addressed a number of issues that you touched on. I'm concerned about the housing situation in smaller communities around this nation, and you certainly highlighted a lot of the issues that are very disturbing in terms of barriers to getting the services that we need. But one very provocative thought that you had is really the better use that can be made of existing nursing facilities that are already licensed to give that care at the end stage of disease, HIV disease.

The Los Angeles County Commission and its precursor, the LA City and County Task Force, which was in place early in the epidemic, identified that problem also in California, and we were given a number of reasons why existing nursing homes that are federally financed or have federal reimbursement cannot deal with HIV patients and still continue not to do it.

I'm wondering if you had any specific recommendations of how we can really cross that barrier in terms of really looking at the facilities scattered throughout this country and saying in some communities we're not going to be able to build new programs and license them fast enough to

meet the need; what are you specifically suggesting because we hit this problem in numerous states, not just yours?

MR. TEACHOUT: What I'm suggesting is a mandate to a requirement to nursing homes that if they accept Medicaid and Medicaid they must accept patients on a first come/first serve basis regardless of the nature of their disease. We had to cross this border with doctors who said that they would not treat HIV, they didn't know how to take care of HIV patients when we knew that there was nothing complicated about it at all. We had to cross that line with our local hospitals who would turn people away or send them to larger clinics further away because they were quote-unquote "not equipped" to treat HIV patients, and we would ask them what kind of special little doodad they needed.

And it was just a matter of demand and a matter of requirement that initially got them over that hump and started taking care of people to some extent, and we're going to have to do that with nursing homes. I don't think, especially in small communities, that it's really a very wise idea to have separate housing for HIV patients because as long as we do that, then we do not challenge our community to address this issue.

MS. DIAZ: Thank you.

CHAIRMAN OSBORN: Thank you very much. Commissioner Goldman and Commission Johnson, I know, have questions, and I would again urge you to be succinct so that we can --

MR. GOLDMAN: I'll try to be succinct. And I guess my comment is mostly directed at, my comment is directed primarily at Assistant Secretary Kondratas. I'm probably the only member of the commission here who has closed as an attorney 236 projects, 202 projects, mod rehabs. I've worked with HUD on numerous occasions, and I've worked with community governments, local-state housing finance agencies, as well as commercial developers and that whole process. And there is one thing that I've always learned, and that is that if HUD wants to do something, it can usually find a way to do it, and if HUD doesn't want to do something it can usually find a regulatory way in order to make sure that it doesn't get done or that road blocks are put in to ensure that it doesn't get done, and there's enough leg room in the legislation and the regulatory process to achieve whatever purpose may be.

And yet we come across the recommendations of the former, of Admiral Watkins Presidential Commission, which suggested that more needed to be done in housing. When this

commission was first formed, one of our tasks was to look at the responses to the Reagan Watkins' commission's recommendations. With respect to that recommendation, HUD indicated tot his commission that specialized housing and housing of concerns for people with AIDS and HIV infection was not a concern and not a high priority. We could go through a whole long argument about what's disabled and what isn't, and what's covered by Section 504 and what isn't.

The reality is that the question is what is the commitment of HUD, in fact, to meet the challenges of the needs of the people that we have heard here before us, that we've seen on our site visits. You sit here before and said that persons with HIV disease face unique challenges, deserve a targeted response. I've never heard Secretary Kemp mention the word AIDS or HIV infection in terms of the needs of housing. I've never seen any overall direction on HUD's part go in that direction. And rather than get into -- I don't want to get into a lawyer's debate over various sections, but please take this message back to Washington, and that is that people with AIDS and HIV infection need housing. People with AIDS and HIV infection do face unique challenges, as you recognize. They do deserve a targeted response. They do

deserve to be qualified for the various programs, whether it be Section 202 or 811 or Section 8.

The local communities that want to provide support to those programs deserve HUD's cooperation and not obfuscation and not lack of cooperation, and the Secretary and the department needs to have an overall policy direction that those needs need to be supported, and I hope that you take that message back that that's both necessary and vital. Thank you.

MS. KONDRATAS: I appreciate your comments, and in fact I share some of your frustrations about the federal bureaucracy. I think the slowness with which bureaucracies can be changed or the slowness with which priorities become part and parcel of every last employee of an agency, it's certainly a long process and sometimes very frustrating. I know Secretary Kemp has expressed the very same frustration when we set priorities for the department that it was so difficult to get a bureaucracy to turn around really fast or to do what it's supposed to do.

The only thing I can say is that we are committed to service supported housing. We've created a new office for service supported housing. We are creating, we have not done

all we should, but as far as the AIDS issue is concerned on the service supported housing, I think you will recognize that it wasn't until very recently that how important housing is was recognized by the overall community concerned with this issue. I'd like to point out that the Secretary is not on the national commission even though there are three federal agencies represented on the national commission. Obviously, somebody didn't think to include the Department of Housing and Urban Development on this national commission.

So I think we all got a late start in making sure that housing is developed, but I can assure that you we are doing our best. It is a catch-up game, and we are as responsible, but it wasn't something that was generally recognized, and we are doing our best to make sure that we do have service supported housing. I can assure you that I will not only carry your message to the Secretary but we are fully committed to that.

CHAIRMAN OSBORN: We, of course, had not too much to do with who's on the commission, but we did invite the Secretary to talk with us more than a year ago, and he wasn't able to fit it into his schedule.

MS. KONDRATAS: Right.

CHAIRMAN OSBORN: Commissioner Johnson.

(Applause.)

MR. JOHNSON: The problem is while we're waiting for the housing people are dying. Now there is available housing, and if HUD acts now and supply more certificates, then these people can get housing now.

MS. KONDRATAS: We have requested more certificates of the Congress. You may know the rules of your game, but what you were suggesting to me earlier indicates that you don't know the rules of my game. I'd go to jail for what you suggested.

MR. JOHNSON: No, I'm not suggesting that you go to jail for anything. What I'm just saying that people need housing because they're dying.

MS. KONDRATAS: Yes, and I sympathize with that. We're trying to do everything we can.

MR. JOHNSON: And what you just told me is you have $7 million available, so you should make that available to these people who are out here who are homeless. As you can hear from every testimony, Ms. Shubert, Ms. Chinn, and so on, they all said that people need housing. They feel like they function better, they're going to live a better life and live

longer, and I think that, you know, we all understand HUD has been dragging their feet. And I guess I am young on here in that I just came on board, but -- young, period -- yes, you're right. But I see how things have been working. This commission has been doing an excellent job, and what happens is they take the bark of the complaints, and everybody is frustrated and think it's their fault when it's not.

And I'm sure they tired of hearing it, the complaints of people because they're frustrated. We're frustrated that we can't get nothing done. I mean if HUD would just take one day and just go around like we did yesterday.

MS. KONDRATAS: Well, I did yesterday and today.

MR. JOHNSON: And hear these people. Then you understand what we're trying to tell you.

MS. KONDRATAS: Yes.

MR. JOHNSON: You see, but we know right now that HUD has to act right now, not, we can't act a year from now or two years from now. There's too many lives, people are just dying day by day. So that's one thing. The second thing is this. Ms. Shubert brought up a good point that 90 percent of the people that live in those houses, like I told you, are minority. And I still look at that list and there's

no dominant minority cities that are getting these houses or the grants, I should say, excuse me. And that still just blows my mind, and that just can't happen.

Detroit, Los Angeles, on and on and on. You got one in there, Chicago. But we cannot do that because we make up over half the people that are infected with AIDS or HIV. So I'm going to continue to be on you about this.

(Laughter and applause.)

MR. JOHNSON: And I know it's not entirely your situation, and I'm not -- but you're here representing the people --

MS. KONDRATAS: Right.

MR. JOHNSON: -- that we're trying to get to. And so I just think you need to revamp that whole situation because we just make up a big part of that. And we got three people here sitting here that can give you numbers that can identify what I'm trying to say.

MS. KONDRATAS: Let me just say first of all that I hear you. I hear you, and I know exactly what you want us to do, and I give you my utmost commitment that we will do our best to address that problem specifically. And I also just want to say that I don't mind at all being here as the symbol

of the federal government. I understand the frustrations. I'm not taking it personally. I am the federal government here. So you should be bringing all your complaints and issues and problems to me. And I take them in that spirit.

I take them in the spirit that we need to do better at the federal level in doing things that need to be done. So please don't be concerned about that. On the other hand, there have been some political statements here this morning, and it would be amiss of me, as a representative of the Bush administration, not to remind everyone that HUD or even the administration is not the whole federal government. The Congress is also the federal government, and it's the Congress that sets the rule of our game and it's the Congress that tells us how much money we have to do what we have.

And in every single year, some of the things I've heard indicate that people's perceptions blur, the Reagan administration's and the Bush administration's. I think anybody who doesn't know that the Bush administration's initiatives at HUD are quite different from the former administration haven't been reading the papers or doing their homework. The Bush administration every single year has asked for more overall money -- we've had different priorities

so some programs have been cut as new ones have been created -- but our overall budget request of the Congress have been higher in every year for new additional spending than the Congress has seen fit to appropriate.

For homeless spending, we have increased spending by 66 percent in the Bush administration in spite of the budget problems, and every year we've asked for more money than the Congress has seen fit to appropriate. So I would be very happy to take your frustrations back to Washington, and I will work within the administration and do my best to see that those concerns that you just mentioned are met. But you also need to remember that the federal government is also your representatives in Congress, and you need to convince the taxpayers and the voters and the congressmen to do what needs to be done as well.

MR. JOHNSON: Well, we understand that. And the president has to do more as you well know that.

MS. KONDRATAS: Yes. We all do. We all have to do more.

(Applause.)

MR. JOHNSON: We still run into a problem because we still only have, you're talking about 500 new houses; am I

correct?

MS. KONDRATAS: Well, that's another one of those political comments. The 500 houses are houses that were in a specific set-aside in a much larger program. It's only one of many programs that I described this morning. We're providing far more than 500 housing units for persons with AIDS and they're eligible for all kinds of assistance. Moreover, the 501 units that Boston is touting as its contribution that it's doing more than the federal government, not only did they unfairly compare themselves with one federal set-aside in a larger federal program, but they're using Community Development Block Grant money to fund their portion of what they're doing here which is also federal money.

I personally send out the money to Boston for the Community Development Block Grant Program, which is what the city has committed to develop its AIDS housing. As far as I'm concerned, that's a city-federal partnership. We're doing our part there too because we provided the money.

CHAIRMAN OSBORN: Thank you. I like how you got heated there. That's good.

(Laughter and applause.)

MS. KONDRATAS: I don't -- this is actually -- somebody commented to me that they said you're doing okay under very severe fire. I said come on, this is like a dinner conversation at my house. We have a very argumentative family. I'm used to this.

(Laughter.)

CHAIRMAN OSBORN: I think I'm going to take a couple more questions, and I'm frustrated myself now because we have such a rich resource here at the table and so little time to take advantage of your presence, but let me ask, again ask the commissioners to be quite brief in their questions and see if we can take good advantage of a few extra minutes. Diane Ahrens.

MS. AHRENS: While I have this opportunity, I suppose it's not so much a question actually, but just a kind of a comment and an observation directed primarily to Ms. Kondratas, and I thank you for representing the federal government. You said the goal of HUD really was to end homelessness, and that certainly is where it should be and very laudable. I guess my sense is that we really have been and are now marching in the opposite direction. I speak as a person who works at the local level and what I see happening

is an institutionalization of the homelessness and homeless shelter structure in our society.

I know it's happening in my community. That's a very sad commentary, I think, on this country, and let me just say that it's so cost inefficient. We spend $600 a month in emergency shelter per person in my community. I think that's probably a low figure. In other cities, I know in New York it's much higher than that, but a very inadequate, inappropriate use of resources, and that's all local property tax money. That's coming right out of my county's budget, $1.5 million that we wouldn't have dreamed of spending five years ago. Now, 1.5 million doesn't sound like much, I'm sure, at the federal level, but when it's coming out of small communities and small counties across this country, that's a big hunk, a big extra hunk that you have to take out of a budget when you have a zero increase in your levy, which is mandated.

So it's taking away from other programs, and it's so inefficient. I guess we can't solve this issue at the local level. We can play our part, but we can't solve it. We need an awful lot of leadership in Washington, and I suppose the message of all of us on this commission would be

you're here. We hope the message goes back. We hope it goes to Secretary Kemp. We understand, we understand the federal process. We know that Congress has to appropriate the money, but if the President doesn't take the leadership and the Secretary doesn't give the kind of advice to encourage him to take the leadership, it isn't going to happen. I think it isn't going to happen. So thank you for being here. Thank you for accepting all of our input, but we do hope that the message gets back.

MS. KONDRATAS: I agree with you, and I will do that.

CHAIRMAN OSBORN: Thank you, Diane. I think that's a very good place to give the commission's thanks to all of you, and as I say, I wish we had more time because your testimony was very rich and helpful, but I think these exchanges have been worth the time we spent on them. So thank you very much. I now have my most difficult job which is to try and get I think 14 people to give two minutes or less a person of comment in the public comment period. It's terribly important we do that. That will still take us a little late. We want to hear from you, and we're grateful that you've come to give us your thoughts. But I urge you --

I'm going to have to be quite unpleasant about cutting you off after two minutes so I urge you to be very focused so we can hear the very major point you want us to understand from your testimony.

In addition, we know that there are many of you with many concerns across the broad range of topics and issues that this epidemic raises. This hearing is on housing and so one of the ways I think you'll be able to focus is if you can make quite sure your comments are focused on housing issues for purposes of public comment period. Having said that, let me begin, and again I never do read these names well so please excuse mispronunciations. Is it Kelo Ammons-Blenman? And then if Michele Rose could be ready to speak right afterwards. Then I think Donovan Brown, Meyra Morales, Eugene DeClerqc, David McCammack and I think Kip Tiernan, Caleb Clapp, Susan Simes, Doris Barros, Marian Barros, Eugene Handler and Carl Walker, Nicolas Parkhurst Carballeira, in that order, and not wasting too much time trying to reposition yourselves, if you can be quite efficient in that.

Kelo Ammons-Blenman. Not here. Michele Rose. And as I say, I hope you heard the order in which you were named. Why don't you use that microphone over there, please, and as

I say, two minutes, and I'd like the person who is going to speak next to be standing right there. So that we don't spend time. Please.

MS. ROSE: I want to speak about one of the smaller communities, New Bedford. New Bedford has a very proud history. It was the home of Frederick Douglas and also where most of the men of the 54th Regiment of Massachusetts were born. New Bedford is facing very serious problem right now: drugs and poverty and has the second highest percentage of its people of any city in Massachusetts with AIDS. Most of the cases in New Bedford are through substance abuse, IV drug use, and a very high percentage of those people infected with AIDS are women. These women are of childbearing age and many of them are having children.

We also have a very large population of children with AIDS. New Bedford's population is made up of Cape Verdian community, Spanish-speaking community and people of color. Although we have requested through RFPs, request for proposals, to many different agencies, New Bedford has not received any money for housing. Our problem is twofold. Number one, we're a small community. There's only 179,000 people in New Bedford and almost one percent of those people

are infected with AIDS. Our other problem is the statistics. When we identify people for the latest housing grant which is the Housing Opportunities Act, the money only goes to cities with people that have over 1500 people with AIDS. That doesn't include people who are HIV positive or people HIV positive and symptomatic. That cuts out a lot of the people that really do need housing.

The people in New Bedford who are in need of housing are either homeless or living in housing that is inadequate, and by inadequate I mean a lot of people who are living in drug houses, which means --

DR. ROGERS: Ms. Rose, you're going to have to close, but thank you very much. We've heard you and appreciate your coming. Donovan Brown, and then after Donovan, Meyra Morales, and I would like it if you'd come and sort of be ready to be at the microphone. Is Donovan Brown here? If not, then Meyra Morales. I hope I'm not mispronouncing that too badly. No? All right. David McCammack. Thank you.

MR. MCCAMMACK: Good morning and welcome to Boston. My name is David McCammack, and I'm with the Arlington Street Church in Boston here, and I'm the chairperson of the AIDS Task Force, and I want to tell you that the churches are

doing as much as they can for people with AIDS, and I'm not sure how much more we can do. We're doing everything we can to feeding, clothing, housing people with AIDS and it's appalling that the government has dropped the responsibility on to the churches and on to the nonprofit organizations to try and pick up the burden which we feel they should be helping us with.

I'm also a person with AIDS who was lucky enough to get a Section 8 housing certificate in Boston three years ago, and I can't tell you the difference it's made in my life. It's given me the freedom to live and not to be worried about the month to month and the day to day living and struggling, and as you can see I was very sick three years ago, and I have gotten much better. And my quality of life has been increased because of my housing, and I encourage you to pressure the administration and Congress to increase the level of Section 8s available, specifically because Section 8s allow you to live in housing with other people who don't necessarily have AIDS and allow some movement and some freedom of judgment and decision about where you do choose to live.

That really is considered the Rolls Royce among

programs for people with AIDS that I've talked with my friends. I also want to point out one last thing, and that is that I have a friend who I'm helping who has AIDS and he's in the hospital. He's applying for housing to the AIDS Action Committee and he's becoming a client and what have you. There's a period now where if I wasn't there to help him, he would be in a shelter. Do you know how brutal the shelters are to people with AIDS? I mean brutal, violent.

People that go to shelters who do not have AIDS are very violent toward the people who do have AIDS and that occurs in every city that I've seen and talked to people that I've gone to. The violence is tremendous. And I'm asking that something be done in this interim period that was mentioned up here by one of the panel members that something be available to people with AIDS so they don't have to go to those shelters. They're horrible places for people who are sick. Thank you very much.

CHAIRMAN OSBORN: Thank you. We really appreciate your comments.

(Applause.)

CHAIRMAN OSBORN: And your good work, I think, from what I can tell. Kip Tiernan and then Caleb Clapp.

MR. TIERNAN: Philip Clay from the Urban Studies in MIT said two years ago that unless something substantive is done about urban housing in this country, by the year 2003 there will be 19 million homeless people. In Massachusetts today, there are some 24,000 homeless people. In the city of Boston alone, there are 27,000 on a waiting list for housing. There were $32 billion in HUD which was removed during the Reagan years. That's 70 percent of the entire HUD budget. And however, Mr. Reagan left in 1988, and I'm not sure what Mr. Bush has done since then this time.

It's the terms of the debate that we're talking about here. And the terms of the debate tells us who lives and who dies, and the debate then becomes academic. So what you get are hearings like this where you have homeless people and people with AIDS and people with HIV and tots and loony-tunes and families all asking about the one thing that we need so desperately in this country, and that happens to be housing. In 1986, William Bennett, former education czar and former drug czar and equally inept at both, when he was addressing the Heritage Foundation said it, and now it is American conservatism that sets the terms of the debate.

And I think that that's terribly true, and today in

Boston we have 500 women known with AIDS, known with AIDS. We have thousands who are HIV positive. There are simply not enough resources, and yet when Mr. Bush wanted a war, we had the money like that. We need an equal amount of money at least for housing in this country. And I think, I started the first drop-in center and emergency shelter for women in this country when I was told there weren't any homeless women in Boston. I said give me ten minutes. That was 18 years ago. And now what we're dealing with at Rosie's Place and RUAH, another group that I'm helping with, now what we're faced with is an increasing, a vastly increasing number of women who are HIV positive who don't come under the CDC epidemiology incidentally.

So now we have thousands more people who have AIDS in this country. We have thousands more in the city of Boston. I think if you can get the money up to have a war, you can get the money up to have housing.

DR. ROGERS: Mr. Tiernan, thank you very much.

(Applause.)

DR. ROGERS: Well said.

CHAIRMAN OSBORN: Thanks very much. Caleb Clapp and then Susan Simes after that.

MR. CLAPP: Hi. My name is Caleb Clapp from Renwood Company. We're a private developer in Boston, and we're building 120 units of supportive special needs housing throughout Boston's neighborhoods, 60 of which are housing for people with AIDS. Of that approximately half of it is family housing and the other half is housing for individuals and most of the family housing is for substance abuse families.

I have lots of comments I'd love to make, but in the interest of time I'll limit it to one, which is something that hasn't been mentioned yet which is out of banking. This is housing, and it's the most complicated housing that can possibly be built. As housing, it requires mortgages. A couple of agencies that are conspicuously missing from the roles of this endeavor are Fannie Mae and Freddie Mac who are the largest mortgage lenders in the country.

There is one, two or maybe three local banks that are willing to participate in this housing. Wainwright Bank is one of the very few that does do it, but it takes more than one or two local banks to make this work. We need some national efforts and Fannie Mae and Freddie Mac are the lenders to do that. They happen to be having some of their

most profitable years right now. Their stock is soaring through the roof because of lowering interest rates, and I think we could look to them to put aside a pool of funds which could come to provide the permanent mortgages for the 15 to 30 years that will be required to finance this housing. Thank you.

CHAIRMAN OSBORN: Thank you very much for your comments. And I was negligent before not to comment that if you have additional things you'd like us to know about, we really do urge you to write to the commission, National Commission on AIDS, 1730 K Street, Washington, D.C., and we'll be very eager to have additional, particularly additional helpful and constructive input of that sort. Thank you so much.

Okay. Susan Simes. Doris Barros.

MR. DECLERQC: Could I? You read my name before and then skipped it. It's Eugene Declerqc. I think we were up about fourth or fifth.

CHAIRMAN OSBORN: Okay. Why don't you go ahead?

MR. DECLERQC: Okay. Thank you. My name is Gene Declerqc. I'm the chairman of the AIDS and Housing Committee for Lazarus House. Our ministry is in Lawrence, Massachu-

setts. And we're here to speak to a local problem that we have, but we think it has national implications. And the difficulty is in a sense we see ourselves as the future of the housing problem. The need for housing is serious in major cities, but the need for housing in smaller cities is growing at a faster rate. And models need to be developed in dealing with that. We've run into some specific problems that would not likely arise in a New York or a Boston or a San Francisco. And we'd like to address that but keep the focus on the national need to deal with this.

This is Patricia Gisane (phonetic). She's the project director for this, and she's going to read a statement that I think we distributed to the commission members.

CHAIRMAN OSBORN: If you've distributed it, please don't read it. We're really out of time. If you have a one-liner that can summarize it, fine. But anything that we could read would be much better for, we'd get much more out of by so doing.

MS. GISANE: Okay. I will simply refer to pieces in here, a piece in here.

MR. KESSLER: I did distribute it to the commissioners so they have it.

MS. GISANE: Okay.

MR. KESSLER: And they're very good at reading these things.

MS. GISANE: Right. But there are recommendations that we would like to present on the basis of that.

DR. ROGERS: Just bear in mind -- please do, but bear in mind that you have about a minute and a half to do so.

MR. DECLERQC: That's fine. The two major recommendations we have are (1) to provide greater support for people involved in housing in smaller communities. Those of us who are involved in housing issues have moved to AIDS as a current need. We're not AIDS specialists; we're housing specialists who have seen a need, and we've moved to that, and we need to get that kind of support. And in smaller communities, as you'll read in the handout, the kinds of responses that we've gotten are the kinds of responses political figures wouldn't dare to make in larger, more diverse communities.

The second recommendation is the need to develop models appropriate for smaller communities. The first grant that we had applied for indicated we had to provide housing for either single men or for mothers with children, and the

fact of the matter is in a smaller community we have a significant problem with AIDS. But we developed models that are appropriate for mixed populations. I'm not sure that's a model that's being looked at nationally and needs to be picked up and considered by certainly others beyond us.

DR. ROGERS: Thank you both very much, and we will indeed read your statement.

CHAIRMAN OSBORN: Thank you. Marian Barros. Eugene Handler.

MR. BARROS: My name is Marvin Barros. I'm age 15. You got that wrong, but that's okay.

CHAIRMAN OSBORN: Excuse me. I have trouble with these written names.

MR. BARROS: I'd like to take this time to thank and welcome everyone at the committee for coming today. I have a poem that I'd like to read that's pertaining to the AIDS subject. The title of the poem is "Let It Be Magic."

"In the beginning, God brought us to the center of the world when he brought us the hustle of Big Bill Russell. He brought us a goliath of a man when he named Wilt Chamberlain, whose rule brought order to the land, whose rule brought order on the court. God brought us to dream, a

vision of ways and means, his name reigns supreme, life's shining star, his name is Kareem Abdul Jabar. God brought us Moses, Moses Malone, who towers as high as Mount Sinai. The man who brought the ten commands to the courts promiseland. God brought us a bird, one Larry Bird, whose message is to deliver the deliverance for all to see and for all to hear.

"God brought us the prophet Isaiah, Isaiah Thomas, a man of promise in a big man's world to keep them honest. A smile of pearls that rules both worlds. God brought us Jordan, Michael Jordan. Like the river, he flows through every heart like a fine work of modern art. Then came the virus, HIV. Then came the plague called AIDS. If we were to handle this crusade, we'd have to add another disciple to the Bible and let him be immortal to keep us all strong with the will to go on. Then let it be Magic. Then let it be Magic. So God chose Earvin "Super Magic" Johnson."

(Applause.)

CHAIRMAN OSBORN: Do you have that written? I think the commission would love to have that as a written poem if you have a chance to send it to us.

MR. BARROS: My mother has a copy.

CHAIRMAN OSBORN: Good. We'd love to have it.

Thank you.

(Applause.)

CHAIRMAN OSBORN: Carl Walker. I think the number of people not here who had been planning, that ends the public comment period, which -- I'm sorry -- are you on our list? I'm sorry. I missed the last name. Nicolas Parkhurst Carballeira.

MR. WALKER: I am taking this opportunity to do something more than just speak in behalf of AIDS.

CHAIRMAN OSBORN: Could you introduce, sir?

MR. WALKER: Yes, I am Dr. Walker. I came from the backwoods of West, by God, Virginia. I was hitchhiking to school, working in the coal mines when I was 17. Since that time, I have been head of a pharmaceutical company. I have been an educator. I've just recently had an adolescent child life center, and the problem that we have run into -- and for the first time in my life I've decided to use politics. I come with solutions, not just questions. Just give me a few minutes.

CHAIRMAN OSBORN: I'm going to give you less than two now, and I want to ask you to talk about housing because we really --

MR. WALKER: That's exactly what I'm going to get into.

CHAIRMAN OSBORN: Good. Thank you very much because we hate to be so brief but we must.

MR. WALKER: Right. One of the problems that we run into was no jobs for youth. This is the big problem outside of medical that we have here in Boston. So I created, just recently created a center for actually creating jobs for youth. The only way I could get it in -- the jobs we're talking about is not only training, decreased crime, but housing. Within Boston, we sit with a big facility and many facilities here that youth could actually renovate and be used for housing, creating many, solving many problems with little money. This program now is in the hands of -- I got into the governor and when I couldn't get it directly to Washington, I went by way of Mexico.

And I sent it to Salinas in Mexico who actually sent it to Bush, who has now recently got a call from the Minority Whip. We want to create housing, but all I want to say you can do it, and I have the solutions for doing it without a tremendous cost. When you ask for handouts from federal government, which is great, but where does that money

come from? It's got to come from the cities or the states. So there are programs, there are ways of doing it, and that's what I wanted to say.

DR. ROGERS: Dr. Walker, thank you very much.

CHAIRMAN OSBORN: And now Nicholas Carballeira. Thank you for being patient.

MR. CARBALLEIRA: My name is Nicolas Parkhurst Carballeira. I'm executive director of the Latino Health Network of Massachusetts. I want to take this opportunity to welcome you all but particularly welcome the newest member of the commission, Mr. Earvin Johnson. I do so because the Latino community has great admiration and respect for his work both on the court and after seeing him today on the commission because we know that this addition to the commission will signal a greater interest in and support for meeting the needs of all non-dominant, so-called minority ethnic and cultural populations affected by the AIDS pandemic in the United States.

Although I don't have the time to repeat the statistics that attest to the changing demographic of this pandemic in its second decade, still the commission, the National Commission on AIDS has only one valiant Latino

commissioner, Eunice Diaz, and one staff person. There has been no testimony here today, no solicited testimony from the commission on the Latino-specific housing projects that do exist throughout the nation and are successful. We are seeing how the Latino community is still expecting a report on the commission's visit to Puerto Rico in November of 1990 and also waiting for a report on the commission's hearing of testimony, of Latino testimony in Chicago in March of 1991.

I have read with great interest and so have all Latino AIDS service providers the recommendations that the commission has made, but with the possible exception of your support for erasing the Medicaid cap in the Commonwealth of Puerto Rico, there have been no Latino or any other ethnic specific recommendations regarding prevention, education, treatment or housing, and I would like to invite you to address that reality because our populations are being disproportionately affected and unfortunately not even proportionally addressed. Thank you.

DR. ROGERS: Thank you very much for your comment.

CHAIRMAN OSBORN: Thank you.

DR. ROGERS: Much appreciated. We hear you.

CHAIRMAN OSBORN: Now let me give the camera people

that I so rudely interrupted a chance to finish doing what they were doing, and then we'll go ahead.

DR. ROGERS: For those of you in the audience who are puzzled, we are breaking this session. We are having a short press conference. You are welcome to stay if you so desire.

(Whereupon, at 11:55 a.m., the hearing recessed, to reconvene at 3:55 p.m., this same day.)

AFTERNOON SESSION

(3:55 p.m.)

CHAIRMAN OSBORN: We think we can have a quick meeting, but we wanted to have a quick meeting because then you can all get out to your trains and planes. Let me just say what we wanted to do. We wanted to be sure we knew what we needed to decide about April. We have at the moment, I think, three days held. We may not need all three, and it would be good to release whatever we're not going to use. We need to decide where we're going to meet and what we're going to do. And then in addition I think we might want to decide May, if it's not going to be in Washington so that the staff has time to anticipate.

In addition, David and I have informally talked and talked with many of you, but it seemed like a good idea to have a formal talk about, or at least a semi-formal talk about writing a mini-report on housing in sort of an urgent way. Our instinct is that there are some sort of main comments that could be made quite analogous to the very, very first report. This is a crisis. Remember we said that health care -- we didn't say much about he health care system except that it was a rotten mess and needed fixing. And I

think that maybe that that kind of report is what David and I were talking about. I don't think it should be daunting to do that.

Obviously, it's very daunting as soon as you get into the level of understanding that you and Don were going after today. But that's -- well, I don't want to carry on the whole discussion, but that's the idea would be to stay off that level of complexity and yet get across in a focused way that housing is at the basis of everybody's health and we're in disaster, heading for bigger disaster.

DR. ALLEN: June, I think for many of the health providers that even a basic discussion of the types of assistance that are there, for example, you know I had an intuitive understanding what an SRO was, but I didn't know for sure, and I passed a little note to Goldman. I mean nobody explained it. Everybody just started talking about SROs, and I asked Eunice, do you know what it is? And she said, well, I think so, but I'm not sure. I mean the fact is even on the commission, and there may have been in our briefing package, which I started to go through but didn't go through in detail.

MR. DALTON: New York.

DR. ALLEN: Well, you see I didn't go to New York.

CHAIRMAN OSBORN: That's when I learned was in New York.

DR. ALLEN: But the point is there are probably a lot of people out there who don't even have this basic level of understanding of what is out there, what are the --

CHAIRMAN OSBORN: Yes. I think that could be done descriptively too.

MR. KESSLER: You can do a glossary.

CHAIRMAN OSBORN: Very simple sort of thing and maybe a narrative version of a glossary, and the range of choices, range of things that can be done, all of which are cost effective. David has given that a lot of thought. You may want to --

MR. KESSLER: Rob is a very excellent writer, and he's fast, and I would be okay with lending him to the commission for a day.

DR. ROGERS: Good. Well, a couple nights ago after I was so impressed, I told Roy, I tried just a brief outline of it. There are only about six points, and it seems to me that could be made very powerfully. Next to dying, the major terror of an AIDS victim is losing housing, that charter.

Despite that, here's what we've done -- I guess my points were the terror is justified. Our failure to supply housing approaches a national scandal. It's most tragic and most evident with AIDS. And then the scorecard. Federal level funding -- here's what's happening to AIDS. Here's what it costs to do somebody in housing versus what it cost to do something to somebody in the hospital.

The particular irony: it would cost one hell of a lot less if you did it this way. And that you could --

CHAIRMAN OSBORN: But there's a long start up time so you have to plan.

DR. ROGERS: The human equation -- some of the things we heard that were so powerful, absolutely. And then three or four recommendations, and I think you could almost do it with a series of graphs, and I think it would be wonderful. I thought the most powerful testimony was Greenwald, if he could help.

MR. KESSLER: He has generally pulled out some stuff overnight that's just great.

CHAIRMAN OSBORN: Do you want this as sort of an outline set of ideas of ours?

MR. KESSLER: Okay.

CHAIRMAN OSBORN: I mean I know he doesn't need it, but that's at least work done already.

MR. KESSLER: Okay.

MR. GOLDMAN: I concur that we ought to do it, and just let me add on to that list, if I may, with the ideas of what kind of recommendations I think that we can fairly come up with aside from the one that we need more housing and we need more federal support for housing and some of the things the witnesses mentioned specifically, but some things that are not so specifically funding sensitive and funding related, that don't cost anything.

I think that, number one, we should use the report as an opportunity to reassert our need for a national plan and underscoring the fact that AIDS and HIV infection is not an HHS issue, it's not a PHS issue, it's also a HUD issue, it's also a Justice issue. It's an issue that cuts across cabinet lines. I think we can make that same point in terms of local communities and look and point to Boston as a community in which the housing folk are talking to the health folk, and the two are talking to each other and coordinating and planning activities and not acting in the kind of isolation and say that that kind of activity ought to be

encouraged on both a state and local community basis.

I think we ought to be saying that the planning component under, that there ought to be a tie-in between the planning component that's going to be set up probably under the Affordable Housing Act for local communities, and whatever kind of housing they do for AIDS and HIV infection, and local communities ought to be coordinated with the Ryan White planning structures that already exist out there, and we ought not be setting up duplicative administrations with different people doing different sets of planning, and there ought to be coordination of them.

And I think we also ought to be recommending that there ought to be AIDS/HIV components of every CHAS. The CHAS' are the HUD required planning document. Every community that has a Public Housing Authority and every state is required to have a CHAS.

DR. ALLEN: Comprehensive Housing.

MR. GOLDMAN: Comprehensive Housing something or other.

DR. ALLEN: Harlon, do you have her testimony or did you give it --

MR. DALTON: I gave it to her.

MR. BLEVINS: If I'm not mistaken, that's a mandatory part of CHAS. I mean I think it's built in there that HIV has to be explicitly addressed.

MR. GOLDMAN: Okay.

CHAIRMAN OSBORN: Well, if Rob is going to help us with this, a lot of this can shake out.

MR. GOLDMAN: Right. And I just want to make these recommendations for the record so that when the transcript is done, he can be given it and the ideas can get off my little scrap of paper into somebody's useful pen.

MR. DALTON: I have no idea whether we should be at that level of detail, that Don just suggested. But if we do, it strikes me that every bit as important as interagency coordination is intra-agency. And we might recommend that HUD have a point person or some mechanism for pulling together what it does around AIDS because one of the problems is it's just not thinking about AIDS as a phenomenon, and it's so divided across its different agencies.

CHAIRMAN OSBORN: And also the federal, state, local, CBO stuff was coming out every once in a while, and not as fully as we could probably bring it out in a written report because it didn't really need to be, but it sounded to

me as if there were times -- you were muttering to me that New York had managed to sort of box in some things because either the state or the local regulations ran so badly across the federal that it was going to take two years to untangle. And that, I think, you know, in a way this can be a reprise and a reminder of some of the very early reports that we did.

I mean that's the way I'm thinking of it is almost like let's do it again with that first report, boy, we have got trouble. And that one was a prototype in the sense that it didn't get quite as detailed as some of the comments. It did get at the sense of crisis and urgency, and it was readable enough to make sure that -- I mean I'm personally not sure I want to get into the SRO level of stuff in this report because that's something that could be done as an addendum document or something. And I don't know that people have to understand SRO versus something else in order to understand that there are sick people dying on the streets because we haven't addressed housing. And so my hope was that we could go back to the mode that has worked for us sometimes.

DR. ROGERS: I like Don's idea also of it seems to me it can revisit our two year report. There's another window of opportunity here, and to pick up and slam home some

of our former recommendations, I think they'll be heard quite differently.

CHAIRMAN OSBORN: Yes.

DR. ROGERS: And we can pick up the ones that -- that's what I think you're suggesting, aren't you?

MR. GOLDMAN: Yes. Yes.

DR. ROGERS: We revisit those, put them in again.

DR. ALLEN: And in terms of the local component, certainly Leo Teachout had some very important lessons, and I think Diane would probably like to see those amplified, and the need for local response picked up and acted on.

CHAIRMAN OSBORN: Well, is it everybody's sort of consensus that we try for this? I mean obviously it will go back and forth a little bit, but we'll get an initial try at something that we could do fairly swiftly? Is that -- any staff comments on that?

DR. ROGERS: My reaction it be fast, too. I think this could be written fast. I think we're talking about a five page document.

MR. DALTON: That doesn't mean it's fast. That may be more time than a ten page. I mean --

DR. ROGERS: There are a few charts in this one,

too, that could be very powerful.

MS. KONDRATAS: I think it's more than five pages, but at least ten.

DR. ALLEN: I think let's make sure that the charts are accurate because as -- .

DR. ROGERS: Oh, I don't worry about that.

(Laughter.)

DR. ALLEN: As I heard what Anna --

DR. ROGERS: I pick the charts to portray my prejudices. You know that.

DR. ALLEN: Well, I understand that, David, but I couldn't begin to understand all that Anna was saying, but it sounds like there is a very complex formula there in terms of --

MR. GOLDMAN: If you'd like me to explain it to you, I'll explain it to you some day.

DR. ALLEN: Over a drink, Don, when we have lots of time.

MR. GOLDMAN: But not right now.

MR. KESSLER: Did she supply us with her testimony?

MR. DALTON: Yes.

MR. GOLDMAN: No.

DR. ROGERS: But she hasn't supplied us with those figures.

MS. SILVER: Harlon has it.

MR. DALTON: Frank has it.

DR. ROGERS: But she promised us to supply us with those figures that I thought were largely BS that she was giving out there at the end.

MR. GOLDMAN: They're not.

DR. ALLEN: Well, I'll bet they're not.

MR. GOLDMAN: They're not. It's a long story. I'll explain it to you on the plane.

DR. ROGERS: Oh, no, no, no, please don't.

(Laughter.)

MR. DALTON: But there was something she did say, though, that was not entirely -- but never mind. Her 25 billion figure was I think not just housing, but also community development.

MR. GOLDMAN: And also it has to do with the expenditures rather than the budgeted which is a whole other different issue.

CHAIRMAN OSBORN: That was the swamp it was clear we were about to fall into.

DR. ROGERS: Let's make it expenditures.

CHAIRMAN OSBORN: So okay, the general consensus, and we'll give it a try. Roy, any comments about it? It's not going to break the back of the system or anything like that? Okay. So that's good. April. In April, we are scheduled to be somewhere on the 20th and 21st.

DR. ROGERS: 20th and 21st.

DR. WIDDUS: We have dates reserved, but we don't, I suggest --

DR. ALLEN: I have not heard from within the department. I've still got feelers out trying to check on the potential for that.

MR. DALTON: For what?

DR. ALLEN: For the dates that were set aside on the 21st and 22nd.

CHAIRMAN OSBORN: Monday, the 20th of April, and Tuesday, the 21st, were held as was Thursday, the 23rd, at the time that we were sort of holding everything.

DR. WIDDUS: And what I was trying to negotiate with Jim is if Secretary Sullivan and Assistant Secretary Mason were available at that time, that might be a time to take the commission back in to meet and discuss the response

to the recommendations. In part, that was --

DR. ROGERS: At the risk of starting something all over again that I guess you tried last time, do we need it? My gut reaction would be let's not do it unless they want to meet with us.

DR. WIDDUS: That's what I'm trying to get underway, but I don't have an answer back yet.

DR. ROGERS: Unless we've got some real red meat for, I wouldn't meet just to meet. Meet, meat, meet.

CHAIRMAN OSBORN: Yeah, I noticed. That was good, David.

MR. GOLDMAN: Well, the reason to meet, if there is a reason to meet, is that --

MR. DALTON: You don't have to make up one, honest. It's okay.

MR. GOLDMAN: No, there is -- at the present time, the way things stand is there is supposed to be some kind of response from HHS which is forthcoming. So we are in a position where we can't say that the HHS has not responded and we can't say that they have responded, and we can't say their response has been satisfactory, and we can't say the response has been unsatisfactory. And the discussion that we had was

whether or not it would at least be useful and desirable to be able to say one way or the other that they've responded and their response is not satisfactory as opposed to the present state of --

DR. ROGERS: Jim, how much pressure can we put on them? Can we say we have the dates of either the 20th or the 21st to meet with you, Dr. Sullivan, and to meet with you, Dr. Mason, to find out after five months what the response to the report is going to be? I think we can do that, can't we?

DR. ALLEN: Yeah. Let me get back with them and see what we can do and then let you know.

DR. ROGERS: Why don't you indicate we're serious about it that either that five months seems enough, and that those are the dates we've got set aside, and the whole commission can meet with him.

MR. DALTON: I was going to suggest that we release the 23rd date.

CHAIRMAN OSBORN: Yeah, I was too. If we could get -- that's part of what I wanted to do was to release some of those extra times because we had done that to maximize our flexibility, but if that's something that matters to you, Harlon, I was looking -- I don't care which date we release,

but I think we've got to start doing a little of that. Is that okay? Is that all right? Nobody has any concerns about that?

DR. ROGERS: And it seems to me the understanding for the 20th or 21st should be we are meeting in Washington to hear the response of the administration to our report.

MR. DALTON: Does that mean if they're not going to give a response or not going to give it, that we don't meet? I'm not sure that that's a full reason for a meeting, and I also -- by the way, it's not clear to me that meeting them we're going to be in a better position to say whether we've had a response. I think it's sometimes harder to say that was not a satisfactory response after they've sort of showed up and smiled but said nothing. But in any event -- all right. What else are we going to do in April besides that?

DR. WIDDUS: I was suggesting to June that if those dates don't turn around, we could release that date for a hearing somewhere if it turns out that we've got the money.

CHAIRMAN OSBORN: Which we almost surely do, and so the other part of what we were muttering up here is that the power of visiting places is clearly something that we can, and out of this morning's discussion and everything, we're

going to keep going. This is one good thing we can keep doing. And so if that's enough turn-around time, we could, you know, do Kansas City or do something like that, and be able to achieve a different kind of effect entirely.

MS. SILVER: I think my only question is how long are we going to wait for the answer from Secretary Sullivan?

DR. ALLEN: Well, it's really less an issue of Sullivan because Sullivan isn't going to spend much time. It's an issue of getting it on Mason's calendar, and let me put a call back right afterwards and I'll see what I can find out. I won't have an answer this afternoon, I don't think, unless my staff has gotten it already, but I'll put some more pressure on it.

CHAIRMAN OSBORN: Do you want to make a call now just in case or -- I mean is there enough of a chance to be worth your going out and we could talk about where we want to meet.

MR. GOLDMAN: You have your portable phone on you anyway, don't you?

CHAIRMAN OSBORN: I got a quarter.

(Laughter.)

CHAIRMAN OSBORN: I've got a commission calling

card.

DR. ALLEN: I can make the call. I won't be able to get through and get an absolute answer, you know, right now because people have got to -- I mean to find out what Sullivan's schedule is, you know, he doesn't fix it literally until very close on in.

CHAIRMAN OSBORN: I mean I don't to press you, if it's foolish, but I just thought it sounded like if there might be --

DR. ROGERS: Probably we ought to know fairly soon.

CHAIRMAN OSBORN: If there was an answer sitting on your desk that you didn't know, I thought it might be convenient to --

MR. DALTON: Jim, did you say he doesn't fix it until close on to the date? Does that mean that we really won't know until well into April?

DR. ALLEN: I think if he made a commitment to meet, there would be a very high probability that he would be there unless something else happened. I mean, you know, well, if Bush commands him to go somewhere, he goes. But that's --

CHAIRMAN OSBORN: Yeah, I think what I'd like to do

is to get at least that kind of planning, maybe either/or. I mean if you've got both April and May on hold, and by making those two decisions, the staff could be pacing themselves a bit. Do we want to do -- let's assume for the moment that we have the money so that we are no longer -- and I think that's a pretty healthy assumption. That's a much --

DR. ALLEN: June, what is the process for deciding that? Is it GAO that has to make the determination? Who makes the --

DR. WIDDUS: GSA had to confirm with Treasury that their opinion, which I've relayed to you, was, in fact, correct. That will probably give us an answer by the time that I get back to Washington in the office tomorrow. If it's still uncertain, it then has to go back to the authorizing committees just for them to, or to the staff of the authorizing committees to confirm that it was the intention that the money go over from year to the next.

MR. GOLDMAN: Authorization, not appropriation.

DR. WIDDUS: Authorizing, yes.

DR. ALLEN: Oh, okay. That is authorizing, yeah.

DR. WIDDUS: All of the appropriations legislation language refers back to the original authorization, which is

why GSA was pretty clear in its opinion that it was just a bookkeeping error.

MR. GOLDMAN: So that's Tim Westmoreland.

DR. WIDDUS: That's Tim Westmoreland and Michael.

MR. GOLDMAN: And Michael, okay.

CHAIRMAN OSBORN: Think about it for a nanosecond.

DR. ROGERS: Money in the bank.

MR. DALTON: So now let's go back to the --

CHAIRMAN OSBORN: Yes. So now you see what I want to do is to get a contingency plan so that we know what we're doing. We've got a two day hearing possibility in April. We've got a two day hearing possibility in May.

DR. ALLEN: What are the May dates?

CHAIRMAN OSBORN: I've got the 18th and 19th, but we also again have the 21st on hold, and again I suspect it would help all of us if we could take some of those hold dates off.

DR. ROGERS: 18 and 19 are a Monday and a Tuesday, June?

CHAIRMAN OSBORN: That's right. 18th is Victoria Day in Canada, but I presume that will be all right.

MR. GOLDMAN: Did we ever have results of the

ranking that we did of the potential topics?

DR. WIDDUS: It's not complete yet, and we haven't sort of looked at whether we could combine some of those topics, but we'll do that very rapidly.

CHAIRMAN OSBORN: My suggestion would be that we almost think more about place than topic. I mean one of the things we did discuss was that those topics could mix, some of them at least, and they would probably mix differently with different places.

MS. SILVER: Sex in Kansas.

CHAIRMAN OSBORN: Sex in Kansas.

DR. WIDDUS: There isn't any.

(Laughter.)

DR. ALLEN: That's not true.

MR. GOLDMAN: What are we going to have? An agricultural visit?

CHAIRMAN OSBORN: Now, now, now, now, now.

DR. WIDDUS: One thing I can do is briefly relay back to you that the topics of youth, sex, communication about HIV, behavioral sciences, all came up high. I may have missed one or two, but those would clearly be either individual hearings or a mix of those topics.

CHAIRMAN OSBORN: Well, now that we've thought about going on to the fourth year, just to throw out on the table a couple of other places, because we didn't get very far down that discussion. We were talking Middle West, Middle West, and I confess I was not thinking expansively for both budgetary and time reasons.

MR. DALTON: You did mention Michigan in your non-expansive thinking last time. I recall that.

CHAIRMAN OSBORN: Well, Detroit is on there, but in addition, thinking now if we're doing some good in places that are hard hit, we haven't done San Diego, which is a very seriously underserved area. And we haven't done Houston. I mean what I started doing in my head, as I began to think more expansively, is to start going down to places that are being hit --

MR. GOLDMAN: The working group went to Dallas.

CHAIRMAN OSBORN: -- very hard. The working group went to Dallas. Otherwise, we haven't done Texas at all.

MR. DALTON: The working group also went to Boston. I mean working group and commission aren't the same.

CHAIRMAN OSBORN: Right.

MR. DALTON: Scott Allen, I spoke to him on

Saturday, and he asked me to please be sure to put in a word for Houston.

CHAIRMAN OSBORN: Good.

MR. DALTON: And in his view, Houston is not Dallas in terms of the epidemic. Scott also has no particular interest in hosting the commission in Dallas.

CHAIRMAN OSBORN: No. I would say Houston even -- the working group was just that in Dallas, but we had a pretty high visibility while we were there, which is a little different from some of the other groups that were not quite so heavily covered. So I would think if we went there, we'd want to do Houston this time just for coverage purposes. Similarly, San Diego, we included in southern California before, but we had one lone voice saying you're not even covering San Diego, and we've got the sixth highest --

MR. DALTON: Or the Marianas Islands or was that something different? I'm sorry.

CHAIRMAN OSBORN: Beg your pardon?

MR. DALTON: Marianas Islands. Never mind.

CHAIRMAN OSBORN: That's right. Guam.

MR. KESSLER: I agree those two cities are two that have particular problems. We might want to look at some mid-

size places, you know, Pittsburgh, North Carolina, a place like Charlotte which we one time considered.

MR. GOLDMAN: Are there any places that particularly want us or that have approached the commission?

CHAIRMAN OSBORN: Well, Detroit and Michigan do for sure.

MR. BLEVINS: Atlanta is another one.

CHAIRMAN OSBORN: Atlanta.

MR. KESSLER: Atlanta. Atlanta has gone through a lot of changes. Philadelphia is another place as well. Major problems even though like Atlanta has the CDC, it has nothing to do with AIDS services in that city and so on. Someplace else I was thinking of.

CHAIRMAN OSBORN: What I would suggest, I mean --

MR. KESSLER: Austin is a good alternative to Houston. Austin has another sort of slice in a different way from Dallas and from Houston.

CHAIRMAN OSBORN: What I was doing, in that thinking, I would suggest be done more systematically which is to go back and look at the demographic determinants. I mean I was trying to pick out. If this dynamic is one that we all embrace, which I think it is, go to a city that's got

a lot of trouble, that can use the focusing effect of our visit, so it's not pure nuisance value, and would like, roughly like to have us, at least some good fraction would. Then I would think that that's the way to go about it, and we could, and then some of it would be practicality. I mean we probably don't want to go to Houston in the middle of July, you know, and things like that, and we can work around it.

MR. GOLDMAN: We went to Dallas in July. It was wonderful.

CHAIRMAN OSBORN: Yeah, I remember that.

MR. KESSLER: New Orleans is another place that has unique problems.

CHAIRMAN OSBORN: Oh, New Orleans is a very interesting place, yeah. A city that forgot to care.

MR. BLEVINS: Also looking at flight costs and connections, in and out, and those kinds of things to consider.

CHAIRMAN OSBORN: Yes, right.

MR. GOLDMAN: Houston is pretty good though.

MR. BLEVINS: Houston is good. I mean it's when you start looking at places like Kansas City and St. Louis.

CHAIRMAN OSBORN: Well, St. Louis is okay as long

as TWA doesn't go bankrupt.

MR. GOLDMAN: They are in bankruptcy.

CHAIRMAN OSBORN: Maybe we should mean -- well, I mean go bankrupt bankrupt.

MR. BLEVINS: Logistical factors come into play.

CHAIRMAN OSBORN: Well, yes, and you might want to choose, for instance, between St. Louis and Kansas City. Those were talked about so coequally and maybe some of the choice there would be some hosting groups and how enthusiastic they were. What I was going to propose was that that be some staff work that could come back to us. If you agreed with the general approach that we look for hard-hit cities, and we look for medium-sized city and we look, we try very hard to keep the center of the country in our sites as much as possible in the meantime. And certainly Detroit at some point is fine. If we did that in the fall, I could get you all to go to a University of Michigan football game, if you'd like.

But I mean there's stuff that we can talk about. But I wanted to get that process underway, and the agreement might be if we get a pretty clear negative that nothing very exciting is going to happen with HHS in April, that we try

for a fairly simple hearing with good -- simple in the sense of good transportation and ease of access.

DR. ROGERS: Limited number of --

CHAIRMAN OSBORN: Yes. This was really fine. And you know if it --

MS. SILVER: And all we need is Larry Kessler in Nebraska.

DR. ROGERS: That's right.

CHAIRMAN OSBORN: But that's part of the simple is if there is a very key person that you find that you can work with very well.

MS. SILVER: Which is sort of how we've done some other things like Georgia when you find a Ted Holloway and --

CHAIRMAN OSBORN: My guess is the Michigan folks could help you pretty efficiently. At least there are some that might, and that, again, you've got me around to push things.

MR. KESSLER: The issuance of the report may be a consideration, too, in terms of a setting.

CHAIRMAN OSBORN: Well, that's the other criterion I was going to bring up. Magic today did something really quite good, I thought, in bringing out that much of our

conversation should be proportionate to who's in difficulty, and I loved the way he kept going, yeah, but it isn't who's got the problem kind of thing. Certainly some of our choices about these things should be that, and that, again, argues for Detroit and Philadelphia.

DR. ROGERS: If we have Magic along, we probably just should have one witness. We won't get anywhere if we go to Detroit with Magic. But we'll have a good time.

CHAIRMAN OSBORN: No, if we did Detroit, I would propose that we do Detroit one day and Ann Arbor or Lansing, but probably Ann Arbor for ease of, it's easier to get to the airport from Ann Arbor, to the Detroit airport from Ann Arbor than it is from Detroit. So they are the same place for purposes of in and out. We could even stay in Ann Arbor both nights but have a -- it takes less than an hour to get into wherever you want to go in Detroit by bus, and going through Detroit by bus is in itself a happening because, you know, the first time I drove from North to South, I figured we'd wasted all that money developing nuclear weapons when you could bomb out a city without ever needing a single fission, you know.

And that's what it looks like. And so there are

things that can be done rather simply there, and there is a fairly good coordination of health care folks and some others. A lot of trying, and I got the most pitiful, horrible, little piece of mail the other day because I'm on everybody's mailing list in Michigan -- please, please, please report all your AIDS cases because we're going to be 1945, and they need 2,000. So, please, we know there are 55 cases out there; report them. You know -- yuk.

MR. KESSLER: Where was this at?

CHAIRMAN OSBORN: This was coming from Detroit.

MR. KESSLER: Detroit.

CHAIRMAN OSBORN: Yes. So lots of interesting things. In that sense, it's a medium-sized epidemic city, which is another thing. Cleveland, by the way, would give us a hero's welcome. I mean Cleveland would just flip. They feel under-noticed as cities go.

MR. KESSLER: And I know the director of the AIDS service group there. He's an ex-employee of AIDS Action.

CHAIRMAN OSBORN: There are very good people there. You'd be in clover with the Cleveland people, and both David and I are closely hooked into Case Western Reserves, not to mention my daughter.

MR. GOLDMAN: I just have one request is that whatever city and topic you ultimately decide that you very rapidly, even by fax, communicate that decision with the rest of the commission.

CHAIRMAN OSBORN: Yes, that's why I wanted to talk as much about it as we could here.

MR. GOLDMAN: So that ultimately each of us including those who are not here have an opportunity to provide some input, not to the choice, but --

CHAIRMAN OSBORN: When the choice is made.

MR. GOLDMAN: When the choice is made and the topic is done, each of us may have some ideas about that particular city or about that particular topic that we might want to be of help to staff and providing some insight.

CHAIRMAN OSBORN: Yes, that's a good comment, but that is one reason why I wanted to get us to talk this as far along as we could together. Go to New Haven, Harlon, and watch the needle exchange or something. May in New Haven, late May in New Haven. Are we at a point where we're comfortable with how to proceed from the staff point of view and from the commissioners point of view? Everybody is happy?

DR. ROGERS: Fine.

CHAIRMAN OSBORN: Okay. Good. We should do this more often. Nat, on behalf of all us, enormous thanks for a spectacular job.

DR. ROGERS: Wonderful.

CHAIRMAN OSBORN: Wonderful, wonderful. And Jane and Tom and Frank and Roy, but Nat especially. Thank you.

(Whereupon, at 4:25 p.m., the hearing adjourned.)