ORDINANCE No. 113091

Law Department

COUNCIL BILL No. 105733

AN ORDINANCE relating to the Seattle-King County Department of Public Health; increasing an expenditure allowance in the 1986 Budget of the Department for the Acquired Immune Deficiency Syndrome (AIDS) Project; making an appropriation from the Emergency Fund; and declaring an emergency therefor.

9/23/86 Do Pass

COMPTROLLER FILE No. _____

Introduced: SEP 2 1986	By: EXECUTIVE REQUEST
Referred: SEP 2 1986	To: PS
Referred:	To:
Referred:	To:
Reported: SEP 29 1986	Second Reading: SEP 29 1986
Third Reading: SEP 29 1986	Signed: SEP 29 1986
Presented to Mayor: SEP 30 1986	Approved: OCT 6 1986
Returned to City Clerk: OCT 6 1986	Published:
Vetoed by Mayor:	Veto Published: OK
Passed over Veto:	Veto Sustained:

REC'D OMF SEP 2 1986

The City of Seattle--Legislativ

REPORT OF COMMITTEE

Honorable President:

Your Committe on Public Safety

to which was referred the within Council Bill No. 105 [illegible]
report that we have considered the same and respectfully recomm

Do Pass

Norman B. Rice
Committee Chair

Law Department

The City of Seattle--Legislative Department

Date Reported and Adopted

REPORT OF COMMITTEE

Honorable President:

Your Committe on Public Safety

to which was referred the within Council Bill No. 105733

report that we have considered the same and respectfully recommend that the same:

Do Pass

Norman B. Rice

Committee Chair

REC'D OMF SEP 9 A 1998

ORDINANCE 113091

AN ORDINANCE relating to the Seattle-King County Department of Public Health; increasing an expenditure allowance in the 1986 Budget of the Department for the Acquired Immune Deficiency Syndrome (AIDS) Project; making an appropriation from the Emergency Fund, and declaring the emergency therefor.

BE IT ORDAINED BY THE CITY OF SEATTLE AS FOLLOWS:

Section 1. As requested by the Mayor in the materials attached hereto entitled 'AIDS and AIDS Related Conditions in Seattle: A Status Report' dated March 10, 1986, the expenditure allowance for Object of Expenditure 55000 - Governmental Services in the 1986 Budget of the Seattle-King County Department of Public Health, Program Category "Support to King County" (Code 3100) is hereby increased by the sum of Forty-One Thousand Six Hundred Fifty-Three Dollars ($41,653) by the appropriation and transfer, hereby made and authorized, of a like amount from the Emergency Fund to the appropriate expenditure account in the General Fund. The City Comptroller is authorized to draw and the City Treasurer to pay the necessary warrants and make the necessary transfers.

Section 2. WHEREAS, the appropriation herein made is to meet actual necessary expenditures of the City for which no appropriation has been made due to causes which could not reasonably have been foreseen at the time of making the 1986 Budget; Now, Therefore, in accordance with RCW 35.32A.060, by reason of the facts above stated and the emergency which is hereby declared to exist, this ordinance shall become effective immediately upon the approval or signing of the same by the Mayor or passage over his veto, as provided by the Charter of the City.

Passed by the City Council the 29th day of September, 1986, and signed by me in open session in authentication of its passage this 29th day of September, 1986.

President _____ of the City Council.

Approved by me this 6th day of October, 1986.

Attest Norward J. Brooks
City Comptroller and City Clerk.

(SEAL)

Published _____ By Margaret Carter
Deputy Clerk.

Approved by me this 6th day of Oct, 1986

Mayor

City of Seattle

0638

Executive Department-Office of Management and Budget
Gary Zarker, Director
Charles Royer, Mayor

August 20, 1986

The Honorable Douglas Jewett
City Attorney
City of Seattle

Dear Mr. Jewett:

The Mayor is proposing to the City Council that the enclosed legislation be adopted.

REQUESTING DEPARTMENT: Seattle-King County Department of Public Health

SUBJECT: Expansion of City support for AIDS in 1986.

Pursuant to the City Council's S.O.P. 100-014, the Executive Department is forwarding this request for legislation directly to your office for review and drafting.

After reviewing this request and drafting appropriate legislation:

(X) File the legislation with the City Clerk for formal introduction to the City Council as an Executive Request.

( ) Do not file with City Council, but return the proposed legislation to OMB for our review. Return to _____.

Sincerely,

Charles Royer
Mayor

by

Germaine A. Covington for

JIM RITCH
Acting Budget Director

JR/mm/fa

Enclosure

cc: Director, Health Department

COPY RECEIVED
AUG 27 1986
Douglas N. Jewett
CITY ATTORNEY

REC'D AUG 15 1986

City of Seattle
Charles Royer, Mayor

King County
Tim Hill, Executive

Seattle-King County Department of Public Health
Bud Nicola, M.D., M.H.S.A., *Director*

833094

August 14, 1986

Mr. Jim Ritch, Acting Director
Office of Management and Budget
300 Municipal Building
Seattle, WA 98104

ATTN: Marian Troyer-Merkel

Re: Supplemental Appropriation Ordinance

Dear Mr. Ritch:

Enclosed is a proposed ordinance appropriating $41,653 from the Seattle Emergency Fund to the Seattle-King County Department of Public Health for the Acquired Immune Deficiency Syndrome (AIDS) Project. This appropriation is needed for additional staff as identified in the enclosed response to SOP 100-014 and as fully explained in the Mayor's Task Force Report, "AIDS and AIDS-Related Conditions in Seattle." Position Description Questionnaires have been prepared for the new positions required and have been sent to the Seattle Personnel Department.

Please feel free to contact Patricia McInturff at 587-2752 if you have any further questions regarding this request. Thank you for your assistance.

Sincerely,

Bud Nicola

Bud Nicola, M.D., M.H.S.A.
Director of Public Health

BN:JN:nr
Enclosure

cc: Bruce Miyahara
Patricia McInturff
Joanne Nicolai
Mark Leaf
Jill NivenSmith
Steve Oien

7.0 PROCEDURES

Section 1: Title:

AIDS Project, Seattle-King County Department of Public Health

Section 2: Statement of Objectives

Attached please find a document entitled "AIDS and AIDS-Related Conditions in Seattle: a Status Report", developed by the Mayor's AIDS Task Force, March 10, 1986. The Mayor has reviewed and endorsed the report and has established its principles as City policy. The purposes of the report are to:

1. Assess the service needs of persons with AIDS and persons disabled with ARC.

2. To develop specific recommendations to meet those needs.

3. To advocate for the implementation of the recommendations.

This report designates the Seattle-King County Department of Public Health as the lead agency in carrying out the recommendations of the Task Force report. In order to accomplish this task, the Seattle-King County Department of Public Health is requesting additional personnel resources for 1986 (July-December). The report clearly lays out the recognized needs, the objectives, the population group to be served, and a clear statement that the requested actions will improve efficiency and service delivery and will result in cost savings.

Section 3: Fiscal Requirements

The Department is requesting $41,653 in 1986 beginning July 1, and approximately $34,000 in budget year 1987. These costs are exclusively personnel. The Department will absorb O&M costs, administrative costs, and equipment costs.

Section 4: Personnel Requirements

Below please find a list of the requested 1986 personnel additions.

1. Consultant to prepare AIDS-related grant proposals for private and public agencies. Approximately 400 hours at $25/hour. One time only; will end in mid-1986. — $ 10,000

2. Long-Term Care Expertise/Consultant — $ 20,000
   Will be for 6 months only. A full-time Long-Term Care Coordinator will be requested in the Robert Wood Johnson grant which, if funded, will begin January 1, 1987.

3. Clerical Assistant--Word processing ASI--0.5 FTE (6 mos.) $ 11,653
This position will be requested in a 1987 supplemental budget request.

The need for the first position will end in mid- to late-1986. The need for the second position will end at the conclusion of the Robert Wood Johnson grant (December 1990), if funded. The third position will address ongoing needs.

Section 5: Facilities and Equipment Requirement

The Project will take no special facilities or equipment requirements. The Regional Division of the Seattle-King County Department of Public Health has the space available for staff on the 12th floor of the Public Safety Building. The cost of facilities and equipment will be absorbed by the existing AIDS project.

Section 6: Evaluation Criteria and Reporting

The Project will be evaluated by the Mayor's Task Force measuring the outcome of the project against the recommendations and time tables set up in the attached report. The City Council will be given reviews at 6 and 12 months.

Section 7: Alternatives

The guidelines of the report specifically state that the recommendations should be carried out so that the services match the level of care with the level of need and that the model maximize the quality of life for patients and at the same time contains costs. It is clearly the intent of the report to establish a model for care that minimizes expensive hospital care and maximizes out-of-hospital care. Without a comprehensive continuum of care for persons with AIDS and disabling ARC, individuals will continue to be hospitalized at over $800/day because there are no housing alternatives. The alternative to the recommendations in the report would be to continue to waste precious health-care dollars in an inefficient and inhumane manner.

AIDS and AIDS Related Conditions in Seattle

A Status Report

1986

Produced By:

The Mayor's AIDS Task Force

March 10, 1986

AIDS AND AIDS RELATED CONDITIONS IN SEATTLE - A STATUS REPORT

I BACKGROUND OF THE TASK FORCE

Early in 1985 members of the Seattle community approached Mayor Royer with a proposal to spend Senior Housing Bond money on shelter for people with AIDS who were unable to afford adequate housing. In response to this request, the Mayor convened a Task Force to identify the housing needs of people with AIDS and develop recommendations for addressing these needs in a cost effective and humane manner.

The Mayor's Task Force on AIDS was set up to include representatives from various city, county and state departments and from other public, private and nonprofit community-based organizations that serve PWAs and D-ARCs. The members of the Task Force are:

Lori Anaya, the Morrison Hotel
Gail Baker, Department of Social & Health Services
Barry Bianchi, Northwest AIDS Foundation
Carol Dickinson, Department of Community Development
Rick Gilbert, Seattle Housing Authority
Stan Henry, AIDS Support Group
Bea Kelleigh, Northwest AIDS Foundation
Andy Kruzich, Puget Sound Health Systems Agency
Bruce Miyahara, Seattle-King County Department of Public Health
Pam Ryan, Harborview Medical Center
Robert Rohan, Northwest AIDS Foundation
Linda Taylor, Office for Women's Rights
Nancy Welton, Office for Women's Rights
Mark Whetzel, Seattle Lesbian/Gay Nurses Association
Robert Wood, M.D., Seattle-King County Department of Public Health

As the Mayor's AIDS Task Force began its work it became clear that the provision of adequate and appropriate housing is only one part of what needs to be an integrated approach, combining housing with health care and social services. Therefore, the Task Force amended its purpose to:

- assess the service needs of PWAs and D-ARCs;
- develop specific recommendations to meet these needs; and
- advocate with the appropriate public or private organizations for implementation of the Task Force recommendations.

This purpose is consistent with the draft City Human Services Policies of September 1985, which state that when the city is not able to provide needed services directly, it should be a catalyst in solving the problems confronting the community.

The Task Force quickly identified four basic needs:

- a centralized clearinghouse for coordinating housing, medical and support services;
- interim housing for PWAs in emergency situations;
- permanent housing for indigent PWAs; and
- long term housing combined with health care and support services on site.

The Task Force has partially addressed these issues already with the assistance of City departments and the Seattle Housing Authority. The City's 1986 budget included funds to hire a Medical Resources Coordinator through the Northwest AIDS Foundation. The need for interim housing has been met through the efforts of the Seattle Housing Authority, the City, and the Northwest AIDS Foundation to provide three rooms at the Morrison. The third goal to provide permanent housing for indigent, disabled PWAs has been partially addressed by the Seattle Housing Authority through the provision of apartments located in various facilities to eligible PWAs. The fourth goal, long term housing with strong health service support, has not yet been accomplished.

This report was prepared to provide the Mayor with a current summary of the nature and range of services still needed by people with AIDS and recommendations for meeting these remaining needs.

II FINDINGS OF THE TASK FORCE

A. Definition of AIDS and AIDS Related Conditions

Acquired Immune Deficiency Syndrome (AIDS) is a disease believed to be caused by a virus that damages the body's immune system, leaving it vulnerable to attack from certain infections and cancers that are not usually a threat. The AIDS virus, called HTLV-III, is believed to be transmitted only by some types of intimate sexual contact or direct contact with contaminated blood.

To date, almost all PWAs have died within 35-135 weeks after diagnosis. People do not die from AIDS itself; rather, the cause of death is usually either one or more opportunistic infections, particularly pneumocystis pneumonia or Kaposi's sarcoma, an otherwise rare form of cancer found in PWAs. These and other infections cause such symptoms as fever, difficulty in breathing, prolonged coughing, severe weight loss, persistent diarrhea, swollen lymph nodes, skin lesions, and yeast infections. Local health care professionals are also reporting increased numbers of persons with AIDS who are experiencing some degree of dementia and related psychiatric disorders.

The federal Center for Disease Control (CDC) limits a diagnosis of "frank" or overt AIDS to those with one of these major opportunistic infections or cancers. Many more people, however, experience symptoms similar to those listed above, which are believed to be caused by exposure to HTLV-III but who are not considered to have "frank" AIDS. The Seattle-King County Department of Public Health (SKCDPH) believes that ten times as many people have some form of AIDS-related condition (ARC) as the number diagnosed as having "frank" AIDS. Most of these people are not disabled and pursue normal daily lives, although ten to twenty percent of people with ARC will go on to develop "frank" AIDS.

In addition, two to five percent of people with AIDS-related conditions suffer and die from symptoms as debilitating as AIDS itself. The actual number of cases of disabling (and terminal) ARCs are about equal to the number of those who will suffer and die from "frank" AIDS. Because disabling AIDS related conditions (D-ARC) are so debilitating, because the prognosis for D-ARCs are similar to those of PWAs, the Task Force has investigated the needs of people with D-ARCs as well as the needs of PWAs.

B. The Rate of Increase in the Numbers of Cases in Seattle/King County

The Seattle-King County Department of Public Health (SKCDPH) estimates that approximately 160 people in King County have been diagnosed as having AIDS as defined by CDC. About half of these persons have died. The rest will probably die within the next two years during which time an estimated 300 new cases will be reported. Most research confirms that the number of cases reported to the CDC will continue to double every 9-12 months for at least five years. If these estimates prove correct, by 1988 there will have been a cumulative total of 1,300 cases of overt AIDS reported in the Seattle-King County area, with an equal number of D-ARC. In addition, Dr. Hunter Hansfield of the SKCDPH estimates that 15-20% of the people with AIDS who are being treated in King County were diagnosed outside the County and are not included in the statistics above. These people came to the Seattle-King County area to receive treatment that is not available in other places around the State.

The following chart summarizes the progression of the AIDS health crisis in King County.

KING COUNTY PERSONS WITH AIDS (PWAs) AND DISABLING AIDS-RELATED CONDITIONS (D-ARC)

Prepared January, 1986 by the
Mayor's AIDS Task Force

	1982	1983	1984	1985	1986	1987	1988	1989
PWAs Diagnosed[1]								
This Year	1	8	52	100	200	400	500	600
Cumulative	1	9	61	151	360	760	1300	1900
D-ARCs - Cumulative[2]				80	180	380	650	950
Subtotal				241	540	1140	1950	2850
Adjustment[3]				24	54	114	195	285
Subtotal				265	594	1254	2145	3135
Surviving Patients[4]				132	297	627	1072	1567

[1]The Seattle-King County Department of Public Health (SKCDPH) estimates that the number of new cases of AIDS will continue to double every 12 months through 1987 and increase at a slower rate thereafter as health education and other disease prevention programs begin to have an effect.

[2]SKCDPH estimates that ten times as many people as have AIDS have some form of AIDS related condition and that two to five percent of them are affected to a degree to be considered disabled (D-ARCs).

[3]Dr. Hunter Hansfield, Sexually-transmitted Diseases Officer for SKCDPH, estimates that 15-20 percent of local providers' patients were diagnosed elsewhere and came to King County for treatment and that 7-10 percent of those who are diagnosed in King County obtain treatment elsewhere. Thus, the number of those requiring care in King County is approximately 10 percent more than the number of cases diagnosed.

[4]Approximately 50-60 percent of the cumulative number of those diagnosed with AIDS and D-ARC are alive at the present time.

C. The Community's Response

The Seattle community's response to the AIDS epidemic has been aggressive, quick and effective in meeting many of the current needs of people with AIDS or D-ARC. Much of the credit for this success goes to the gay community and the Health Department for working in cooperation. Through this partnership, Seattle and King County have won substantial funding support form the US Public Health Service for surveillance and health education activities designed to halt the spread of the disease. In addition to the work of this Task Force and the efforts of the Seattle-King County Department of Public Health, many volunteer organizations have emerged to face the demands of this health crisis by providing counseling, chore services and other support to PWAs. Without the outstanding efforts of organizations such as Shanti Seattle, the Chicken Soup Brigade, the Seattle AIDS Support Group, and Seattle Counseling Service, the service need in Seattle would be far greater than it is. The Northwest AIDS Foundation and other groups are constantly fundraising to support service providers. (A summary of the services currently available to people with AIDS in the Seattle area is presented on pages 18-19.)

While the Task Force commends the Seattle community for its effective response, it recognizes that there are limits on the extent to which volunteer organizations can meet the increasing needs of PWAs and D-ARCs as their numbers continue to rise. The volunteer organizations that do exist are in need of funds to pay for volunteer coordination and for basic operating expenses (i.e., Shanti Seattle provides emotional support and advocacy with 35 volunteers and no paid staff). Further, there is a need to provide the existing services in more adequate facilities. At present, the Health Department's AIDS programs are scattered in three crowded and inefficient settings.

D. Special Factors Affecting Service Delivery

Numerous economic, social, health care and legal factors must be considered in responding to those suffering from any serious or terminal disease. PWAs and D-ARCs are also subject to some factors which are unique. The Task Force has identified the following factors which add complexity to the service needs of PWAs and D-ARCs:

- AIDS victims are young. The disease strikes apparently healthy people in the prime of life. AIDS is the leading cause of death for males between 21-40 years old in New York City. Fifty percent of PWAs are in their 30's.

- The course of the disease is erratic and unpredictable. Some PWAs and D-ARCs recover form bouts of serious illness and return to some degree of normal life several times during the course of the disease. While they are "well" they may be able to live independently or need only chore and meal services, but the next bout of serious illness may require attendant care. Further, the changes are dramatic, erratic and sudden. PWAs and D-ARCs may need very different levels of care from one day to the next.

- Many PWAs and D-ARCs suffer from dementia. HTLV-III is believed to affect brain tissue, and health care providers report that increasing numbers of PWAs and D-ARCs are experiencing dementia, a disease similar to Alzheimer's Disease, which impairs a person's mental capacity. Many of these PWAs and D-ARCs with impaired mental functioning become completely unable to care for themselves and need 24-hour attendant care.

- Most PWAs and D-ARCs in King County are gay men. Ninety percent of the cases of AIDS reported in the Seattle-King County area involve homosexual or bisexual men. In a society that still condemns homosexuality, a gay person with AIDS or D-ARC experiences the double stigma of having AIDS and of being found out to be homosexual. The culture has historically responded with great fear and discrimination against homosexuals even apart from AIDS. Gay men are often forced to deal with individual and institutional homophobic responses at a time when they are most vulnerable. Many PWAs (or even those perceived to be at risk for getting AIDS) have been fired from jobs, evicted from homes and/or refused treatment. The Task Force believes that PWAs and D-ARCs have a right to expect health care, housing and other services in a non-discriminatory and humane fashion. Gay men also need services that are sensitive to the cultural norms and issues within the gay community in order to be effective in working with this population.

- PWAs and D-ARCs experience discrimination due to unwarranted fears about their illness. Despite ongoing efforts to educate the public about the causes of AIDS and how it is and is not transmitted, PWAs and D-ARCs often find themselves treated as outcasts and pariahs. Because they have AIDS, they may suffer painful rejection by families, friends, loved ones, professional colleagues and service providers at a time when they are most in need of support. Because AIDS is usually transmitted through some forms of intimate sexual contact, PWAs and D-ARCs are sometimes blamed for contracting the disease.

- According to the reports of social workers, no nursing home facilities in the State of Washington are willing to admit PWAs or D-ARCs. The Task Force believes nursing home facilities may be unwilling to admit PWAs and D-ARCs not only due to homophobia and perceived health risks to other patients, but also because PWAs and D-ARCs have special health care needs and lack funds to pay for care. In addition, most PWAs and D-ARCs are much younger than traditional nursing care facility patients.

- Some high risk groups are hard to reach and require special outreach efforts. Other high risk populations include intravenous drug users and people with multiple or unknown sex partners. These people have been viewed in ways that create barriers to effective service or educational efforts.

  Very little of the educational resources developed to date have targeted IV drug users, prostitutes, or the "customers" of prostitutes.

- One third of people with AIDS or D-ARC have practically no social nor financial resources. One of the most important factors in determining a course of treatment is the presence or absence of a family member, loved one or friend who is able and willing to provide care, support and some advocacy services for the patient. A recent Pacific Medical Center study found that about one-third of the PWAs and D-ARCs who used the Center did not have a primary caregiver in the home.

- AIDS is financially devastating to some PWAs and D-ARCs. Some PWAs and D-ARCs have financial resources sufficient to purchase needed health care services or are able to continue paying for medical insurance which covers some of the costs. Most patients who initially have some financial resources exhaust them before the illness is over. Many who did not have insurance or who are unable to continue paying the premiums must rely on public assistance programs.

  Since the federal government considers a diagnosis of AIDS as a presumptive disability, low income PWAs are immediately eligible for SSI benefits upon diagnosis. Persons with D-ARC are not presumed to be disabled and must go through a lengthy process to obtain federal benefits. While PWAs and D-ARCs wait for SSI benefits to begin, state GA-U program funds can be available to them. PWAs and D-ARCs receive between $314 (GA-U) and $364 (SSI) a month, which must support them. For those unable or too ill to obtain public housing, most of these funds go toward rent with little remaining.

E. Options for Delivering Services to PWAs

The rate of increase in numbers of cases of AIDS in Seattle/ King County is similar to the rate of increase in New York and San Francisco 6 months ago. This has allowed the Task Force some lead time in which to analyze the various strategies used by other cities in responding to this health crisis. While some differences exist between the various localities (i.e., a higher percentage of IV drug users have been affected in New York than in Seattle), the rate of increase and basic issues remain similar to the experience of the Seattle area.

The primary lesson learned from studying other cities' responses to the AIDS epidemic is that it is crucial to provide a range of out-patient services that prevent unnecessary and extremely expensive hospital care. As the October 1985 issue of Atlantic Magazine pointed out, the national average cost of hospitalization for a person with AIDS is $140,000, while in San Francisco it is $25,000 - $32,000. While there are several factors involved, a major reason for higher costs in such cities as New York is the absence of an adequate range of services: a continuum of care. Because New York has no nursing home care and no case management services for PWAs, the city is forced to leave PWAs and D-ARCs in hospitals, the most expensive care facility. San Francisco, in contract, has housing, food service programs, free legal advice, hospice services, emotional support programs, chore services, long term subsidized housing, etc. Because San Francisco has all these services in place, people with AIDS and D-ARC spend far less time in hospitals. The average hospital length of stay for PWAs in New York is 50 days, compared with a national average of 31 days and San Francisco's 12-day lengh of stay.

The Center for Disease Control (CDC), Atlanta, estimates that the national cost per day for an AIDS patient is $830 (Hospitals Magazine, 1/5/86 p. 54). Since the highest estimated cost for a long term nursing care facility is $300, the financial urgency of keeping people with AIDS out of unnecessarily long hospital stays is clear. Seattle social workers have already reported several cases where Seattle patients have been forced to stay 3-4 months in a hospital when they could have been placed in a far less expensive facility and still received appropriate care. As the experience of San Francisco demonstrates, it is much more cost effective to provide a continuum of care.

F. Guidelines for the Development of a Continuum of Care

The Task Force believes that the community should work vigorously to establish a continuum of care because:

- It will contain costs.

  As described above, a continuum of care approach has proven to be an effective method of reducing costs otherwise born by hospitals, the government and the patient.

- It matches the level of need with an appropriate level of care.

  A PWA or D-ARC should receive the amount of care that is needed, no more nor less. It does not make sense to force someone to use hospital facilities when he or she could stay in a facility where some supervision and meals were provided. Likewise, a person should not be forced to live in an independent living facility when he or she needs 24-hour nursing care.

- It offers the best possible quality of life for a person with AIDS or D-ARC.

  When an appropriate range of services is available, it allows the patient to make genuine choices about his or her care. Many people with terminal illness wish to remain in their own home. To be forced to stay in a hospital may be seriously detrimental to a patient capable of pursuing a semi-independent lifestyle. Likewise, a person who is in need of congregate or nursing care but who must remain alone in private housing is at risk of being fearful and unsafe. Allowing the patient to be involved in the treatment and care plan by offering choices makes an important difference in his or her quality of life. Due to ongoing fear and discrimination, safeguards protecting confidentiality are also crucial in maintaining a person's quality of life.

G. Components of a Continuum of Care

The components of a continuum of care include, but are not limited to: case management (both medical and social services); basic support services (services that can be used as "auxiliary" services while a person lives in his or her own home); and housing and residential care (where housing and/or health care services are available to varying degrees). (See the chart on pages 18-19 for a detailed listing of the current status of each of these services in the Seattle area.)

1. Case Management

   Two types of case management systems are needed: medical case management and social services case management.

Caregivers and patient advocates report that PWAs and D-ARCs often enter the social and medical service delivery system in crisis. PWAs may show up in hospital emergency rooms without identified treatment and care plans and hospital social workers have few choices when making discharge arrangements. These and other problems could be effectively addressed through medical and social services case management systems.

a. In a medical case management system, medical services are coordinated to provide consistent care by one physician or a small team of providers. The case manager would coordinate in-patient and out-patient medical services and provide 24-hour medical service availability to the patient. This approach would be in contrast to a medical approach used in several area hospitals where care is primarily delivered by housestaff in training and where the patient has no constant medical provider whom s/he can come to know and trust. In San Francisco, care is organized so that most PWAs have a primary provider. This model not only provides potential cost savings, but the community believes it to be more humane. For terminally ill patients, continuity of care by one physician or a small team of providers is especially crucial.

   At present, a disproportionate number of PWAs and D-ARCs are being cared for by a small percentage of the County's medical community; approximately 13 doctors have treated most of the cases of AIDS and D-ARC. Many doctors may not want to care for AIDS patients due to their fears about AIDS, the fears of their other patients, and the difficulty of treating uncompensated care cases (cases where neither insurance nor Medicaid covers the full expense).

   Nationally, the care of PWAs and D-ARCs has also fallen on a disproportionately small number of hospitals, particularly on public hospitals. There is evidence that this same pattern is occurring in Seattle. While it may be appropriate to have a few hospitals which specialize in AIDS, the result is a disproportionate financial drain on these hospitals due to the high level of uncompensated care in AIDS related cases.

b. In a social services case management system, the case manager coordinates all non-medical services such as housing, meal delivery, aid in obtaining financial

assistance, counseling, etc. This type of case management system includes comprehensive client assessment, service plan development, and follow-up, designed to achieve the maximum level of health and independence for the client. The case manager maintains contact with the client to enable prompt response to changes in his or her condition.

Social services case management would be designed to resolve the following kinds of problems that have been reported in Seattle: (1) fragmentation of services and programs, (2) service gaps, (3) duplication of services, (4) programs working at cross purposes, (5) lack of comprehensiveness in service arrangement and delivery and (6) inability of the system to deal with the special needs of PWAs and D-ARCs, particularly the rapid and dramatic changes in health experienced by these clients. Case management resolves these difficulties by helping PWAs and D-ARCs obtain needed services throughout the course of their disease.

2. Support Services

In addition to medical and social service case management, certain support services need to be provided as elements of a continuum of care:

a. Information and Referral provides comprehensive information and referral services and short-term assistance via telephone to members or groups at high risk for AIDS, PWAs and those with AIDS related conditions, health and human service professionals, and the general public. Functions include information-giving, service referral, client advocacy, and screening to determine whether the caller should be referred for case management.

b. Chore Services provides household tasks such as shopping, laundry, cleaning, and personal care including cooking, bathing, and dressing in a participant's home. Chore services can be provided by a contracted community agency, an individual, or a contracted volunteer organization. Home delivered meals are not provided to people under 65 years of age through existing programs. PWAs and D-ARCs need to have home cooked meals made available through chore service programs, through dropping the age limitation of other programs (Meals on Wheels), or through additional funding of community volunteer organizations who are attempting to provide meals (Chicken Soup Brigade).

c. Counseling Services are essential to assisting those who are affected by AIDS. The following populations each need special services:

(1) PWAs and D-ARCs
(2) Families, friends of PWAs or D-ARCs
(3) Substance abuse counseling for PWAs and D-ARCs
(4) At-risk populations
(5) Hospice out-patient counseling
(6) Bereavement counseling for families, lovers
(7) Care givers counseling for those who provide services

d. COPES (Community Option Program Entry System) provides an array of services under a Medicaid waiver to persons who would otherwise be eligible for care in an intermediate care facility or skilled nursing facility. The program involves a complex application process which makes it unuseful for people who are seriously ill and dying unless they have an advocate working through the process on their behalf. The funding for the COPES program itself is unstable.

e. COPES Hospital Alternative Projects (COHAPS - Private Duty Nursing) provides intensive home care services in the recipient's home to those individuals who remain hospitalized because no traditional long-term care setting (ICF or SNF) can be located to meet their special needs. This program is also difficult to apply for, making it ineffective in dealing with people who are seriously ill and drying from AIDS.

f. The Hospice Concept employs an interdisciplinary team approach of skilled nursing care under the direction of an autonomous hospice administration. This care is sometimes provided in a facility 24 hours a day, seven days a week. When used as a support service, the care is provided in the patient's home or on an out-patient basis and emphasizes counseling related to death and dying.

3. Housing and Residential Care

When a person is too ill to remain in his or her own home, another range of services is needed, providing housing and medical care in a special setting.

a. Interim Housing and Permanent Housing - Housing for PWAs needing emergency shelter can now be obtained through the Seattle Housing Authority.

b. Low cost, permanent housing for displaced PWAs and D-ARCs has been made available by the Seattle Housing Authority, which has approximately 20 units being used by PWAs at present.

c. Adult Family Homes (AFH) - Adult family homes are private residences boarding up to four adults in a family-like environment with personal and social care and supervision if necessary. If operated by a licensed nurse (RN or LPN), it may offer health-related services. Barriers for entry are far less for this housing option than for others, including congregate care facilities. AFH clients may receive hands-on help with activities of daily living and health-related services under COPES.

One problem with this type of facility is that if a client is gone from the home 2 weeks (for hospitalization), DSHS withholds funds from the facility, forcing the facility to open its bed to someone else.

Another major barrier to the development of these facilities is provider burnout. The emotional needs of PWAs or D-ARCs are acute and intense. These needs place a high degree of pressure on the care provider.

There are no licensed Adult Family Homes designed for PWAs and D-ARCs in the Seattle area at this time.

d. Boarding Home/Congregate Care Facilities (CCF) - Boarding homes/congregate care facilities are licensed facilities (four beds or more) providing room and board. Legally they cannot provide nursing care, but can be a site for short term nursing care from outside. These sites are appropriate for those who don't need access to constant medical attention but who need meal preparation and other assistance.

Congregate care facilities are licensed boarding homes which hold contracts with DSHS to provide room, board, necessary 24 hour supervision, assistance with daily living skills and medications, and some other social services (includes "regular CCFs," CCF/Mental Health, CCF/Alcohol and Substance Abuse, and Group Homes (DDD).

CCF clients may receive hands-on help with activities of daily living and health-related services under COPES if they are qualified.

e. Long Term Care Facility - Intermediate care and skilled nursing facilities ordinarily provide room, board, nursing services, 24 hour supervision/help with personal care, and other social-rehabilitation services in a residential facility. They provide a stable living environment, with built-in care which provides a more home-like and far less expensive alternative to long-term, unnecessary hospital care.

"Intermediate care" includes some nursing services in addition to personal care for patients with stable physiological and psychological functioning who also need ongoing individually planned programs under daily RN supervision.

"Skilled nursing care" includes round-the-clock nursing services in addition to personal care for patients needing frequent or continuous observation and intervention.

However, according to social workers neither intermediate care nor skilled nursing facilities will accept people with AIDS or D-ARC in the State of Washington. These programs are primarily geared for the elderly, not for people in the prime of life suffering from a terminal illness. People with AIDS and D-ARC require special services not provided by nursing homes. In addition, other residential staff may have unwarranted fears about AIDS.

Regardless of the reasons, no nursing home care is available to people with AIDS or D-ARC. Therefore, a significant gap in the continuum of care exists between acute care in hospitals and semi-independent living.

The average cost of care per day in a hospital setting is $830 (not including physician fees). Nursing home care ranges in cost from $35 - $300) per day; hospice care facilities average $120 per day.

Conservatively, each day that a patient spends in one of these alternative settings rather than remaining in a hospital represents a savings of approximately $400 per day per patient. If San Francisco's success can be matched in Seattle, this savings would represent approximately $9,500 per patient.

In addition, an intermediate or skilled nursing facility can provide greater flexibility and choice to the patients. They are not forced to go to an acute care facility and are able to live in a more home-like atmosphere with necessary services available when needed. A long term care facility that would combine congregate care (room and board) with intermediate care, skilled nursing care, and hospice care available as needed (CCF, ICF, SNF and Hospice) would be a critical addition to the service system in Seattle. This hybrid facility would be designed to meet the particular needs of PWAs and D-ARCs. DSHS, the major public provider of funds for care, would be billed various rates depending on what services the patient used on a day-to-day basis or on a capitated basis. People with financial resources would be able to pay for their own service.

This long term care facility could be based on a model of a retirement home which provides apartment living with meals (if desired) and an attached nursing care facility which provides health care services as needed. (The Hearthstone Retirement Home at Greenlake is one example of this type of facility.)

In a long term care facility, the following services could be provided:

- temporary housing for people being released from an acute care facility who are not yet set up or ready for more independent living;

- long-term housing for those who are no longer able to live more independently (people who are feeling well would be able to use the facility for room and board until other services were needed. They would be charged day-by-day on the basis of services used);

- psychological support for dealing with the trauma of diagnosis, the progression of the disease, and death;

- medical and nursing services available on a 24-hour, seven-day a week basis (LPN on duty at all times, RN staffing, nursing administration on call at all times);

- physician/patient direct services;

- provision for care by an interdisciplinary team (physician, RN, SW, etc.)
- provide a clearinghouse for community-based volunteer support services. Perhaps provide space for these organizations in the facility and use volunteers as an integral part of the care team;
- supportive hygiene care (assisting the patient in hygienic care as needed);
- physical therapy (exercise, movement);
- nutritional care (special diets as needed);
- chemotherapy;
- legal assistance (wills, living wills, power of attorney, etc.);
- recreation;
- education;
- hospice services.

STATUS OF SERVICE CONTINUUM FOR PEOPLE WITH AIDS AND D-ARC IN SEATTLE/KING COUNTY

COMPONENTS/SERVICES	SERVICE CURRENTLY AVAILABLE/CASE #	CRITERIA FOR ELIGIBILITY	COST TO CLIENT	FUNDING SOURCE	RECOMMENDATION
Case Managers	A small portion of 2 positions: 1 located at Harborview 1 located at NW AIDS Foundation	Harborview patients only Any AIDS or ARC patient	No No	Harborview NW AIDS Found.	See Recom. # 6 A
Support Services (services that can be provided while a client continues to reside in his or her own home. May also be provided at certain residential facilities).					
a. Information & Referral	AIDS Information Line AIDS Assessment Clinic Northwest AIDS Foundation AIDS Support Groups	None (Gen'l Public) None None Varied	No No No	Health Dept. Health Dept. Donations NW AIDS Found.	
b. Chore Services	DSHS (may provide limited in-home cooking)	Low income and disabled	No	State	
Home delivered meals	Chicken Soup Brigade (provides meals on limited basis)	None	No	Donations	See Recom. # 6 D
c. Counseling:	Seattle AIDS Support Groups	Varied	No	NW AIDS Found.	
(1) For PWAs and D-ARCs	Seattle AIDS Support Groups Seattle Counseling Service (SCS) SHANTI/Seattle (emotional support) AIDS Mental Health Network (private) Social Workers NW (private)	Varied None None None	No Sliding No Sliding Sliding	NW AIDS Found. Varied Donations	See Recom. # 6 D
(2) For families, friends	Shoulders SHANTI/Seattle	None None	No No		
(3) Substance abuse	Chemical Dependency Program (2 month waiting list at times) Gay AA/NA	None None	Sliding No	Varied Donations	
(4) For at-risk populations	Gay Men's Health Group Worried Well Group	Gay or bi-sexual man No	No No	SCS Donations	
(5) Hospice Counseling *Includes home health care	SHANTI/Seattle (emotional support) *Hospice of Seattle (home healthcare) *Visiting Nurse Services Transition Team *Community Home Health Care	No. Self Referral Requires skilled nursing care	No 3rd party	3rd party Medicaid/Others	See Recom. # 6 D
(6) Bereavement Counseling	None				

COMPONENTS/SERVICES	SERVICE CURRENTLY AVAILABLE/CASE #	CRITERIA FOR ELIGIBILITY	COST TO CLIENT	FUNDING SOURCE	RECOMMENDATION
(7) Caregivers Counseling	None				See Recom. # 6 D
d. Legal Assistance	Informal Network	No	Negotiable		
e. Dental Assistance	Dental Clinic, Harborview Informal Network	No AIDS or D-ARC	Yes Varies	Harborview Needs to be formalized	
f. Financial Assistance	DSHS (Medicaid, Food Stamps, GA-U) SSI, SSDI, Medicaid Northwest AIDS Foundation (loans)	Very low income, disabled	No	State Federal Gov't Donations	
g. COPES	Funding unstable Difficult to access	Medicaid eligible		Fed. & State	
h. COHAP (includes private duty nursing)	Difficult to access	Medicaid eligible		Fed. & State	
i. Miscellaneous	Massage AIDS Spiritual Assistance	AIDS & permission from Dr. None	No No	Donations Donations	
Housing & Residential Care					
a. Interim and permanent subsidized housing for independeng living	The Morrison Seattle Housing Authority (3 interim rooms, up to 15 reg. rooms)	Low income	Low fee	City N.W. AIDS Found. SHA	See Recom. # 6 C
b. Adult Family Homes	No licensed homes, 2 pending				See Recom. # 6 C
c. Boarding Homes/ Congregate Care	None				See Recom. # 6B & 6C
d. Nursing Home Care	None				See Recom. # 6B & 6C
e. Hospital	Harborview Swedish Pacific Medical Center Group Health Virginia Mason Providence		Health Ins., Medicaid		

III RECOMMENDATIONS OF THE TASK FORCE

After investigating the housing and health care needs facing PWAs and D-ARCs, the Task Force makes the following recommendations to the Mayor:

1. In light of the pre-eminence of the health issues involved in the AIDS crisis, the Task Force recommends that the Mayor appoint Dr. Bud Nicola, Director of the Seattle-King County Department of Public Health, to take the lead in seeing that the following recommendations are met.

2. In recognition of the importance of support from members of the high risk community in implementing these recommendations and the role of the Office for Women's Rights in advocating for this community, the Task Froce recommends that the Mayor designate Linda Taylor, Director of the Office for Women's Rights, to assist Dr. Nicola in implementing these recommendations.

3. The Task Force recommends that the Mayor's designees continue to work in close collaboration with community based organizations which already have a close, realistic knowledge of the specific service needs of people with AIDS and D-ARC. The Task Force suggests that the Health Department's existing advisory committee be broadened in its membership to include service providers and used to provide guidance in the implementation of these recommendations.

4. The Task Force believes that any and all services developed in the Seattle-King County area to meet the needs of PWAs and D-ARCs should adhere carefully to the following guidelines:

   - Match the level of care with the level of need.
   - Maximize the quality of life for the patient.
   - Contain Costs.

5. The Task Force recommends tha Mayor's designees attempt to secure a policy decision from DSHS and other providers to deliver services to people with D-ARC as well as to people with AIDS on an equitable basis depending on the severity of their illness.

6. To provide the most cost effective and humane treatment possible, the Task Force recommends that the Mayor's designees work actively to develop a full continuum of care for PWAs and D-ARCs. The priority services that still need to be developed are:

A. Case Management

1. Medical Case Management: The Mayor's designees should advocate for the development and maintenance of a medical case management system providing continuity of care through one physician or a small team of providers. This approach has proven to be the most cost effective, efficient and humane in coordinating the treatment of PWAs and D-ARCs in other cities.

2. Social Service Case Management: The Mayor's designees should work to get DSHS to contract with a community based service provider to provide social service case managers in 1986. This is an urgent and immediate need. Each case manager should have a maximum caseload of 25, due to the extraordinary demands placed on these workers in dealing with this particular disease.

   This concept could take the form of a demonstration project in order to show the cost savings and improved service delivery derived from case management. The social service case managers should report after six months to the Director of DSHS, recommending any changes needed in administrative codes and procedures to improve services to PWAs and D-ARCs.

B. Long Term Care Facility

The Mayor's designees should work to develop a Long Term Care Facility where a range of housing and residential care needs of PWAs and D-ARCs could be met in one building. This program would fill several critical gaps in the continuum of care and provide alternatives to unnecessarily long and expensive hospital stays, saving thousands of dollars per patient and providing a more humane living environment. (This program could be funded through a joint effort of DSHS and local hospitals. The initial funds for the building of this facility could potentially come from a bond from the Washington Health Care Facility Athority.)

The range of services would be designed to meet the specific needs of PWAs and D-ARCs, whose medical condition can vary tremendously from day to day. The facility would be a combination of the following:

- Congregate Care Facility (CCF) - room and board for those who are able to live semi-independently.

- Intermediate Care Facility (ICF) - 24 hour skilled nursing care for those who need more than ICF but do not require hospitalization.

- Hospice Care - in-patient counseling and medical assistance in dealing with the dying process (with an emphasis on personal attention and pain relief, rather than on treatment or a "cure").

Each of the above services, and others, would be provided on an "as needed" basis. Billing would be based on the services used each day by the individual patient or on a capitated system. The facility would be available to private pay patients as well as those needing public support.

- While the building of the Long Term Care Facility is in progress, the Task Force recommends that DSHS be asked to license an unused wing or wings of a local hospital for temporary use as a nursing care facility. This would provide a service that is urgently needed now, use space that is already available, and still contain costs below the standard hospital fees.

- Since PWAs and D-ARCs need skilled nursing care immediately, SKCDPH should strongly advocate for the acceptance of PWAs and D-ARCs in existing nursing homes where patients can receive 24-hour health care. This program should remain an option even after the long term care facility is established to maintain patients' freedom to choose their care.

C. Interim and Permanent Housing

The Mayor and SKCDPH should continue to work with the Seattle Housing Authority, the Northwest AIDS Foundation and DSHS to ensure that adequate interim and permanent low income housing is provided to people with AIDS and D-ARC.

Additional adult family homes, congregate care facilities (room and board), and additional independent living facilities will be needed as the number of cases of AIDS continues to rise. These programs should be designed to make maximum use of "support services" listed on pages 12-13.

D. Support Services (services that enhance the patient's ability to stay in his or her own home)

While many support services have already been developed, there are several key services that still need to be established or strengthened. The Mayor's designees should work to develop the following services as a high priority:

- Home delivered or home cooked meals available on a daily basis. (Meals on Wheels serves only people over 65 years of age and the Chicken Soup Brigade is not funded for providing a comprehensive meal program.)

- Counseling - Bereavement counseling for people who have lost loved ones and caregiver counseling to prevent burnout.

- Funding to volunteer agencies to provide staff coordination. At this time, several organizations are overburdened by having no paid staff to assist with volunteer coordination.

- Increased availability of home care nursing.

7. The Task Force commends the SKCDPH and the Northwest AIDS Foundation and others involved in education efforts aimed at preventing the spread of AIDS for their excellent efforts to date and recommends that the Mayor's designees work to secure funds to continue to develop these programs.

8. The Task Force recognizes that the service needs of people with AIDS and AIDS related conditions will continue to evolve and that ongoing study and assessment must continue. The Task Force recommends further study in the following areas:

- Tracking system and economic analysis - The purpose of the Task Force was not to do a detailed economic analysis, nor is such an analysis feasible given the lack of an adequate tracking system based on case management. Therefore, the Task Force recommends that DSHS develop a tracking system for services used, costs incurred, sources of funding for services, etc., for use in future planning.

- The Task Force recommends the SKCDPH assess the need for in-patient substance abuse treatment for people with AIDS and D-ARC. These people may not have access to existing drug and alcohol treatment programs and will need special treatment services.

- We also recommend that the Mayor's designees and DSHS monitor the disproportionate impact of uncompensated care of PWAs and D-ARCs on a few hospitals and advocate for the development of a shared risk plan in which hospitals pool resources in order to share the risk of uncompensated care more equitably.

9. Finally, the Task Froce recommends that the Mayor's designees provide comprehensive reports on the progress of the community's response to AIDS twice annually to the Mayor and City Council until the disease has been brought under control.

Case Studies

Patient number one is a 35 year old male with AIDS related encephalopathy and dementia. Neuro-psychological testing showed memory and problem solving deficits and the need for assistance with normal living skills. This patient was found sleeping on a downtown sidewalk, unable to even take advantage of mission services. He was admitted to an area hospital. Upon discharge he was placed into Seattle Housing Authority emergency housing for AIDS patients and referrals were made for chore services, visiting nurse services and to community volunteers. A referral was made to the jail diversion program when patient was incarcerated for the third time for shoplifting small amounts of food when he was hungry. This combination of services was not sufficient to guarantee two meals a day, adequate supervision of unsafe smoking behaviors or needed help with daily living tasks. He was re-admitted to a hospital isolation room on October 7th and a COPES referral was made. When no 24 hour attendant could be found to move in with the patient, a nursing home referral was made. The patient was rated by DSHS for placement in an intermediate/skilled nursing facility. No such facility could be found that would accept this AIDS patient. The patient does not require the acute care services of a hospital, yet remains hospitalized in the absence of other options. At an average daily cost to Medicaid of $360 per day (not including physicians' fees) this patient's bill is now more than $25,000 for the first 70 days he has been hospitalized.

Patient number two is a 33-year-old male first admitted to the hospital in October with a new diagnosis of AIDS but with a three-month history of increased confusion, forgetfulness and impaired mental functioning. His father is terminally ill and being cared for by his mother in another state. His only sibling lives with his family in a small house in rural King County and is unable to house or care for this patient. Upon his release from the hospital, the patient moved in with an acquaintance in a one-bedroom apartment and received volunteer support for up to 40 hours a week while the friend was at work. This patient is experiencing increasing weakness and incontinence with episodes of falling, depression and inappropriate behavior. The acquaintance is no longer able to provide the level of care and supervision required by this patient, even with the help of volunteers. This patient will soon be hospitalized indefinitely for lack of viable home care options.

Patient number three was first diagnosed with AI in December of 1984. Subsequent psychometric testing indicated a progressive Alzheimer's-like dementia, depression and inability to complete simple daily living tasks. This patient's family lives in rural King County, and with the assistance of visiting nurse services was able to keep their son at home until October 25, 1985. At that time this patient was almost totally bedbound with episodes of incontinence. His mother, herself in poor health, was no longer able to care for her son in the family home. At the time of his hospital admission he had no acute care needs and could have been placed in a nursing home facility if such a facility willing to accept AIDS patients could have been found. This patient has now been in terminal stage having spent the last two months of his life in a hospital.

Patient number four is a 35-year-old male with AIDS currently living with his elderly grandparents outside of King County. His mother, who lives in Seattle, began contacting AIDS support services in June desperate for a place to take her son where she could live with him until he died. He was no longer able to walk or care for himself. Her family refused to allow him in their homes or to help her financially in her attempt to secure an apartment or attendants. She was finally forced to choose between son and her husband and left her husband to be with her son during the last few months of his life.

AN ORDINANCE relating to the Seattle-King County Department of Public Health; increasing an expenditure allowance in the 1986 Budget of the Department for the Acquired Immune Deficiency Syndrome (AIDS) Project; making an appropriation from the Emergency Fund, and declaring the emergency therefor.

BE IT ORDAINED BY THE CITY OF SEATTLE AS FOLLOWS:

Section 1. As requested by the Mayor in the materials attached hereto entitled 'AIDS and AIDS Related Conditions in Seattle: A Status Report' dated March 10, 1986, the expenditure allowance for Object of Expenditure 550XX - Governmental Services in the 1986 Budget of the Seattle-King County Department of Public Health, Program Category "Support to King County" (Code 3100) is hereby increased by the sum of Forty-One Thousand Six Hundred Fifty-Three Dollars ($41,653) by the appropriation and transfer, hereby made and authorized, of a like amount from the Emergency Fund to the appropriate expenditure account in the General Fund. The City Comptroller is authorized to draw and the City Treasurer to pay the necessary warrants and make the necessary transfers.

Section 2. WHEREAS, the appropriation herein made is to meet actual necessary expenditures of the City for which no appropriation has been made due to causes which could not reasonably have been foreseen at the time of making the 1986 Budget; Now, Therefore, in accordance with RCW 35.32A.060, by reason of the facts above stated and the emergency which is hereby declared to exist, this ordinance shall become effective immediately upon the approval or signing of the same by the Mayor or passage over his veto, as provided by the Charter of the City.

Passed by the City Council the 29th day of September, 1986, and signed by me in open session in authentication of its passage this 29th day of September, 1986.

SAM SMITH,
President of the City Council.

Approved by me this 6th day of October, 1986.

CHARLES ROYER,
Mayor.

Filed by me this 6th day of October, 1986.

Attest: NORWARD J. BROOKS,
City Comptroller and City Clerk.

(Seal) By MARGARET CARTER,
Deputy Clerk.

Publication ordered by NORWARD J. BROOKS, Comptroller and City Clerk.

Date of official publication in Daily Journal of Commerce, Seattle, October 10, 1986. (C-508-X)

Affidavit of Publication

C-508X

City of Seattle

STATE OF WASHINGTON
KING COUNTY—SS.

The undersigned, on oath states that he is an authorized representative of The Daily Journal of Commerce, a daily newspaper, which newspaper is a legal newspaper of general circulation and it is now and has been for more than six months prior to the date of publication hereinafter refered to, published in the English language continuously as a daily newspaper in Seattle, King County, Washington, and it is now and during all of said time was printed in an office maintained at the aforesaid place of publication of this newspaper. The Daily Journal of Commerce was on the 12th day of June, 1941, approved as a legal newspaper by the Superior Court of King County.

The notice in the exact form annexed, was published in regular issues of The Daily Journal of Commerce, which was regularly distributed to its subscribers during the below stated period. The annexed notice, a

Ordinance 113091

was published on October 10, 1986

B. Blair

Subscribed and sworn to before me on

October 10, 1986

Notary Public for the State of Washington,
residing in Seattle.