

**KENTUCKY
HIV/AIDS PLANNING AND ADVISORY COUNCIL**

**YEAR-END REPORT
SEPTEMBER 2006**

**COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR PUBLIC HEALTH**

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Executive Summary

The 2006 Year-End Report of the Kentucky HIV/AIDS Planning and Advisory Council (KHPAC) summarizes KHPAC's actions throughout the last year and offers recommendations to the Cabinet for Health and Family Services (the Cabinet) and the Kentucky General Assembly to ensure better health for HIV positive Kentuckians. Despite successful past efforts, critical issues remain that require immediate and ongoing attention.

KHPAC IS RECOMMENDING LEGISLATIVE ACTION IN THE FOLLOWING AREAS:

Kentucky AIDS Drug Assistance Program

KHPAC recommends that the State increase its contribution to KADAP by \$1.4 million. Kentucky is number 1! The National Alliance of State & Territorial AIDS Directors' June 15, 2006 article, "The ADAP Watch," reports that Kentucky has more individuals on its AIDS Drug Assistance Program (ADAP) waiting list than any other state or territory. In fact at the time of the report Kentucky had 188 of the total 331 individuals on ADAP waiting lists nationally.¹ These are not numbers to be proud of. As of July 31, 2006, Kentucky had 136 individuals on its ADAP waiting list. The recommended \$1.4 million increase would provide these individuals with access to lifesaving medications.

Guardianship of Minor Children

Currently Kentucky has no legislative provision for standby guardianship of minor children, or for parents to designate a guardian for their minor child without surrendering their parental rights. Recognizing this need in the population of persons infected with, and affected by, HIV/AIDS, KHPAC recommends that Kentucky adopt standby guardianship legislation, as endorsed by Congress with the passage of the Adoption and Safe Families Act of 1997. Standby guardianship would provide Kentucky parents with a legal option to plan for the care of their minor child, without surrendering their parental rights. Such legislation would benefit all children in Kentucky, in the event of parental incapacity due to illness or injury.

Increase access to HIV information

KRS 214.620 Subsection 4 ensures that Kentuckians will have access to information related to HIV infection when receiving services through certain identified facilities. KHPAC is concerned that several treatment facilities are not currently covered under KRS 214.620 and that critical information related to HIV testing is not mandated under the statute as written. Therefore KHPAC recommends that KRS 214.620 Subsection 4 be amended.

Promote Harm Reduction

KHPAC recommends implementation of a statewide Harm Reduction Program, targeting individuals engaging in high-risk behavior, in order to prevent/reduce the transmission of HIV, Hepatitis and other blood borne diseases. KHPAC further recommends that current legislation be revised/ repealed to permit implementation of a fully effective harm reduction program. Considering limited funding, strategies employing harm reduction have been proven to be both highly successful, and cost effective, when compared with more stringent interventions used in the past. These recommendations are based on the fact that the use of a new, sterile syringe for

¹ National ADAP Monitoring Project – Kaiser Family Foundation and NASTAD, June 15, 2006.

every injection is a critical component to preventing the spread of HIV, Hepatitis and other blood borne diseases.

HIV/AIDS Continuing Medical Education Requirements

KHPAC recommends implementing a two-tier, profession specific approach to continuing HIV medical education for healthcare providers. This continuing HIV education will be required every two years, thereby providing timely and relevant HIV information in a complex and ever-changing field.

OTHER RECOMMENDATIONS:

Disease Surveillance

KHPAC recommends that the Cabinet revise 902 KAR 2:020 Section 7 (1) so that the regulation is more inclusive, regarding which healthcare providers and facilities are required to report diagnosed cases of HIV and AIDS. Currently 902 KAR 2:020 Section 7 (1) reads, “Physicians and Medical Laboratories shall report...” KHPAC contends that 902 KAR 2:202 Section 7 should be revised to more clearly state who is required to report new HIV and AIDS cases to the State.

Media Campaign

KHPAC recommends that the State implement policy to assure the implementation of a statewide media campaign that will be designed to decrease HIV infections by encouraging HIV testing in the general population.

Section I LEGISLATIVE ACTION

A. Kentucky AIDS Drug Assistance Program Funding (KADAP)

HIV/AIDS Planning and Advisory Council Recommendation:

Increase the State's financial contribution to KADAP.

KHPAC recommends that the State increase its contribution to KADAP by \$1.4 million. Kentucky is number 1! The National Alliance of State & Territorial AIDS Directors' June 15, 2006 article, "The ADAP Watch," reports that Kentucky has more individuals on its AIDS Drug Assistance Program (ADAP) waiting list than any other state or territory. In fact at the time of the report Kentucky had 188 of the total 331 individuals on ADAP waiting lists nation wide.² These are not numbers to be proud of. As of July 31, 2006, Kentucky had 136 individuals on its ADAP waiting list. The recommended \$1.4 million increase would provide these individuals with access to lifesaving medications.

KHPAC is aware that Kentucky has experienced some financial struggles in recent years, and despite this, legislative action has been taken to increase the State's annual contribution to KADAP. In fact, in 2006 the House Budget Review Committee recommended a \$750,000 increase to KADAP. Although this was not approved, KHPAC appreciates the \$70,000 funding increase authorized through H.B.1 of the 2006 Legislature. But more must be done!

State funding of this critical program now stands at \$250,000 annually. Using the average annual cost of HIV medication at \$9,960, Kentucky assists 25 of its HIV infected residents each year. The 2006 Federal contribution is \$4,857,637, and KADAP has already served 680 unduplicated clients in the first quarter (Jan thru Mar) of 2006. As of June 30, 2006, there were 136 Kentuckians on the KADAP waiting list and this number continues to grow by an average of 23 new cases per month.³

The medications that KADAP makes available to eligible Kentuckians are necessary to keep individuals in the work force, keep them from becoming more ill, and to help prevent other healthcare costs. For each additional \$100,000 the State contributes to KADAP, ten more Kentuckians will have access to life-saving medications that can enhance their health and quality of life. Increased State funding would likely reduce other costs to the State through decreased hospitalizations, decreased urgent care and emergency care needs. Patients on the KADAP waiting list are likely to experience disease progression and end up on Medicaid without rapid access to medications. KADAP clients, who remain healthy, are more able to work, pay taxes, and participate in the daily economy of our State. Consequently, KHPAC recommends increasing the State's financial funding of KADAP to \$1.65 million (the current \$250,000, plus \$1.4 million) thus preventing future more costly health care expenditures and providing access to medications to the 136 individuals on Kentucky's waiting list.

² National ADAP Monitoring Project – Kaiser Family Foundation and NASTAD, June 15, 2006.

³ Appendix 1

B. Guardianship of Minor Children

HIV/AIDS Planning and Advisory Council Recommendation:

Amend Kentucky's guardianship laws to create standby guardianship for minor children.

KHPAC recommends that the Legislature amend Kentucky's guardianship legislation to create a new section for standby guardianship of minor children.⁴ Furthermore, KHPAC requests the Cabinet support KHPAC's recommendation for standby guardianship, and make a commitment to encourage the creation of standby guardianship legislation in its communications, and interactions with the legislature in the 2007 session.

Currently Kentucky has no legislative provision for standby guardianship of minor children, or for parents to designate a guardian for their minor child without surrendering parental rights. Recognizing this need in the population of persons infected with, and affected by, HIV/AIDS, KHPAC recommends that Kentucky adopt standby guardianship legislation, as endorsed by Congress with the passage of the Adoption and Safe Families Act of 1997. Currently, twenty-two States and the District of Columbia have passed a version of standby guardianship legislation that incorporates the spirit of the Adoption and Safe Families Act of 1997. Standby guardianship would provide Kentucky parents with a legal option to plan for the care of their minor child, without surrendering their parental rights. Such legislation would benefit all children in Kentucky, in the event of parental incapacity due to illness or injury.

Any parent could become seriously ill at any time, and be unable to meet the responsibilities of caring for their child. Examples of such situations include: major trauma, chemotherapy, radiation, or diagnosis with a serious illness such as cancer or HIV/AIDS. Some previously terminal illnesses have become chronic, even curable illnesses due to advances in medical science. Standby guardianship allows a parent to grant temporary custody of their child to a person of their choosing, during the parent's intermittent or temporary incapacity related to illness or injury. Standby guardianship provides a means for legislation to keep pace with advances in medical care and treatment by addressing one of the many societal issues associated these advances.

In enacting the Adoption and Safe Families Act of 1997, Congress endorsed standby guardianships and urged states to adopt standby guardianship legislation or similar legislation for cases where a child's future care is at risk and adoption is not feasible. In addition to the previously noted states with such legislation, several other states have standby guardianship legislation pending. These states have all recognized that standby guardianship laws allow a parent with a progressive or chronic illness to designate a caregiver for a child in the event of the parent's incapacity. This designation can occur during the parent's life and may be triggered by

⁴ Kentucky currently does have a guardianship provision that allows for a petitioner to name a person to act on the petitioner's behalf in the event of the petitioner's incapacity. This provision allows the petitioner to designate this "standby" guardian in advance, subject to court approval. The standby guardian becomes legally authorized to act for the petitioner upon a "triggering event", i.e. the petitioner's incapacitating illness. However, this only allows the stand-by guardian to act for the petitioner; it does not authorize the guardian to act as the legal custodian or guardian for the petitioner's minor children. See KRS 387.330.

the parent's incapacity. The standby guardian has authority to make legal, medical and other decisions for the child. The legislation allows for an orderly transfer of legal authority from parent to standby guardian and back to parent with minimal need for court oversight or approval.

During the 2006 legislative session, H.B. 221, relating to the standby guardianship of minors, was passed 94-0 by the House of Representatives, and received in the Senate Judiciary committee for consideration. The session ended before the Senate was able to consider the bill. However, the bill had wide support in both chambers, as well as the support of educational professionals across the state. The legislator who sponsored H.B. 221 has agreed to sponsor this legislation again in the 2007 legislative session, as well as seek bipartisan sponsorship of the legislation in both chambers of the legislature.

C. Increase Access to HIV Information

HIV/AIDS Planning and Advisory Council Recommendation:

Amend KRS 214.620 subsection 4 to expand the type of facilities covered in the statute and to include additional information related to HIV testing.

KRS 214.620 Subsection 4⁵ ensures that Kentuckians will have access to information related to HIV infection when receiving services through certain identified facilities. KHPAC is concerned that several treatment facilities are not currently covered under KRS 214.620 and that critical information related to HIV testing is not mandated under the statute as written. Therefore KHPAC recommends that KRS 214.620 Subsection 4 be amended to read in whole as:

“Information on the human immunodeficiency virus infection shall be presented to any person who receives treatment at any hospital, however named, skilled nursing facilities, primary-care centers, rural health clinics, outpatient clinics, ambulatory-care facilities, ambulatory surgical centers, emergency-care centers, substance abuse inpatient and outpatient treatment centers, mental health inpatient and outpatient facilities, primary care medical offices, adult daycare facilities, senior citizen assisted living facilities and homeless shelters licensed pursuant to KRS Chapter 216B. The information shall include but not be limited to methods of transmission and prevention and appropriate behavior and attitude change, and HIV testing availability and/or sites available for free and/or sliding fee scale financial consideration and/or anonymous and/or confidential testing.”

The original statute was enacted in 1990, with amendments being made in 1998, 2001 and 2002. KHPAC’s recommendation is based on current knowledge of HIV risk factors and new technology in HIV testing. KHPAC believes the updated information contained in this recommendation will increase the usefulness of the statute. The Centers for Disease Control and Prevention (CDC) estimates that of the estimated 1.2 million persons living with HIV, 252,000 to 312,000 (24-27%) are unaware that they are infected.⁶ Expanding access points for HIV information to include sites of high risk populations such as those found in substance abuse treatment facilities, mental health facilities, and homeless shelters will help to identify HIV infection in early, less cost consuming stages. Making this information available to primary care offices will address the April 18, 2003 CDC initiative⁷ for primary care medical providers to incorporate HIV risk assessment and /or testing into routine health maintenance thereby addressing the increasing rates of infection. Rapid HIV tests are now available nationally, for use on site, with preliminary test results returned in 20 minutes. This technology coupled with the statute amendments can help primary care physicians promote early identification of HIV positive Kentuckians, and reinforce risk reduction behaviors in those Kentuckians currently HIV negative.

⁵ Appendix 2

⁶ MMWR, June 2, 2006/ 55(21); 589-592

⁷ Appendix 3

D. Promote Harm Reduction

HIV/AIDS Planning and Advisory Council Recommendation:

Promote Harm Reduction

KHPAC recommends implementation of a statewide Harm Reduction Program, targeting individuals engaging in high-risk behavior, in order to prevent/reduce the transmission of HIV, Hepatitis and other blood borne diseases. KHPAC further recommends that current legislation be revised/ repealed to permit implementation of a fully effective harm reduction program. Considering limited funding, strategies employing harm reduction have been proven to be both highly successful, and cost effective, when compared with more stringent interventions used in the past. These recommendations are based on the fact that the use of a new, sterile syringe for every injection is a critical component to preventing the spread of HIV, Hepatitis and other blood borne diseases.⁸

Harm Reduction is the adoption of policies and programs designed to reduce the adverse medical/public health, social and economic consequences of risky behaviors to the individuals engaging in the behavior, as well as their families and the community, without requiring the cessation of the behavior. The societal benefit of harm reduction programs is the protection of the health and welfare of both the individual, and the community, until such time as the individual engaging in the risky behavior is ready and able to enter rehabilitation. Harm reduction is not the same as legalization, nor does adoption of harm reduction express support for legalization of the specific behavior. The success of harm reduction techniques applied to other public health concerns is well documented and generally accepted by the public.

With the exception of providing lifesaving medication for people living with HIV, harm reduction principles provide the most effective means to target limited funding to the individuals most at risk. KHPAC is not suggesting that a harm reduction program be implemented among the general population in Kentucky, but rather targeted to the population within the community engaging in high-risk behavior. Harm reduction strategies would:

- Test and educate individuals who are truly at risk for HIV infection.
- Provide HIV positive citizens, and those most at risk, with complete and culturally appropriate education for living a healthy lifestyle and preventing the spread of HIV.
- Decriminalize possession and distribution of sterile injection equipment, and provide for safe disposal of syringes, while simultaneously providing education on healthy lifestyles and access to addiction treatment.

The magnitude of the HIV infection among injection drug users (IDUs) is strongly indicative that treatment, prevention and criminal penalties have been ineffective in reducing the adverse effects of injection drug use. Harm reduction strategies such as needle exchange programs, which provide sterile syringes, decriminalize the possession/sale of injection equipment and promote

⁸ Robert Wood Johnson Foundation – Grants Results Report: A U.S. Needle Exchange Program Dramatically Reduces HIV Transmission, March 2002

safe disposal of syringes, have been proven to effectively reduce HIV infection in IDUs, their families and the community as a whole.

CDC estimates that intravenous drug use accounts for nearly one-third of all AIDS cases, and nearly half of all cases of Hepatitis C cases. Currently there are needle exchange programs in over 140 cities, and 13 states. Many respected national organizations support open access to sterile injection equipment. These organizations include: the American Bar Association, the Association of Pharmacists, CDC, the American Medical Association, and the National Institutes of Health. Access to sterile injection equipment is crucial to preventing disease, and the U. S. Public Health Service has recommended use of sterile syringes as an important risk reduction strategy. Providing access to sterile syringes has been shown to help, and does not hurt, efforts to reduce drug use and related social problems. CDC reports that IDUs share injection equipment primarily because of legal and regulatory barriers limiting access to, and possession of, injection equipment a crime.

Safe disposal of used syringes is an important part of insuring an IDU will not reuse/share a blood-contaminated syringe. Therefore, removal of barriers to safe disposal of syringes is an integral part of any harm reduction program. Safe disposal of syringes would also address community fears regarding the risks of discarded syringes in neighborhoods, parks and other public places. After changing their legislation to permit possession and sale of up to 10 syringes to an individual, Connecticut has seen needle sharing among IDUs decrease by 40%, and needle stick injuries to police decrease by 66%. According to a March 2002 Grant Result Report from the Robert Wood Johnson Foundation, which studied Connecticut's needle exchange program, "the program reduced the incidence of HIV transmission by an estimated 33%, and assisted more than 1000 clients in entering drug treatment during the RWJF-funded period."

Currently the Cabinet has implemented a limited harm reduction program, to the extent possible under present legislation.⁹ However, to fully implement an effective harm reduction program in Kentucky will require revision and/or repeal of selected existing legislation. Therefore, KHPAC makes the following recommendations to the legislature, for legislative reform in the 2007 legislative session:

- KRS 217.177 Sale and disposal of hypodermic syringes or needles – Repeal
- KRS 218A.500 Drug Paraphernalia Definitions – Revise; remove "syringes used for disease prevention purposes."
- KRS 218A.1404 Controlled Substances – Revise; allow for an exception for residue found in injecting equipment when such equipment has been properly disposed of in a puncture proof container.

⁹ Appendix 4

E. HIV/AIDS Continuing Medical Education Requirements

HIV/AIDS Planning and Advisory Council Recommendation:

Support legislation and programs that strongly encourage timely and relevant directed continuing medical education for all providers delivering health care to people with HIV and AIDS.

KHPAC continues to strongly encourage timely continuing medical education (CME) for all providers delivering health care to people with HIV and AIDS. Primary care providers, including internists, family practice physicians, pediatricians, and obstetricians, are caring for patients on a daily basis, who are either currently infected, or at risk of becoming infected. In February 2001, the legislature changed requirements for specific education for HIV/AIDS from every two years, to every ten years (KRS 214.610).¹⁰ As disease management continues to be a complex and ever-changing field, an interval of ten years for up-to-date education is both inadequate and inappropriate. The health care community's ability to deliver appropriate care to people living with HIV/AIDS and to those at risk of acquiring HIV disease without up-to-date HIV specific education will be significantly impaired.

KHPAC supports a two-tiered system of CME for medical providers in order to facilitate patient provider educational needs. Tier one would consist of basic HIV education, stressing current scientific updates in HIV disease, recognition of patient signs and symptoms, patient risk factors, state reporting requirements and occupational exposure prophylaxis. Tier two would be a more intensive HIV management course targeting Kentucky physicians rendering primary and specialty HIV care for infected Kentuckians. These medical providers would be encouraged to complete American Academy HIV Medicine (AAHIVM) certification to ensure quality HIV care for all infected Kentuckians.

The U.S. Department of Health and Human Services through the Health Resources and Services Administration has developed the AIDS Education Training Centers Program (AETC), which supports a national network of regional centers that conduct clinical HIV education, and training programs for health care providers. Kentucky is associated with the Southeast AETC (SEATEC), and is currently developing programs throughout the state to accomplish this mission. Such programming must reflect the socioeconomic, cultural, and clinical aspects of the epidemic as seen in the state of Kentucky. Health care providers must avail themselves of this education, and apply it to the care of their patients. Educational opportunities exist in many venues, and these should continue to be developed and promoted to providers throughout the state.

KHPAC holds to the following key points:

- CME courses should be flexible to allow for targeting of the addressed audience
- 10 year requirement must still be addressed as too long
- HIV certification is the national benchmark

¹⁰ Appendix 5

- CME requirements need to reach generalized and ER doctors who do not necessarily work with HIV on a daily basis
- CME must be profession specific

KHPAC recommends that all providers of care to patients with HIV/AIDS or at risk of becoming infected with HIV, be required to have relevant, timely and profession specific education on HIV/AIDS every two years, and that this be facilitated through the individual licensing board or certifying entity which pursuant to KRS 214.610 has the authority to require more frequent completion of CME. The licensure boards will work in cooperation with the Cabinet to determine the course content.

Section 2 OTHER RECOMMENDATIONS

A. Disease Surveillance

HIV/AIDS Planning and Advisory Council Recommendation:

Clarify regulation 902 KAR 2:020. Disease Surveillance to clearly identify what entities are required to report new HIV and AIDS cases.

KHPAC recommends that the Cabinet revise 902 KAR 2:020 Section 7 (1) so that the regulation is more inclusive, regarding which healthcare providers and facilities are required to report diagnosed cases of HIV and AIDS.

Currently 902 KAR 2:020 Section 7 (1) reads, “Physicians and Medical Laboratories shall report.”¹¹ Because of this wording, there has been some confusion as to who is required to report HIV and AIDS cases. Therefore KHPAC recommends that the regulation be revised to make the regulation language clearer and more inclusive regarding who is required to report diagnosed cases of HIV and AIDS.

KHPAC is fully aware that the Cabinet maintains a professional staff experienced at writing and revising statutes and regulations. Therefore KHPAC recommends that the Cabinet and its staff be responsible for these revisions. KHPAC would appreciate the opportunity to be part of the review and edit of 902 KAR 2:020 and thus allow for input into the revised language before it is finalized. The goal of this input will be to provide the Cabinet with a greater understanding of the problems encountered with the current language and offer suggestions for revising the regulation.

¹¹ 920 KAR 2:020. Disease surveillance.

B. Statewide Media Campaign

Kentucky HIV/AIDS Planning and Advisory Council Recommendation:

The State establish a media campaign designed to decrease HIV infections by encouraging HIV testing in the general population.

In compliance with CDC guidance, HIV prevention efforts in the state of Kentucky have focused almost exclusively on high-risk groups. To date, little effort has been made to reach the general population of Kentucky.

A statewide media campaign using billboards as well as printed publication, radio, and television advertisements would be a powerful way to address that gap. Such a strategy would reach a majority of Kentuckians, including individuals knowingly practicing high-risk behaviors, as well as individuals who may not consider themselves to be at risk. Anecdotal evidence from localized media campaigns in Lexington, Paducah, and northern Kentucky strongly suggests that there will be a direct increase in those seeking testing and prevention counseling as a result of such a statewide campaign. This is consistent with the CDC's own *Morbidity and Mortality Weekly Report*, "National HIV Testing Day at CDC-Funded HIV Counseling, Testing, and Referral Sites—United States, 1994–1998" (June 23, 2000), which reported that media campaigns have had a direct and positive effect on counseling and testing nationally.

Key components of a statewide counseling and prevention media campaign would be:

- The involvement of an action/advocacy entity such as the Kentucky HIV/AIDS Advocacy and Action Group to actually facilitate the implementation of the campaign throughout the state.
- One key message translated as appropriate to reach primary populations that speak languages other than English (examples include "HIV is alive and well. Are you?" "Are you (HIV+)? How do you know?" "Got HIV?").
- A coordinated effort to secure donated advertisement space/time as well as grant and matching funding (examples include local access cable channels, working with local media outlets to obtain donated time/space, and applying for grants from sources such as the Tony Cox Grant Foundation).
- Visible signs providing the contact information of the nearest facility that offers confidential HIV testing and counseling to be displayed in facilities offering health care and social services.
- A standardized means of tracking the numbers of people statewide who respond to the campaign, by indicating that it was a factor in their decision to seek counseling and testing.
- A commitment from the Kentucky Legislature of funding for such a campaign upon presentation of evidence that the pilot phase of the program has generated a measurable increase in counseling and testing statewide.

KHPAC recommends that the State take the following actions in **policy** rather than legislation to assure implementation of the media campaign:

1. The Legislature passes a resolution supporting the campaign.
2. The Governor signs a proclamation adopting the campaign.
3. The Secretary for the Cabinet directs the Commissioner for Public Health to establish a committee consisting of representatives from the HIV/AIDS and STD Branches, State and Local Health Departments, the Kentucky HIV/AIDS Advocacy and Action Group, Community Based Organizations and other volunteers to discuss means of funding a statewide media campaign in the shortest possible time.
4. Provide the concept of this campaign to state and local medical communities and strongly encourage their support in making this a Statewide-Community effort.

Appendices

Appendix 1

KENTUCKY AIDS DRUG ASSISTANCE PROGRAM Fiscal Year 2006-2007 Estimated Funding Needs

	# of Clients	Cost/Month	# of Months	
Cost to serve current waiting list July 2006 – June 2007	136	\$830.00	12	\$1,400,000.00
Cost to serve additional clients July 2006 – June 2007	276	\$830.00	12	\$1,386,020.00
Additional Amount Needed for July 2006 – June 2007				\$2,786,020.00

Fiscal Year 2006-2007

Month	Add'l Clients Served	Amount/Client/Month	Total/Month
July	23	\$830	\$19,090
August	46	\$830	\$38,180
September	69	\$830	\$57,270
October	92	\$830	\$76,360
November	115	\$830	\$95,450
December	138	\$830	\$114,540
January	161	\$830	\$133,630
February	184	\$830	\$152,720
March	207	\$830	\$171,810
April	230	\$830	\$190,900
May	253	\$830	\$209,990
June	276	\$830	\$229,080
Total			\$ 1,386,020

Appendix 2

Legislation affecting access to HIV information

KRS 214.620 Planning for implementation of professional education requirement -- Information and education requirements for certain groups.

- (4) Information on the human immunodeficiency virus infection shall be presented to any person who receives treatment at any hospital, however named, skilled-nursing facilities, primary-care centers, rural health clinics, outpatient clinics, ambulatory care facilities, ambulatory surgical centers, and emergency-care centers licensed pursuant to KRS Chapter 216B. The information shall include but not be limited to methods of transmission and prevention and appropriate behavior and attitude change.

Appendix 3

April 18, 2003 CDC Initiative

Advancing HIV Prevention: New Strategies for a Changing Epidemic --- United States, 2003

In several U.S. cities, recent outbreaks of primary and secondary syphilis among men who have sex with men (MSM) (1) and increases in newly diagnosed human immunodeficiency virus (HIV) infections among MSM and among heterosexuals have created concern that HIV incidence might be increasing. In addition, declines in HIV morbidity and mortality during the late 1990s attributable to combination antiretroviral therapy appear to have ended. Until now, CDC has mainly targeted its prevention efforts at persons at risk for becoming infected with HIV by providing funding to state and local health departments and nongovernmental community-based organizations (CBOs) for programs aimed at reducing sexual and drug-using risk behavior. Some recent programs have focused on prevention efforts for persons living with HIV (2). Funding HIV-prevention programs for communities heavily affected by HIV has promoted community support for prevention activities. At the same time, these communities recognize the need for new strategies for combating the epidemic. In addition, the recent approval of a simple rapid HIV test in the United States creates an opportunity to overcome some of the traditional barriers to early diagnosis and treatment of infected persons. Therefore, CDC, in partnership with other U.S. Department of Health and Human Services agencies and other government agencies and nongovernmental agencies will launch a new initiative in 2003, Advancing HIV Prevention: New Strategies for a Changing Epidemic.

Trends in HIV/AIDS Morbidity and Mortality

The first cases of acquired immunodeficiency syndrome (AIDS) were reported in the United States in June 1981, and the number of cases and deaths among persons with AIDS increased rapidly during the 1980s. During 1981--2001, an estimated 1.3--1.4 million persons in the United States were infected with HIV (3), and 816,149 cases of AIDS and 467,910 deaths were reported to CDC (4). During the late 1990s, after the introduction of combination antiretroviral therapy, the numbers of new AIDS cases and deaths among adults and adolescents declined substantially. From 1995 to 1998, the annual number of incident AIDS cases declined 38% from 69,242 to 42,832, and deaths from AIDS declined 63% from 51,670 to 18,823. The annual number of incident AIDS cases and deaths have remained stable since 1998, at approximately 40,000 and 16,000, respectively (4). The number of children in whom AIDS attributed to perinatal HIV transmission was diagnosed peaked in 1992 at 954 and declined 89% to 101 in 2001 (4).

Since the early 1990s, an estimated 40,000 new HIV infections have occurred annually in the United States. During 1999--2001, in the 25 states that had HIV reporting since 1994, the number of persons who had HIV infection newly diagnosed increased 14% among MSM and 10% among heterosexuals. The number of persons in the United States living with HIV

continues to increase, and of an estimated 850,000--950,000 persons living with HIV, an estimated 180,000--280,000 (25%) persons are unaware of their serostatus (3).

HIV Testing

Many HIV-infected persons do not get tested until late in their infection, and many persons who are tested do not return to learn their test results. In 2000, of an estimated two million CDC-funded tests for HIV, approximately 18,000 tests represented new HIV diagnoses. During 2000, of persons with positive tests for HIV, 31% did not return to learn their test results (CDC, unpublished data, 2000). Of 573 HIV-infected young MSM who were studied in six U.S. cities, 77% were unaware that they were infected (5). During 1994--1999, of 104,780 persons in whom HIV was diagnosed, AIDS was diagnosed in 43,089 (41%) persons within 1 year after their positive HIV test (6).

Reasons for HIV testing vary. In a study of 7,236 persons in whom HIV was newly diagnosed, the reason given most frequently (42%) for seeking the test was illness. Only 10% of HIV-infected men and 17% of HIV-infected women reported that they were tested primarily because the test was offered or recommended by a health-care facility or provider (CDC, unpublished data, 2002).

Many persons who learn that they are HIV infected adopt behaviors that might reduce the risk for transmitting HIV (7). In a study of 1,363 HIV-infected men and women, among the 69% who were sexually active during the preceding 12 months, 78%--96% used a condom at most recent anal or vaginal intercourse with a known HIV-negative partner, and 52%--86% reported condom use with a partner of unknown serostatus (CDC, unpublished data, 2002).

The development of new tests for HIV creates new prospects for expanding HIV testing to identify and treat HIV-infected persons earlier. The OraQuick[®] HIV rapid test (OraSure Technologies, Inc., Bethlehem, Pennsylvania) was approved by the Food and Drug Administration in November 2002 and categorized as a waived test under the Clinical Laboratory Improvement Amendments in January 2003. This simple, rapid test provides HIV results in 20 minutes, can be stored at room temperature, requires no special equipment, and can be performed outside clinical settings. Although the use of the OraQuick[®] test facilitates receipt of test results, HIV-positive test results will require confirmation by Western Blot or immunofluorescence assays.

Reported by: *RS Janssen, MD, IM Onorato, MD, Div of HIV/AIDS Prevention--Surveillance and Epidemiology; RO Valdiserri, MD, TM Durham, MS, WP Nichols, MPA, EM Seiler, MPA, HW Jaffe, MD, National Center for HIV, STD, and TB Prevention, CDC.*

Editorial Note:

The new initiative, Advancing HIV Prevention: New Strategies for a Changing Epidemic, is aimed at reducing barriers to early diagnosis of HIV infection and increasing access to quality medical care, treatment, and ongoing prevention services. The HIV initiative emphasizes the use of proven public health approaches to reducing the incidence and spread of disease. As with

other sexually transmitted diseases (STDs) or any other public health problem, principles commonly applied to prevent disease and its spread will be used, including appropriate routine screening, identification of new cases, partner notification, and increased availability of sustained treatment and prevention services for those infected.

Stable HIV-associated morbidity and mortality, concerns about possible increases in HIV incidence, and the recent availability of a simple, rapid HIV test combined with strong prevention collaborations among communities heavily affected by HIV support the need to reassess and refocus some of CDC's HIV-prevention activities. An emphasis on greater access to testing and on providing prevention and care services for persons infected with HIV can reduce new infections and lead to reductions in HIV-associated morbidity and mortality (2,8). In addition, simplifying prenatal and other testing procedures can lead to more effective use of resources that CDC provides to prevent perinatal and other HIV transmission.

The initiative consists of four key strategies:

- **Make HIV testing a routine part of medical care.** CDC will work with professional medical associations and other partners to ensure that all health-care providers include HIV testing, when indicated, as part of routine medical care on the same voluntary basis as other diagnostic and screening tests. Previously, CDC has recommended that patients be offered HIV testing in high HIV-prevalence acute care hospitals (9) and in clinical settings serving populations at increased risk (e.g., clinics that treat persons with STDs). This initiative adds to those recommendations to include offering HIV testing to all patients in all high HIV-prevalence clinical settings and to those with risks for HIV in low HIV-prevalence clinical settings (10). Because prevention counseling, although recommended for all persons at risk for HIV, should not be a barrier to testing, CDC will promote adoption of simplified HIV-testing procedures in medical settings that do not require prevention counseling before testing. In 2003, CDC will support state and local health departments in conducting demonstration projects offering HIV testing to all patients in high HIV-prevalence health-care settings and referral into care, treatment, and prevention services, and will assess the outcomes of these projects.
- **Implement new models for diagnosing HIV infections outside medical settings.** In 2003, CDC will fund new demonstration projects using OraQuick[®] to increase access to early diagnosis and referral for treatment and prevention services in high-HIV prevalence settings, including correctional facilities. In addition, CBOs will pilot new models, particularly in nonmedical settings, for diagnosis and referring persons for treatment and prevention services. Also, because 8%--39% of partners tested in studies of partner counseling and referral services (PCRS) were found to have previously undiagnosed HIV infection (11), CDC will increase emphasis on PCRS. In 2004, CDC will implement these new models through health departments and CBOs.
- **Prevent new infections by working with persons diagnosed with HIV and their partners.** Although many persons with HIV modify their behavior to reduce their risk for transmitting HIV after learning they are infected, some persons might require ongoing prevention services to change their risk behavior or to maintain the change. In 2003, CDC, in collaboration with the Health Resources and Services Administration (HRSA), the National Institutes of Health, and the

HIV Medical Association of the Infectious Diseases Society of America, will publish *Recommendations for Incorporating HIV Prevention into the Medical Care of Persons with HIV Infection*. CDC will work with professional associations to disseminate the new guidelines to primary care providers and infectious disease specialists and to assess their integration into medical practice. CDC will work closely with HRSA and other partners to reach persons in whom HIV infection has been diagnosed but who are not in ongoing medical or preventive care. CDC also will conduct demonstration projects through state and local health departments to provide prevention case management for persons living with HIV to reduce HIV transmission. Finally, CDC will increase emphasis on partner notification and also will support new models of partner notification, including offering rapid HIV testing to partners and using peers to conduct partner prevention counseling and referral. In 2004, acting through health departments and CBOs, CDC will implement these prevention services for persons living with HIV. CDC also will require grantees to employ standardized procedures for prevention interventions and evaluation activities.

- **Further decrease perinatal HIV transmission.** CDC will promote recommendations for routine HIV testing of all pregnant women, and, as a safety net, for the routine screening of any infant whose mother was not screened. CDC will work with prevention partners, including the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Nurse-Midwives, to disseminate the recommendations and support their implementation. CDC also will develop guidance for using rapid tests during labor and delivery, or post partum if the mother was not screened prenatally, and provide training for health departments and providers in conducting prenatal testing. In 2003, CDC will expand its activities to monitor the integration of routine prenatal testing into medical practice.

Reporting of HIV infections to public health authorities is now required in 49 states. In 2002, CDC initiated a pilot system to monitor HIV incidence. To track the impact of the new initiative, beginning in 2003, CDC is expanding this surveillance system by implementing a national behavioral surveillance system. In addition, CDC will monitor the implementation of these new activities through several systems, including new performance indicators for state and local health departments and CBOs.

Stable HIV morbidity and mortality, increased numbers of syphilis and HIV cases, and growing concern about increasing HIV incidence in some communities require new strategies to control the spread of HIV in the United States. Through *Advancing HIV Prevention: New Strategies for a Changing Epidemic*, every HIV-infected person should have the opportunity to be tested and have access to state-of-the-art medical care and to the prevention services needed to prevent HIV transmission.

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Appendix 4

Legislation relative to Harm Reduction

KRS 217.177 Sale and disposal of hypodermic syringes or needles.

- (1) No person engaged in sales at retail shall display hypodermic syringes or needles in any portion of the place of business which is open or accessible to the public.
- (2) Every person engaged in sales of hypodermic syringes or needles at retail shall maintain a bound record in which shall be kept:
 - (a) The name of the purchaser; and
 - (b) The address of the purchaser; and
 - (c) The quantity of syringes or needles purchased; and
 - (d) The date of the sale; and
 - (e) Planned use of such syringes or needles.
- (3) Said record shall be maintained for a period of two (2) years from the date of the sale and shall be available for inspection during business hours by any law enforcement officer, agent or employee of the Cabinet for Health and Family Services or Board of Pharmacy engaged in the enforcement of KRS Chapter 218A.
- (4) No person shall present false identification or give a false or fictitious name or address in obtaining or attempting to obtain any hypodermic syringe or needle.
- (5) No person engaged in the retail sale of hypodermic syringes or needles shall:
 - (a) Fail to keep the records required by this section; or
 - (b) Fraudulently alter any record required to be kept by this section; or
 - (c) Destroy, before the time period required by this section has elapsed, any record required to be kept by this section; or
 - (d) Sell, or otherwise dispose of, any hypodermic syringe to any person who does not present the identification required by this section; or
 - (e) Disclose the names in said book except to those required by this section.
- (6) Any physician, other licensed medical person, hospital, or clinic disposing of hypodermic syringes or needles shall crush the barrel of same or otherwise render the instrument incapable of further use.

Effective: June 20, 2005

History: Amended 2005 Ky. Acts ch. 99, sec. 513, effective June 20, 2005. -- Amended 1998 Ky. Acts ch. 426, sec. 458, effective July 15, 1998. -- Created 1974 Ky. Acts ch. 404, sec. 1.

KRS 218A.500 Definitions for KRS 218A.500 and 218A.510 -- Unlawful practices -- Penalties.

As used in this section and KRS 218A.510:

- (1) "Drug paraphernalia" means all equipment, products and materials of any kind which are used, intended for use, or designed for use in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, injecting,

ingesting, inhaling, or otherwise introducing into the human body a controlled substance in violation of this chapter. It includes, but is not limited to:

- (a) Kits used, intended for use, or designed for use in planting, propagating, cultivating, growing, or harvesting of any species of plant which is a controlled substance or from which a controlled substance can be derived;
 - (b) Kits used, intended for use, or designed for use in manufacturing, compounding, converting, producing, processing, or preparing controlled substances;
 - (c) Isomerization devices used, intended for use, or designed for use in increasing the potency of any species of plant which is a controlled substance;
 - (d) Testing equipment used, intended for use, or designed for use in identifying, or in analyzing the strength, effectiveness or purity of controlled substances;
 - (e) Scales and balances used, intended for use, or designed for use in weighing or measuring controlled substances;
 - (f) Diluents and adulterants, such as quinine hydrochloride, mannitol, mannite, dextrose and lactose, used, intended for use, or designed for use in cutting controlled substances;
 - (g) Separation gins and sifters used, intended for use, or designed for use in removing twigs and seeds from, or in otherwise cleaning or refining marijuana;
 - (h) Blenders, bowls, containers, spoons, and mixing devices used, intended for use, or designed for use in compounding controlled substances;
 - (i) Capsules, balloons, envelopes, and other containers used, intended for use, or designed for use in packaging small quantities of controlled substances;
 - (j) Containers and other objects used, intended for use, or designed for use in storing or concealing controlled substances;
 - (k) Hypodermic syringes, needles, and other objects used, intended for use, or designed for use in parenterally injecting controlled substances into the human body;
 - (l) Objects used, intended for use, or designed for use in ingesting, inhaling, or otherwise introducing marijuana, cocaine, hashish, or hashish oil into the human body, such as: metal, wooden, acrylic, glass, stone, plastic, or ceramic pipes with or without screens, permanent screens, hashish heads, or punctured metal bowls; water pipes; carburetion tubes and devices; smoking and carburetion masks; roach clips which mean objects used to hold burning material, such as marijuana cigarettes, that have become too small or too short to be held in the hand; miniature cocaine spoons, and cocaine vials; chamber pipes; carburetor pipes; electric pipes; air-driven pipes; chillums; bongs; ice pipes or chillers.
- (2) It is unlawful for any person to use, or to possess with intent to use, drug paraphernalia for the purpose of planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packing, repacking, storing, containing, concealing, injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance in violation of this chapter.
 - (3) It is unlawful for any person to deliver, possess with intent to deliver, or manufacture with intent to deliver, drug paraphernalia, knowing, or under circumstances where one reasonably should know, that it will be used to plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, inject, ingest, inhale, or otherwise introduce into the human body a controlled substance in violation of this chapter.

- (4) It is unlawful for any person to place in any newspaper, magazine, handbill, or other publication any advertisement, knowing, or under circumstances where one reasonably should know, that the purpose of the advertisement, in whole or in part, is to promote the sale of objects designed or intended for use as drug paraphernalia.
- (5) Any person who violates any provision of this section shall be guilty of a Class A misdemeanor for the first offense and a Class D felony for subsequent offenses.

Effective: July 14, 1992

History: Amended 1992 Ky. Acts ch. 441, sec. 8, effective July 14, 1992. -- Created 1982 Ky. Acts ch. 413, sec. 2, effective July 15, 1982.

KRS 218A.1404 Prohibited activities relating to controlled substances -- Penalties.

- (1) No person shall traffic in any controlled substance except as authorized by law.
- (2) No person shall possess any controlled substance except as authorized by law.
- (3) No person shall dispense, prescribe, distribute, or administer any controlled substance except as authorized by law.
- (4) Unless another specific penalty is provided in this chapter, any person who violates the provisions of subsection (1) or (3) of this section shall be guilty of a Class D felony for the first offense and a Class C felony for subsequent offenses and any person who violates the provisions of subsection (2) of this section shall be guilty of a Class A misdemeanor for the first offense and a Class D felony for subsequent offenses.

Effective: July 14, 1992

History: Created 1992 Ky. Acts ch. 441, sec. 27, effective July 14, 1992.

Appendix 5

Legislation regarding continuing medical education

KRS 214.610 Educational course to be completed by health-care workers and social workers -- Approval by licensing board or certifying entity -- Publication of courses.

- (1) (a) The Cabinet for Health and Family Services or the licensing board or certifying entity, subject to the board's or entity's discretion, shall approve appropriate educational courses on the transmission, control, treatment, and prevention of the human immunodeficiency virus and acquired immunodeficiency syndrome, that may address appropriate behavior and attitude change, to be completed as specified in the respective chapters by each person licensed or certified under KRS Chapters 311, 311A, 312, 313, 314, 315, 320, 327, 333, and 335. Each licensing board or certifying entity shall have the authority to determine whether it shall approve courses or use courses approved by the cabinet. Completion of the courses shall be required at the time of initial licensure or certification in the Commonwealth, as required under KRS 214.615 and 214.620, and shall not be required under this section or any other section more frequently than one (1) time every ten (10) years thereafter, unless the licensing board or certifying entity specifically requires more frequent completion under administrative regulations promulgated in accordance with KRS Chapter 13A.
- (b) The Department for Public Health shall publish on its Web site the current informational resources for the development of the educational courses or programs. To the extent possible, the educational courses or programs under this subsection shall:
1. Include changes in Kentucky law affecting HIV testing and reporting; confidentiality and privacy of HIV-related data, information, and reports; and advances in treatment protocols, intervention protocols, coordination of services, and other information deemed important by the Department for Public Health and the Centers for Disease Control and Prevention (CDC);
 2. Inform all professions involved with or affected by the birthing process about the importance of HIV testing of pregnant women and the probability of preventing perinatal transmission of HIV with appropriate treatment; and
 3. Update all health care professionals identified under paragraph (a) of this subsection requesting information about the potential involvement of their occupation in the treatment or prevention of blood-borne pathogens with the latest CDC guidelines on occupational exposure to HIV and other blood-borne pathogens.
- (2) Each licensee or certificate holder shall submit confirmation on a form provided by the cabinet of having completed the course by July 1, 1991, except persons licensed under KRS Chapters 314 and 327 for whom the completion date shall be July 1, 1992.

Effective: June 20, 2005

History: Amended 2005 Ky. Acts ch. 99, sec. 465, effective June 20, 2005. -- Amended 2002 Ky. Acts ch. 211, sec. 47, effective July 15, 2002. -- Amended 2001 Ky. Acts ch. 61, sec. 1, effective June 21, 2001. -- Amended 2000 Ky. Acts ch. 343, sec. 26, effective July 14, 2000. -- Amended 1998 Ky. Acts ch. 426, sec. 412, effective July 15, 1998. -- Amended 1996 Ky. Acts ch. 369, sec. 3, effective July 15, 1996. -- Created 1990 Ky. Acts ch. 443, sec. 3, effective July 13, 1990.

Appendix 6

902 KAR 2:020. Disease surveillance.

RELATES TO: KRS 211.180(1), 214.010, 214.645, 333.130

STATUTORY AUTHORITY: KRS 194A.050, 211.090(3), EO 2004-726

NECESSITY, FUNCTION, AND CONFORMITY: EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health and Family Services and placed the Department for Public Health under the Cabinet for Health and Family Services. KRS 211.180 requires the cabinet to implement a statewide program for the detection, prevention, and control of communicable diseases, chronic and degenerative diseases, dental diseases and abnormalities, occupational diseases and health hazards peculiar to industry, home accidents and health hazards, animal diseases which are transmissible to man, and other diseases and health hazards that may be controlled. KRS 214.010 requires every physician and every head of family to notify the local health department of the existence of diseases and conditions of public health importance, known to him or her. This administrative regulation establishes notification standards and specifies the diseases requiring urgent, priority, or routine notification, in order to facilitate rapid public health action to control diseases, and to permit an accurate assessment of the health status of the Commonwealth.

Section 7. Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) Surveillance. (1) Physicians and Medical Laboratories shall report:

(a)1. A positive test result for HIV infection including a result from:

- a. Elisa;
 - b. Western Blot;
 - c. PCR;
 - d. HIV antigen; or
 - e. HIV culture;
2. CD4+ assay including absolute CD4+ cell counts and CD4+%;
 3. HIV detectable Viral Load Assay; and
 4. A positive serologic test result for HIV infection; or

(b) A diagnosis of AIDS that meets the definition of AIDS established within the Centers for Disease Control and Prevention (CDC) guidelines and reported in the:

1. "Adult HIV/AIDS Confidential Case Report Form," or
2. "Pediatric HIV/AIDS Confidential Case Report Form."

(2) An HIV infection or AIDS diagnosis shall be reported within five (5) business days and, if possible, on the "Adult HIV/AIDS Confidential Case Report form" or the "Pediatric HIV/AIDS Confidential Case Report form."

(a) A report for a resident of Jefferson, Henry, Oldham, Bullitt, Shelby, Spencer, and Trimble Counties shall be submitted to the HIV/AIDS Surveillance Program of the Louisville-Metro Health Department.

(b) A report for a resident of the remaining Kentucky counties shall be submitted to the HIV/AIDS Surveillance Program of the Kentucky Department for Public Health, or as directed by the HIV/AIDS project coordinator.

(3) A report for a person with HIV infection without a diagnosis of AIDS shall include the following information:

- (a) The patient's full name;
- (b) Date of birth, using the format MMDDYY;
- (c) Gender;
- (d) Race;
- (e) Risk factor, as identified by CDC;
- (f) County of residence;
- (g) Name of facility submitting report;
- (h) Date and type of HIV test performed;
- (i) Results of CD4+ cell counts and CD4+%;
- (j) Results of viral load testing;
- (k) PCR, HIV culture, HIV antigen, if performed;
- (l) Results of TB testing, if available; and
- (m) HIV status of the person's partner, spouse or children.

(4) Reports of AIDS cases shall include the information in subsections (1) through (3) of this section; and

- (a) The patient's complete address;
- (b) Opportunistic infections diagnosed; and
- (c) Date of onset of illness.

(5) (a) Reports of AIDS shall be made whether or not the patient has been previously reported as having HIV infection.

(b) If the patient has not been previously reported as having HIV infection, the AIDS report shall also serve as the report of HIV infection.

Appendix 7

The following are copies of media campaigns to which anecdotal evidence is showing to be effective in Northern Kentucky and Paducah.

Northern Kentucky Independent District Health Department

Message: HIV is alive and well. Are you?

Heartland CARES, Inc. (Paducah)

Message: Got AIDS? Don't know? Got 20 minutes? Get tested!

MEMBERSHIP AND AFFILIATIONS

Executive Committee

Robert Stone	Chairperson
Paul Trickel	Chair, Policy and Promotion Committee
Nick Sauer	Chair, Care and Prevention Committee
Robert Edelen	At-Large
Ann Dills	At-Large

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Glenn Jennings	Commissioner, Kentucky Department for Medicaid Services

Members from State Agencies

Susan (Nikki) White	Louisville Metro Health Department
Paul Trickel	Northern Kentucky Independent District Health Department

Members from Community Based Organizations

Ann Dills	Bluegrass Care Clinic
Gary Fowler	Matthew 25
Aunsha Hall	AIDS Volunteers
Beth Harrison Prado	Volunteers of America
Nick Sauer	Owensboro Task Force
Cynthia Shannon	Cumberland River Comprehensive Care Center
Robert Stone	Owensboro Task Force
Deborah Wade	WINGS Clinic
Krista Wood	Heartland CARES, Inc.

Members of the Public

John Bentley
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Physician Representatives

Carl LeBuhn, MD