

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

**YEAR-END REPORT
SEPTEMBER 2009**



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



ROBERT E. STONE
COMMUNITY CO-CHAIR

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DAVID CLARK
STATE CO-CHAIR

September 3, 2009

Mr. Robert Sherman
Legislative Research Commission
Room 300, Capitol Building
700 Capitol Avenue
Frankfort, KY 40601

Dear Mr. Sherman:

Pursuant to KRS 214.640, the Kentucky HIV/AIDS Planning and Advisory Council, KHPAC submits to the Kentucky General Assembly, Interim Joint Committee on Health and Welfare, and the Cabinet for Health and Family Services, its annual Year-End Report, dated September 3, 2009. Thank you for your attention to this report.

Sincerely,

A handwritten signature in black ink that reads "Robert E. Stone".

Robert E. Stone, Chairman
Kentucky HIV/AIDS Planning and
Advisory Council

Attachments:
2009 KHPAC Year-End-Report

cc: Janie Miller, Secretary, Cabinet for Health and Family Services

Dee Ann Mansfield, Committee Staff Administrator
Interim Joint Committee on Health and Welfare

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Executive Summary

The 2009 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 - KADAP

KHPAC recommends that the state increase its financial contribution to the Kentucky AIDS Drug Assistance Program (KADAP) by \$1.8 million. A growing waiting list averaging 55 clients per month has been instituted as of June 1, 2009. This critical situation is due to a 51.5 % increase in enrollment; decrease in federal funding of KADAP; KADAP being responsible for Medicare "donut hole" payments, and the depletion of rebate dollars accumulated since 2006. The recommended \$1.8 million increase would sustain KADAP's current enrollment and provide the capacity to serve HIV+ individuals with access to lifesaving medications in 2009. Unless financial contributions continue to increase with the demand for services, KADAP will not be able to eliminate the waiting list and will be forced to make significant programmatic changes in 2010 and beyond.

Comprehensive Science Based Education

KHPAC recommends that comprehensive science based education be provided in all public middle and high schools in Kentucky. This education would include developmentally appropriate, medically accurate information on the following topics: human development, relationships, decision-making, peer pressure, goal setting, conflict resolution, abstinence, contraception and disease prevention. This recommendation is consistent with Kentucky's current curriculum standards (704 KAR 3:303). KHPAC also recommends that a process be developed to ensure that all middle and high school students receive this education and that passive consent be adopted by all school districts.

Inmate Testing

KHPAC recommends amending KRS 197.055 to further define procedures for conducting voluntary HIV testing of inmates to include upon entry, and before an inmate's release from any unit or center of the Department of Corrections. Counseling regarding treatment options should be included in the provision of this service should an inmate test positive for the human immunodeficiency virus (HIV).

Drug Use and HIV Infection

KHPAC is recommending the legislature act to prevent HIV transmission by providing clinicians, patients, and the general public with a responsible assessment of the effective approaches to treat drug abuse and its relation to the risk behavior of contracting HIV/AIDS. While funding will be required for comprehensive science based education in schools, funding of KADAP for treatment and for surveillance, the overall fiscal impact is projected to be a cost-savings measure.

FUTURE CONCERNS:

Funding of HIV Surveillance Activities

Within KHPAC's 2008 Year-End Report we called for increased state funding of HIV surveillance activities. However because of some unexpected federal funding increases we are not forwarding that recommendation in our 2009 Report. This is an opportunity to alert the Cabinet and the Legislature of the potential need for such funding. Given that this federal funding is only authorized through 12/31/2012, it is imperative that a significant allocation of state funds be authorized in the future to support the Department for Public Health's efforts accurately capture the demographics of the epidemic and gather resources for the fight against HIV in Kentucky.

Section I

LEGISLATIVE ACTION

A. Kentucky AIDS Drug Assistance Program Funding (KADAP)

Recommendation:

KHPAC recommends that the state increase its financial contribution to the Kentucky AIDS Drug Assistance Program (KADAP) by \$1.8 million. Due to a 51.5 % increase in enrollment; decreasing federal funding of KADAP; KADAP being responsible for Medicare “donut hole” payments, and the depletion of rebate dollars accumulated since 2006, a waiting list was instituted June 1, 2009. An average of 55 new clients are being added to the waiting list every month. The recommended \$1.8 million increase would sustain KADAP’s current enrollment and provide the capacity to serve HIV+ individuals with access to lifesaving medications in 2009. Unless financial contributions continue to increase with the demand for services, KADAP will not be able to eliminate the waiting list and will be forced to make significant programmatic changes in 2010 and beyond.

Grade: Fail - Continuing Recommendation

As of June 1, 2009 KADAP implemented a waiting list. The program enrolls 55 new clients on average a month. The recommended \$1.8 in state funding increase would provide KADAP with the capacity to provide clients with lifesaving medications. Recently, legislative action has been taken to increase State funding of KADAP. In 2004 an additional \$90,000 in State funds was allocated to KADAP; doubling the amount of State funding that existed prior to that allocation. In 2005 legislative action allocated another \$70,000 in State funding to KADAP; bringing the total annual KADAP State funding to \$250,000. KHPAC welcomed the legislature’s support of these increases. However in fiscal year 2007, \$250,000 was redirected away from the KADAP budget by the Cabinet, this was due to required budget cuts. In the Cabinet’s fiscal year 2008 and 2009 budget no State funding was allocated to KADAP.

Background:

KADAP makes available to eligible Kentuckians medications that are necessary to keep individuals in the work force, keep them from becoming more ill, and to help prevent other healthcare costs. 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, the Council appreciates the \$70,000 funding increase authorized through H.B.1 of the 2006 Legislature. However as is indicated above the \$250,000 previously allocated was redirected by the Cabinet in 2007 and was not included in the 2008 nor 2009 KADAP budget.

In a letter dated July 10, 2008, the Honorable United States Senator Mitchell McConnell, states, "AIDS Drugs Assistance Programs (ADAP) are state-based programs..."¹ Kentucky's ADAP budget for 2008 is \$4,372,876 and no state funds are included in that budget. If as Senator McConnell states, ADAP's are state-based programs, where is Kentucky's financial commitment to this program and the Kentuckians who benefit from KADAP?

For each additional \$100,000 the State contributes to KADAP, approximately ten more Kentuckians will have access to life-saving medications that will 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 decreased emergency care needs. KADAP clients, who remain healthy, are more able to work, pay taxes, and participate in the daily economy of our State.

In addition, Kentucky has seen cuts to its federal funding of KADAP over the past two years; a \$227,900 decrease in 2007 and a \$22,231 decrease in 2008.²

Why this is still important?

Individuals, who are diagnosed with HIV, must have access to treatment medications in order to maintain their health and be positive productive family members, employees and members of our community who will continue to contribute to society in a myriad of ways.

For anyone without health insurance that provides a solid prescription plan, HIV medications remain unaffordable with an average monthly regimen costing \$1,200. KADAP currently provides 1379 Kentuckians with affordable access to HIV medications. Without KADAP most of these individuals would be unable to obtain their medications.

What needs to be done?

KHPAC recommends the:

1. Reinstatement of the already allocated \$250,000 in State funds to KADAP.
2. Allocation of additional State funds would meet an identified unmet need for securing that Kentuckians already infected with HIV will continue to have access to necessary lifesaving medications.

¹ McConnell, Mitch, US Senator, letter to Mr. Timothy McAdoo, July 10, 2008. Appendix B.

² Ibid

B. Comprehensive Science Based Education

Recommendation:

KHPAC recommends that comprehensive science based education be provided in all public middle and high schools in Kentucky. This education would include developmentally appropriate, medically accurate information on the following topics: human development, healthy relationships, decision-making, peer pressure, goal setting, conflict resolution, influences (e.g., family, peers, media, technology, and culture), accessing accurate information, abstinence, contraception, and disease prevention. This recommendation is consistent with Kentucky's current curriculum standards (704 KAR 3:303). KHPAC also recommends that a process be developed to ensure that all middle and high school students receive this education and that passive consent be adopted by all school districts. Comprehensive science based education would be offered to all students (e.g., students in regular classrooms, students in special education classrooms, etc.).

Grade: Fail - Continuing Recommendation

ADMINISTERED WITHIN ALL PUBLIC KENTUCKY MIDDLE AND HIGH SCHOOLS. While current curriculum standards include comprehensive science based education, there is no evidence to show that all middle and high school students in Kentucky's public schools are receiving it. In fact, there is documentation to show that HIV prevention education is not being taught in all middle and high schools, even though it is required by KAR (704 KAR 3:303). HIV prevention education is needed because almost half (48.3%) of high school students have had sexual intercourse.³ According to the CDC, 15 to 24 year olds are 25% of the sexually active population but acquire nearly half of all new sexually transmitted infections.⁴

Fiscal Impact

<i>Condition</i>	<i># of Cases in Kentucky</i>	<i>Period</i>	<i>Total cost</i>
HIV	931	4 years	\$372.4 million ⁵
Teen child bearing	115,300	14 years	\$2.9 billion ⁶

³ 2009 Kentucky Youth Risk Behavior Survey

⁴ www.cdc.gov/STD/STATS/adol.htm

⁵ One estimate shows that the lifetime cost of treating a person with HIV was \$400,000 (The Benefits of HIV and the Price Tag, 2007, <http://www.thebody.com/hivmonth/thismonth0107-2.html#5>).

⁶ <http://www.thenationalcampaign.org/costs/pdf/states/kentucky/onepager.pdf>

What needs to be done?

- All site-based decision making councils in Kentucky will be educated on the risk of HIV and other sexually transmitted infections to Kentucky youth.
- All middle and high schools must develop a reporting process to ensure all students in Kentucky's public schools receive education that complies with the Program of Studies.
- Schools will report to the Health Program Administrator, HIV Prevention Program at the Kentucky Department of Education.
- The Health Program Administrator at the Kentucky Department of Education, in collaboration with the Division of Curriculum at the Kentucky Department of Education will provide technical assistance to schools on this process. The HIV Prevention Program is available to offer professional development and technical assistance to all Kentucky public schools.
- The Health Program Administrator of the HIV Prevention Program will collaborate with the Division of Curriculum at the Kentucky Department of Education to keep updated on program review requirements and progress⁷

Background:

Comprehensive science based education provides a complete message, and is effective in providing adolescents with information to make responsible decisions, as well as building knowledge, attitude, and skills.⁸ The majority of comprehensive programs had a positive effect.⁹ Comprehensive programs work for both genders, for all major ethnic groups, for sexually experienced and inexperienced teens, in different settings, and in different communities.¹⁰

Comprehensive programs are effective at assisting young people to make healthy decisions about sex.¹¹ No abstinence-only-until-marriage program has been shown to help teens delay the initiation of sex or to protect themselves when they do initiate sex.¹² Young people who receive comprehensive education were significantly less likely to get pregnant compared to those who received no sexuality education.¹³ In comparing abstinence-only programs with comprehensive programs, comprehensive education was associated with a 50% lower risk of teen pregnancy.¹⁴

⁷ Program review refers to program review of practical living/career studies as required by SB1 of the 2009 Session. KRS 158.6453

⁸ Healthy Teen Network <http://www.healthyteennetwork.org/vertical/Sites/{B4D0CC76-CF78-4784-BA7C-5D0436F6040C}/uploads/{4C5F842E-E67A-4AC2-921B-287950431BD7}.PDF>

⁹ Kirby, Emerging Answers www.thenationalcampaign.org/EA2007/EA2007_full.pdf

¹⁰ Ibid

¹¹ Advocates for Youth Effective Sex Education Fact Sheet http://www.advocatesforyouth.org/index.php?option=com_content&task=view&id=450&Itemid=336

¹² Advocates for Youth Effective Sex Education Fact Sheet

¹³ Ibid

¹⁴ Ibid

Supporters of comprehensive programs include The American Academy of Pediatrics; American Medical Association; American Public Health Association; Society for Adolescent Medicine; National Education Association; National Medical Association; American College of Obstetricians and Gynecologists; and the National School Boards Association.

The Kentucky Department of Education includes HIV, Sexually Transmitted Infections, STI's, and teen pregnancy prevention in Program of Studies¹⁵. The Program of Studies for middle and high school states that students will

- Analyze personal decisions that impact an individual's emotional, sexual and reproductive health (e.g., abstinence)
- Explain basic structures and function of the reproductive system
- Describe symptoms, causes, patterns of transmission, prevention and treatments of communicable diseases (colds, flu, mononucleosis, hepatitis, HIV/STD, tuberculosis)
- Explain how health is influenced by the interaction of body systems (e.g., reproductive, digestive, circulatory, skeletal, respiratory)

The Program of Studies outlines the minimum content standards required for all students. See 704 KAR 3:303, which incorporates the Program of Studies for Kentucky Schools Primary-12 (2006).

Why this is important

CURRENT GUIDELINES ARE NOT BEING ADMINISTERED WITHIN ALL KENTUCKY MIDDLE AND HIGH PUBLIC SCHOOLS AND STUDENTS ARE ENGAGING IN RISKY BEHAVIORS.

- Almost half (48.3%) of high schools students have had sexual intercourse and this number has remained steady since 2003 (2009 Kentucky YRBS)
- 17.2% of Kentucky *middle* school students reported that they have had sexual intercourse (2009 Kentucky YRBS)
- The number of high school students who said they had been taught about HIV has declined by over 12,000 students from 2003 to 2009 (2009 Kentucky YRBS)
- According to the CDC, 15 to 24 year olds are 25% of the sexually active population but acquire nearly half of all new sexually transmitted infections
- There were over 115,300 teen births in Kentucky over a 15 year period

For more information, contact:

Renee White, Ph.D.: renee.white@education.ky.gov

The Program of Studies outlines the minimum content standards required for all students. See 704 KAR 3:303, which incorporates the Program of Studies for Kentucky Schools Primary-12 (2006). For more information, see

¹⁵ For more information,

see <http://www.education.ky.gov/KDE/Instructional+Resources/Curriculum+Documents+and+Resources/Program+of+Sudies/>

<http://www.education.ky.gov/KDE/Instructional+Resources/Curriculum+Documents+and+Resources/Program+of+Studies/>

Other References: Abstinence only vs Comprehensive Sexuality Education (Collins, Alagiri, and Summers 2002)

2009 Kentucky YRBS

www.cdc.gov/STD/STATS/adol.htm

One estimate shows that the lifetime cost of treating a person with HIV was \$400,000 (The Benefits of HIV and the Price Tag, 2007, <http://www.thebody.com/hivmonth/thismonth0107-2.html#5>).

<http://www.thenationalcampaign.org/costs/pdf/states/kentucky/onepager.pdf>

Program review refers to program review of practical living/career studies as required by SB¹⁶ For more information, see

<http://www.education.ky.gov/KDE/Instructional+Resources/Curriculum+Documents+and+Resources/Program+of+Studies/>

¹⁶ 2007 Kentucky Senate Bill 201.

C. HIV Testing of Inmates

Recommendation:

Amend KRS 197.055 to further define procedures for conducting voluntary HIV testing of inmates to include upon entry, and before an inmate's release from any unit or center of the Department of Corrections. Counseling regarding treatment options must be included in the provision of this service if an inmate tests positive for the human immunodeficiency virus (HIV).

Grade:

Grade: Poor – Continuing Recommendation

KHPAC has made a similar recommendation for the past three years and legislative action has been introduced in the previous two legislative sessions. However no changes have been approved and KHPAC learned this year that we overlooked existing Kentucky legislation, KRS 197.055, which already provides some guidance regarding HIV testing of inmates.

Background:

HIV testing of inmates is an issue that was brought to the forefront of the 2007 Kentucky Legislative session in Senate Bill 201.¹⁷ While KHPAC concurs with the need for inmate testing for HIV upon release, there are other critical issues that need to be considered when implementing an HIV testing protocol within correctional settings. KHPAC supports the development and implementation of a comprehensive HIV testing process for inmates that not only tests prior to release, but upon admission and as warranted by an inmate's "known" engagement in risky behaviors. The later of these is already identified in KRS 197.055.

HIV rates are fourteen times higher in this [the correctional] population than the general U.S. population.¹⁸ It has also been estimated that 13-19% of all HIV+ individuals in the U.S. each year are released inmates.¹⁹ Consequently, HIV testing of inmates when entering a correctional facility and once released is a practical step for reducing the spread of HIV disease within the prison system and in the general population. KHPAC contends and research supports that HIV testing within correctional settings should be designed to educate individuals on

¹⁷ Public Health & Corrections, "HIV Prevention Community Planning Groups and Correctional Institutions: A Collaboration for All." March, 2003.

¹⁸ American Journal of Public Health, "Characteristics & Behaviors Associated with HIV infection Among Inmates in the North Carolina Prison System." June, 2009.

¹⁹ Designer drug use and HIV risk behavior in Los Angeles County, California. **Graphic note:** Note. Based on data from 33 states with long-term, confidential name-based HIV reporting. Because of rounding, percentages may not equal 100. ."

effective ways to reduce the spread of HIV, and if an individual tests HIV positive, to help that person understand an HIV diagnosis, access treatment and medications, and reduce the risk of exposure to others. KHPAC could not support recent legislation (SB 201 in 2007 and SB 50 in 2008), due to the stringent reporting requirements regarding testing upon exit.

Why this is still important?

Four key factors speak to why this is a crucial topic for Kentucky today:

- A. HIV infection rates in the United States are much higher in correctional settings than in the general public.
- B. Individuals who know their status are more apt to take steps to reduce the risk of exposure to others.
- C. Early diagnosis, leads to treatment, which maintains health, which promotes an individual's ability to have a positive impact on our community
- D. Accurately documenting the rate of HIV infections in Kentucky could result in additional federal funding for addressing prevention and care needs within the state.

What needs to be done?

Fortunately, the ground work for addressing this issue exists in KRS 197.055. KHPAC recommends that the following actions be taken to broaden the scope of 197.055 and thus, more comprehensively address this issue:

1. Amend KRS 197.055 as recommended in Appendix D.
2. Assure HIV testing of inmates is voluntary, meaning inmates have the option to "opt out" of testing, except when there is a risk of exposure to another individual.
3. Provide inmates diagnosed with HIV appropriate medical treatment and prompt access to treatment medications.
4. Collaboration between the Department of Corrections and the Cabinet for Health and Family Services is crucial to the success of inmate testing and care, and prevention of new infections within the prison population. Agencies can collaborate by providing and updating educational materials; providing technical assistance to the Department of Corrections in jointly identified areas. The HIV/AIDS Branch is currently participating in HIV support groups within a prison with hopes of duplicating these efforts across the state.

D. Drug Use and HIV Infection

Recommendation:

HIV prevention is most effective when it is supported by strong and visible political leadership, and by policies that address the root causes of vulnerability to HIV, including poly-substance abuse education, treatment and surveillance. KHPAC considers substance abuse within the HIV/AIDS policy framework a legislative priority because it affects all races, ages, economic classes and genders of the Commonwealth.

Due the addictive and intoxicating effects of many drugs, which alter judgment and inhibition and lead people to engage in impulsive and unsafe behaviors, and by extension, increase exposure to HIV/AIDS.

KHPAC is recommending the legislature act to prevent HIV transmission by providing clinicians, patients, and the general public with a responsible assessment of the effective approaches to treat drug abuse and its relation to the risk behavior of contracting HIV/AIDS. While funding will be required for comprehensive science based education in schools, funding of KADAP for treatment and for surveillance, the overall fiscal impact is projected to be a cost-savings measure.

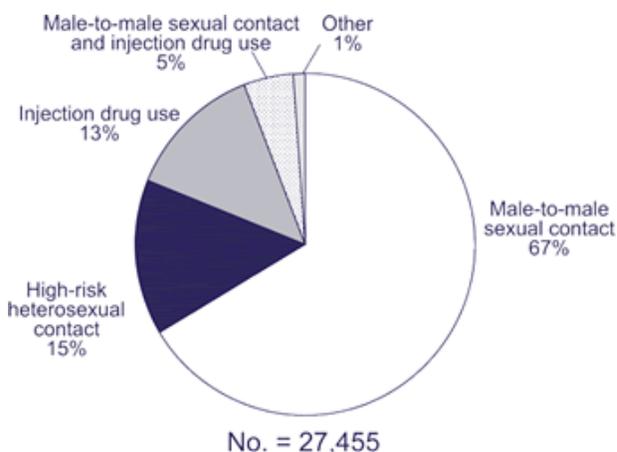
Grade: No Progress – New Recommendation

KHPAC has not been advised of significant progress in this category that was originally noted on the 2008 KHPAC year-end report (YER) as a new recommendation.

Background:

Substance abuse is a major cause of new HIV infections, thereby weakening the immune system, creating an opportunity for infections to develop. The costs to the public health system are difficult to calculate, but prevention and early treatment have been proven to be among the most effective interventions.

Drug abuse and addiction have been inextricably linked with HIV/AIDS since the beginning of the epidemic. In fact, the CDC considers drug abuse treatment as a form of HIV prevention. KHPAC defines substance abuse as a range of drugs (pharmacy and street, & designer drugs) including IV drug use, methamphetamines (meth), cocaine/crack to alcohol & liquor among others.



Shared equipment can spread HIV, hepatitis, and other diseases. Alcohol and drug use, even when just used recreationally, contribute to unsafe sexual activities according to www.aids.org. Moreover, as use of these drugs is associated with

younger age, these users may be less likely to consider themselves at risk and less likely to use safer sex methods. ^[1]

Many recreational drugs interact with ARVs. The information on these interactions is incomplete and surveillance funding is needed for formulation of community-based resources for legislative districts.

KHPAC is recommending the legislature review published studies provided by KHPAC and/or the cabinet for consideration of a funded pilot needle exchange program.

- Injection drug use has directly and indirectly accounted for more than 36% of AIDS cases in the United States since the epidemic began. (<http://www.cdc.gov/hiv/resources/factsheets/idu.htm>)
- Beyond abstinence, using a new, sterile needle or syringe with each injection remains the safest, most effective approach for limiting HIV and hepatitis transmission.
- According to the Drug Enforcement Agency (DEA), like heroin, meth can be injected, increasing the risk of contracting disease through shared needles or syringes. HIV cases have increased significantly among intravenous drug users, and they now make up the fastest growing percentage of those who are HIV positive.

According to the CDC, “Non injection drugs (such as "crack" cocaine) also contribute to the spread of the epidemic when users trade sex for drugs or money, or when they engage in risky sexual behaviors that they might not engage in when sober. One CDC study of more than 2,000 young adults in three inner-city neighborhoods found that crack smokers were three times more likely to be infected with HIV than non-smokers.” ²⁰ (footnote: <http://www.cdc.gov/hiv/resources/factsheets/idu.htm>)

Why this is important?

According to the National Institute of Health, “The erosion of funding for drug abuse treatment programs must be halted because research data clearly show that such programs reduce risky drug abuse behavior and often eliminate drug abuse itself.” ²¹ [NIH Consens Statement](#). 1997 Feb 11-13;15(2):1-41.)

Additionally, AIDS.ORG has determined that “drug and alcohol use can also be dangerous for people who are taking antiretroviral medications (ARVs). Drug users are less likely to take all of their medications, and street drugs may have

²⁰ <http://www.cdc.gov/hiv/resources/factsheets/idu.htm>)

²¹ [NIH Consens Statement](#). 1997 Feb 11-13;15(2):1-41.)

dangerous interactions with ARVs.”²² (<http://www.aids.org/factSheets/154-Drug-Use-and-HIV.html>)

Although new therapies have raised hopes for longer life spans and better quality of life for people living with HIV/AIDS, these therapies are not appropriate or effective for all consumers, and they have dramatically increased the already high cost of care and treatment for this disease.

Recommendations

1. Support legislation to promote HIV Prevention as part of substance abuse programs.
2. Support legislation to increase funding and allow for collaborative programs between HIV/AIDS, STI's and substance abuse treatment facilities (including adjustments for caseload and cost-of-care driven budget increases, for KADAP)
3. Initiate needle exchange programs in areas of highest risk as identified by the cabinet to give free, clean syringes to people so they won't need to share needles, thus decreasing exposure to HIV/AIDS by an estimated 36%.
4. Provide an allocation of resources to be administered in conjunction with the cabinet and the Kentucky Board of Education (see section B); any existing legislative barriers that discourage effective programs aimed at youth must be eliminated.
5. Support legislation that would expand substance abuse counseling and education with an emphasis on HIV risk reduction aimed at both jail inmates and jail personnel.
6. Fund a pilot mass media message program that targets the areas of greatest risk of exposure to drug use related activities. Assign the cabinet the mandate and resources to study outcomes through surveillance. (Additional recommendations are found in section II of this report.)

²² (<http://www.aids.org/factSheets/154-Drug-Use-and-HIV.html>)

Section II

FUTURE CONCERNS

A. State Funding for HIV Surveillance

For 2009, the State HIV/AIDS Surveillance program was reduced from \$306,647 to \$302,678 (a difference of \$3969). Though this reduction was relatively small, further reductions will be problematic and could affect the services that the surveillance office will be able to provide. One possible area that will be affected is the capability to distribute accurate and timely information of HIV/AIDS and its effect on populations in Kentucky. Money is budgeted to print fact sheets and the Integrated Epidemiologic Profile *The epidemiologic profile is a document that describes the effect of the HIV/AIDS epidemic on an area in terms of sociodemographic, geographic, behavioral, and clinical characteristics. The profile is a valuable tool that is used at the state and local levels by those who make recommendations for allocating HIV prevention and care resources, planning programs, and evaluating programs and policies*—both are important ways to distribute information to the public about the disease. With further reductions, the quantity and/or frequency of these publications could be reduced. Another avenue that would be affected would be site visits to providers who may not report as completely as they should. Travel includes visits to providers to gather additional information on cases and to train on how to report HIV/AIDS cases in a correct and timely manner.

This could easily lead to cases **not** being reported as AIDS until later in the progression of the disease. Other areas suffer when AIDS cases are not reported in a timely manner, namely the Human Resources and Services Administration, (HRSA) grant which mandates that the state has to match funding once the total number of AIDS cases reaches 1% of Kentucky's total population. If these cases aren't captured, there is no way to mandate the state to adequately fund the areas of services and surveillance.

Consequently, expansion and improvement of surveillance activities would not occur. Activities include discovering new data sources, researching and matching with new data programs. Without current or expanded funding, these activities will be on hold due to not having personnel for the funds to allow for such programming to occur. Given that federal funding is only authorized through 12/31/2012, it is imperative that a significant allocation of state funds be authorized in the future to support DPH's efforts to characterize the epidemic and gather resources for the fight against HIV in Kentucky.

Effective HIV surveillance efforts are crucial to addressing prevention, and care and services issues related to HIV disease. Recent Centers for Disease Control and Prevention studies indicate a significantly higher incidence of new HIV infections in the United States than previously indicated.²³ Consequently, the

²³ Estimation of HIV Incidence in the United States, Hall HI, Song R, Rhodes P, Prejean J, An Q, Lee LM, Karon J, Brookmeyer R, Kaplan EH, McKenna MT, Janssen RS for the HIV Incidence Surveillance Group. Journal of the American Medical Association, August 6, 2008.

need for effective HIV surveillance efforts has not declined but, “significantly increased.”

Therefore, it is imperative that a significant allocation of state funds be authorized in the future to support DPH’s efforts to characterize the epidemic in Kentucky, gather resources for the fight against HIV/AIDS, and maximize limited resources by directing assets to areas where they are likely to have the greatest impact. KHPAC continues to strongly support DPH’s past and anticipated future requests for funding for statewide core HIV surveillance activities.

APPENDIX A

KENTUCKY AIDS DRUG ASSISTANCE PROGRAM (KADAP)

Number of KADAP Clients Enrolled as of 07-27-09: 1379

Start date for re-implementation of KADAP Waiting List: 06-01-09

Average number of new Kentuckians being added to KADAP monthly: 55

Estimated cost to sustain current enrollment: \$1.8M in addition to Federal funding.

<u>KADAP Total Federal Award by Year</u>	<u>KADAP State Award by Year</u>
2009 - \$4,712,107	2009 - \$0
2008 - \$4,909,103	2008 - \$0
2007 - \$4,637,372	2007 - \$250,000 (Rescinded)
2006 - \$4,857,637	2006 - \$250,000
2005 - \$5,178,691	2005 - \$180,000
2004 - \$4,640,297	2004 - \$90,000

Explanation of Purchasing of Medications

KADAP contracts with the University of Kentucky, as the sole provider of medications through KADAP. This contract is awarded on an annual basis. Currently, KADAP pays 340 B pricing plus a dispensing fee. KADAP also covers the cost of shipping medications to clients – the program expends <1% of its total expenditures annually on shipping costs.

Other Cost Saving Mechanisms

The AIDS Drug Assistance Program (ADAP) Crisis Task Force, a national group, has worked with pharmaceutical companies to offer price relief to state ADAPs nationwide. As a result of negotiations with the Task Force, the following companies are offering special pricing/discounts/rebates to all ADAPs: Abbott, Agouron/Pfizer, Boehringer Ingelheim, Bristol-Myers Squibb, Gilead Sciences, GlaxoSmithKline, Merck, and Roche. The contents of each company's negotiation are strictly confidential but a substantial savings is anticipated and will help to serve additional clients.

****KADAP estimates that approximately \$3.1M will be received in rebates for 2009. KADAP has received \$8.4M in rebates since 2006. The \$3.4M remaining, in addition to receiving an estimated \$3.1M in 2009, will be spent during the 2009 grant year in order to sustain clients already enrolled on KADAP.**

Eligibility Criteria

KADAP requires that all clients meet the following:

- Be a resident of Kentucky
- Have income at or below 300%FPL
- Have cash assets less than \$10,000

- Be HIV+
- Have no other full third party payers (i.e., Medicaid, Veteran’s Health Administration)
- All clients must maintain enrollment in the Kentucky HIV/AIDS Care Coordinator Program (KHCCP)

Persons who meet the above criteria qualify for KADAP, regardless of their disability and/or employment status. Those who qualify will have their names added to the waiting list in a first-come, first-served manner.

History of Federal KADAP Funding 2005 to 2009

Year	ADAP Earmark*	Supplemental	Carryover Funds	RW Title II Funds	Total	Base Award Increase
2009	\$ 4,330,107	\$ 232,000	\$ -	\$ 150,000	\$4,712,107	\$ 22,231
2008	\$ 4,307,876	\$ -	\$ 83,463	\$ 517,764	\$4,909,073	\$ (22,231)
2007	\$ 4,330,107	\$ -	\$ 307,235	\$ -	\$4,637,342	\$ (227,900)
2006	\$ 4,558,007	\$ 227,356	\$ -	\$ 72,274	\$ 4,857,637	\$ 116,535
2005	\$ 4,441,472	\$ 465,945	\$ 199,000	\$ 72,274	\$ 5,178,691	\$ 354,731

APPENDIX B

MITCH McCONNELL

KENTUCKY

2009 KHPAC Year End Report

361-A RUSSELL SENATE OFFICE BUILDING
WASHINGTON, DC 20510-1702
(202) 224-2541

United States Senate

REPUBLICAN LEADER

COMMITTEES:

AGRICULTURE

APPROPRIATIONS

RULES AND ADMINISTRATION

July 10, 2008

Mr. Timothy McAdoo
1012 Richwood Way
La Grange, Kentucky 40031-8930

Dear Mr. McAdoo:

Thank you for contacting me regarding improvements for the Medicare prescription drug benefit for people with HIV/AIDS. I appreciate your taking the time to share your thoughts with me, and I welcome the opportunity to respond.

Since the program began, more than 37 million Americans, or roughly seven out of eight eligible seniors, have enrolled in prescription drug coverage. The Department of Health and Human Services recently reported that the average senior enrolled in a plan will save \$1,200 in drug expenses this year. Despite the dire predictions of the program's critics, the drug plans have cost 30 percent less than anticipated, and residents in every state can choose a plan that costs less than \$20 per month. Most importantly, a recent independent survey of seniors found that 8 out of 10 Medicare beneficiaries were satisfied with the new benefit.

As you know, some of the new Medicare drug plans limit coverage once a certain dollar threshold has been reached. This is sometimes referred to as a "coverage gap" or "doughnut hole." Plans are not required to include a coverage gap and there are plans available to Kentuckians that do not.

AIDS Drugs Assistance Programs (ADAP) are state-based programs funded in part by Title II of the Ryan White CARE Act created in 1990 by the US Congress. ADAP provides medications to treat HIV disease or prevent related serious deterioration of health. Drugs provided and eligibility criteria are determined state by state with a focus on serving low-income individuals.

In your correspondence, you suggest that the Medicare Part D program should be improved so that ADAP expenditures could count towards True Out of Pocket (TrOOP) costs. Senator Jeff Bingaman introduced legislation, S. 1103, which would allow ADAP expenditures to count towards TrOOP. I appreciate your suggestions and assure you that I am closely following the implementation of this new benefit. As the Senate considers measures to improve access to these programs I will be certain to keep your views foremost in mind.

It may also interest you to know that the Senate Appropriations Committee, on which I serve, recently approved funding for the ADAP when it approved the Labor, Health and Human Services, and Education Appropriations bill for Fiscal Year 2009. This bill will provide nearly

Page 2
July 10, 2008

\$2.2 billion in funding for Ryan White AIDS Programs. Of this total, \$800 million will fund ADAP, which is a \$6 million increase from the previous year.

Again, thank you for sharing your thoughts with me. I hope you will continue to keep me informed of issues that are important to you.

Sincerely,

A handwritten signature in black ink, appearing to read "Mitch McConnell", with a long horizontal flourish extending to the right.

MITCH McCONNELL
UNITED STATES SENATOR

MM/la

APPENDIX C

SIECUS Releases Special Report on Abstinence-Only-Until-Marriage Programs in Kentucky

On July 29, 2008 the Sexuality Information and Education Council of the United States (SIECUS) released a special report on abstinence-only-until-marriage programs in Kentucky. The report provides an in-depth look at the funding for abstinence-only-until-marriage programs in Kentucky, the status of adolescent sexual health in the state, and Kentucky's current law and policy. In addition, the report found that a significant portion of state and federal funds are being directed towards crisis pregnancy centers (CPCs), and that some of the worst abstinence-only-until-marriage curricula are being used throughout Kentucky.

As abstinence-only-until-marriage funds have poured into Kentucky, youth in the state have faced increasingly poor health outcomes. The teen birth rate is nearly 20 percent higher than the national average (49.2 per 1,000 young women ages 15–19 compared to 41.1 in the same age group nationally).^[i] In a single year the Centers for Disease Control and Prevention (CDC) reports Kentucky's rate rose nearly 7 percent. The nationwide teen birth rate increased by less than half that in the same year.^[ii] HIV statistics in the state are also disturbing. The overall prevalence is low, but the disease disproportionately impacts some communities: African Americans make up only seven percent of the total population of Kentucky but nearly 34 percent of new HIV cases in the state, according to the CDC.^[iii] Since 1997, the state of Kentucky, through the Cabinet for Health and Family Services and numerous community-based organizations, has received over \$16.9 million in abstinence-only-until-marriage funding through the three funding streams. In Fiscal Year 2007 alone, over \$3 million went into these programs in Kentucky.

In Kentucky, the state distributes abstinence-only-until-marriage funding to 16 local health departments – 11 of which use fear and shame based curricula. The state also provides Title V abstinence-only-until-marriage sub-grants to more CPCs than any other state. CPCs are anti-choice establishments that function to dissuade women with an unintended pregnancy from choosing abortion. These centers often pose as family planning/reproductive health clinics and claim to offer “abortion information and referrals.”

In looking at the curricula used by these health departments, CPCs, and other community-based organizations, five central, and disturbing, themes emerged:

- advancing religious messages;
- relying on messages of fear and shame;
- fostering gender myths and stereotypes;
- promoting the questionable practice of virginity pledges; and

- providing misinformation.

One example of this is Marsha's Place (Pregnancy Resource Center of Henderson County), a Title V abstinence-only-until-marriage sub-grantee and CPC, which makes a clear effort to scare and shame students on its website. In the "Your Life" section, Marsha's Place lists reasons "why I will wait for sex," including: "to stop the need for lying," "to avoid bad memories," and "to avoid guilt and disappointment." The same section of the website offers different ways of "Saying 'NO'" including, "I don't give free samples—try Baskin Robbins," and "You see these dotted lines? If you touch anything between them, you do it at your own risk. My dad has a very large gun.[\[iv\]](#)

"The young people of Kentucky deserve evidence-based and comprehensive sex education," said William Smith, vice president for public policy at SIECUS. He continued, "The statistics around teen pregnancy and HIV make the case clear: we simply cannot wait any longer to provide the information and education Kentucky youth need to make fully informed decisions about their health."

APPENDIX D

KRS 197.055 Education program on AIDS -- Policies for inmates -- Testing program.

- (1) The Department of Corrections, in conjunction with the Cabinet for Health and Family Services, shall establish introduce and maintain a mandatory introductory and continuing education program on human immunodeficiency virus and acquired immunodeficiency syndrome for all inmates. Programs shall be specifically designed for inmates while incarcerated and in preparation for release into the community. Consideration shall be given to cultural and other relevant differences among inmates in the development of educational materials and shall include emphasis on behavior and attitude change. The education program shall be continuously updated to reflect the latest medical information available.
- (2) ~~If there is evidence that an inmate, while in the custody of the department,~~
~~has~~
~~engaged in behavior which places the inmate at a high risk of transmitting or~~
~~contracting a human immunodeficiency disorder,~~ The department shall begin a testing program which is consistent with guidelines of the Centers for Disease Control and Prevention and recommendations of the correctional medical authority and shall target persons at entry into the state correctional system, who have been involved in or reasonably thought to have been involved in a high-risk behavior and upon release from the state correctional facility. For purposes of this subsection, "high-risk behavior" includes:
 - (a) Sexual contact with any person within the institution;
 - (b) The use of intravenous drugs;
 - (c) Tattooing; and
 - (d) Any other activity medically known to transmit the virus.
- (3) Except as authorized in section (7) below inmates will be informed of their right to "opt out" or not get tested. Except as outlined in section (7) below, HIV testing will not be mandatory.
- (4) The results of the tests shall become a part of that inmate's medical file, accessible only to persons designated by agency administrative regulations.
- (5) The department shall establish policies consistent with guidelines of the Centers for Disease Control and recommendations of the correctional medical authority on the housing, physical contact, dining, recreation, and exercise hours or locations for inmates with immunodeficiency disorders as are medically indicated and consistent with the proper operation of its facilities.
- (6) The department shall report to the General Assembly by July 1 each year as to the implementation of this program and the participation by inmates and staff.
- (7) If an inmate is involved in a situation with ~~a department employee~~ another person which could result, according to the institution's physician, in the transmission of the human immunodeficiency virus infection, the inmate shall be tested.
- (8) All testing procedures, disclosure, and payment shall be pursuant to KRS 438.250.

Effective: June 20, 2005

History: Amended 2005 Ky. Acts ch. 99, sec. 171, effective June 20, 2005. -- Amended 1998 Ky. Acts ch. 426, sec. 131, effective July 15, 1998. -- Amended 1994 Ky. Acts ch. 309, sec. 3, effective July 15, 1994. -- Amended 1992 Ky. Acts ch. 211, sec. 47, effective July 14, 1992. -- Created 1990 Ky. Acts ch. 443, sec. 36, effective July 13, 1990.

Legislative Research Commission Note (11/19/91). No subsection (3) was contained in this statute as enacted in 1990 Acts ch. 443, sec. 36. Pursuant to KRS 7.136(1), the Reviser of Statutes has renumbered the subsections of this statute to correct this problem.

APPENDIX E

2008 Senate Bill 50

AN ACT relating to inmates.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

1 ➔Section 1. KRS 197.055 is amended to read as follows:

2 (1) The Department of Corrections, in conjunction with the Cabinet for Health and
3 Family Services, shall establish a mandatory introductory and continuing education
4 program on human immunodeficiency virus and acquired immunodeficiency
5 syndrome for all inmates. Programs shall be specifically designed for inmates while
6 incarcerated and in preparation for release into the community. Consideration shall
7 be given to cultural and other relevant differences among inmates in the
8 development of educational materials and shall include emphasis on behavior and
9 attitude change. The education program shall be continuously updated to reflect the
10 latest medical information available.

11 (2) *The department shall administer a test to detect the human immunodeficiency*
12 *virus and the acquired immunodeficiency syndrome to all inmates of a*
13 *penitentiary, as defined in KRS 197.010, and all inmates who are in the custody*
14 *of the Department of Corrections and confined in a county jail, no less than*
15 *thirty (30) days prior to the inmate's release. The test shall be consistent with*
16 *guidelines of the Centers for Disease Control and recommendations of the*
17 *correctional medical authority.*

18 *(a) A copy of the results of these tests, once known by the department, shall be*
19 *sent within five (5) business days via registered mail to the following:*

20 *1. The inmate;*

21 *2. The warden of the appropriate penitentiary or jailer of the county in*
22 *which the inmate is incarcerated;*

23 *3. The secretary of the Justice Cabinet; and*

24 *4. The current legal spouse, if any, of the inmate at his or her last known*

1 mailing address.

2 (b) The results of the tests shall not be public record. The results of the tests
3 shall become a part of the inmate's medical file, accessible only to persons
4 designated by agency administrative regulations.

5 (3) If there is evidence that an inmate, while in the custody of the department, has
6 engaged in behavior which places the inmate at a high risk of transmitting or
7 contracting a human immunodeficiency disorder, the department shall begin a
8 testing program which is consistent with guidelines of the Centers for Disease
9 Control and recommendations of the correctional medical authority and shall target
10 persons who have been involved in or reasonably thought to have been involved in
11 a high-risk behavior. For purposes of this subsection, "high-risk behavior" includes:

- 12 (a) Sexual contact with any person within the institution;
13 (b) The use of intravenous drugs;
14 (c) Tattooing; and
15 (d) Any other activity medically known to transmit the virus.

16 ~~(4)(3)~~ The results of the tests shall become a part of that inmate's medical file,
17 accessible only to persons designated by agency administrative regulations.

18 ~~(5)(4)~~ The department shall establish policies consistent with guidelines of the
19 Centers for Disease Control and recommendations of the correctional medical
20 authority on the housing, physical contact, dining, recreation, and exercise hours or
21 locations for inmates with immunodeficiency disorders as are medically indicated
22 and consistent with the proper operation of its facilities.

23 ~~(6)(5)~~ The department shall report to the General Assembly by July 1 each year as to
24 the implementation of this program and the participation by inmates and staff.

25 ~~(7)(6)~~ If an inmate is involved in a situation with a department employee which
26 could result, according to the institution's physician, in the transmission of the
27 human immunodeficiency virus infection, the inmate shall be tested.

- 1 ~~(8)~~~~(7)~~ All testing procedures, disclosure, and payment shall be pursuant to KRS 438.250.

APPENDIX F

Census Quick Facts

People QuickFacts	Kentucky
Population, 2006 estimate	4,206,074
Population, percent change, April 1, 2000 to July 1, 2006	4.1%
Population, 2000	4,041,769
Persons under 5 years old, percent, 2000	6.6%
Persons under 18 years old, percent, 2000	24.6%
Persons 65 years old and over, percent, 2000	12.5%
Female persons, percent, 2000	51.1%
White persons, percent, 2000 (a)	90.1%
Black persons, percent, 2000 (a)	7.3%
American Indian and Alaska Native persons, percent, 2000 (a)	0.2%
Asian persons, percent, 2000 (a)	0.7%
Native Hawaiian and Other Pacific Islander, percent, 2000 (a)	Z
Persons reporting two or more races, percent, 2000	1.1%
Persons of Hispanic or Latino origin, percent, 2000 (b)	1.5%
Living in same house in 1995 and 2000, pct 5 yrs old & over	55.9%
Foreign born persons, percent, 2000	2.0%
Language other than English spoken at home, pct age 5+, 2000	3.9%
High school graduates, percent of persons age 25+, 2000	74.1%
Bachelor's degree or higher, pct of persons age 25+, 2000	17.1%
Mean travel time to work (minutes), workers age 16+, 2000	23.5
Housing units, 2000	1,750,927
Homeownership rate, 2000	70.8%
Median value of owner-occupied housing units, 2000	\$86,700
Households, 2000	1,590,647
Persons per household, 2000	2.47
Median household income, 1999	\$33,672
Per capita money income, 1999	\$18,093
Persons below poverty, percent, 1999	15.8%
Wholesale trade sales, 2002 (\$1000)	51,838,719
Retail sales, 2002 (\$1000)	40,062,561
Retail sales per capita, 2002	\$9,799
Accommodation and foodservices sales, 2002 (\$1000)	4,908,331
Total number of firms, 2002	300,685
Black-owned firms, percent, 2002	2.5%
American Indian and Alaska Native owned firms, percent, 2002	0.4%
Asian-owned firms, percent, 2002	1.1%
Hispanic-owned firms, percent, 2002	0.7%
Native Hawaiian and Other Pacific Islander owned firms, percent, 2002	Z
Women-owned firms, percent, 2002	25.7%

Source: <http://quickfacts.census.gov/qfd/states/21/2128900.html>

APPENDIX G

Cumulative AIDS Statistics: Kentucky vs. The United States

Table 3. Kentucky AIDS Cases Cumulative through December 31, 2008

Characteristics	Total Cases	% of AIDS cases ⁽¹⁾
SEX		
Male (adult/adolescent)	4,199	84%
Female (adult/adolescent)	782	16%
Child (<13 yrs)	34	1%
TOTAL	5,015	100%
AGE AT DIAGNOSIS		
<13	34	1%
13-24	283	6%
25-44	3,650	73%
45-64	1,001	20%
65+	47	1%
TOTAL	5,015	100%
RACE/ETHNICITY		
White, Not Hispanic	3,238	65%
Black, Not Hispanic	1,582	32%
Hispanic	168	3%
Other/Unknown	27	1%
TOTAL*	5,015	100%
TRANSMISSION CATEGORY		
MSM ⁽²⁾	2,730	54%
IDU ⁽³⁾	667	13%
MSM/IDU	289	6%
Heterosexual	766	15%
Perinatal	29	1%
Other/Undetermined ⁽⁴⁾	534	11%
TOTAL	5,015	101%

Table 4. Estimated United States AIDS Cases Cumulative through 2007⁽⁵⁾

Characteristics	Total Cases ⁽⁶⁾	% of AIDS cases ⁽¹⁾
SEX		
Male (adult/adolescent)	810,676	80%
Female (adult/adolescent)	198,544	19%
Child (<13 yrs)	9,209	1%
TOTAL[†]	1,018,429	100%
AGE AT DIAGNOSIS		
<13	9,209	1%
13-24	45,433	4%
25-44	719,221	71%
45-64	228,713	22%
65+	15,853	2%
TOTAL[†]	1,018,429	100%
RACE/ETHNICITY		
White, Not Hispanic	404,465	40%
Black, Not Hispanic	426,003	42%
Hispanic	169,138	17%
Other	11,724	1%
TOTAL[†]	1,011,330	100%
TRANSMISSION CATEGORY		
MSM ⁽²⁾	487,695	48%
IDU ⁽³⁾	255,859	25%
MSM/IDU	71,242	7%
Heterosexual	176,157	17%
Perinatal	8,434	1%
Other/Undetermined	19,041	2%
TOTAL[†]	1,018,428	100%

(1) Percentages may not always total 100% due to rounding
 (2) MSM=Men Having Sex With Men
 (3) IDU=Injection Drug Use
 (4) Includes hemophilia, blood transfusion, and risk not reported or not identified.

(5) U.S. cases from Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report: HIV Infection and AIDS in the United States, 2007*: 19.
 (6) These numbers do not represent actual cases, rather they are point estimates which have been adjusted for reporting delay and for redistribution of cases originally reported with unknown risk.
 † Totals among subpopulations may be different because values were calculated independently.

Kentucky's distribution of AIDS cases by age at diagnosis (Table 3) closely parallels that of the U.S. distribution (Table 4). However, compared to U.S. data, the percentage of cases who are white is greater in Kentucky. This could be due to the greater percentage of white persons in Kentucky's general population.

In addition, a greater percentage of Kentucky AIDS cases report their primary mode of exposure to be men having sex with men (MSM) at 54% in comparison to 48% of U.S. AIDS cases.

APPENDIX H



Grant Number: 1U62PS000998-01 REVISED

Principal Investigator(s):
KRAIG E HUMBAUGH, MD

Project Title: KENTUCKY HIV/AIDS SURVEILLANCE ACTIVITIES

KY CABINET FOR HLTH AND FAMILY
275 E. MAIN STREET HS2GWC
FRANKFORT, KY 40621

Budget Period: 01/01/2008 – 12/31/2008
Project Period: 01/01/2008 – 12/31/2012

Dear Business Official:

The Centers for Disease Control hereby revises this award to reflect an increase in the amount of \$141,393 (see "Award Calculation" in Section I and "Terms and Conditions" in Section III) to KENTUCKY ST CABINET FOR HEALTH & FAMILY SERVICES in support of the above referenced project. This award is pursuant to the authority of 307,317K2 PHSA,42USC241,247BK2,PL108 and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

Acceptance of this award including the "Terms and Conditions" is acknowledged by the grantee when funds are drawn down or otherwise obtained from the grant payment system.

If you have any questions about this award, please contact the individual(s) referenced in Section IV.

Sincerely yours,

Merlin Williams
Grants Management Officer
Centers for Disease Control

Additional information follows

SECTION I – AWARD DATA – 1U62PS000998-01 REVISED

2009 KHPAC Year End Report

Award Calculation (U.S. Dollars)

Salaries and Wages	\$44,000
Fringe Benefits	\$13,130
Personnel Costs (Subtotal)	\$57,130
Supplies	\$20,210
Travel Costs	\$7,991
Other Costs	\$13,010
Consortium/Contractual Cost	\$208,306

Federal Direct Costs	\$306,647
Approved Budget	\$306,647
Federal Share	\$306,647
TOTAL FEDERAL AWARD AMOUNT	\$306,647

AMOUNT OF THIS ACTION (FEDERAL SHARE) \$141,393

Recommended future year total cost support, subject to the availability of funds and satisfactory progress of the project.

02	\$165,254
03	\$165,254
04	\$165,254
05	\$165,254

Fiscal Information:

CFDA Number: 93.941
 EIN: 1610600439B5
 Document Number: UPS000998A

IC	CAN	2008	2009	2010	2011	2012
PS	9212466	\$138,867	\$165,254	\$165,254	\$165,254	\$165,254
PS	9213700	\$38,432				
PS	9214061	\$38,432				
PS	921Z0GQ	\$3,969				
PS	921ZEHP	\$86,947				

SUMMARY TOTALS FOR ALL YEARS			
YR	THIS AWARD		CUMULATIVE TOTALS
1		\$306,647	\$306,647
2		\$165,254	\$165,254
3		\$165,254	\$165,254
4		\$165,254	\$165,254
5		\$165,254	\$165,254

Recommended future year total cost support, subject to the availability of funds and satisfactory progress of the project

CDC Administrative Data:

PCC: N / OC: 4151

SECTION II – PAYMENT/HOTLINE INFORMATION – 1U62PS000998-01 REVISED

For payment information see Payment Information section in Additional Terms and Conditions.

INSPECTOR GENERAL: The HHS Office Inspector General (OIG) maintains a toll-free number (1-800-HHS-TIPS [1-800-447-8477]) for receiving information concerning fraud, waste or abuse under grants and cooperative agreements. Information also may be submitted by e-mail to hhstips@oig.hhs.gov or by mail to Office of the Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington DC 20201. Such

APPENDIX I



Press Release

New Technology Reveals Higher Number of New HIV Infections in the United States than Previously Known

The Centers for Disease Control and Prevention (CDC) announced today that an estimated 56,300 HIV infections occurred in the United States in 2006. That estimate differs from the agency's previous estimate of 40,000 because CDC is now using a more precise method for estimating annual HIV incidence, which is the number of individuals who become newly infected with HIV in a given year. The new estimate is published today in a special HIV/AIDS issue of the *Journal of the American Medical Association*, released at the XVII International AIDS Conference in Mexico City.

“These data, which are based on new laboratory technology developed by CDC, provide the clearest picture to date of the U.S. HIV epidemic, and unfortunately we are far from winning the battle against this preventable disease,” said CDC Director Dr. Julie Gerberding. “We as a nation have to come together to focus our efforts on expanding the prevention programs we know are effective.”

The new estimate is derived from the first national surveillance system of its kind that is based on direct measurement of new HIV infections and builds on a new laboratory test (the BED HIV-1 Capture Enzyme Immunoassay) that can distinguish recent from long-standing HIV infections. CDC's prior annual HIV incidence estimate was based on indirect and less precise methods available at the time.

A separate CDC historical trend analysis published as part of today's study suggests that the number of new infections was likely never as low as the previous estimate of 40,000 and has been roughly stable overall since the late 1990s.

“It's important to note that the new estimate does not represent an actual increase in the number of new infections, but reflects our ability to more precisely measure HIV incidence and secure a better understanding of the epidemic,” said Kevin Fenton, M.D., director of CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. “This new picture reveals that the HIV epidemic is and has been worse than previously known and underscores the challenges in confronting this disease.”

Burden Greatest Among Gay and Bisexual Men of All Races and African Americans

CDC's new surveillance system also provides more precise estimates than previously possible of new infections in specific populations. Results confirm that the impact of HIV remains greatest among gay and bisexual men of all races and among African American men and women. In 2006, men who have sex with men (MSM) accounted for 53 percent of those with new infections (28,700), heterosexuals for 31 percent (16,800), and injection drug users (IDU) for 12 percent (6,600). Infection rates among blacks were 7 times as high as whites (83.7/100,000 people versus 11.5/100,000) and almost 3 times as high as Hispanics (29.3/100,000 people), a group that was also disproportionately affected.

“Too many Americans continue to be affected by this disease,” stressed Fenton. “These new findings emphasize the importance of reaching all HIV-infected individuals and those at risk with effective prevention programs.”

Separate Trend Analysis Sheds New Light on History of U.S. Epidemic

In addition to the 2006 HIV incidence estimates, CDC conducted a separate, historical analysis that provides new insight into HIV incidence trends over time overall and for specific populations. Results confirm dramatic declines in the number of new HIV infections from a peak of about 130,000 in the mid-1980s to a low of roughly 50,000 annual infections in the early 1990s. However, findings also indicate that new infections increased in the late 1990s, but have remained roughly stable since that time (with estimates ranging between 55,000 and 58,500 during the three most recent time periods analyzed).

“Prevention can and does work when we apply what we know,” said Richard Wolitski, Ph.D., acting director of CDC's Division of HIV/AIDS Prevention. “While the level of HIV incidence is alarming, stability in recent years suggests that prevention efforts are having an impact. In this decade, more people are living with HIV and living longer than ever before due to advances in treatment. Even though this could mean more opportunities for transmission, the number of new infections has not increased overall.”

The analysis revealed some other encouraging signs of progress as well as significant challenges among specific groups. Findings indicated reductions in new infections among both injecting drug users and heterosexuals over time. Yet, the findings also indicate that HIV incidence has been steadily increasing among gay and bisexual men since the early 1990s, confirming a trend suggested by other data showing increases in risk behavior, sexually transmitted diseases and HIV diagnoses in this population throughout the past decade. The analysis also found that new infections among blacks are at a higher level than any other racial or ethnic group, though they have been roughly stable, with some fluctuation, since the early 1990s.

“These data confirm the critical need to revitalize prevention efforts for gay and bisexual men of all races and to build upon the growing momentum in the African American and Hispanic communities to confront HIV,” said Wolitski. “We must all remember that we are dealing with one of the most insidious infectious diseases in history. Reducing this threat will require action from everyone individuals at risk, community leaders, government agencies and the private sector.”

For more information on HIV prevention, visit www.cdc.gov/hiv
or <http://www.aids.gov/>.

###

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
SAFER • HEALTHIER • PEOPLE™

MEMBERSHIP AND AFFILIATIONS

Executive Committee

Robert Stone	Community Co-Chair
David Clark	State Co-Chair (ex-officio)
Vacant	Chair, Policy and Promotion Committee
Robert Edelen	Chair, Care and Prevention Committee
Tim McAdoo	At-Large
Gary Fowler	At-Large

Members Ex-Officio

William Hacker, MD	Commissioner, Kentucky Department for Public Health
Elizabeth Johnson	Commissioner, Kentucky Department for Medicaid Services

Members from State Agencies

Sandy Kelly	DPH Reportable Disease section, Infectious Diseases Section
Mary-Lynn Philbeck	Cumberland Valley District Health Department
Terry Carl	Kenton County Fiscal Court

Members from Community Based Organizations

Gary Fowler	Matthew 25
Michael Wagner	Louisville Metro Community Center
Beth Harrison Prado	Volunteers of America
Deborah Wade	WINGS Clinic
Krista Wood	Heartland CARES, Inc.
Lesi Nelson	Matthew 25
Deborah Wade	Wings Clinic
Deonna Williams	U of L Dental Clinic

Representation of HIV/AIDS Epidemic - Statewide

Robert Edelen
Charles Kessinger
Michael Logsdon
Bruce Mullan
Gary Robertson
Robert Stone
Courtney Wheeler
Michael Hacker
Maria Montgomery

Physician Representatives

Carl LeBuhn, MD
Theresa Mayfield DMD