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Does the New Orleans EMA contribute to your state ADAP Program? Would support from Title I enable you to expand your formulary or increase access to ADAP? Would patients living with HIV/AIDS in your state –and other states–benefit from more coordination between different CARE Act Titles? How can we ensure better coordination?

During the ten years that Louisiana has operated a State ADAP, the New Orleans EMA made contributions to ADAP during three grant years. These allocations have ranged from \$166,000 to \$339,631, and all funds have been utilized to provide antiretroviral medications to ADAP-eligible individuals living within the New Orleans EMA.

Additional support from the Title I EMA would allow the State ADAP to potentially expand the formulary or increase access to the program, but only if these allocations were consistent from grant year to grant year. Sporadic and random allocations will not enable to the program to provide consistent services over the course of time, and such actions make the process of planning and allocating scarce resources difficult—if not nearly impossible. Current utilization of the State ADAP in the greater New Orleans metropolitan area is approximately \$450,000 per month, which is down from an average of \$675,000 per month prior to Hurricane Katrina.

Clients residing in areas outside of the Title I EMA rely on the Louisiana ADAP for assistance with their medications. Louisiana ADAP is restricted to those living at or below 200% poverty and has a formulary of only 25 medications. However, if an individual resides in the New Orleans EMA they are eligible for assistance with medications through Title I if they are living at 201% to 400% of poverty. Title I clients also have access to hundreds of medications that ADAP is unable to cover due to limited resources. If Title I made a consistent contribution of at least 10% (\$700,000) to ADAP, access could be expanded and a more equitable distribution of medications could occur across the State.

Patients living with HIV/AIDS in Louisiana would benefit from increased coordination between the CARE Act Titles, but the State, as the Title II grantee, has found that such an effort is very difficult to implement under current authority. While all Title participation and coordination is required for the generation and ratification of the SCSN and the Title II HIV Comprehensive Plan, in reality that participation from other Titles is limited and is often only nominal. Furthermore, it appears that these documents are then not consulted when designing, implementing or monitoring other CARE Act-funded programs. Unfortunately, though there is a requirement to participate in these endeavors and for all Titles to propose activities consistent with the plan, there is no consequence when a grantee does not. Nor is there adequate oversight or action on the part of HRSA to assist with grantees that do not actively participate, coordinate, or abide by the SCSN.

There is often significant duplication of services between Title III providers that are located in the same geographic area, and the disparity between the level of services

offered in the New Orleans EMA and those offered in the rest of the state is significant. Failing grantees are not frequently monitored or asked to implement corrective actions, and are very rarely de-funded. While greater coordination among CARE Act grantees would be an optimal goal, such responsibility *without true authority* will continue to result in lack of coordination and duplication. In addition, the Title II Program does not receive adequate information about which organizations have been funded in the State, the level of funding, or the services the grantee has been funded to provide. Nor is the State consulted on funding decisions. This has resulted in agencies being funded by HRSA that have been banned from doing business with the State and are not ideal providers of HIV services.

Louisiana has had a names based HIV reporting system since 1993. Over the past 13 years, has the state experienced any breach of confidentiality with this system? Is there any evidence that this reporting system has deterred at risk populations from seeking testing?

Both HIV and AIDS have been reportable by name since they were integrated into the state's Sanitary Code as reportable conditions—AIDS in 1984, HIV in 1993. We are not aware of any breaches of confidentiality with the state's HIV/AIDS surveillance system. We also do not have any evidence that the state's name-based reporting system deters at-risk populations from seeking testing. For those who may be reticent to test confidentially, anonymous testing continues to be available through the State's publicly funded HIV Counseling and Testing Program.

HIV-positive individuals who are unaware of their infection may account for up to 70 percent of all new sexually transmitted HIV infections in the United States, according to a “conservative” mathematical calculation from the CDC published in the June 26th edition of the journal, AIDS. What percentage of those living with HIV in Louisiana do you estimate are unaware of their status? Does Louisiana intend to adopt the CDC's “Advancing HIV prevention” initiative that recommends making HIV testing a routine component of medical exams?

It is estimated that between 5,035 and 7,135 persons in Louisiana are unaware of their HIV infection. Louisiana is committed to and has made great strides in adopting the CDC's “Advancing HIV Prevention” (AHP) initiative. Although Louisiana supports the concept of making HIV testing a routine component of medical exams, we do not have the fiscal resources to implement this protocol. Our intention is to work with private providers and insurance companies to integrate HIV testing as a routine component of medical exams. With our current level of resources, we offer HIV testing as a routine component of medical exams in publicly-funded pre-natal clinics and STD clinics, and to persons at increased risk in other medical settings. In adopting CDC's AHP, we have expanded testing in correctional facilities, emergency rooms, and through partner counseling and referral services. Testing through these venues has resulted in higher positivity rates than testing in more traditional settings.

GAO found that Louisiana experienced an increase in perinatal HIV transmission between 1997 and 2002. Louisiana has an “opt in” approach to HIV testing of pregnant women. What percentage of pregnant women is not screened for HIV in Louisiana each year? Have you considered updating your state policy making HIV testing of pregnant women routine with the right to “opt out” or requiring testing of newborns whose mothers’ HIV status is unknown, as recommended by the CDC?

The GAO report requested perinatal HIV transmission data from two specific years—1997 and 2002. While 1997 represented the year with the lowest rate of transmission and 2002 represented the year with the highest rate of transmission during that five-year period, the rates did not necessarily increase. Rather, the annual rates of transmission have remained relatively stable—between 4-6% each year. For births in 2003, the program currently estimates that approximately 3% of the perinatally exposed children were ultimately infected.

At this time, state law mandates that HIV testing, including those conducted during pregnancy requires informed consent. The Louisiana Office of Public Health HIV/AIDS Program is currently exploring the legislative changes that would be required, as well as the feasibility and the potential impact of adopting an “opt out” approach to HIV screening during pregnancy and/or screening of newborns for children born to women without documentation of HIV status at the time of delivery.

Louisiana does not have information about testing among all pregnant women in the State because the program does not have the authority or a system to report or collect that information. Some information about the general population may soon be available through the Louisiana Pregnancy Risk Assessment and Monitoring System (PRAMS), a national population-based risk factor surveillance system funded by the Centers for Disease Control and Prevention (CDC) designed to identify and monitor certain maternal behaviors that occur before, during, and after pregnancy. Louisiana PRAMS recently added a question to the survey that specifically asks if the woman was tested for HIV during pregnancy. According to Louisiana’s HIV/AIDS surveillance data, most delivering women with HIV who are reported to the surveillance system are diagnosed prior to or during pregnancy or delivery (98% in 2002). Through the state’s perinatal HIV prevention efforts, the Louisiana Office of Public Health HIV/AIDS Program actively promotes prenatal HIV screening during prenatal care as the standard of care and posits that failure to offer testing is a breach of duty.