2009 HIV/AIDS Program Report

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Office of Public Health

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Table of Contents

List of Figures iv
List of Tables vi
Louisiana Office of Public Health, HIV/AIDS Program Overview 1
Executive Summary 2
Staying Connected with HAP 4
Geographic Guide to Louisiana's Public Health Regions and Metro Areas 5
Louisiana's Population and Healthcare Environment 6
Break Out: National HIV/AIDS Strategy 8

CHAPTER 1 – PROFILE OF THE HIV EPIDEMIC IN LOUISIANA

Introduction to the Surveillance Unit 11
Break Out: National HIV/AIDS Strategy 12
10-Year Trends in New HIV Diagnoses (2000-2009) 12
10-Year Trends in New AIDS Diagnoses (2000-2009) 21
AIDS Rates in the United States, 2009 23
Southern AIDS Coalition 25
Persons Living in Louisiana with HIV Infection (Prevalence) 26
Post-Hurricane Katrina Investigations 30
Late HIV Testing in Louisiana 31
Louisiana Survival Data 33
Mortality of Persons with HIV Infection in Louisiana 34
Break Out: HIV Among Men Who Have Sex with Men (MSM) 37
Surveillance of Perinatal Exposure to HIV 38
Break Out: Fetal Infant Mortality Review (FIMR) and HIV 43
National HIV Behavioral Surveillance 44

CHAPTER 2 – CARE AND SERVICES

Introduction to the Care and Services Unit 47
Break Out: National HIV/AIDS Strategy 48
Primary Medical Care and Support Services Coordinated through HAP: Louisiana's Ryan White "Part B" Program 49
Assistance Obtaining HIV Medications 51
Break Out: 2010: Major Challenges and Changes to the Louisiana ADAP Program 52

Provision of Medical Case Management and Support Services 53
Payment of Health Insurance Premiums, Co-payments and Deductibles 54
Break Out: What is Ryan White Funding? 55
Housing and Housing Related Services 56
Break Out: What is the State Formula HOPWA Program? 57
Assessing Consumer Needs and Prioritizing the Care and Services Funding Allocations 58
2008 Statewide Needs Assessment of Persons Living with HIV/AIDS 58
Assessing "Unmet Need" and Allocating Resources in Louisiana 61
Care and Services Challenges and Accomplishments 63

CHAPTER 3 - PREVENTION

Introduction to the Prevention Unit 65
Break Out: National HIV/AIDS Strategy 67
HIV Counseling, Testing, and Referral and Linkage Services (CTRLS) 68
HIV Partner Services (HPS) 72
Outreach to High-Risk Individuals 74
Prevention with HIV-Positive Persons 76
Public Information and Prevention Material Distribution 77
Public Awareness 78
Programs Targeting Special Populations 79
Break Out: What are the Current CDC Testing Guidelines? 81
Prevention Challenges and Accomplishments 82

CHAPTER 4 - EVALUATION

Introduction to the Evaluation Unit 83
Evaluation of Prevention Interventions 84
Evaluation of Care and Services 86

CHAPTER 5 - APPENDICES

Technical Notes 95
Works Cited 98

LIST OF FIGURES

Geographic Guide to Louisiana's Public Health Regions and Metro Areas 5

CHAPTER 1 – PROFILE OF THE HIV EPIDEMIC IN LOUISIANA

Number of HIV Diagnoses, Deaths, and Persons Living with HIV Infection, Louisiana, 1979-2009 11
New HIV Diagnoses and Rates, Louisiana, 2000-2009 13
Trends in HIV Rates by Sex, Louisiana, 2000-2009 13
Trends in HIV Rates by Race/Ethnicity, Louisiana, 2000-2009 14
Trends in HIV Rates Among Females by Race/Ethnicity, Louisiana, 2000-2009 14
Trends in HIV Rates Among Males by Race/Ethnicity, Louisiana, 2000-2009 14
Trends in New HIV Diagnoses by Age Group, Louisiana, 2000-2009 15
HIV Transmission Categories, Louisiana, 2000-2009 Combined 16
Trends in New HIV Diagnoses by Transmission Category, Louisiana Adult HIV Cases, 2000-2009 16
Trends in New HIV Diagnoses by Transmission Category, Females in Louisiana, 2000-2009 17
Trends in New HIV Diagnoses by Transmission Category, Males in Louisiana, 2000-2009 17
Trends in New HIV Diagnoses by Transmission Category, Blacks in Louisiana, 2000-2009 18
Trends in New HIV Diagnoses by Transmission Category, Whites in Louisiana, 2000-2009 18
HIV Diagnosis Rate by Selected Region, Louisiana, 2000-2009 19
New HIV Diagnoses by Rate and Region, Louisiana, 2009 19
New AIDS Diagnoses and Rates, Louisiana, 2000-2009 21
AIDS Diagnosis Rates by Sex, Louisiana, 2000-2009 22
AIDS Diagnosis Rates by Race/Ethnicity, Louisiana, 2000-2009 22
AIDS Diagnosis Rates by Selected Region, Louisiana, 2000-2009 23
AIDS Rates in the United States, 2009 23
AIDS Case Rates by State, 2009 25
AIDS Case Rates by MSA, 2009 25
Persons Living with HIV Infection, Louisiana, 2000-2009 26
Persons Living with HIV Infection by Parish, Including State Prisoners, Louisiana, 2009 28
Persons Living with HIV Infection by Parish, Excluding State Prisoners, Louisiana, 2009 29
Deaths Among Persons with HIV Infection, Louisiana, 1999-2008 34
Persons Living with HIV Infection and Deaths in Persons with HIV Infection, by Race/Ethnicity, Louisiana, 2008 35
Persons Living with HIV Infection and Deaths in Persons with HIV Infection, by Sex, Louisiana, 2008 35
Persons Living with HIV Infection and Deaths in Persons with HIV Infection, by Transmission Category, Louisiana, 2008 36
Perinatal HIV Exposures and Transmission, Louisiana, 1999-2008 38

Women of Childbearing Age Living with HIV Infection by Parish, Louisiana, 2008 39
Timing of Mother's Diagnosis, Louisiana, 2008 41
Frequency of Prenatal Care, Louisiana, 2008 42
Three-Part Antiretroviral Therapy, Louisiana, 2008 42
Babies Born to Women with HIV by Region and Status, Louisiana, 2006-2008 43
HIV Testing Results Among NHBS Participants 45

CHAPTER 2 – CARE AND SERVICES

Entry into Medical Care within 3 Months of Diagnosis, Louisiana, 2005-2009 48
Louisiana Ryan White HIV Program Clients in Continuous Care, Louisiana, 2006-2009 48
Ryan White Coverage and Service Locations, Louisiana 50
Select Ryan White Part B Community-Based Services, Louisiana, 2007-2009 53
Health Insurance and Cost Sharing Assistance by Type, Louisiana, 2009 54
Unmet Need by Year and Status, Louisiana, 2005-2009 61

CHAPTER 3 - PREVENTION

New HIV Diagnoses and Rapid Tests, Louisiana, 2003-2009 67
Number of HIV Tests and Percent Positivity, Louisiana, 2000-2009 68
HIV Testing Trends by Type of Test, Louisiana, 2000-2009 69
HIV Testing Trends by Test Technology, Louisiana, 2000-2009 69
HIV Partner Services, 2009 73

CHAPTER 4 - EVALUATION

HAP Unit Flow Chart 84

LIST OF TABLES

Distribution of the General Population by Region, Louisiana 2000, 2006 & 2009 6

CHAPTER 1 – PROFILE OF THE HIV EPIDEMIC IN LOUISIANA

Reducing HIV-Related Disparities and Health Inequities, Louisiana Baseline Results, 2009 12

Characteristics of Persons Newly Diagnosed with HIV, Louisiana, 2008-2009 20

Characteristics of Persons Newly Diagnosed with AIDS, Louisiana, 2008-2009 24

Characteristics of Persons Living with HIV Infection and Cumulative Cases, Louisiana, 2009 27

Estimated Number of Persons Living with HIV Infection in Metro New Orleans Before and After Hurricane Katrina 30

Late HIV Testing, Louisiana, 2008-2009 31

Persons Surviving More Than 12, 24, and 36 Months After AIDS Diagnosis, Louisiana, 2000-2004 33

Demographics of New HIV Diagnoses Among MSM, Louisiana, 2009 37

Demographics of Mothers with HIV Infection, Louisiana, 2008 40

National HIV Behavioral Surveillance (NHBS), Louisiana, 2005-2008 46

CHAPTER 2 – CARE AND SERVICES

Newly Diagnosed Persons Entering Care in 3 Months, Louisiana, 2009 48

Persons Utilizing ADAP and Persons Living with HIV Infection by Region, Louisiana, 2009 51

Unmet Need for Primary Medical Care, Louisiana, 2009 62

CHAPTER 3 - PREVENTION

HIV Tests by Characteristic, Louisiana, 2009 70

Outreach Survey Results, Louisiana, 2010 75

Baseline Survey of HIV-Positive Persons, Louisiana, 2009 77

Psychosocial Characteristics of Wellness Center Clients at Intake, Louisiana, 2009 80

CHAPTER 4 - EVALUATION

Evaluation Activities, Louisiana HAP Office 83

Evaluation of Prevention Interventions 85

CHAPTER 5 - APPENDICES

Trends in HIV Infection, Louisiana, 1979-2009 90

New HIV Diagnoses by Region and Year, Louisiana, 2000-2009 91

New AIDS Diagnoses by Region and Year, Louisiana, 2000-2009 91

Geographic Distribution of HIV in Louisiana, 2009 92

Deaths Among Persons with HIV Infection, Louisiana, 2008 94

Louisiana Office of Public Health HIV/AIDS Program Overview

About the Program

The HIV/AIDS Program (HAP) administers statewide and regional programs designed to prevent the transmission of HIV, to ensure the availability of quality medical and social services for HIV-infected and -affected individuals, and to track the impact of the epidemic in Louisiana. HAP's main programmatic units include:

- Surveillance: This unit is responsible for monitoring the HIV epidemic throughout the state. Surveillance also aids in the planning of prevention efforts and guides the allocation of resources for HIV treatment, care, and other supportive services.
- Prevention: This unit is responsible for behavioral interventions and educational activities that are focused on reducing the spread of HIV infection in Louisiana. Prevention activities include HIV counseling, testing and referral, prevention with HIV-positive individuals, outreach, partner services, and behavioral interventions.
- Services: This unit provides a variety of patient care services to individuals living with HIV infection such as primary medical care, medications, dental services, assistance with transportation, rent and utilities, assistance with the payment of health insurance premiums, co-payments and deductibles, child care, supplemental food items, and other needed support services.
- Evaluation: This unit is responsible for examining the services provided to persons infected or affected by HIV and the prevention activities targeted at reducing the spread of HIV to ensure the quality, effectiveness, and efficiency of those activities.

About this Report

HIV infection in Louisiana requires responsive interventions to decrease new infections, slow disease progression, increase individual awareness of HIV status, and help ensure access to medical care for persons who have HIV. The *2009 HIV/AIDS Program Report* provides a thorough surveillance profile, as well as descriptions of the state's prevention, counseling and testing, care, services, housing, and evaluation programs. While many challenges remain, the report highlights several areas of progress.

Executive Summary

The HIV epidemic continues to have a significant impact on the public health of Louisiana. Although there is still no cure for HIV, recent advances in treatment have significantly slowed the progression from HIV to AIDS and from AIDS to death. As of December 31, 2009, a cumulative total of 29,713 persons were diagnosed with HIV infection in Louisiana, including 315 cases in children under 13.

The following report provides detailed information regarding demographic and risk characteristics of individuals with HIV infection and trends in the epidemic over time. This report includes cases diagnosed through 2009 and reported by August 1, 2010. Some of the most significant trends are highlighted below:

- At the end of 2009, 17,155 persons were living with HIV infection in Louisiana, of whom 9,283 (54%) have been diagnosed with AIDS. There are persons living with HIV in every parish in Louisiana, and this number continues to increase each year, largely because of a decrease in mortality due to more effective drug therapies and a steady number of new infections diagnosed each year.

- In the most recent CDC *HIV Surveillance Report* (Vol. 21), Louisiana ranked 5th highest in estimated state AIDS case rates (19.4 per 100,000) and 12th in the number of estimated AIDS cases in 2009. In 2008, Louisiana ranked 4th highest in estimated state AIDS case rates (24.0 per 100,000) and 11th in the number of estimated AIDS cases.

- In the CDC *HIV Surveillance Report* (Vol. 21), the Baton Rouge metropolitan area ranked 2nd in estimated AIDS case rates (30.6 per 100,000) and the New Orleans metropolitan area ranked 9th in estimated AIDS case rates (23.0 per 100,000) in 2009 among the large metropolitan areas in the nation. In 2008, the Baton Rouge metropolitan area ranked 2nd (40.0 per 100,000) and the New Orleans metropolitan area ranked 3rd (32.4 per 100,000) in estimated AIDS case rates.

- In 2009, 1,242 individuals were newly diagnosed with HIV infection in Louisiana, a 13% increase from the 1,095 new diagnoses in 2008. New HIV diagnoses occurred in 58 of Louisiana's 64 parishes in 2009.

- The New Orleans region had the highest number of new HIV diagnoses and the 2nd highest rate of new diagnoses (new cases per 100,000 persons) in 2009 out of all nine public health regions. The Baton Rouge region had the 2nd highest number of new diagnoses but the highest HIV rate in 2009.

- The HIV rate for blacks continues to be disproportionately high; the rate for blacks was eight times higher than among whites. Although blacks make up only 32% of the state's population, 75% of newly-diagnosed HIV cases and 76% of newly-diagnosed AIDS cases were among blacks in 2009.

- Women represented 32% of new HIV diagnoses in 2009. The HIV rate among men has increased since 2005, but among women has remained relatively stable over time.

- The annual number of new AIDS diagnoses has fluctuated over the history of the disease. From 1979 to 1996, the annual number of new AIDS diagnoses increased dramatically until highly active antiretroviral treatment (HAART) became available. Since the introduction of HAART, there have been periods where the number of AIDS diagnoses has increased, which may have been due to factors such as late testing, limited access to or use of health care services, and limitations of available therapies. In 2009, the number of AIDS diagnoses decreased 5% from 2008.

- In 2009, 24% of persons newly diagnosed with HIV had AIDS at the time of their diagnosis, and an additional 7% of persons developed AIDS within six months of their diagnosis. Men, Hispanics, and persons aged 45 and older were most likely to be diagnosed late in the course of their disease.

- Perinatal transmission rates have dropped dramatically from 19% in 1994 to less than 2% in 2006 through 2008 due to increased screening of pregnant women and increased use of antiretroviral therapy by pregnant women with HIV and their infants.

- Because of the association between sexually transmitted diseases (STDs) and HIV transmission, testing and treatment of STDs is an important factor in preventing the spread of HIV. Louisiana continues to have very high rates of STDs. In 2009, Louisiana ranked 1st in the nation in primary and secondary syphilis rates (16.8 per 100,000), 6th in congenital syphilis rates (17.4 per 100,000); 2nd in gonorrhea rates (204.0 per 100,000); and 3rd in chlamydia rates (626.4 per 100,000) according to the CDC's *2009 STD Surveillance Report*. The syphilis and gonorrhea rankings have not changed from 2008, but the chlamydia ranking increased from 5th to 3rd and the congenital syphilis ranking dropped from 1st to 6th.

- In 2009, there were a total of 100,571 HIV tests conducted through HAP's HIV Counseling Testing and Referral Program. Of these tests, 948 were positive, accounting for 0.9% of the total tests. A total of 53% of these positive tests were new HIV diagnoses for the HIV Surveillance system.

- Of the 100,571 tests conducted, 67% were among blacks and 52% were among females. Males had a higher positivity rate than females, and male-to-female transgender persons, men who have sex with men (MSM) and men who have sex with men and are injection drug users (MSM/IDU) had the highest percent positivity. Community-based organizations, prisons/jails, and emergency departments had the highest positivity rates of all testing sites in 2009.

- In 2003, when rapid testing began in Louisiana, only 2% of all tests were rapid. In October 2007, Louisiana began a testing initiative which significantly expanded the locations where rapid tests were available and the number of rapid tests conducted. By 2009, 90% of all tests were rapid tests.

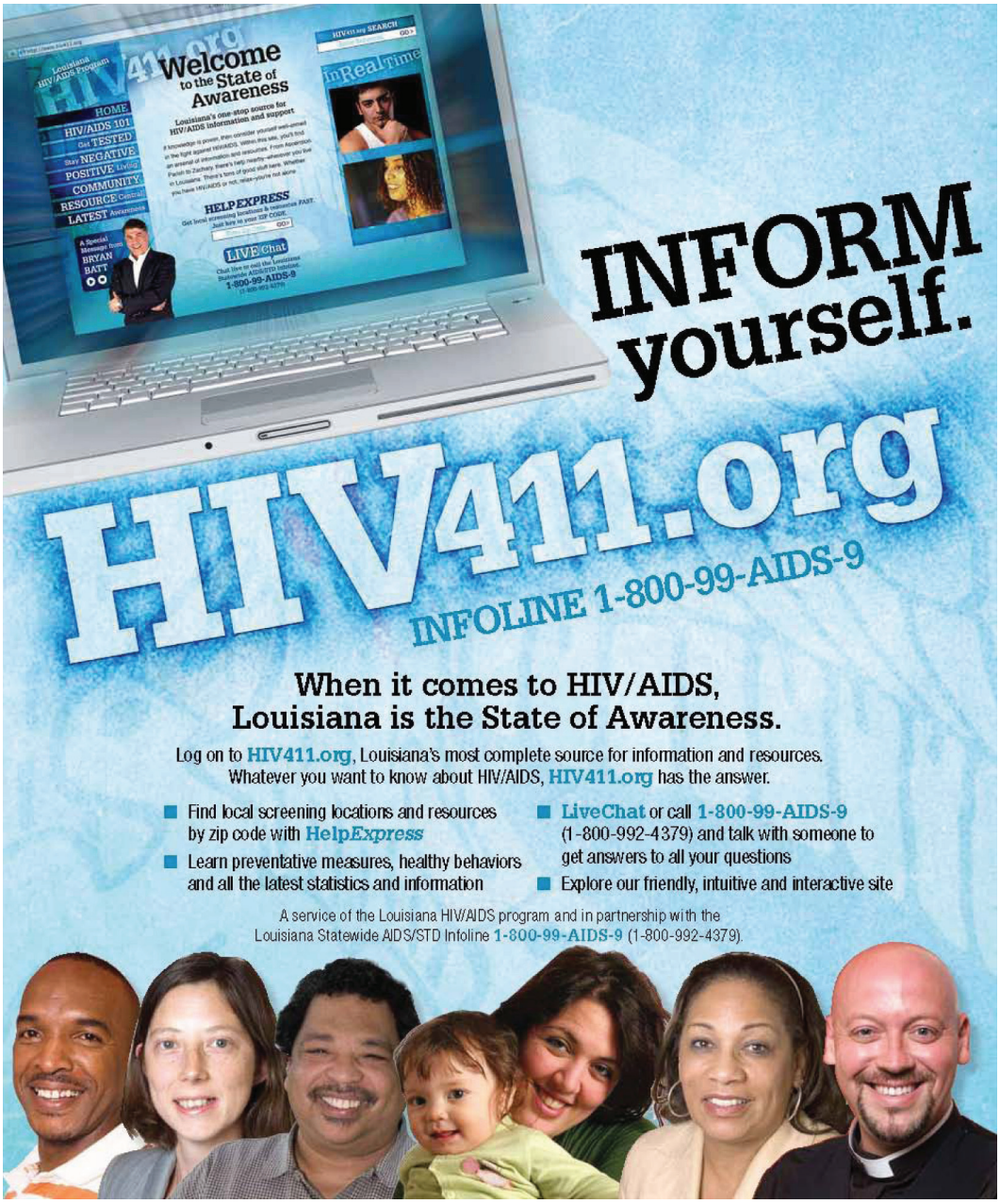
- In 2009, 1,449 persons were referred to the Disease Intervention Specialists (DIS) in the HIV Partner Services Program. A total of 669 partners were contacted by the DIS, 54% of whom were tested for HIV. A total of 73 partners contacted by DIS were newly-diagnosed with HIV, a positivity rate of 20% among partners tested by DIS.

- In 2009, 38% of all persons living with HIV infection in Louisiana were not in care (did not have a CD4 or viral load test conducted in 2009). Males, Hispanic/Latinos, and persons age 25-44 and over the age of 65 years had the highest percentage of people not in care.

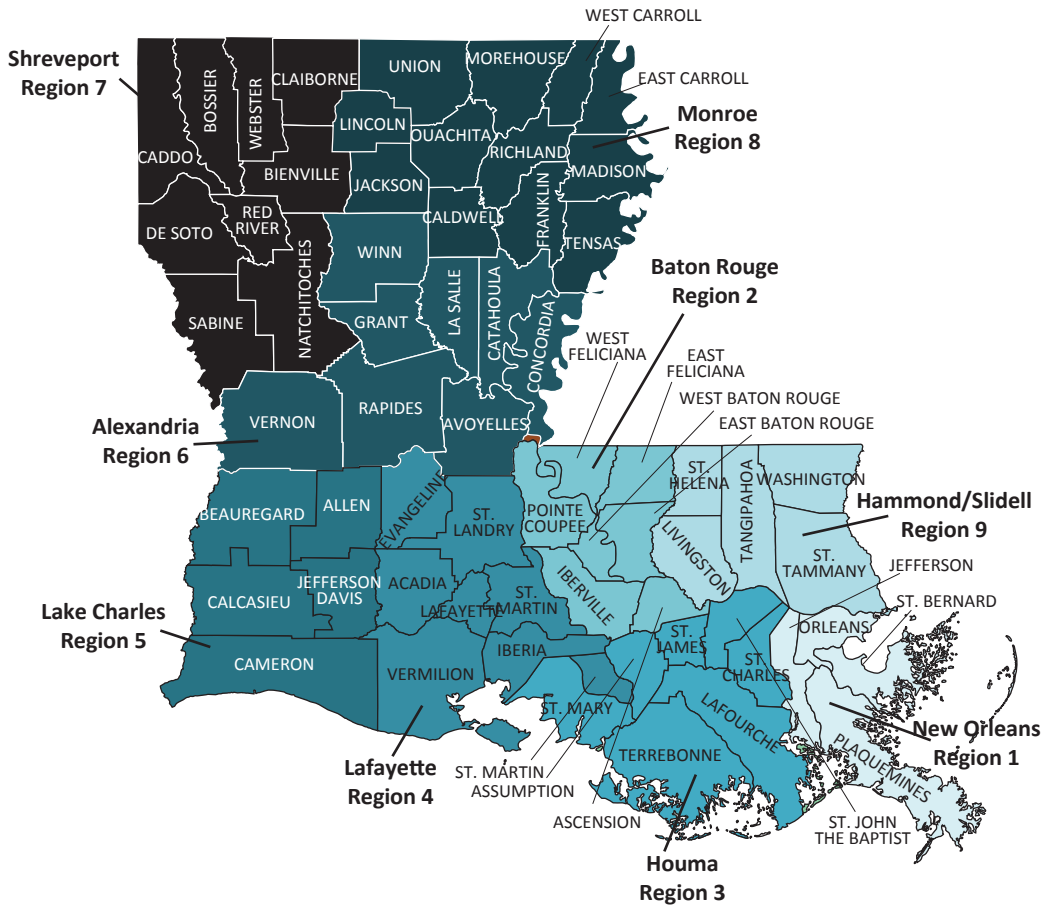
- In 2009, HAP coordinated HIV-related care, treatment and support services for 6,405 people living with HIV infection in Louisiana. These services were sponsored through the Ryan White Part B and the state formula Housing Opportunities for Persons with AIDS (HOPWA) programs.

Staying Connected with HAP

In August, 2009, HAP launched HIV411.org, to serve as a comprehensive resource of HIV and AIDS and support services for Louisiana residents living with HIV infection. This website contains a search engine to locate HIV testing locations and HIV-related resources by zip code. Publications, including this Annual Report, can be found under the "Resource Central" tab. An archive of all Annual Reports can be found at HAP's Office of Public Health website, www.hiv.dhh.louisiana.gov.



Geographic Guide to Louisiana's Public Health Regions and Metro Areas



	Parishes in Public Health Region	Parishes in MSA
Region 1:New Orleans	Jefferson, Orleans, Plaquemines, St. Bernard	Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles, St. John the Baptist, St. Tammany
Region 2:Baton Rouge	Ascension, E. Baton Rouge, E. Feliciana, Iberville, Pointe Coupee, W. Baton Rouge, W. Feliciana	Ascension, E. Baton Rouge, E. Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, W. Baton Rouge, W. Feliciana
Region 3:Houma	Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary, Terrebonne	Lafourche, Terrebonne
Region 4:Lafayette	Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, Vermillion	Lafayette, St. Martin
Region 5:Lake Charles	Allen, Beauregard, Calcasieu, Cameron, Jefferson Davis	Calcasieu, Cameron
Region 6:Alexandria	Avoyelles, Catahoula, Concordia, Grant, La Salle, Rapides, Vernon, Winn	Grant, Rapides
Region 7:Shreveport	Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine, Webster	Bossier, Caddo, DeSoto
Region 8:Monroe	Caldwell, E. Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, W. Carroll	Ouachita, Union
Region 9:Hammond/Slidell	Livingston, St. Helena, St. Tammany, Tangipahoa, Washington	No MSA

Louisiana's Population and Healthcare Environment

Louisiana's Population

In the 2009 estimated census, the total population of Louisiana was 4,492,076 persons. Louisiana is made up of 64 county-equivalent subdivisions called parishes. In 2009, parish populations ranged from a low of 5,609 persons (Tensas Parish) to a high of 443,342 persons (Jefferson Parish). The New Orleans region (composed of the Orleans, Jefferson, Plaquemines, and St. Bernard Parishes) represented 19% of the state's population. While the state is considered rural—75% of the population resides in urban areas[1]. The state has nine public health regions and eight metropolitan statistical areas (MSAs).

Distribution of the General Population by Region
Louisiana, 2000, 2006 & 2009

Public Health Region	2000 Total Population[a]	2006 Total Population[b]	% Change from 2000-2006	2009 Total Population[b]	% Change from 2006-2009	% Change from 2000-2009
1 - New Orleans	1,034,126	665,017	-36.0%	859,789	29.3%	-16.9%
2 - Baton Rouge	603,634	640,611	6.1%	653,070	1.9%	8.2%
3 - Houma	383,697	396,152	3.2%	396,413	0.1%	3.3%
4 - Lafayette	548,154	570,615	4.1%	582,164	2.0%	6.2%
5 - Lake Charles	283,429	281,764	-0.6%	286,290	1.6%	1.0%
6 - Alexandria	301,390	302,252	0.3%	301,972	-0.1%	0.2%
7 - Shreveport	522,560	531,005	1.6%	534,898	0.7%	2.4%
8 - Monroe	353,865	348,525	-1.5%	347,751	-0.2%	-1.7%
9 - Hammond/Slidell	438,121	504,386	15.1%	529,729	5.0%	20.9%
Louisiana	**4,468,976**	**4,240,327**	**-5.1%**	**4,492,076**	**5.9%**	**0.5%**

Source: a Census 2000, US Bureau of the Census; b Census Population Estimates, US Bureau of the Census

- In 2009, the New Orleans region (Region 1) had the largest population in the state and the Lake Charles region (Region 5) had the smallest.
- From 2000 to 2006, the population of the New Orleans region decreased 36%, largely due to the impact of Hurricane Katrina. The hurricane devastated the New Orleans metropolitan area in August 2005 and caused a massive displacement of the population. Between 2006 and 2009, the population of the New Orleans region increased 29.3% but is still 16.9% below the population in 2000. Each year since the hurricane, the population of the New Orleans region continues to increase.
- The Hammond/Slidell region (Region 9) had the largest population increase, 91,608 persons, (21%) from 2000 to 2009.

Demographic Composition

According to the 2009 estimated census data, the racial and ethnic composition of the state was estimated to be 61.5% white, 32.1% African American, 1.5% Asian, and 0.6% American Indian. Persons of Hispanic origin were estimated to make up 3.6% of the total population.[2] Almost 80% of persons living in Louisiana in 2009 were born in Louisiana and 3.3% are foreign born. Of the foreign-born population, 56% are non-US citizens.[3]

Age and Sex

In 2009, persons under the age of 18 made up 25% of the population while persons 65 and older made up 12.3% of the population. As in previous years, the proportion of females in the overall population in 2009 was slightly higher than the proportion of males (51.4% vs. 48.6%).[4]

Poverty, Income, and Education

In 2009, the average household size in Louisiana was 2.6 persons and the average family size was 3.2 persons. Of all Louisiana households, 67% are considered family households of which 16% have a female head of house with no husband present. In the 2009 estimated census, 81.1% of Louisiana residents aged 25 years and older had attained a high school degree or higher, and 20.8% had a bachelor's degree or higher. In 2009, the median household income in Louisiana was $42,438. According to the 2009 estimates, approximately 17.9% of the population has an income below the federally defined poverty level, and 13.8% of families have an income below the poverty level. Louisiana has one of the highest proportions of children living in poverty with 25.4% of all children 18 years or younger in 2009 compared to the national estimate of 18.9% of all US children.[5] The unemployment rate as of December 2010 in Louisiana was 8.0%.[6]

Incarceration/Crime

In 2008, the crime rate in Louisiana was 18% higher than the national average rate, property crimes account for 85% of the crime rate and violent crimes account for 18% of the crime rate. Louisiana's incarceration rate is 48% higher than the national average of incarcerated adults per 100,000. Louisiana ranked 50th out of 50 in incarceration rates with 866 per 100,000 adults incarcerated in 2009 and a total of 36,083 inmates managed by the Louisiana Department of Public Safety and Corrections.[7]

Health Indicators

In the 2009 United Health Foundation's *America's Health Rankings* report, Louisiana ranked 47th out of 50 in overall health. This national health survey compares multiple health outcomes and health determinates in all states. The low-place ranking is predominately due to increases in obesity, low high school graduation rates, high infant mortality rates, and high infectious disease rate. An estimated 19.3% of Louisiana residents lack health insurance, compared to a national average of 15.3%.[8]

Public Aid

In 2009, Medicaid covered 16% and Medicare covered 13% of all persons living in Louisiana.[9] Medicaid expenditures in Louisiana totaled $6 billion in the 2008 fiscal year. In 2009, 36% of children ages 0-18 were insured through Medicaid, and 10% of children were uninsured.

Publicly Available Healthcare in Louisiana

The Office of Public Health (OPH) provides free and low-cost basic health services through parish health units in the regions. Services include family planning, HIV testing, STD screening and treatment, maternal and child health, special health services for children, nutrition programs, and immunizations. Regional activities also include sanitation, environmental monitoring, and epidemiologic investigations. (See the Office of Public Health website for additional information about OPH programs www.oph.dhh.louisiana.gov). Comprehensive inpatient and outpatient medical services are also available in each region of the state through regional public medical centers. The three medical centers in the central and northern parts of the state operate under the auspices of the Louisiana State University (LSU) – Shreveport system, and the seven medical centers in the southern part of the state operate under the LSU Health Care Services Division. Individuals may access care at these facilities regardless of insurance status or ability to pay.

National HIV/AIDS Strategy

The National HIV/AIDS Strategy (NHAS) was released by the White House on July 13, 2010. This strategy is the first of its kind for the United States. The NHAS, outlines measureable targets to be achieved by 2015. The NHAS was constructed between Federal and community partners to create a common purpose and to determine what strategies and programs are working effectively to reach these common goals.

The Vision for the National HIV/AIDS Strategy

"The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination."

The NHAS divides 10 goals into three distinct categories. These goals are further outlined in the Surveillance, Services and Prevention sections of this 2009 HIV/AIDS Report with Louisiana specific data.

Reducing New HIV Infections

- By 2015, lower the annual number of new infections by 25% (from 56,300 to 42,225).
- Reduce the HIV transmission rate, which is a measure of annual transmissions in relation to the number of people living with HIV, by 30% (from 5 person infected per 100 people with HIV to 3.5 persons infection per 100 people with HIV).
- By 2015, increase from 79% to 90% the percentage of people living with HIV who know their serostatus (from 948,000 to 1,080,000 people).

Increasing Access to Care and Improving Health Outcome for People Living with HIV

- By 2015, increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65% to 85% (from 26,824 to 35,078 people).
- By 2015, increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care (at least 2 visits for routine HIV medical care in 12 months at least 3 months apart) from 73% to 80% (or 237,924 people in continuous care to 260,739 people in continuous care).
- By 2015, increase the number of Ryan White clients with permanent housing from 82% to 86% (from 434,000 to 455,800 people). (This serves as a measurable proxy of our efforts to expand access to HUD and other housing supports to all needy people living with HIV.)

Reducing HIV-Related Health Disparities

- Improve access to prevention and care services for all Americans.
- By 2015, increase the proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20%.
- By 2015, increase the proportion of HIV diagnosed Blacks with undetectable viral load by 20%.
- By 2015, increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20%.

National HIV/AIDS Strategy

The NAHS advocates for a more coordinated national response to the HIV epidemic. In coordination with the release of the NHAS, the White house also released a NHAS Federal Implementation Plan that outlines the activities and steps the Federal government will undertake to meet the goals set forth.

The implementation of NHAS, while spearheaded by the Federal government, will require the efforts of "all parts of society, including state, local and tribal governments, businesses, faith communities, philanthropy, the scientific and medical communities, educational institutions, people living with HIV, and others."

The NHAS outlines 11 Action Steps that the government, communities and agencies can use to help reach the strategy goals.

Reducing New HIV Infections

- Intensify HIV prevention efforts in the communities where HIV is most heavily concentrated.
- Expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches.
- Educate all Americans about the threat of HIV and how to prevent it.

Increasing Access to Care and Improving Health Outcomes for People Living with HIV

- Establish a seamless system to immediately link people to continuous and coordinated quality care when they learn they are infected with HIV
- Take deliberate steps to increase the number and diversity of available providers of clinical care and related services for people living with HIV.
- Support people living with HIV with co-occurring health conditions and those who have challenges meeting their basic needs, such as housing.

Reducing HIV-Related Disparities and Health Inequities

- Reduce HIV-related mortality in communities at high risk for HIV infection.
- Adopt community-level approaches to reduce HIV infection in high-risk communities.
- Reduce stigma and discrimination against people living with HIV.

Achieving a More Coordinated National Response to the HIV Epidemic

- Increase the coordination of HIV programs across the Federal government and between Federal agencies and state, territorial, tribal and local governments.
- Develop improved mechanisms to monitor and report on progress toward achieving national goals.
- More information about the National HIV/AIDS Strategy can be found on the AIDS.gov website via the following link: http://www.aids.gov/federal-resources/policies/national-hiv-aids-strategy/.

Chapter 1

Profile of the HIV Epidemic in Louisiana

Introduction to Surveillance

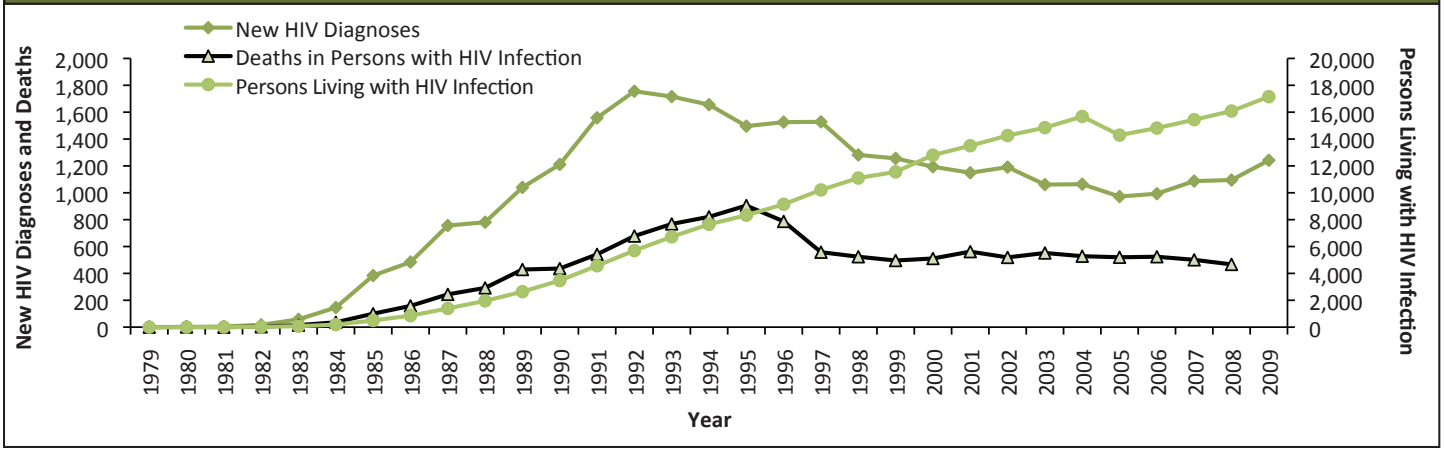
The Louisiana Office of Public Health HIV/AIDS Program's (HAP) Surveillance Program conducts general case ascertainment through the receipt of reports of potential cases of HIV infection from clinical providers, laboratories and other public health providers throughout the state with funding from the Centers for Disease Control and Prevention (CDC) and in accordance with the Louisiana Sanitary Code. Basic demographic and risk information are also collected. Additionally, the program monitors perinatal exposure to and transmission of HIV, HIV incidence, medication resistant strains of HIV, clinical manifestations of HIV disease, mortality, the utilization and impact of care and treatment, and measures of high-risk behavior.

Louisiana began confidential name-based reporting of AIDS cases in 1984 and confidential name-based reporting of HIV (non-AIDS) cases in 1993. In 1999, the Louisiana Sanitary Code was revised to mandate the reporting of all HIV-related laboratory results (e.g., CD4 counts, viral loads, Western blots). In 2010, the Sanitary Code was revised to explicitly require the reporting of HIV in pregnancy as well as prenatal exposure to HIV. The maternal and pediatric medical records are reviewed to assess testing and treatment received. Follow-up occurs until the infant's infection status can be determined.

Data from the above surveillance activities are analyzed and non-identifying summary information is provided to public health programs, community based organizations, researchers, and the general public through reports, presentations, data requests, and regional profiles. The information is provided for the purposes of program planning and education, such as to assess the risks for HIV infection and develop effective HIV prevention programs; to help identify where services for people living with HIV infection are needed; and to assist with the allocation of federal and state funding.

This report includes data for persons diagnosed with HIV or AIDS through December 31, 2009 and reported to HAP before August 1, 2010. The report presents both numbers and rates of diagnosed HIV cases and AIDS cases. Newly diagnosed HIV cases are the number of people diagnosed with HIV at any stage of the disease within a given year. Rates take into account differing population sizes among demographic groups or areas, and comparing rates between two or more groups or areas can identify important differences.

Number of HIV Diagnoses, Deaths, and Persons Living with HIV Infection Louisiana, 1979-2009



- The first reported Louisiana resident with AIDS was diagnosed in 1979. In the three decades since then, the number of persons living with HIV infection in the state has continued to increase. New HIV diagnoses peaked in 1992 and deaths among persons with HIV infection peaked in 1995. Deaths have decreased since 1995 due to the availability of more effective treatments. The decreases seen in 2005 in both persons living with HIV infection and new HIV diagnoses were due to the impact of Hurricane Katrina which resulted in the dislocation of a large number of persons from the New Orleans metropolitan area.

National HIV/AIDS Strategy
Reducing HIV-Related Health Disparities

The national goal is to improve access to prevention and care services for all Americans.

2015 Objectives:

- Increase the proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20%.
- Increase the proportion of HIV diagnosed blacks with undetectable viral load by 20%.
- Increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20%.

Reducing HIV-Related Disparities and Health Inequities
Louisiana Baseline Results, 2009

	Persons Living with HIV as of 12/31/09	Percent with a Viral Load in 2009	Percent with Undetectable Viral Load in 2009*
Total	**17,155**	**58%**	**54%**
MSM	7,592	60%	59%
Black/African American	11,450	58%	49%
Hispanic/Latino	624	44%	66%

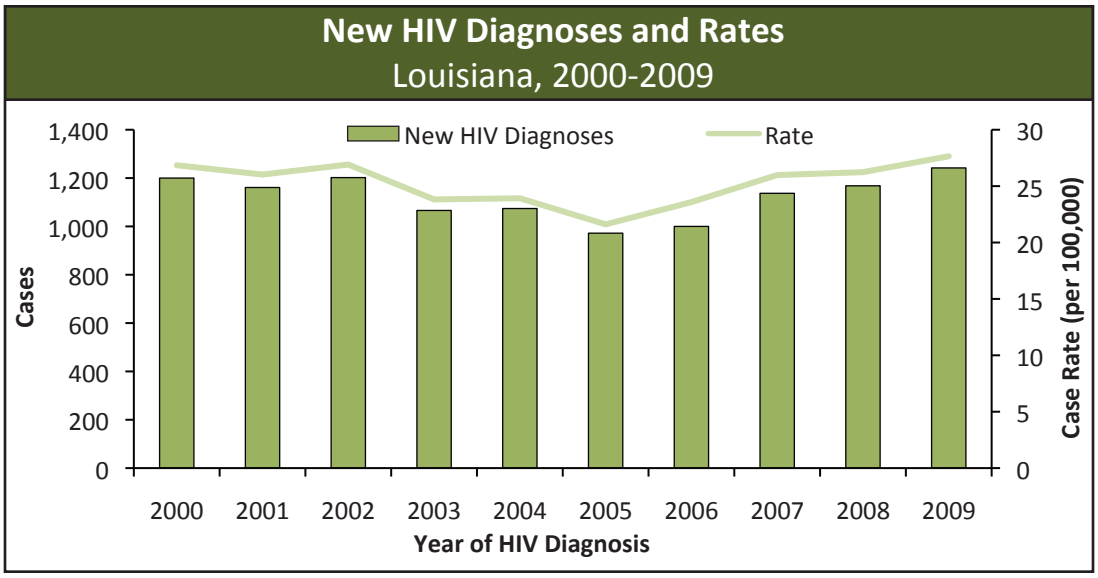
* Of those who had a VL in 2009.

- In 2009 in Louisiana, 59% of gay/bisexual men, 49% of blacks and 66% of Latinos living with HIV had an undetectable viral load.
- This proportion will be monitored over time to determine if there is an annual increase and to see if disparities among subgroups are reduced.

National HIV/AIDS Strategy (www.thewhitehouse.gov)

10-Year Trends in New HIV Diagnoses (2000-2009)

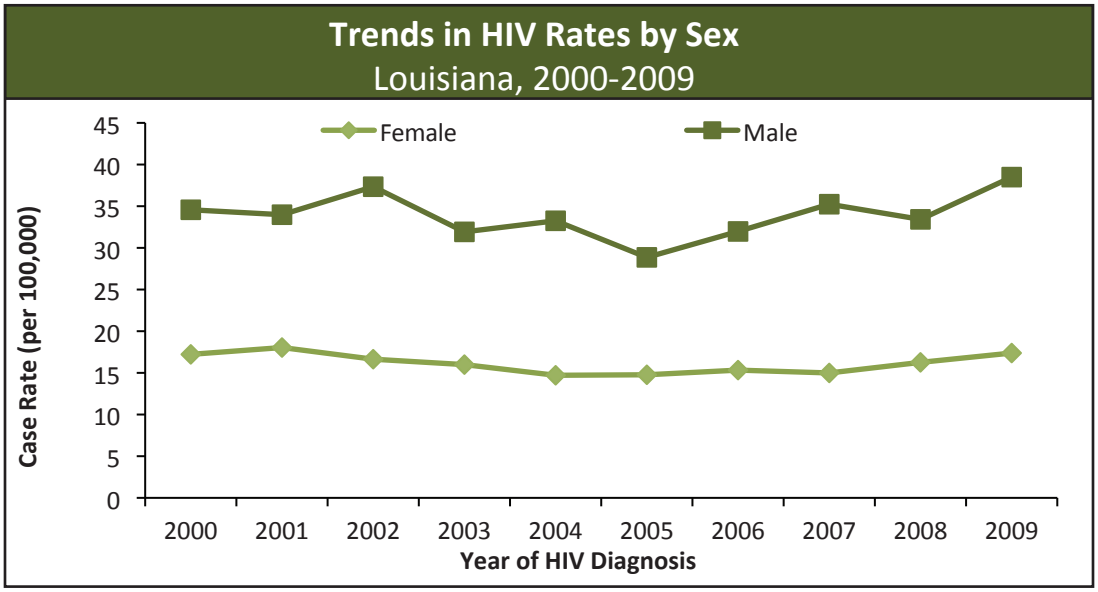
The number of new HIV diagnoses in a given year has historically served as a measure of new infections (incidence). However, since individuals can be infected with HIV for a long time before they are diagnosed, counting new HIV diagnoses is not an accurate representation of new infections in a given year. Louisiana is one of 25 selected states that has been participating in a CDC initiative to develop a new national system to measure recent HIV infections (HIV incidence). In 2011, the CDC expects to publish data from the incidence estimation methodology that was revised in 2010. Louisiana specific data will be released in a fact sheet when the new methodology is published.



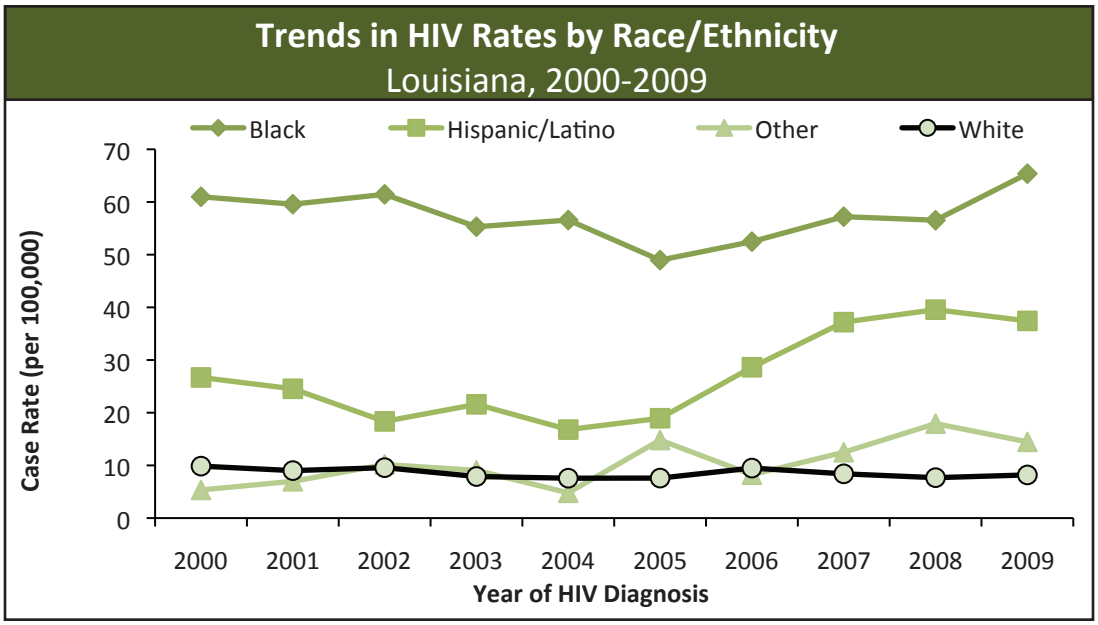
- In 2009, 1,242 individuals were newly diagnosed with HIV infection in Louisiana, a 13% increase from 2008. Although the number of new HIV diagnoses decreased from 1999 to 2005, it has increased each year since then. The lower number of new diagnoses in 2005 and 2006 was due to the impact of Hurricane Katrina in August 2005, which caused a significant dislocation of the population and a disruption of HIV testing services.
- The rate of new HIV diagnoses follows a similar pattern. From 2005 to 2009, the rate (per 100,000 persons) has increased in Louisiana from 22 to 28 per 100,000.

HIV Diagnoses by Sex, Race/Ethnicity, and Age

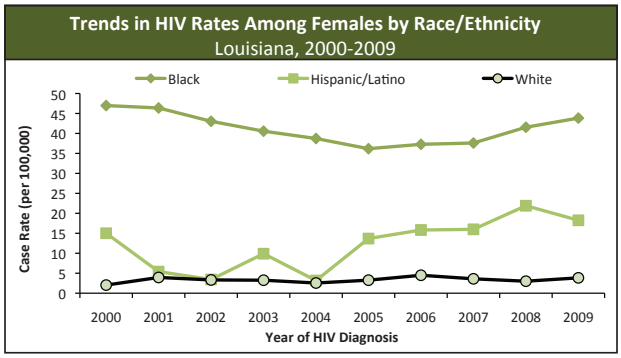
Although the HIV epidemic affects persons of all genders, ages, race/ethnicities and geographic locations in Louisiana, the impact is not the same across all populations. Identifying the populations most at risk for HIV infection helps in planning HIV prevention activities and services, and in determining the most effective use of limited resources.

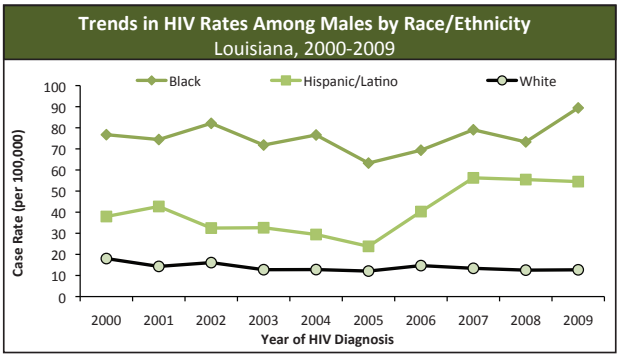


- While the HIV case rate for females in Louisiana has remained relatively stable over the past 10 years (between 14.7 and 18.0 per 100,000), the case rate for men has been more variable (between 28.9 and 38.5 per 100,000). From 2000 to 2005 the case rate for males declined significantly but since then has risen to its highest level in the past 10 years.

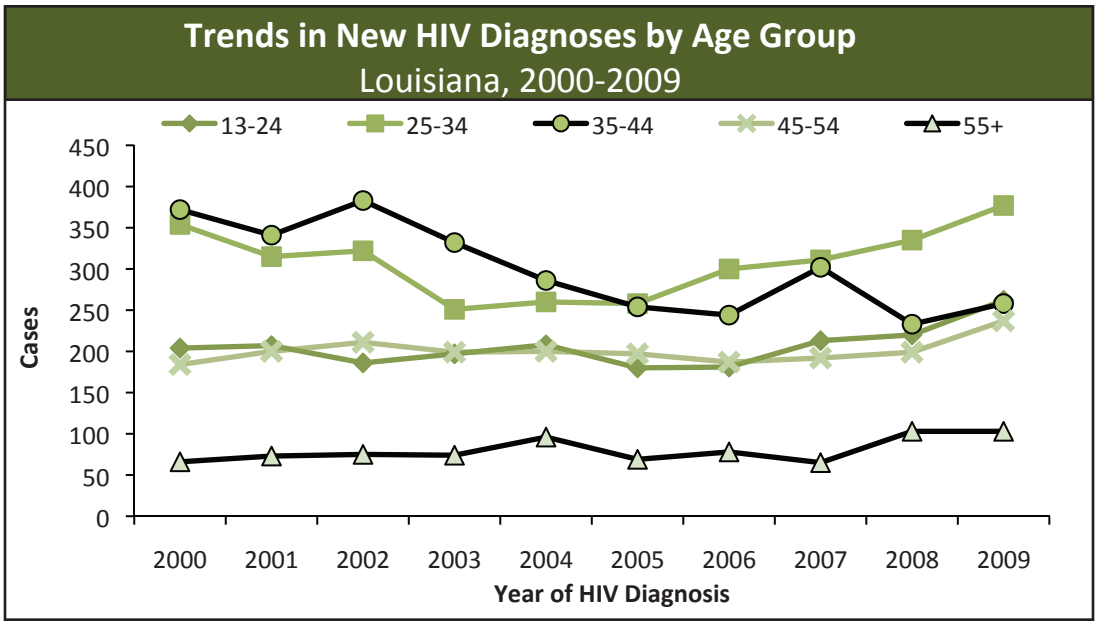


- The HIV case rate among whites has remained stable over the past 10 years. Since 2005, the HIV rates for blacks and Hispanic/Latinos have increased.
- In 2009, the HIV case rate for blacks was nearly eight times greater than the HIV case rate for whites, and almost twice the HIV case rate for Hispanic/Latinos. Although for Hispanic/Latinos the HIV case rate is almost five times greater than for whites, the total HIV case count for Hispanic/Latinos remains below 70 cases per year.





- For both females and males in Louisiana, the majority of new HIV diagnoses are in blacks. The HIV diagnosis rates for Hispanic/Latino females and males are higher than for white females and males, although the case counts are higher among whites.
- In 2009, the HIV diagnosis rate in black females was over 11 times greater than the HIV diagnosis rate for white females, and was over twice the HIV diagnosis rate for Hispanic/Latino females.
- In 2009, the HIV diagnosis rate in black males was over seven times greater than the HIV diagnosis rate for white males, but only 1.6 times greater than the HIV diagnosis rate for Hispanic/Latino males.
- The HIV diagnosis rate for Hispanic/Latino females is six times greater than it was in 2004 and the rate for Hispanic/Latino males has nearly doubled. During this same time period, rates have also increased among blacks but have remained stable among whites.



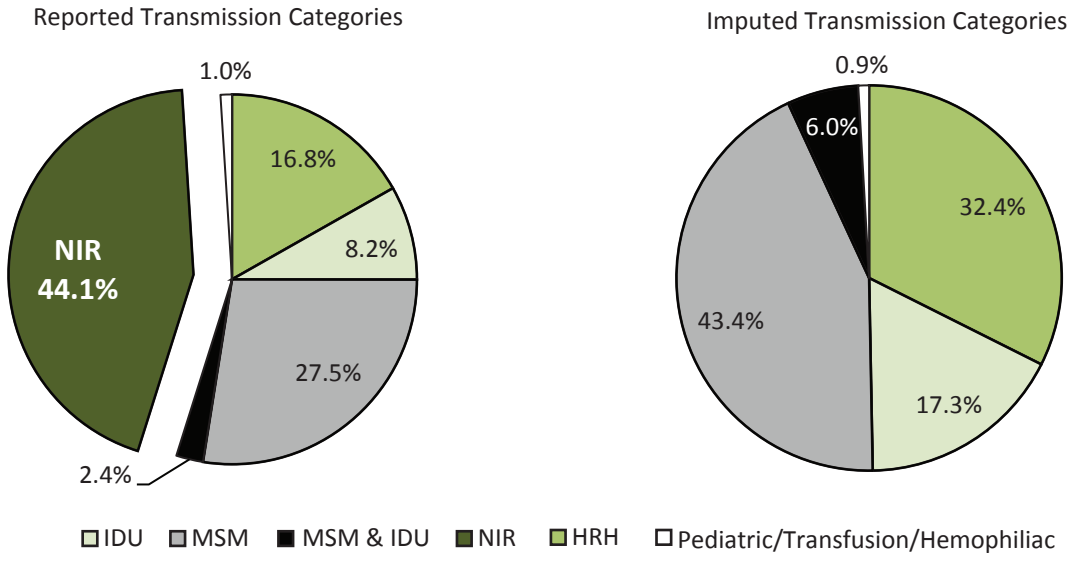
- The majority of all new infections have historically occurred in persons aged 25-44; 51% of all new diagnoses in 2009 were in this age group. While the number of new diagnoses in persons 25-34 decreased from 1999 to 2003, it has steadily increased since then to become the age group with the highest number of new diagnoses (30% of all new HIV diagnoses in 2009).
- The number of cases in youth between the ages of 13-24, and the number of cases in persons 45 and older has remained relatively stable over the past 10 years, although small increases have been recorded since 2006.

HIV Diagnoses by Transmission Category

In accordance with the transmission categories used by the CDC, HAP classifies cases into six transmission categories: men who have sex with men (MSM); high risk heterosexual contact (HRH); injection drug use (IDU); "men who have sex with men and inject drugs" (MSM/IDU); mother-to-child transmission (Pediatric); and cases who received a transfusion or hemophiliac products (Transfusion/Hemophilia). As illustrated in the graph on the following page, many cases do not have risk information reported or do not meet the transmission category criteria and are labeled as no identified risk (NIR). For all cases diagnosed between 2000 and 2009, 44% do not have a reported risk.

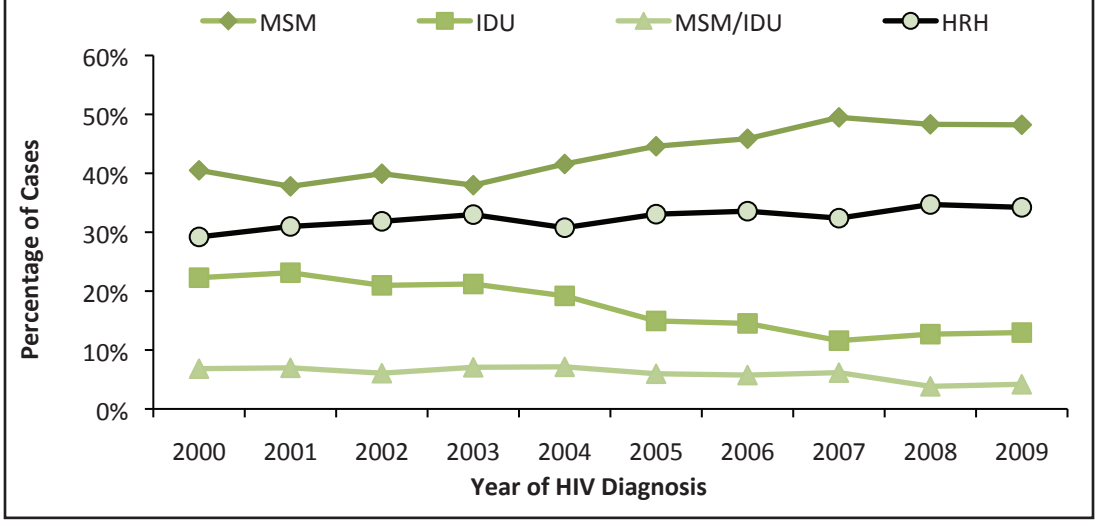
Risk information is difficult to ascertain because individuals may not know how they acquired the infection, their healthcare provider may not feel comfortable collecting the information, or the person may not be willing to share that information possibly due to stigma or fear of discrimination. A person who reports only heterosexual contact is not classified with a transmission category because according to the CDC "persons whose transmission category is classified as high-risk heterosexual contact are persons who report specific heterosexual contact with a person known to have, or to be at high risk for, HIV infection (e.g., an injection drug user)." Due to the large number of NIR cases, HAP uses a statistical method to assign a mode of transmission for NIR cases called "imputation" (described in the Technical Notes located at the end of this report).

HIV Transmission Categories
Louisiana, 2000-2009 Combined

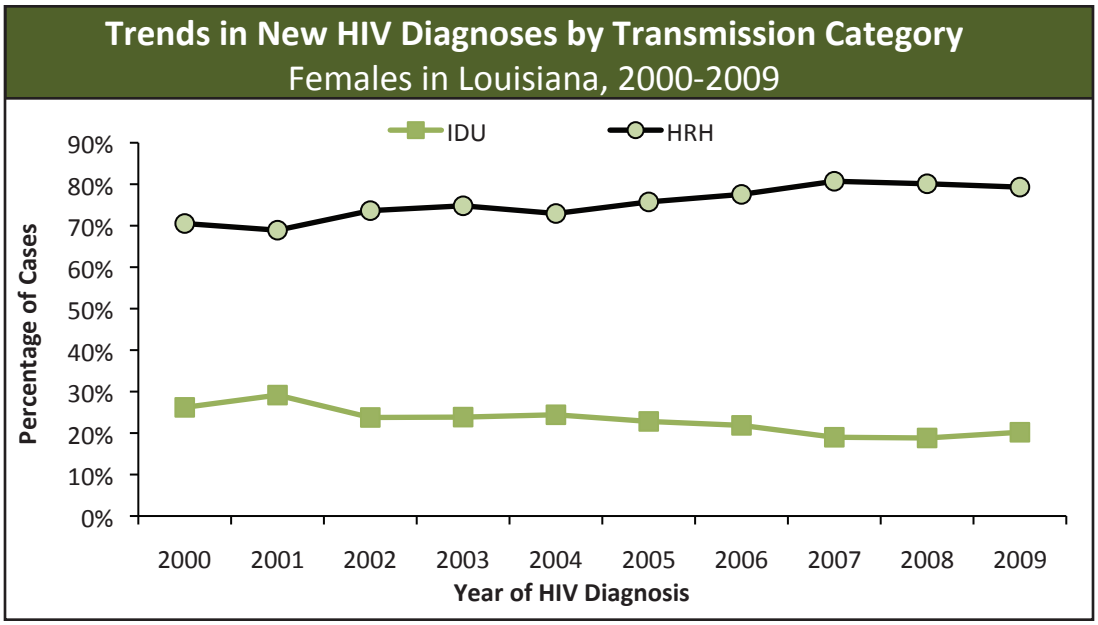


After assigning a transmission category for all NIR cases through imputation, trends in the percentage of cases for each transmission category can be analyzed. The following graphs use imputed transmission category unless otherwise noted.

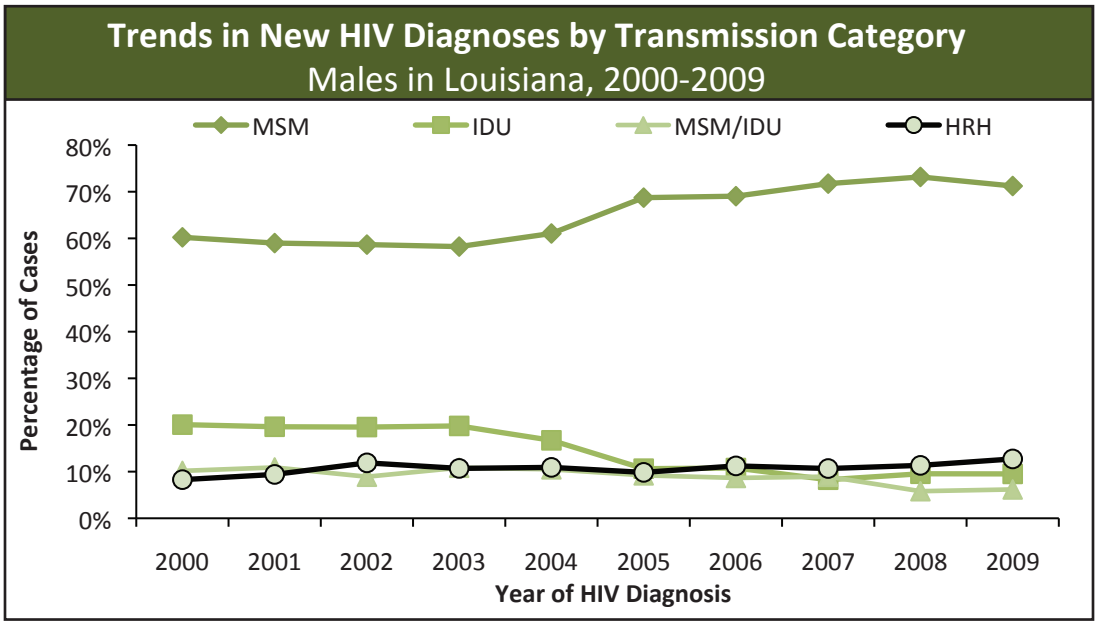
Trends in New HIV Diagnoses by Transmission Category
Louisiana Adult HIV Cases, 2000-2009



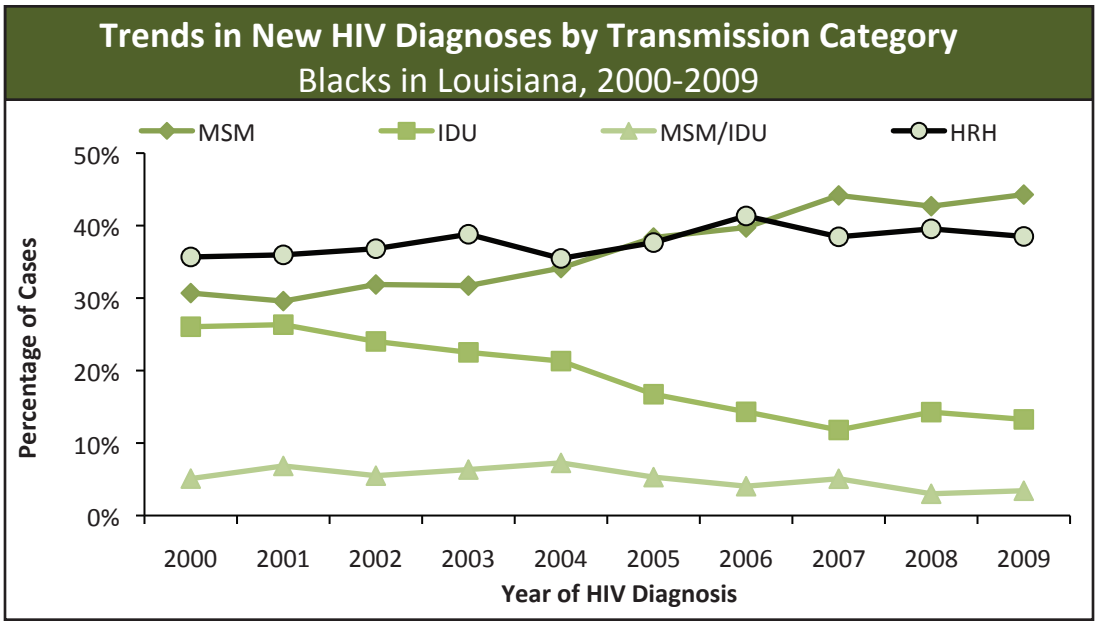
- The percentage of adult HIV cases attributed to MSM has increased from a low of 38% in 2001 to a high of 50% in 2007. In 2009 the percentage of MSM cases was 48%. The percentage of HRH cases has increased slightly, from 29% in 2000 to 35% in 2008. In 2009 the percentage of HRH cases was 34%. The percentage of cases attributed to IDU and MSM/IDU has declined dramatically over the past 10 years to 13% and 4% respectively in 2009.



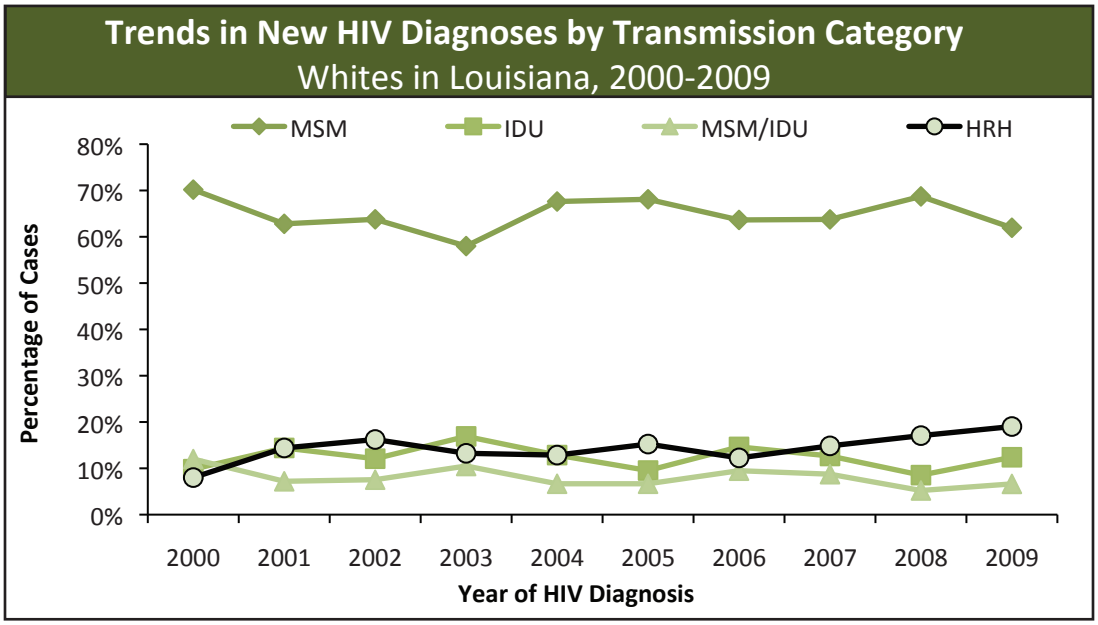
- The primary mode of transmission for women is HRH contact.
- Although there has always been a significant difference in the percentage of female cases attributed to HRH and IDU, the difference was greatest in 2007 when 81% of female cases were high risk heterosexuals. In 2009, 79% of the female cases were high risk heterosexuals and 20% were injection drug users.



- The primary mode of transmission for males in Louisiana continues to be MSM, with far fewer cases of IDU, MSM/IDU and HRH. In 2009, the percentage of male cases that are MSM is 71%, compared to ten years ago when MSM accounted for only 60% of all male cases. The percentage of HRH cases among men has increased in the past five years from 10% in 2005 to 13% in 2009.
- The percentage of new cases with a transmission category of IDU and MSM/IDU has declined since 2000 to one of the lowest percentages since the beginning of the epidemic. In 2009, IDU accounted for 10% and MSM/IDU accounted for 6% compared to 20% and 10% in 2000, respectively.

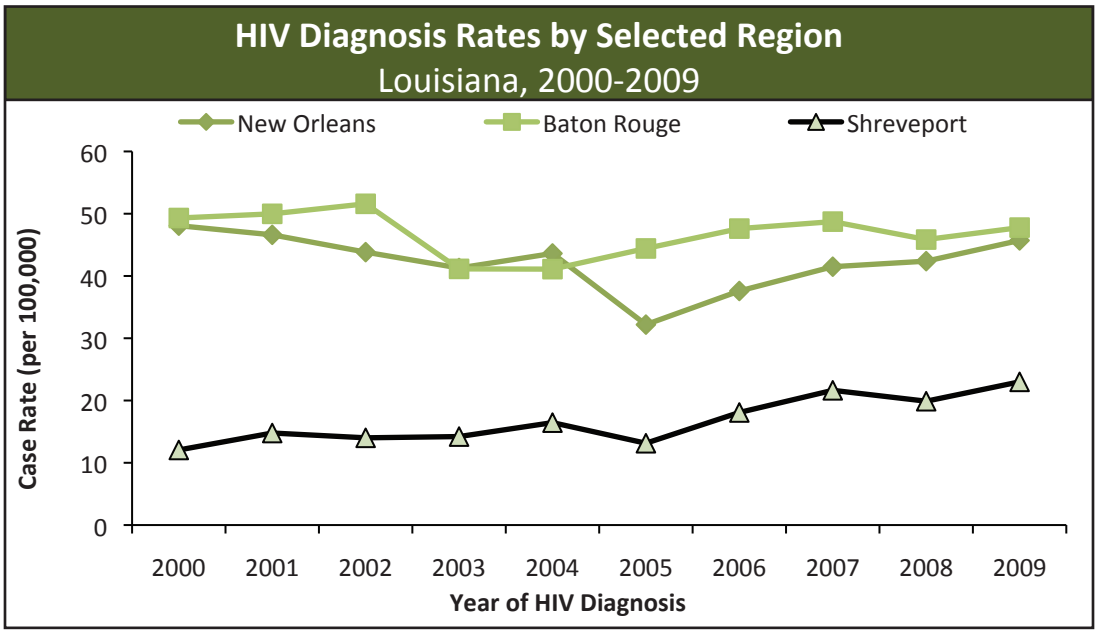


- Until recently, the primary mode of transmission for blacks was HRH contact followed closely by MSM. In 2005 the percentage of new cases of MSM in blacks reached and has since surpassed the percentage of cases attributable to HRH.
- In 2009, 44% of all new HIV diagnoses among blacks were MSM and 39% were HRH.
- Since 2000 to 2009, the percentage of HIV diagnoses resulting from IDU and MSM/IDU among blacks has declined significantly from 26% to 13% for IDU and 5% to 3% for MSM/IDU.

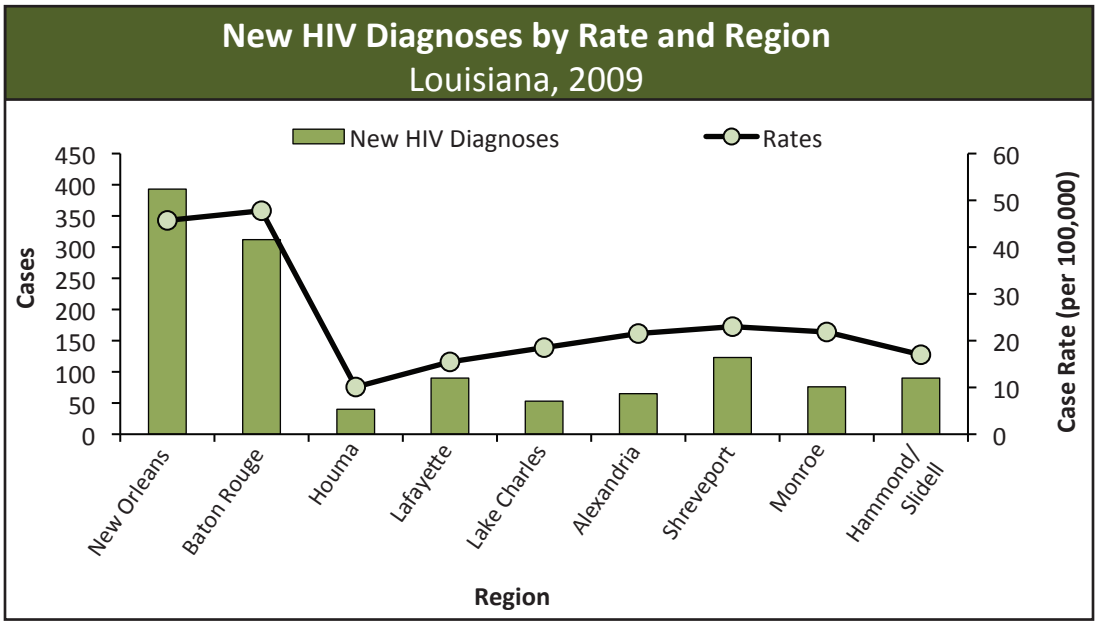


- The predominant mode of transmission among whites has historically been and continues to be MSM. From 2000 to 2009, the percentage of cases attributed to MSM has fluctuated between 58% to 70%.
- In 2009, 62% of cases were attributed to MSM, 19% of cases were attributed to HRH, 12% to IDU and 7% to MSM/IDU. There has been an increase in the percentage of white HIV diagnoses attributed to HRH in the past 10 years from 8% in 2000 to 19% in 2009.

HIV Diagnoses by Public Health Region



- The three public health regions in Louisiana with the largest number of new HIV diagnoses in 2009 are New Orleans, Baton Rouge and Shreveport (regions 1, 2, and 7 respectively). The ten year trends for these three regions are shown above.
- Since 2005, the HIV diagnosis rate in Baton Rouge has been higher than the diagnosis rate in New Orleans, largely due to the impact of Hurricane Katrina in August 2005. In 2009 the HIV rate in Baton Rouge was 47.8 per 100,000 and the HIV rate in New Orleans was 45.7 per 100,000. The HIV diagnosis rate in Shreveport was 23 per 100,000 in 2009, which was a significant increase from 2005 when it was 13 per 100,000. A table with the HIV case count for each region, 2000-2009, is located in the Appendix.



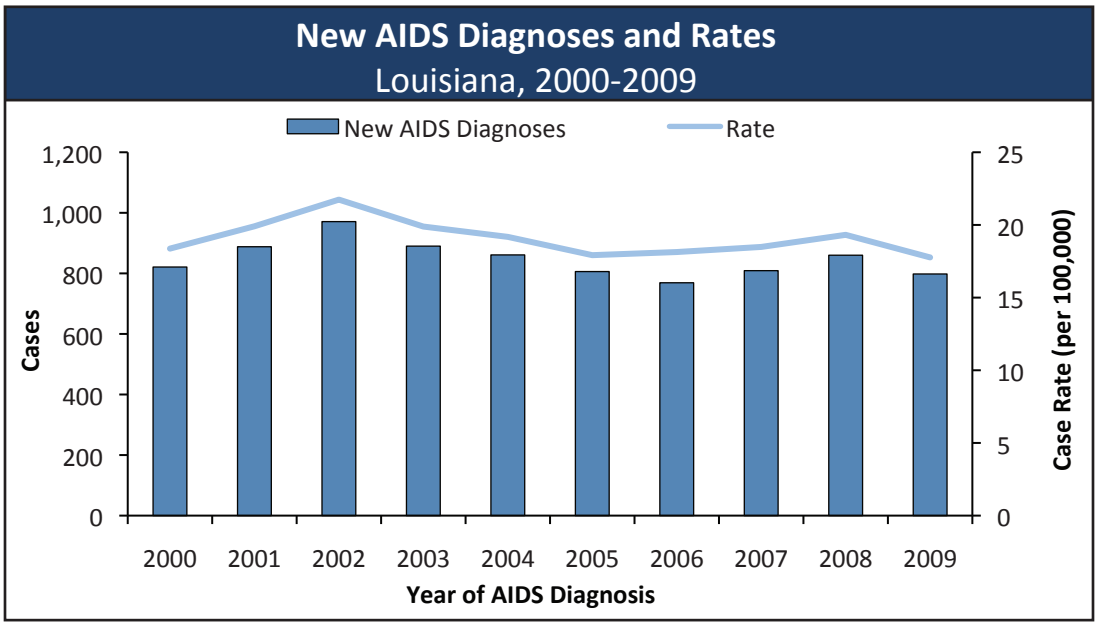
- In 2009, New Orleans had the highest number of new HIV cases but Baton Rouge had the highest HIV diagnosis rate.
- The Houma region has the lowest number and lowest rate of new HIV diagnoses.

Characteristics of Persons Newly Diagnosed with HIV Louisiana, 2008-2009				
	Persons First Diagnosed with HIV in 2008		Persons First Diagnosed with HIV in 2009	
	Cases	Percent	Cases	Percent
TOTAL	**1,095**	**100%**	**1,242**	**100%**
Sex				
Female	372	34.0%	401	32.3%
Male	723	66.0%	841	67.7%
Race/Ethnicity				
Black/African American	799	73.0%	935	75.3%
Hispanic/Latino	61	5.6%	61	4.9%
White	211	19.3%	226	18.2%
Other/Unknown/Multi-race	24	2.2%	20	1.6%
Age Group	**Age at HIV Diagnosis**		**Age at HIV Diagnosis**	
0-12	5	0.5%	5	0.4%
13-19	54	4.9%	44	3.5%
20-24	166	15.2%	218	17.6%
25-34	335	30.6%	377	30.4%
35-44	233	21.3%	258	20.8%
45-54	199	18.2%	237	19.1%
55-64	76	6.9%	86	6.9%
65+	27	2.5%	17	1.4%
Imputed Transmission Category				
Men who have sex with men (MSM)	529	48.3%	599	48.2%
Injecting Drug User (IDU)	139	12.7%	161	13.0%
MSM/IDU	42	3.8%	52	4.2%
High Risk Heterosexual (HRH)	380	34.7%	425	34.2%
Transfusion/Hemophilia/Other	0	0.0%	0	0.0%
Perinatal/Pediatric	5	0.5%	5	0.4%
Rural/Urban				
Rural	176	16.1%	207	16.7%
Urban	919	83.9%	1,035	83.3%

- In 2009, 1,242 persons were newly diagnosed with HIV; a 13% increase from 2008.
- From 2008 to 2009, the number of female HIV diagnoses increased 8% while the number of male diagnoses increased 16%.
- From 2008 to 2009, the number of black and white cases increased while the number of Hispanic cases remained stable.
- In 2008 and 2009, the greatest number and percentage of cases were in persons age 25-34.
- From 2008 to 2009, the number of MSM and HRH cases increased but the percentages remained stable.
- In Louisiana, most new diagnoses (83% in 2009) were among persons residing in urban areas.

10-Year Trends in New AIDS Diagnoses (2000-2009)

AIDS diagnoses are the number of individuals diagnosed with AIDS within a given time period. An AIDS diagnosis is made when a person has a CD4 cell count <200, a CD4 % <14%, or develops an opportunistic infection (OI) such as Pneumocystis carinii pneumonia (PCP) or wasting syndrome. Once a person is diagnosed with AIDS they remain categorized as AIDS even if their CD4 count rises above 200, their CD4% above 14% or they are cured of their OI. The number of AIDS diagnoses has been collected since the beginning of the epidemic both nationally and in Louisiana. AIDS diagnoses are useful for highlighting issues regarding access to testing, medical care, medication and adherence.

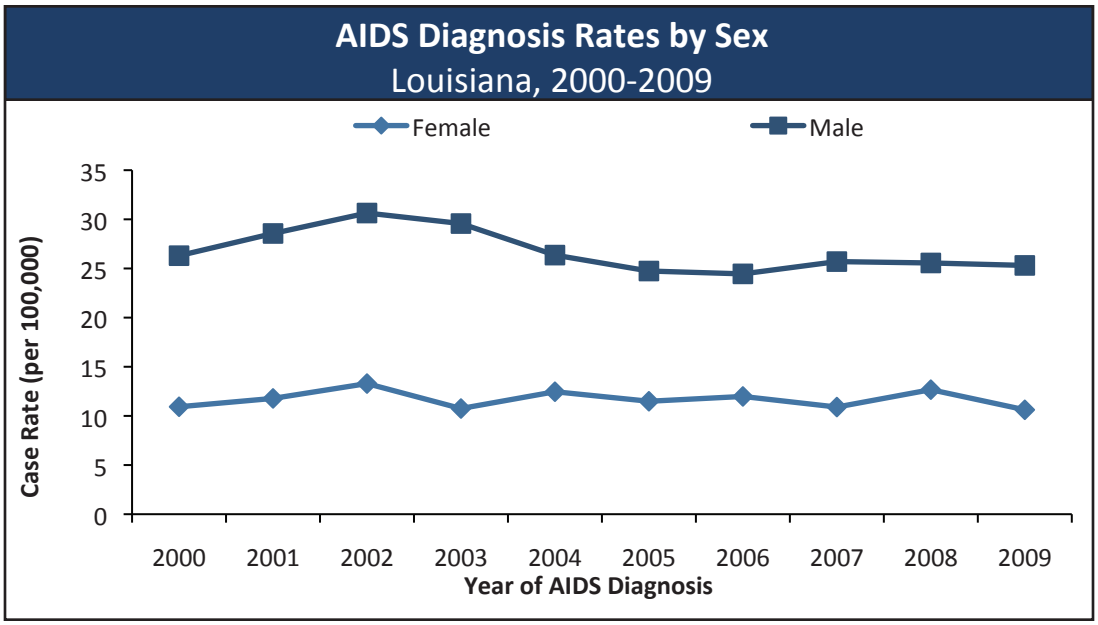


- The number of new AIDS diagnoses in 2009 remains below its highest level in 2002 as a result of the availability of more effective treatments.
- The AIDS diagnosis rate fluctuates slightly each year in accordance with the change in the number of AIDS diagnoses. In 2009, the AIDS diagnosis rate for Louisiana was 17.8 per 100,000.

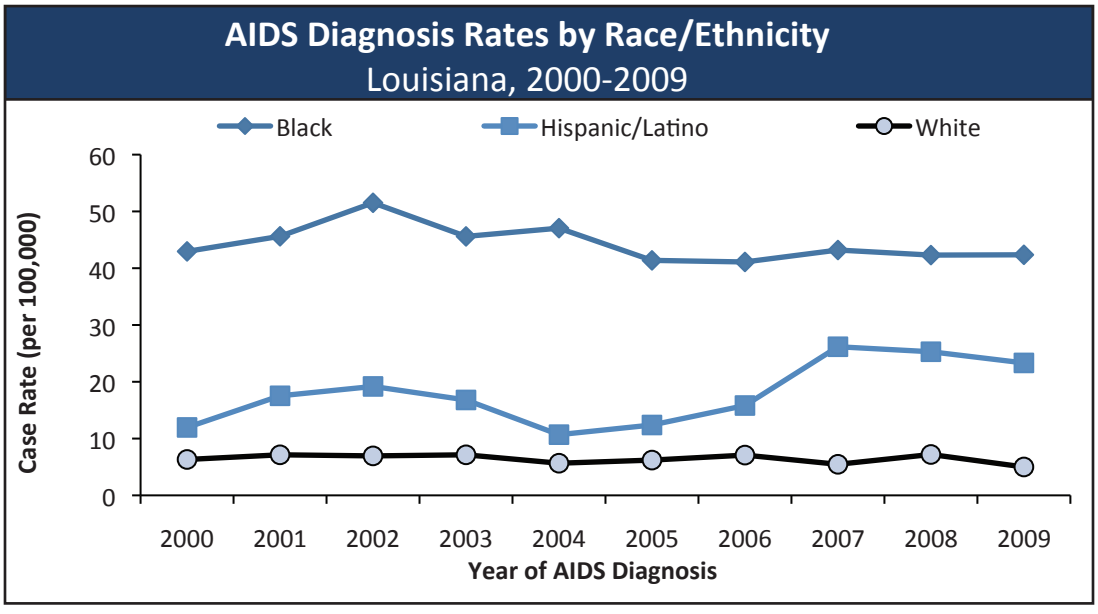
AIDS diagnoses and deaths in the United States

In June 1981, the first cases of what would later be diagnosed as AIDS were reported in the US. During the 1980s, there was a rapid increase in the number of AIDS diagnoses and deaths in persons with AIDS. Cases peaked in 1993 with the expansion of the AIDS case definition. The most dramatic drop in both new diagnoses and deaths began in 1996, with the widespread use of combination antiretroviral therapy. Since 2000, the annual numbers of AIDS diagnoses have been relatively constant, with an estimated 34,247 new AIDS diagnoses in 2009. The CDC estimates that since the beginning of the epidemic through the end of 2009, approximately 1,108,611 people have been diagnosed with AIDS in the US. By region, the South has the greatest number of people living with AIDS, AIDS deaths, and new AIDS diagnoses.

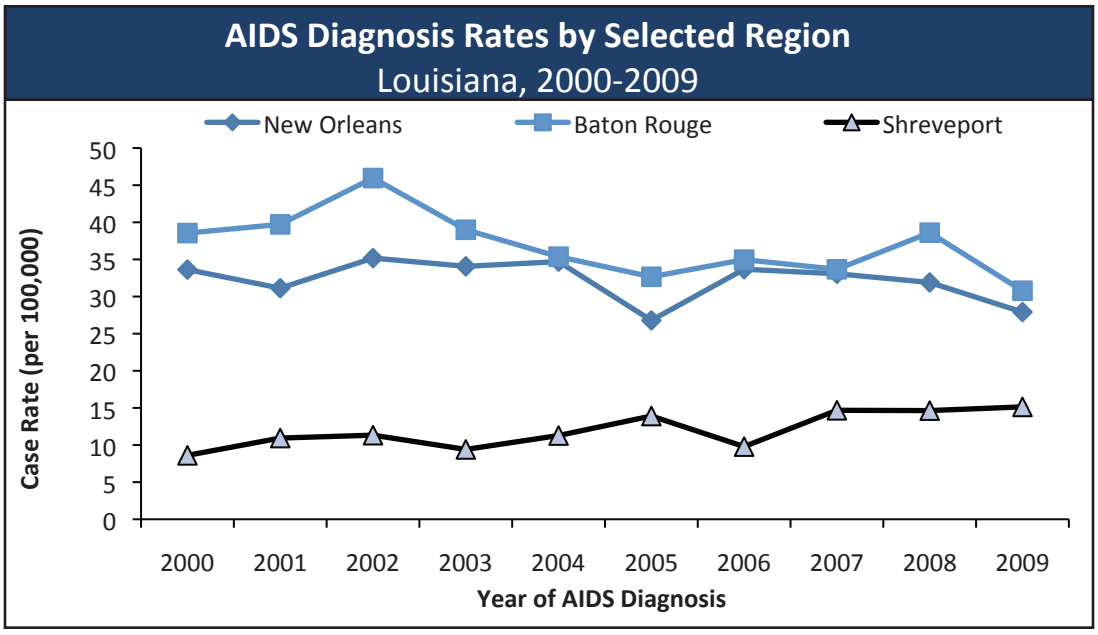
Centers for Disease Control and Prevention. *HIV Surveillance Report, 2009*. Vol. 21.



- The AIDS diagnosis rate for females has fluctuated slightly over the past 10 years but in 2009 it reached its lowest rate of 10.6 per 100,000.
- The AIDS diagnosis rate for males has also fluctuated within a relatively small range (low of 24.5 per 100,000 in 2006, and a high of 30.6 per 100,000 in 2002). In 2009 the male AIDS diagnosis rate was 25.3 per 100,000.
- In 2009, the AIDS diagnosis rate in males was 2.4 times greater than the rate in females whereas in 2003 the male rate was 2.8 times higher than among females.

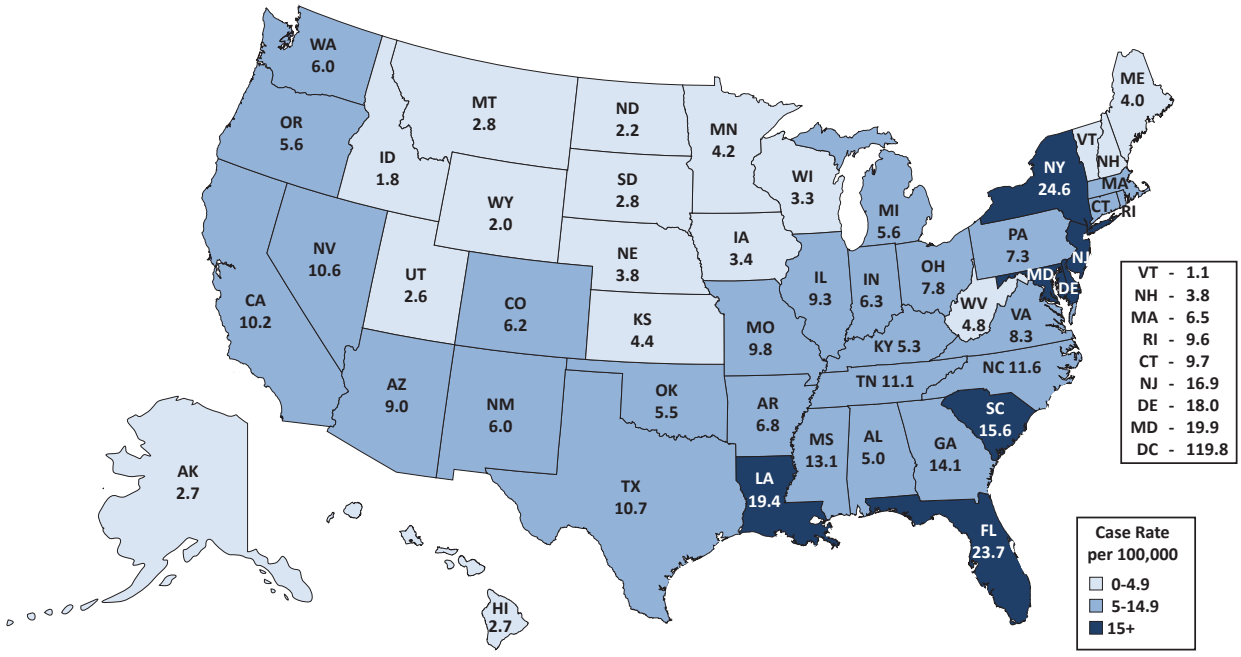


- From 2000 to 2002, the AIDS diagnosis rate for blacks increased by 20% but since then has decreased. In 2009, the AIDS diagnosis rate for blacks was 42.4 per 100,000 which was 1.8 times greater than for Hispanic/Latinos and 8.5 times greater than for whites.
- From 2000 to 2009, the AIDS diagnosis rate among Hispanic/Latinos doubled, from 12.0 per 100,000 in 2000 to 23.3 per 100,000 in 2009.
- The AIDS diagnosis rate for whites has remained relatively stable over the last decade with the lowest rate of 5.0 per 100,000 persons being reached in 2009.



- The Baton Rouge region continues to have the highest AIDS diagnosis rate in 2009 of all nine public health regions (30.8 per 100,000) in Louisiana.
- In 2009, the New Orleans region had the second highest AIDS diagnosis rate (27.9 per 100,000). The AIDS diagnosis rate in Shreveport continues to be the third highest in the state, and in 2009 reached its highest rate to date (15.1 per 100,000).

AIDS Rates in the United States (2009)[10]



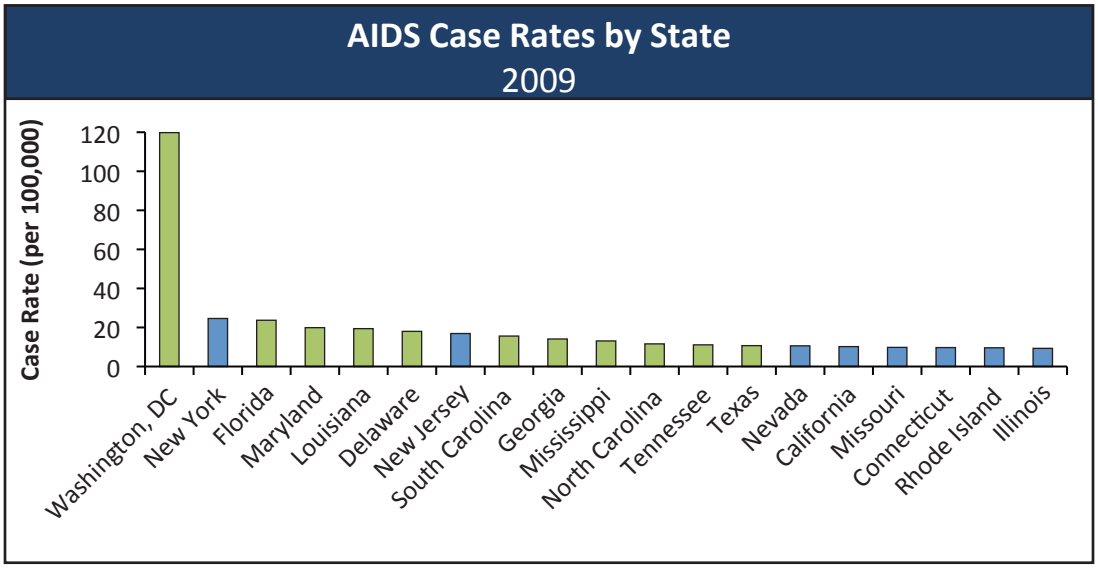
- In the US, there were an estimated 34,247 new AIDS cases in 2009, for a national rate of 11.2 AIDS cases per 100,000 persons. In 2008 the national AIDS case rate was 12.2 per 100,000.
- In 2009, Louisiana ranked 5th highest in state estimated AIDS case rates (19.4 per 100,000) and 12th in the number of estimated AIDS cases in the US, according to the most recent CDC *HIV Surveillance Report* (Vol 21). In 2008, Louisiana ranked 4th highest in state estimated AIDS case rates (24.0 per 100,000).

Characteristics of Persons Newly Diagnosed with AIDS Louisiana, 2008-2009				
	Persons First Diagnosed with AIDS in 2008		Persons First Diagnosed with AIDS in 2009	
	Cases	Percent	Cases	Percent
TOTAL	**843**	**100%**	**798**	**100%**
Sex				
Female	290	34.4%	245	30.7%
Male	553	65.6%	553	69.3%
Race/Ethnicity				
Black/African American	598	70.9%	606	75.9%
Hispanic/Latino	39	4.6%	38	4.8%
Other/Unknown/Multi-race	8	0.9%	16	2.0%
White	198	23.5%	138	17.3%
Age Group	**Age at AIDS diagnosis**		**Age at AIDS diagnosis**	
0-12	1	0.1%	0	0.0%
13-19	12	1.4%	8	1.0%
20-24	51	6.0%	59	7.4%
25-34	223	26.5%	221	27.7%
35-44	249	29.5%	205	25.7%
45-54	208	24.7%	225	28.2%
55-64	90	10.7%	65	8.1%
65+	19	2.3%	15	1.9%
Imputed Transmission Category				
Men who have sex with men (MSM)	341	40.5%	356	44.6%
Injecting Drug User (IDU)	168	19.9%	144	18.0%
MSM/IDU	53	6.3%	50	6.3%
High Risk Heterosexual (HRH)	274	32.5%	246	30.8%
Transfusion/Hemophilia/Other	3	0.4%	2	0.3%
Perinatal/Pediatric	4	0.5%	0	0.0%
Rural/Urban				
Rural	132	15.7%	133	16.7%
Urban	711	84.3%	665	83.3%

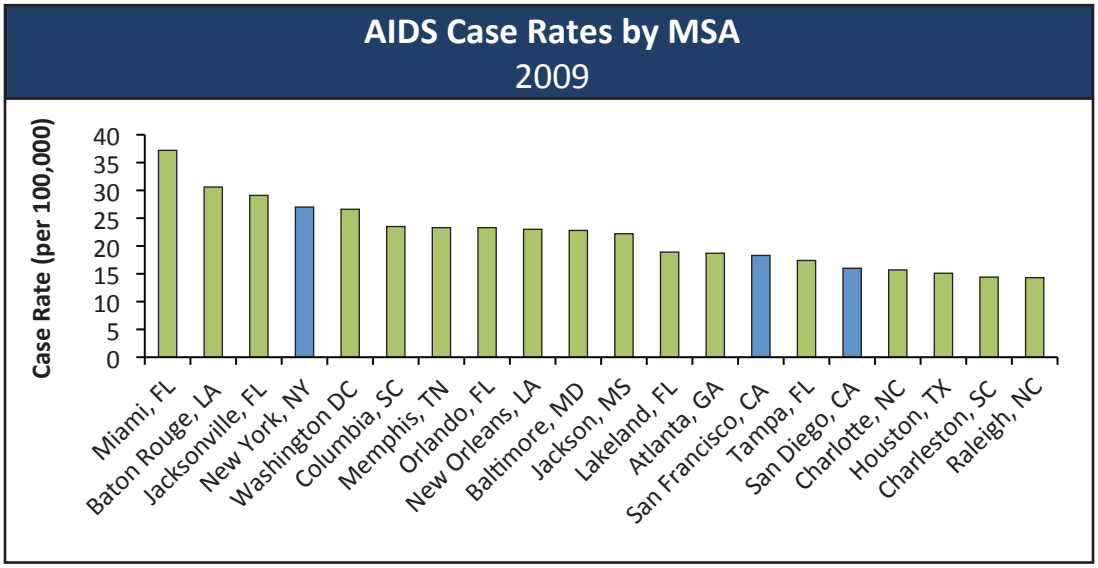
- In 2009, there were 798 new AIDS diagnoses in Louisiana, a 5% decrease from 2008.
- From 2008 to 2009, the number of new female AIDS diagnoses decreased by over 15% and the number of new AIDS diagnoses among males remained unchanged.
- The number of new AIDS diagnoses increased among blacks from 2008-2009 but decreased by 30% among whites.
- In 2009, the greatest number of new AIDS diagnoses were among people age 45-54, followed by people age 25-34. In 2008, the age group with the greatest number of new AIDS diagnoses was 35-44 year olds followed by people age 25-34.
- In 2008 and 2009, the greatest number and percentage of new AIDS diagnoses were in men who have sex with men, followed by high risk heterosexuals and injection drug users.
- The majority of AIDS diagnoses occurred in urban areas in 2009 (83%).

Southern AIDS Coalition

HAP is an active member of the Southern AIDS Coalition (SAC) which highlights the disproportionate impact that the HIV epidemic has had in the southern United States. Seventeen states are included in the southern region of the US: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia. Southern states are represented in green below.[11]



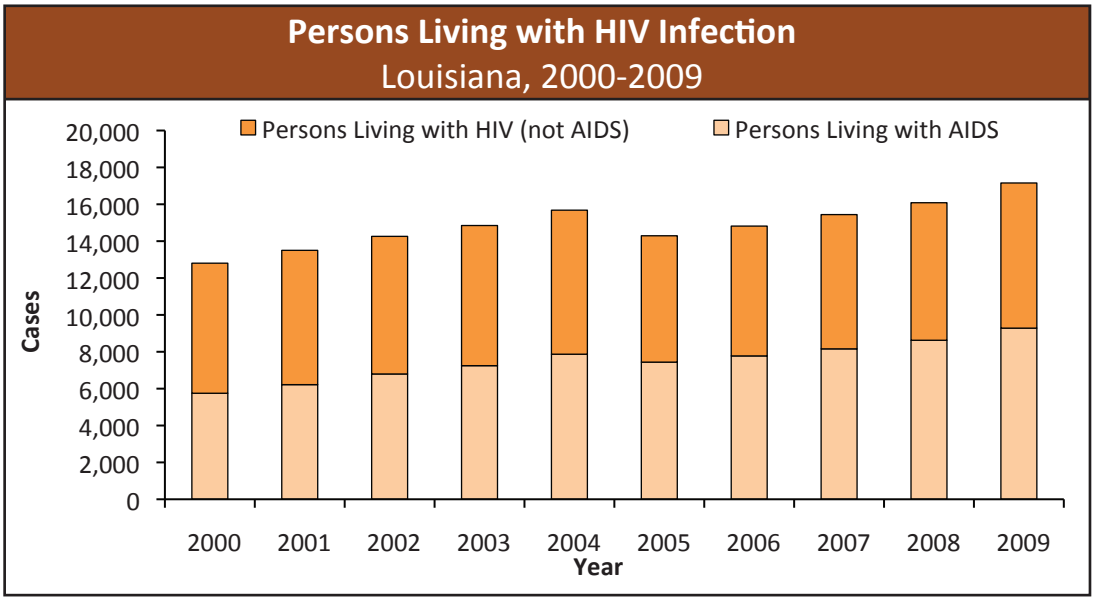
- In 2009, southern states represented 37% of the US population but over 40% of person living with AIDS and 46% of new AIDS cases.
- Of the 20 states that had the highest AIDS case rates in 2009, 12 (60%) were in the South.



- Of the 20 metropolitan areas that had the highest AIDS case rates in 2009, 17 (85%) were in the South. According to the CDC, the Baton Rouge metro area ranked 2nd and the New Orleans metro area ranked 9th in estimated AIDS case rates in 2009 among metropolitan areas in the US with more than 500,000 persons. The Baton Rouge and New Orleans metro areas have both been in the top ten metropolitan areas with the highest AIDS case rates since 2004.

Persons Living in Louisiana with HIV Infection (Prevalence)

Prevalence is a measure describing the number of persons living with HIV Infection at a certain point in time and includes people living with all stages of HIV or AIDS. Prevalence is the accumulation of diagnoses for people who are still living with the disease. Prevalence numbers and rates are important for ascertaining the burden of HIV on health care systems, allocating resources and monitoring trends over time. Reported HIV diagnosis data provide only the minimum estimate of the number of people living with HIV, since persons who have not been tested and those who test anonymously are not included. The CDC estimates that 21% of persons living with HIV are unaware of their infection status.



- The number of persons living with HIV infection increased each year from 2000 to 2004. The decrease from 2004 to 2005 was due to the dislocation of a large number of persons from the New Orleans metropolitan area who left Louisiana following Hurricane Katrina in August 2005. Since then, the number of persons living with HIV infection has surpassed pre-Katrina numbers.
- At the end of 2009, 17,155 persons were known to be living with HIV infection in Louisiana, 9,283 (54%) of whom have progressed from HIV to AIDS.

Persons living with HIV Infection in the United States

At the end of 2006, the CDC estimated that the number of people living with HIV infection in the US had reached over 1.1 million adults and adolescents. Of these one million people, gay and bisexual men of all races, blacks, and Hispanics/Latinos were most heavily affected. There has been a steady increase in the US in the number of persons living with HIV infection, which is expected, due to the widespread use of antiretroviral treatment and the development of new antiretroviral regimens. In the US more people become infected with HIV than die from the disease each year.

Historically, it has been estimated that 25% of HIV-positive persons are undiagnosed or are unaware of their status. In 2008, the CDC released a new analysis that indicates that the percentage of HIV-positive persons who are unaware of their status has decreased from 25% to 21%.

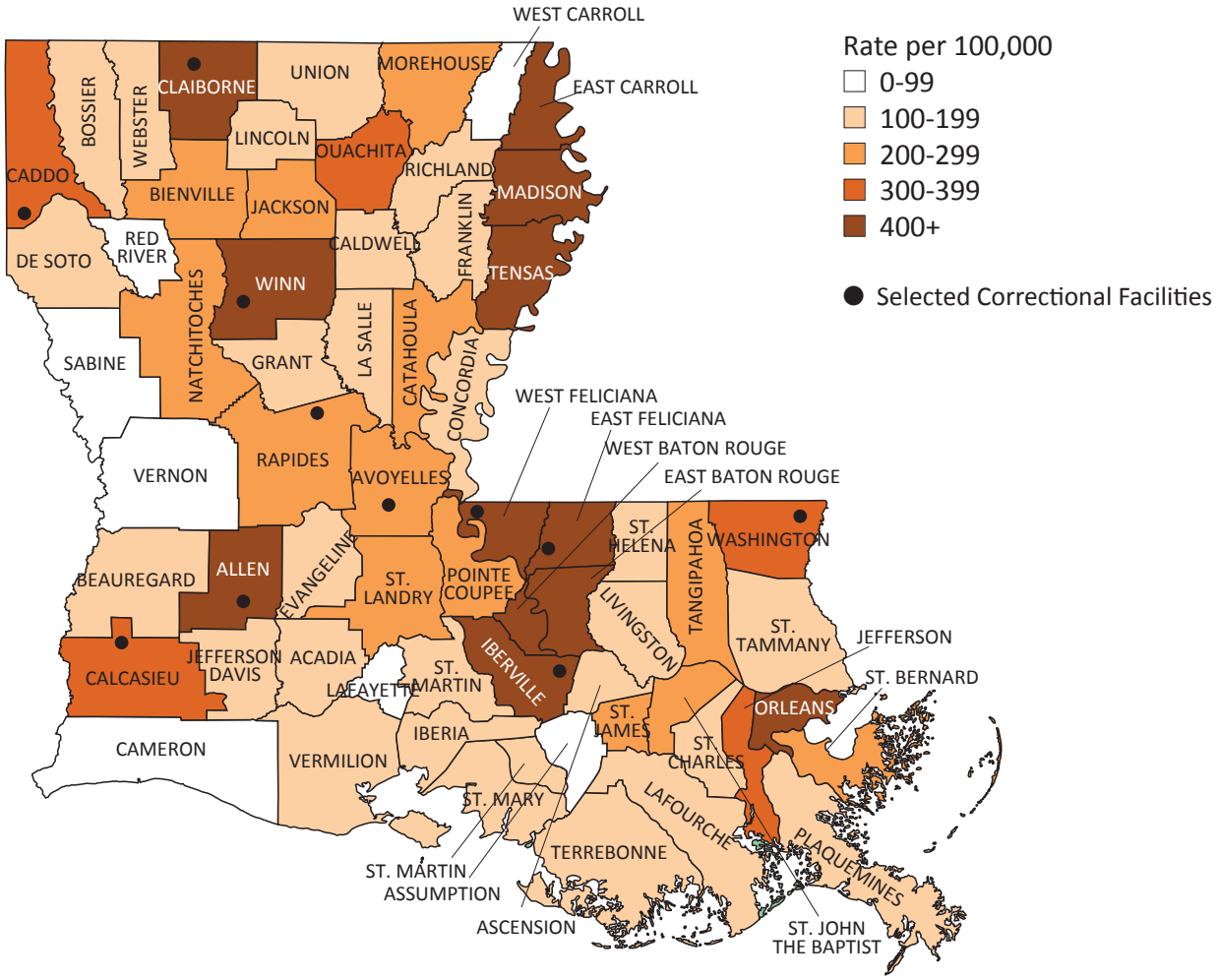
MMWR 2008; 57(39):1073-1075

Characteristics of Persons Living with HIV Infection and Cumulative Cases Louisiana, 2009				
	Persons Living with HIV Infection as of 12/31/2009		Cumulative Persons with HIV Infection as of 12/31/2009*	
	Cases	Percent	Cases	Percent
TOTAL	17,155	100%	29,713	100%
Sex				
Female	5,118	29.8%	7,653	25.8%
Male	12,037	70.2%	22,060	74.2%
Race/Ethnicity				
Black/African American	11,450	66.7%	19,052	64.1%
Hispanic/Latino	624	3.6%	832	2.8%
White	4,906	28.6%	9,539	32.1%
Other/Unknown/Multi-race	175	1.0%	290	1.0%
Age Group	Age in 2009		Age in 2009	
0-12	79	0.5%	315	1.1%
13-19	181	1.1%	1,138	3.8%
20-24	777	4.5%	3,575	12.0%
25-34	3,354	19.6%	10,491	35.3%
35-44	4,882	28.5%	8,640	29.1%
45-54	5,402	31.5%	3,957	13.3%
55-64	1,999	11.7%	1,196	4.0%
65+	481	2.8%	401	1.4%
Imputed Transmission Category				
Men who have sex with men (MSM)	7,592	44.3%	13,348	44.9%
Injecting Drug User (IDU)	2,905	16.9%	5,990	20.2%
MSM/IDU	1,432	8.4%	2,791	9.4%
High Risk Heterosexual (HRH)	4,938	28.8%	6,783	22.8%
Transfusion/Hemophilia/Other	108	0.6%	497	1.7%
Perinatal/Pediatric	180	1.1%	304	1.0%
Rural/Urban				
Rural	2,551	14.9%	3,577	12.0%
Urban	14,604	85.1%	26,136	88.0%

* Cumulative persons reflects the total number of HIV-infected persons diagnosed in Louisiana, including those who have died.

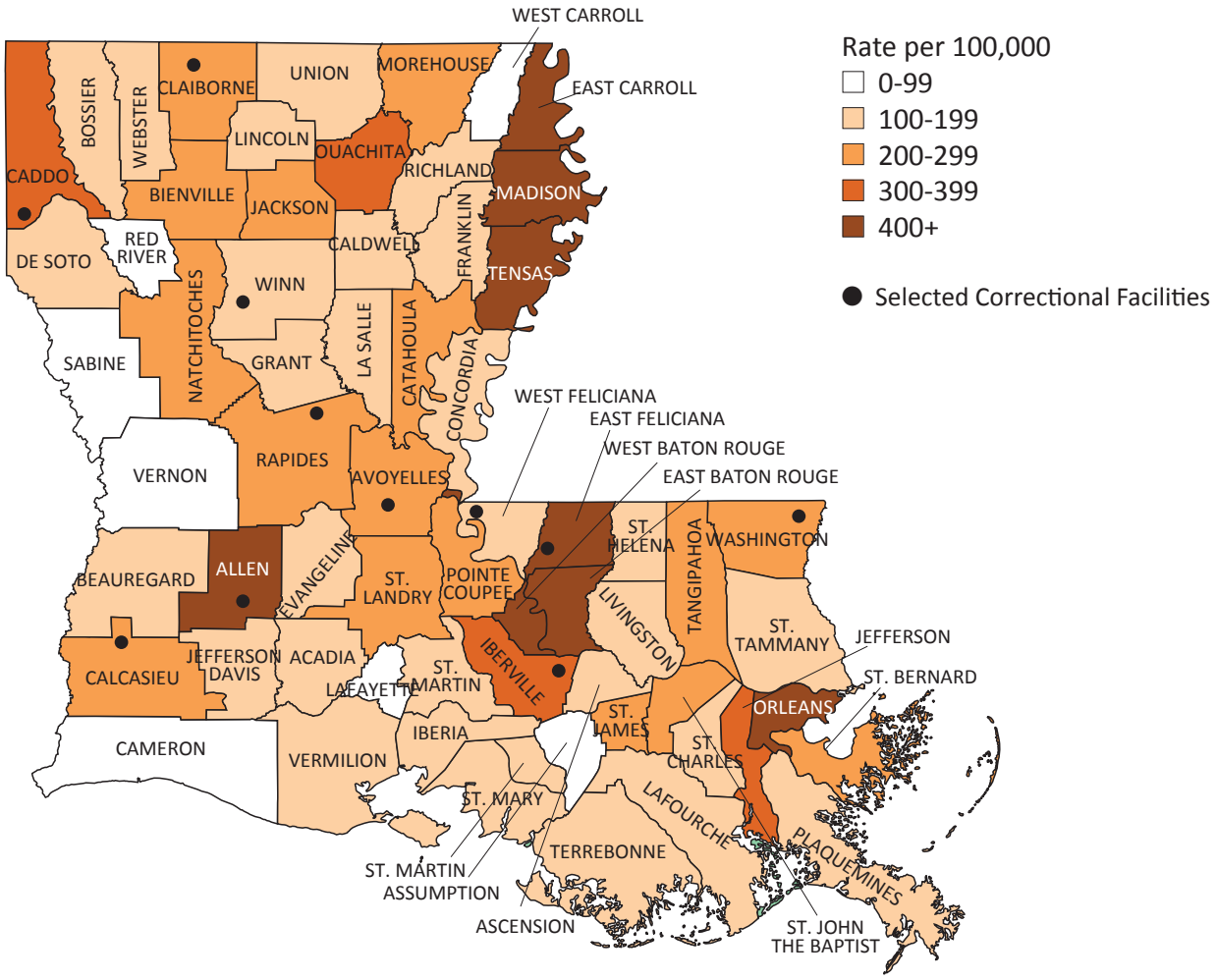
- In 2009, males made up more than 70% of all people living with HIV infection in Louisiana.
- Although blacks only made up 32% of Louisiana's population in 2009, they accounted for almost 67% of all people living with HIV infection.
- The majority of people living with HIV infection are between the ages of 35-54, live in urban areas, and are men who have sex with men or are high risk heterosexuals.

Persons Living with HIV Infection by Parish, Including State Prisoners
Louisiana, 2009



- The above map illustrates the geographic distribution of persons living with HIV infection in the state. There are persons living with HIV in every parish in Louisiana.
- At the end of 2009, 18 parishes had a prevalence rate of HIV infection greater than 300 per 100,000. Many of the parishes with disproportionate prevalence rates have correctional facilities that have reported a large number of HIV cases.
- Although the majority of persons living with HIV reside in urban areas, 12% live in rural parishes.

Persons Living with HIV Infection by Parish, Excluding State Prisoners
Louisiana, 2009



- Louisiana has 12 state correctional facilities marked on the above two maps. Almost 20,000 inmates are located in these 12 facilities. State correctional facilities are located in Allen, Avoyelles, Caddo, Calcasieu, Claiborne, East Feliciana, Iberville (x2), Rapides, Washington, West Feliciana and Winn parishes.
- The map above displays the HIV infection prevalence rate by parish excluding people in correctional facilities.
- Parishes such as Avoyelles, Claiborne, Washington, West Feliciana and Winn had significantly lower HIV prevalence rates once the prisoners were removed from the analysis. Other parishes such as Caddo, Calcasieu, and Iberville had only slightly lower rates once the prisoners were removed but the prevalence rate still remained high due to other persons living in the parish with HIV. Allen and East Feliciana parishes still had very high prevalence rates, even after the removal of the prisoners.

Post-Hurricane Katrina Investigations

Shortly after Hurricane Katrina and the ensuing failure of the levee system devastated New Orleans and southeastern Louisiana on August 29, 2005, HAP assembled a team to assess and monitor the impact of this event on HIV rates, shifting disease prevalence, and health status of persons living with HIV infection.

Prevalence

Because a large percentage of the HIV-infected population left, prevalence information from the HAP surveillance database was no longer accurate. To address this problem, HAP developed HIV prevalence estimates for the New Orleans MSA in early 2006, which have been continuously updated since. By viewing cases with a confirmed current residence as a sample of the total population who had contact with the surveillance system, current residency was estimated as a proportional change. A detailed description of these methods may be found in Robinson et al.[12] It should be noted that over time these estimates have converged with the prevalence data from eHARS, which may now be more reliable.

Estimated Number of Persons Living with HIV Infection in Metro New Orleans Before and After Hurricane Katrina

	Pre-Katrina	Post-Katrina				
Parish	**Jul-05**	**Mar-06**	**Aug-06**	**Oct-07**	**Nov-08**	**Dec-09**
Orleans	5,224	2,089	2,615	3,177	3,596	3,902
Jefferson	1,265	1,114	1,254	1,464	1,578	1,683
St. Tammany	251	282	280	324	353	318
St. Bernard	121	37	46	68	82	85
St. John the Baptist	68	136	170	117	135	105
St. Charles	66	71	73	82	92	90
St. James	43	86	86	61	66	66
Plaquemines	30	20	19	19	27	30
New Orleans MSA	**7,068**	**3,836**	**4,543**	**5,311**	**5,929**	**6,279**

Incidence

Calculation of HIV and AIDS rates requires accurate population estimates of the total number of person-years of exposure. Unfortunately these data were not easily obtainable or were subject to controversy for the time periods following Katrina, especially for Orleans Parish. Further complicating the matter is the fact that many of the estimates, including the U.S. Census data, are point estimates taken at a single time during the year and may have overrepresented the number of person-years of exposure in 2005 and 2006 dramatically. For this reason rates calculated with Census data underestimate the actual rates for Region I and Orleans Parish.[13]

Disease Progression

Recently, HAP investigators have explored the impact of Hurricane Katrina on the health status of persons living with HIV in Louisiana, particularly those who were residing in the New Orleans area before the storm. It was hypothesized that individuals' health status may have been affected by this event. Analysis of CD4 counts from laboratory reports to HAP Surveillance showed a significant decline in the health status of pre-Katrina residents of the New Orleans MSA relative to the rest of the state. Moreover, pre-Katrina evacuees who had not returned to the area by 18 months after the storm had significantly lower CD4 counts on average than those who were able to return by that time.[14]

Late HIV Testing in Louisiana

Since improved antiretroviral medications and preventive therapies are now available for people living with HIV, it is important that people are tested for HIV, and if positive, are referred into care early so that they can benefit from these treatment advances. However, a significant number of people are not tested for HIV until they are symptomatic. In 2006, the CDC released new recommendations for HIV testing of adults, adolescents and pregnant women in health-care settings. HIV screening is recommended for all patients age 13 and older, unless the patient declines testing ("opts out"). Persons at high risk of HIV should be tested annually. HIV screening is recommended for all pregnant women as part of their routine prenatal screening tests.

Late HIV Testing
Louisiana, 2008-2009

	Persons Diagnosed with HIV, 2008			Persons Diagnosed with HIV, 2009		
	New HIV Diagnoses	AIDS at Time of Diagnosis*	AIDS Within 6 Months of Diagnosis	New HIV Diagnoses	AIDS at Time of Diagnosis*	AIDS Within 6 Months of Diagnosis
Total	**1,095**	**23%**	**33%**	**1,242**	**24%**	**31%**
Sex						
Female	372	19%	28%	401	22%	29%
Male	723	25%	36%	841	24%	33%
Race/Ethnicity						
Black/African American	799	22%	32%	935	23%	31%
Hispanic/Latino	61	26%	41%	61	36%	46%
White	211	28%	36%	226	25%	30%
Other/Unknown/Multi-race	18	11%	28%	20	20%	25%
Age Group						
0-12	5	20%	20%	5	0%	0%
13-19	54	7%	13%	44	7%	16%
20-24	166	8%	17%	218	11%	15%
25-34	335	16%	26%	377	20%	29%
35-44	233	30%	39%	258	26%	34%
45-54	199	34%	46%	237	37%	47%
55-64	76	47%	59%	86	33%	40%
65+	27	37%	52%	17	47%	53%
Imputed Transmission Category						
MSM	529	23%	32%	599	25%	31%
IDU	139	30%	42%	161	28%	37%
MSM/IDU	42	33%	52%	52	15%	33%
HRH	380	20%	29%	425	21%	30%
Perinatal/Pediatric	5	20%	20%	5	0%	0%
Region						
1-New Orleans	356	22%	33%	393	21%	29%
2-Baton Rouge	297	21%	32%	312	20%	26%
3-Houma	43	30%	42%	40	25%	33%
4-Lafayette	75	24%	29%	90	24%	32%
5-Lake Charles	55	27%	33%	53	26%	38%
6-Alexandria	49	8%	29%	65	25%	32%
7-Shreveport	106	31%	41%	123	31%	36%
8-Monroe	52	23%	29%	76	34%	43%
9-Hammond/Slidell	62	27%	34%	90	28%	39%

*If AIDS diagnosis was within 1 month of HIV diagnosis

- Of the 1,242 persons diagnosed with HIV in 2009, 24% had an AIDS diagnosis at the time of their initial HIV diagnosis. Males, Hispanic/Latinos, and persons 65 and older were more likely to have an AIDS diagnosis at the time of their HIV diagnosis.
- Overall, 31% of persons had an AIDS diagnosis within six months of their HIV diagnosis. Males, Hispanic/Latinos and persons over the age of 45 were more likely to have an AIDS diagnosis within six months.

- Injection drug users were more likely to have AIDS at the time of their HIV diagnosis and to have an AIDS diagnosis within six months of their initial HIV diagnosis compared to persons with other risk factors.
- Of the 9 public health regions in Louisiana, Shreveport and Monroe had the greatest percentage of new cases with AIDS at the time of HIV diagnosis, but Monroe and Hammond/Slidell had the greatest percentage of new cases with an AIDS diagnosis within six months.

Louisiana Survival Data

Survival data examines how long a person lives once they have received an AIDS diagnosis (more than 12, 24, or 36 months). The most recent surveillance report from the CDC reported survival data for the nation from 2000-2004. [15] Below is an analysis of survival data for Louisiana in 2000-2004 to serve as a comparison to the national statistics.

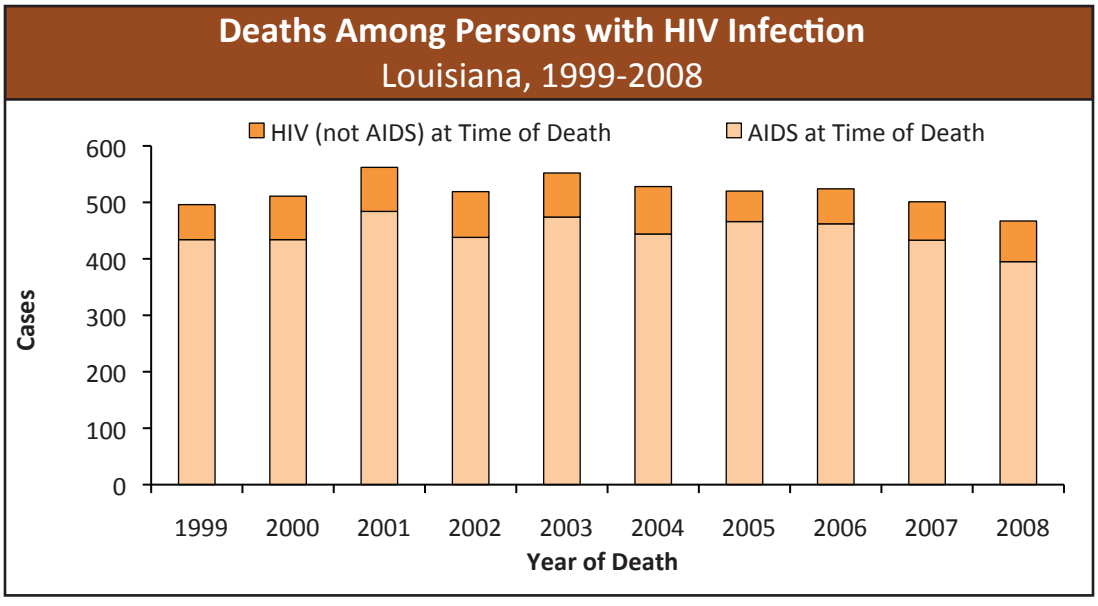
Persons Surviving More than 12, 24, and 36 Months After AIDS Diagnosis
Louisiana, 2000-2004

		Survival in Months		
	New AIDS Diagnoses	> 12	> 24	> 36
Total	**4,429**	**86%**	**80%**	**75%**
Year of Diagnosis				
2000	821	86%	80%	73%
2001	888	86%	80%	75%
2002	969	85%	80%	75%
2003	889	88%	82%	77%
2004	862	85%	79%	73%
Sex				
Female	1,365	87%	80%	75%
Male	3,064	86%	80%	75%
Race/Ethnicity				
Black/African American	3,379	86%	80%	74%
Hispanic/Latino	91	90%	86%	86%
White	924	86%	81%	78%
Other/Unknown/Multi-race	35	86%	71%	63%
Age				
0-12	13	100%	100%	100%
13-19	70	94%	94%	89%
20-24	285	90%	85%	81%
25-29	502	91%	86%	80%
30-34	693	91%	84%	80%
35-39	827	88%	83%	77%
40-44	815	86%	80%	74%
45-49	577	83%	78%	72%
50-54	330	80%	73%	67%
55-59	175	71%	63%	55%
60-64	85	67%	58%	55%
65+	57	67%	53%	47%
Imputed Transmission Category				
Men who have sex with men (MSM)	1,639	88%	84%	80%
Injecting Drug User (IDU)	1,176	82%	74%	65%
MSM/IDU	399	84%	76%	71%
High Risk Heterosexual (HRH)	1,165	89%	83%	78%
Transfusion/Hemophilia/Other	34	71%	71%	62%
Perinatal/Pediatric	16	100%	100%	100%
Region				
1-New Orleans	1,780	87%	84%	77%
2-Baton Rouge	1,204	84%	76%	69%
3-Houma	159	86%	81%	75%
4-Lafayette	282	86%	80%	75%
5-Lake Charles	192	85%	79%	76%
6-Alexandria	179	86%	79%	76%
7-Shreveport	269	87%	85%	81%
8-Monroe	210	84%	78%	72%
9-Hammond/Slidell	154	87%	82%	81%

- Nationally, 82% of people who received an AIDS diagnosis in between 2000-2004 survived more than 36 months (3 years) past their diagnosis. In Louisiana, only 75% of persons with an AIDS diagnosis between 2000-2004 survived more than 36 months.
- In the US, males survived at a slightly higher percentage past 24 and 36 months then their female counterparts; 85% of males and 84% of females survived past 24 months, and 82% of males and
- 81% of females survived past 36 months. In Louisiana, females had the same survival percentages as males past 24 and 36 months.
- Hispanic/Latinos had the best survival percentages in Louisiana, but the total number of cases was small. Both nationally as well as locally, whites had higher survival percentages than blacks past 24 and 36 months. Nationally, 83% of whites and 80% of blacks survived past 36 months, in Louisiana, 78% of whites and 74% of blacks survived past 36 months.
- In Louisiana, persons age 35 and older and persons with a reported history of injection drug use (IDU and MSM/IDU) had poorer survival outcomes. Nationally, injection drug users had the lowest survival rates of all transmission categories.
- Individuals in the Baton Rouge region of Louisiana had the poorest survival outcomes of all nine public health regions (69% at >36 months); individuals from the Hammond/Slidell and the Shreveport region had the highest survival percentage (81% at >36 months).

Mortality of Persons with HIV Infection in Louisiana

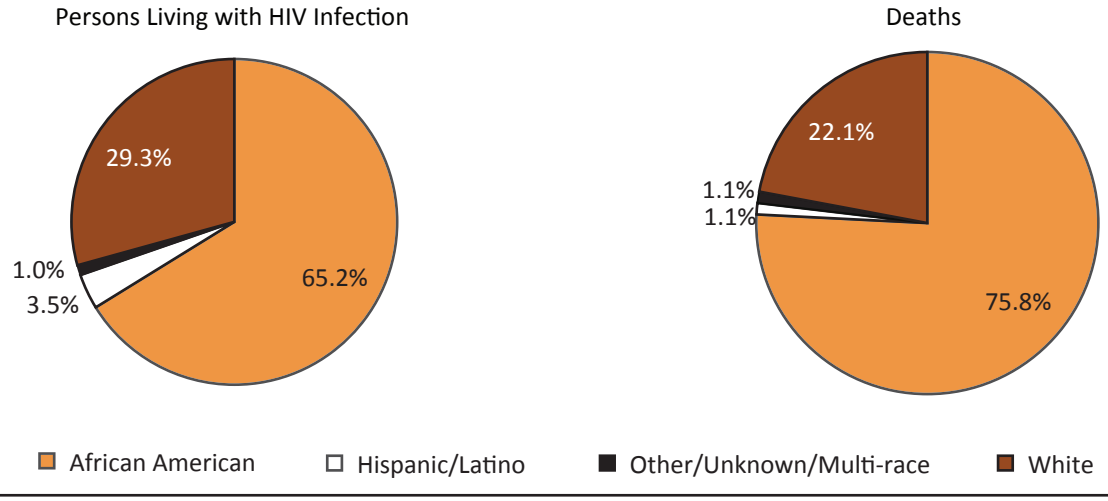
Data are collected on the number of persons with HIV infection who die each year. While individuals may die from HIV related illnesses, others may die from other causes such as vehicle accidents, heart disease, or diabetes.



- In 2008, 395 persons with AIDS and 72 persons with HIV (not AIDS) died in Louisiana. From 1999-2008 deaths among persons with HIV (not AIDS) have remained relatively stable and the percentage with an AIDS diagnosis has fluctuated between 81-88%. *Mortality data for 2009 are not yet complete*.
- The Louisiana death data includes all causes of death in persons living with HIV infection. The cause of death is not limited to HIV or AIDS and may be due to sepsis, cancer, accidental death, or other causes.

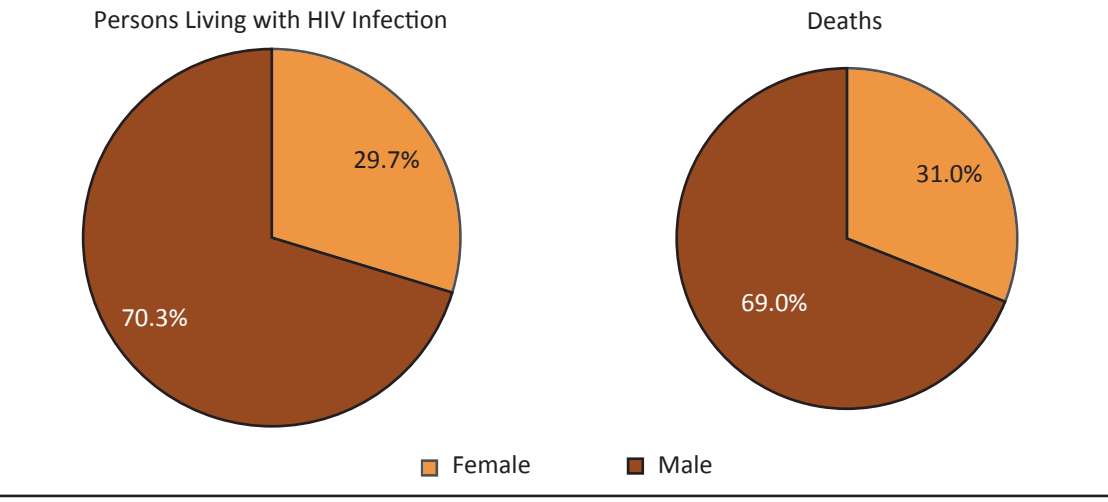
Comparisons between the demographic percent distribution of people living with HIV infection and persons with HIV infection who died can help identify if certain groups have higher mortality.

Persons Living with HIV Infection and Deaths in Persons with HIV Infection by Race/Ethnicity, Louisiana 2008



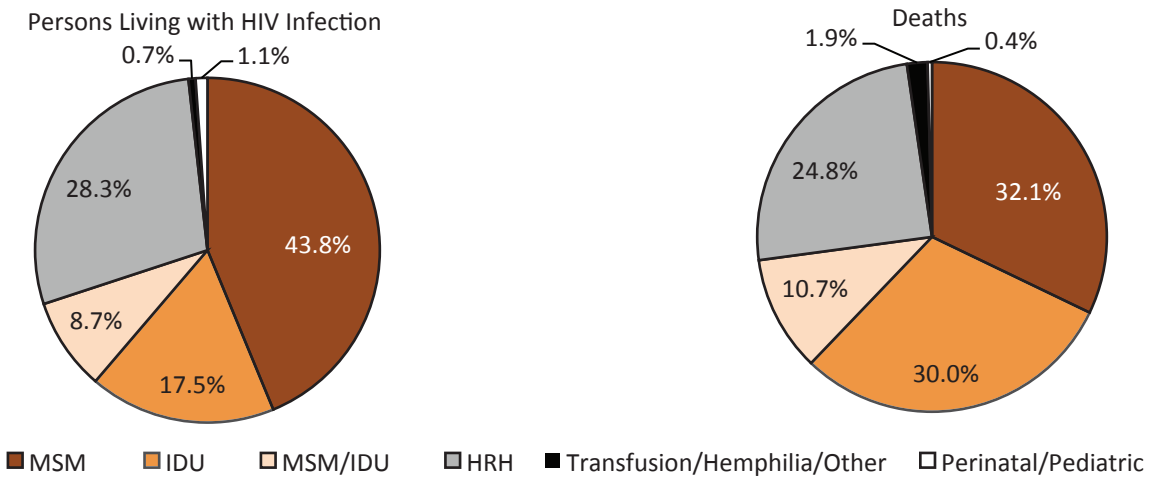
- Blacks are experiencing a disproportionate percentage of deaths compared to the percentage of persons living with HIV infection. In 2008, 66% of persons living with HIV infection were black and 76% of deaths among persons with HIV infection were black. In contrast, 30% of persons living were white but only 22% of the deaths were in whites.

Persons Living with HIV Infection and Deaths in Persons with HIV Infection by Sex, Louisiana, 2008



- In 2008, females made up 30% of persons living with HIV infection and 31% of deaths in persons with HIV infection. Males made up 70% of persons living with HIV infection and 69% of deaths in persons with HIV infection. Therefore, there does not appear to be a disparity in mortality by gender.

Persons Living with HIV Infection and Deaths in Persons with HIV Infection
by Transmission Category, Louisiana, 2008



- Men who have sex with men (MSM) made up 44% of persons living with HIV infection in 2008 but only 32% of the deaths in persons with HIV infection.
- IDUs are experiencing a disproportionate percentage of deaths compared to other risk groups. Injection drug users (IDU and MSM/IDU) made up 26% of persons living with HIV infection but 41% of all deaths in persons with HIV infection in 2008.

HIV Among Men Who Have Sex with Men (MSM)

Nationally, MSM account for almost half of the one million people living with HIV and more than half of all new HIV infections in the US each year. Louisiana is experiencing a similar epidemic among MSM as is being seen nationally.

HAP has made a concerted effort to analyze the epidemic among MSM to adequately target prevention efforts. The following table shows the demographics of all new HIV diagnoses in 2009 among MSM who may or may not be injection drug users.

Demographics of New HIV Diagnoses Among MSM
Louisiana, 2009

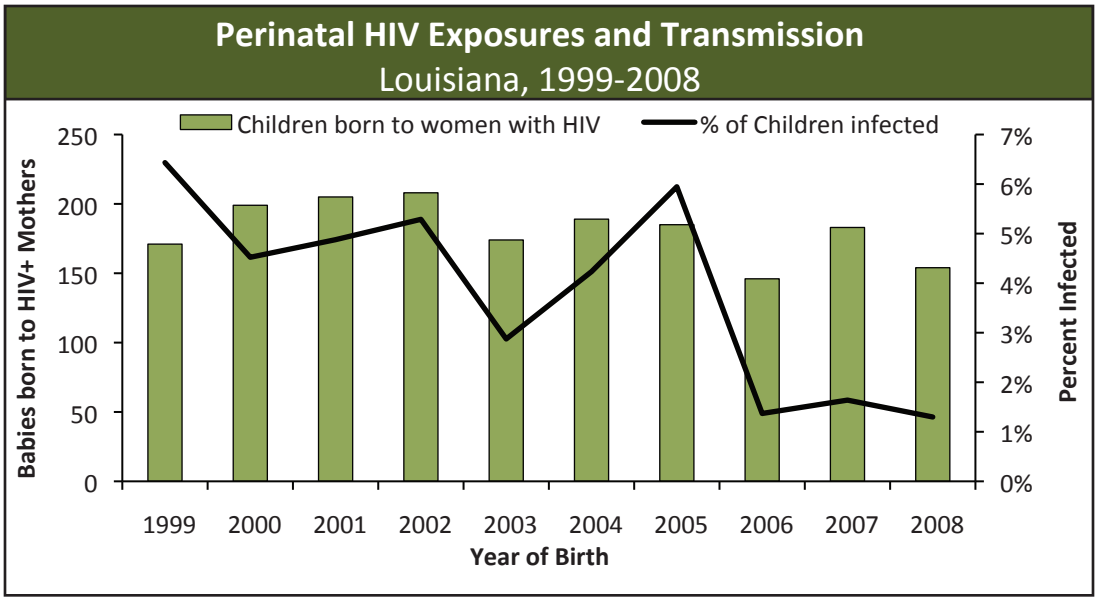
	MSM/Non-IDU		MSM/IDU		All MSM	
	Cases	Percent	Cases	Percent	Cases	Percent
TOTAL	**599**	**100%**	**52**	**100%**	**651**	**100%**
Race/Ethnicity						
Black/African American	414	69%	32	62%	446	69%
Hispanic/Latino	32	5%	4	8%	36	6%
White	140	23%	15	29%	155	24%
Other/Unknown/Multi-race	13	2%	1	2%	14	2%
Age at HIV Diagnosis						
13-24	167	28%	5	10%	172	26%
25-34	186	31%	14	27%	200	31%
35-44	125	21%	12	23%	137	21%
45-54	85	14%	14	27%	99	15%
55-64	30	5%	5	10%	35	5%
65+	6	1%	2	4%	8	1%
Region						
1-New Orleans	218	36%	16	31%	234	36%
2-Baton Rouge	120	20%	10	19%	130	20%
3-Houma	22	4%	2	4%	24	4%
4-Lafayette	50	8%	3	6%	53	8%
5-Lake Charles	29	5%	3	6%	32	5%
6-Alexandria	17	3%	4	8%	21	3%
7-Shreveport	66	11%	9	17%	75	12%
8-Monroe	40	7%	2	4%	42	6%
9-Hammond/Slidell	37	6%	3	6%	40	6%
Late Testers						
AIDS at Time of HIV Diagnosis	151	25%	8	15%	159	24%
AIDS Within 6 Months of HIV Diagnosis	188	31%	17	33%	205	31%

- In 2009, there were 1,242 new HIV diagnoses in Louisiana; 52% (651) were among MSM.
- The majority of the new diagnoses among MSM in Louisiana are black and under the age of 34.
- In the New Orleans and Baton Rouge regions almost 60% of all new HIV diagnoses were among MSM.
- Whites account for a greater percentage of MSM/IDU then MSM/non-IDU.
- Persons who identify as MSM/IDU tend to be older than persons who identify as MSM/non-IDU.
- The percentage of late testers who are MSM is similar to that of the population overall.

Surveillance of Perinatal Exposure to HIV

In 1994, the Pediatric AIDS Clinical Trials Group demonstrated that zidovudine (ZDV) could reduce the risk of mother-to-child HIV transmission. As a result, the United States Public Health Service (USPHS) issued recommendations for the use of ZDV to reduce perinatal HIV transmission. These guidelines were updated in May 2010 to include additional treatment guidelines for HIV-infected pregnant women and their infants.[16] The CDC has published recommendations to include HIV screening as part of the routine screening panel for all pregnant women, as well as repeat testing during the third trimester in areas with high HIV incidence. (The CDC identifies Louisiana as a state where third trimester testing is recommended). The CDC also recommends a rapid test at delivery for women without documented HIV status.[17] In FY 2007, Louisiana passed legislation (Louisiana RS 40:1300:13) that requries any physician providing medical care to a pregnant woman to conduct an HIV test as a component of her routine prenatal laboratory panel unless the patient specifically declines ("opts out"). In addition, the law allows physicians to test a child born to a woman whose HIV status is unknown at the time of delivery, without parental consent. In 2010, Louisiana updated Title 51 of the Louisiana Administrative Code: Public Health--Sanitary Code (available at: http://doa.louisiana.gov/osr/lac/books.htm) to require the explicit reporting of pregnancy in an HIV positive woman as well as all HIV tests performed on children aged 0-6 regardless of result (positive or negative). Surveillance requires several rounds of tests to determine whether an infant is HIV positive or HIV negative. Changes to the Sanitary Code were necessary to ensure effective monitoring of all perinatal HIV transmissions.

Between January 1, 1990 and December 31, 2008 an estimated 2,819 infants were born to mothers with HIV infection in Louisiana; 243 (8.6%) of these children were infected with HIV via mother-to-child transmission. Over this period, the implementation of the USPHS guidelines in Louisiana has led to a significant decline in perinatal transmission rates, from a high of nearly 16% in 1994 to 1.3% in 2008.



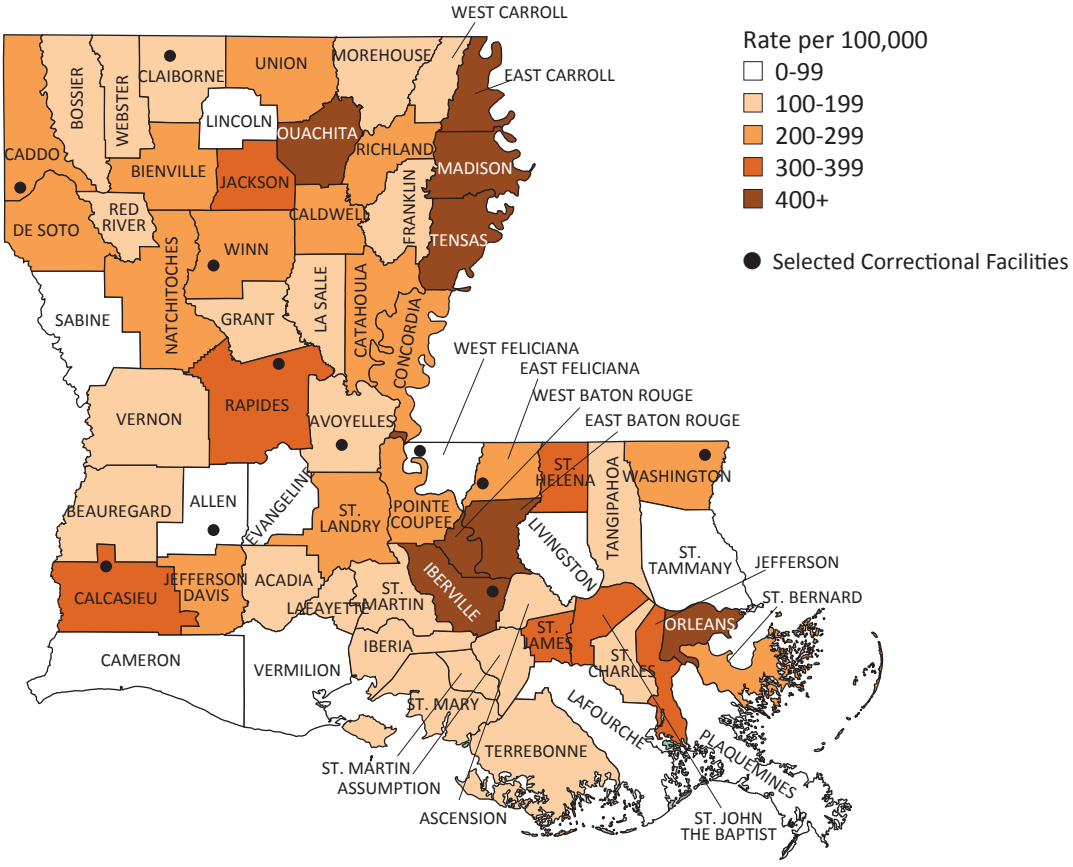
- In Louisiana in 2008, 154 infants were born to women with HIV infection, and 2 of the infants (1.3%) were infected with HIV. The perinatal transmission rates from 2006 through 2008 are the lowest rates seen in the past 10 years. This is likely due to increased HIV testing during pregnancy and successful perinatal prevention efforts such as changes to the law and hospital policy.

In order to guide efforts for the prevention of perinatal HIV transmission, the Institute of Medicine developed a cascade of events leading to a mother-to-child transmission. The cascade shows the missed opportunities in perinatal HIV prevention:

A woman becomes HIV infected
⇩
becomes pregnant
⇩
receives inadequate prenatal care
⇩
not offered/refuses HIV test
⇩
not offered/refuses/does not complete ARV's
⇩
child is infected

The map below shows where Louisiana is after the first step in the cascade.

Women of Childbearing Age Living with HIV Infection by Parish
Louisiana, 2008

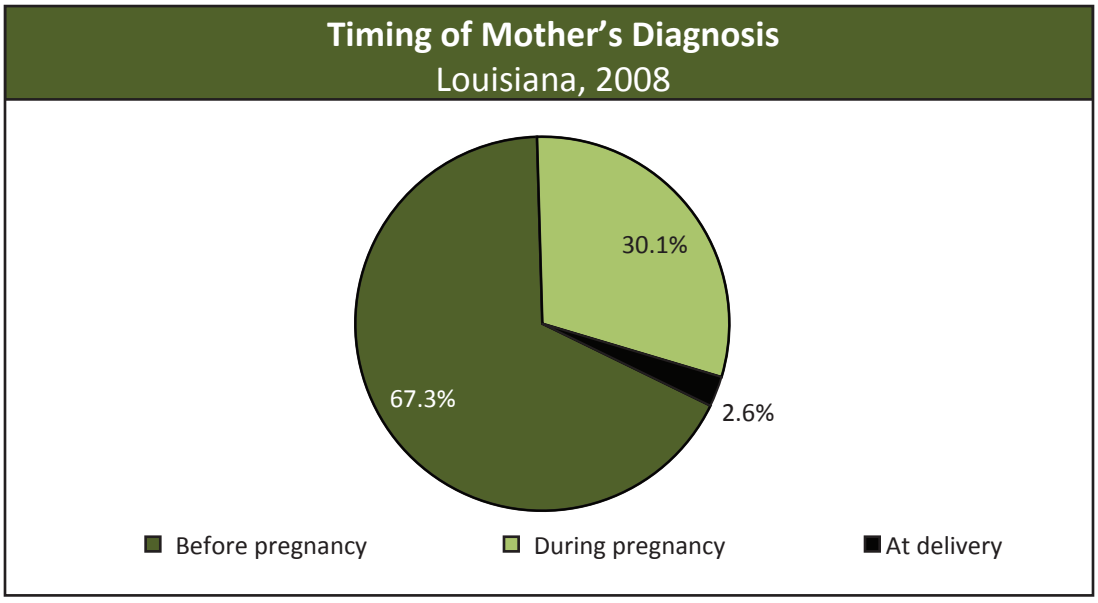


- The areas with highest rates of HIV prevalence for women of reproductive age (15-44) were in the New Orleans metropolitan area, the Baton Rouge metropolitan area, and the northeast corner of the state.

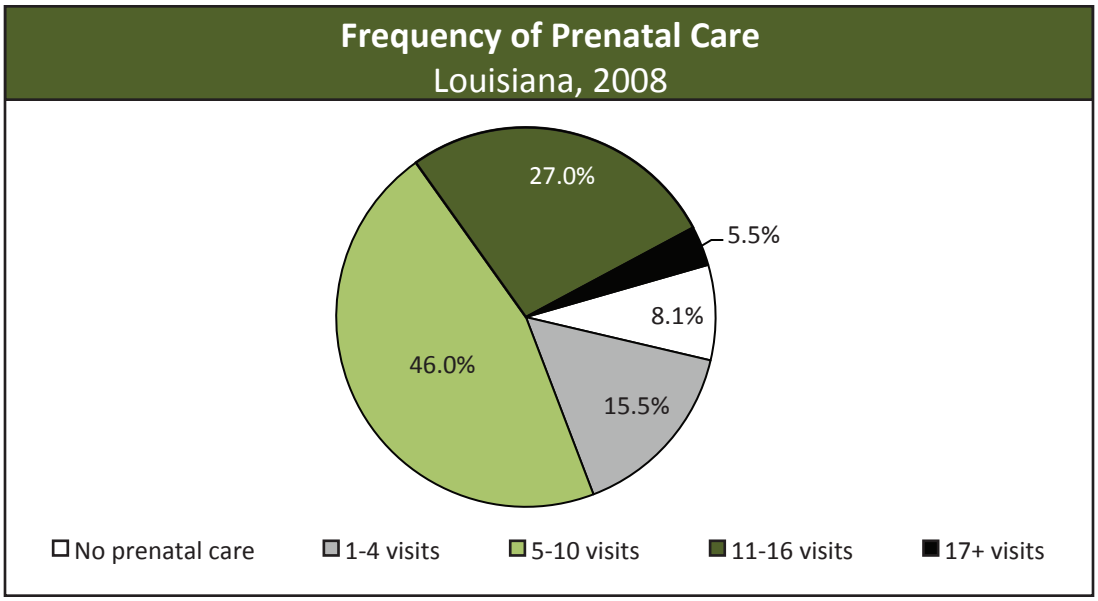
Demographics of Mothers with HIV Infection Louisiana, 2008		
	HIV Positive Women Delivering in 2008	**Percent**
Total	**153**	**100.0%**
Race		
American Indian/Alaska Native	0	0.0%
Asian/Pacific Islander	1	0.7%
Black/African American	132	86.3%
Hispanic/Latino	4	2.6%
White	13	8.5%
Other/Unknown/Multi-race	3	2.0%
Age		
13-19	10	6.5%
20-24	48	31.4%
25-34	84	54.9%
35-44	11	7.2%
Transmission Category		
Injection Drug User (IDU)	15	9.8%
High Risk Heterosexual (HRH)	136	88.9%
Perinatal/Pediatric*	2	1.3%
Substance Use During Pregnancy		
Yes	43	28.1%
No	106	69.3%
Unknown	4	2.6%
Parity		
1-2 Births	86	56.2%
3-4 Births	42	27.5%
5+ Births	21	13.7%
Unknown	4	2.6%
Delivery Type		
Vaginal	54	35.3%
Elective C-Section	78	51.0%
Non-Elective C-Section	16	10.5%
Unknown C-Section	5	3.3%
Birth Weight		
Very Low (< 1500g)	8	5.2%
Low (< 2500g)	24	15.7%
Normal	122	79.7%
Gestational Age		
Preterm (< 37weeks)	60	39.2%
Normal	94	61.4%
Region		
1-New Orleans	44	28.8%
2-Baton Rouge	51	33.3%
3-Houma	6	3.9%
4-Lafayette	6	3.9%
5-Lake Charles	3	2.0%
6-Alexandria	13	8.5%
7-Shreveport	12	7.8%
8-Monroe	10	6.5%
9-Hammond/Slidell	8	5.2%

* Perinatal transmission is not imputed.

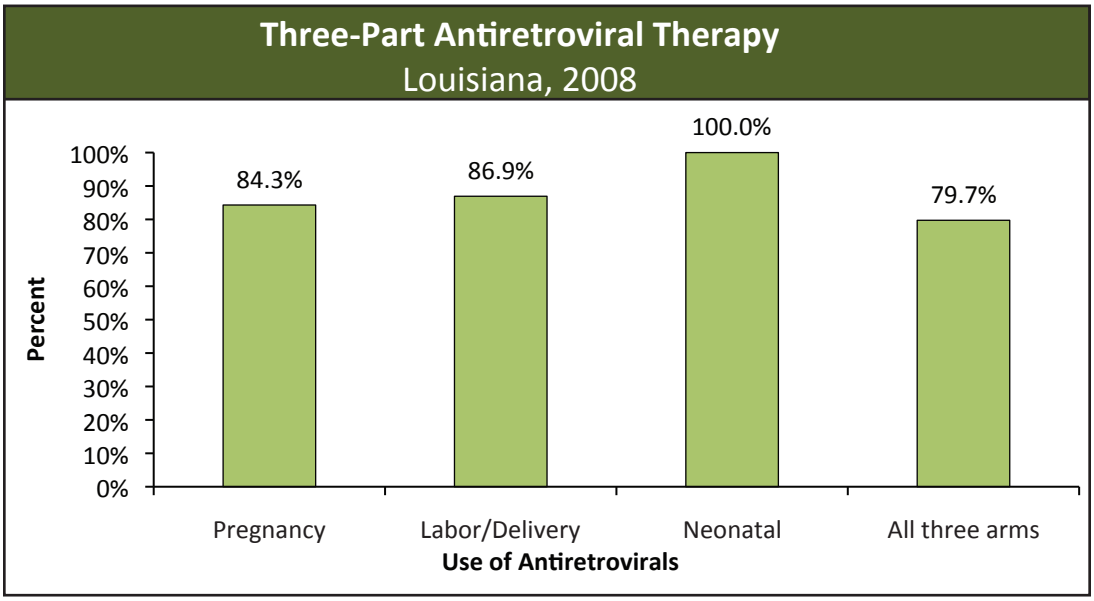
- Mothers with HIV infection were predominately black (86%) and 25-34 years old (55%). Ten percent (10%) of the mothers with HIV infection were likely infected through injection drug use, and two mothers were themselves infected through perinatal transmission.
- Enhanced Perinatal Surveillance (EPS) collects data on indicators of infant health such as birth weight, gestational age, parity, and substance use during pregnancy. Low birth weight, preterm birth, substance use during pregnancy, and high parity are factors shown to lead to poor birth outcomes. In 2008, 20% of babies born to HIV positive mothers had a low or very low birth weight (<2,500 grams), and 39% of babies were born preterm (<37 weeks gestational age) compared to all 2008 births in Louisiana where 11% of babies were born at low or very low birth weight and 15% were born preterm. In addition, 28% of HIV positive women who delivered used some sort of substance (alcohol, tobacco, or a narcotic) during pregnancy, 14% had 5 or more children.
- The American College of Obstetricians and Gynecologists (ACOG) recommends that HIV-infected pregnant women with plasma viral loads of >1000 copies per milliliter be counseled regarding the benefits of elective cesarean delivery.[18] In 2008, 35% of HIV positive women delivered vaginally and 51% delivered via an elective c-section.
- In 2008, 33% of women with HIV infection who gave birth lived in the Baton Rouge region, and 29% lived in the New Orleans region.



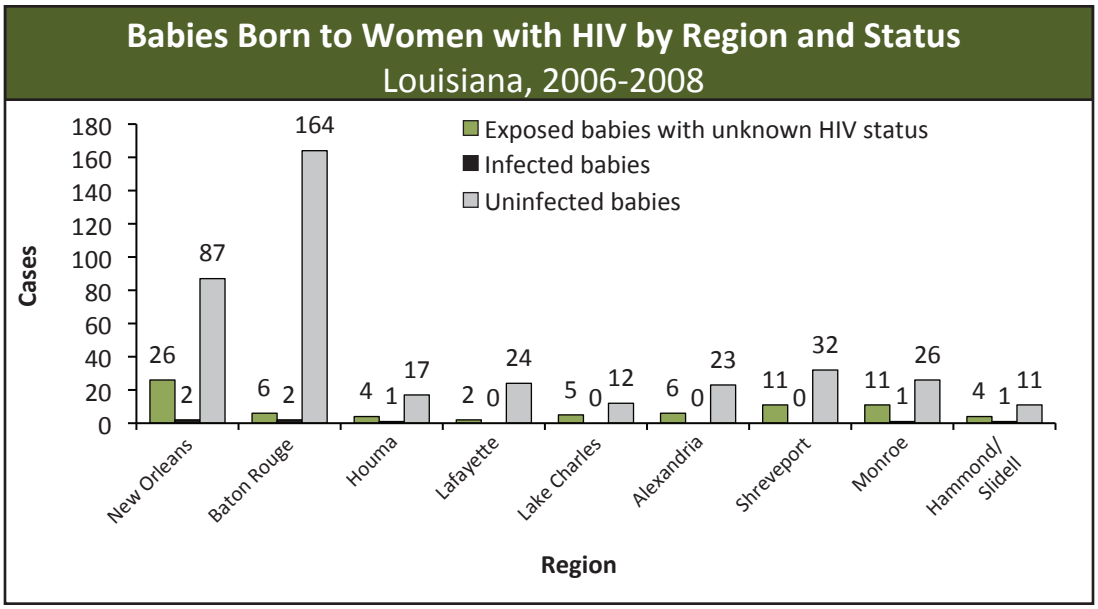
- In Louisiana, 67% of the women with HIV infection who delivered in 2008 were diagnosed with HIV prior to their delivery, and 30% were diagnosed during their pregnancy. In 2008, 2.6% of women found out they were HIV positive at delivery as compared to 5% of women from 2000-2004. The percentage of women who know their HIV status prior to delivery has increased over time due to an emphasis on screening pregnant women during prenatal care.



- In 2008, 8% of mothers with HIV infection did not receive any prenatal care, and only 30% had more than 10 prenatal care visits. Lack of prenatal care is one of the factors that most significantly impacts perinatal transmission since women who are not in prenatal care are less likely to get tested for HIV and receive antiretroviral therapy during their pregnancy.



- Perinatal HIV transmission can be reduced to 2% if antiretroviral therapy (ARV) is administered to women with HIV during pregnancy, at labor and delivery, and then to the newborn. In 2008, 84% of mothers received ARVs during pregnancy; 87% received ARVs during labor and delivery; and all infants received prophylactic ZDV shortly after birth. Overall, 80% of mother-infant pairs received all three recommended components of the antiretroviral prophylaxis protocol.
- Of the two infants born in 2008 who were infected with HIV, one of the mothers did not receive any ARV therapy (the infant did receive ARVs), had no prenatal care, and was diagnosed at delivery. The mother of the other positive baby received all three arms of ARV therapy, had 2 prenatal care visits and knew her HIV status before becoming pregnant.



- Births to women with HIV infection occurred in every region of the state. The Baton Rouge region had the highest number of births between 2006 and 2008, but the New Orleans and Baton Rouge regions had comparable perinatal transmission rates (1.7% and 1.2% respectively). The Lafayette, Lake Charles, Alexandria, and Shreveport regions had no cases of perinatal HIV transmission during this time period.
- Nearly 16% of HIV exposed infants born during 2006-2008 continue to have an indeterminate HIV status. This may be due to reporting delays, incomplete testing, and infants being lost to follow-up.

Fetal Infant Mortality Review (FIMR) and HIV

In 2009, the Louisiana HIV/AIDS Program along with the Louisiana Maternal and Child Health Program were funded to carry out a perinatal HIV prevention methodology, based upon the Fetal Infant Mortality Review (FIMR), in the New Orleans metro area. The FIMR/HIV Prevention Methodology is an action-oriented community process that continually assesses, monitors, and works to improve service systems and community resources for women, infants, and families. The goal of the FIMR/HIV Prevention Methodology is to improve perinatal HIV prevention systems by using the FIMR case review and community action process. The FIMR/HIV Methodology follows a five step process for data collection, review, and community action:

The New Orleans FIMR/HIV Prevention Methodology was initiated in October, 2009. Cases reviewed to date include all cases of perinatal HIV transmission in 2009, as well as other cases with noted gaps in HIV or prenatal care. During the 2009-2010 grant year, 15 cases were abstracted and 5 cases were interviewed. There were four Case Review Team meetings during which members reviewed 9 cases and made 37 recommendations to reduce perinatal HIV transmission in the New Orleans area. These were narrowed down to 10 key recommendations to present to the Community Action Team. Louisiana has been funded for 2010-2011 to continue the FIMR/HIV Prevention Methodology in New Orleans.

National HIV Behavioral Surveillance Survey

Initiated in 2003, the National HIV Behavioral Surveillance (NHBS) system collects behavioral data among people at highest risk for HIV infection in the United States. The rationale for this surveillance system is to "provide ongoing, systematic collection of data on behaviors related to HIV acquisition.[19] New Orleans was among the twenty- one U.S. metropolitan areas conducting NHBS in 2009. This study collects data from three target populations: men who have sex with men (MSM), injection drug users (IDU), and heterosexuals living in areas at high-risk for HIV/AIDS (HRH), each in discrete annual cycles. The NHBS survey instrument contains items regarding sexual behavior, substance use, and HIV testing behaviors. In 2007, anonymous HIV testing of participants was added to NHBS.

Because many of the behaviors are highly stigmatized or illegal, the populations surveyed are considered hard to reach using traditional probability based sampling methods. Each cycle therefore utilizes specialized sampling methods for recruitment of participants in order to yield the most valid population estimates. MSM are recruited using a venue-based time-space sampling procedure, where individuals are approached within venues that are attended by MSM. Injection drug users are recruited using a modified chain referral strategy known as respondent-driven sampling (RDS) wherein a small number of known injectors are recruited and interviewed by staff and asked to recruit other injectors from within their own social network. These respondents are then subsequently interviewed and offered a similar opportunity to recruit their peers. Recruitment then continues in this fashion until a desired sample size is reached. HRH recruitment is conducted using a similar RDS procedure; however, the initial recruits or "seeds" are individuals who reside in areas that have been identified by staff as having high local rates of HIV infection and poverty.

Key Findings from the New Orleans NHBS Surveys:

Sexual Preference and Disclosure

- Eight of the 528 men included in the analysis of the 2008 MSM survey identified themselves as straight or heterosexual.
- A portion of males in all three samples who identified as heterosexuals were found to have been behaviorally bisexual by virtue of having had sex with both men and women in the last 12 months.
- Conversely, a percentage of individuals in all three cycles who identified as homosexual, gay or lesbian had had sex with both men and women in the past 12 months.
- Black MSM were more likely to identify as being bisexual (23%) than white (13%) and other race/ethnicities (18%) MSM.

Substance Use

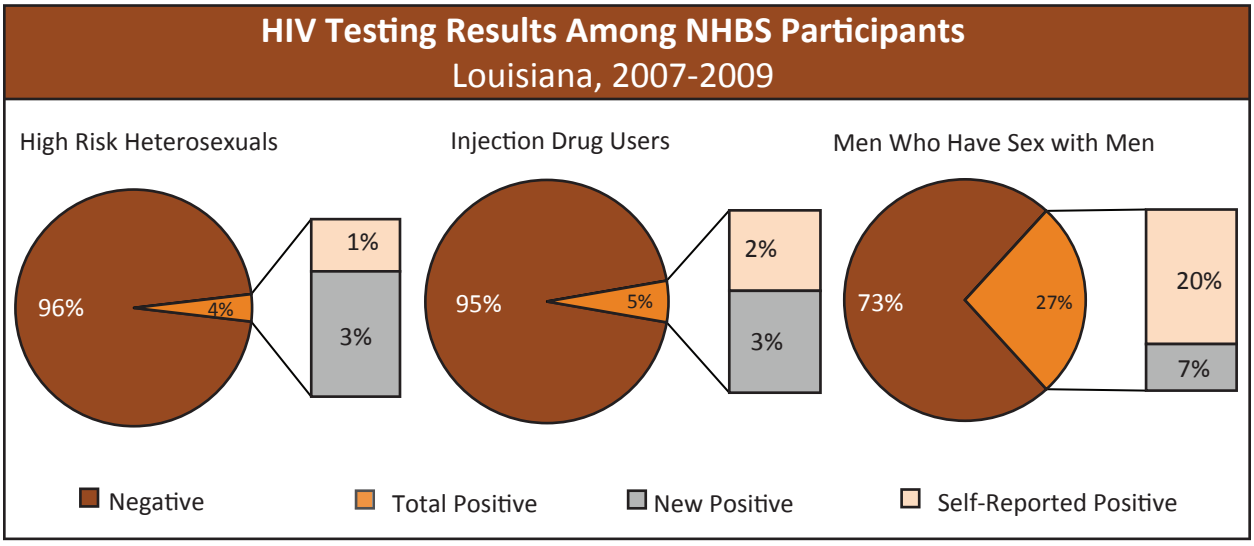
- Injection drug users were most likely (87%) to also have used non-injection drugs during the previous 12 months followed by MSM (52%) and HRH (38%) participants.
- Among those who used non-injection drugs in the past 12 months, marijuana was the most commonly used substance in all populations, HRH (76%), MSM (80%) and IDU (74%). Crack (67%) and powdered cocaine (65%) were also commonly used in the IDU sample.
- Consistent with other national reports of methamphetamine use among MSM, 19% of MSM who were substance users had used methamphetamine in the past 12 months.
- Among those who injected drugs, heroin was the most commonly used injection drug among MSM (66%) and IDU (77%), while powdered cocaine was the most common injection drug in the HRH sample (80%).
- A total of, 64% of IDU participants reported having shared injection equipment (cooker, works, cotton) and 41% of the IDU respondents reported sharing needles in the past 12 months.

Hepatitis

- Among those who had been told they have had hepatitis, hepatitis C was the most common diagnosis for both IDU (80%) and HRH (57%), while Hepatitis B was more common (57%) than Hepatitis C (33%) among MSM.

Testing

- MSM were most likely to have received their last HIV test at a HIV counseling and testing site or street outreach location (43%). IDU were initially tested within a hospital or emergency room setting (30%) or in a correctional facility (18%) and HRH were initially tested at a public health clinic or community health center (30%).
- IDU were significantly less likely to have been tested at a private doctor's office (5%) than MSM (25%) or HRH (24%).



- Of the MSM who were tested, 73% were negative and 27% were positive. Of the MSM who tested positive, 74% were previously aware of their positive status.
- Of the IDUs who were tested, 95% were negative and 5% were positive. Of the IDUs who were positive, only 40% were previously aware of their positive status.
- Of the HRHs who were tested, 96% were negative and 4% were positive. Of the HRHs who were positive, only 25% were previously aware of their positive status.
- Over 30% of the HRH participants reported having never been tested while 18% of the IDU participants and 7% of the MSM participants reported never being tested for HIV.

The table on the following page is a demographic breakdown of the NHBS participants as well as survey responses from the three groups.

Key Points:

- The majority of IDU and HRH participants were black but the majority of MSM participants were white.
- People over the age of 50 were excluded from participation in the HRH survey.
- Female participants were most highly represented in the HRH surveys.
- IDU participants reported the greatest percentage of unprotected sex and the greatest percentage of non-injection drug use.

National HIV Behavioral Surveillance (NHBS) Louisiana, 2005-2009						
	Injection Drug Use (2005 & 2009)		High-Risk Heterosexual (2006-2007)		Men Who Have Sex With Men (2008)	
Category	**No.**	**%**	**No.**	**%**	**No.**	**%**
Race/Ethnicity						
Black/African American	344	56%	791	86%	151	29%
White	229	37%	110	12%	306	58%
Other	41	7%	24	3%	71	13%
Sex						
Male	504	82%	43	47%	528	100%
Female	111	18%	490	53%	N/A	N/A
Age						
18-24	13	2%	190	21%	83	16%
25-29	33	5%	102	11%	73	14%
30-34	59	10%	103	11%	73	14%
35-39	47	8%	98	11%	83	16%
40-44	89	14%	168	18%	78	15%
45-50	171	28%	264	29%	71	13%
51+	203	33%	N/A	N/A	67	13%
Sexual Identity						
Heterosexual or "Straight"	540	88%	845	91%	8	2%
Homosexual, Gay, or Lesbian	11	2%	1	0%	431	82%
Bisexual	63	10%	76	8%	89	17%
Other	0	0%	3	0%	0	0%
Sex	**Average number of sex partners in the past 12 months***					
Males						
Men	5.2		3.28		9.98	
Women	9.43		5.23		10.88	
Females						
Men	9.38		1.85		N/A	
Sexual Activity	**Proportion reporting unprotected sex during the last 12 months****					
Vaginal Sex						
M-F	89%		75%		53%	
F-M	90%		78%		N/A	
Anal Sex						
M-M	68%		63%		57%	
Injection Drug Use						
Ever Injected Drugs	613	100%	93	10%	62	12%
Injected in the Past 12 Months	613	100%	16	2%	18	3%
Shared Needle in Past 12 Months	250	41%	6	38%	8	44%
Shared Works/Equipment in Past 12	392	64%	9	56%	8	44%
Non-Injection Drug Use						
In Past 12 Months	536	87%	350	38%	275	52%
Hepatitis						
Physician Diagnosed any Hepatitis	179	29%	68	7%	84	16%
Self Reported HIV Test						
Never Been Tested	116	19%	281	30%	35	7%
Negative	430	70%	578	62%	379	72%

*Among those who reported sex specific to gender.
**Among those who reported having sex.

Chapter 2

Care and Services

Introduction to the Care and Services Unit

The Louisiana Office of Public Health HIV/AIDS Program (HAP) Care and Services Unit coordinates programs throughout the state for low-income individuals living with HIV infection to help ensure ongoing access to primary medical care and medications, and to a continuum of high-quality community-based supportive social services. In 2009, HAP coordinated HIV-related care, treatment and support services for 6,405 people living with HIV infection in Louisiana. HAP's Care and Services Unit receives funding from two primary sources:

- For medical and supportive service programs, HAP receives an annual grant from the Health Resources and Services Administration (HRSA) through the federal Ryan White HIV/AIDS Treatment Extension Act of 2009. Ryan White resources are available through several programs or "Parts" that are awarded to states, cities, medical providers, and community-based organizations to assist low-income individuals living with HIV disease in accessing medical care and treatment (See "What is Ryan White Funding?" on page 55). HAP's funding is awarded through "Part B" of HRSA's Ryan White Program. The City of New Orleans and the City of Baton Rouge receive separate funding from HRSA under "Part A" of the Ryan White Program to administer medical and support programs in those jurisdictions. The amount of funding allocated to Louisiana each year is determined primarily by a federal formula that uses data collected through HAP's Surveillance Unit.
- For housing related services, HAP receives funds from the federal Department of Housing and Urban Development (HUD) through the State Formula Housing Opportunities for Persons With AIDS (HOPWA) program. These resources support a continuum of housing options for HIV-infected persons living in areas of the state outside of the greater New Orleans and Baton Rouge metropolitan areas, as these cities receive direct awards of HOPWA funds. The annual State Formula HOPWA award to Louisiana is also impacted by the number of AIDS cases reported by HAP's Surveillance Unit.

HAP contracts with medical centers and community-based agencies throughout the state to provide the following services at low or no cost to eligible clients:

- assistance in obtaining HIV medications;
- the payment of health insurance premiums, co-payments and deductibles;
- the provision of medical case management;
- support services: medical transportation, nutritional services, and emergency assistance;
- short-term and tenant-based housing assistance and support of community residences.

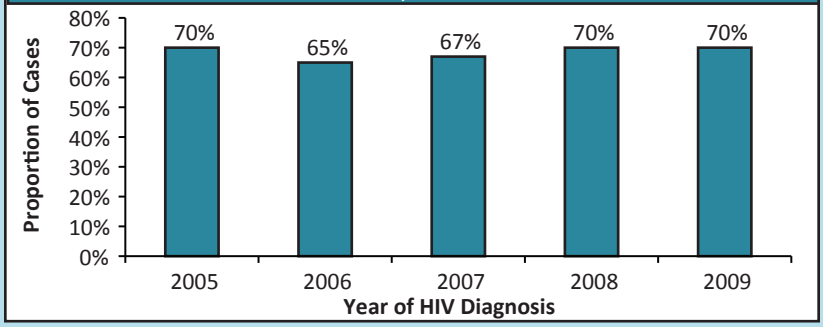
HAP's Care and Services Unit works with other programs that provide similar services with state or federal funding, throughout the state in order to reduce gaps in services for clients. Specifically, HAP works closely with the state's other HRSA-funded Ryan White grantees, Louisiana Medicaid, the Louisiana State University (LSU) regional public medical centers, and other entities that provide services to low-income persons with HIV. These efforts are undertaken to reduce fragmentation in service delivery and strengthen the continuum of care.

National HIV/AIDS Strategy
Increasing Access to Care and Improving Health Outcomes for People Living with HIV

2015 Objectives:

- Increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65% to 85%.
  - In 2009, 70% of newly-diagnosed persons entered care within 3 months, which is above the national average of 65% but below the 2015 goal of 85%.

Entry into Medical Care within 3 Months of Diagnosis
Louisiana, 2005-2009



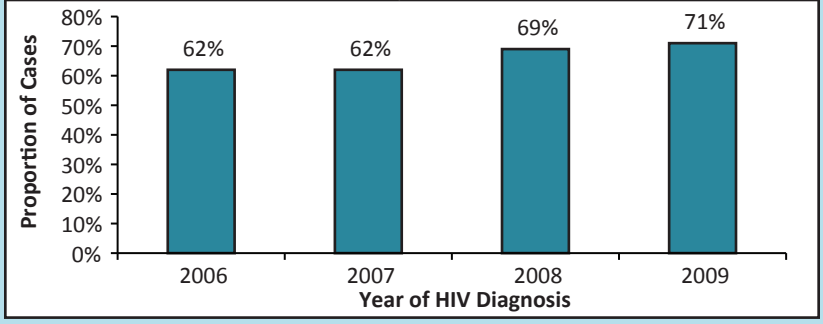
  - Males and blacks were less likely to enter care within 3 months.

Newly Diagnosed Persons Entering Care in Three Months
Louisiana, 2009

	Percent
Sex	
Female	74%
Male	68%
Race/Ethnicity	
Black/African American	66%
Hispanic/Latino	82%
White	82%

- Increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care (at least 2 visits for routine HIV medical care in 12 months at least 3 months apart) from 73% to 80%.
  - Among Ryan White clients, the percent in continuous care has increased from 62% in 2006 to 71% in 2009 but is still below the 2015 goal of 80%.

Louisiana Ryan White HIV Program Clients in Continuous Care*
Louisiana, 2006-2009



*>=2 visits in 12 months at least 3 months apart

- Increase the number of Ryan White clients with permanent housing from 82% to 86%.
  - Among all Ryan White clients in Louisiana, the percentage with permanent housing was 76% in 2009, which is below the 2015 goal of 86%. The Louisiana State Formula HOPWA program has achieved stable housing for 56% of its clients.

National HIV/AIDS Strategy (www.thewhitehouse.gov)

Primary Medical Care and Support Services Coordinated through HAP: Louisiana's Ryan White "Part B" Program

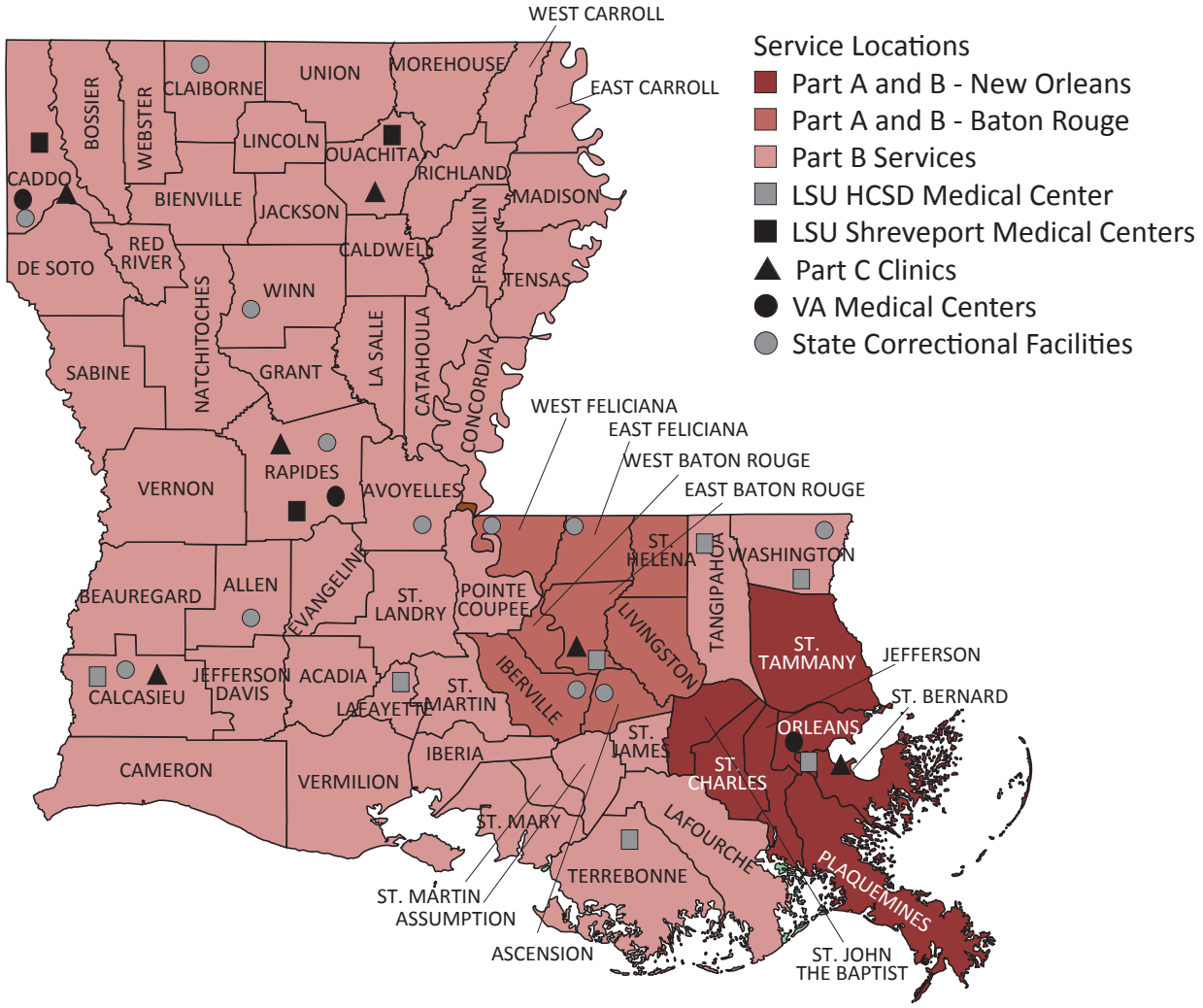
Louisiana's Care and Services Unit administers Ryan White Part B funding for the provision of medications and support services for low-income HIV-infected persons living throughout the state (see "What is Ryan White Funding?" on page 55 for an overview of the federal Ryan White Program and Parts). These resources primarily ensure ongoing access to medical care and treatment for low income persons with HIV disease. Support services are intended to reduce barriers to accessing medical care.

Louisiana has a unique healthcare infrastructure that provides an array of medical services to residents through a partnership between public and private providers. In addition to many for-profit hospitals and private infectious disease specialists throughout the state, the LSU Health Care Services Division (HCSD) operates seven state-funded medical centers in the southern half of the state which primarily provide care to low income individuals who are uninsured or underinsured. Additionally, LSU-Shreveport oversees three medical centers in Shreveport, Monroe, and Pineville that provide similar medical services in the northern part of the state. All ten of these regional medical centers operate clinics that offer HIV-specific medical services. Of all persons living with HIV in Louisiana who are in care, sixty-two percent (62%) access care through the ten LSU regional public medical centers.

In addition, primary care is provided by independent community-based outpatient clinics supported with Ryan White Part A, C, and/or D resources; 12 facilities operated by the Louisiana Department of Public Safety and Corrections; and 3 Veterans Affairs Medical Centers (see map on opposing page). It is important to note that the Ryan White funding available to support HIV primary medical care in Louisiana is very limited when compared to state funds supporting the LSU regional public medical centers and federal reimbursements from Medicaid and Medicare.

HAP's Care and Services Unit works very closely with medical providers throughout the state to help connect the systems of care together through coordinated program implementation, collaboration, and where possible, program integration. Community-based HIV medical case management agencies (primarily funded through Medicaid or Ryan White Part A, B, or D programs) help link clients to the most appropriate medical and supportive services in their local area.

Ryan White Coverage and Service Locations, Louisiana



Managing HIV Disease: Resources for HIV Primary Care Providers

HIV is a complicated disease to manage – for both patients and their providers. Due to the complex nature of the medications and their interactions with other HIV and non-HIV pharmaceuticals, the U.S. Public Health Service (USPHS) provides a variety of treatment guidelines for physicians and prescribers. These guidelines are tailored for specific populations (adults, pediatric patients, pregnant females, etc.) and are "living documents" that are continuously updated to provide the most current treatment information to practitioners.

(http://aidsinfo.nih.gov/guidelines)

The federal Ryan White HIV/AIDS Program Part F component also funds technical assistance to medical care providers through regional AIDS Education and Training Centers (AETC). For Louisiana clinicians, support and training resources can be accessed through the Delta Region AETC in New Orleans.

(www.deltaaetc.org)

Assistance Obtaining HIV Medications

What does HAP do? *Contracts with the 10 LSU regional public medical center pharmacies to provide HIV-related formulary medications to qualifying clients*

Area covered: *Statewide*

The Louisiana AIDS Drug Assistance Program (ADAP) helps ensure that eligible low-income clients can access specific FDA-approved HIV medications. These pharmaceutical interventions have been proven to slow disease progression, reduce the risk of HIV transmission, enhance quality of life, and extend life. The allocation of resources to Louisiana ADAP comprises the greatest percentage of the Ryan White Part B award. Clients can access the program through private providers, the ten LSU regional public medical centers, and medical case management service providers. The Louisiana ADAP currently has 63 FDA-approved medications supported by the formulary.

Louisiana's Ryan White Part B programs serve eligible HIV-infected clients in every parish of the state. Below is an overview of the major components of HAP's Ryan White Part B program and a description of how those services complement and are coordinated with HIV medical care and support services available through other programs in Louisiana.

Persons Utilizing ADAP and Persons Living with HIV by Region
Louisiana, 2009

	Persons Utilizing ADAP	Percent	Persons Living with HIV Infection	Percent
Region	**3,724***	**100.0%**	**17,155**	**100.0%**
1-New Orleans	1,433	38.5%	6,106	35.6%
2-Baton Rouge	843	22.6%	4,191	24.4%
3-Houma	116	3.1%	624	3.6%
4-Lafayette	286	7.7%	1,251	7.3%
5-Lake Charles	219	5.9%	926	5.4%
6-Alexandria	170	4.6%	780	4.6%
7-Shreveport	278	7.5%	1,384	8.1%
8-Monroe	218	5.9%	940	5.5%
9-Hammond/Slidell	161	4.3%	953	5.6%

* Region by dispenser, not client address

- Approximately 60% of ADAP clients are from the New Orleans and Baton Rouge regions.
- The percentage of individuals receiving ADAP services in each region is comparable to the percentage of persons living with HIV infection in each region.

Who pays for HIV care and treatment in the U.S.?

According to the *Kaiser Family Foundation*, the major payor sources in 2009 for HIV-related care and treatment, including medications, were private insurance and federal funding sources such as Medicaid, Medicare, and the Ryan White HIV/AIDS Program. The $12.3 billion in federal funding requested in the FY 2009 budget represents a 6% increase from FY 2008.

The main components of the federal Ryan White HIV/AIDS Program that pay for medications are the AIDS Drug Assistance Program (ADAP) and the Local AIDS Pharmaceutical Assistance Programs (LAPA). ADAP is available in every U.S. state and territory for persons who are low income, living with HIV and uninsured—although eligibility criteria and formulary medications vary from state to state.

Kaiser Family Foundation http://www.kff.org

2010: Major Challenges and Changes to the Louisiana ADAP Program

For the past five years, client utilization of the Louisiana AIDS Drug Assistance Program (LA ADAP) and expenditures on eligible services have been increasing steadily without a corresponding increase in resources. These documented trends are the result of many factors, including but not limited to: increased targeted HIV testing, intensive efforts to link newly diagnosed persons into care, assertive activities to identify persons who know their HIV status and are not in care, and the overall economic downturn with a corresponding loss of income and insurance benefits, coupled with level allocation of federal resources to Louisiana to address these growing needs. Since 2008, the cost of providing medication services through the LA ADAP has increased 33% while the number of clients served has increased 15%. As a result, in spring 2010, it was projected that Louisiana ADAP would face a potential shortfall of $11.7 million.

These factors forced the implementation of cost-savings measures in order to avoid the need to disenroll all ADAP clients before the end of the budget period. The elimination of primary medical care contracts, as well as a decrease in contracted budgets for community-based organizations, yielded some savings. However, they did not offset the projected client need for core services funded through Ryan White Part B resources, and as such, LA ADAP was capped to new enrollment on June 1, 2010. Individuals newly eligible for LA ADAP after June 1st were referred to Patient Assistance Programs (PAPs) administered by pharmaceutical manufacturers. These individuals comprise the LA ADAP "Unmet Need" list. Unlike the concept embodied in a waiting list, these individuals are not waiting for medication, but rather are using the PAPs as their primary source of no-cost or low cost HIV-related medications for the duration of capped enrollment to LA ADAP.

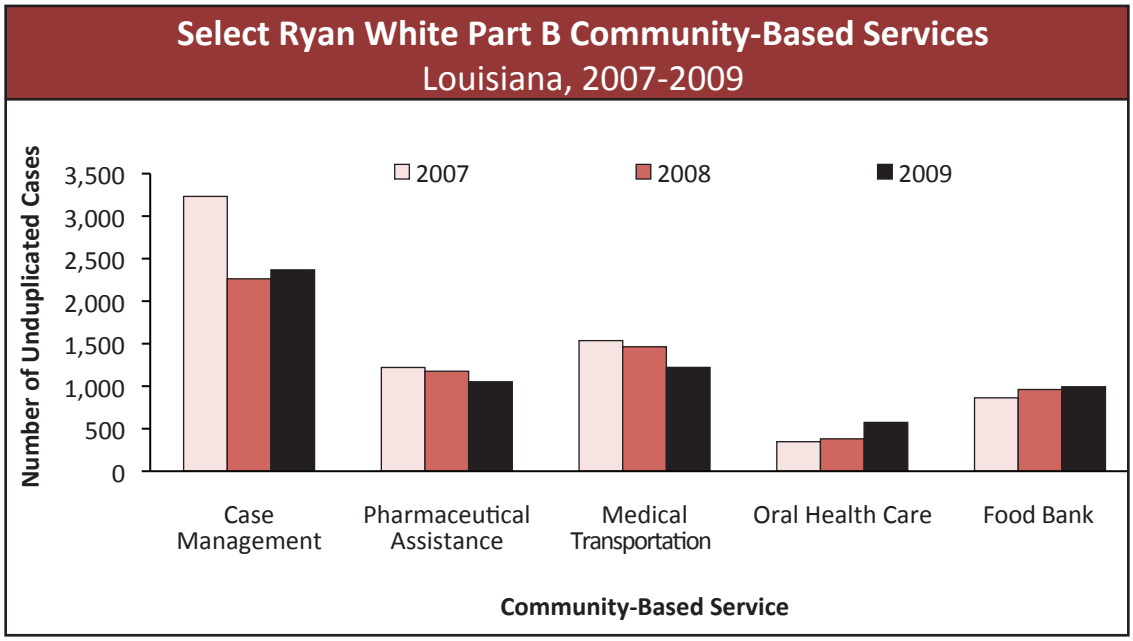
As of mid-December 2010, more than 800 individuals had been documented on the Unmet Need list. Of these, 280 have been removed following the receipt of emergency funds from HRSA, as well as the determination that several individuals did not meet ADAP eligibility criteria. Although HAP staff continue diligently to identify and secure every available resource for this crucial program, it is anticipated that the Unmet Need list will continue to grow unless new funding resources are secured.

Provision of Medical Case Management and Support Services

What does HAP do? *Contracts with community-based agencies to provide medical case management services to assist people living with HIV access medical care.*

Area covered: *Statewide, but excludes the New Orleans and Baton Rouge areas where Ryan White resources for similar services are awarded to these cities directly by HRSA.*

Medical case management is a service that helps eligible clients navigate HIV medical care systems and access other support resources. Case managers help clients access supportive services through federal, state, and local community based programs. When available, Ryan White Part B funding maybe utilized when there are no other resources to pay for oral health care services, transportation to medical appointments, and nutritional services. Below is a summary of the number of clients served and the units of service provided for some of the Ryan White Part B-funded services in Louisiana.



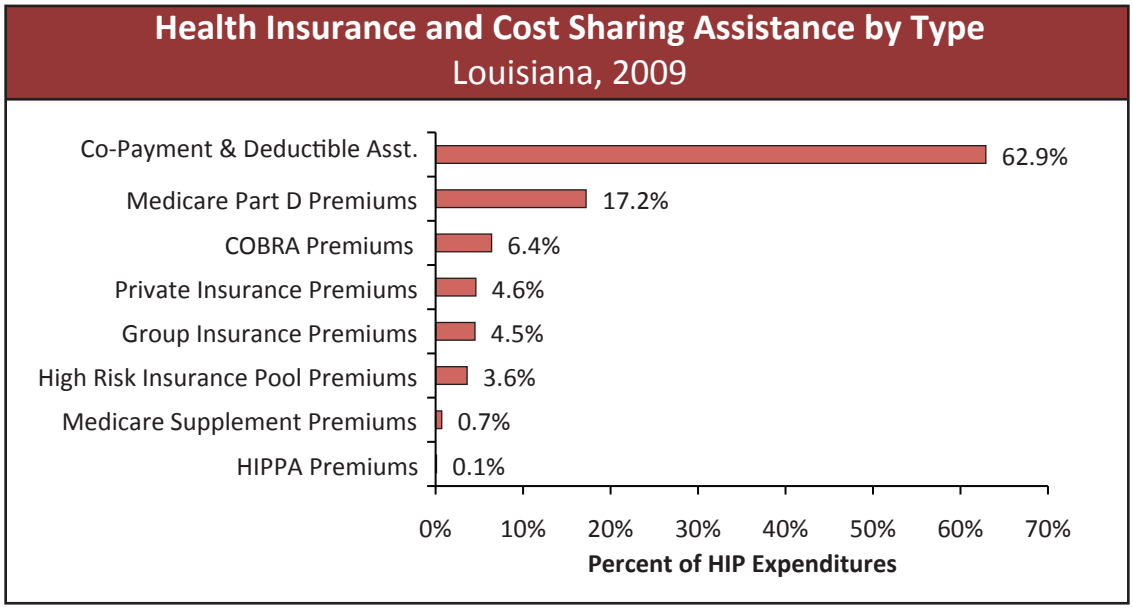
- Of those persons known to be living with HIV infection outside of the Baton Rouge and New Orleans metropolitan areas, 2,235 persons received medical case management in 2009 supported by Ryan White Part B resources.
- Oral healthcare needs for persons with HIV can be more pronounced than those of the general population due to side effects of the prescribed medications. When combined with poor oral health care histories, those persons seeking dental care may have more severe or more urgent needs.[20]
- The availability of medical transportation to low-income persons living with HIV infection is crucial to their access to medical care, especially in rural areas. Transportation to and from medical appointments was identified by respondents of the 2008 Statewide Needs Assessment as the top service needed to assist in accessing HIV-related medical services.

Payment of Health Insurance Premiums, Co-payments and Deductibles

What does HAP do? *Contracts with a single entity for the payment of health insurance premiums, co-payments, or deductibles for eligible clients.*

Area covered: *Health insurance premiums are paid for clients statewide, while the co-payment and deductible program currently excludes the New Orleans area. Similar services are administered by the Ryan White Part A program.*

HAP's Ryan White Part B program supports comprehensive health insurance services to assist eligible clients maintain or obtain health insurance coverage. These services are provided through the Louisiana Health Insurance Program (HIP). Clients access these services by applying directly to the entity that administers the program, or through the local agency that provides HIV medical case management services. The graph below shows the type of payments supported through Ryan White Part B resources in 2009.



In 2009, HAP allocated slightly more than $1,500,000 to provide insurance premium assistance to 534 persons. Without this resource, the cost of their comprehensive HIV care would have been absorbed by other federal and state resources.

In 2009, approximately $1,200,000 was allocated to assist 792 persons with their co-payments and deductibles, including 355 persons with prescription drug coverage through Medicare Part D.

What is Ryan White Funding?

The Ryan White HIV/AIDS Program was first authorized by federal legislation in 1990 and is currently funded at $2.1 billion. The program is for those who do not have sufficient health care coverage or financial resources for coping with HIV disease. Ryan White fills the gaps in care not covered by these other resources. The majority of Ryan White HIV/AIDS Program funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training and research on innovative models of care. Federal funds are awarded to cities, states, and local community-based organizations to provide HIV-related services to more than half a million people each year, under funding categories called Parts, as outlined below.

Part A: *Grants to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs)*
Provides grants to areas most severely affected by the HIV epidemic. In Louisiana, the cities of New Orleans and Baton Rouge receive awards directly from HRSA under Part A.

- ***Part B:*** *Grants to States and Territories*
  Provides grants to all 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and five U.S. Pacific Territories or Associated Jurisdictions. Part B grants include a formula-driven Base award, ADAP earmark, and ADAP supplemental allocation, as well as a competitive Part B supplemental grant. These annual awards are made directly to the state of Louisiana and are administered through HAP.
- ***Part C:*** *Early Intervention Services (EIS) through Community-Based Non-Profit Entities*
  Funds comprehensive primary health care in an outpatient setting for people living with HIV infection. Nine clinics in Louisiana are currently supported through this resource. Part C funding from HRSA is the state's third major funding source for primary medical care for HIV-infected individuals living in Louisiana, after the allocation of state funds and federal reimbursements through Medicare and Medicaid.
- ***Part D:*** *HIV Healthcare for Women, Infants, Children, and Youth*
  Provides for family-centered outpatient or ambulatory care and support services for women, infants, children, and youth with HIV. In Louisiana there are three awards for services which are delivered in eight regions of the state.
- ***Part F:***
  - *Special Projects of National Significance (SPNS) Program*
    SPNS grants fund innovative models of care and support the development of effective delivery systems for HIV care. In Louisiana, three entities received funding through SPNS in 2009.
  - *AIDS Education and Training Centers (AETC) Program*
    Supports a network of 11 regional centers that conduct targeted, multidisciplinary education and training programs for health care providers treating people living with HIV infection. The AETC for Louisiana, Mississippi and Arkansas is based in New Orleans, LA.
  - *Dental Programs*
    Provides funding for oral health care services for people with HIV through the Dental Reimbursement Program (DRP) and the Community-Based Dental Partnership Program (CBDPP). The LSU School of Dentistry is the single grantee for the provision of these services in the state.
  - *Minority AIDS Initiative (MAI)*
    Provides funding to evaluate and address the disproportionate impact of HIV on African Americans and other minorities. In Louisiana, MAI funding is allocated annually to the Part A grantee (New Orleans), the TGA (Baton Rouge) and Part B (HAP).

Housing and Housing-Related Services: Louisiana's Formula Housing Opportunities for Persons with AIDS Program

HAP administers the State Formula Housing Opportunities for Persons With AIDS (HOPWA) program, funded by the federal Department of Housing and Urban Development (HUD). (See "What is the State Formula HOPWA Program?" on the next page for an overview of the federal program). The primary goal of HOPWA is to ensure stable housing for people living with HIV to prevent homelessness.

HAP's HOPWA services are available to eligible clients (those living at or below 80% of the Area Median Income or AMI) living outside of the New Orleans and Baton Rouge metropolitan statistical areas (MSAs). Similar services are available in those areas through HOPWA resources that are awarded directly to those city governments. HAP's main HOPWA services include:

- Short-term rent, mortgage, and/or utility payments to support eligible clients in their current housing;
- Tenant-based rental subsidies to maintain long-term housing;
- Operating costs and supportive services for residential facilities that are providing comprehensive housing services to persons with HIV;
- Permanent Housing Placement Services that help to pay rent and utility deposits and some moving expenses; and
- Identification of other housing resources within a community.

The federal HOPWA administration has set a goal for 2010 that 80% of all persons served through the State Formula HOPWA will be stably housed by the end of that program year. Currently, HAP estimates that Louisiana's State Formula HOPWA program has achieved stable housing for 56% of individuals served by the program. HAP continues to work toward meeting the 2010 HUD goal, even with reduced housing stock in many of the hurricane-impacted areas of the state. In 2009, there were 735 persons living with HIV infection who received housing services through State Formula HOPWA and an additional 505 family members who benefited from this assistance, for a total of 1,240 individuals who received services.

- Of the 735 HIV-infected clients who received housing services in 2009:
  - 33 were Veterans
  - 60 met the HUD definition of being chronically homeless
  - 27 were survivors of domestic violence
  - The vast majority (73%) had an income at or below 50% of the median income for their parish of residence
- Of the 1,240 beneficiaries of HOPWA-funded services in 2009:
  - 59% were male and 41% were female
  - 65% identified themselves as black/African American
  - 20% were dependent minors under the age of 18, 65% were persons between the age of 18-50, and 16% were 50 or older

How does stable housing affect health for people living with HIV?

The Community Health Advisory & Information Network (CHAIN) project is an ongoing prospective study of persons living with HIV in greater New York City conducted by the Mailman School of Public Health at Columbia University. This study has consistently found over the past 10 years that homeless individuals accessing supportive housing were more likely to engage in primary medical care than individuals who only accessed case management services. Stable housing was also shown to increase the possibility of being prescribed anti-retroviral medications. Additionally, those who received housing assistance were 2.5 times more likely to retain appropriate medical care as those who did not receive the assistance.

What is the State Formula HOPWA Program?

The U.S. Department of Housing and Urban Development (HUD) began the Housing Opportunities for Persons with AIDS (HOPWA) program in 1992 to address the specific needs of persons living with HIV and their families. This program is guided by the Fair Housing Act of 1968, as amended in 1990 to include the Americans with Disabilities Act. HOPWA distributes 90% of its program funds using a statutory formula that relies on AIDS statistics from the Centers for Disease Control and Prevention (CDC). Three quarters of HOPWA formula funding is awarded to qualified states and metropolitan areas with the highest number of AIDS cases. One quarter of the formula funding is awarded to metropolitan areas that have a higher-than-average per capita incidence of AIDS.

HOPWA State Formula Grants are awarded upon submission and HUD approval of a Consolidated Plan pursuant to the Code of Federal Regulations (24 CFR Part 91), which is published by the Office of the Federal Register. Metropolitan areas with a population of more than 500,000 and at least 1,500 cumulative AIDS cases are eligible for HOPWA Formula Grants. In these areas, the largest city serves as the Formula Grant Administrator. States with more than 1,500 cumulative AIDS cases (in areas outside qualifying cities that are eligible to receive HOPWA funds) are eligible to receive HOPWA State Formula Grants. Louisiana is a qualifying state.

HOPWA makes grants to local communities, states, and nonprofit organizations for projects that benefit low-income persons medically diagnosed with HIV infection and their families. The funds can be utilized to:

- identify new housing options;
- pay rent, mortgage, and utilities in specific circumstances;
- support the operating costs of housing programs for persons living with HIV;
- provide supportive services that maintain persons in housing; and
- support the acquisition, rehabilitation, and development of housing specifically for persons living with HIV and their families.

Assessing Consumer Needs and Prioritizing the Care and Services Funding Allocations

Legislative language in section 2617(b)(6) of the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White HIV/AIDS Program) requires grantees to conduct activities to enhance coordination across Ryan White HIV/AIDS Program Parts by mandating participation in the development every three years of a Statewide Coordinated Statement of Need (SCSN). The purpose of the SCSN is to provide a collaborative mechanism to identify and address significant HIV care issues related to the needs of people living with HIV infection and to maximize the coordination, integration, and effective linkages across the Ryan White HIV/AIDS Program Parts. The SCSN process is expected to result in a document that reflects the input and approval of all Ryan White Program Parts and guides the creation of the Comprehensive Plans developed by the Part A, Part B and TGA grantees.

Comprehensive Plans, as described in 2617(b) (5), are also submitted to HRSA every three years. The Plans are required to address the organization and delivery of health and support services in each jurisdiction and should include strategies, goals, and timelines that focus on: 1) primary care and treatment, 2) efforts to increase flexibility to target Ryan White resources, and 3) accountability through sound fiscal management and evaluation of program effectiveness.

A copy of the 2009 Statewide Comprehensive Statement of Need (SCSN) and the 2009 Part B Comprehensive Plan are available at: www.hiv.dhh.louisiana.gov.

2008 Statewide Needs Assessment of Persons Living with HIV/AIDS

In preparation for the creation of the 2009 SCSN and Comprehensive Plan, in June 2008 HAP released a call for proposals for the coordination and implementation of the 2008 Statewide Needs Assessment. Staff from the successful proposer worked closely with members of HAP, representatives from the Part A grantee and the New Orleans Regional AIDS Planning Council, staff from the Office of Community Development in Baton Rouge, and employees of the Part D grantee to revise and edit the previous survey instrument. Several meetings and conference calls were held to develop a tool that truly assessed current consumer need. The 16-page survey was then field tested with consumers and revised based on their suggestions.

The contractor trained more than a dozen Peer Advocates to work closely with Case Managers at the community based organizations and with Ambulatory Site Coordinators at the LSU regional public medical centers to assist in administering the Needs Assessment survey. They educated consumers about the purpose of the survey, stressed the importance of consumer input, encouraged each client to complete the survey, assisted consumers with reading or understanding the questions, and collected the completed surveys in a confidential manner.

The facility-based survey was promoted to persons living with HIV infection over a four-week period, from September 22, 2008 through October 17, 2008, using a self-administered instrument in both English and Spanish. The survey was also made available online in English. The survey instrument covered twelve domains: general information, health insurance, employment, income and resources, primary medical care, housing, childcare, transportation, mental health and substance use, other services, support services, and positive prevention.

A statewide goal of 2,250 completed surveys was set, which would represent approximately 13% of all persons known to be living with HIV in Louisiana. Upon receipt, surveys were counted and inspected for errors that could be corrected prior to scanning. Surveys that were at least 50% complete were considered useable. A total of 1,944 surveys were returned during the data collection period, of which 111 were deemed unusable because they were less than 50% complete. Regions 5, 7, and 8 exceeded their targets during the first three weeks of data collection and did not have to continue into the fourth week. The lowest response rate came from Region 3, which was severely affected by Hurricane Gustav.

In terms of regional representation, the 2008 Needs Assessment Survey sample of 1,833 responses closely reflects the distribution of people living with HIV across the state. For every region except one, the regional sample proportion is within two percentage points of the number of people living with HIV infection in that region. Descriptive statistics of demographic data likewise show that in terms of observable characteristics the 2008 Needs Assessment sample is reflective of the HIV-infected population in Louisiana. Survey respondents were predominantly in their forties (48%), black (70%), and male (60%). While women were slightly overrepresented in the sample, as were blacks, and Hispanics/Latinos, by age groups, the sample represents the population very closely.

Below are select findings from the 2008 Statewide Needs Assessment:

Primary Medical Care and Medications

- The top three barriers to receiving HIV-related medical services were lack of transportation, lack of knowledge about where to get services, and lack of funds to pay for services.
- The top three reported reasons for not seeking HIV-related medical care were lack of knowledge about where to get care, not feeling sick, and feeling depressed.
- Dental and eye care were the most often identified unmet HIV-related medical service needs.
- 32% of respondents reported being out of treatment for at least 12 months, with the most commonly reported reason being that they were not ready to deal with their HIV status.
- The top three reasons for not taking medications were that they made the respondent feel bad, respondents had trouble remembering to take them, and respondents did not like taking the medications.

Mental Health and Substance Use

- Very few respondents (<7%) indicated an unmet mental health need or unmet need for substance abuse assistance. However, about half of respondents reported having little interest or pleasure in doing things and feeling down, depressed or hopeless during the last two weeks.
- 62% of substance-using respondents expressed a desire to stop their substance use.
- 4% of respondents reported using injection drugs in the past three months; of these, 56% reported sharing a needle with others in the last three months, 23% reported not using a clean needle the last time, and 35% stated they did not know where to get clean needles.

Supportive Services

- The top barrier to accessing support services was lack of knowledge about where to get services, despite the fact that 72% of the respondents had been HIV positive for at least five years and 82% were living in Louisiana at the time of their HIV diagnosis.
- The most commonly reported unmet support service need was food bank/food vouchers.
- While 42% of respondents received food stamps, 11% said they did not have enough food to eat and this stopped them from taking care of their HIV infection.
- Financial assistance with utilities and “other critical needs” were the most often identified unmet “other service” needs.
- The top three barriers to getting to places in general were not being able to afford transportation, being without personal transportation, and living too far to walk or bike.
- The top barriers to obtaining HIV-related services early in HIV diagnosis were that the respondent didn’t know where to go, felt healthy, wasn’t ready, and didn’t want anyone to know that she/he was HIV positive.
- Over half of the respondents reported they had disclosed their HIV status within one month of their HIV diagnosis; however, 60% reported they did not disclose earlier out of fear of rejection.

Health Insurance

- 59% of respondents reported having one of more types of health insurance: Medicaid (60%), Medicare (40%), or coverage through work (9%).
- For those without coverage, the most often identified barrier to obtaining insurance was that it is unaffordable.
- 58% of respondents reported they were not working; of these, 62% were on disability.
- 66% of respondents reported a total household monthly income of $1,000 or less.

Housing

- The three most often identified barriers to receiving HIV-related housing services were that respondents did not know where to get services, did not qualify for services, or were put on a waiting list.
- The top two unmet HIV-related housing service needs were money to pay utilities and money to pay rent.
- 49% of respondents had lived in their current residence for less than a year.
- 14% of respondents reported they did not have enough money to pay rent and said that this stops them from taking care of their HIV infection.
- 26% of respondents said they had problems obtaining housing in the last six months.
- The most commonly identified barriers to obtaining housing included not having enough money for the deposit, being unable to find affordable housing, and lacking transportation to search for housing.
- 28% of respondents had spent at least one night without a place to sleep in the last year.
- 11% of respondents were incarcerated in the past 12 months; of these respondents, 82% said they received HIV medical care while in prison or jail.

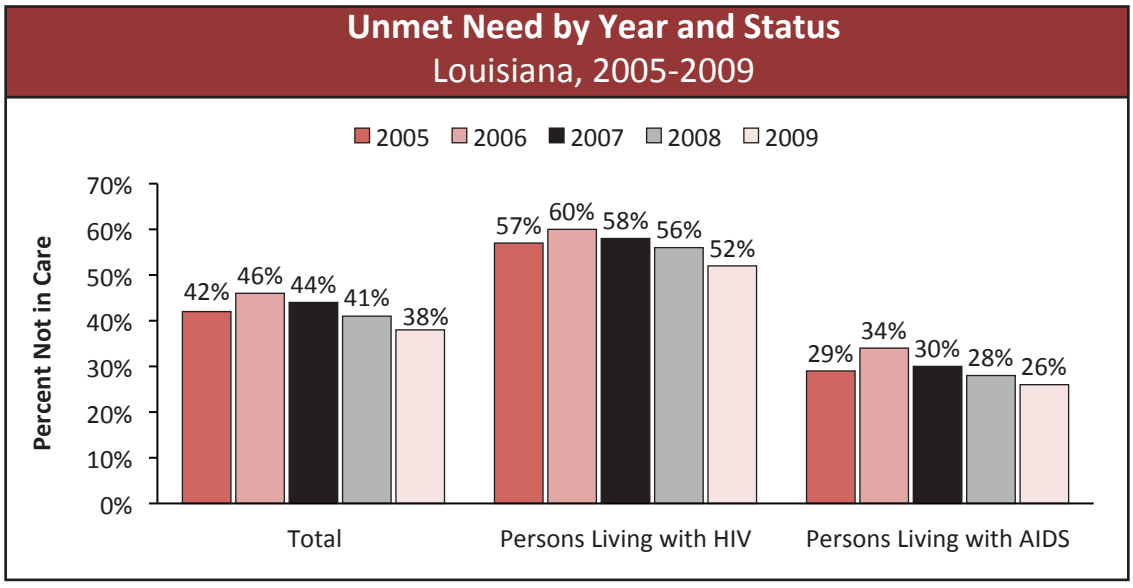
The next needs assessment will be conducted in 2011. For additional findings and regional results, the 2008 Statewide Needs Assessment and regional reports can be found in their entirety at http://www.dhh.louisiana.gov/offices/reports.asp?ID=264&Detail=612.

Assessing "Unmet Need" and Allocating Resources in Louisiana

The primary focus of the Ryan White HIV/AIDS Program is to help ensure that individuals living with HIV routinely access primary medical care and medications in order to maintain their health and delay progression to an AIDS diagnosis or death. There are, however, many people who are living with HIV infection who do not regularly access medical care. As part of the annual resource planning and allocation processes, the federal Ryan White HIV/AIDS Program requires that Part A and B grantees take into consideration "unmet need" for primary medical care in their jurisdiction. Unmet need is defined as the number of individuals in a set geographic area who know their HIV status but have not accessed HIV-related primary medical care in a 12-month period, as measured by lack of evidence of a CD4 or viral load (VL) test result in the last 12 months.

The allocation of resources to reduce the amount of consumer unmet need is further supported by the current legislative requirements in the Ryan White HIV/AIDS Treatment Extension Act of 2009. Both Part A and Part B grantees must allocate a minimum of 75% of their annual award to Core Services in an effort to link low income HIV-infected persons into primary medical care and maintain them in those crucial services. Core Services for Part B include ADAP, Health Insurance Premium and Cost-Sharing Assistance, Core Medical Services (i.e., Ambulatory/Outpatient Medical Care, Local AIDS Pharmaceutical Assistance, Medical Case Management, Mental Health Services, Substance Use Treatment Services and Oral Health Care), Home- and Community-Based Care, Early Intervention Services, and Medical Nutrition Therapy. Support services may not exceed 25% of the annual Ryan White resource allocation and must be utilized to fund services that will engage a client with an HIV-related health care provider and support them in remaining in care, such as medical transportation.

In Louisiana, HAP's Surveillance Unit provides the data for estimating unmet need for the state's Ryan White grantees. Persons who had at least one CD4 or VL test within a 12-month period are considered to have been "in care" during that year. Persons who did not are considered "out of care," and are deemed as having an "unmet need" for care and treatment. Louisiana's Public Health Sanitary Code requires that laboratories report all test results indicative of HIV infection for persons residing in Louisiana. As a result, laboratory data received by HAP's Surveillance Unit can be used to assess whether a person is in care or not in care during a specified time period.



- The overall percentage of persons not in care has decreased since 2006 to 38% of all persons living with HIV infection.

- Persons living with AIDS continue to have lower percentages of unmet need than persons living with HIV. People living with AIDS may require more medications and may have more symptoms, leading them to seek out more frequent medical visits.

Unmet Need for Primary Medical Care
Louisiana, 2009

	2009	
	Percent in Care	**Percent Not in Care (Unmet Need)**
Overall	**62%**	**38%**
Persons living with HIV	48%	52%
Persons living with AIDS	74%	26%
Sex		
Female	66%	34%
Male	60%	40%
Race/Ethnicity		
Black/African American	62%	38%
Hispanic/Latino	47%	53%
White	64%	36%
Age Group		
0-12	80%	20%
13-24	63%	37%
25-44	61%	39%
45-64	63%	37%
65+	59%	41%
Region		
1-New Orleans	57%	43%
2-Baton Rouge	67%	33%
3-Houma	74%	26%
4-Lafayette	64%	36%
5-Lake Charles	53%	47%
6-Alexandria	64%	36%
7-Shreveport	61%	39%
8-Monroe	62%	38%
9-Hammond/Slidell	69%	31%

- Of persons living with HIV infection in 2009, only 62% had at least one primary medical care visit during the year.[21] Persons living with AIDS were more likely to have a medical visit (74%) compared to persons living with HIV (48%).
- Females, non-Hispanics, and persons under the age of 13 were also more likely to be receiving medical care.
- Persons residing in the Houma and Hammond/Slidell regions were most likely to be in care, while persons in the Lake Charles and New Orleans area were least likely to be in care.
- NOTE: The unmet need estimate should be considered a maximum estimate. While Louisiana has comprehensive laboratory reporting requirements, laboratory reporting is not 100% complete. In addition, some people included in the surveillance system as living in Louisiana may have moved out of state or died. While HAP monitors lab reporting carefully and updates out of state information and vital status, this information is not complete.

Care and Services Challenges and Accomplishments

Without a doubt, the most significant challenge faced by the Louisiana Ryan White Part B Program in 2009/2010 was the projected shortfall of funding for LA ADAP, resulting in capped enrollment starting June 1, 2010 (see page 52 for additional information). The re-allocation of Part B resources to Louisiana ADAP resulted in the reduction or discontinuation of supportive community services in the areas of the state outside of New Orleans and Baton Rouge. Despite these challenges, staff continued to strive towards improving services throughout the state. The following is a brief description of accomplishments during this period.

Improved Data Management System: HAP has continued to customize CAREWare to improve its data reporting system. With the onset of required client-level data reporting, HAP staff have worked towards assessing and improving the functions of CAREWare, as well as training contracted providers to enter all data in a timely manner. In 2010, HAP received a HRSA Special Projects of National Significance (SPNS) information technology (IT) grant to establish a centralized storage network for five HRSA Ryan White grantees in the state. Partners include Part A New Orleans, Part A Baton Rouge, Part B Louisiana OPH HAP, Part C NO/AIDS Task Force, and Part D FACES of Children's Hospital. Once this system is complete, providers will be able to share data on clients enrolled in multiple services, improving their ability to assess client needs, coordinate services across systems, and evaluate health outcomes.

Health Insurance Program: During 2009, HAP staff assessed the administrative functions of the Health Insurance Continuation Program (HICP) and the Co-payment and Deductible Assistance Program (CDAP) and decided to combine these two programs into one comprehensive and uniform program called the Health Insurance Program (HIP). Through a Request for Proposals (RFP) process that occurred in early 2010, HAP awarded the HIP contract to a single provider. This arrangement has resulted in a seamless and efficient system that processes all eligible clients' insurance premiums, as well as co-payments and deductibles. In addition, these changes have improved HAP staff's ability to effectively coordinate and monitor this administrative system, to ensure that all non Ryan White resources are being utilized prior to accessing services funded by HAP and that clients' health insurance plans are maintained without interruption.

Contracted Regional Services: HAP released a RFP in 2009 to enter into a three-year contract with service providers of Ryan White Part B-funded services. In order to ensure that services would not be fragmented within each region, the call for proposals required that all potential applicants provide "bundled" services. These bundled services include Ryan White-funded medical case management, non-medical case management, and medical transportation, as well as HOPWA-funded housing assistance. Each applicant was also invited to propose the delivery of "optional" services, which were considered on a region-by-region basis and were dependent on available resources after the allocation of bundled services was finalized. As a result of this RFP, one service provider was selected in each of the seven public health regions covered by Ryan White Part B funding to deliver these particular services to eligible clients living with HIV infection.

Chapter 3

Prevention

Introduction to the Prevention Unit

The Louisiana Office of Public Health HIV/AIDS Program (HAP) Prevention Unit is responsible for behavioral interventions and educational activities that are focused on reducing the spread of HIV in the state. The program is supported with funding from the Centers for Disease Control and Prevention (CDC), State General Funds, and private foundation funding.

Over the course of the HIV epidemic, targeted populations and interventions for reducing the spread of HIV have changed in response to shifts in the epidemic. Prevention is not a stagnant activity. Prevention has and will continue to change throughout the epidemic. HAP's HIV prevention activities currently focus on several areas:

- intervening with HIV-positive individuals to increase their skills and address barriers to reducing the risk of transmission of HIV;
- reducing stigma and understanding the impact it has on prevention efforts and those impacted by HIV;
- utilizing holistic outreach and integrated health services as a means to connect individuals to needed services;
- implementing evidence-based interventions; and
- providing a continuum of prevention programs and services rather than isolated programs, and addressing the range of issues that put individuals at risk of becoming infected with HIV or transmitting HIV, such as mental health issues, substance abuse, partner violence, unemployment, poverty, homelessness and other social and health issues.

The following sections will describe several key activities of the Prevention including: HIV Counseling, Testing, Referral and Linkage Services (CTRLS); HIV Partner Services (HPS); outreach to high-risk individuals; prevention with positives; programs targeting special populations; public information and prevention materials distribution; and public awareness.

In accordance with the National HIV/AIDS Strategy outlined on pages 8 and 9, the Prevention Unit will focus efforts to:

- intensify HIV prevention efforts in communities where HIV is most heavily concentrated;
- expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches; and
- educate all Americans about the threat of HIV and how to prevent it.

In an effort to address the goals of the National HIV/AIDS Strategy, the Prevention Unit conducts or coordinates the following activities:

- HIV counseling, testing, referral and linkage services
- HIV partner services
- outreach to high-risk individuals
- behavioral interventions
- programs targeting HIV-positive individuals
- dissemination of STD/HIV educational materials
- training and technical assistance on HIV counseling, testing, referral and linkage services and other prevention interventions
- a statewide toll-free information line, "Infoline," for HIV, STD, hepatitis, and TB-related information and referral (1-800-99-AIDS-9/992-4379)
- a website with population specific information and referrals – www.HIV411.org
- a statewide planning process for HIV prevention
- HIV awareness raising, stigma reducing events/activities
- integrated prevention services (i.e., LA Wellness Center Project)
- HIV prevention in Latino communities
- enhancing collaboration among community stakeholder groups (community based organizations (CBOs), parish health units (PHUs), etc.)
- conducting process and outcome evaluation of prevention programs

National HIV/AIDS Strategy
Reduce New Infections

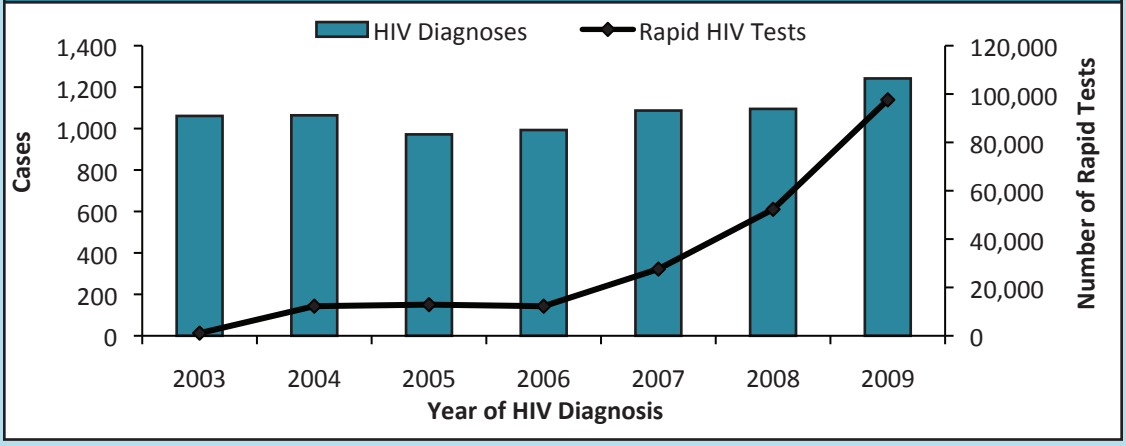
2015 Objectives:

- Lower the annual number of new infections by 25%.
- Reduce the HIV transmission rate by 30%.
- Increase from 79%-90% the percentage of people living with HIV who know their serostatus.

In 2011, Louisiana will complete an incidence estimate to determine the number of new HIV infections in 2009 in the state of Louisiana. This number will be used as a baseline to evaluate any reductions in new infections by 2015.

In 2009, 1,242 persons were newly diagnosed with HIV in Louisiana, a 13% increase from 2008, largely due to the expansion of rapid testing, particularly in emergency departments and correctional facilities. The CDC estimates that 21% of people who are infected with HIV are unaware of their status. Applying this percentage to the approximately 17,000 persons known to be living with HIV in Louisiana at the end of 2009, there are an estimated 4,500 persons either unaware of their status or undiagnosed. Expanded rapid testing will increase the number of HIV diagnoses and decrease the number of people living with HIV who are unaware of their status.

New HIV Diagnoses and Rapid Tests
Louisiana, 2003-2009



National HIV/AIDS Strategy (www.thewhitehouse.gov)

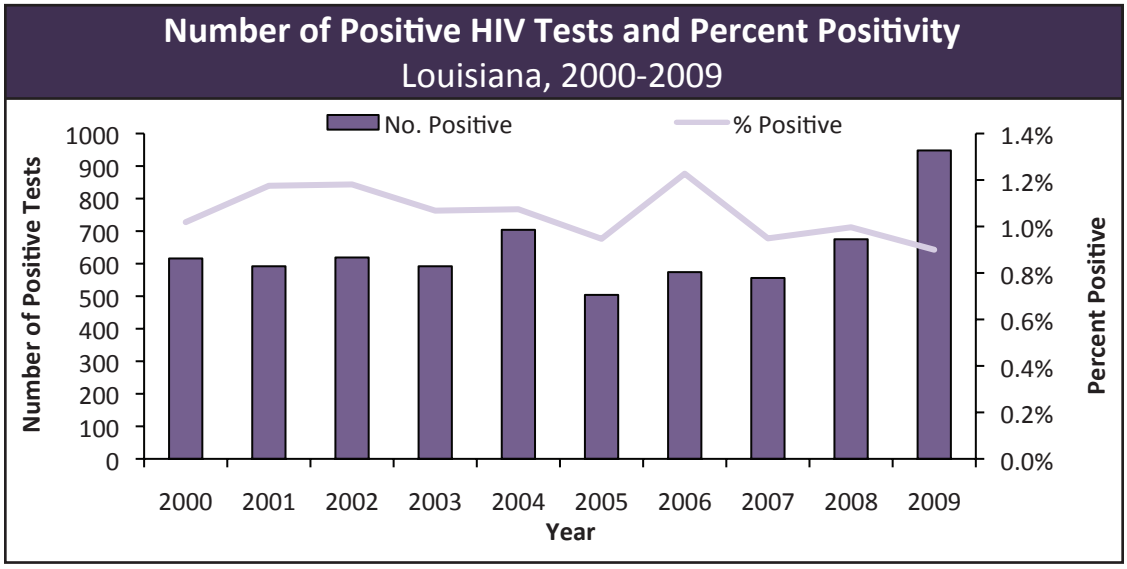
HIV Counseling, Testing, Referral and Linkage Services (CTRLS)

What does HAP do? *Ensures access to no-cost HIV testing*
Area covered: *Statewide*

HAP supports HIV testing through contracts with CBOs and PHUs (STD, family planning, and prenatal clinics), hospital emergency departments, substance abuse treatment programs, Federally Qualified Health Centers, and school-based health clinics. For persons who test positive, counseling, referral and linkage services are provided to link individuals to medical care and other support services.

Testing for HIV is most effective when: 1) it is offered as a routine part of medical care, and 2) those who test positive are engaged in healthcare quickly. By entering care early, overall costs of healthcare for HIV-positive persons are reduced;[22] and knowledge of their positive status results in the individual taking measures to prevent transmission to others.

The graph below illustrates the number of HIV tests conducted through HAP's HIV CTRLS program. In 2009, there were a total of 100,571 HIV tests conducted through HAP's HIV CTRLS - 2.5% of Louisiana's population. For comparison, several states have varying total numbers of tests when compared with population: North Carolina tested 276,017 persons in 2009 (2.9% of the population), Pennsylvania tested 64,050 persons in 2007 (0.5% of the population), and Florida tested 395,299 persons in 2009 (2.0% of the population).[23,24,25]



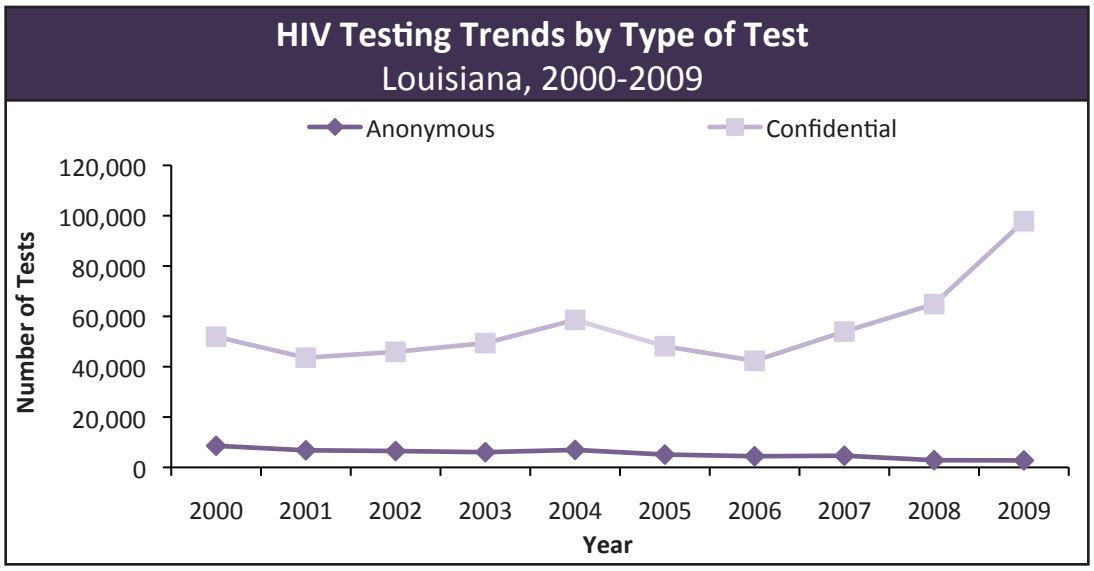
- Between 2000 and 2009, the number of HIV tests conducted has varied between a low of 46,769 tests in 2006 following testing disruption due to Hurricane Katrina, to a high of 100,571 tests in 2009. Over the past eight years, the percent positivity rate has fluctuated around 1.0% with a peak of 1.2% in 2006. By comparison to other states, in recent years, North Carolina had an HIV positivity rate of 1.5%, Florida had a 1.3% positivity rate, and Pennsylvania had a 0.7% positivity rate.[26,27,28]
- There were 948 persons found to be HIV-positive in 2009 through the state's publicly funded programs, accounting for 0.9% of the total tests. A total of 53% of the persons with an HIV-positive test were new HIV diagnoses to the HIV Surveillance system.

In Louisiana, both confidential and anonymous testing are offered.

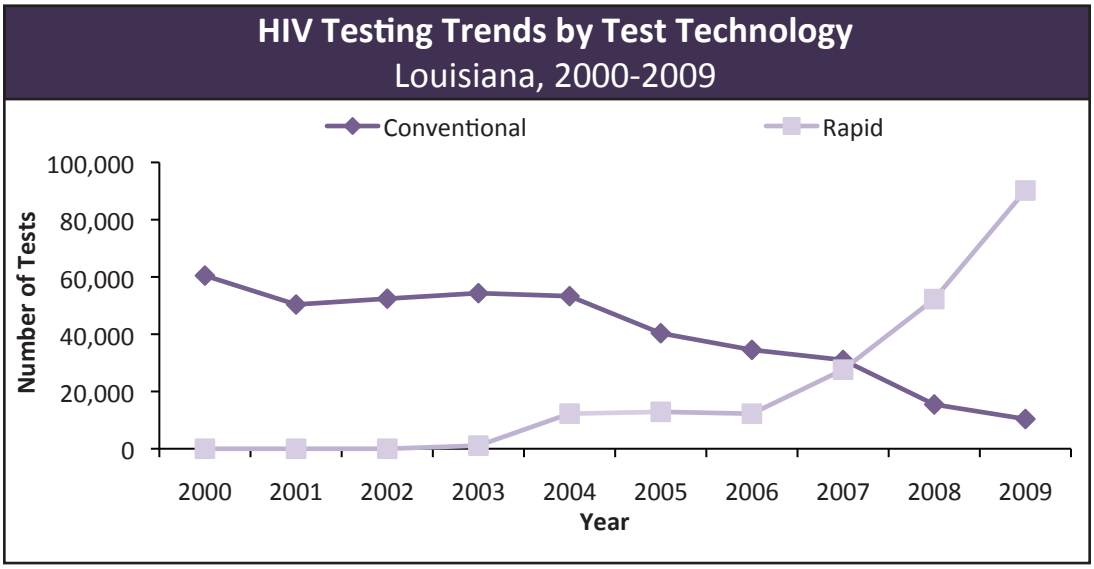
- Confidential testing - the testing center records the person's name along with the results of his/her test.

The only people with access to the test results are medical personnel and HAP. Confidential testing is encouraged, as it facilitates entry into care for HIV-positive persons, and allows for much more accurate monitoring of the testing program as well as patterns in risk behaviors reported by patients/clients.

- Anonymous testing - the tester's name is not given to the testing center, and only the person who is having the test is aware of the results.



- The vast majority of tests in Louisiana are confidential, and the number of anonymous tests has decreased since 2000. From 2000 to 2009, the percentage of all tests that were confidential increased from 86% to 97%.
- In October 2007, Louisiana began an HIV testing initiative with the main goal of increasing the number of African Americans who are tested. Through this initiative, the use of rapid HIV tests and the locations where these tests were available was significantly expanded. The rapid HIV test allows individuals to receive their results in 15-30 minutes (depending on the device used and testing protocol at the site) and can easily be done at different testing locations that lack laboratory facilities required for conventional tests. A positive rapid HIV test does require a laboratory confirmatory test to meet the CDC case definition. In 2003, when rapid HIV testing began in Louisiana, 2% of the total tests were rapid, and by 2009, 90% of the total tests were rapid tests.



The table below provides the characteristics of those receiving a HAP-funded HIV test in 2009.

HIV Tests by Characteristic
Louisiana, 2009

	Total Number Of Tests	% of Total Tests	Number of Positive Results	% Positivity Rate
Total	**100,571**	**100%**	**948**	**0.9%**
Gender				
Female	51,796	51.6%	249	0.5%
Male	48,627	48.4%	693	1.4%
Transgender - M to F	43	0.0%	5	11.6%
Transgender - F to M	1	0.0%	0	0.0%
No Gender Specified	***104***	-------	***1***	***1.0%***
Race/Ethnicity				
American Indian/Alaska Native	195	0.2%	2	1.0%
Asian/Pacific Islander	703	0.7%	4	0.6%
Black/African American	65,531	67.4%	742	1.1%
Hispanic	3,393	3.5%	31	0.9%
White	27,078	27.9%	155	0.6%
Multi-race	311	0.3%	1	0.3%
No Race/Ethnicity Specified	***3,360***	-------	***13***	***0.4%***
Age Group				
0-12	145	0.1%	0	0.0%
13-19	13,781	14.1%	47	0.3%
20-29	43,167	44.1%	336	0.8%
30-39	18,526	18.9%	233	1.3%
40-49	13,038	13.3%	199	1.5%
50+	9,275	9.5%	118	1.3%
No Age Specified	***2,639***	-------	***15***	***0.6%***
Transmission Category				
Men Who Have Sex with Men (MSM)	4,213	7.1%	209	5.0%
Heterosexual	54,014	90.6%	259	0.5%
Heterosexual/Injection Drug User (IDU)	1,274	2.1%	10	0.8%
MSM/IDU	108	0.2%	11	10.2%
No Risk Specified	***9,122***	-------	***78***	***0.9%***
Risk Information Not Reported	***31,840***	-------	***381***	***1.2%***

- Of the tests with a reported race, blacks accounted for 67% of total tests, compared to 67% of total persons living with HIV infection and 75% of total new diagnoses in 2009.
- Of the tests with reported gender, males accounted for only 48% of the total tests while accounting for 70% of total persons living with HIV infection and 68% of total new diagnoses.
- Of the 59,609 tests that were reported with a risk, MSM accounted for only 7% of the tests with a reported risk while accounting for 44% of total persons living with HIV and 48% of total new diagnoses; heterosexuals accounted for 91% of the total tests while accounting for only 29% of total persons living with HIV and 34% of total new diagnoses. Risk information is not collected at the hospital emergency departments or at state correctional facilities.
- Males had a higher positivity rate than females, and male-to-female transgender persons and MSM and MSM/IDUs had the highest percent positivity.

HIV Tests by Characteristic Continued Louisiana, 2009				
	Total Number Of Tests	**% of Total Tests**	**Number of Positive Results**	**% Positivity Rate**
Total	**100,571**	**100%**	**948**	**0.9%**
Testing Site Type				
Parish Health Units - Clinic not specified	6,967	6.9%	35	0.5%
Sexually Transmitted Disease Clinics	32,082	31.9%	256	0.8%
Family Planning Clinics	7,170	7.1%	11	0.2%
Prenatal/OB-GYN Clinics	574	0.6%	1	0.2%
Tuberculosis Clinics	1,683	1.7%	0	0.0%
Community Based Organizations	12,189	12.1%	240	2.0%
Emergency Departments	17,946	17.8%	241	1.3%
State Drug Treatment Programs	3,674	3.7%	17	0.5%
Prisons/Parish Jails	12,497	12.4%	121	1.0%
Community Health Clinics	1,658	1.6%	9	0.5%
School/University	3,131	3.1%	12	0.4%
Other	1,000	1.0%	5	0.5%
Region				
1-New Orleans	36,003	35.8%	449	1.2%
2-Baton Rouge	17,088	17.0%	225	1.3%
3-Houma	3,254	3.2%	12	0.4%
4-Lafayette	9,710	9.7%	56	0.6%
5-Lake Charles	5,431	5.4%	39	0.7%
6-Alexandria	4,981	5.0%	28	0.6%
7-Shreveport	6,956	6.9%	48	0.7%
8-Monroe	9,116	9.1%	39	0.4%
9-Hammond/Slidell	8,032	8.0%	52	0.6%

- Persons testing in PHUs, which includes STD clinics, family planning clinics, prenatal/OB-GYN clinics, and TB clinics accounted for 48% of all of the HIV tests and 32% of all positive tests in 2009.
- CBOs, emergency departments and correctional facilities with testing had the highest positivity rates in 2009 of all testing sites and accounted for 42% of all HIV tests. Emergency departments at LSU medical centers and selected prisons/jails have recently rolled out large-scale rapid testing programs as a routine part of medical care.
- The New Orleans region conducted the greatest number of tests and had the second highest positivity rate (1.2%) of all nine public health regions. The Baton Rouge region conducted the second highest number of HIV tests but had the highest positivity rate (1.3%).

HIV Partner Services (HPS)

What does HAP do? *Outreach to individuals newly diagnosed or newly reported with HIV to help ensure awareness of diagnosis and access to care, as well as to identify and anonymously inform partners of possible exposure to HIV and offer testing and referral to services.*

Area covered: *Statewide*

HIV Partner Services is a high priority intervention in the CDC HIV Strategic Plan. HPS is offered to persons who test positive for HIV to provide post-test counseling and referral into care, assist them in contacting their sexual and/or needle-sharing partners, as well as ensure that people are not only aware of their status but also understand what it means. HPS provides an important opportunity to link HIV-positive individuals to care and case management, if needed. HPS also reaches persons not receiving HIV CTRLS in other venues and provides HIV prevention education for both high-risk negative and HIV-positive individuals.

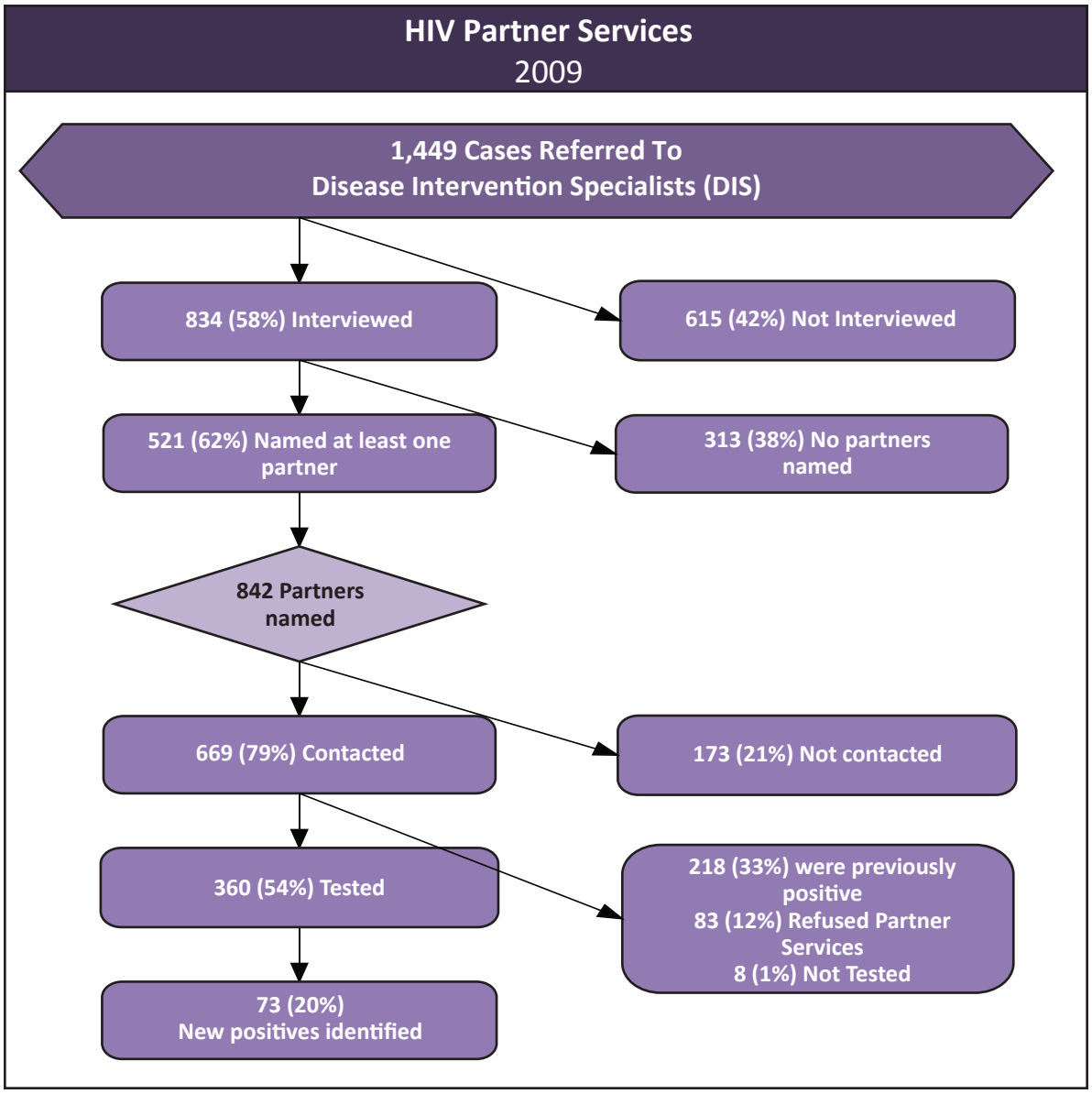
HAP maintains a cohesive, working relationship with the STD Program, CBOs, hospitals, and other health care providers to ensure all individuals newly diagnosed with HIV are offered HPS. Through a partnership between HAP and the STD Program, HPS are provided by Disease Intervention Specialists (DIS). Individual cases are assigned to a DIS, who is then responsible for offering Partner Services following CDC standards and guidelines, as well as the State of Louisiana Sanitary Code.

When an individual is located, the DIS interviews and counsels the client to inform him/her of Partner Services and, if the client agrees to receive these services, his/her partner referral options are discussed. The options are as follows:

- OPH/DIS-referral - DIS notifies partners and refers them for testing without revealing the original patient's identity. This is the most frequently used option and the preferred option.
- Client-referral - the patient agrees to notify partners him/herself and refer them for testing. It is difficult to verify if a partner has been notified with this method and, therefore, it is not preferable.
- Provider-referral - the physician agrees to notify partners following CDC guidelines.

If the client agrees to have a DIS contact his/her partners, he/she voluntarily discloses information to aid in locating them. The DIS then confidentially locates and counsels partners regarding their possible exposure to HIV and provides HIV counseling, testing and referral services. During the process, the identity of the original patient is never revealed, nor are the gender, type of exposure, or exposure dates.

The CDC released revised recommendations for Partner Services in November, 2008 and Louisiana's policies and protocols have been updated in response to these new recommendations. (www.cdc.gov/nchhstp/partners/Recommendations.html)



- In 2009, 1,449 persons were referred to DIS for HPS, 834 of whom were interviewed (58%).
- From the 834 HIV-infected persons who were interviewed, a total of 842 partners were identified who may have been exposed to HIV. This resulted in 360 partners being tested, 73 (20%) of whom were positive.
- There has been a major increase in the number of persons interviewed since 2001, when 31% of persons were interviewed, compared to 58% in 2009. DIS often have trouble locating persons who are referred to them because individuals have moved, disconnected phone lines, provided incorrect addresses when they received their HIV test, or are homeless. People may also refuse assistance from DIS and, therefore, will not be interviewed. Future projects look to increase the interview percentage in the coming years.
- The percentage of persons who newly tested positive in the partner-identified group has ranged from 10% to 23% during the last eight years.

Outreach to High-Risk Individuals

What does HAP do? *Contracts with CBOs to conduct holistic outreach to high-risk individuals and persons living with HIV infection.*

Area covered: *Statewide*

Outreach, a community-level intervention and one of HAP's most important prevention activities, occurs on the street and/or in community settings rather than at clinics or agency offices. Over the last two years, a new model of outreach has begun to be implemented in Louisiana based on the health agent model utilized in Brazil.[29] The Brazilian model of outreach involves conducting an in-depth assessment of a community (including high-risk areas, current services, and locations where high-risk individuals congregate); developing deeper relationships with residents; and connecting them to needed services.

The goal of outreach is to:

- develop ongoing relationships with target area residents/visitors to provide information and referrals that will promote healthy behaviors and reduce the risk of acquiring or transmitting HIV and other STDs;
- connect agencies providing services to residents who need them; and
- develop collaborations with other HIV providers and other social service agencies to establish holistic referral networks.

The priority target populations for HIV outreach have been determined using HIV and STD surveillance information, CDC guidelines, and the community-based planning process. Outreach is concentrated among priority populations which include:

- persons infected with HIV
- men who have sex with men
- high-risk heterosexuals
- injection drug users
- special populations (homeless, migrant workers, people with Hepatitis C, youth, transgender, incarcerated/newly released)
- women with or at risk for HIV infection

Outreach and referral are conducted in fixed and active sites and consists of one-on-one interactions with individuals from targeted populations. Information and referrals are offered during outreach to promote healthy behaviors and reduce the risk of acquiring or transmitting HIV and other STDs.

The CDC has developed a *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* to aid in the design and implementation of HIV prevention activities.[30] The Prevention Unit utilizes several of these interventions and oversees one peer program: MPowerment. MPowerment is a community level intervention for young men who have sex with men (ages 18-29). MPowerment uses a combination of outreach, discussion groups, social interactions, and social marketing to mobilize men to reduce sexual risk taking, encourage regular HIV testing, build positive social connections and support peers to have safer sex. The state contracts with agencies statewide to implement this and other strategies to target high-risk individuals.

On a yearly basis, a subsample of individuals is surveyed in the areas where outreach is conducted. Below are some of the highlights of the 2010 survey where a total of 1,178 persons participated.

Outreach Survey Results
Louisiana, 2010

	Percent
Sex	
Female	36%
Male	60%
Race/Ethnicity	
Black/African American	77%
Hispanic	2%
White	23%
2+ Partners in Prior 12 Months	
Males Reporting	56%
Females Reporting	32%
Condom Use	
Always	33%
Rarely or Never	22%
Used Condom at Last Sex	51%
Did Not Use Condom While Drunk or High	25%
Condom Availability	
Aware of Location of No-Cost Condoms	85%
Available at Home	71%
Bought Last Condom Used	23%
HIV Testing History	
Ever Tested	70%
Tested in Last 12 Months	60%
Had Contact with Outreach Worker in Last 6 Months	71%

- Blacks and males accounted for the overwhelming majority surveyed through outreach.
- More males than females reported having multiple sex partners in the last 12 months.
- 22% of participants responded that they “Rarely or Never” used a condom and that 49% did not use a condom the last time they engaged in sex despite the fact that 85% indicated they knew where to get a free condom.
- 70% of participants reported being previously tested for HIV.

Prevention with HIV-Positive Persons

What does HAP do? *Provide programs that assist HIV-positive persons in becoming educated about HIV, encouraging them to enter or stay connected to care and overcome barriers that inhibit healthy decision making and risk reduction. Additionally, it helps HIV-positive persons who are at high risk for HIV transmission or other STD acquisition to reduce risk behaviors and address the psychosocial and medical issues that contribute to risk behavior or poor health outcomes.*

Area covered: *Statewide*

The CDC has prioritized HIV-positive individuals as the number one target population for prevention. In Louisiana, several interventions are implemented for this population: Project AYA, risk management, Partnership for Health, and Consumers Advocating for Consumers (CACs).

Project AYA is a small group interactive health education intervention implemented by and for HIV-positive African American women. AYA is a six-week curriculum that includes information on the initiation and maintenance of healthy behaviors, understanding of the disease process, identifying self-defeating attitudes and behaviors, improving self-esteem and awareness, enhancing communication skills, building skills to maintain healthy decision-making and understanding risky behavior and its consequences.

Risk Management, based on CDC's Comprehensive Risk Counseling and Services (CRCS) intervention, is an individual-level intervention designed to help HIV-positive persons who are at high risk for HIV transmission to reduce risk behaviors and common co-factors affecting HIV risk such as STD acquisition, substance abuse and use, physical and mental health and social and cultural factors.

Partnership for Health (PfH), is a safer-sex intervention in HIV clinics, using message framing, repetition, and reinforcement during patient visits to increase HIV-positive patients' knowledge, skills, and motivations to practice safer sex. The program is designed to improve patient-provider communication about safer sex, disclosure of HIV serostatus, and HIV prevention.

Consumers Advocating for Consumers (CAC) are regional peer-based education and support groups for HIV-positive persons.

The table on the next page shows results from a 2009 baseline survey of HIV-positive persons participating in the above interventions and emphasizes the need for these programs.

- Stigma among HIV-positive persons continues to be an issue. The majority (52%) *always or most of the time* found it difficult to talk about their HIV status with most people.
- Prevention with HIV-positive people should focus on reducing high-risk sexual behavior:
  - 35% did not use a condom the last time they had anal or vaginal sex
  - 66% did not use a condom the last time they had oral sex
  - 23% had been diagnosed with an STD in the past 3 months.

Baseline Survey of HIV-Positive Persons Louisiana, 2009			
	Number Responding	**Number answering "YES"**	**Percent answering "YES"**
It's *always or most of the time* hard for me to tell my sexual partners about my HIV status	276	77	27.9%
I *always or most of the time* find it difficult to talk about my HIV status with most people	286	148	51.8%
Since becoming HIV positive, I *always or most of the time* feel less comfortable spending time with other people	286	86	30.1%
In the last 3 months, I've had one or more sex partners	274	138	50.4%
I did *NOT* use a condom the last time I had anal or vaginal sex	184	65	35.3%
I did *NOT* use a condom the last time I had oral sex	175	115	65.7%
My most recent sex partner did not know my HIV status	171	54	31.6%
In the last 3 months I had sex with partners whose HIV status I didn't know and did *NOT* use a condom	186	25	13.4%
In the last 3 months, I've been diagnosed with a STD	274	64	23.4%
In the last 3 months, I've used injection drugs	277	17	6.1%
If Yes, shared a needle when using injection drugs	17	4	23.5%

Public Information and Prevention Materials Distribution

What does HAP do? *Provide information to the public on STDs/HIV/Hepatitis and provide materials that support STD/HIV prevention.*

Area covered: *Statewide*

The Prevention Unit coordinates the operation of the Louisiana HIV/STD Infoline (1-800-99-AIDS-9/992-4379) and the HIV411.org website. The Infoline, which received over 600 calls last year, provides general information about HIV, other STDs, Hepatitis and TB as well as referrals to HIV/STD testing, case management, and other services. Callers are from around the state with 42% from the New Orleans area and 57% of callers are black. The HIV411.org website, which provides population specific information, a referral search engine, and updates on events statewide, had over 24,000 page views and over 8,000 visitors (over half of whom utilized the referral search engine) in 2010. The Prevention Unit also coordinates the distribution of prevention materials and distributed over 150,000 brochures (7,500 of these in Spanish) on a variety of HIV, STD and Hepatitis topics, and over 8 million no-cost condoms through 900 sites statewide.

Public Awareness

What does HAP do? *Increase the awareness of Louisiana residents on the impact of STDs and HIV in Louisiana and services available to them.*

Area covered: *Statewide*

The Prevention Unit works with its partners to raise awareness of STDs and HIV throughout the state by the observance of national HIV awareness days; large scale testing events; and special displays and activities.

In 2010, the Prevention Unit participated in National Counseling and Testing Day; Black AIDS Awareness Day; Latino AIDS Awareness Day; World AIDS Day; and the Kaiser We Are Greater Than AIDS Campaign targeting African Americans; and in collaboration with the Black AIDS Institute, Orasure Technologies and Alere, conducted a statewide testing tour with stops in Shreveport, Alexandria, Lake Charles, Opelousas, Baton Rouge and New Orleans. The Prevention Unit also collaborated with the United Methodist Church at their statewide conference in Shreveport to offer HIV education, an exhibit of the Crowns of Glory, tours of clinics and HIV testing. The Bishop received an HIV test to emphasize the ease and importance of HIV testing to his members.

Event-Based Testing has as its goals, increasing awareness and decreasing stigma of HIV among African Americans, increasing awareness and acceptance of HIV testing, and increasing knowledge of prevention of HIV transmission. In 2010, HAP participated in a larger, national campaign entitled 'WE>AIDS'. The Official Farm Bayou Classic Health Fair, an annual event on Thanksgiving weekend, was a collaboration between HAP, Bickers Staff Group (BSG), the Kaiser Family Foundation, and Orasure Technologies Inc. State and national press conferences promoted the Health Fair and HIV testing on the internet, television and in newspapers. During one day at the Bayou Classic, 197 people received an HIV test.

The Health Fair not only included HIV testing but also blood pressure and glucose screenings as part of the strategy to help reduce the stigma associated with HIV testing. Almost half of the participants surveyed at the event completed the other health screenings. All participants said they would recommend others to get tested and 100% would come back to the Bayou Classic HIV Testing Event next year. The Essence Music Festival, which takes place 4th of July weekend in New Orleans, was another successful testing collaboration with the Black AIDS Institute and nearly 700 people were tested for HIV in three days.

Crowns of Glory: Honoring African American Women Impacted by HIV, an ongoing project and traveling display, was established as a result of the huge impact HIV has had on African American women in Louisiana and a desire to increase the public's awareness of this issue and honor the women lost to the epidemic. The exhibit is a group of over 30 hats honoring African American women who have been lost to the AIDS epidemic or are living with HIV infection. The project strives to strip away the stigma and silence and tell the stories of these women who often had to call on inner strength to survive when they were rejected by those around them. Each hat, created by family, friends or communities, represents an individual woman or the women in a city or region of Louisiana.

Winds of Change: Bringing Knowledge and Sweeping Away Ignorance, is the culmination of a statewide competition to design hand fans to raise awareness of the importance of HIV testing among African Americans. Two winning designs were chosen and fans are produced and distributed at community events and churches to encourage HIV testing and awareness of one's status.

Programs Targeting Special Populations
What does HAP do? Target increased efforts at populations of special interest.
Area covered: Statewide

The Prevention Unit coordinates a number of programs that have target populations of special interest because of the disproportionate impact the epidemic is having on them or the need for special emphasis to adequately reach them. Currently, these populations include Latinos, pregnant women, African Americans, and men who have sex with men (MSM).

Reaching Louisiana's growing Latino population: Following Hurricanes Katrina and Rita, HAP established the Latino Outreach Program. This program, which began providing direct CTRS and outreach to Latinos in New Orleans, now provides technical assistance and capacity building to community-based agencies and clinics across the state to expand services to reach Latinos.

Preventing mother-to-child transmission of HIV (perinatal transmission): Since its inception in early 2000, the Perinatal HIV Prevention Program in Louisiana has made great strides in bringing the perinatal infection rate down from 4.5% in 2000 to less than 2% from 2006-2008. To move towards the elimination of perinatal HIV infection in Louisiana, HAP has undertaken two initiatives:

- Promoting routine, universal HIV screening of pregnant women on an opt-out basis and repeat HIV testing in the third trimester and
- Ensuring that appropriate HIV prevention counseling and therapies are provided for HIV-infected women to reduce the risk of perinatal transmission.

HAP has worked to ensure that women of child-bearing age are encouraged to be tested. This has been achieved through the continued implementation of routine HIV screening in STD clinics, prenatal clinics, family planning clinics, LSU hospital emergency rooms, and CTRLS through CBOs. Women who are HIV-positive are referred to medical care and other support services. These referrals are followed-up to ensure successful connections with the appropriate services. In addition to modifying legislation in 2007 to mandate the provision of "opt-out" testing for pregnant women, HAP has also partnered with health care providers to promote HIV screening of pregnant women through mailings to all OB/GYNS with the American College of Obstetricians and Gynecologists that includes detailed information about preventing perinatal HIV transmission.

Cutting Out Stigma - The Louisiana Stylist Initiative 2010: The Louisiana Stylist Initiative, targeting primarily African American women, utilizes the significant role salons play in black women's lives, a major source of support and community. This project, utilizing trained stylists, combines health education and the promotion of lifestyle modification, such as reducing risky behavior, increasing acceptance of HIV testing, encouraging screening and referrals in a culturally-based community setting - the hair salon.

Promoting total wellness among gay and bisexual men: The goal of the Louisiana Wellness Center Project is to prevent HIV and STD transmission among gay men and transgender individuals by offering holistic health and wellness services in a safe and welcoming environment. The project's pilot site, the Monroe Gay Men's Wellness Center (MGMWC), opened in Monroe, Louisiana in July, 2009 and is a collaboration among the state of Louisiana's HIV, STD, and Hepatitis programs and GO CARE, a non-profit AIDS service organization. The project functions as a bridge between existing resources in the community and those who are in need of those services. The aim is to engage members of the target population in the process of improving their overall well-being. During 2009, the MGMWC provided STD and HIV screening as well as mental health and substance abuse screenings and referrals to services. Additional programming included smoking cessation, community lead spiritual services, support groups, and safer sex discussions. Of those served, approximately 40% had no health insurance, 40% of the clients said they had not used a condom the last time they had sex, and approximately a quarter had sex with two or more partners in the

past three months. The psychosocial characteristics of the clients are described in the table below and demonstrate a need for mental health and substance use interventions.

Psychosocial Characteristics of Wellness Center Clients at Intake
Louisiana, 2009

	Percent Answering "YES"
Total (N=25)	**100%**
Currently Smoke	64%
Had 5 or More Drinks on the Same Occasion, 2x in the Last Month	77%
Used Drugs in the Past Year	12%
Been Physically, Verbally or Emotionally Abused in the Past Year	20%
Ever Attempted Suicide	8%
Ever Diagnosed with Depression	32%
Ever Diagnosed with Anxiety	20%
Ever Diagnosed with Depression/Anxiety	16%
Ever Diagnosed with Bipolar Disorder	12%
Ever Diagnosed with an Eating Disorder	12%

What are the Current CDC Testing Guidelines?

In 2006, the CDC released *"Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings."* The CDC and the U.S. Preventive Services Task Force recommends that screening for HIV should be performed routinely for all patients aged 13-64 years; all patients initiating treatment for TB should be screened routinely for HIV; all patients seeking treatment for STDs should be screened routinely for HIV during each visit for a new complaint; and all pregnant women should be screened, regardless of risk. The goal of these recommendations is to increase the number of HIV-positive persons who know their HIV status.

Louisiana responded to these recommendations in 2007 with House Bill 512, now signed into Louisiana's Revised Statue Chapter 40, sections 1300.12-13. Louisiana's HIV testing and counseling legislation now stipulates:

- HIV diagnostic testing offered as a routine medical screening will now be "opt-out" in certain settings such as hospital emergency rooms, STD clinics, correctional facilities, and drug treatment programs. This means persons certified to offer HIV tests will inform the person that an HIV test will be performed unless the patient refuses. If the patient decides to "opt out," it will be recorded in their medical record.
- The legislation now also stipulates that the opt-out testing can take place in healthcare settings, substance abuse treatment facilities, mental health treatment facilities, and correctional settings. Community-based settings must follow all of HAP's protocols.
- Opt-out testing will also be performed on all women who are pregnant.
- Physicians have the option of testing newborns who they feel are at high risk of having been exposed to HIV and whose mother does not have an HIV test result on record.
- Anyone receiving a positive HIV antibody test must be referred to follow-up medical services.

This expansion of legal authority allows Louisiana to further focus and expand HIV testing initiatives. The statutory changes also led to a complete revision of HAP's *Prevention Policies and Procedure Manual* detailing protocols, methods, and reporting requirements for all testing sites across the state. There are ongoing training programs for all persons involved in HIV testing.

Prevention Challenges and Accomplishments

Accomplishments

- Collaborated with the Louisiana Department of Corrections to complete implementation of HIV testing as a routine part of medical care for all incoming inmates.
- Maintained rapid testing to LSU hospital emergency rooms, Orleans Parish Prison, Jefferson Parish Prison, and added new partnerships with community clinics, colleges, and universities.
- Expanded the implementation of holistic outreach and developed a comprehensive referral documentation and follow-up protocol.
- Established wellness center targeting MSMs and transgender individuals in Monroe.
- Conducted two successful large-scale testing events at the Essence Music Festival and Bayou Classic football game.
- Competed for and was awarded over $2 million dollars from the CDC to expand testing and increase linkage to care.
- Partnered with the Louisiana Community AIDS Partnership in a successful five year grant from the National AIDS Fund and Bristol-Myers Squibb to increase linkage to care and reconnecting of persons out of care.
- Awarded a grant for 5 AmeriCorps members focused on HIV prevention from AIDS United.

Challenges

- The continued promotion of HIV testing as a routine part of medical care for all persons 13-64 years of age.
- Although the continued promotion and maintenance of HIV screening as a routine part of medical care has proven to be a successful prevention strategy, maintaining and identifying funding to sustain and/or expand testing to additional healthcare venues continues to be a challenge.
- Addressing the issue of stigma which impacts an individual's perception of risk and testing behaviors, as well as accessing medical care for persons living with HIV infection.
- Current funding levels are not sufficient to adequately scale up successful efforts to reach the goals set forth in the National HIV/AIDS Strategy.
- Identifying community-based providers with expertise to access the hardest to reach populations including men who have sex with men, African American males, and HIV-positive persons not in primary medical care and other supportive services such as case management.

Chapter 4

Evaluation

Introduction to the Evaluation Unit

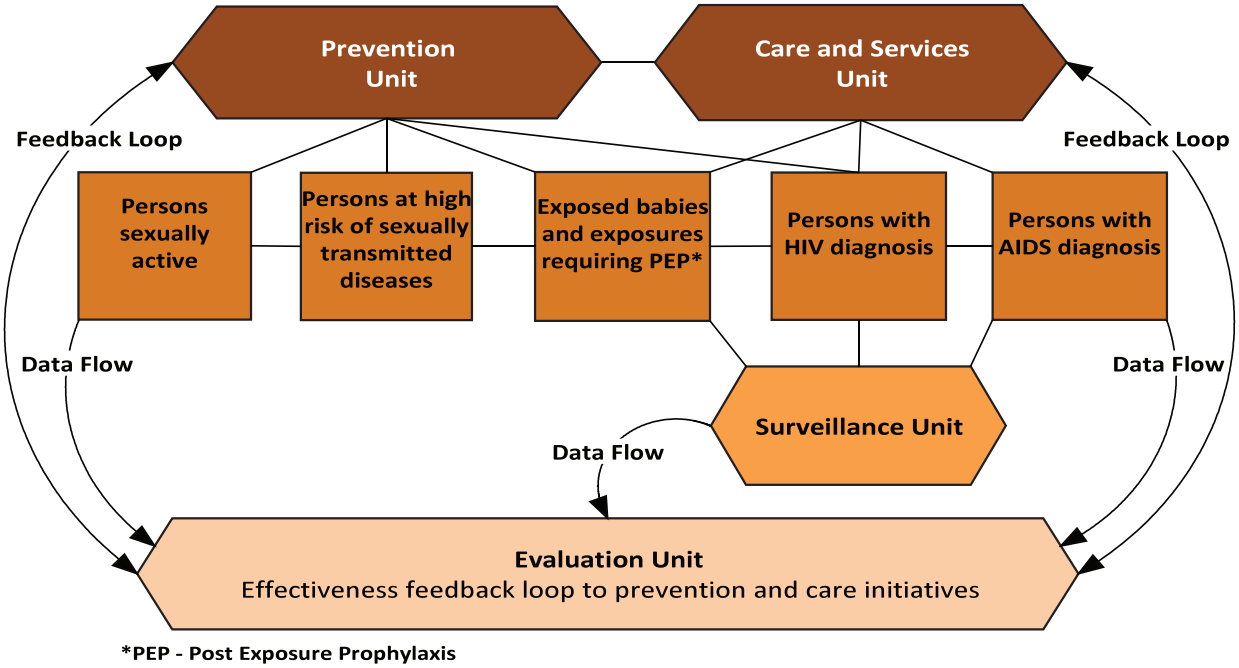
The Louisiana Office of Public Health HIV/AIDS Program (HAP) Evaluation Unit collaborates with HAP's Prevention, Services, and Surveillance Units to review program activities, measure program effectiveness, and continually apply these results for program improvement. The Evaluation Unit assists with the creation of evaluation plans for each program, the design of data collection protocols, and the training of staff regarding evaluation techniques and principles. The Evaluation Unit conducts the following types of evaluation activities:

Evaluation Activities Louisiana HAP Office	
Formative Research	**What have we learned in the past and how can we design a program to best address the needs of the population?** • Review existing research • Assist with designing intervention • Develop data collection forms • Gather data in the early stages of the intervention or program Implementation
Process Monitoring	**What services were delivered and what populations were served?** • Review program activities • Determine the populations served • Determine the services provided • Analyze trends to inform program planners
Process Evaluation	**Were the programs implemented as intended and did they reach the intended population?** • Assess planned versus actual program performance over a period of time for the purpose of program improvement and future planning
Outcome Monitoring	**Did the expected outcomes occur?** • Collect and summarize outcome data • Review program-associated outcomes in order to determine the extent to which program objectives are being met
Outcome Evaluation	**Did the intervention cause the expected outcomes?** • Collect data before and after an intervention (or from persons who had an intervention, and those who did not) • Determine whether behaviors, attitudes, or health outcomes changed as a result of the intervention
Impact Evaluation	**What long-term effects did the program or intervention have on HIV infection?** • Examine trends in new HIV diagnosis, health status, morbidity, and mortality of HIV-infected persons

*Modified from CDC's NHM&E Workshop "Evaluation Terms, Explanations, and Sample Questions"

Where and how are evaluation data obtained?

The Evaluation Unit oversees the National HIV Behavioral Surveillance (NHBS) project, the Continuous Quality Improvement (CQI) activities, and collects and summarizes data from the Prevention, Care and Services, and Surveillance Units of HAP. Data for some programs are collected by HAP staff, but HAP also relies on service providers throughout the state to collect and submit process-level data to HAP on an on-going basis. The figure below provides a graphic model of the data exchange between the HAP units, and the populations served by HAP programs.



Evaluation of Prevention Interventions

The Prevention Unit funds HIV counseling, testing and referral services; contacts partners of HIV-infected persons for education, testing and referral; and implements targeted prevention activities through its sub-contractors. In 2009, HAP funded 28 contracts to 16 community-based organizations (CBOs) to implement CDC-approved interventions across Louisiana. Interventions were targeted to groups identified as high-risk, including men who have sex with men (MSM), high-risk heterosexuals, in particular black and Latino persons who engage in high-risk behaviors. Evaluation data collected for prevention programs include client-level data on HIV-testing sessions, referrals, partner services, and small group session attendance, and aggregate-level data on outreach activities. The process and outcome measures for selected prevention interventions that are monitored on an ongoing basis are shown in the table on the following page.

Evaluation of Prevention Interventions	
Program	**Process and Outcome Measures**
HIV Counseling, Testing and Referral Services	• Number of HIV tests conducted annually and percent seropositive • Percentage of clients who receive their test results • Percentage of HIV-negative clients who receive an appropriate referral to needed services • Percentage of HIV-positive clients who receive an appropriate referral to HIV medical care and other needed services and the percentage who access HIV medical care
HIV Partner Services	• Percentage of newly-diagnosed persons who are interviewed by a Disease Intervention Specialist • Percentage of persons interviewed who name at least one partner • Percentage of named partners who receive an HIV test • Number of new HIV positive persons identified through HIV Partner Services
Outreach and Referral	• Number of referrals made during outreach and the percentage of referrals that were successfully accessed

In 2009, the Evaluation Unit also completed special projects which enhanced prevention activities. Some of these projects included:

- Evaluating the organizational capacity of CBOs
- Evaluating the cultural competency of CBOs and HAP staff
- Evaluating the process for making medical and non-medical referrals
- Evaluating health fairs and public events, including events for Hispanic/Latinos
- Evaluating a needs assessment for MSM throughout the state
- Evaluating an MSM Wellness Center in Monroe, Louisiana

Evaluation of Care and Services

The major goals for evaluation of care and services for persons living with HIV infection include:

- Evaluating and revising care systems to meet emerging needs
- Ensuring access to quality HIV care
- Evaluating the impact of Ryan White program funds

Evaluating and revising care systems to meet emerging needs

The Evaluation and Care and Services Units routinely review data collected by each contracted agency to ensure contract objectives are being met. In 2009, the Care and Services Unit provided 30 contracts to 21 organizations in Louisiana for care and treatment services, including primary medical care; assistance in obtaining HIV medications; oral health care; medical case management; support services, such as medical transportation, nutritional services, and emergency assistance; legal services; and short-term and tenant-based housing assistance. Each of these contracts specified process and outcome reporting requirements for all services provided. HAP staff also continuously assess the overall service needs of persons living with HIV/AIDS and modify systems as needed to improve service delivery. For example, following extensive review of ADAP service utilization and expenditure data, as well as collecting the projected number of persons living with HIV infection who did not qualify for ADAP due to income (more than 200% of the federal poverty level), but who may benefit from receiving ADAP-funded medications, HAP implemented a significant systems change by increasing ADAP's eligibility criteria to 300% poverty level.

A significant evaluation component for the Care and Services Unit was the implementation of the Continuous Quality Improvement (CQI) plan. The CQI Steering Committee meets routinely to review quarterly services data and make recommendations for performance improvement. Participation is statewide and among all Ryan White Parts. In addition three CQI subcommittees were established to assess existing systems of care, determining quality of services, and recommend activities that would improve access, increase utilization and enhance quality.

Oral Health CQI Subcommittee: To address the lack of data on clients' dental needs and experiences, the HAP Oral Health CQI Subcommittee designed and implemented a survey in 2008 and 2009. All Part B-funded case managers and several Part A/TGA providers administered this survey to over 2000 clients in 2008 and 2009. Some of the key findings show marked improvement from 2008 to 2009: the percent of respondents who had visited a dentist during the past year increased from 49% to 56% and the percent who were "very satisfied" with their last dental visit increased from 56% to 61%. A major barrier, "not knowing where to find dental care" decreased from 24% to 12%. However, the percentages for the two primary barriers, not affordable and lack of transportation, increased. In order to emphasize the importance of oral health care, oral hygiene kits were also distributed to the respondents.

Mental Health/Substance Abuse (MH/SA) Services Subcommittee: In 2009, this subcommittee revised the primary assessment tool used to capture clients' MH/SA needs. The MH/SA Screening Tool is now more accurate and efficient and better able to capture referrals. In 2009, 98% of all clients newly enrolled in case management received the MH/SA Screening Tool at intake. The HAP CQI goal is to have 100% of all newly enrolled clients screened using the tool and then receive the appropriate referrals. Also, in the fall of 2009, an improved system was developed to document referrals. Besides documenting the referral on the MH/SA Screening Tool, the case manager enters the referral and referral follow-up information in CAREWare.

Many of the primary medical care quality management activities and outcomes data are collected by the Louisiana State University Health Care Services Division (LSU HCSD) public hospital system and shared with the CQI Steering Committee. Consistently, clinical quality indicators at these regional medical centers meet or exceed the USPHS guidelines for those persons living with HIV infection.

Medications Access Subcommittee: In 2009, HAP decided to combine its Health Insurance Continuation Program (HICP) and the Co-payment and Deductible Assistance Program (CDAP) into one, comprehensive, uniform, and statewide program. The Subcommittee conducted formative research by interviewing the representatives of eleven state Ryan White-funded HIV Insurance Programs in the country. In addition, the ADAP Coordinator and a public health graduate student conducted a Health Insurance Continuation Program Survey. The purpose of this survey was twofold:

1. Identify barriers to care (strength and weaknesses) related to the current health insurance assistance services provided through HICP and CDAP;
2. Recommend strategies to improve future program guidelines, policies, and service delivery mechanisms for future Ryan White Part B health insurance services.

The survey identified the most significant barrier for both HICP and CDAP—application completion requirements. As a result the application was shortened and revised to cover both HICP and CDAP.

Besides working on the issues described above, the Medications Access Subcommittee conducted a survey among all Part A and Part B CBOs on medication adherence counseling/services provided at each CBO. The findings indicated that of the 16 CBOs surveyed, 15 provide medication adherence counseling, primarily offered by case managers. Several case managers requested materials and training regarding adherence counseling and the Medications Access Subcommittee has acted on these recommendations. In March 2010, the Case Management Coordinator facilitated a day-long training on medication adherence counseling for all Part B case managers, which was conducted by experts in the field.

Ensuring access to quality HIV care

The primary focus of Part B Medical Case Management and Ryan White-funded supportive services is to facilitate access to and retention in care. Programmatic objectives are tied to improving the timeliness and effectiveness with which a newly identified person can be enrolled and maintained in medical care and case management with the theory that persons fully engaged in routine care will experience fewer medical complications and a slower immune system decline. The Evaluation and Surveillance Units review laboratory data to routinely monitor whether persons living with HIV infection are accessing primary medical care. Persons who do not have at least one primary medical care visit in a 12-month period are considered to have "unmet need." Persons who have at least one CD4 or viral load test result in a calendar year are considered to be "in care," and those who do not are considered to be "out of care." Historically, an estimated 40-55% of the population living with HIV infection in Louisiana appears to be "out of care" when using this annual unmet need indicator. In 2009, the percent of persons with unmet need dropped to 38%.

Another concern is that persons enter the care system much too late and in a state of physical decline. In 2009, 24% of newly identified persons living with HIV infection received an AIDS diagnosis simultaneously with their HIV diagnosis, and an additional 7% progressed to AIDS within six months of their HIV diagnosis. The 2009 HIV surveillance data of newly diagnosed persons were also analyzed in order to determine the percentage of those who entered care within 3 months of diagnosis. The overall percentage of those entering care within 3 months was 70%.

Evaluating the impact of Ryan White Program funds

The Evaluation Unit routinely reviews program indicators in order to evaluate the impact of Ryan White program funds on the health status of persons living with HIV infection. These include reviewing trends in new AIDS diagnoses, late diagnosis of HIV, and mortality. In April 2009, HAP developed four additional indicators as part of a HRSA Performance Review that will be updated on an annual basis. The indicators include both process and outcome measures.

- Percentage of HIV-infected persons receiving Louisiana Ryan White Part B services who had two or more CD4 T-cell counts (>90 days apart) performed in the measurement year.
  - In 2009, 71% of all HIV–infected persons receiving Ryan White Part B services had two or more CD4 counts, > 90 days apart.
- Percentage of HIV-infected persons newly enrolled in Louisiana Ryan White Part B (HAP)-funded case management in the measurement year who had a care plan completed within 30 days following initial assessment.
  - In 2009, 99% of all HIV-infected persons newly enrolled in Ryan White Part B case management had completed a care plan within 30 days.
- Percentage of HIV-infected persons newly enrolled in HAP-funded case management services in the measurement year who received a mental health/substance use screening upon intake.
  - In 2009, 98% of all HIV-infected persons newly enrolled in case management had a MH/SA screening upon intake.
- Percentage of HIV-infected persons newly enrolled in Louisiana ADAP in the measurement year who had at least one viral load (VL) result of <400 within the 12 months after ADAP enrollment.
  - In 2008, 75% of all HIV-infected persons newly enrolled in Louisiana ADAP had at least one VL <400 within 12 months after ADAP enrollment. (*2009 data not yet available*).

Chapter 5

Appendices

The appendix contains additional tables relevant to the Surveillance chapter of this report, Chapter 1. Immediately following the tables are the Technical Notes.

Included Tables

Trends in HIV Infection, Louisiana, 1979-2009

- This table includes the number of HIV Diagnoses, AIDS Diagnoses, Persons Living with HIV Infection, and Deaths in Persons with HIV Infection from 1979 to 2009.

New HIV Diagnoses by Region and Year, Louisiana, 2000-2009

- This table includes the number of New HIV Diagnoses from 2000 to 2009, for each of the nine public health regions in Louisiana.

New AIDS Diagnoses by Region and Year, Louisiana, 2000-2009

- This table includes the number of New AIDS Diagnoses from 2000 to 2009, for each of the nine public health regions in Louisiana.

Geographic Distribution of HIV in Louisiana, 2009

- This two page long table includes new AIDS Diagnoses in 2009, HIV Diagnoses in 2009, HIV Diagnosis Rate in 2009, Persons Living with HIV Infection in 2009, and Deaths in Persons Living with HIV Infection in 2008 for each of the nine public health regions and the 64 parishes of Louisiana.

Deaths among Persons with HIV Infection, Louisiana, 2008

- This table contains the demographic breakdown of Persons with HIV Infection who died in 2008 in Louisiana.

Trends in HIV Infection Louisiana, 1979-2009				
Year	**New HIV Diagnoses**	**New AIDS Diagnoses**	**Persons Living with HIV Infection**	**Deaths**
1979	1	1	1	0
1980	1	1	1	1
1981	5	0	7	0
1982	17	10	22	3
1983	58	27	70	15
1984	146	84	187	36
1985	384	151	498	100
1986	484	242	852	158
1987	756	417	1,391	244
1988	781	450	1,954	292
1989	1,040	613	2,638	429
1990	1,211	709	3,466	436
1991	1,558	936	4,568	542
1992	1,756	1,065	5,698	678
1993	1,716	1,135	6,726	768
1994	1,656	1,104	7,653	821
1995	1,496	1,043	8,330	905
1996	1,526	1,128	9,144	787
1997	1,528	946	10,213	558
1998	1,282	847	11,097	524
1999	1,256	790	11,555	496
2000	1,194	821	12,805	511
2001	1,149	888	13,502	562
2002	1,191	971	14,260	519
2003	1,061	890	14,848	552
2004	1,064	861	15,680	528
2005	972	806	14,292	520
2006	993	769	14,817	524
2007	1,087	809	15,441	501
2008	1,095	860	16,084	467
2009	1,242	860	17,155	*

*Data are not complete

New HIV Trends by Region and Year Louisiana, 2000-2009										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Louisiana	1,194	1,149	1,191	1,061	1,064	972	993	1,087	1,095	1,242
1-New Orleans	496	477	446	418	440	322	250	325	356	393
2-Baton Rouge	298	302	312	250	251	272	305	314	297	312
3-Houma	41	30	36	35	27	34	38	45	43	40
4-Lafayette	86	67	91	97	75	77	72	67	75	90
5-Lake Charles	48	46	53	40	38	42	40	53	55	53
6-Alexandria	55	59	61	41	46	38	50	44	49	65
7-Shreveport	63	77	73	74	86	69	96	115	106	123
8-Monroe	55	62	75	56	62	61	83	74	52	76
9-Hammond/Slidell	52	29	44	50	39	57	59	50	62	90

New AIDS Trends by Region and Year Louisiana, 2000-2009										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Louisiana	**821**	**888**	**969**	**889**	**862**	**806**	**765**	**792**	**843**	**798**
1-New Orleans	347	380	358	345	350	268	224	259	268	240
2-Baton Rouge	233	240	278	237	216	200	224	217	250	201
3-Houma	34	30	33	35	27	29	42	31	32	33
4-Lafayette	50	42	77	57	56	66	65	57	62	51
5-Lake Charles	28	36	39	47	42	38	35	39	37	43
6-Alexandria	34	34	37	35	39	30	30	32	36	41
7-Shreveport	45	57	59	49	59	73	52	78	78	81
8-Monroe	25	43	53	44	45	57	48	38	40	56
9-Hammond/Slidell	25	26	35	40	28	45	45	41	40	52

Geographic Distribution of HIV Louisiana, 2009						
Region	**Parish**	**AIDS Diagnoses in 2009***	**HIV Diagnoses in 2009**	**HIV Diagnosis Rate 2009****	**Persons Living with HIV Infection 2009**	**Deaths 2008**
Statewide		**798**	**1,242**	**28**	**17,155**	**467**
Region 1		**240**	**393**	**46**	**6,106**	**115**
	Jefferson	69	126	28	1,590	26
	Orleans	166	262	74	4,379	88
	Plaquemines	1	0	0	30	0
	St. Bernard	4	5	12	107	1
Region 2		**201**	**312**	**48**	**4,191**	**148**
	Ascension	9	19	18	174	3
	East Baton Rouge	167	250	58	3,248	126
	East Feliciana	3	7	33	146	2
	Iberville	12	19	58	327	3
	Pointe Coupee	2	3	n/a	45	4
	West Baton Rouge	5	9	40	107	4
	West Feliciana	3	5	33	144	6
Region 3		**33**	**40**	**10**	**624**	**12**
	Assumption	1	3	n/a	21	2
	Lafourche	4	3	n/a	96	1
	St. Charles	5	5	10	82	3
	St. James	5	12	57	60	0
	St. John the Baptist	4	6	13	105	2
	St. Mary	5	2	n/a	78	0
	Terrebonne	9	9	8	182	4
Region 4		**51**	**90**	**16**	**1,251**	**42**
	Acadia	4	10	7	87	5
	Evangeline	2	5	6	53	5
	Iberia	1	6	1	100	5
	Lafayette	22	36	10	602	14
	St. Landry	16	21	17	233	11
	St. Martin	4	5	8	96	0
	Vermilion	2	7	4	80	2
Region 5		**43**	**53**	**19**	**926**	**21**
	Allen	6	4	n/a	234	0
	Beauregard	1	2	n/a	38	0
	Calcasieu	31	42	22	598	18
	Cameron	0	0	0	5	0
	Jefferson Davis	5	5	16	51	3

Geographic Distribution of HIV
Louisiana, 2009

Region	Parish	AIDS Diagnoses in 2009*	HIV Diagnoses in 2009	HIV Diagnosis Rate 2009**	Persons Living with HIV Infection 2009	Deaths 2008
Statewide		**798**	**1,242**	**28**	**17,155**	**467**
Region 6		**41**	**65**	**22**	**785**	**20**
	Avoyelles	5	6	14	152	3
	Catahoula	0	0	0	24	1
	Concordia	3	3	n/a	37	0
	Grant	2	4	n/a	28	2
	La Salle	3	9	64	19	0
	Rapides	21	34	25	393	11
	Vernon	1	5	11	46	1
	Winn	6	4	n/a	81	2
Region 7		**81**	**123**	**23**	**1,384**	**58**
	Bienville	0	0	0	30	0
	Bossier	11	14	13	157	6
	Caddo	54	85	34	898	42
	Claiborne	4	4	n/a	70	2
	De Soto	3	2	n/a	52	1
	Natchitoches	7	9	23	96	5
	Red River	0	0	0	8	0
	Sabine	0	1	n/a	22	1
	Webster	2	8	20	51	1
Region 8		**56**	**76**	**22**	**940**	**31**
	Caldwell	1	1	n/a	18	0
	East Carroll	2	4	n/a	38	3
	Franklin	2	3	n/a	27	1
	Jackson	1	2	n/a	36	2
	Lincoln	4	8	18	59	1
	Madison	6	6	53	57	2
	Morehouse	5	8	28	58	3
	Ouachita	26	35	23	522	13
	Richland	3	1	n/a	39	2
	Tensas	0	0	0	35	2
	Union	2	3	n/a	40	1
	West Carroll	4	5	44	11	1
Region 9		**52**	**90**	**17**	**953**	**20**
	Livingston	12	20	16	145	6
	St. Helena	1	1	n/a	17	0
	St. Tammany	12	20	9	334	5
	Tangipahoa	14	29	24	286	6
	Washington	13	20	44	171	3

*AIDS diagnoses will be included in counts of HIV diagnosis (3rd Column) for persons first detected with HIV at an AIDS diagnosis or within the same year; therefore numbers from the two columns should not be added.
**Rates per 100,00 persons in parish. Rates derived from numerators less than 20 may be unreliable and are not available (n/a) for numerators less than 5

Deaths Among Persons with HIV Infection Louisiana, 2008		
	2008 Deaths	**Percent**
Total Deaths	**467**	**100%**
Diagnosis at Death		
AIDS	395	84.6%
HIV	72	15.4%
Sex		
Female	145	31.0%
Male	322	69.0%
Race/Ethnicity		
Black/African American	354	75.8%
Hispanic/Latino	5	1.1%
White	103	22.1%
Other	5	1.0%
Age at Death		
0-12	0	0.0%
13-19	2	0.4%
20-24	11	2.4%
25-34	55	11.8%
35-44	135	28.9%
45-54	166	35.5%
55-64	79	16.9%
65+	19	4.1%
Imputed Transmission Category		
Men who have sex with men (MSM)	150	32.1%
Injection Drug User (IDU)	140	30.0%
MSM/IDU	50	10.7%
High Risk Heterosexual (HRH)	116	24.8%
Transfusion/Hemophilia/Other	9	1.9%
Perinatal/Pediatric	2	0.4%
Region		
1-New Orleans	115	24.6%
2-Baton Rouge	148	31.7%
3-Houma	12	2.6%
4-Lafayette	42	9.0%
5-Lake Charles	21	4.5%
6-Alexandria	20	4.3%
7-Shreveport	58	12.4%
8-Monroe	31	6.6%
9-Hammond/Slidell	20	4.3%
Rural/Urban		
Rural	58	12.4%
Urban	409	87.6%

Annual Report Technical Notes

Tabulation of Data

This report includes all information received at the HIV/AIDS Program office as of August 1, 2010. HIV and AIDS cases diagnosed through 2009 are included in this report. The 2009 data are very complete and are not adjusted for a potential reporting delay. Due to reporting and collection delays for deaths and pediatric cases, those data are reported only through 2008 to ensure complete data.

HIV and AIDS Terminology

Previously the term *HIV/AIDS* was used to refer to three categories of diagnoses collectively: a diagnosis of HIV (not AIDS), a diagnosis of HIV infection with a later diagnosis of AIDS within the same year, and concurrent diagnoses of HIV and AIDS. For this report, the term *HIV Infection* was substituted for *HIV/AIDS* to represent the same three categories.

In previous reports, risk categories were referred to as *Mode of Exposure or Exposure Categories.* For this report, risk categories were referred to as *Transmission Categories.* All of the transmission categories selected for this report are described below under "Definitions of Transmission Categories."

Interpretation of HIV Data

Antiretroviral treatment regimens are initiated earlier in the course of HIV infection than in the past. These therapies postpone and/or prevent the onset of AIDS, resulting in a decrease in AIDS incidence. Consequently, recent AIDS incidence data can no longer provide the basis of HIV transmission estimates and trends, and the dissemination of surveillance data now places an emphasis on the representation of HIV-positive persons. Throughout this report, all AIDS data are depicted by characteristics at year of AIDS diagnosis under the 1993 AIDS case definition, and HIV data are characterized at year of HIV diagnosis (earliest positive Western blot or detectable viral load reported to the health department).

HIV data are not without limitations. Although an HIV diagnosis is usually closer in time to HIV infection than is an AIDS diagnosis, data represented by the time of HIV diagnosis must be interpreted with caution. HIV data may not accurately depict trends in HIV transmission because HIV data represent persons who were reported with a positive confidential HIV test, which may first occur several years after HIV infection. In addition, the data are underreported because only persons with HIV who choose to be tested confidentially are counted. HIV diagnoses do not include persons who have not been tested for HIV or persons who have only been tested anonymously.

Therefore, HIV diagnosis data do not necessarily represent characteristics of persons who have been recently-infected with HIV nor do they provide a true measure of HIV incidence. Demographic and geographic subpopulations are disproportionately sensitive to differences and changes in access to health care, HIV testing patterns, and targeted prevention programs and services. All of these issues must be considered when interpreting HIV data.

Definitions of the Transmission Categories

For the purposes of this report, HIV and AIDS cases were classified into one of several hierarchical transmission (risk) categories, based on information collected. Persons with more than one reported mode of exposure to HIV were assigned to the category listed first in the hierarchy. Definitions are as follows:

Men who have Sex with Men (MSM): Cases include men who report sexual contact with other men, i.e. homosexual contact or bisexual contact.

Injection Drug User (IDU): Cases who report using drugs that require injection - no other route of administration of illicit drugs at any time since 1978.

High-Risk Heterosexual Contact (HRH): Cases who report specific heterosexual contact with a person who has HIV or is at increased risk for HIV infection, e.g., heterosexual contact with a homosexual or bisexual man, heterosexual contact with an injection drug user, and/or heterosexual contact with a person known to be HIV-infected.

Hemophilia/Transfusion/Transplant (Hemo/Transf): Cases who report receiving a transfusion of blood or blood products prior to 1985.

Perinatal: HIV infection in children that results from transmission from an HIV-infected mother to her child.

Unspecified/NIR: Cases who, at the time of this publication, have no reported history of exposure to HIV through any of the routes listed in the hierarchy of exposure categories. These cases are traditionally marked as No Identified Risk Factor (NIR). NIR cases include: persons for whom risk behavior information has not yet been reported and are still under investigation; persons whose exposure history is incomplete because they have died, declined risk disclosure, or were lost to follow-up; persons who deny any risk behavior; and persons who do not know the HIV infection status or risk behaviors of their sexual partners. For this report, all cases with an unspecified transmission category were assigned an imputed transmission category. Imputation procedures are described below under *Imputed Transmission Category.*

Case Definition Changes

The CDC HIV and AIDS case definitions have changed over time based on knowledge of HIV disease and physician practice patterns. The original definition for AIDS was modified in 1985.[31] The 1987 definition[32] revisions incorporated a broader range of AIDS opportunistic infections and conditions and used HIV diagnostic tests to improve the sensitivity and specificity of the definition. In 1993, the definition was expanded to include HIV-infected individuals with pulmonary tuberculosis, recurrent pneumonia, invasive cervical cancer, or CD4 T-lymphocyte counts of less than 200 cells per ml or a CD4 percentage of less than 14.[33] As a result of the 1993 definition expansion, HIV-infected persons were classified as AIDS earlier in their course of disease than under the previous definition. Regardless of the year, AIDS data are tabulated in this report by the date of the first AIDS-defining condition in an individual under the 1993 case definition.

The case definition for HIV infection was revised in 1999 to include reports of detectable quantities of HIV virologic (non-antibody) tests.[34] The revisions to the 1993 surveillance definition of HIV include additional laboratory evidence, specifically detectable quantities from virologic tests. The perinatal case definition for infection and seroreversion among children less than 18 months of age who are perinatally-exposed to HIV was changed to incorporate the recent clinical guidelines and the sensitivity and specificity of current HIV diagnostic tests in order to more efficiently classify HIV-exposed children as infected or non-infected.

Most recently, the surveillance case definitions were revised in 2008 for adults and adolescents (age ≥13 years).[35] A single case definition was created that incorporates AIDS and an HIV classification system. HIV infection is now categorized into four stages based on severity. Stage 1 is HIV infection with no AIDS-defining conditions and either the CD4+ T-lymphocyte count is >500 cells/µl or the lymphocyte percentage is ≥29%. Stage 2 is HIV infection with no AIDS-defining conditions and either the CD4+ T-lymphocyte count is between 200-499 cells/µl or the lymphocyte percentage is between 14-28%. Stage 3 is AIDS where one of the following three conditions is met: CD4+ T-lymphocyte count is <200 cells/µl, or the lymphocyte percentage <14%, or there is documentation of an AIDS-defining condition. An AIDS-defining condition supersedes the CD4 count or percentage. Stage 4 is an unknown stage where no information has been collected on AIDS-defining conditions, CD4 count, or percentage. Once a person is classified as Stage 2 or 3, they cannot be reclassified at a lower stage.

The case definition for children less than 18 months of age has also been revised. The only category that was revised was “presumptively uninfected” with HIV. Additional laboratory criteria were added. In chil-

dren age 18 months to <13 years, the surveillance case definition requires laboratory-confirmed evidence of HIV infection.

Imputed Transmission Category

Newly reported cases, especially HIV (non-AIDS) cases, are often reported without a specified risk exposure, thereby causing a distortion of trends in exposure categories. Thus, statistical procedures to provide or impute predicted values of transmission category were used. All data in the graphs and tables throughout the surveillance section of the report represent imputed transmission categories. Values for transmission category for cases with no known risk were estimated using a statistical procedure known as hotdeck imputation, similar to methods used by the U.S. Census on the American Community Survey (www.census.gov/acs/www/Downloads/tp67.pdf). The Louisiana hotdeck imputation method was locally developed and validated against the CDC methodology. Logistic regression models were developed to identify those variables that are highly correlated with either a) missingness or b) one of the three chief risk factors for HIV infection (MSM, IDU, HRH). Next, a profile for each case was constructed using information from these variables, including age, race, sex, parish of residence, incarceration history, substance use, and year of infection. Finally, a predicted value for risk was then obtained by matching cases with no known risk to cases with a known risk along this profile and substituting the missing risk value.

Census Data and Rate Calculation

Mid-year population estimates for the state of Louisiana and each parish are obtained from the U.S. Census Bureau. These estimates are used to calculate changes in the population, and incidence and prevalence rates. All rates are calculated per 100,000 persons except for death rates, which are calculated per 1,000 persons. An example of how rates are calculated is as follows. For the HIV diagnosis rate in 2009 for the New Orleans Public Health Region 1, the July 1, 2009 populations for the four parishes within Region 1 are added together equaling a regional population of 859,789 persons. Then the number of new HIV diagnoses in Region 1 in 2009, 393 new diagnoses, is divided by the totaled population, 859,789 persons to get 0.000457. This number is multiplied by 100,000 to result in an HIV case rate of 45.7 per 100,000 for Region 1 in 2009.

Additional Notes

- HIV data collection began in 1993 in the state of Louisiana.
- All percentages displayed in this report are rounded to either one or zero decimal points. Due to this rounding, they may not equal 100% when summed.
- When calculating rates, if the numerator was <5, the rate is unstable and marked as 'n/a.'

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