



- 1  PACHA – 36<sup>th</sup> Full Council Meeting  
Alabama – 2008  
Impact of Ryan White Reauthorization

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- 2  HIV/AIDS in Alabama  
Deaths and Total Living: **Figure 1: HIV/AIDS Cases – PLWHA and Deaths, Alabama 1982 – 2006**  
Reported Cases by Year: **Figure 2: HIV/AIDS Cases by Year of Diagnosis, Alabama 1982 - 2006**

- 3  Structure of Alabama's Program  
November 1987, HIV was designated as notifiable disease.  
Since 1988, 67 county HD provide HIV CTRPN) & CPM.  
11 HIV Coordinators facilitate & coordinate HIV/AIDS activities including ERTS.  
HIV/AIDS works with STD, TB, Mental Health, Corrections, and Substance Abuse Treatment personnel to establish agreements allowing the exchange of patient information.  
In 1987, the Alabama AIDS Network was initiated to provide coordination for health care professionals and volunteers working to prevent and manage HIV/ AIDS in Alabama.  
In 1994, a CPG was implemented in each public health area. The state now supports only one Statewide CPG.

- 4  Structure of Alabama's Program

HIV/AIDS - disproportionate impact on African-Americans (AF-AMs) in Alabama. Less than 26% of the state's population is AF-AM. HIV/AIDS cases reported since 1982, AF-AM account for 75% of cases in women,

65% - young people and 69% - infants & children. Since 1998, more than 70% of newly infected individuals were Af-Am.

Alabama's has 11 community-based ASOs. Since 1990, ADPH has contracted with the CBOs to do post-test education sessions for individuals infected with or at high-risk for HIV.

Ryan White funding in 1991 allowed development of a Direct Care Services Branch responsible for all direct patient services including a drug reimbursement program & development and implementation of HIV Care Consortia.

In 1994-1995, HIV Care Consortia were implemented in each of eight public health areas in Alabama. Consortia were discontinued in 2005.

5  Structure of Alabama's Program

Alabama's ADAP program operates a central pharmacy licensed to ADPH using contracted pharmacy services. Distribution of drugs is to the HIV clinics for pick-up by clients.

Drugs are purchased from wholesaler using 340B pricing plus some drug rebates.

Alabama has one lead agent who subcontracts with 20-22 providers.

Funds are allocated to providers based on formula calculated on number of documented clients and available funding.

6  Immediate Impact of Reauthorization

Alabama had a waiting list for drugs for 5 years –  
Now no waiting list for last 2 years.

Alabama was unable to fund adequate care and social services.

Additional funding allowed almost doubling for funding for service providers.

ADAP formulary included only FDA approved anti-retrovirals & less than 10 other medications.

Two weeks ago 45 “other” medications were added to the formulary.

Casemangers spent a major part of their time working to get meds for clients on waiting lists and for meds not on the formulary.

Casemangers are now able to case manage clients.

7  *Southern States Manifesto*

(Six Years after Original Document)

In a context of disproportionate rates of HIV/AIDS, poverty, inadequate funding and resources, and infrastructure challenges, SAC wants to:

reduce new infections;  
identify infections as early as possible; and  
provide adequate care, treatment, and housing.  
(Slide shows image of cover of document)

8  Disproportionate Impact

South Comprises 36.4% of the Population

Top 20 states (includes 18 states, Washington, DC, and Puerto Rico) with highest AIDS case rates in 2006, 11 (55%) were in South.

Number of persons living with AIDS from 1993 to 2005 increased at a greater rate in South than in any other region of country.

Of 20 metropolitan areas with highest AIDS case rates in 2006, 16 (80%) are in South.

South has highest percentage of new AIDS cases in persons living in non-metropolitan areas than in any other region of the country.

9  CDC Minority HIV/AIDS Research Initiative:

In 2005 South leads in AIDS case rates for adults and adolescents in metropolitan statistical areas of all sizes.

(Slide shows image of Reports AIDS Cases and Rates for Adults and Adolescents by Region and Population of Area of Residence

2005 – 50 States and DC

10  Greatest Number of Medically Disenfranchised

(Slide shows image of Overall Health Ranking of states)

11  The Ultimate Outcome: Highest Death Rates

(Slide shows two tables – Deaths estimated from AIDS according to the CDC – Numbers; Death estimated from AIDS according to the CDC – Percents)

- 12  Inequity  
(Slide shows two tables: Person Living with AIDS in 2005 by Region; Federal Funding for HIV/AIDS – Dollars Spent per Person Living with AIDS by Region, 2005)
- 13  Issues that must be addressed by nature of the language in the law

Authorization levels

Hold Harmless provisions

Length of reauthorization

Extension of protection for state with maturing HIV data

Transitional Grant Area (TGA) eligibility issues

Issues where a high level of consensus may exist

Two year housing limit

ADAP as TrOOP

Treatment of ADAP rebate dollars

Early Diagnosis grant program

Inclusion of HIV prevention/focus on testing – no change necessary

Client Level Data

Formulas

Issues that do not fall into either of the above categories, but warrant discussion by the group

Severity of Need Index

Core Medical Services/Support Services

-Definition of

-Split

Addressing grantee mismanagement

-Provision for federal management

Level of unobligated funds allowed

Role and composition of planning councils

Simplify grant and reporting requirements

Issue of decreasing HIV clinical workforce in Ryan White

Coordination with other programs

Minority AIDS Initiative

- 14  Everyone who is HIV-positive or has any form of sexually transmitted disease has a right to access a range of health care and necessary support services to achieve and maintain optimal health regardless of gender, sexual orientation, geographic location, economic condition, race or social status.