CDC *Vital Signs* Town Hall Teleconference

New Hope for Stopping HIV
Q&A Transcript

December 13, 2011
2:00pm – 3:00pm EST

Amanda Miller Thank you all for these excellent presentations and sharing your work. In just a moment the Operator will open all the lines. As a courtesy to everyone on the call, I'm going to ask that each of you mute your phone by pressing star 6 when you are not talking.

Operator, can you please open the lines now?

Coordinator: Thank you. At this time, all lines are open. And as a reminder, it's star 6 to mute and unmute your line. Go ahead please.

Amanda Miller: I'm going to turn the call over to Dr. Holzman for initial comments and thoughts to kick off our discussion today.

Dr. Greg Holzman: Well once again, thank you to all our speakers. That was excellent. It's really interesting, while there's still a lot of work to do, and we know that there's 240,000 people who are walking around with HIV and don't know it, and also that there's a lot of room for improvement, we do see some strategies that have been interesting and successful here.

And I'm always amazed, especially with this epidemic, considering I've lived through it -- in my life I was in high school when - in '81 -- just to watch how this has progressed and how the public health and the clinical community has worked to address these issues. It's been very interesting to see that we've made great strides, although there's still lots of room to be done.

I just wanted to ask one quick question and then I'll hand it over to the -- I'm sure there's many other things -- but to Dr. Gruber, on your work that sounds absolutely fantastic that's going on in Louisiana, have you had any problems with feedback that has been negative regarding people going into the emergency room, not basically - maybe not saying their status - of HIV status, and then it coming back through this that the provider finds out that they are HIV positive? Anything of those concerns?

Dr. DeAnne Gruber: (Yes, mentioning that) Jane Herwehe, who was very much a lead on this entire project over the last five years, and I'm going to pass that question over to her, because she's been very involved in some of the evaluation process.

Dr. Greg Holzman: Great, thank you.

Jane Herwehe: No actually we haven't had any negative feedback from patient or providers. And, you know, DeAnne had a challenge here to discuss the whole project in ten minutes.

And we do have a pretty extensive evaluation methodology that includes mechanisms for people to call the HIV AIDS hotline at the Office of Public Health, implements as well as we do interviews with people who've been identified through LaPHIE after they've, you know, connected to care on what the LaPHIE, you know, getting the information in the emergency room or whatever the other clinical venue was.

And so far we haven't had any negative feedback from patients or their providers. Now this does - you know, I'd like to caveat that if somebody was really so ticked off, you know, and they were so mad they didn't call the

hotline or they never came back to get interviewed, we're not catching those folks.

But in general, we do have mechanisms in place to gauge the patients' thoughts on acceptability of this method. And so far we haven't had any negative feedback.

Dr. Greg Holzman: That's fantastic. Really excellent work. Let's open it up. I'm sure there's many questions on the call.

Amanda Miller: Do we have any questions from callers on the line?

Man: Yes, I have a question. Hello?

Amanda Miller: Yes?

Man: My question is I see that before LaPHIE was implemented that there was a legal review of any state legislation related to the sharing of public health information. My question is, was there a need for any promulgation of any regulation or to make this happen or you worked with what was available?

Jane Herwehe: No. We didn't find the need to revise any legislation that was currently on the books in order to implement it.

Man: All right. Thank you.

Amanda Miller: Do we have another question on the line?

Dr. Greg Holzman: There's not. This is Dr. Holzman again. I'm just going to ask one quick question to Dr. Mermin if I could. We were talking a lot - you mentioned about some of the different strategies that are going on.

I know we didn't give you much time here, but what are some of the new or (unintelligible) the main strategies that we know at the community level to help increase the HIV testing and what have been some of the barriers to implementing those strategies? Can you comment on that a little bit?

Dr. Jonathan Mermin Sure. Thank you. There's probably two major ways that we could increase access to testing. I mean, one, that people have to understand the importance of knowing your status, especially when you're positive. But also people who are partners of other people who have HIV, if you don't normally use condoms or understand other ways of protecting yourself from getting HIV, unless you know that your partner has HIV.

So understanding the importance in the overall context of both accessing the treatment but also prevention is critical. And so we actually have large community-based organization funding announcements through our division at CDC that actually provides resources across the nation to organizations that are ensconced in the communities at higher risk of HIV and helping them to access testing, either through rapid HIV testing at storefronts or at venues that - bars at events, at Gay Pride events.

I mean, there's a lot of different places where bringing rapid testing out into the field, either/or fluid testing or rapid finger stick testing can be very beneficial.

At the same time, that won't do it all. So targeted testing like that is very cost effective but it doesn't reach everyone who has HIV. And so the second

opportunity is to ensconce routine offering of HIV testing in an opt out fashion in healthcare settings, as already discussed by the other speakers today.

So having - we've shown that having, you know, routinely offering HIV testing and things is part of services that we provide to everyone who comes into our emergency department, to our clinic or our hospital. That actually increases the proportion of people with HIV who find out their status by about 75% or more.

So if it's actually implemented it can be very productive. And you want to be able to do that in circumstances where the prevalence of HIV infection that's undiagnosed is about .1% or greater.

And in most circumstances in urban settings in the U.S that's the case. And in some rural cities that's the case. But we also know that it's not done in the majority of clinical situations.

So increasing that will both get people who don't think they're at risk and would never bring it up with their clinician. And in fact, their clinician would probably never bring it up with them. And they don't think they're at risk so they're not going to be going out of these other venues.

It would actually get them to be tested, just the same way that routinely offering cholesterol screening or high blood pressure screening would be part of routine care, so should HIV screening.

And those are two ways that we actually support health departments and hospitals to do HIV testing in that routine way. And it's been very well received by most places. So testing is critical.

The second issue, I'd say, that had already been highlighted by Dr. Sweeney was linkage to care, as well. We need to make sure that people who are diagnosed have the support they need to get their next appointment, to get into care, and to join the system that really can help take care of people with HIV in the long run, from both the social aspects as well as the health-related ones.

Amanda Miller: Thank you, Dr. Mermin. Do we have any final questions?

Man: Yes I have a question.

Amanda Miller: Please go ahead.

Man: Hi this is for the Louisiana team. I've three brief questions. How much lead time did you have to prepare the providers to look out for this new information that might be coming down the electronic system?

Dr. DeAnne Gruber: Well one thing to mention is that we did not turn it on before we trained providers and let them know that it was coming. So really, we started probably, I would think, about two to three months before we implemented the messaging so that they were aware of what they could see in the care setting and then how they were to respond to it.

And then many of our providers, too, were involved in our development of what we call the user interface. So the messaging that comes up in the electronic medical record.

And so those folks were leads within their emergency department or within their clinic setting, and so they were our champions. And they were

instrumental in, you know, in forming others their set - in their clinical area that this was coming and working with them.

Man: And this was offered to all and each and every provider. It wasn't specific groups on this?

Dr. DeAnne Gruber: No. It - essentially, once it was turned on in the emergency room it was available to any emergency room provider who would be treating someone who had been part of the OPH out of care...

Man: Okay.

Dr. DeAnne Gruber: ...set.

Man: Okay.

Dr. DeAnne Gruber And then once it rolled out to the outpatient setting it could be a provider in a medicine clinic, or a provider in a diabetes clinic. So we made sure that before it rolled out to the clinic setting, that we trained, like superusers and clinic managers from all of the different outpatient venues and let them know that this was coming, and gave them materials and tools to go back and train their staff.

Man: Oh that's very nice. And did you try - have you tired to find out why these patients are not in care? The ones that they eventually picked up?

Dr. DeAnne Gruber Yes, we ask as part of that interview after they've been identified by LaPHIE, we asked what kept them away. And then actually we have another evaluation activity where we survey people through the clinics every six months as part of the multi-site evaluation for the SPINS Project. And those

folks weren't all out of care people. But we did ask some of them if they'd delayed entry to care for 12 months or had a break in care.

So from the people who had delayed entry or break in care from the survey, as well as the individuals that we've interviewed, really the reasons that they list are things we've certainly known for many years here in Louisiana.

You know, I was out - well I felt healthy. I didn't think there was a problem. I had other things going on in my life at the time. I was in jail. I was, you know, running the streets and doing drugs. Transportation issues. My kids were little and I was busy with them.

So these are all the things that those of us that have been involved with case management programs over the years have known or barriers to people accessing care.

We haven't had anyone say specifically, you know, it was too hard to get an appointment. Or, you know, I came to your hospital system and, you know, I didn't like what I heard, or something like that. It's primarily the social barriers that we - that - the personal barriers that we hear over the years.

Man: The very last question. Since you're bringing all these new patients, were there any issues with the capacity of the system to absorb the added load?

Jane Herwehe: Not at this point. Certainly each one of our hospitals has an HIV outpatient clinic associated with it. And the - that's where the patients are referred to. And of course, they're given the names of other community-based clinics if they're interested in going somewhere else.

So no, there hasn't been a problem. I'm going to let DeAnne talk about just ADAP in general. And we do have what's called an unmet need list here. But we had that problem outside of LaPHIE, just in terms of the number of people that were (unintelligible) to a system. Go ahead.

Dr. DeAnne Gruber: Yes. I mean, it is true that I think as far as medical care of getting appointments we haven't heard any significant delays or waiting lists. But ADAP, because of resources and our projection of the increased costs and the number of individuals who are being enrolled in ADAP we had to cap new enrollment about 18 months ago in June of 2010, and collectively have had over 1700 or 1800 individuals on that waiting list.

We've managed because of some new resources and supplemental resources, and also just attrition in other projections, we've been able to remove over 1300 of those individuals from the list, and we're now down to right around 500, I think, is what's on our list right now.

Jane Herwehe: And let's point out too that people don't go without medication. Because either within our hospital systems every clinic has patient assistance programs. So if you can't, you know, if you're not one of those people who's on the ADAP unmet need list, the clinical staff for - and your social worker work with you to make sure that you get your drugs through pharmaceutical assistance programs.

Man: Great. Thank you very much.

Amanda Miller: Thank you for all of the questions today. Unfortunately it looks like we are running out of time. And before we close I'd like to point out on Slide 41 there are a number of ways that you can stay connected and integrate *Vital*

Signs and the health topics covered by *Vital Signs* into your Web site and social media channels.

And also on the very last slide, our email address (ostiltsfeedback@cdc.gov) is available. Please let us know how we can improve the teleconference so it's more beneficial to you.

A special thank you to all of our presenters and everyone who participated in today's call. I hope you'll join us again next month on January 17 for the next *Vital Signs* Town Hall Teleconference. Thank you.

Coordinator: Thank you. That does conclude today's conference. You may disconnect at this time.