

**CDC *Vital Signs* Town Hall Teleconference**

**New Hope for Stopping HIV  
Transcript**

December 13, 2011  
2:00pm – 3:00pm EST

Coordinator: Welcome and thank you for standing by. At this time, all participants lines are in a listen-only mode. Today's conference is being recorded. If you have any objections you may disconnect at this time.

And now I'll turn today's meeting over to Greg Holzman. Thank you. You may begin.

Dr. Greg Holzman: Thank you, Operator. Good afternoon and welcome to CDC's December's *Vital Signs* Town Hall Teleconference.

I'm glad you could join us today to discuss new hope for stopping HIV through testing and medical care. Modern day treatment for HIV, called antiretroviral therapy or ART, can lower the level of virus in the body, helping people with HIV live longer and healthier lives, and lowering the chance of passing HIV on to others.

The *Vital Signs* Report shows that we can do more in the United States to treat and prevent HIV. First of all, many people don't know they have HIV because too few are getting tested. The startling fact is that about 1.2 million people are living with HIV in the United States. But about 240,000 don't know they are infected.

On top of that, many people with HIV do not get the medical care they need. Only 28% of all people with HIV are getting the care they need to manage the

disease and keep the virus under control. And of those with HIV getting medical care, less than 45% have received prevention counseling from their healthcare provider in the past year.

I also want to take a moment to highlight another important resource, the National Prevention Strategy. Much like *Vital Signs*, it is focused on leading - the leading causes of preventable death and major illness. Developed and released this past spring by the National Prevention Council, the National Prevention Strategy highlights that increasing access to and fostering linkages between healthcare and community systems can improve early detection and treatment.

On today's call we'll hear from colleagues in New York City and Louisiana on how they have integrated many of the strategies identified in *Vital Signs* into their states' activities to prevent and treat HIV.

So without further delay, I will turn the teleconference over to my colleague, Amanda Miller, from the communication team here at OSTLTS, who will introduce our speakers and facilitate the discussion portion of today's meeting.

Amanda Miller: Thank you, Dr. Holzman. Good afternoon everyone. Thank you for joining us today. Before we get started I want to remind everyone that you can download today's PowerPoint presentation and view bios for each of our presenters on the OSTLTS Web site. The web address is [www.cdc.gov/ostlts](http://www.cdc.gov/ostlts). That's O-S-T-L-T-S. Double click on the town hall tab in the large flash module at the top of the page.

This site is also where we will add the audio recording and transcript for today's meeting. They should be available by the end of the week. If you have

any problems viewing this PowerPoint presentation, right click on the link and select save as to download the presentation to your computer. This should eliminate issues with your browser opening a large file.

After our presentations today, there will be time for questions. I encourage you to take advantage of this opportunity to share strategies, lessons learned, challenges and success stories.

Now it is my pleasure to introduce our speakers. I will introduce all of the speakers now, but then each speaker will hand off to the next after their presentation.

Joining us today to provide a summary of this month's *Vital Signs* report is Dr. Jonathan Mermin, Director of the Division of HIV/AIDS prevention within CDC's National Center for HIV/AIDS, Viral Hepatitis, STD and TB prevention.

Then, Dr. Monica Sweeney, Assistant Commissioner for the Bureau of HIV/AIDS Prevention and Control in the New York City Health Department - New York City Department of Health and Mental Hygiene, will discuss high impact HIV prevention interventions in New York City.

Our next speaker will be Dr. DeAnne Gruber, Administrative Director for the STD HIV Program in the Louisiana Office of Public Health.

She will be followed by Jane Herwehe, Special Projects Coordinator for the Healthcare Services Division at Louisiana State University.

Monica Sweeney, DeAnne Gruber and Jane Herwehe will discuss many ongoing efforts in their states to improve testing and treatment for HIV. And now I will turn the call over to Dr. Mermin.

Dr. Jonathan Mermin: Thank you very much Ms. Miller and Dr. Holzman. It's a pleasure to be on this telebriefing.

So this should be Slide 5 in the set, which is - I'm going to just give a brief overview of the magnitude of the HIV epidemic in the U.S, touch on the most important findings from the *Vital Signs* presentation, and then highlight some areas that CDC is concentrating on over the - currently and over the next couple of years.

So first, there are about 1.2 million people living with HIV in the country. And each year there are about 50,000 new infections and about 17,000 deaths among people living with AIDS. And that means there's a net increase of a bit over 30,000 people with HIV every year.

Some of this is because people who start antiretroviral therapy, especially early in the time of their infection, are expected to live at least an additional 35 years. And the number of persons with HIV in the U.S increased 60% in the past 15 years.

So essentially, we have a growing HIV epidemic because of this excessive access to care and treatment, but we haven't kept pace with our prevention efforts.

Next slide. In this slide, you'll see that of the number of people living with HIV has grown, because incidents shown in the bottom of the graph is relatively stable. And yet survival has dramatically increased.

Next slide. This figure highlights some of the major challenges and opportunities that we have for HIV prevention -- primarily that the faster action and more productive implementation that we do now will save lives and resources later.

The top line is - shows what would happen in terms of the number of new infections if we had stable incidents over the next ten years. The next line shows that if we reduced incidents by 25% over the next ten years that we would actually save about 62,000 new infections and about \$23 billion in healthcare costs alone.

If we were able to reduce HIV incidents by 25% in - over the next five years, which is the goal presented for the nation in the National HIV AIDS Strategy, we would prevent over \$100 billion in healthcare costs.

So HIV prevention is both a lifesaving and infection preventing activity. But it's also good economics.

Next slide please. This just highlights some of the major findings of our *Vital Signs* in terms of the HIV continuum of care and prevention. The first step is that people with HIV need to know that they have HIV. And so they need to get tested.

This is because diagnosis both reduces transmission in terms of helping people not participate in sexual activities that will transmit the virus to their partners, and it also prolongs life. Because the only way to access HIV-specific care is to actually know that you have HIV.

In addition, recent results from a randomized trial indicate that antiretroviral therapy reduces transmission risk by 96%. And, yes, given all this success, we find that only 20% of people with HIV have viral suppression -- meaning that their virus is below 200 copies per milliliter, which is the goal for successful treatment.

And in the next slide, Number 9, we show the continuum of care. And you can see how long this continuum - if we miss opportunities they accumulate over time. So first you'll see about 1.2 million people with HIV on the far left. Those are the number of people.

But only 80% of those people, or about 941,000, know that they actually have HIV. So we need to improve on our testing and diagnosis for people with high risk and also some people who are at relatively low risk and have - don't think that they're at risk for acquiring HIV, but they have it.

The next bar shows the proportion of people who have been diagnosed with HIV but who are then linked to care. And you can see that that's about 77%. We have some difficulties at times with people being diagnosed with HIV but then not actually getting access to the services they need.

In addition, of those people who actually are linked to care, retention in care, ongoing treatment, even using a fairly minimalist approach to what would be designated as being retained in care show that there's a pretty large drop-off -- that only about 66% of the people who are linked to care are continually retained in care. And that compared to the number diagnosed, it's only 51%.

Of those who are retained in care, however, the data that we have seem to indicate that the vast majority are taking antiretroviral therapy -- about 89%. And yet, of those, only 77% have a suppressed viral load.

And that can be just because either they're unable to regularly access their medication or to adhere well to their medication, or because they have been taking medication for a long time and have resistant virus.

But 77% is not as good as we would hope in terms of both achieving maximal transmission reduction, as well as prolonging people's lives as long as possible.

In the end of the continuum of HIV care we see that there are about 850,000 people with HIV who do not have their virus under control or suppressed. And that's about 72% of all the people with HIV in the nation.

And so thinking of it this way, this presents both policy and programmatic challenges to all of us.

If you go to the next slide I also wanted to highlight, in terms of risk reduction interventions we have additional challenges. Only 45% of the people with HIV received prevention counseling from their provider in the prior year. Yet interventions focused on sexual behavior change for people with HIV reduced unprotected sex by about 43% and acquisition of STDs by 80%.

So even in addition to the reductions from antiretroviral therapy, there are these behavior change interventions that can also help everyone with HIV reduce the chance that they're going to transmit HIV to their partners.

So next slide. What are some of the barriers to viral suppression? Well anything that impedes our progress along that continuum of care can lead to not achieving our ultimate goal of suppression and prevention intervention.

So that can include lack of knowledge of HIV status, poverty, lack of insurance and access to care, which can limit people being able to access clinics and other health services.

Patient and practitioner beliefs about taking ART, although the HHS guidelines about taking antiretroviral therapy have become increasingly liberal and recommending ART earlier in the times of infection, some patients are still not convinced that ART will help them.

And some practitioners are not convinced that people with higher CD4 counts, especially above 500, would benefit, even though the new data on transmission indicates that it would benefit from a prevention standpoint.

And Dr. Sweeney will be able to highlight some ways that New York City is trying to address the situation.

Other issues that come up are poor adherence to ART, potential antiretroviral resistance, and the virus itself, substance use and mental health issues, which are often quite prevalent among some people with HIV. And really, unless we address those issues, it's increasingly difficult for our patients and clients to actually maintain themselves on both in-care and taking regular medication.

Transportation to clinics can be a difficult challenge for people, especially poor people living in rural areas. And sometimes there's a limited feedback loop and available assistance for people in and outside of care. So if someone does drop out of care, how do we help them get back into care?

And if someone is - and, you know, regularly seeing a clinician and has been prescribed ART but doesn't take it regularly, what are the services that we can

help provide them with that will increase their adherence? All of these are important.

Next slide. So some key CDC activities with which we are implementing over the next year are surveillance supplements for CD4 cell count and viral load reporting. This is something that we've put out over the past two years, primarily to assist health departments to both come up with policies that enable better data collection so that they can highlight gaps in service provision in their jurisdiction.

The Health Department Prevention Funding announcement, which starts in the beginning of 2012 includes both an expanded testing initiative, which will increase the proportion of people with HIV who know their status and CD4 cell count and viral load demonstration projects.

So this feedback loop regarding monitoring of our success will be improved. We are developing a new surveillance funding announcement for all of HIV surveillance for 2013. And in that we're going to be thinking about some of these issues of how we both monitor and provide information for prevention purposes.

We have a study of comprehensive prevention with positives, which is essentially this entire continuum of care and prevention services that we will be implementing with some partners shortly.

And then we're - we have increased activities with testing and prevention with positives with community based organizations. So we're trying to link in through trusted organizations in the community to encourage people with HIV and they're fit to access services and to help them with the services they need so that they can have a suppressed virus and live a long life.

So in summary, and the next slide, more people with HIV need to be diagnosed. Many people with HIV do not receive the medical care they need, increasing both their transmission risk to their partners and also affect - greatly affecting their quality and length of life.

Only 28% of all people with HIV have viral suppression. And only 45% of people with HIV getting medical care actually receive prevention counseling from healthcare providers in the past year. And a focus on the continuum of care will prolong lives and reduce HIV incidents across the whole nation.

So thank you very much. I'm now going to turn the speaker podium over to Dr. Monica Sweeney from New York City. And this'll be Slide 15.

Dr. Monica Sweeney: Thank you very much Jonno. One only needs to look at the last datapoint on the continuum of care diagram to see the challenge of treatment as prevention, which has already been talked about.

In New York City the diagram on the right, you can see that of the 110,000 PLWHAs in the city only 28% had a suppressed viral load at their most recent test.

For the rest of the presentation, CDC's information will be on the left side of the screen, and New York City's information will be on the right side of the screen.

I'm going to briefly describe three New York City high impact interventions to get us to the National HIV AIDS strategic goals. They are expanded HIV testing -- that's on Slide 16 -- ART therapy and other preventions with positives.

So New York City working on expanded HIV testing worked extensively with community based organizations to expand routine HIV testing as seamless linkage to care. We launched the Bronx Knows HIV Testing Initiative in 2008 to test 250,000 people who had never had a test.

The three-year goal was to pass by more than 70% by conducting over 607,000 HIV tests. Building on the success of the Bronx Knows, Brooklyn Knows was launched on December 1 on World AIDS Day in 2010 with the goal of testing 500,000 Brooklynites by the end of 2014.

To date, both initiatives have conducted over 722,000 HIV tests and identified more than 2000 new positives, linking more than 3/4 of them to care.

Slide 19 -- in addition to expanded HIV testing, test and treat, also called TLC, which the Bronx is -- going back I inadvertently went ahead -- the Bronx is one of only two cities to be a part of TLC, based on what we did in the Bronx already -- the Bronx was chosen.

Additionally, SPINS -- Special Project of National Significance -- was awarded to New York State and New York City to address testing, linkage and retention to HIV care.

We also were diligently on passing new legislation to facilitate HIV testing in New York State and of course, in the city. The law was passed in 2010, which mandates the offering of HIV testing to all patients 13 to 64 in hospitals and in primary care settings with limited exceptions -- of course, including the ED.

It also allows for oral consent and requires linkage to care by the provider for anyone who tests positive.

Slide 20 - antiretroviral therapy we recently in New York City released a new treatment recommendation. HIV medical care providers were urged to start HIV positive patients on ART as soon as they were diagnosed, regardless of their CD4 count.

Slide 21 shows the research and which prompted this new recommendation. As many of you already know about the HPTN052, which showed a 96% reduction in serodiscordant couples when the positive partner was treated with ARTs regardless of the CD4 count.

New York City is the second city to make this recommendation. San Francisco released it in 2010, urging all medical providers to do the same. And this is not following exactly the DHHS recommendation which the panel was split on treatment over with CD4 counts over 500.

This is a headline in the New York Times that we're very proud of. Based on the recommendations, New York City, as I said, released this recommendation. And as many of you know, New York City is the epicenter of HIV and AIDS. And there are currently more AIDS cases in New York City than San Francisco, Los Angeles and Washington, DC combined.

And this headline, "Seeing Chance to End the Spread of HIV City's Health Chief Pushes Earlier Drug Treatment" -- we didn't get to write the headline. We're happy that we have one, though.

With more than 110,000 New Yorkers living with HIV, which is almost three times the national rate, and with it being the third leading cause of death for New York City residents between the ages of 35 and 54, this treatment recommendation is one more important tool to help us end the epidemic.

Slide 23 -- another high impact HIV prevention for us is partner notification and contact tracing. We expanded our partner notification and contact tracing program in 2006 where all newly diagnosed patients are - an attempt is made to not only reach them, but to get them to tell us who their partners were so that we can interview the partners and recommend testing.

Not only do we recommend testing, we do testing right in the field where they are so that they don't have to go anywhere.

Additionally, we have a positive life workshop for newly diagnosed patients with HIV. At the time that the diagnosis is given, the person is offered HIV one-on-one.

We are trying to get as many people in treatment as possible within the three months, but knowing that there's a certain percentage -- about 17% -- who delays for more than three months, we want them to understand how to take care of themselves, to encourage them to get into treatment, and how not to transmit HIV even when they're not in treatment.

We also have a prevention with positive pilot. It is a three-armed intervention which is clinician-led intervention to screen patients when they go for care to see if they have continued ongoing HIV risk -- I should say transmission risk - - and if so, to have three different arms to show which one that is most effective in decreasing their continued risk of transmission. That is going to be going on, this pilot, for the next couple of years.

We also launched a care coordination medical management program in December 2009, which the medical management program is in charge of making sure that the patient who has lost the care is found, brought back to

care, given all the support they need, including transportation, languages, babysitting, even directly observed therapy to see that they could be maintained in care.

Slide 24 -- I'm not going to be able to do anything other than mention that we have prevention programs for intervention for high risk groups including focus, social marketing and media. And of course, the Debbies and the Ebbies still have a place for individual level intervention.

We have harm reduction services. I have to talk briefly just to say we have 13 syringe exchange programs in New York City and that intravenous drug use as a transmission risk has decreased for the people who are diagnosed from 17% of the transmission of people who are positive to under 5%.

So that the syringe exchange programs have remained a very vital part of decreasing the epidemic. We're soon to release an RFP for Ryan White Plans with substance abuse issues with the stages of change as a model.

All of our high impact interventions are aligned with the vision and goals of the National HIV AIDS Strategy. I just want to take one minute to thank my colleagues for their assistance with putting this presentation together.

At this point I would like to present DeAnne Gruber.

Dr. DeAnne Gruber: Thank you, Monica. First of all, I'd like to thank the CDC for inviting us to present information about the Louisiana Public Health Information Exchange or LaPHIE. And where we are at this point is on Slide 29.

And this is a project that began approximately four to five years ago as a collaboration between several organizations in our state. The first is the

Louisiana Office of Public Health, which is responsible for disease surveillance, as well as implementing prevention and treatment services for conditions that have public health importance.

The key programs that have been involved in LaPHIE include the HIV AIDS Program, the STD Control Program which, since the initiation of LaPHIE has now merged, and the TB Control Program.

The second organization is LSU Healthcare Services Division, or HCSD, which administers seven public hospitals that serve persons who reside in six of the nine public health regions in our state. And this network of hospitals is the fifth largest in the country and serves more than 50,000 patients each year, including persons living with HIV.

And then the third partner in LaPHIE in this collaborative is the Louisiana Public Health Institute, or LPHI, which served as a neutral convener of all interested parties to ensure that the process for decision making and implementation was conducted in a thoughtful, fair, and methodical manner.

So moving on to the next slide -- so let's talk briefly about the disease burden in the state. And if you click one more time you'll see Louisiana, based on the latest CDC HIV surveillance report using 2009 data, Louisiana is fifth in AIDS case rates in the country.

In addition, the two largest cities -- Baton Rouge and New Orleans -- were among the top 20 US metropolitan areas in AIDS case rates in 2009. Baton Rouge was number 2 and New Orleans was number 9 in the country.

Next slide. Here is some additional statistics about HIV, STDs and TB in our state, again using 2009 data. At that point we had over 17,000 persons living

with HIV in Louisiana. And at this point we actually have now over 18,500. And of the more than 17,000 persons living with HIV, only 62% had had at least one primary medical care visit during that year.

In addition, of all HIV-exposed infants who were born during the period 2006 to 2008, 16% had an indeterminate HIV status. And this may be due to reporting delays, incomplete testing and infants being lost to follow-up.

And then following this same reporting period of 2009 when Louisiana was number one in primary and secondary syphilis case rates and sixth in congenital syphilis rates in the nation, and actually based on the recently released 2010 CDC STD Surveillance Report that was released at the end of October, Louisiana continues to be first in the nation for primary and secondary syphilis.

But it has also moved actually from number 6 in congenital syphilis to number 1.

And then finally Louisiana ranks ninth in the number of TB cases nationwide.

Next Slide. So in order to address the need to link more individuals into medical care, LSU and Office of Public Health desired to leverage available information and offer an intervention for infected individuals with the goal of improving health outcomes and reducing transmission.

And as a result, LSU, HTSD and OPH administrators embarked on a process to develop an information exchange partnership to reach people needing important public health follow-up. Individuals asked, well how can we utilize real time health information that is maintained and utilized in two separate organizations? That being the Office of Public Health and LSU Hospital

System for distinct purposes and to integrate and alert to clinicians in the electronic medical record system.

So using the no wrong door approach, meaning that regardless of where a person enters in the hospital system to seek care for a condition that may not be related to their HIV, the treating clinician would have an opportunity to inform the patient of his or her condition and link him or her to HIV specialty care while they were in the healthcare setting.

And with this system, we wanted to identify persons who had not been in HIV specialty care for the past 12 months or more and be aware of whenever and wherever they interface with the LSU health system, so as to not lose what could be a fleeting opportunity to engage with a patient and link them to HIV medical services.

Next slide. So these are two hypotheses, that patients who are lost to care or public health follow-up will be successfully linked to care and treatment through LaPHIE.

And that the second hypothesis was that the medical setting is an appropriate and acceptable venue to electronically deliver public health notices to clinicians for their patient with important public - with important health conditions requiring follow-up.

The next slide -- and these were our proposed target populations based on HIV laboratory surveillance information individuals who were identified as being not in care for at least 12 months -- meaning we had no record of a CD4 viral load during the past year.

The second group includes persons who we have no record that they received their HIV test results, and that they're unaware that they're HIV positive.

And finally, we wanted to include HIV-exposed infants who needed follow-up to determine their status.

We also took the stance that this system would not and does not replace other vital mechanisms that are already in place for public health follow-up purposes. For example, partner services.

The next slide. So how did we develop this project? It actually started in 2005 where initial discussions on better ways to address out-of-care populations began. And a proof of concept was started in 2006 with some seed funding that we received from the Robert Wood Johnson Foundation.

In 2007, LSUHPSD received a Ryan White Special Projects of National Significance, or SPENDS, grant to develop, implement, and evaluate the LaPHIE. And LSU then contracted with both the Louisiana Office of Public Health and the Louisiana Public Health Institute, or LaPHIE, to embark on this venture.

I've listed the key activities and accomplishments on this slide that occurred, particularly during the first two years of the grant period to - before having LaPHIE go live.

And actually I think it's very challenging to adequately describe each step in this very brief 10 minute presentation. But let me hit some of the highlights.

First of all, a governance structure was established, particularly with the assistance and continued facilitation provided by our neutral convener, LPHI,

where an executive leadership team and miscellaneous work groups were created.

One work group focused on compliance and ethics, while another one worked out the technical or programming aspects that would allow these two data systems to talk to one another.

We also felt that it was very important to hear from consumers and their reactions to this proposed system. Those formative research was conducted to systematically ask questions and collect information from persons living with HIV, as well as individuals who may not be living with HIV, but who had a chronic or stigmatizing condition.

Thus, during 2007 and 2008 there were 16 focus groups convened comprised of 146 individuals. We also felt that it was important to gather information from persons in different regions of the state, so we held eight of these groups in Shreveport or the northern part, as well as eighth in New Orleans.

Also, we had - we conducted 23 key informant interviews in the New Orleans area to collect additional information.

We proceeded with a formal ethics review, which was organized by the CDC National Center for Public Health Informatics, and the HIV AIDS Policy Branch. And they convened a panel of experts for us where the LaPHIE team had the opportunity to present its ideas and information about LaPHIE. And the panel then proceeded to ask many questions and discuss a number of issues that came up. And ultimately they provided valuable feedback to the LaPHIE team.

Related to this, we also engaged with our legal teams from both the Department of Hospital - Health and Hospitals in LSUHCSD to conduct a formal review of federal and state legislation, and to ensure that we were proposing did not violate any laws.

On the technical and programming side, our team determined what needed to be modified in order for the two systems to talk to one another and to maintain all high level security measures as these exchanges occurred.

In addition, the design of the alert messages and the graphical interface was accomplished with the input of the end users or clinicians who would actually be utilizing this system.

A formal data sharing agreement between OPH and LSHUHCDS was executed. And we also established a comprehensive evaluation methodology with both process and outcome measures.

So how does this work? And we're on Slide 36 at this point. Where - so after all of these key steps were accomplished, the system then went live in February 2009 in the Emergency Department of the LSU Hospital located in New Orleans.

And to briefly describe this bidirectional electronic information exchange that links public health in the public hospital system it - briefly, each night, using surveillance data, OPH populates the data set with those determined to be out of care per the LaPHIE criteria that has been established. And that's pretty much then that cylinder that is on the right.

When a patient registers -- and if you click at this point -- when a patient registers at a participating LSU facility, his or her identifying information's

immediately and securely transmitted to OPH and bounced off the data set to see if there's an exact match on four different criteria -- first name, last name, date of birth and Social Security number.

If a match occurs, a standardized message is immediately returned, which will appear on the patient's electronic medical record when it is accessed by an authorized clinician at the point of care.

So this is guided by an onscreen messages on how to proceed and any actions taken are then forwarded back to OPH and are processed to update the out-of-care data set.

Since its initial startup in the New Orleans facility in February 2009, the system has been successfully rolled out to all seven hospitals and 63 clinics, completing this process by May of 2010.

So how will this be worked? You know, and I'm going to say that the next series of slides are animated. And so there's going to be a number of clicks that I'll guide you through.

But first of all, you know, this first slide provides some additional information that identifies the seven hospitals in the LSUHCSD system and where (LUSD) has been successfully implemented.

If you go to the next slide - so let's walk through a step-by-step process of how this system works. Let's say that a person comes into the emergency department at one of these hospitals with a broken toe. And when they register -- next slide -- their information is transmitted from LSUHCSD to the Office of Public Health and it is compared with the established data set to determine if there is a match.

If you go to the next slide. Based on this exchange is determined that there is no records that this person has had a CD4 viral load during the past year and that they are considered out of care. Thus, an alert message is displayed on the page -- that you can see as being the yellow at the bottom -- of the electronic medical record at LSU indicating there's - that there is information regarding this patient that is of public health importance. And it provides the clinician an opportunity to discuss this information with his or her patient.

If you go to the next slide there is a list of recommendations. Next slide -- good. And what you should be seeing is a full screen that says patient may require a follow-up at the top with the purple line, provided for the clinician to follow, who then documents the various actions that he or she took, including a referral process to facilitate the patient's reengagement in HIV specialty care.

Click again. And ideally, then, this patient proceeds to follow through with his or her appointment that is made at the HIV clinic.

In addition, the clinician's actions are transmitted back to the OPH data system in order to document that an encounter occurred, and update the out of care data set, and to provide us with data for monitoring and evaluation purposes.

So conclusion -- and we're on Slide 38 now -- using LaPHIE - since LaPHIE went live, more than 500 persons living with HIV who had not received HIV-related medical care for the past 12 months have been identified. And based on follow-up data analysis for 345 of these patients it was determined that 24% had had no prior labs reported in the OPH surveillance system, meaning that they had not received any HIV-related medical care in Louisiana.

In addition, 32% had never received any HIV test or care in the LSU healthcare system. So we're very pleased with the follow-up results, indicating that 82% of these patients have successfully engaged or reengaged into HIV specialty care since their encounter with the LaPHIE system.

So the development and implementation of this process, we feel that LaPHIE is one tool to successfully offer clinical services to improve both individual and population level health. And in addition, through the formative research activities, as well as the ongoing evaluation processes, we've determined that this system is a mechanism that is acceptable to both patients and providers.

And finally, this process, which has been well thought out, thorough and collaborative, that has included both consumers and key stakeholders, has resulted in a very high level of success.

So we look forward to continuing to utilize and expand this system to other medical facilities during the upcoming year, and that this system demonstrates another tool that can promote new hope for stopping HIV.

I'd like to acknowledge the many, many partners on the next slide who have been a part of this process who are listed here. And thank you very much.