How Quality Improvement Informs Hepatitis Elimination: A Health Department Data-to-Care Approach

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NYC HEALTH DEPARTMENT | VIRAL HEPATITIS PROGRAM
Almost all people can be treated and cured of hepatitis C in less than 12 weeks with few side effects, including people who use drugs and people living with HIV.
DATA TO CARE MODEL

Analysis of Mono and Co-Infected Population through matching of surveillance data

Provider Education & Training
Clinical Practice Facilitation
Telephone Outreach & Linkage to Care
OBJECTIVES

- Use surveillance data to identify health care facilities with a high burden of hepatitis C (HCV) and form partnerships
- Develop and disseminate surveillance–based facility specific dashboards with HCV screening and treatment metrics to support HCV quality improvement initiatives
- Provide training, technical assistance, tools and prompts to encourage providers to review facility electronic health record data at least annually to assess and improve HCV screening and treatment rates
DATA-TO-CARE TOOLKIT

Multiple resources to use in various combinations based on need

- Provider Guidance, Education and Training
- Facility specific surveillance-based dashboards and patient lists
- Electronic Health Record data review tool
- Technical assistance for quality improvement project implementation
Provider Guidance Tools

City Health Information

New York City Department of Health and Mental Hygiene

January 2019

Dear Colleagues,

People living with HIV and hepatitis C infection are at high risk for developing serious liver disease and liver cancer. Fortunately, antiviral medications can cure hepatitis C infection in the majority of patients living with HIV in 8 to 12 weeks with few side effects. Among 55,796 HIV-positive persons residing and receiving care in NYC in 2017, 12% had ever had an RNA-negative result reported for hepatitis C, of these, only 68% had initiated hepatitis C treatment.

The residual community has an unprecedented opportunity to prevent cirrhosis, end stage liver disease, liver cancer, and deaths from hepatitis C infection through early identification and treatment.

To improve health outcomes of persons with HIV, the NYC Health Department recommends that providers:

1. Test all HIV-positive individuals for hepatitis C at intake into care. If there is no record of previous hepatitis C testing, test with antibody and reflex to RNA. If there is a history of hepatitis C infection, test for the presence of hepatitis C RNA.

2. Test HIV-positive individuals with ongoing risk for hepatitis C annually. Individuals at risk include people who use drugs and men who have sex with men.

3. Treat all co-infected patients for hepatitis C. With support, almost all people can successfully complete hepatitis C treatment, including those who are actively using drugs or alcohol and those with untreated HIV.

There are many programs that specialists in treatment for people who use drugs and provide income supportive services such as direct observed therapy (DOT) throughout NYC. Contact HEP Navigation Line (917) 899-0824 for assistance helping your patients get treated and cured.

The Health Department encourages all infectious disease and primary care providers to learn how to treat hepatitis C infection. Review the resources below for information about free trainings available for clinical and allied health providers.

Sincerely,

Shyro Daskalakis, MD, MPH
Deputy Commissioner, Division of Disease Control

Recommendations for Hepatitis C Screening and Treatment in People Who Use Drugs in New York City

July 2020

Dear Colleague:

July 20th is World Hepatitis Day and an opportunity to remind providers of the impact you can have on the lives of your patients by providing prevention and treatment for hepatitis B and C. An estimated 200,000 New Yorkers are living with chronic hepatitis B, and 115,000 are living with chronic hepatitis C, many persons undiagnosed and at risk for cardiovas and liver cancer.

In March 2020, the United States Preventive Services Task Force recommended one-time screening for hepatitis C in people aged 18-79. The important message in screening will increase the number of people who are aware of their status and get tested and treated.

Simplified treatment guidelines have been developed for hepatitis B and C, enabling most people to be treated in a primary care setting. All people can be treated, regardless of their alcohol and drug use.

All PWUD with Hep C should be evaluated for treatment:

- Hep C treatment with direct acting medications in 8-12 weeks with few side effects. See the algorithm for the management and care of Hep C in adults at https://www.hopitality.org.
- Over 90% of PWUD with Hep C are treated with a new cure, less than 5% get reinfected.
- During Hep C treatment patients can engage, resume and resume activities and sexual partners.
- Patient-centered care practices including Hep C patient navigation can help PWUD get care and complete treatment. To find a program in NYC, visit: www.nyc.gov/health/hepc
- Health Insurance approves Hep C medications for PWUD
- In NYC, there are no Hep C medication restrictions based on smoking status, sexual orientation, gender or other conditions.
- Speciality pharmacies can support the medication prior authorization process.
- If health insurance denies medication coverage due to drug use, contact the New York State Office of Health Insurance Programs at ohepc@health.state.ny.us.

Resources

- To find Hep C patient navigation programs and programs for overdose in NYC, visit: health.nyc.gov.
- For more information email: hep@health.state.ny.us

Receiving and interpreting test results:

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<thead>
<tr>
<th>Test type</th>
<th>If positive</th>
<th>If negative</th>
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</thead>
<tbody>
<tr>
<td>Antibody test:</td>
<td>If test positive:</td>
<td></td>
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<tr>
<td></td>
<td>If test negative:</td>
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<tr>
<td></td>
<td>If antibody test:</td>
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Test people who use drugs (PWUD) for Hep C at least annually.

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**HIV/HCV Dashboards**

**Provider A**

- **33.1% Initiated HCV Treatment**
- **266 Coinfected Patients**

**Hepatitis C Antibody Testing**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of people who tested hepatitis C antibody positive at Hospital XYZ System, 2016-2018</th>
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</thead>
<tbody>
<tr>
<td>2016</td>
<td>1,101</td>
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<tr>
<td>2017</td>
<td>1,066</td>
</tr>
<tr>
<td>2018</td>
<td>953</td>
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</table>

**Hepatitis C RNA Confirmatory Testing**

- Percentage of people who tested hepatitis C antibody positive who received a confirmatory RNA test within three months, 2016-2018

- The New York City Health Department’s goal is 85% hepatitis C RNA confirmation compliance. This can be accomplished by implementing hepatitis C antibody to RNA reflex testing.

- **85% Goal**
  - **32** Hospital XYZ
  - **35** 40 Hep C Clinical Exchange Hospitals

**Hepatitis C Treatment Initiation**

- Number of people who tested hepatitis C RNA positive at Hospital XYZ in 2016 and 2017, and percentage who initiated treatment by the end of 2017 and 2018.

- **513 RNA Positive 2016**
  - **50%** Not Treated
  - **50%** Treated

- **352 RNA Positive 2017**
  - **51%** Not Treated
  - **49%** Treated

Data source: New York City Health Department Surveillance.
To read the “Hepatitis A, B and C in New York City: 2017 Annual Report,” visit [nyc.gov/health](http://nyc.gov/health) and search for hepatitis. For more information about the dashboard, email hep@health.nyc.gov.
Clinical Practice Facilitation Projects

Formal agreements with high burden facilities

▶ Provide mini-grants to health care facilities for 1 - 2 year projects

▶ Project Teams include Health Department project management staff, subject matter experts, health care facility clinical and IT and or Quality Improvement staff

▶ Collaborate on development, implementation, monitoring and evaluation of quality improvement projects
Communities of Practice and Learning

- **Hep Free NYC** – Citywide network of professionals, advocates, and affected people working to build capacity to prevent, manage and treat Hepatitis B and C in NYC

- **NYS Hepatitis Telemedicine Workgroup** – building capacity of NYS providers to deliver hepatitis care via telemedicine, with a focus on substance use treatment programs

- Special events including symposiums, trainings, and other events based on community request
## Case Study 1: Brightpoint Health

Community Health Center provider of integrated primary care, behavioural care, dental, and substance use services – 70% of population served experience homelessness

<table>
<thead>
<tr>
<th>Goals</th>
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<tbody>
<tr>
<td>• Develop EHR query report on HCV screening rate and number in need of HCV treatment</td>
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<tr>
<td>• Increase staff capacity to outreach and link coinfected patients to care</td>
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<tr>
<td>• Promote HCV treatment education and best practices</td>
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<table>
<thead>
<tr>
<th>QI Activities</th>
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<tbody>
<tr>
<td>✓ Created weekly EHR query report through health informatics quality management</td>
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<tr>
<td>✓ Reviewed patient list weekly to identify those in need of treatment</td>
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<tr>
<td>✓ Provided quarterly HCV trainings for frontline staff</td>
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| Outcomes                                                                 | 45% of patient on the coinfected list were linked to HCV care, treated and cured                                               |

| Staff Responsible                                                          | Assistant Director for Business Operations: Senior Director, Grants Programs, HCV Navigator (funded through 340B) |
Case Study 2: BronxCare Health System
Multisite Family Medicine Department of a non-profit hospital

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>• Provide training to clinical providers via Hep C Grand Rounds</td>
<td>• Implement reflex testing</td>
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<td>• Promote HCV treatment education and best practices</td>
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<tr>
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<td>• Increase screening of baby boomers and patients at risk for hepatitis C</td>
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<tr>
<td>✓ Leverage Hepatitis C Dashboard to gain leadership buy-in for system upgrade</td>
<td>✓ Develop monitoring report to identify patients with a positive HCV RNA test in the EMR</td>
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<tr>
<td>➢ Implemented reflex testing in the laboratory and EMR order set</td>
<td>➢ Number of patients at risk screened for hepatitis C increased from 4,466 in 2017 to 11,038 in 2018</td>
</tr>
<tr>
<td>➢ Number of patients at risk screened for hepatitis C increased from 4,466 in 2017 to 11,038 in 2018</td>
<td>➢ Proportion of patients receiving an RNA confirmatory test within 3 months after a positive antibody test increased from 35% in 2017 to 88% in 2018</td>
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<th>Staff Responsible</th>
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<tbody>
<tr>
<td>Medical Director of Family Medicine, HIV/HCV Program Manager</td>
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Stay Connected!

**Hepatitis Clinical Exchange**

Find capacity building tools: [HepFree.nyc/hepcx](https://HepFree.nyc/hepcx)

Contact: [hep@health.nyc.gov](mailto:hep@health.nyc.gov)

Follow us: [@hepfreenyc](https://twitter.com/hepfreenyc)