Project SUCCEED: Using a Data to Care Approach to Eliminate Hepatitis C in People Living with HIV in NYC

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Data to Care

• CDC-developed public health framework

• Promotes use of Health Department surveillance and other data to identify people living with HIV (PLWH) and link to them to medical care and other services

• Multiple methods:
  • Health Department-initiated
  • Health care provider-initiated
  • Combined approach

• The NYC Health Department has applied this framework to HIV and hepatitis C (Hep C) coinfected individuals in a HRSA funded project, locally called Project SUCCEED
Project SUCCEED Model

Analysis of Co-Infected Population through matching of HIV and Hep C surveillance data

Provider Education & Training

Practice Transformation

Case Investigation & Linkage to Care
NYC Health Department
HIV and Hep C Surveillance Registries

Reportable to the NYC Health Department:

HIV surveillance registry (Provider and Laboratory Reporting)
  • All HIV diagnosis, viral load, CD4 count, and HIV genotype test results
  • Demographic data available

Hep C surveillance registry (Laboratory Reporting)
  • Positive antibody, positive and negative RNA, and genotype test results
  • Negative antibody tests and Hep C rapid tests results are not reported
  • Minimal demographic data available
HIV and Hep C Co-infection Estimates for NYC

HIV and Hep C surveillance data were matched in May 2016 and May 2017 to estimate prevalence of co-infected population:

- 85,890 HIV-diagnosed people as of December 2016*
- 11,536 ever infected with HIV and Hep C
- 88,710 Hep C-diagnosed people as of December 2016*

4,200 people currently co-infected with HIV and Hep C (May 2017)

*To better account for out-migration and deaths, the number of individuals considered to be diagnosed and living in NYC has been restricted to people who had at least one HCV or HIV lab test reported since 2014 and weren’t known to have died prior to 2017.
Data to Care Approach

Matched HIV and Hep C surveillance data findings were used to:

1. Assess patient care status
2. Identify facilities with the highest burden of HIV and Hep C co-infection
3. Create Hep C dashboards for HIV health care facilities
4. Create lists of co-infected patients for linkage to care or return to care
5. Conduct a Practice Transformation intervention with high burden facilities
6. Monitor project progress towards Hep C elimination
## Characteristics of Co-infected Individuals in NYC, 2017

### Race/Ethnicity (%)

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>HIV only</th>
<th>HIV/HCV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>46</td>
<td>41</td>
</tr>
<tr>
<td>Hispanic</td>
<td>33</td>
<td>42</td>
</tr>
<tr>
<td>White</td>
<td>18</td>
<td>16</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

### Area-based Poverty Level (%)

<table>
<thead>
<tr>
<th>Area-based Poverty Level</th>
<th>HIV only</th>
<th>HIV/HCV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower poverty (&lt;30% below FPL)</td>
<td>30</td>
<td>39</td>
</tr>
<tr>
<td>Very high poverty (&gt;=30% below FPL)</td>
<td>70</td>
<td>61</td>
</tr>
</tbody>
</table>

### History of Incarceration (%)

<table>
<thead>
<tr>
<th>History of Incarceration</th>
<th>HIV only</th>
<th>HIV/HCV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>91</td>
<td>28</td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>72</td>
</tr>
</tbody>
</table>
Assessing HIV Care Status to Plan Intervention

Of 4,200 co-infected people (May 2017):

- **HIV virally suppressed, 60%**
- **In HIV care, 84%**
- **Out of HIV care, 16%**

HIV Field Services Unit provides linkage to care for HIV out-of-care patients.

SUCCEED Target Patients
Care Status of Co-Infected People in NYC

Of the 84% in HIV care:

- In care at largest HIV care facilities in NYC, 56%
- In care at other or multiple facilities, 24%
- In sporadic care, 20%
Hep C Dashboards for HIV Care Providers

Dashboards were created for 47 largest HIV health care facilities, showing:

• % HIV patients co-infected with Hep C
• % co-infected patients at facility who initiated treatment vs. treatment initiation rates across NYC

These clinics were offered surveillance based lists of their own co-infected patients to promote Hep C treatment.
Patient Lists

• **23** facilities accepted a list of their co-infected patients (799 patients in total)

• Facilities were asked to:
  • Review list and promote Hep C treatment
  • Return the list to the Health Department with patient status (i.e. Hep C care status of each patient, treatment barriers)
Patient List Outcomes

12 facilities returned patient lists (406 patients total), of these:

- Lost to care: 21%
- To be returned to care: 19%
- Not infected with Hep C: 14%
- Currently in treatment: 5%
- Not treatment candidates*: 5%
- Declined treatment: 4%

* Not treatment candidates (HIV uncontrolled, drug/alcohol use, co-morbid conditions)
Provider Training

Health care providers across NYC were invited to participate in training on patient navigation, care and treatment for Hep C patients. Since November 2017:

174 service providers participated in a full day Hep C Navigation Training.*

53 HIV clinical providers completed a 10-CME comprehensive online training on Hep C evaluation, care, treatment and monitoring.*

6 HIV providers participated in a half-day preceptorship at a liver clinic.

*Training topics included Hep C medication coverage/prior authorization/patient assistance programs, HIV/Hep C treatment, and co-occurring mental health and substance use disorders.
Practice Transformation Model

• Using surveillance data, Health Department identified and recruited high burden facilities

• Health Department supports facilities to:
  1. Identify PLWH in need of Hep C screening or treatment
  2. Train HIV clinical and non-clinical providers in Hep C navigation, testing, care and treatment
  3. Develop, implement and report on Hep C service improvement plan
Site Selection for Intervention

Using surveillance data, the Health Department

- Generated a full list of facilities with coinfected patients in need of Hep C treatment
- Selected top 15 facilities with highest number or percentage of patients not yet treated for Hep C
- 10 facilities made formal commitments to receive Practice Transformation intervention
  - 4 community health centers
  - 6 hospitals
  - 404 co-infected patients
Practice Transformation Project

EHR Query Support
• Facility runs query to assess baseline, monitor progress and generate up to date patient lists:
  • Number and rate of PLWH screened for Hep C
  • Number of PLWH who are in need of Hep C treatment
  • Generate lists of patients in need of screening or treatment

Hep C Service Improvement Plan
• Health Department supports facility to create the plan at baseline
• Facility submits interim progress report and final report with sustainability plan
## Practice Transformation Methods & Tools

### Methods
- Introductory presentation and call
- Brief needs assessment
- Three site visits
- Training
- Technical assistance

### Project Tools
- Organization profile
- Screening report
- Hep C service and workflow description
- Hep C Service Improvement planning worksheet (SMART)
- Electronic Health Record Query Tool
Hep C Toolkit

Project SUCCEED | Hep C Toolkit

Clinical Provider Resources  Non-Clinical Provider Resources  Patient Resources

AETC National Curriculum | HIV/HCV Co-infection – AIDS Education & Training Center
Includes topics on prevention, screening, diagnosis and treatment recommendations as well as barriers and other co-factors that may impede optimal treatment outcomes for co-infected people of color

Guide | The Basics of Living with Two Infections HIV & HCV – Project Inform
Overview of both HIV and Hep C and what to expect when living with both infections including suggested support resources

Table | Interpretation of Hepatitis C Virus Test Results – Center for Disease Control and Prevention (CDC)
Clear interpretations of Hep C test outcomes and guidance necessary action

Fast Facts | HIV and Viral Hepatitis – CDC
General overview of Viral Hepatitis and HIV along with United States statistics related to coinfection

www.HepFree.NYC/ProjectSUCCEED
**Electronic Health Record Query Tool**

**Health Centers included in this report:**

**Review Period:**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Interpretation</th>
<th>Number in column</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Total adult patients with a visit [la] in the specified review period in your Health Center + a diagnosis of HIV [ib]</td>
<td>At-risk visits</td>
</tr>
<tr>
<td>2</td>
<td>From Row #1, number with documentation of a HCV antibody test order/result [Ila] or HCV RNA test order/result in or prior to review period [Iib]</td>
<td>Column 2 / Column 1</td>
</tr>
<tr>
<td></td>
<td>Proportion of HIV patients seen at health center ever tested for HCV</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Of Row #2, number with a positive HCV RNA test result or diagnosis of HCV in problem list/ICD 9/10 codes [III]</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Of Row #3, number whose most recent HCV RNA test result was positive [IV]</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Number of patients from Row #3 for whom HCV medication was prescribed/initiated treatment [V]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion of patients with HCV who initiated treatment</td>
<td>Column 5 / Column 3</td>
</tr>
</tbody>
</table>

[la] CPT codes for patient encounter during the reporting period: CPT codes 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215 or HCPCS codes (Medicare) G0402, G0438, G0439 (outpatient only) Inpatient CPT codes could include: 99221, 99222, 99223 (initial care), 99231, 99232, 99233 (subsequent care), or 99218, 99219, 99220 (observation initial care) [ib] ICD-10 codes for HIV: B20 “Human immunodeficiency virus [HIV] disease” or Z21 “Asymptomatic human immunodeficiency virus [HIV] infection status”, ICD-9 codes for HIV: V08 “Asymptomatic HIV” or 042 “HIV Disease”
Baseline EHR Query Results (7 Facilities)

Hep C screening rates in PLWH
- Range 57% – 100%

Number of PLWH in need of Hep C treatment
- Range: 31 - 183

Findings
- Screening rates were lower than expected
- Informed Hep C Service Improvement Plan
- Facilities reported conducting EHR query was helpful
Hep C Services Improvement Plans (7 Facilities)

1. Staff Support
   • Training and motivation
   • Hire staff to fill service gaps (e.g. Hep C testing)
   • Clinical mentoring to promote treatment in PWUD (facilitated by a clinical expert)

2. Enhanced Case Management
   • Use EHR query to update lists of cases in need of screening and treatment
   • Set up regular case conferences
   • Develop community outreach capacity (e.g. phone calls, home visits, community health workers)
   • Identify and utilize case finding tools to return lost patients to care
Hep C Services Improvement Plans (Cont’d)

3. Improve Utilization of Existing Facility Resources
   • Support referral to HIV or Hep C navigation, case management and care coordination programs available at the facility
   • Leverage 340B to support Hep C navigation staff
   • Utilize incentives and other priority resources to promote engagement in care

4. Systems Changes
   • Develop and implement QI tools to monitor patient status/outcomes and provide feedback to staff
   • Improve EHR systems (alerts, order sets, auto ordering, patient panels)
Progress Eliminating Hep C in PLWH, NYC*
May 2017 – August 2018

4200 PLWH who were Hep C RNA positive in May 2017

- 27% are now Hep C RNA negative
- 58% Hep C RNA positive/indeterminate
- 15% No follow up needed**

*Result at the time of their last test, as of September 30, 2018.
** Deceased, found to be uninfected with HIV or HCV, now living outside of NYC
Resources Needed for HIV and Hep C Data to Care Project

- Surveillance systems for HIV and Hep C
- Ability to match surveillance systems (IT)
- Analyst Staff
  - Knowledgeable and experience with the intricacies of HIV and Hep C surveillance data
  - Generate care dashboards and patient lists
  - Ability to translate data for provider use
- Working relationships with providers at health care facilities
Outstanding Hep C Elimination Needs Identified through Project SUCCEED

- **Increased resources for Hep C surveillance**
  - Enhance surveillance system capacity to enable receipt of negative Hep C antibody test results (to assess screening rates)
  - Case investigation resources (to assess demographics and risk)
  - Generate surveillance based tools for data to care projects (dashboards, patient lists, facility lists)

- **Case finding resources**
  - Tools to assist with finding patients who are lost to care
  - Community outreach, navigation and retention in care

- Interventions to improve health care facility and provider capacity to provide care for people who use drugs or have uncontrolled HIV
NYC Department of Health
HIV Capacity Building Assistance Program

• The NYC Health Department is funded to provide Capacity Building Assistance (CBA) to integrate Hep C into HIV services
  • Health Departments and Community Based Organizations
  • CBA request ions have included: Hep C Testing and Navigation Program Development, Sharing of Tools and Resources, coalition building and clinical capacity building/detailing
• To request assistance, contact Hep@health.nyc.gov
Disclaimer:

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THANK YOU!!

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- Ann Winters, VHP Medical Director
- Graham Harriman, Director, HIV Care & Treatment Program
- Sera Morgan, New York EMA’s HRSA Project Officer
HIV Undetectable, Hep C Cured!

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ELIMINATION OF HEPATITIS C AMONG PLWHIV IN LOUISIANA: BUILDING A CARE PATHWAY AND PRIORITIZING ACCESS

October 10, 2018
Emilia Myers, MPH
Viral Hepatitis Coordinator
OUTLINE

❖ Health Disparities
❖ Gaps (patient-, provider-, system-)
❖ SPNS Project Framework
❖ Tool
❖ Mindset
❖ Developing a Movement Mindset
❖ Lessons Learned
❖ Future Needs
HEALTH DISPARITIES IN LOUISIANA

State Ranking

- Health care, 47th
- Education, 49th
- Economy, 44th
- Opportunity, 50th
- Infrastructure, 44th
- Crime & Corrections, 48th
- Fiscal Stability, 48th
- Quality of Life, 42nd

Persons Living with HIV/HCV Co-Infection (n=1,143)

- 68% of dual diagnoses are black. Only 32% of the state population is black.
- Rates in black males are 4.6 times higher than in white males.
- 52% of dual diagnoses indicated injection drug use as mode of HIV transmission.

1 US News & World Report 2018 Rankings
2 Louisiana 2016 HIV/HCV Co-Infection Surveillance Data
## GAPS

### System-level barriers:
- HCV treatment cost
- Provision of HCV treatment under Medicaid guidelines
- Case ascertainment (existing co-infection among PLWHIV)
- Communication between data systems and EHR needs

### Provider-level barriers:
- Treatment guideline confusion
- Attitudes towards social and behavioral determinants of health
- Provision of harm reduction services
- Gatekeepers

### Patient-level barriers:
- Accessing HCV services and healthcare in general, especially around substance use disorder
- Knowledge of HCV symptoms and treatment
How does a State Health Department support development of a Hepatitis C care pathway to achieve cure?
LOUISIANA SPNS PROJECT FRAMEWORK

Activities

- Health information systems
- Provider training
- Patient education and harm reduction service delivery
- Annual opt-out HCV screen: 90-90-80 target
- Access to DAAs
- Leadership / Governance

Engagement with/by PLWHIV

Integrated/Co-Located HIV/HCV Care

- Support and resources for substance use disorder
- MAT services
- Psychiatric services
- Syringe services
- Data to care
- Ongoing innovation

Tool & Mindset
PERFECT STORM OF OPPORTUNITY AND COLLABORATION

Office of the Secretary
Louisiana Medicaid
Medicaid Affinity Group

2017 to Present

STD/HIV
Infectious Disease Epidemiology
Viral Hepatitis

Louisiana Hepatitis C Coalition

Shreveport
Alexandria
Baton Rouge
New Orleans
TOOL — POLICY

*Ryan White Part B/ADAP Service Delivery: Louisiana Health Access Program (LA HAP)*

- Expanded pharmacy eligibility to cover HCV medications
- Removed inefficient processes Medicaid providers went through to submit the request for the HCV cure

*90-90-80 Target*

- Clinic HCV screening practices
- EHR investment

*Louisiana Medicaid Prior Authorization*

- Eliminated nonmedical barriers to access (sobriety requirements)
- Removed fibrosis score for HIV/HCV co-infection
- Removed prescriber limitations
MINDSET — HEARTS AND MINDS

How to go from:
- “I can’t treat this issue so I’ll just defer on it”
- “I can treat this issue, but it is going to take extra time and work and I’m already overwhelmed”
- “We should refer for Hep C to help manage it”
- “There are so many programmatic changes, I can’t keep up with them AND the medical advances/changes in HCV treatment”

To:
- “We can eliminate HIV/HCV co-infection and it is our obligation as HIV providers to do so”
**MINDSET — HEARTS AND MINDS**

- Hep C Champion
- Provider Trainings
- HCV Report Card and Quality Improvement Meetings
- Hot-topic webinars during Grand Rounds
- Provider and Patient Relationships = patient education, prevention and harm reduction
  - trust, safety, respect, health, time
Progress towards meeting 90-90-80 goals:
- 90% of HIV+ clients screened for HCV in last 12 months
- 90% of HIV/HCV co-infected clients linked to HCV Care within 90 days of positive HCV RNA test
- 80% of HIV/HCV co-infected clients completed HCV treatment

81% (690/857) screened

100% (99/99) linked to care

32% (32/99) completed treatment

Steps to Identify HIV/HCV Co-infected Clients

- Patients Receiving HIV Care (n=857)
- HIV Care Patients Screened for HCV 81% (690/857)
- HIV Care Patients HCV Antibody Positive 14% (99/690)
- HIV Care Patients HCV Confirmed 100% (99/99)

HCV Care Cascade for HIV/HCV Co-infected Patients at Open Health Care Clinic, February 1, 2017 - January 31, 2018

- 100% (n=99) Prescribed HCV Treatment
- 34% (n=34) Completed HCV Treatment
- 27% (n=27) Achieved SVR

Steps of the HCV Care Cascade:
1) HIV/HCV Co-infected: Patients receiving HIV+ care at clinic who are confirmed positive for HCV by RNA testing
2) Linked to HCV Care: Patients who attended initial visit with a HCV medication prescriber within 90 days of first positive HCV RNA test
3) Prescribed HCV Treatment: Patients prescribed HCV treatment
4) Completed HCV Treatment: Patients completed HCV treatment
5) Achieved SVR: Patients who achieved SVR (sustained virological response) 12 weeks after completion of HCV treatment
PRIORITIES FOR ACTION

System-level barriers:
✓ HCV treatment cost
✓ Provision of HCV treatment under Medicaid guidelines
✓ Case ascertainment (existing co-infection among PLWHIV)
✓ Communication between systems and EHR infrastructure needs

Provider-level barriers:
✓ Treatment guideline confusion
✓ Attitudes towards social and behavioral determinants of health
✓ Gatekeepers
✓ Provision of harm reduction services

Patient-level barriers:
✓ Accessing HCV services and healthcare in general, especially around substance use disorder
✓ Knowledge of HCV symptoms and treatment
DEVELOPING A MOVEMENT MINDSET

“We can eliminate HIV/HCV co-infection and it is our obligation as HIV providers to do so”

**Low-Barrier Asks**
- Data sharing and QI monitoring 1x every 6 months
- Non-medical provider trainings
- Engaging PLWHIV on HCV education and harm reduction services

**Mid-Barrier Asks**
- Hot-topic webinar with CE
- MAT waiver training

**High-Barrier Asks**
- Annual HCV screen policy
- Time-intensive medical provider trainings
- Participation in external QI/CPL groups
- Development of a stigma indicator
LESSONS LEARNED

**Tool v. Mindset**… strength in persistence, encouraging buy-in (state and clinic)… be prepared to adapt and modify approach.

- **Develop genuine partnerships with people living with HIV/HCV** and consult them on the design and operation of health services.

- **Acknowledge the potential disconnect** between the lived experience of HIV/HCV and the assumptions of health professionals and policy makers.

- **Integration of HCV services** with HIV and harm reduction services is critical to EtE.

- **Identifying and cultivating the right connected connectors** (Hep C Champion) is often the difference between takeoff and fizzle.

- Focus on long term HIV/HCV co-located care model, but also on smaller building blocks to build momentum… **lower the barriers, flatten the path.**

- **Sustainability efforts**: what happens when funding dissolves?
  - Invest in EHR, data to care, and integration of HCV patient education/wrap-around services
• Generate an evidence-base for which HIV/HCV interventions work vis-à-vis policy and practice brief.

• Expand flexibility of federally funded HIV programs to support integration with HCV programs.

• Raise and prioritize the profile and understanding of stigma as it relates to HIV/HCV care.
We can eliminate HIV/HCV co-infection and it is our *obligation* as HIV providers to do so.
QUESTIONS?

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Viral Hepatitis