

Developing HCV Care Capacity within an HIV Community Health Center Program

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Brooklyn, New York

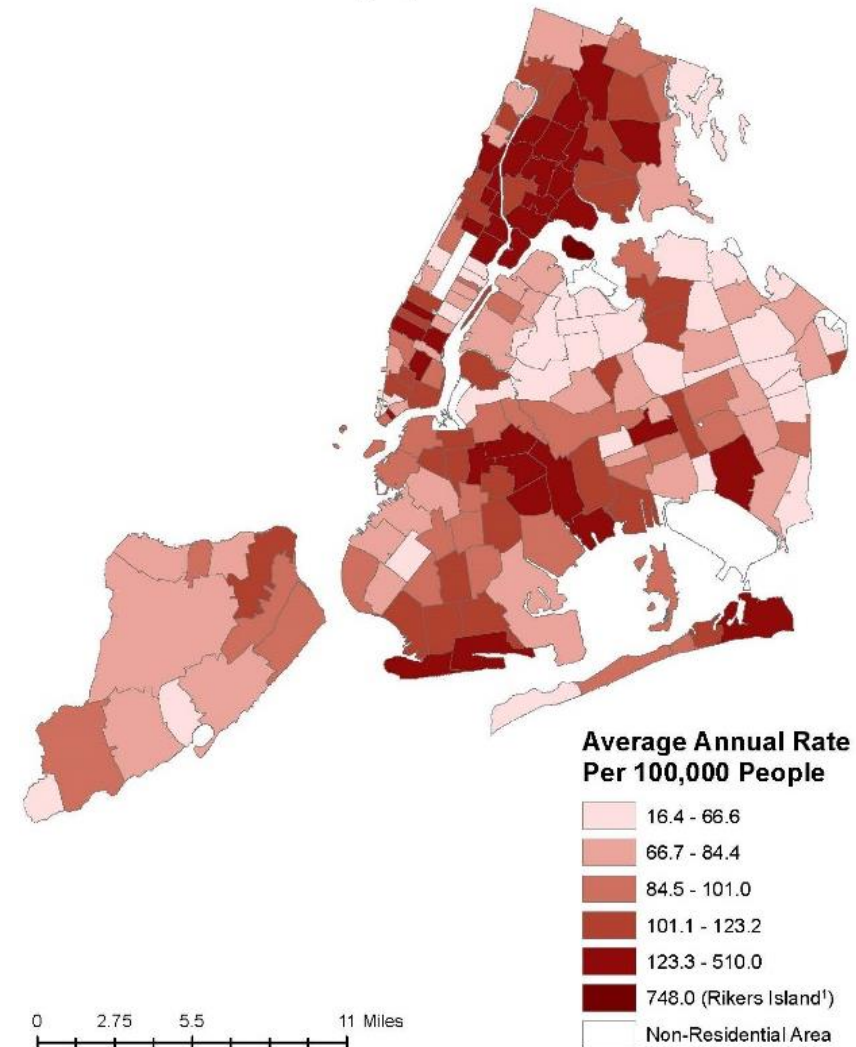
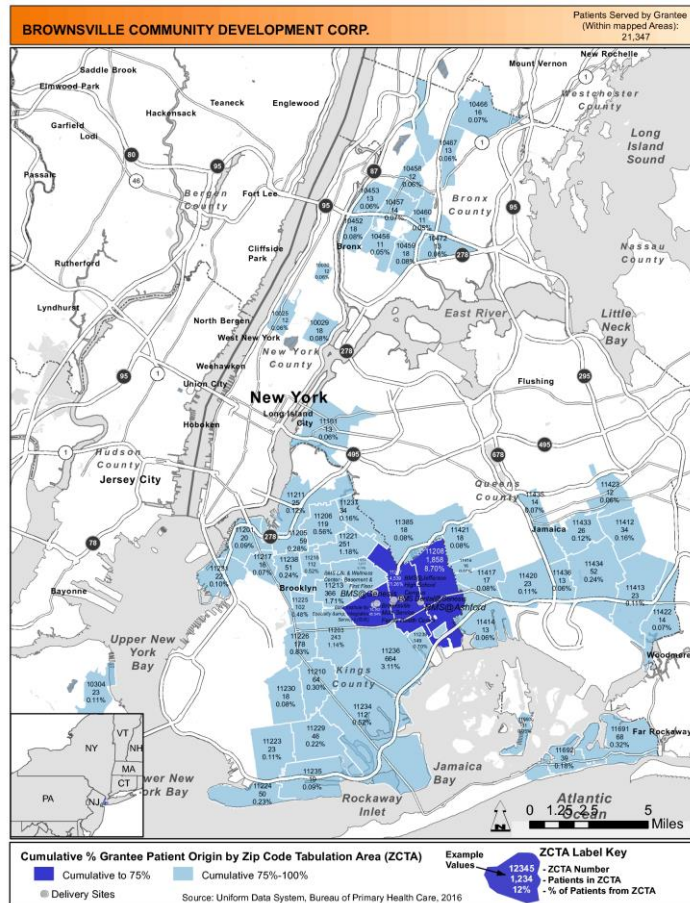
January 24, 2017

Brownsville Multiservice Family Health Center

- Serves over 22,000 patients a year
- Poverty (95% at or below 200% of poverty level)
- Race/ethnicity (19% Hispanic/Latino; 84% Black/African American, 10% more than one race, 2% American Indian/Alaska Native)
- Insurance (77% Medicaid)
- HIV patient population 424 (2016), 82% Virally suppressed
- HCV/HIV Co-infected 46 (11%), 43/46 (93%) treated, 1 failure. 3 untreated, intermittently in care
- Co-located specialty care (Psych, Cardio, GI, Nephro, Pod, Opth, Surg)

High HCV Prevalence and Incidence rates

Newly reported cases of chronic hepatitis C in New York City by ZIP code, 2015-2016



Sources: New York City Health Department, Hepatitis B and C in New York City, 2016, HRSA Health Center Data

Steps taken to eliminate HCV in patient population, esp. HIV/HCV co-infected

- Use of HCV AB with RNA Reflex Testing as only screening assay
- Screening of all HIV Patients at initial visit and thereafter based on risk factors
- Universal Screening of Birth Cohort (Baby Boomers)
- Linkage to HCV evaluation and treatment for all RNA positive patients within a month of HCV diagnosis
- Retention in Care (check Hep C program, MCM, HH)
- Treatment for all patients eligible for therapy
- Linkage to care for Substance abuse and Mental Health

HCV Screening

- Leadership team commitment to HCV elimination
- Health Center Wide Policy on HCV Screening and treatment
- Clinical Team education on HCV and importance of treatment
- HCV Screening as a Quality Measure reported to QA/QI Committee
- Use of EHR to identify population to be screened
- MA/RN/PN/HC involved in identifying patients and ordering screening
- Dashboard on screening performance by provider and site

File Home Insert Page Layout Formulas Data Review View

Clipboard Font Alignment Number Styles Cells Editing

Normal Bad Good Neutral Calculation
 Check Cell Explanatory... Input Linked Cell Note

Check Hep C Program Report on Hepatitis C (HCV) Screening

HCV Screening: Suggested Measures and Uniform Codes

Instructions: Based on Electronic Health Record data, fill in yellow fields. Do not change the grey fields.

List name and address of all Health Center(s) included in this report.

Review Period: 2017 (calendar year) Due Date: January, 2018

Row	Measure	Number	
1	Total adult patients with a visit in the specified review period[i] in the Health Centers included in this report	15,977	All location with exception of Dental and Behavioral Health
2	Of the patients with a visit during the review period (row #1), number who were born between 1945-1965 ^[ii] and/or have a history of injection drug use (IDU), HIV, or other risk factors, if available ^[iii]	3,432	
3	Of the patients in row #2, indicate the number who had HCV listed in their 'problem list' or billing/ICD codes[iv]	107	
4	At-risk visits, need HCV screening (denominator)	3325	
5	From row #4, number with documentation of a HCV antibody test order/result in review period (numerator) [v]	2,356	
6	Proportion of at-risk patients screened for HCV	0.708571429	
7	From row #4, the number of patients <u>without</u> a documented HCV antibody test order/result in their health record	969	

[i] 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)

[ii] 12/31/1965 >= Date of birth >= 01/01/1945

[iii] Consider searching for at-risk clients with ICD-10 code F19 "Use of other psychoactive substances and multiple drug use" or F11 "Use of opioids" and/or for HIV: B20 "Human immunodeficiency virus [HIV] disease" or Z21 "Asymptomatic human immunodeficiency virus [HIV] infection status"

[iv] Date of entry for ICD code/HCV in problem list prior to review period; (ICD-9 codes for HCV = 070.70, 070.54, 070.41, 070.44, 070.51, 070.71, and ICD-10 codes for HCV = B17.1, B18.2, B19.2)

[v] HCV antibody test during review period : CPT code 86803 or LOINC codes 16128-1, 13955-0, 48159-8, 5198-7, 72376-7 or HCPCS code G0472

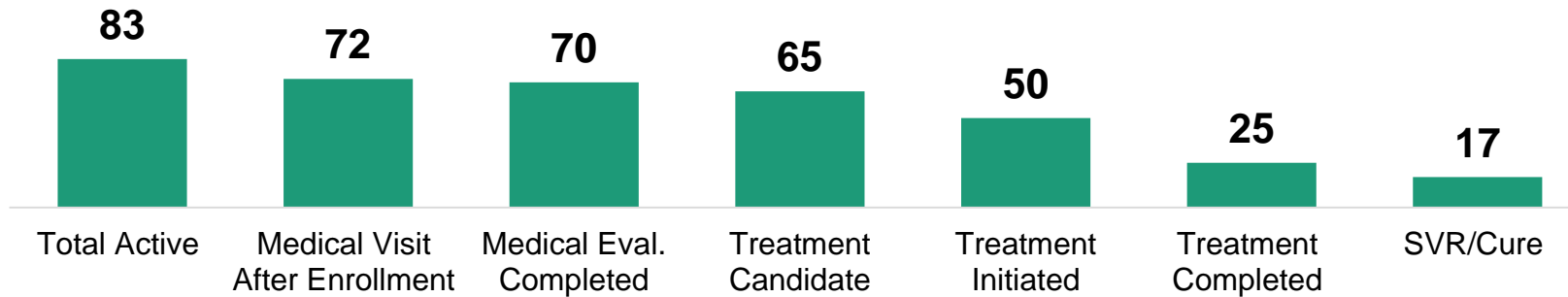
Linkage to Care and Treatment

- All HCV RNA positive patients referred to Bristol site for treatment
- RNs, CMs (MCM/HH), Health Coaches and PNs can schedule appointments
- Patient Navigator(Check Hep C program) reminds patients of appointments and assists with transportation and other needs
- Automated EHR reminders also in place
- Calls to No Shows within 24hrs to reschedule and letters if no available telephone/response
- Adherence support and linkage to other services as needed

Brownsville Multiservice Family Health Center

(July 1, 2016 – June 30, 2017)

Hep C Care Continuum



Patient Psychosocial Status	Percent of Active Patients
Insurance: Medicaid	89%
Homeless/unstably housed	11%
Mental health issue	26%
Injection drug use in past year	4%
Comorbid Conditions	
HIV positive	8%
Hep B positive	0%
Cirrhotic	16%
Liver cancer	0%



Challenges

- Clinicians not ordering HCV screening consistently for various reasons
- Patients seen only for Non Medical visits (Dental, Mental Health & other specialists) not screened
- High no show rate (30%) for treatment evaluation despite reminders
- Substance Use and Mental Health still a significant obstacle to retention in care, initiation and completion of therapy. Working with MMTPs for coordination of care and modified DOT

'Recommendations' for other CHCs

- Secure Leadership support for resources for HCV Screening and treatment or referral for treatment
- Have an Organizational Policy on HCV Screening
- Create a Quality Program for HCV Screening and Treatment
- Educate Staff, including non clinical, on HCV. AETC is a great resource!
- Use EHR to automatically identify patients and for tracking performance
- Partner with CBOs for Screening initiatives, linkage to and retention in care
- Partner with DOHMH!