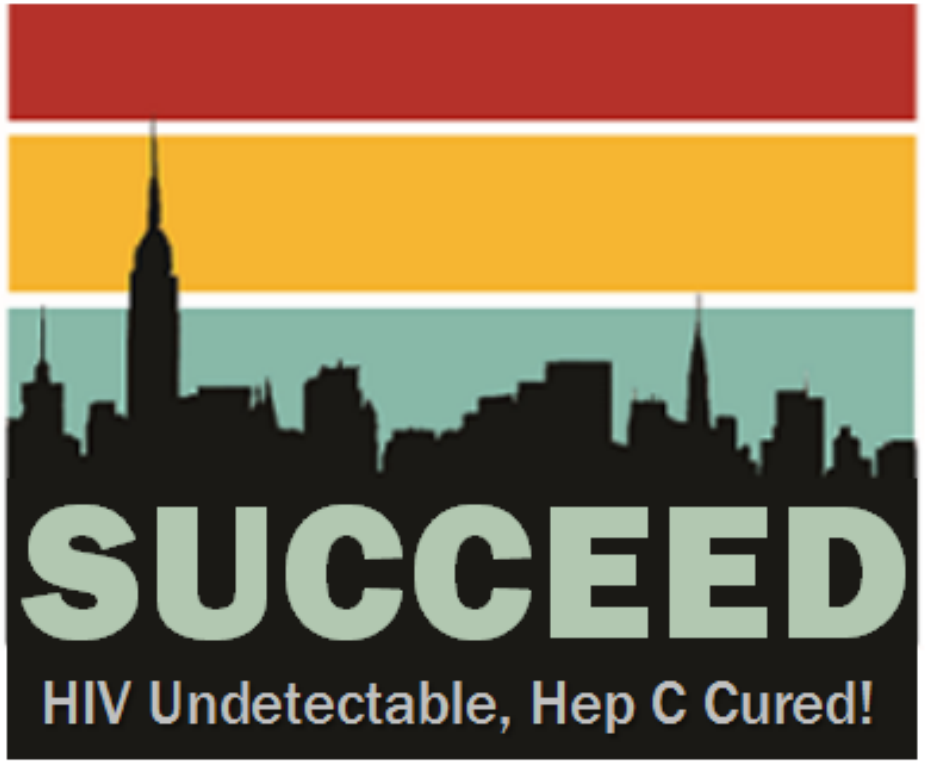


HIV/HCV Treatment Access Committee

October 11, 2018

NYC Health

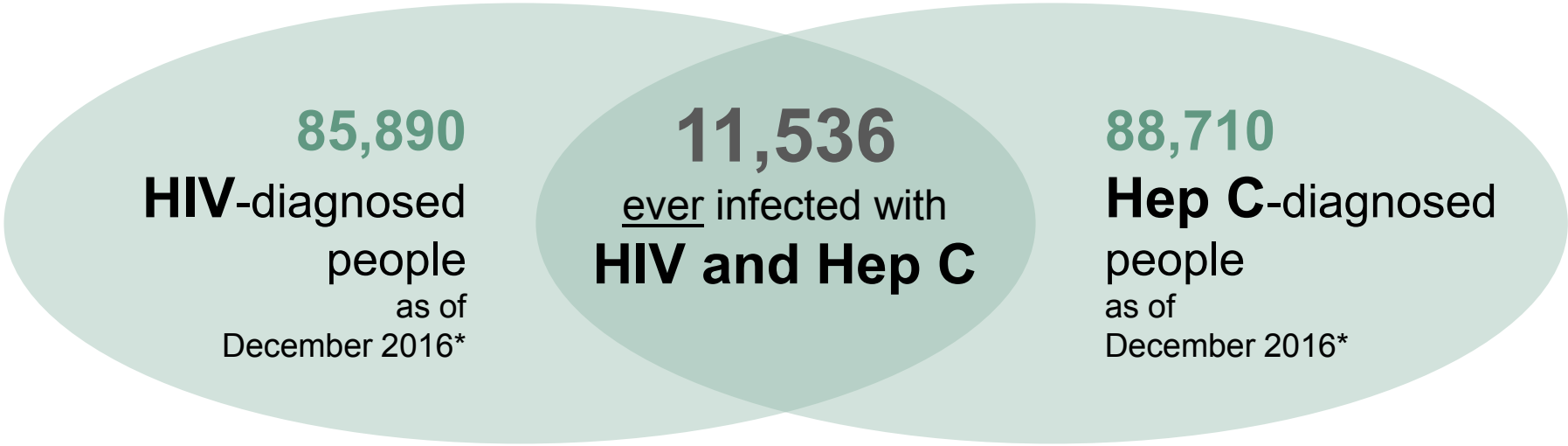
Welcome!

Please introduce yourself to 1 or 2 new people and discuss the questions below:

Think of a patient who was actively using drugs who completed Hep C treatment. What worked?

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:



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 Hep C or HIV lab test reported since 2014 and weren't known to have died prior to 2017.

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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

PRACTICE TRANSFORMATION

Kizzi Belfon, HIV/HCV Surveillance and Evaluation Analyst

SUCCEED 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

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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

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Intervention Sites

- Brightpoint Health
- BronxCare Health System
- Callen Lorde
- Housing Works Community Healthcare
- 5 Mount Sinai Hospital sites
- NYP – Columbia
- Ryan Chelsea Health Center
- St. Barnabas Hospital

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

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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

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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

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Intervention site barriers to Hep C care

- **Common Barrier:**
  - **Lack of staff awareness of available internal Hep C services**
  - Limited Staff (non-clinical) knowledge of importance and capacity to link pts to Hep C care
  - Lack of Community Awareness of available Hep C services at intervention site
  - **Lack of awareness of remaining patients in need of treatment**
  - Lack of Patient Motivation
  - **Lack of clinical provider compliance**
  - Lack of clinical provider capacity to treat or refer for Hep C treatment
  - Medication coverage/Prior Authorization challenges

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

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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)

DIRECT OUTREACH

Farma Pene, Health Care Access Specialist

NYC Health

Experience Providing Direct Outreach and Navigation to Hep C Care for PLWH

- Use Surveillance Data to Identify New Yorkers for Hep C Navigation

- Outreach Methods
  - Call
  - Text messages
  - Mail

Direct Outreach to HIV & Hep C RNA Positive Patients: Progress To Date

Attempted to contact	261	
+Interviewed	77	30%
*Provided services (linkage to care or return to care)	63	82%
*Most recent lab Hep C RNA negative (likely treated)	9	12%

+Percent calculated using “Attempted to contact” for denominator.
*Percent calculated using “Interviewed” for denominator.

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Patient Reactions

- Ask questions about Hep C
- Wish they had been contacted sooner
- Request Navigator Identification
- Uncomfortable disclosing details of treatment delay
- Want help to start treatment

- Concern about treatment side effects
- Concern about liver state
- Confused if treatment was initiated
- Confused about treatment delay
- Confused about SVR12 completion and reinfection.

Patient Reactions – Decline Linkage to Care Services

- Uncomfortable disclosing identity
- Confused about being contacted by the Health Department
- Deny Hep C infection
- Satisfied with current provider
- Provider is applying for treatment
- Not ready to start treatment
- Completed or currently on treatment

Most Successful Linkage to Care Strategies

- Hep C education
- Provide post reinfection preventative education
- Contact current provider and pharmacy
- Update provider on treatment preferred by insurance
- If uninsured, help patient get treatment through other options

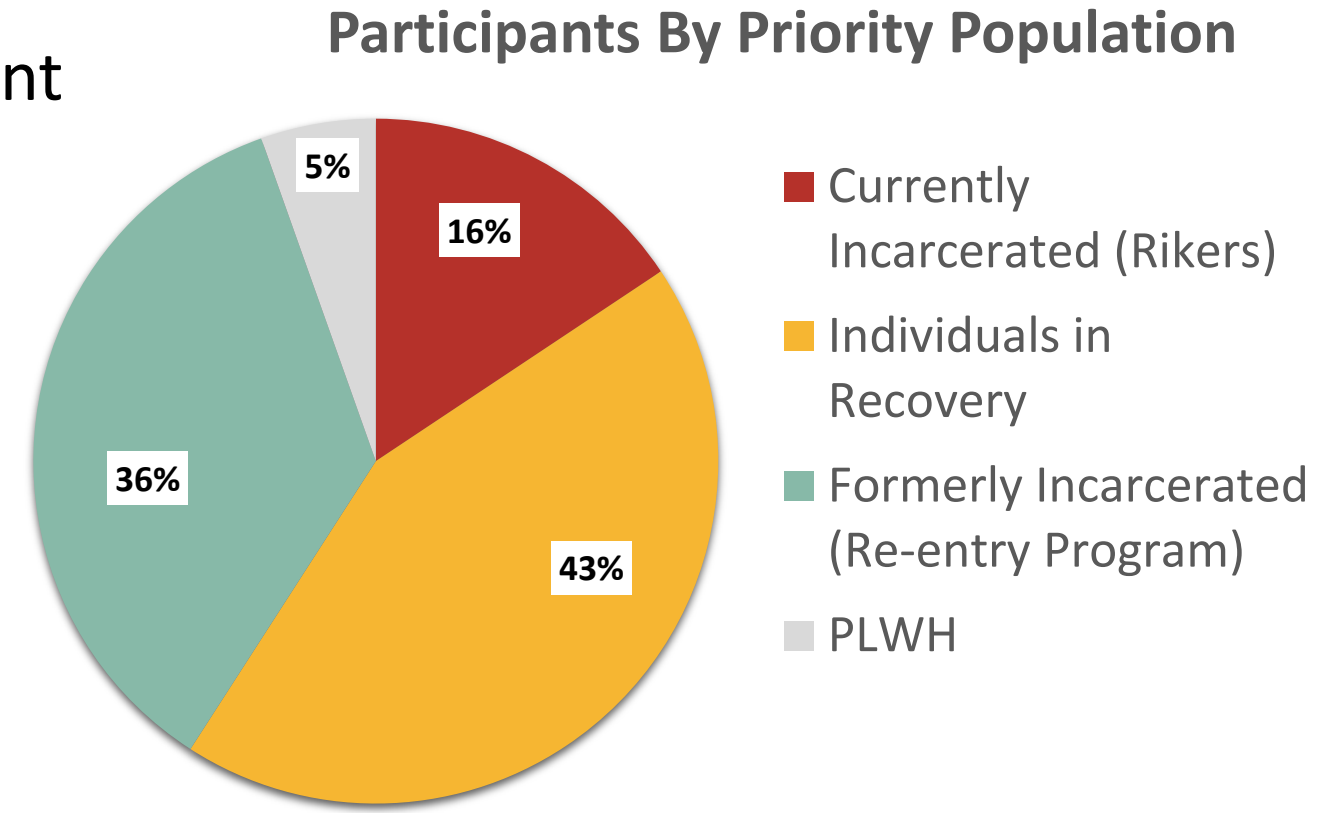
- Provide other treatment locations
- Make appointment with patient
- Provide culturally competent referrals
- Provide escorts when needed
- Provide appointment reminders
- Three way call with Provider and/or Patient Navigator

COMMUNITY OUTREACH – RIKERS ISLAND

Alexis Brenes, Health Care Access Specialist

Hep C Basics Presentation for Communities at Risk

- 25 trainings October ‘17 - Present
- **406 people trained**
  - 313 people at risk
  - 93 organization staff



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Health Navigation for Hep C Patients Leaving Rikers

- Goal: Support Hep C positive clients get into care upon their discharge from Riker's.

- Linkage to Care progress:
  - Trained Rikers Staff in Hep C Patient Navigation
    - Transitional Planning Team
    - HIV Health Educators
  - Forming linkage agreement with Riker's physician
  - Informal referral arrangement with 1 staff member

- Challenges: Consistent Hep C positive client referrals list from Riker's.

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Discussion Questions

- How can the committee help support the NYC Health Department with Hep C navigation for reentrants?

- How can the NYC Health Department better support community organizations serving Hep C positive reentrants?

Key Re-entry Resources

- Transition Guide

- Affordable Housing Resource Guide

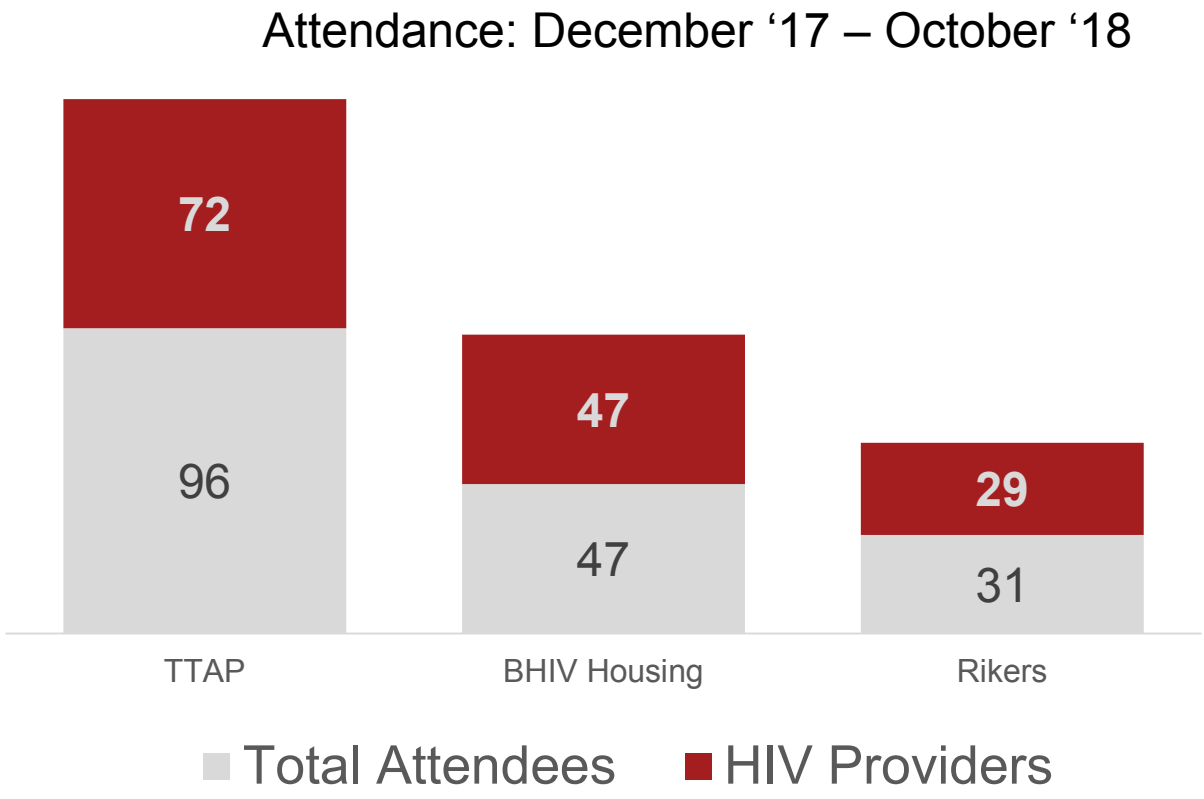
- Assurance Wireless
  Kenia De La Cruz
  keniadelacruz82@gmail.com
  (646) 314-1740

NAVIGATION TRAINING & PWUD WORKGROUP

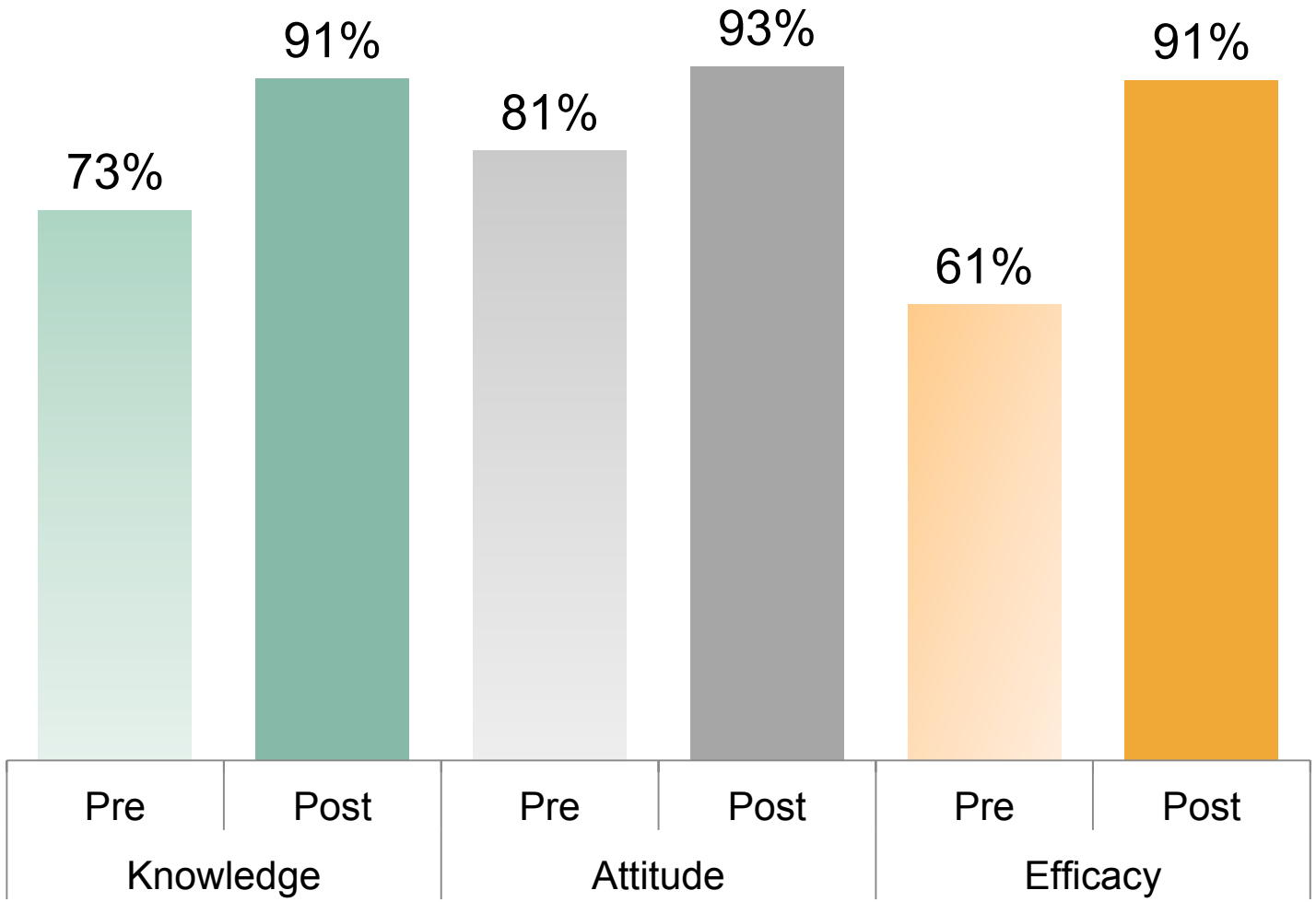
MaNtsetse Kgama, Project Manager

Hep C Patient Navigation Training

- 12 Local Sessions
  - 6 TTAP
  - 4 BHIV Housing
  - 2 Rikers Island
- 174 Participants
- ≥85% HIV providers
- 27 CASAC Certificates



Hep C Patient Navigation Training: Pre/Post Test Summary Data



Workgroup: Treating Hep C in PWUD

Structured Talks at Sites

- Discussion Guide
- Survey Results thus far
- Paper Option
- SurveyMonkey *Barriers to Hep C Treatment for PWUD* closing 10/18

Patient Testimonials

- Moth Application Submitted

Next meeting November 15, 11:00am – 12:30pm

RSVP required mkgama1@health.nyc.gov

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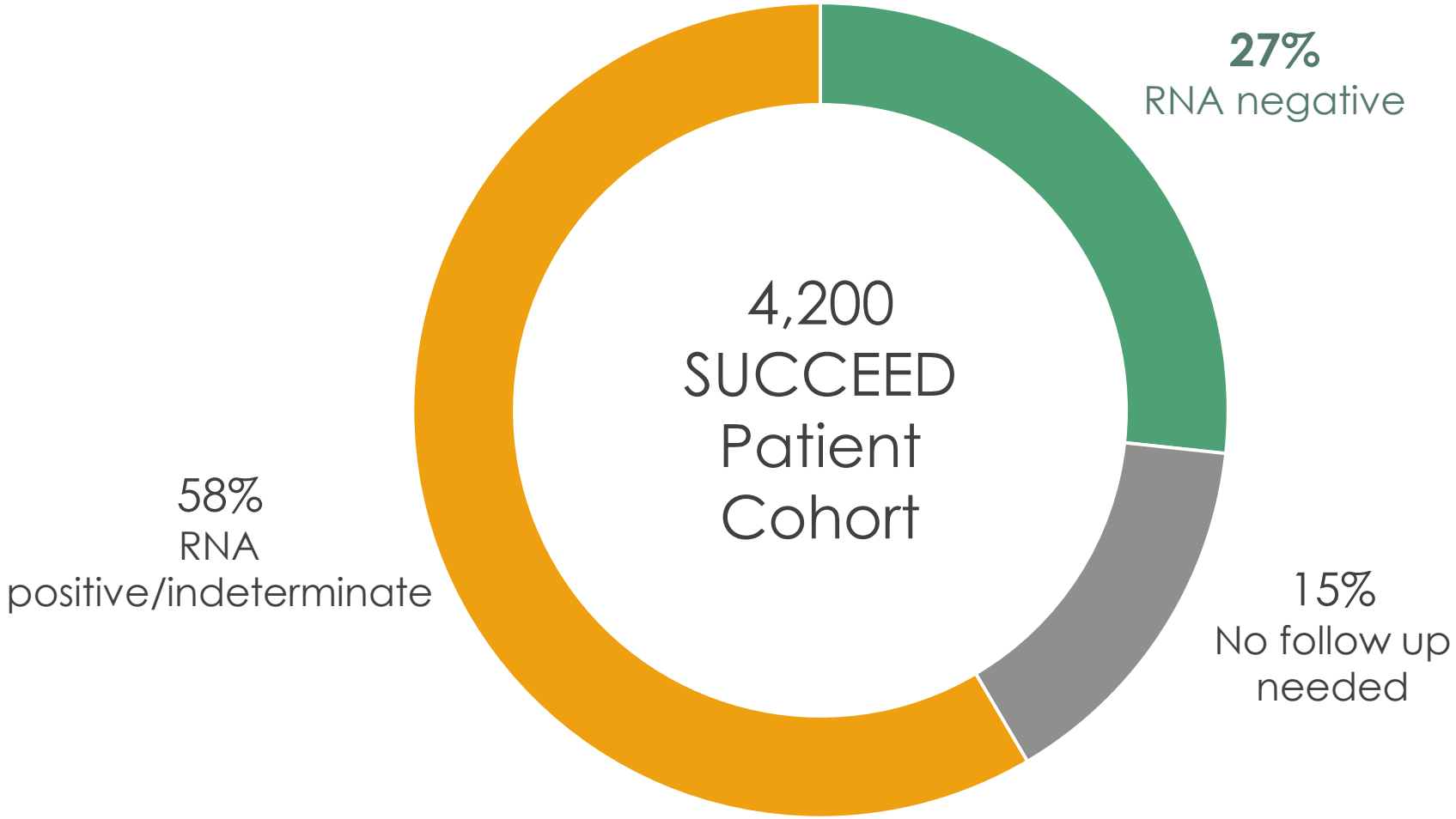
What are you doing to find people lost to care?

Progress Towards Curing Hepatitis C in PLWH, NYC*



*Result at the time of their last test, as of September 30, 2018.