Project SUCCEED:
A Data to Care Approach to Hep C Elimination in People Living with HIV in New York City

Viral Hepatitis Program | Bureau of HIV Care and Treatment
NYC Health Department

NYC Health

Background

- HIV and hepatitis C (Hep C) coinfection
  - Nationally, **25%** of people living with HIV (PLWH) are co-infected with Hep C[1]
  - In New York City, **16%** of PLWH have been co-infected with Hep C[2]

- People infected with both HIV and Hep C are at risk for rapid progression of liver fibrosis, cirrhosis and liver cancer

- PLWH can be cured of Hep C, usually in less than 12 weeks, with few side effects

- All PLWH should be screened for Hep C at intake into care, and if infected - treated and cured. PLWH at risk for Hep C (active drug use, MSM) should be screened annually.

1. CDC, https://www.cdc.gov/hepatitis/hiv-hepatitis-coinfection.htm
2. Prussing, *Epidemiol Infect*, 2015

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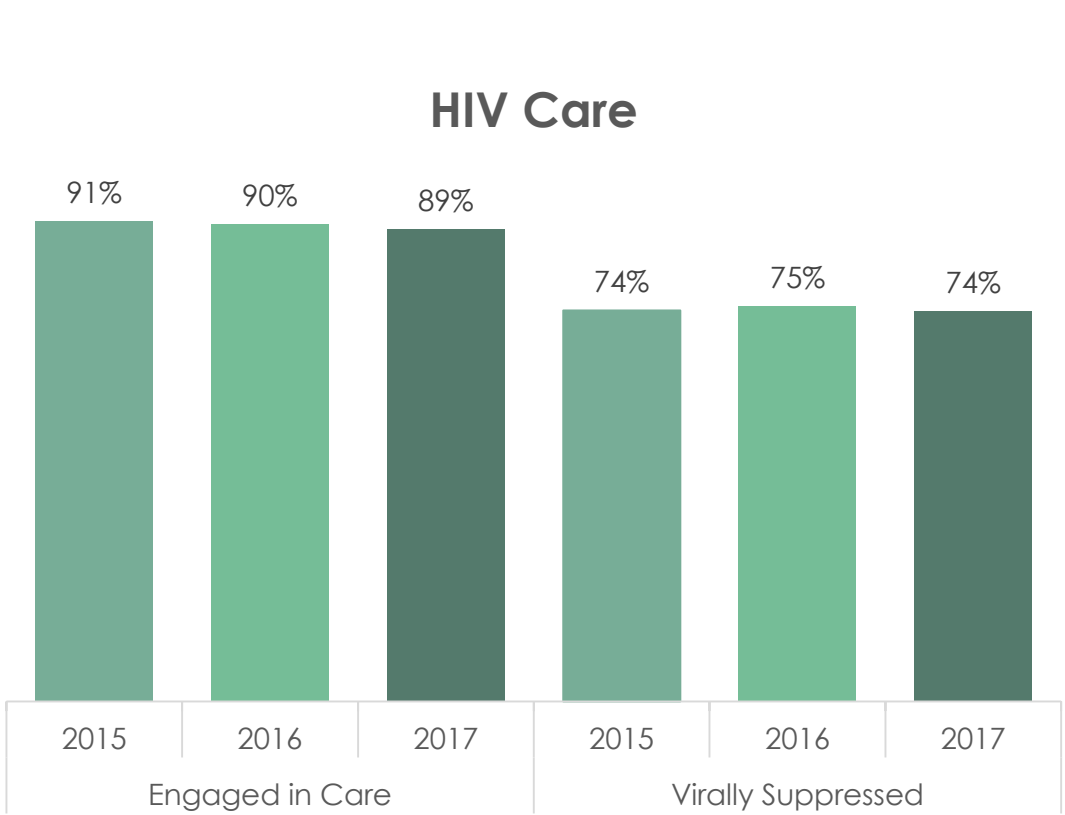
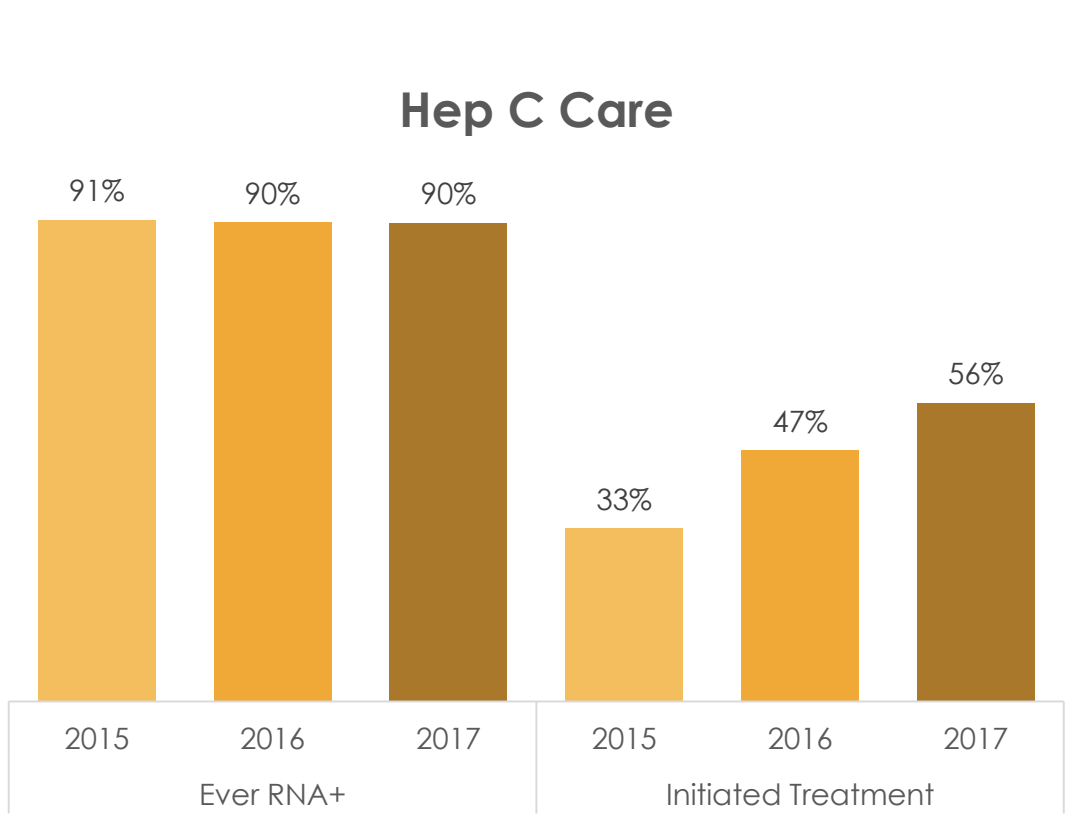
HIV and Hep C Care Outcomes for Co-infected Individuals in NYC, 2015-2017*





*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 the end of the year of interest.

Project SUCCEED Model

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

Provider Education & Training

Clinical Practice Facilitation

Case Investigation & Linkage to Care

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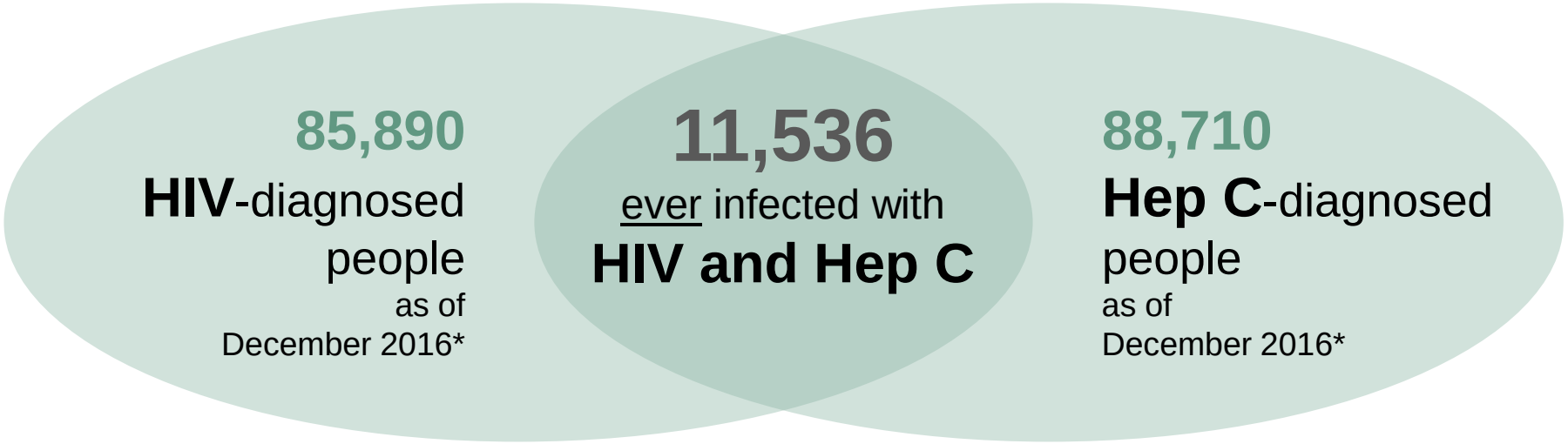
SUCCEED Data to Care Approach

1. **Match HIV and Hep C surveillance data**
2. **Assess patient care status**
3. **Identify facilities** with the highest burden of HIV and Hep C co-infection
4. **Distribute Hep C dashboards** for HIV health care facilities
5. **Provide lists of co-infected patients** for linkage or return to care (health care facilities or Health Department)
6. **Conduct clinical practice facilitation** with high burden facilities
7. **Monitor** progress towards Hep C elimination

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

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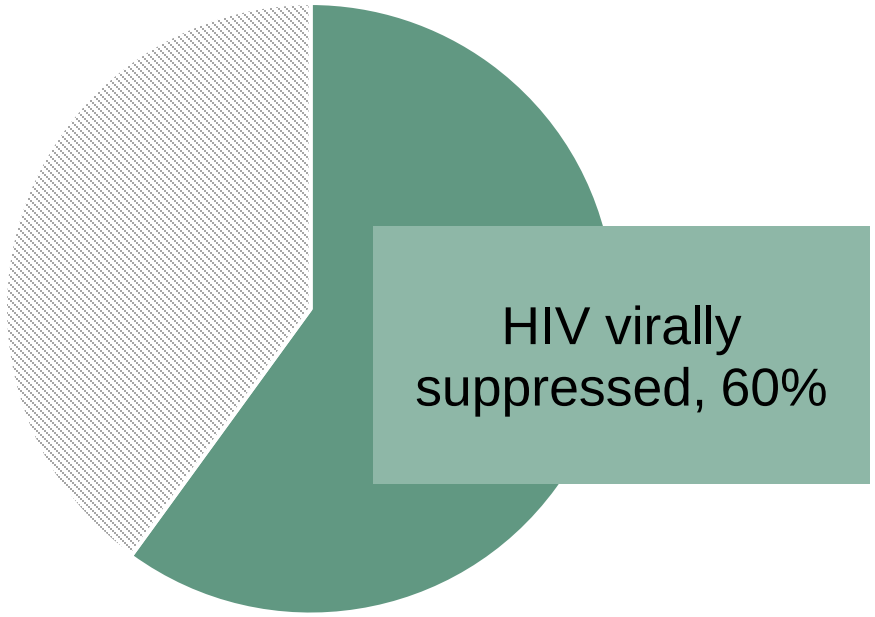
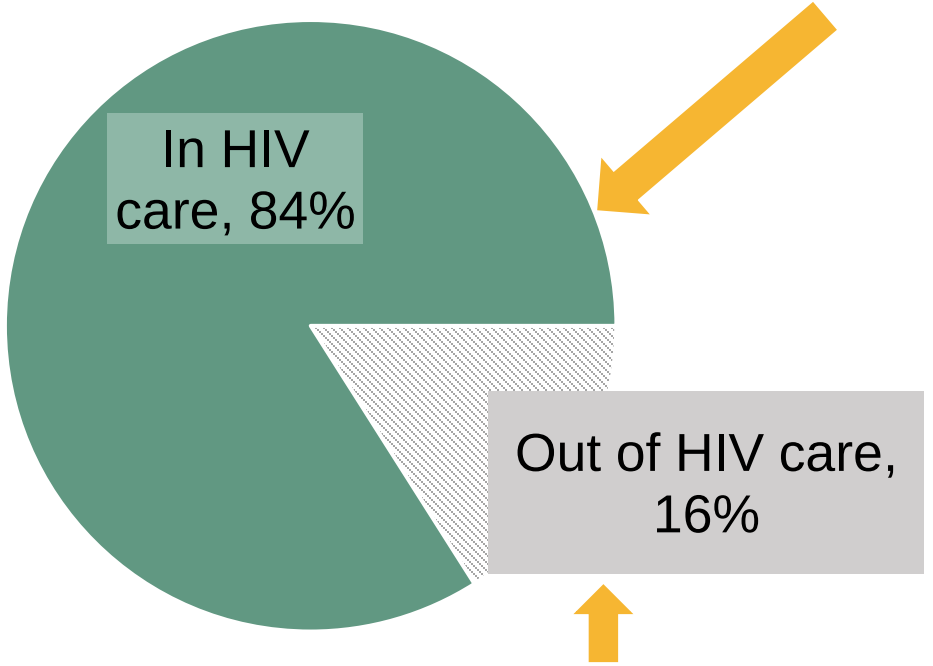
Assessing HIV Care Status to Plan Intervention

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



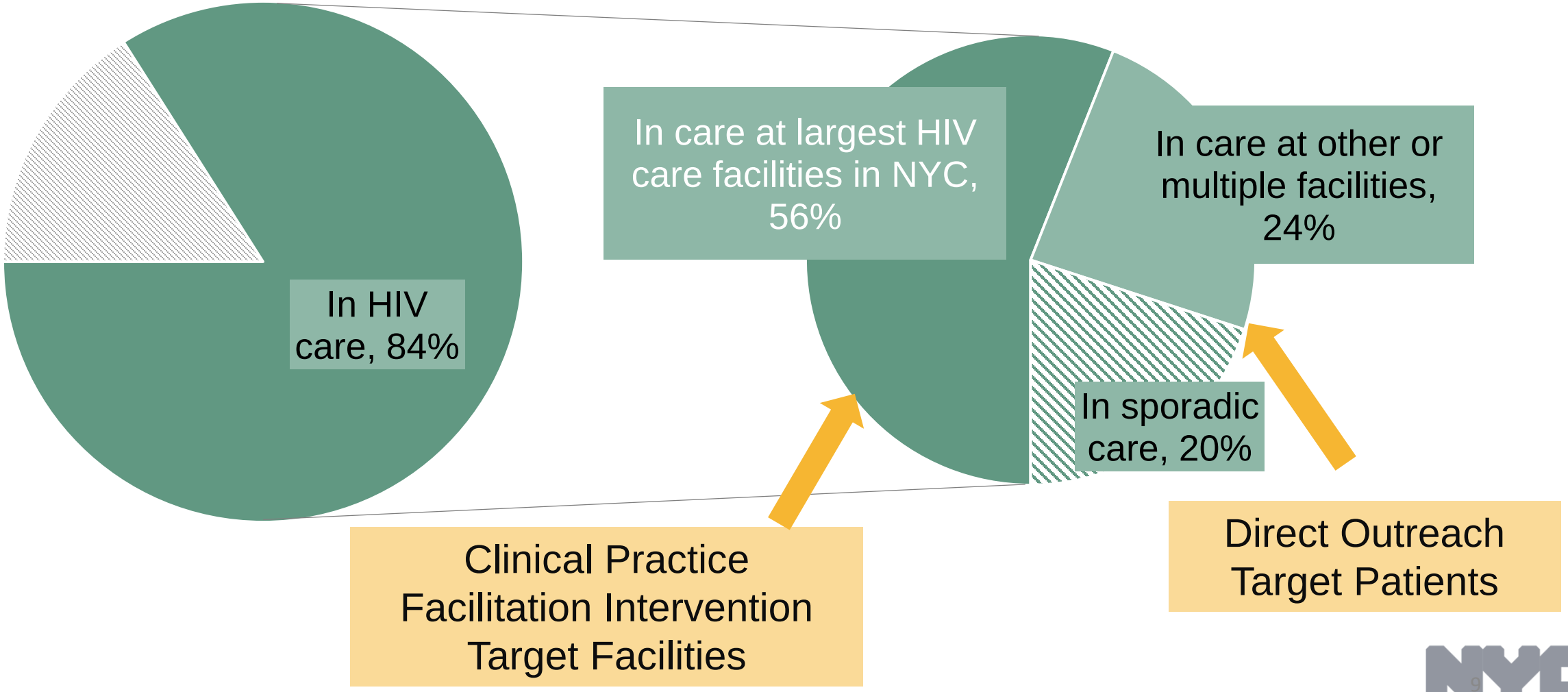


SUCCEED Target Patients

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

Care Status of Co-Infected People in NYC

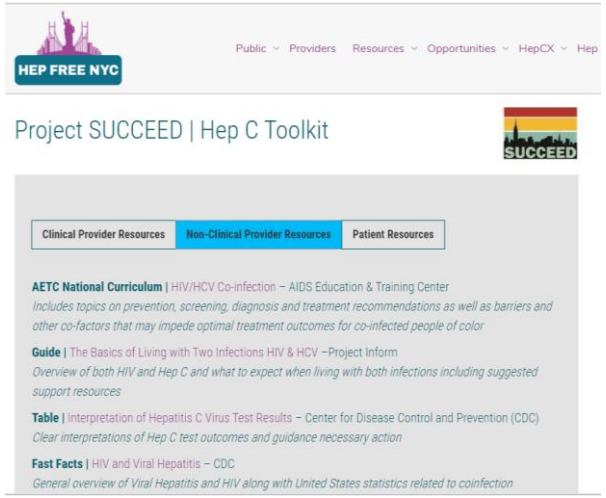
Of the 84% in HIV care:



Provider Training and Toolkit

Promoted citywide, required for intervention sites

- **Hep C Navigation Training*** (full day)
- **Hep C Clinical Training*** (10-CME)
  - Option to attend clinical preceptorship at a liver clinic (half day)
- **Hep C Medication Coverage Training** (1 CME)
- **Hep C Basics** for Communities at Risk (1 hour)



- Encouraged Bridge HCV Training – focus on treating Hep C in People who Inject Drugs (1 – 2 CME)

www.HepFree.NYC/ProjectSUCCEED

*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.

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Training Outcomes

November 2017 – February 2019

Training	Number of People Trained	Identify as HIV Providers
Hep C Navigation	202	173 (86%)
Hep C Clinical Training	144	44 (31%)
Hep C Medication Coverage	75	29 (39%)
Hep C Basics - for people at risk and frontline service providers	566	131 (23%)

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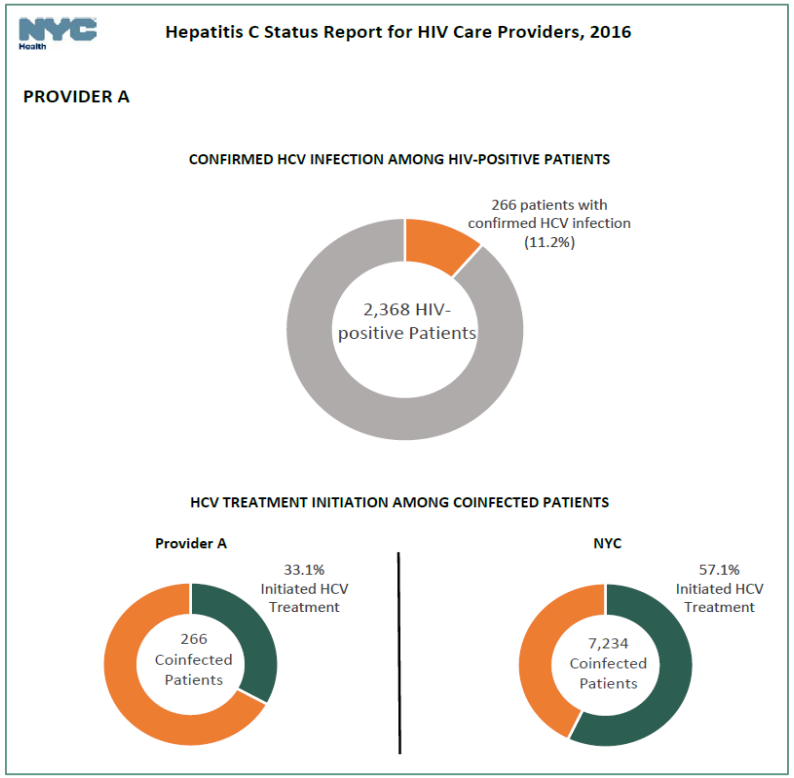
Hep C Dashboards and Patient Lists

Dashboards



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

Patient Lists

Health Department generated facility specific lists of HIV and Hep C RNA positive patients

Facilities were asked to:

- Review list
- Promote Hep C treatment
- Return list to the Health Department with patient disposition

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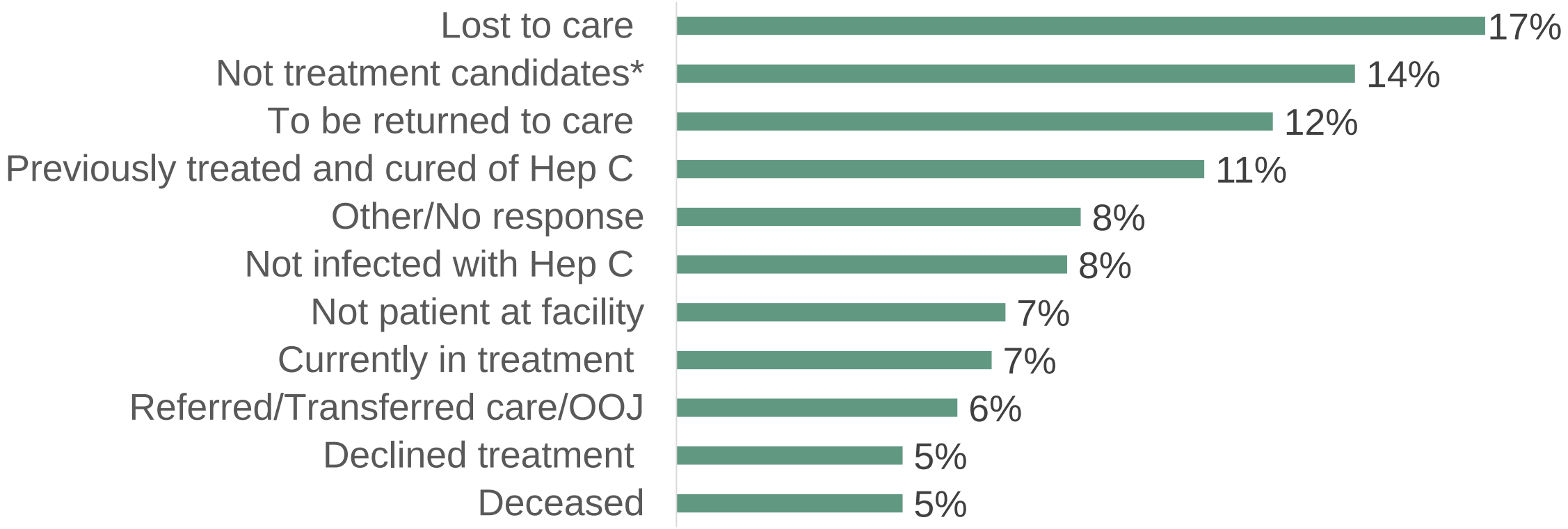
Patient List Outcomes

24 facilities returned patient lists (698 patients total). Providers reported patients were:



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

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SUCCEED Practice Facilitation Intervention

Goal

Improve Hep C screening, linkage to care and treatment in PLWH at health care facilities with a high burden of Hep C in PLWH

Objectives

- Identify PLWH in need of Hep C screening or treatment at the facility
- Train HIV clinical and non-clinical providers in Hep C navigation, testing, care and treatment
- Develop, implement and report on facility Hep C service improvement plan

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Site Selection for Practice Facilitation 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 participate in the intervention

- 4 community health centers
- 6 hospitals
- 785 patients represented

Intervention Sites

Contract

- BronxCare
- Brightpoint Health
- Housing Works
- St. Barnabas Hospital
- Mount Sinai Beth Israel-Peter Krueger Clinic
- Mount Sinai - St. Luke's and Roosevelt Hospitals

Voluntary

- Callen-Lorde Community Health Center
- NewYork-Presbyterian Hospital (Uptown) - Columbia
- Ryan Health Centers

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Data Review Support

- Dashboards and Patient Lists
- **Electronic Health Record Query Tool** to support the facility to review their own data
  - In some cases set up Peer to Peer mentoring
- Facility runs query at baseline and to monitor progress:
  - 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

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Electronic Health Record Query Tool

Health Centers included in this report:			
Review Period:			
	Measure	**Interpretation**	**Number in column**
1	Total adult patients with a visit [Ia] in the specified review period in your Health Center + a diagnosis of HIV [Ib]	*At-risk visits*	
2	From Row #1, number with documentation of a HCV antibody test order/result [IIa] or HCV RNA test order/result in or prior to review period [IIb]		
	Proportion of HIV patients seen at health center ever tested for HCV	*Column 2 / Column 1*	
3	Of Row #2, number with a positive HCV RNA test result or diagnosis of HCV in problem list/ICD 9/10 codes [III]		
4	Of Row #3, number whose most recent HCV RNA test result was positive [IV]		
5	Number of patients from Row #3 for whom HCV medication was prescribed/initiated treatment [V]		
	Proportion of patients with HCV who inititated treatment	*Column 5 / Column 3*	

[Ia] 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"

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Hep C Service Improvement Project

Health Department worked with each facility to develop their project, based on their needs and capacity

Project Tools

- Organization assessment
- Hep C service and workflow description
- Electronic health record query tool
- Screening and treatment report
- Hep C service improvement planning worksheet: SMART plan, progress reports, and sustainability plan

Hep C Services Improvement Project Categories

Staff Support

- Training, motivation, mentoring, hiring

Improve Utilization of Existing Facility Resources

- Identify, utilize, publicize existing programs and opportunities (care coordination, 340B, incentives)

Enhanced Case Management

- Regular data driven case list review, conference, return to care activities

Systems Changes

- Electronic Health Record enhancements (alerts, order sets), QI tools and initiatives

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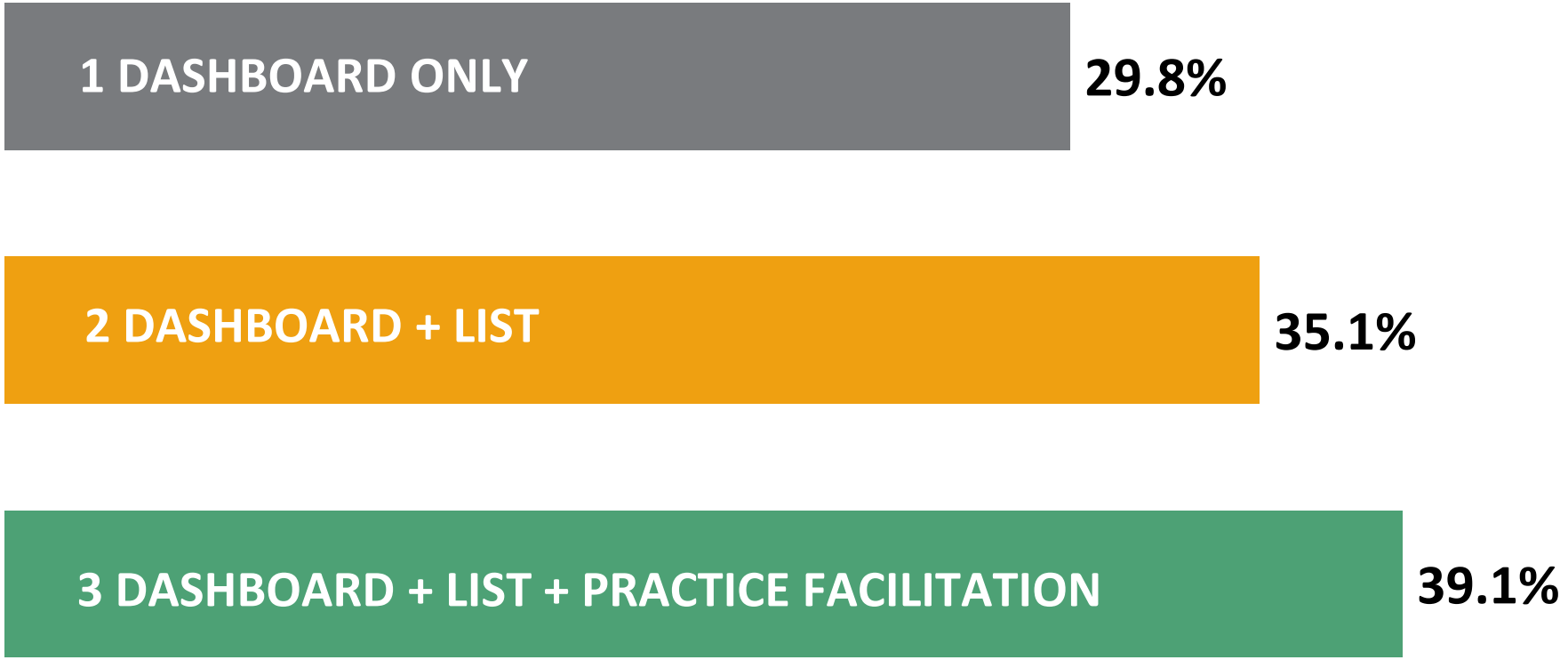
Percentage of RNA Negative by Practice Facilitation Interventions Received*



*Result at the time of their last test, as of February 11, 2019.

Case Investigation and Linkage to Care Intervention

- Health Department Navigators
- Reach out by telephone to PLWH whose last test reported was Hep C RNA positive
- In multiple languages: English, French & Spanish
- Support access to Hep C treatment:
  - Return to Care
  - Linkage to care
- Education and referrals to supportive services
- Developed a new Health Department Navigation documentation system and program

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Case Investigation and Linkage to Care Outcomes

Intervention time frame: May 2018 – February 2019

Assigned	Interviewed	Provided Linkage to care	Provided Return to Care	Hep C RNA Test After Interview (of interviewed)	Most Recent Test result Hep C RNA negative (of interviewed)
467	130 (28%)	6%	74%	44%	14%

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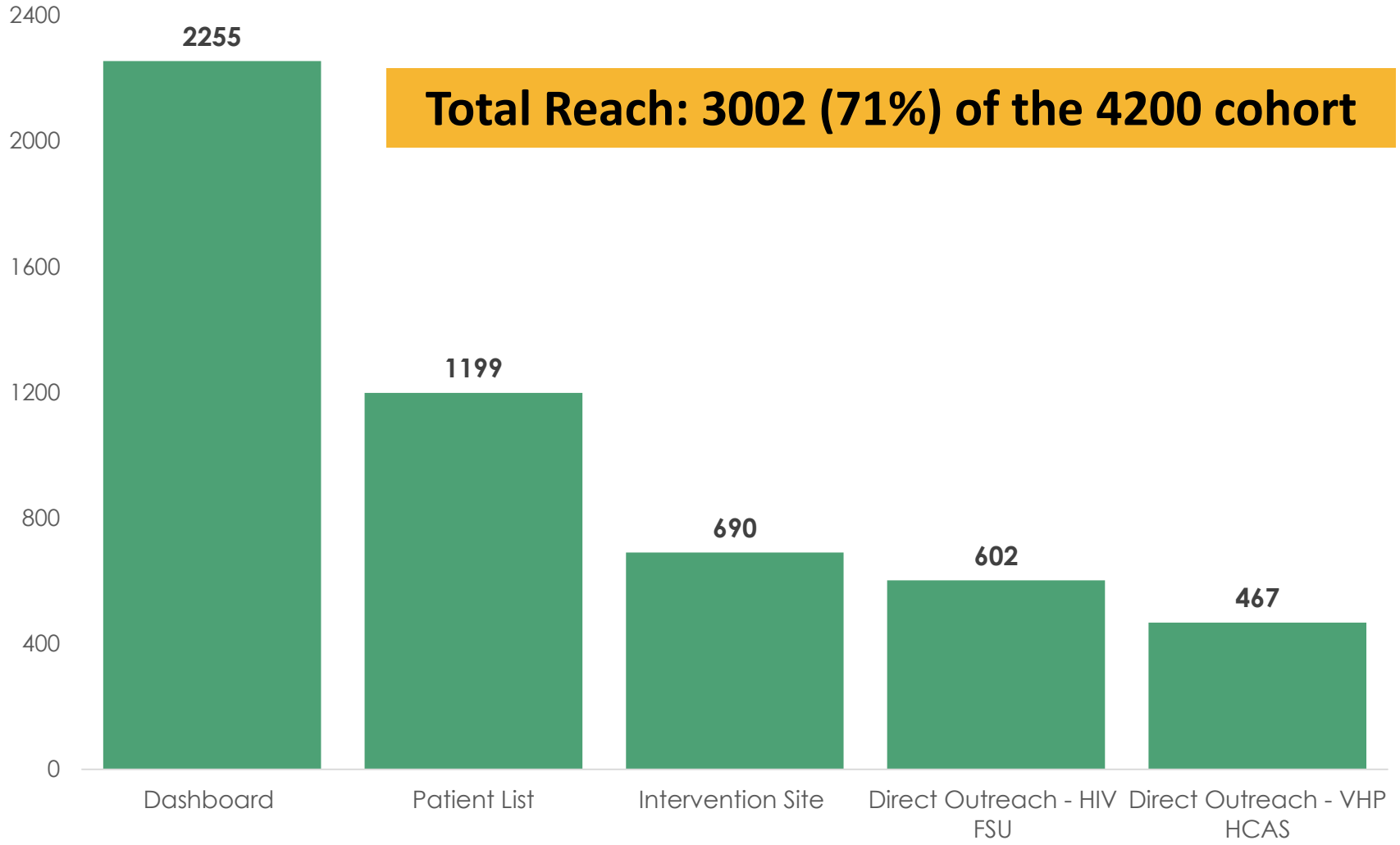
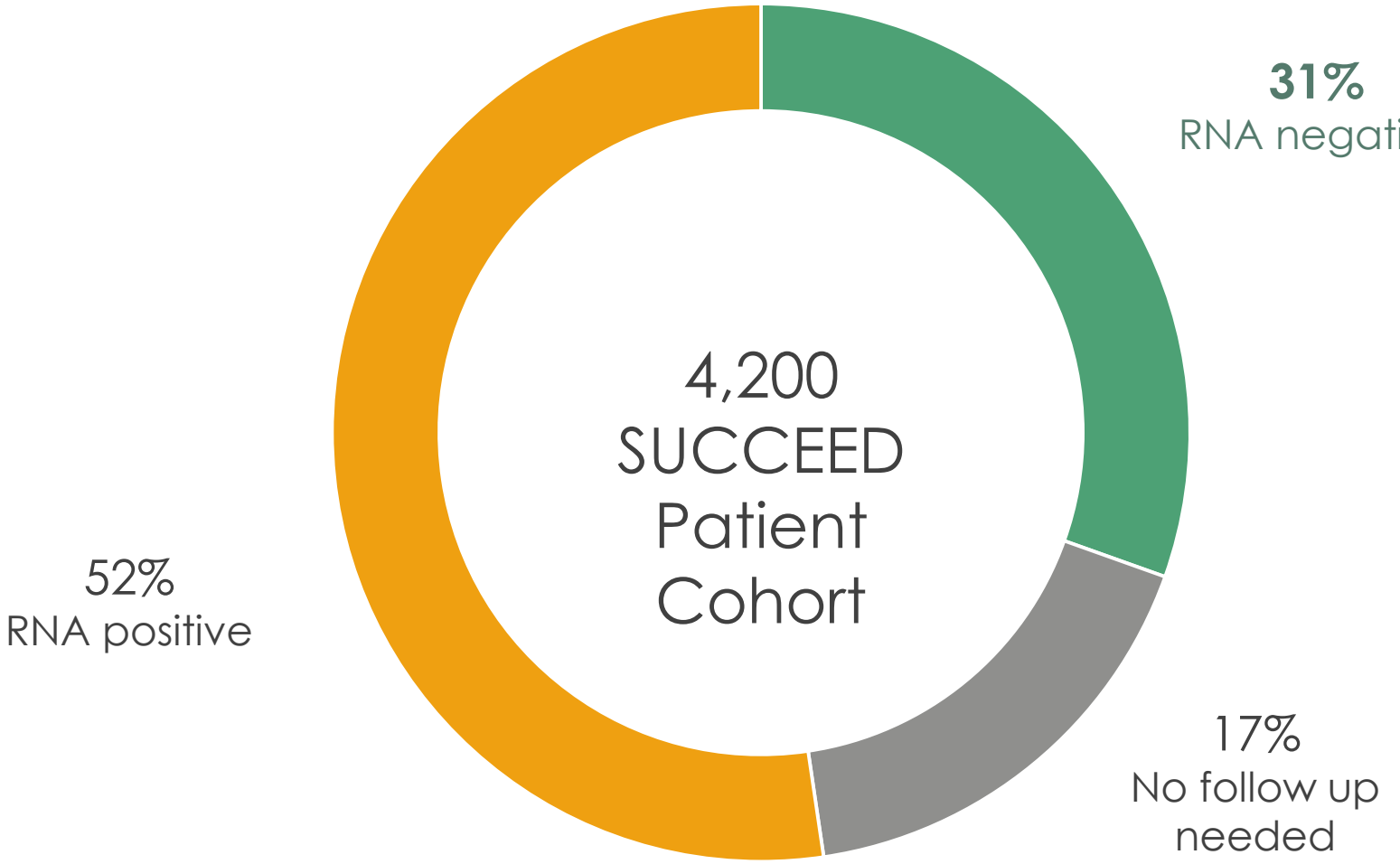
Project SUCCEED Patients by Intervention Type



Total Reach: 3002 (71%) of the 4200 cohort

Progress Towards Curing Hep C in PLWH, NYC*



*Result at the time of their last test, as of February 11, 2019.

Findings

- Hep C Screening rates for PLWH were lower than expected at health care facilitates
- Providers need additional support to treat Hep C in people with uncontrolled HIV and/or active drug or alcohol use
- Unclear who some patients “belong to” if only marginally touched the health care system
- Many patients are intermittently lost to care

Important Resources for Hepatitis Data to Care Projects

- **Surveillance systems:** for HIV and Hep C, and ability to match
- **Staff:** Health Department project management, technical assistance, navigation and data analyst staff
- **Funding and/or strong relationships** with leadership at health care facilities

Outstanding Hep C Elimination Needs

- **Hep C surveillance resources**
  - Negative Hep C antibody reporting - to assess citywide and facility screening rates using surveillance data
  - Generate surveillance based tools for data to care projects (dashboards, patient lists, facility lists)

- **Improved care for people who use drugs and alcohol**
  - Interventions to improve health care facility and provider capacity to provide care for people who use drugs and alcohol

- **Case finding and outreach resources**
  - Tools to assist with finding and engaging patients who are lost to care
  - Navigation staff

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New York City Project SUCCEED Team

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HIV Undetectable, Hep C Cured!

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