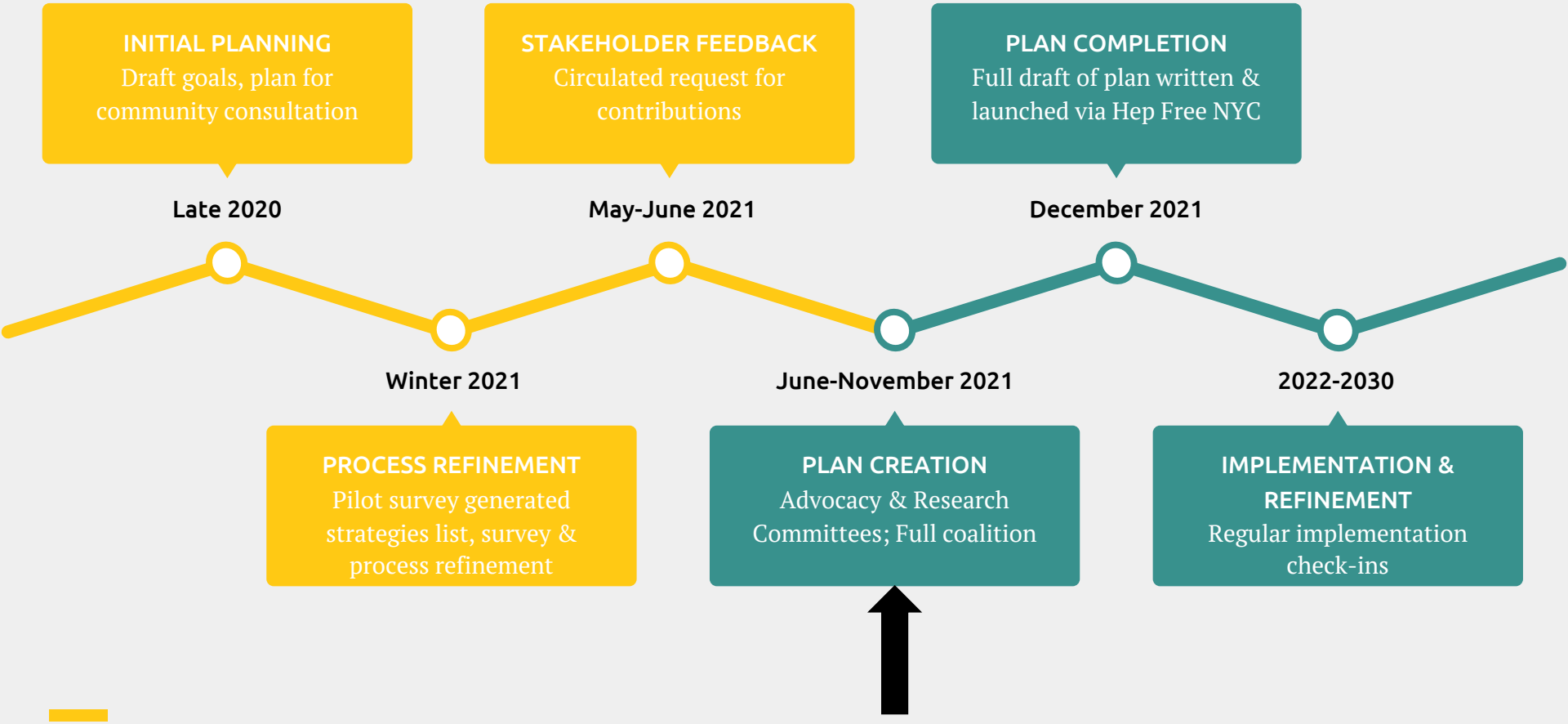
NYC HEPATITIS ELIMINATION PLANNING

Hep Free NYC Meeting
June 30, 2021


INITIAL PLANNING
Draft goals, plan for community consultation
STAKEHOLDER FEEDBACK
Circulated request for contributions
PLAN COMPLETION
Full draft of plan written & launched via Hep Free NYC
Late 2020
May-June 2021
December 2021
Winter 2021
June-November 2021
2022-2030
PROCESS REFINEMENT
Pilot survey generated strategies list, survey & process refinement
PLAN CREATION
Advocacy & Research Committees; Full coalition
IMPLEMENTATION & REFINEMENT
Regular implementation check-ins

GOAL 1

Reduce new hepatitis C infections by 90% by 2030

Progress Indicators	Baseline	2030 (goal)
100% screened for hepatitis C in programs that are contracted by the Health Department Data source: organizations that partner with the Health Department and report screening data	42% (2018)	90%
80% of all newly diagnosed adults initiate treatment within one year Data source: Surveillance data	29% (2018)	80%
Number of people re-infected with hepatitis C annually Data source: Surveillance data	Being assessed in 2021	To be determined after assessing baseline

GOAL 2

Reduce premature deaths due to chronic hepatitis B and C by 65% by 2030; improve the health of people living with hepatitis B and C.

Progress Indicators	Baseline	2030 (goal)
90% of people at risk for hepatitis B infection are screened in programs that are contracted by the Health Department Data source: organizations that partner with the Health Department and report screening data	57% (2018)	90%
80% of people diagnosed with hepatitis B since 2018 will be virally suppressed Data source: Surveillance data	Being assessed in 2021	80%
80% of people reported to the health department with hepatitis C since 2014 will have initiated treatment Data source: Surveillance data	62% (2019)	80%

GOAL 3

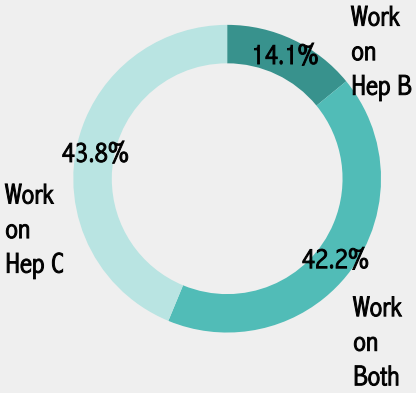
Reduce health disparities related to viral hepatitis infection.

Progress Indicators	Baseline	2030 (goal)
65% reduction in rates of mortality from hepatitis C for Black/African American and Latinx NYC Residents Data source: Surveillance and vital statistics	6.4 per 100K Latinx; 5.7 per 100K Black/African American (2019)	2.24 per 100K Latinx; 2.00 per 100K Black/African American
65% reduction in rates of mortality from hepatitis B for Asian and Pacific Islander NYC residents Data source: Surveillance and vital statistics	2.2 per 100K Asian/Pacific Islander (2019)	0.77 per 100K Asian/Pacific Islander
Eliminate disparities in hepatitis B and C treatment rates by neighborhood of residence Data source: Surveillance and vital statistics	Being assessed in 2021	80% treatment rate across neighborhoods

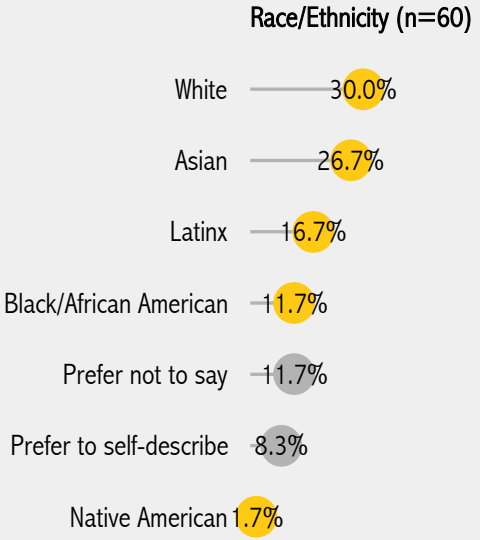
ESSENTIAL QUESTION:

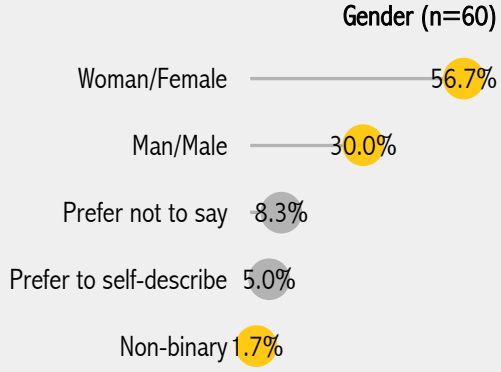
What has to change in NYC's response to hepatitis B and C in order to get closer to the big elimination goals?

66 RESPONDENTS

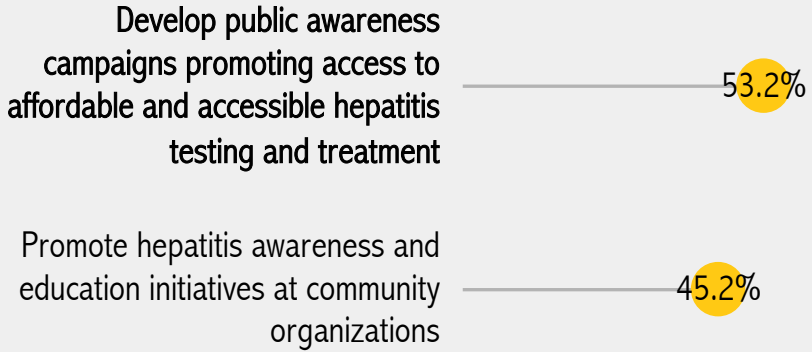


Average years in the hepatitis field: **8.1**; range: 1-32 (n=57)





STRATEGIES: AWARENESS & EDUCATION



HOW TO RAISE AWARENESS?

CONTENT:

- Build capacity of community-based non-clinical workforce to disseminate culturally responsive prevention messaging, education, and testing.
- We need an approach that taps into the hesitancies and motivations of marginalized persons.

DISSEMINATION:

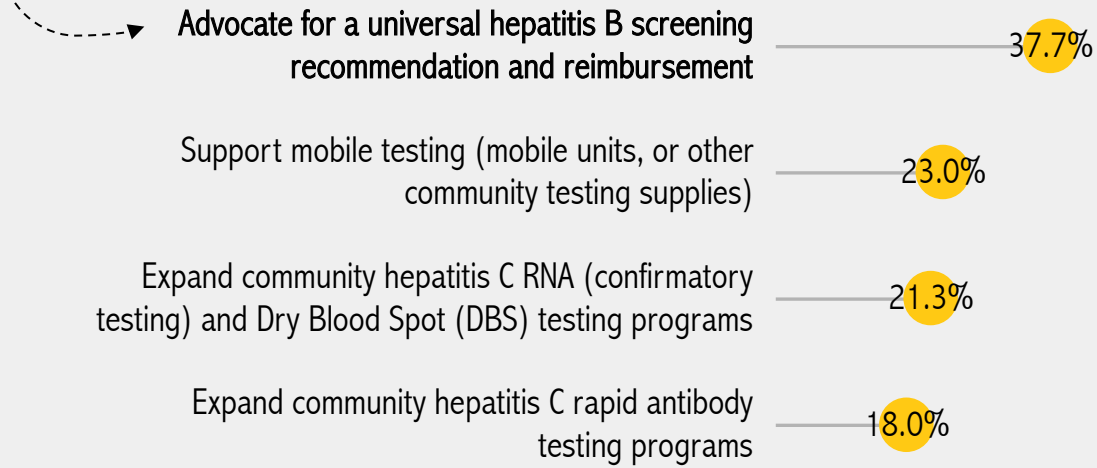
- Awareness and education initiatives should be available anywhere folks at risk frequent: community health centers, methadone clinics, HIV clinics, rehab and detox facilities.
- Advocate for health insurance reimbursement for community health workers (CHW), to build up CHW workforce that can provide education.
- Billboards, TV commercials
- Provider detailing

NOT EFFECTIVE:

- Awareness and education are not very effective. You need systems change.

STRATEGIES: TESTING

RANKED #1



HOW TO EXPAND TESTING?

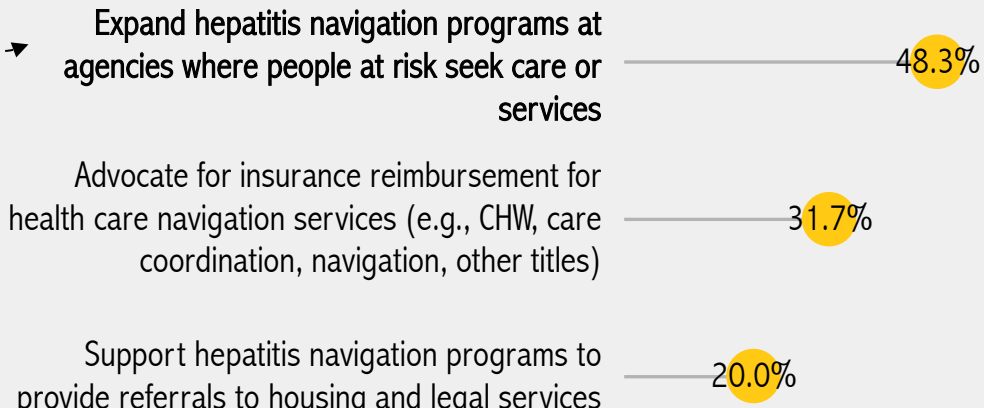
- The more 'non-traditional' means of reaching people, the better.
- Widespread RNA testing, especially at methadone, buprenorphine, and needle exchange facilities; mobile testing on street corners in high risk areas.
- Measure enforcement of reflex testing for HCV.
- Universal testing for adults for both hepatitis B & C in most health care settings; annual testing during physical exams.
- Re-screen HCV treated individuals with ongoing risk.
- Evaluate cost effectiveness of universal HBV screening.
- Improve HBV surveillance (quantify non-immune) to track adult vaccination statistics.
- Educate PCPs serving immigrant communities about the importance of testing.

- Increase funding for testing to match guidelines. It does not accomplish anything if the Task Force advises all adults to be tested but funders say only certain groups can be tested.

- Well-designed pilot programs using point of care RNA platforms + APRI score to do one-visit HCV diagnosis, staging and DAA Rx must be put in the field in partnership with diagnostic companies. Along the same lines, DBS must be expanded and paired with liver staging to develop a simplified, one-visit dx algorithm.

STRATEGIES: HEALTH CARE NAVIGATION

RANKED #1



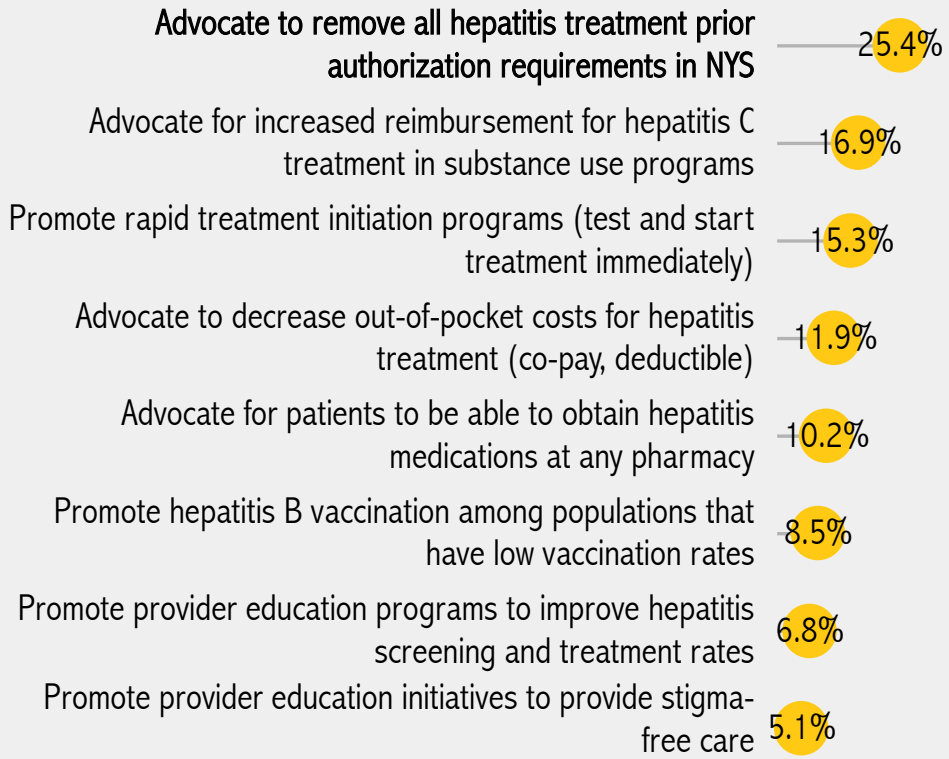
HOW TO EXPAND HEALTH CARE NAVIGATION?

- Sustainable, robust reimbursement. Pay navigators and CBOs reliably and adequately to provide these essential services.

- Eliminate the few pre-authorizations required by a few insurance companies.
- 'Know your rights' training for peers and patients to overcome payer barriers such as Medicaid managed care organizations continuing to require prior authorizations.

- Social media platform for outreach.
- Adherence navigation services.
- Use a syndemic approach to navigation (HIV, mental health, SUD, viral hepatitis).
- Expand hepatitis B navigation in communities with low literacy, low engagement in health care.
- Navigation to a centralized telemedicine program, especially from SSP, methadone programs, or other settings where traditional referrals may not be sufficient.

STRATEGIES: CLINICAL CARE & TREATMENT



HOW TO SUPPORT CLINICAL CARE?

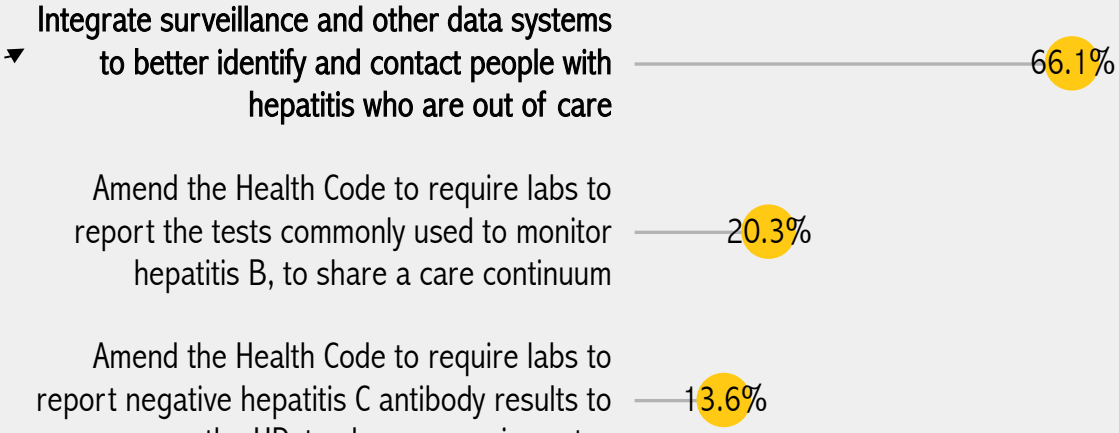
- Promote required harm reduction and trauma-informed approaches for clinical and non-clinical care providers.
- Monitor treatment starts and SVR12 using pharmacy data.

- Free hepatitis B screening & treatment for the uninsured; free liver cancer screening.
- Free hepatitis B vaccines at all pharmacies
- Pharmacies should not be able to lock in a contract with insurance companies because it hinders ability to get hepatitis medication for patients even when prior authorization has been obtained.

- Current voluntary provider education is not meeting the need for stigma-free care or having an impact on screening rates. Screening and reflex testing should be standing orders across provider settings, with EHR flags and/or reimbursement holds for not initiating tx within 90 days of diagnosis.

STRATEGIES: HEALTH DEPARTMENT (SURVEILLANCE)

RANKED #1



HOW TO LEVERAGE SURVEILLANCE FOR OUTREACH AND CARE?

- Permit HIPAA-compliant methods to share member-level details with Medicaid health plans for those with chronic infection and untreated hepatitis B or C.
- Create a status-neutral prevention/treatment continuum for hepatitis B and C, similar to HNS (HIV Navigation Services).
- Identify algorithms for determining treatment-eligible HBV patients through surveillance data.

- Use data systems to develop and implement micro-elimination efforts in patients with comorbidities, using lessons learned from intervention for HIV/HCV co-infected patients. For example, can patient records at STI clinics or dialysis centers be leveraged to find and treat hepatitis cases?
- Disaggregate HBV surveillance data by country of origin.

QUESTIONS?