



Curing Hepatitis C among People of Color Living with HIV (HRSA-17-047)

Final Meeting
September 16, 2020

Sara Woody and John Hannay
HIV/AIDS Bureau, Division of Policy and Data
Health Resources and Services Administration (HRSA)

Vision: Healthy Communities, Healthy People



Welcome and Opening Remarks

- Opening Remarks
 - HRSA welcome and introduction of staff
- Introductions of project and partner staff
 - University of Texas Health Science Center at San Antonio
 - ✓ UT Subrecipient(s)
 - Yale University School of Medicine
 - ✓ Yale Subrecipient(s)
 - RAND Corporation (ETAC)



Multisite Evaluation

LAURA M. BOGART, PH.D.
COURTNEY GIDENGIL, MD MPH
LISA WAGNER, MA MS

Project Goals



Increase capacity to provide comprehensive screening, care and treatment of hepatitis C (HCV) among HIV/HCV coinfecting people of color

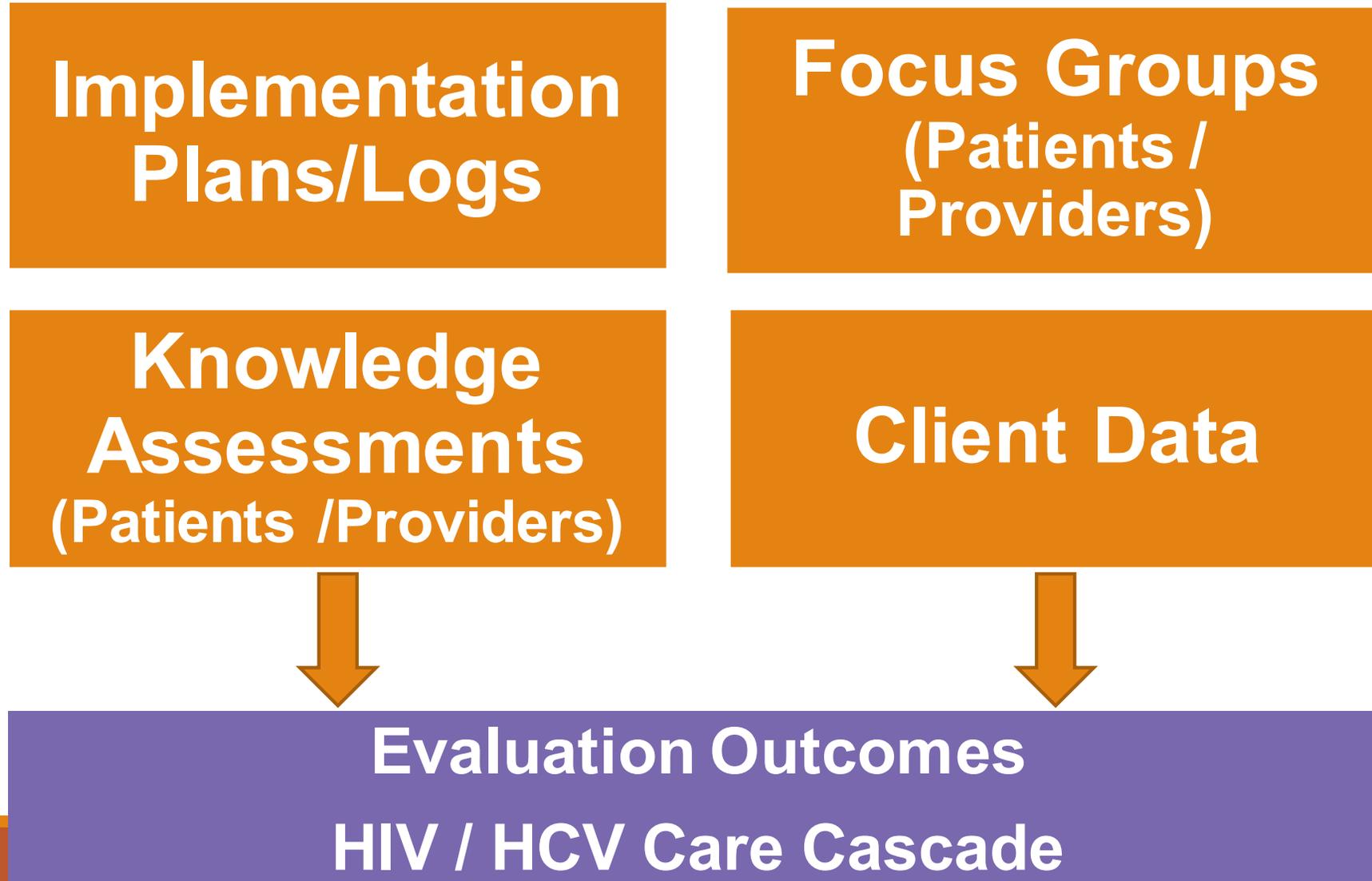


Increase numbers of HIV/HCV coinfecting people of color who are diagnosed, treated, and cured of HCV infection

Evaluation Questions

1. What activities did the jurisdictions engage in to change system-level barriers and provider and patient behaviors regarding the HCV care continuum among people coinfecting with HIV and HCV?
2. How have HIV providers' HIV/HCV co-infection knowledge and behaviors changed as a result of the project?
3. How have HCV knowledge and behaviors changed among people with HIV as a result of the project?
4. What impact has the project had on HCV care continuum outcomes among people coinfecting with HIV and HCV?
5. How have sites built capacity to provide integrated care and enable bidirectional client referrals for appropriate HIV/HCV and SUD treatment, services to prevent overdose and re-infection, and community education programs?
6. How have sites improved the collection of surveillance data for HCV infection among PLWH, especially in areas with high proportions of racial/ethnic minorities?

Multisite Evaluation Data Sources



Evaluation Question 1

What activities did the jurisdictions engage in to change system-level barriers and provider and patient behaviors regarding the HCV care continuum among people coinfecting with HIV and HCV?

- Using implementation logs, the ETAC calculated the number of provider trainings, educational activities, and Communities of Practice and Learning (CPL) events were held across sites
- Using focus groups, the ETAC asked providers about activities related to this project, including changes made at the clinic level

Evaluation Question 1: Jurisdiction Activities

Each sites' activities, based on quarterly implementation logs

	CPL	Provider Training/ Mentorship	Patient Education	Practice Transformation	Improved Access to Care & Treatment	Support for Medication Adherence	Data Enhancement Monitoring/ Quality Improvement
Total (avg) number of activities (189 sites)	202 (50)	462 (116)	4,457 (1,114)	199 (50)	426 (106)	111 (28)	7,753 (1,938)
Total (avg) number of activities (047 sites)	311 (156)	358 (179)	246 (123)	289 (144)	211 (105)	109 (54)	480 (240)

Results: Average number of activities executed from 2017 –2020 by activity category across jurisdictions (N=6) *Source: Implementation Logs*

Structural Barriers to Implementation

In focus groups, jurisdictional stakeholders discussed structural, system-level barriers to improving HCV outcomes

- Insurance issues
- Lack of clinic resources
- Workflow barriers

Insurance Barriers Persisted Across Waves

Pre-authorization, coverage denials, and high treatment cost were barriers across waves

"The prior authorization issue's still an issue. If you have a disengaged population, falls out of care, getting a second prior authorization or a third prior authorization can get progressively more difficult ... You initiate treatment, and you don't see someone again for five months. You've gotta re-initiate treatment, and that turns out to not be such an easy sell with the pharmacy benefit managers." -Medical Provider

Clinic Resource Barriers Continued to be a Concern in Wave 2

Inadequate staffing and underfunding for HCV programs were initially perceived to be barriers in Wave 1 and were addressed by only some sites by Wave 2

*“If someone whose medication arrived and then we can't get in touch with them, **we don't have really anyone to go to his house or do the outreach...** We do [have case managers,], but so far, we don't have anyone to go track people down, so I'm seeing that we need that” -Medical Provider*

Integration into Clinic Workflow Improved Over Time

HCV screening and treatment (and HCV navigator) were not integrated into other patient activities in Wave 1, but were mostly addressed by Wave 2

*"Because we had a number of other programs happening, it was **putting in a lotta effort, at the beginning, to integrate them altogether with the specific on co-infection.** Once all of those things were aligned and tested and any additional protocols that needed to be implemented were put into place, then it could be a lot smoother to also fast track co-infected patients through our clinic... **to really ensure a smooth process. ...it took a substantial upstart to align everything we had going on in the department, to ensure that we could really target this population"***

-Medical Provider

Sites Overcame Barriers Through Practice Transformation and Education

In focus groups, providers discussed three main activities to overcome barriers:

- Practice transformation (linkage to HCV care through case managers, peer navigators, and bridge counselors; integrating HCV testing into usual care, such as having EMR pop-up for screening)
- Client and community education (e.g., tables with information and rapid screenings at community fairs and other public events, such as Pride; to increase knowledge, reduce stigma)
- Provider training (AETC National Curriculum, ECHO sessions, mentorship and communities of practice and learning/CPL; education to address concerns about patient readiness and improve HCV knowledge)

Evaluation Question 2

How have HIV providers' HIV/HCV co-infection knowledge and behaviors changed as a result of the project?

- Conducted a provider knowledge assessment in years 1 and 3, with year 3 focusing on effect of training
- Held clinical and non-clinical provider focus groups

Evaluation Question 2: Provider Knowledge Assessment, Year 3

Across the 7 RWHAP jurisdictions, 396 HIV providers responded in Year 3 (compared to 701 in Year 1)

- 250 included in analysis of knowledge score by provider type
- 199 included in multivariate model

Multi-item HIV/HCV coinfection knowledge assessment

- Developed using information from the American Association for the Study of Liver Diseases and the peer-reviewed literature
- Score calculated by dividing # correct responses by # total items
- Conducted descriptive analyses stratified by provider type
- Multivariate linear regression predicting knowledge score

Respondent Characteristics

Provider characteristics	N (%)	Provider characteristics	N (%)
Provider type		Race	
MD	93 (37%)	White	130 (56%)
NP/PA	63 (25%)	Black	41 (18%)
MCM	66 (26%)	Hispanic	39 (17%)
Other clinical staff	28 (11%)	Other	22 (9%)
Years treating HIV (\pm SD)	13.7 (\pm 11.3)	Gender	
		Female	157 (65%)
		Male	74 (31%)
		Other	9 (4%)
Number of people with HIV in caseload (\pm SD)	39.5 (\pm 99.2)	Sexual orientation	
		Heterosexual	185 (77%)
		Gay/Lesbian	29 (12%)
		Other	26 (11%)

Reported Receipt of Training by Provider Type

Provider characteristics	Received training	Did not receive training	Don't know	p-value
MD	75 (81%)	17 (18%)	1 (1%)	<0.001
NP/PA	49 (78%)	11 (17%)	3 (5%)	
MCM	37 (56%)	25 (38%)	4 (6%)	
Other clinical staff	15 (58%)	6 (23%)	5 (19%)	

Reported Receipt of Training by Provider Demographics

Provider characteristics		Received training	Did not receive	Don't know	p-value
Race	White	80%	16%	4%	0.002
	Black	71%	27%	2%	
	Hispanic	44%	46%	10%	
	Other	73%	18%	9%	
Gender	Female	70%	24%	6%	0.739
	Male	74%	23%	3%	
	Other	78%	22%	0%	
Sexual orientation	Heterosexual	71%	23%	6%	0.711
	Gay/Lesbian	76%	24%	0%	
	Other	69%	27%	4%	

Average Provider Knowledge Score by Provider Type

Domain	Overall percent correct	MD	NP/PA	MCM	Other clinical staff	P-value
Knowledge score	66%*	78%	70%	53%	48%	<0.001
HCV treatment regimen questions	72%	84%	76%	58%	56%	<0.001
SUD/mental health questions	61%	73%	66%	47%	45%	<0.001
Socio-economic barriers questions	52%	66%	54%	43%	23%	<0.001

* Score is % correct

Average Provider Knowledge Score by Training

Domain	Overall percent correct	Training yes	Training no	Training don't know	P-value
Knowledge score	66%*	72%	53%	50%	0.008
HCV treatment regimen questions	72%	78%	61%	55%	<0.001
SUD/mental health questions	61%	69%	44%	46%	<0.001
Socio-economic barriers questions	52%	57%	42%	42%	0.013

* Score is % correct

Predictors of Provider Knowledge

Multivariate regression of provider attributes associated with knowledge score (N=199)

	β	p-value
Provider type		
MD	ref	-
NP/PA	-6.9	0.027**
MCM	-20.9	<0.001**
Other clinical staff	-19.2	0.001**
Years treating HIV	0.11	0.39
Number of people with HIV in caseload	-0.008	0.52
Screening approach to HCV		
Screen all people with HIV for HCV annually	1.1	0.67
All other approaches	ref	-

Predictors of Provider Knowledge

Multivariate regression of provider attributes associated with knowledge score (N=199)

	β	p-value
% people with HIV caseload screened for HCV		
0%	ref	-
1 - 74%	-0.8	0.27
75 - 100%	6.5	0.92
% HIV/HCV patients treated/referred		
0%	ref	-
1-49%	6.5	0.18
50-100%	7.8	0.08
Any people with HIV in caseload with psychiatric disorder	18.0	0.023*
Any people with HIV in caseload with SUD	22.7	<0.001**

Predictors of Provider Knowledge

Multivariate regression of provider attributes associated with knowledge score (N=199)

	β	p-value
Reported having received training on HIV/HCV coinfection		
Received training	ref	-
Did not receive training	-12.7	<0.001**
Don't know	-18.5	0.003**

Summary of Provider Knowledge Findings

- MDs followed by NP/PAs performed strongest across all domains
- Reporting having had **training significantly improved knowledge**
- **Important knowledge gaps in areas of substance use and mental health issues as well as socio-economic barriers** across all provider types
- Gaps between provider types was smallest for socio-economic barriers, but still significant
- Interventions to improve knowledge and support treatment should consider:
 - **Tailoring** to provider type (MD / NP / PA)
 - Including **education around treatment of those with substance use and mental health issues, and addressing socio-economic barriers**

Evaluation Question 2: Clinical and Non-Clinical Provider Focus Groups

Conducted in 7 jurisdictions

- NYC, Philadelphia, Hartford, Baton Rouge and New Orleans, Raleigh / Durham, Connecticut (excluding Hartford), and Southwest Texas

Recruited through clinics, email lists, word of mouth, meeting announcements, and in-person at provider events

- Baseline: 91 clinical providers and 96 non-clinical providers (n=187)
- Follow-up: 54 clinical providers and 36 non-clinical providers at follow-up (n=90)

Used focus group guide with questions on barriers to screening, treatment, and training

Providers Continued to have Concerns about Patient Readiness for HCV Treatment

Themes around readiness were present across waves and participants, and referred to believing clients could not begin or adhere to HCV treatment due to, for example, drug use or lack of viral load suppression

*“They're still denying people if they have positive drug screens, if they test positive, **not just for opiates, but cocaine**, which has nothing to do with anything. They should still be able to get treatment.”* -Non-Medical Provider

*“If a client is not coming virally suppressed because **they're not taking their HIV med, why would we prescribe them treatment for Hep C** if we're uncertain of that compliance?”* -Non-Medical Provider

*“[Viral load] **has to still be undetected before they even treat you for Hep C...That's what they told me.**”* -Expert Client

Patient-Provider Relationship Issues Did Not Seem to Improve Over Time

Across waves, providers (especially medical providers) were perceived to lack of HCV training and cultural humility, to treat patients disrespectfully, and to not educate patients about HCV

"Some doctors [are] not culturally competent. Because each person has their own belief. Regardless if they drug use or whatever, they all have their own belief. If you know how they grew up or whatever, you have to take that to consideration. You can't force something on someone just because you know—you feel that that is going to work. You have to listen to them." -Nonmedical Provider

*"I function as a client navigator, and we were recently able to reengage someone who's coinfectd. It's a person who injects drugs...I think what made a really big difference with him was listening to the fact that **the first provider that I took him to, he didn't like the demeanor of that provider at all. He felt like [the doctor] was shaming him for not adhering to his medication and shaming him as opposed to encouraging him...**"* -Nonmedical Provider

"My doctors haven't asked me [about screening] either....We don't even know that we have it. We might have it...I don't know if I've been tested." -Monoinfected Client

Evaluation Question 3

How have HCV knowledge and behaviors changed among people with HIV as a result of the project?

Evaluation Question 3: Patient Knowledge Assessment

1,853 people with HIV surveyed in year 1 and 1,348 people with HIV surveyed in year 3 across 7 sites

Recruited from clinics and HIV service organizations through flyers and outreach (mostly in care)

Interview or self-administered survey based on literacy

Assessment: Socio-demographics and substance use/mental health service use; **Self-reported** HCV outcomes (e.g., ever screened, offered treated); HCV knowledge (based on patient information from the American Association for the Study of Liver Diseases); HCV-specific medical mistrust (adapted from prior scales related to HIV and general medical mistrust)

Patient Knowledge Assessment

HCV Outcomes (self-reported)	Wave 1 n (%)	Wave 2 n (%)
Ever screened for HCV	1,576 (85.1%)	1113 (85.0%)
Screened for HCV in past year	976 (52.7%)	697 (53.2%)
Positive HCV test (of those screened)	417 (27.8%)	253 (19.3%)
Offered treatment	559 (30.2%)	356 (27.2%)
Started treatment	394 (21.3%)	280 (21.4%)
Finished most recent treatment	311 (16.8%)	254 (19.4%)

Patient Knowledge Assessment

Patient Knowledge	Wave 1 n (%) Correct	Wave 2 n (%) Correct
Hepatitis C can cause liver damage	1,559 (84.13%)	1,092 (81.0%)
There are antiviral medications available to cure hepatitis C	1,221 (65.89%)	873 (64.8%)
People who are cured of hepatitis C, either naturally or with medical treatment, can be infected with hepatitis C again	1,091 (58.88%)	833 (61.8%)
The majority of people who have both HIV and hepatitis C do not have symptoms	799 (43.12%)	551 (40.9%)
There is a vaccine to prevent hepatitis C	379 (20.45%)	280 (20.8%)
Missed 0-1	542 (29.25%)	418 (31.0%)
Missed 2	569 (30.71%)	402 (29.8%)
Missed 3-5	742 (40.04%)	528 (39.2%)
General HCV medical mistrust [1-5, 5 = higher mistrust; M (SD)]	2.7 (0.8)	2.8 (1.0)
HCV treatment-related medical mistrust [M (SD)]	N/A	2.8 (0.9)

Ever Screened for HCV

	Wave 1 Multivariate OR (95% CI)	Wave 2 Multivariate OR (95% CI)
Age	1.02 (1, 1.03) *	1.01 (.997, 1.02)
Black/African American	0.55 (0.3, 1.01) *	
Hispanic/Latinx	0.89 (0.47, 1.69)	
Drug use in last 12 mo.	0.92 (0.59, 1.45)	
RWHAP eligible	1.71 (1.23, 2.37) **	
Ever received substance use services	2.08 (1.41, 3.07) **	4.78 (2.15, 10.60)***
Ever received mental health services	1.52 (1.08, 2.13) *	1.34 (.75, 2.40)
Genral HCV Mistrust	0.71 (0.58, 0.88) **	
HCV Treatment Mistrust	N/A	0.95 (.68, 1.33)
HCV Knowledge Score	1.02 (1.01, 1.03) **	1.02 (1.02, 1.03)***

* p < .05;
 ** p < .01,
 *** p < .001

Ever Offered HCV Treatment

	Wave 1 Multivariate OR (95% CI)	Wave 2 Multivariate OR 95% CI
Age	1.05 (1.04, 1.06) **	1.05 (1.02, 1.09)***
Gay/Lesbian	0.64 (0.46, 0.9) *	
Education: HS or below	1.17 (0.89, 1.53)	2.31 (1.41, 3.80)**
Drug use in last 12 mo.	1.48(1.11, 1.97)**	
Ever received substance use services	2.71 (2.01, 3.64) **	2.67 (1.53, 4.66)***
Ever received mental health services	1.23 (0.91, 1.66)	1.39 (.70, 2.74)
HCV General Mistrust	0.81 (0.7, 0.94) **	
HCV Treatment Mistrust	N/A	0.67 (0.57, 0.77)***
HCV Knowledge Score	1.02 (1.01, 1.02) **	1.03 (1.02, 1.04)***

* p < .05;
 ** p < .01;
 *** p < .001

Discussion:

Patient Knowledge Assessment

- Similar levels of knowledge and mistrust over time

HCV knowledge associated with self-reported screening and treatment (including treatment; not shown)

- Treatment mistrust and treatment mistrust related to reporting not being offered, starting, or finishing treatment

Substance use service use related to HCV screening and treatment:
Integration of SUD and HCV screening and treatment essential

- Limitations: self-reports, convenience sample, structural factors not assessed

Evaluation Question 3: Client Focus Groups

Recruited across 7 RWHAP jurisdictions through clinics, flyers, email lists, word of mouth, direct referrals

- Baseline: 63 coinfecting patients; 82 people with HIV not treated for HCV; 47 expert clients (n=192)
- Follow-up: 65 coinfecting patients; 50 people with HIV not treated for HCV; 33 expert clients (n=148)

Elicited patient barriers

- *What do you think keeps people living with HIV from getting regularly tested for Hep C?*
- *What might make it hard for someone living with HIV to get Hep C treatment, if they test positive for Hep C?*
- *What might make it hard for someone to keep taking Hep C treatment as prescribed, in the way the doctor tells them?*

Clients (and some providers) discussed stigma

Across waves, clients discussed internalized stigma associated with HCV (and substance use) in their networks and communities, and somewhat with providers. **Stigma concerns appeared to decrease over time**

"Some people get offended. If I even approach them about Hep C, 'Why are you comin' to me about that? Do I look like I do drugs? I don't shoot up.'" -Expert Client

*"My daughter is coming over tonight... Even though she probably wouldn't go in my cabinet, I will take [medications] out and put them somewhere else... she doesn't know yet that I am positive for anything. I really worry about that... **I still hide my meds.**" -Coinfected Client*

*"One of the major barriers to care in a population, particularly a population who has a history of injection drug use, is **their own stigma and their own fear of the medical system.**" (Medical Provider)*

"Even when we bring people in and test them—and we offer them information, most times, they won't take it because they don't want anybody to know they were tested. They don't want anybody to know that they were lookin' into any of these kinds of infectious stuff because it's stigma." -Nonmedical Provider

Clients Continued to Show HCV-related Mistrust and Misconceptions, and Low Knowledge

Lack of HCV knowledge, misconceptions about susceptibility to HCV, availability and nature of treatments, and costs, as well as mistrust, may have contributed to lack of HCV testing and treatment over time

*“For me, I didn't wanna deal with hep C until I got my HIV in control because it's too much medications. What my priority was, I was **feared for toxication from having taken both.**” -Coinfected Client*

*“We're not foolish to know that doctors not gods. They learnin' just as we're learnin'. **Sometimes we feel like we're their guinea pigs.**” -Monoinfected Client*

*“...clients sometimes they do their own research, and **they see how expensive the medication is. Then they just don't even wanna mess with it. They're so scared of the cost.** They think it's gonna be on them and stuff. I guess just education and just informing clients... What resources are there out there that we can connect them to?” -Nonmedical Provider*

*“It's really trust. **Trusting that the doctor even listens.** I've been to visits with clients where the client just sat there and stared at the wall.” -Nonmedical Provider*

Illness Fatigue Was Perceived to Lead to Client HCV Screening and Treatment Hesitancy Across Waves

Clients discussed not wanting to “take more pills” or to add appointments and paperwork-- or add "another disease" (and intersectional stigma)

*"My experience is that they're not starting the treatment because... **they don't want to add on more medications** or fear of adding more damage to their body or their liver..." -
Nonmedical Provider*

*"I have HIV. I don't want to know I have anything else. It's enough. It's sad, but it's true." -
Co-infected Client*

"I'm tired of goin' to see the doctors. I'm tired of waitin' for the pharmacy. I'm tired of waitin' for everybody." -Monoinfected Client

Clients Suggested Ways to Address Barriers

- Many clients said their doctors are critical, trusted sources of information, and also trusted information from peers who had similar experiences
- Clients suggested use of social media and other advertising for HCV public health campaigns

“That's why I've stuck with [provider] because he actually took the time to go through everything and look at my numbers and see what I really had and what I didn't have.”

Monoinfected Client

“Say, for instance if I know Veronica knows about Hep C, I would have Veronica come to my church and speak to the people and—with pamphlets and stuff like that so everybody can be aware of certain things that's goin' on.” -Monoinfected Client

Evaluation Question 4: What impact has the project had on HCV care continuum outcomes among people coinfecting with HIV and HCV?

Revised analysis plan to include aggregate data and client -level data across sites

- Not all sites could provide client-level data

Revised approach: meta-analytic method

- Combining aggregate and client-level data from multiple sources
- Individual odds ratios produced at the site-level (masked)
- Frequencies → Provides an overview of the data (demographics, outcomes), provides a data quality check of the data included in the analysis, and allows for weighting by site for the ORs
- Crosstabs → Allow for the analysis on any differential impact on people of color
- Regressions → Identify statistical significance of analytic model

Analysis Delays

- Revised data submitted first week of September
- Analyzing impacts of COVID on clinics and their ability to screen

Challenges with Client Data

Sites were not able to collect data in a consistent manner

- Not all data were captured in data systems
- Pre-existing data were not defined or captured in the same way across sites

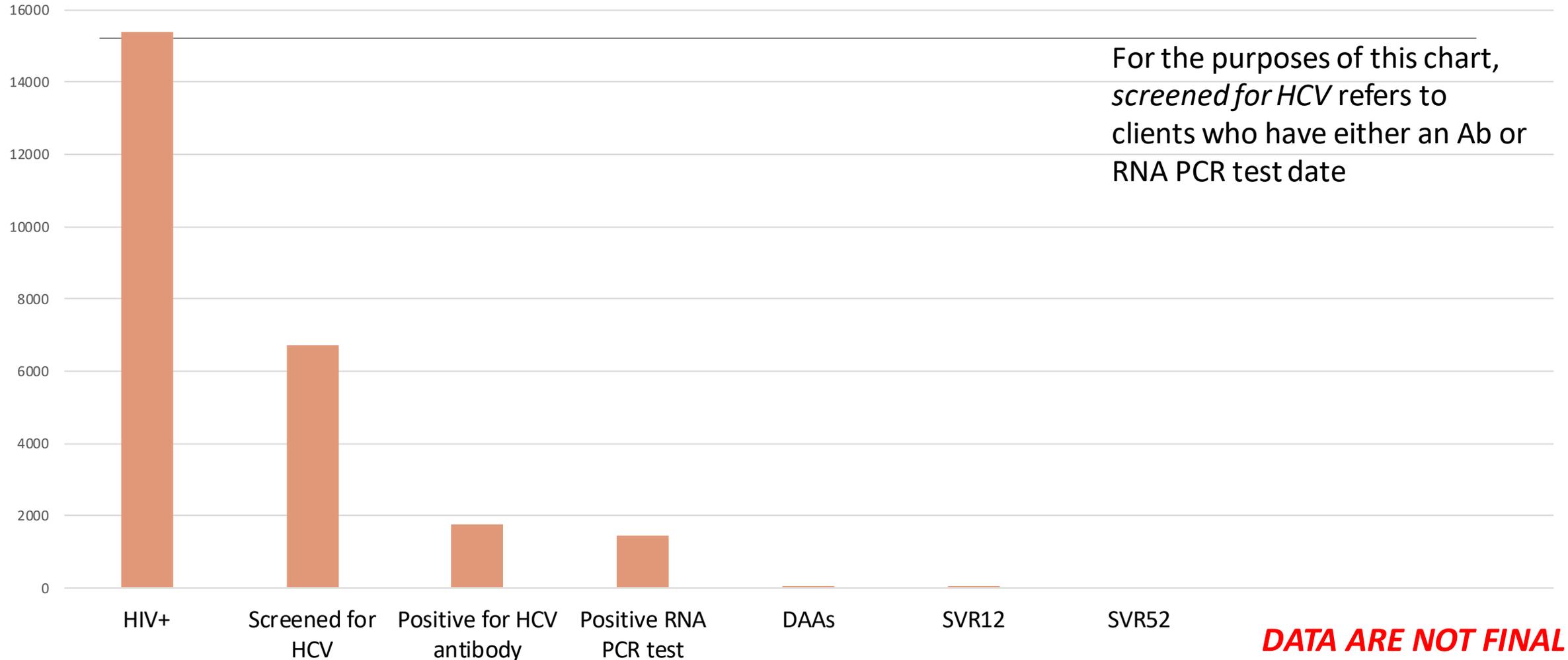
Not all sites were able share data due to external constraints

- Restrictions on sharing surveillance data (e.g., legal restrictions by states)
- Issues with reporting from partner clinics
- Changes in electronic health records (EHRs) during the project period
- Challenges working with data vendors to produce the data tables

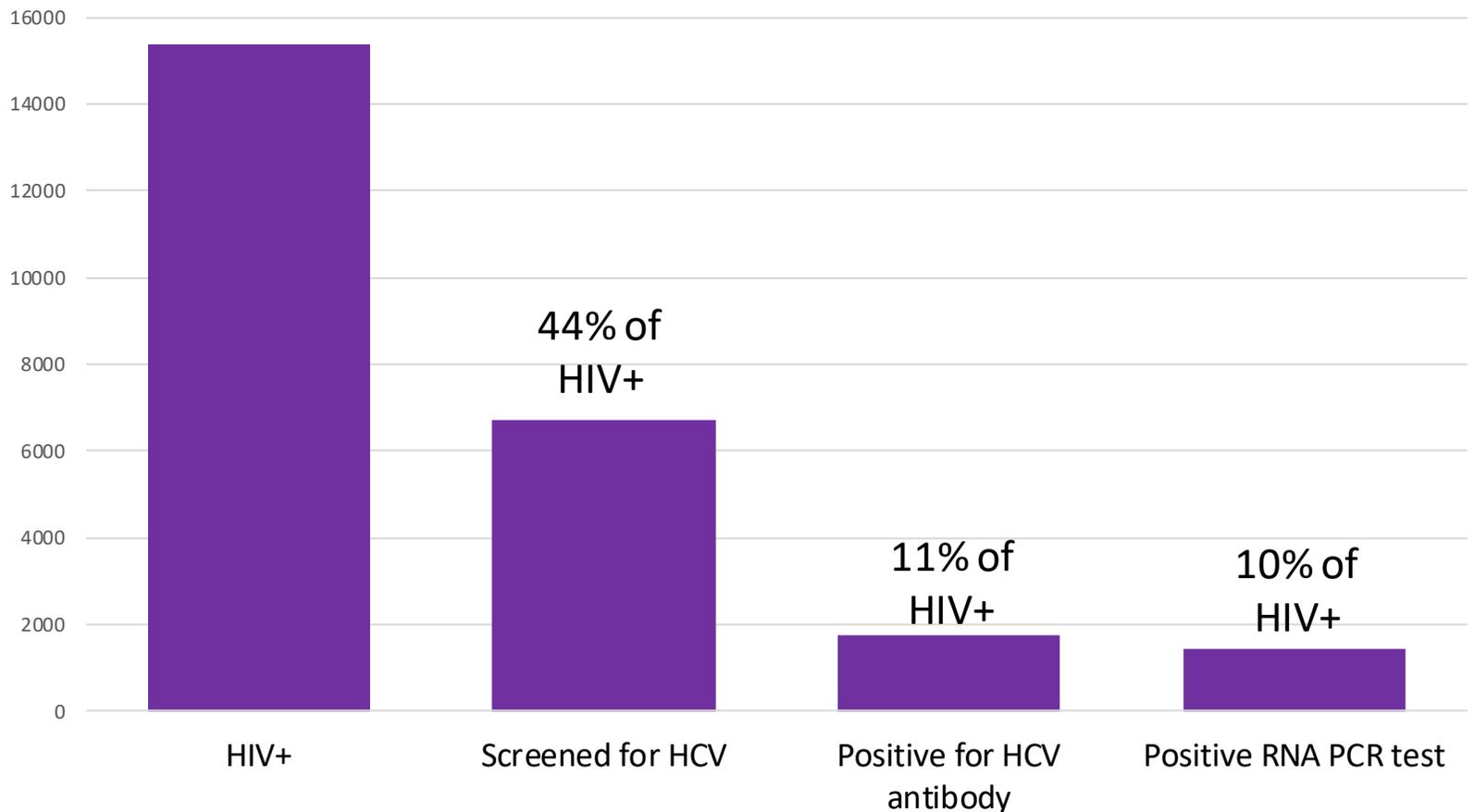
Timeframe of study was relatively short

- Longer period is needed to follow clients through the care cascade– implementation was ongoing throughout the evaluation period
- COVID-19 impacted *Curing Hep C Among HIV/HCV Coinfected People of Color* project clinics' ability to see and screen clients

Care Cascade – Available Data May Not Reflect Screening Efforts or Care Delivery



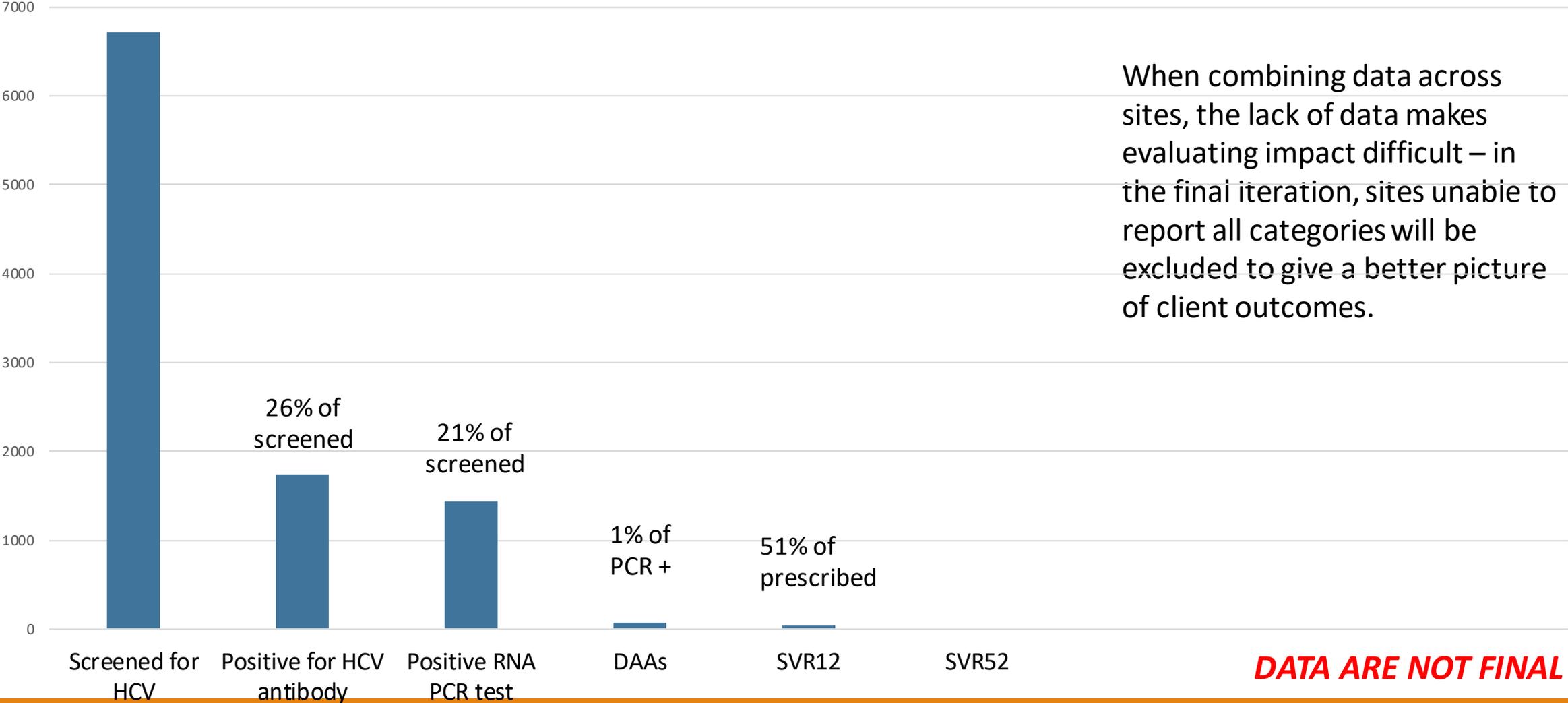
Client Screening– Difficulty Differentiating Between Ab and RNA Screening



The flow of client care is not always linear; using data in aggregate categories does not present the whole story

DATA ARE NOT FINAL

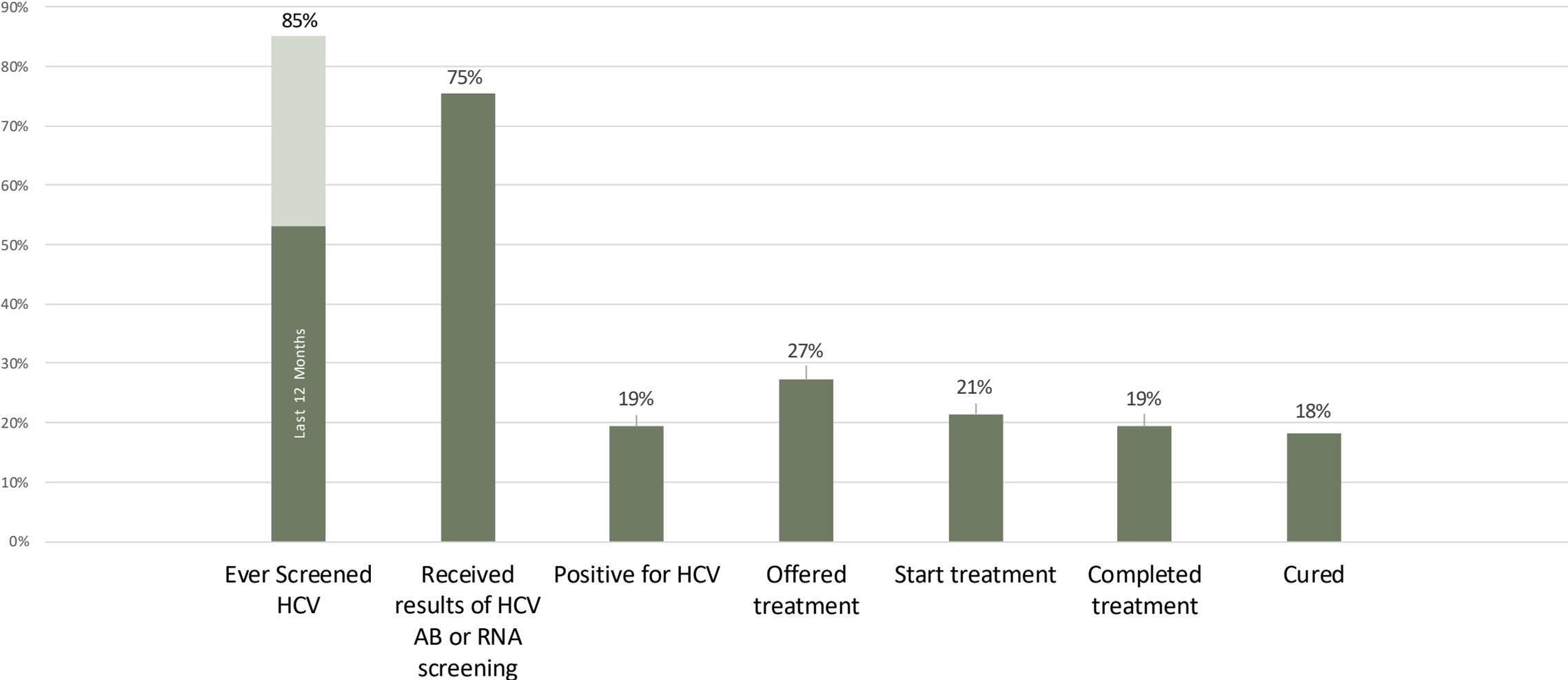
Client Care Across Cascade – Lack of Data Makes Evaluation Difficult



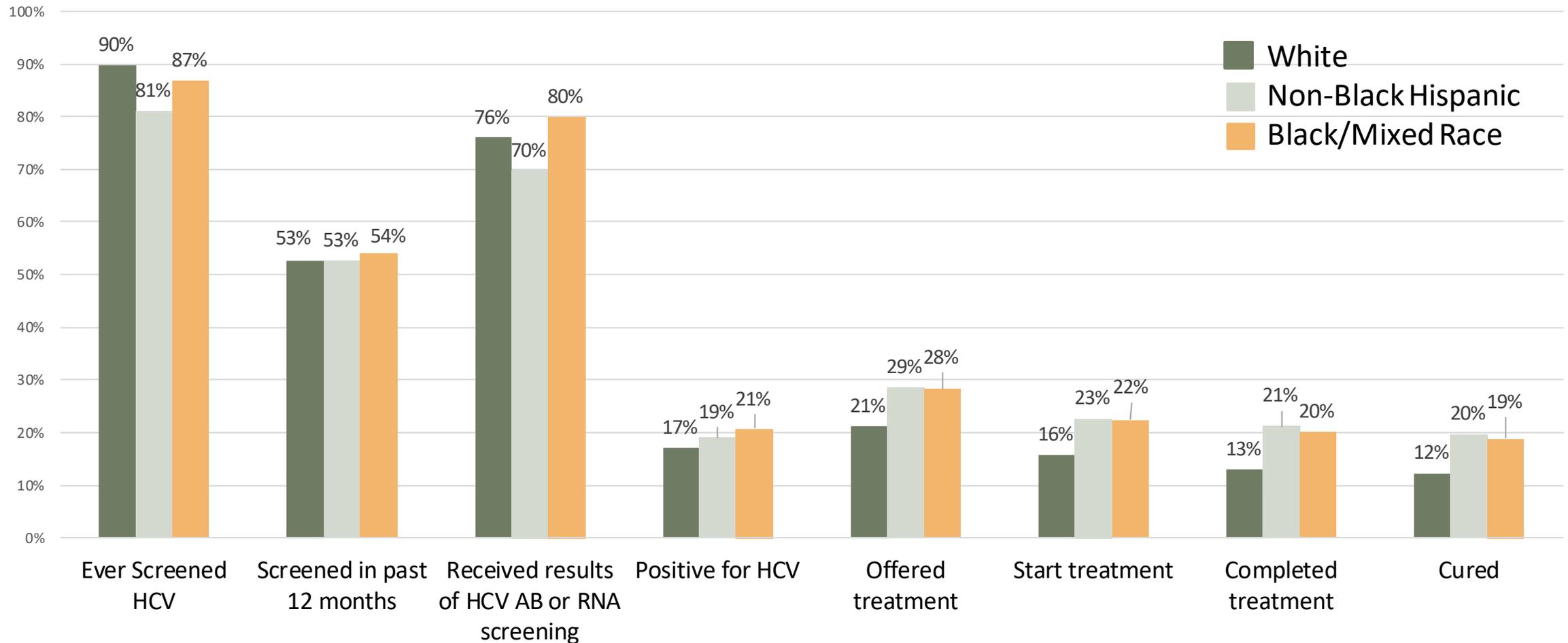
When combining data across sites, the lack of data makes evaluating impact difficult – in the final iteration, sites unable to report all categories will be excluded to give a better picture of client outcomes.

DATA ARE NOT FINAL

Self-Reported Patient HIV/HCV Coinfection Cascade



Self-Reported Patient HIV/HCV Coinfection Cascade, by Race



Next Steps

Compare across client characteristics on client data care cascade

- Where on the cascade are people of color differentially impacted?
- Does the care cascade differ for those who are virally suppressed vs those who are not?

Perform multivariate analyses with client data to evaluate impact on people with color

Evaluation Question 5

How have sites built capacity to provide integrated care and enable bidirectional client referrals for appropriate HIV/HCV and SUD treatment, services to prevent overdose and re-infection (e.g., syringe exchange programs or SSPs), and community education programs (including those that address the benefits of SSPs and medication-assisted treatment or MAT)?

- Data sources include focus groups with medical and SUD providers, focus groups with clients, and self-report from project partner presentations
- Sites implemented common referral forms across partner agencies

Summary of Evaluation Question 5 Findings

Initial Barriers

- Lack of HCV testing in diverse settings, e.g., where services are provided to clients who use drugs

“I don't know if I seen it on somewhere else or they used to have it, like a health mobile, and going out to different sites and asking people if they wanna be tested. I think the health department should be more proactive in the cities with that. Forget the needle exchange. Go out and, you know what I mean, test people, give them blood work.” (Monoinfected Client Group, Site 4, Wave 1)

- Difficulty establishing relationships across agencies
- Difficulties automating referrals across computer systems: staff time is needed to track referrals and follow up with patients about referrals
- Low screening rates in SUD providers, resulting in low numbers of referrals

Focus Group Findings

- Bidirectional referrals were rarely discussed in the focus groups; current systems were largely described as unidirectional, or still being developed

*“We have one program that actually, if you talk about bidirectional referrals, we have one program that’s **a substance abuse residential center that will refer to us.** In [Location]. We’ve gotten some of our substance abuse patients from this particular agency and they’re already connected up with an outpatient system.” -Medical Provider*

- Some clients (across waves) felt that their providers did not communicate with each other

*“**[My doctor] barely has time to see me.** She’s in and out of the room, and I don’t even really get to talk about what’s going on, and my test results, or nothing. **Do I think she has time to talk to the therapist? No, I don’t think so.**” -Monoinfected Client*

Evaluation Question 6

How have sites improved the collection of surveillance data for HCV infection among PLWH, especially in areas with high proportions of racial/ethnic minorities?

- Data sources include focus groups with medical and SUD providers and self-report from project partner presentations

Evaluation Question 6

- In focus groups, providers did not discuss enhanced surveillance data for linkage to HCV care
 - May not have been aware of such efforts
 - More focused on linking with/direct referrals from other providers (e.g., "HCV linkage specialist") and less focused on data system changes and use

*“Well, at the office I'm at, they're right across the hallway from me, so **I walk them over there**. I pretty much let them know, "Hey, I have this positive," and then they'll get ready. Then, I'll walk them over there and introduce them to the individual who's gonna do the intake.”* -Nonmedical Provider

Dissemination Efforts

PEGGY CHEN, MD, MSC

Publications & Dissemination Committee Overview

Meeting changes

- 189 sites and 047 sites participated in the PDC . We made several changes, including moving phone meetings from monthly to quarterly, and later shifting to quarterly email check ins with more frequent communication as needed.

PDC continued maintaining two documents

Publication and Dissemination Outlets

- Meant to serve as a resource to jurisdictions planning dissemination products. Having a sense of the potential outlet for publication can often help to shape and guide the development of the dissemination product. This document is a list of potential outlets for publication and/or dissemination.

Publications and Dissemination Tracking

- Documenting and cataloguing all final dissemination products

Dissemination to date

Over 4 years, the 6 sites/jurisdictions have produced:

- 27 dissemination items
 - 9 conference abstracts
 - 16 conference presentations (including 2 panel presentations)
 - 1 conference poster
 - 6 joint presentations involving HRSA and/or multiple jurisdictions
- 3 manuscripts have been submitted (including 1 invited submission)
- 3 manuscripts are in the process of being submitted
- 30 local and other dissemination efforts (e.g. Facebook pages, local news stories, committee meetings, etc.)

The ETAC has produced:

- 4 conference abstracts, posters or presentations
- 1 manuscript (currently under review at Journal of Healthcare for the Poor and Underserved)
- 2 additional manuscripts in process

Q&A – 15 Minutes

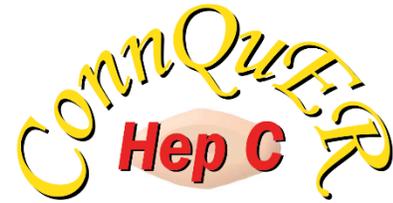
Break

BREAK – 15 Minutes



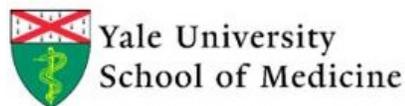
ConnQuER HEPC Project

(Connecticut Quantification, Evaluation, & Response:
HIV/HCV Elimination in Persons of Color)



Curing Hepatitis C among People of Color Living with HIV
Final Initiative Closing Meeting
Yale University School of Medicine

September 16, 2020



Presentation Outline

- Review goals of ConnQuER HEPC Project
- Review specific project activities and progress to date
 - Training/Education Highlights
 - Local Evaluation Plans
 - Multi-site clinics
 - SSP/SUD
- Conclusions and next steps

Overall Project Goals

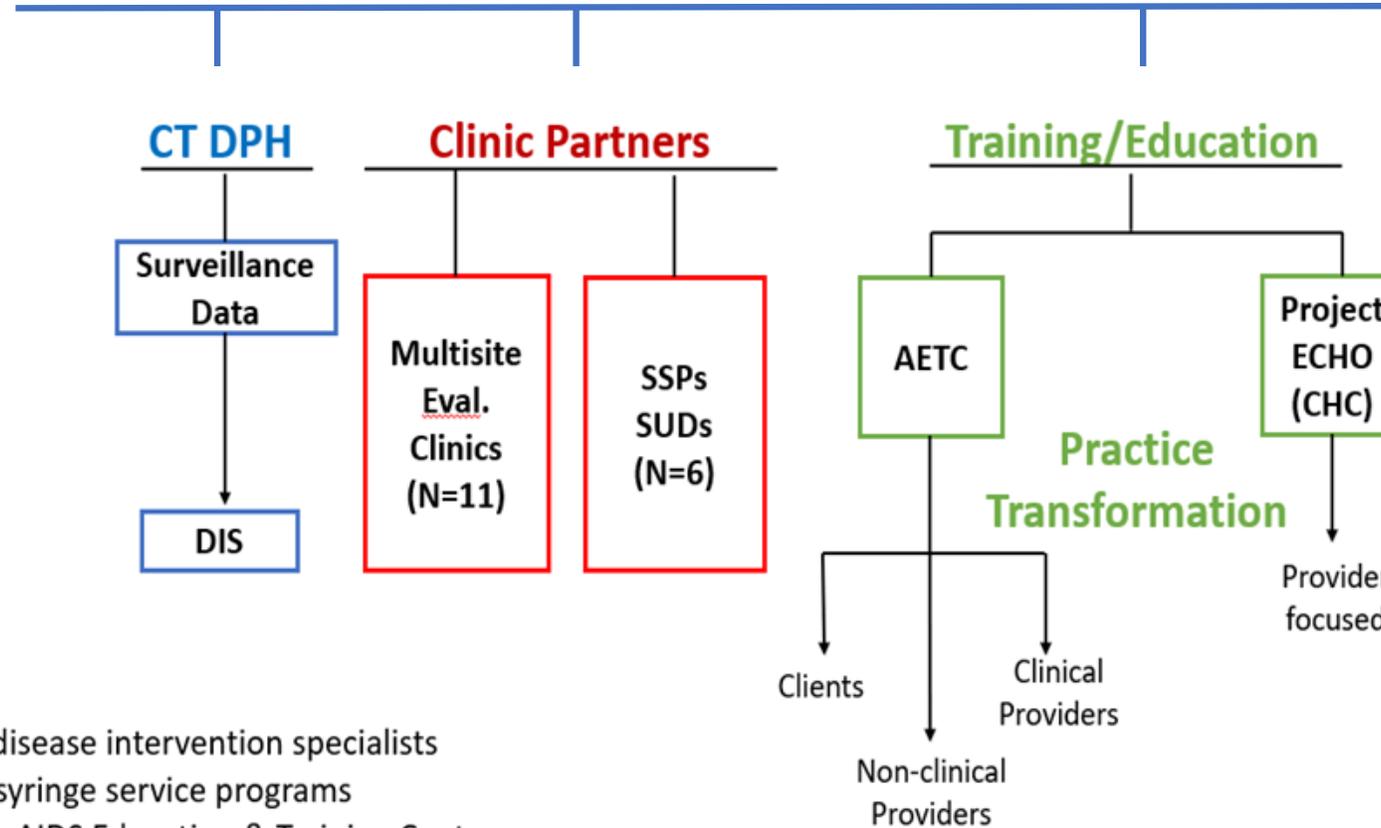
1. Cure Hepatitis C (HCV) in persons with HIV (PWH) in CT, particularly persons of color through improvements in the HCV cascade of care
2. Improve partnerships with key stakeholders
3. Improve surveillance mechanisms statewide for HIV/HCV coinfection

Overall Project Goals

1. Cure Hepatitis C (HCV) in persons with HIV (PWH) in CT, particularly persons of color through improvements in the HCV cascade of care
2. ***Improve partnerships with key stakeholders***
3. Improve surveillance mechanisms statewide for HIV/HCV coinfection

Project Partners

ConnQuER HEPC Coordinating Site: Yale University



DIS: disease intervention specialists
SSP: syringe service programs
AETC: AIDS Education & Training Center

Project Partners - CT DPH

ConnQuER HEPC Coordinating Site: Yale University

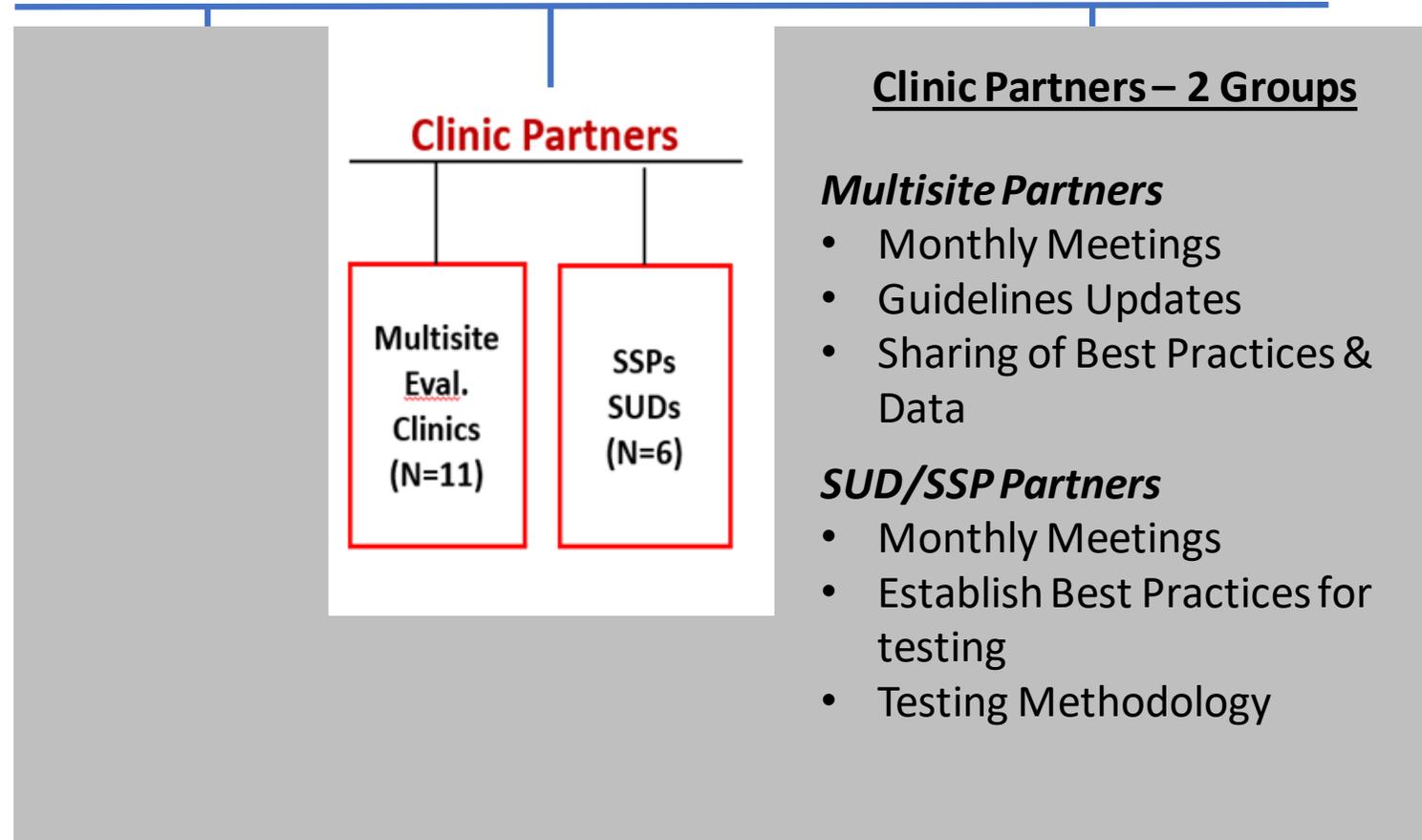


CT DPH

- Monthly Meetings
- Hone Down Surveillance
- Collaboration with DIS Field Workers

Project Partners - Clinics

ConnQuER HEPC Coordinating Site: Yale University



Project Partners - Education

ConnQuER HEPC Coordinating Site: Yale University

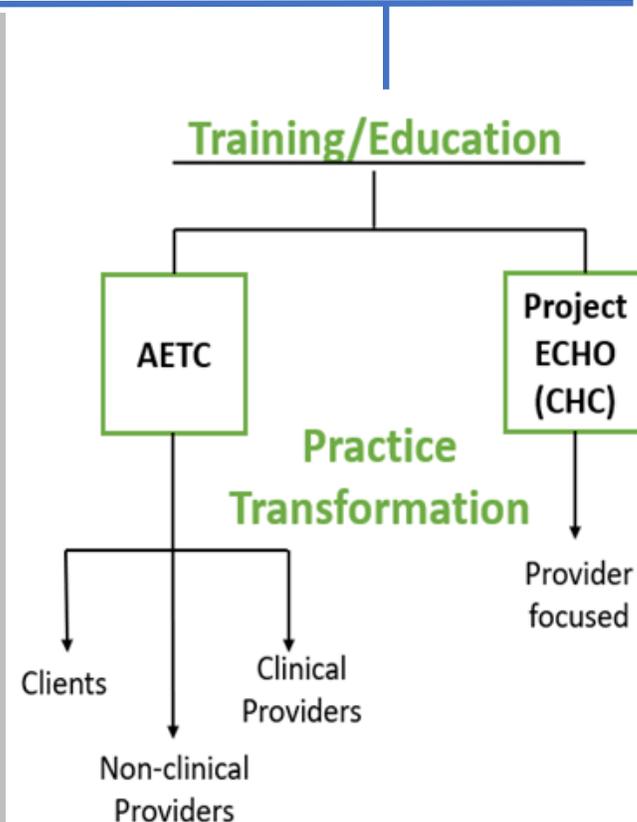
Training/Education – 2 Tracks

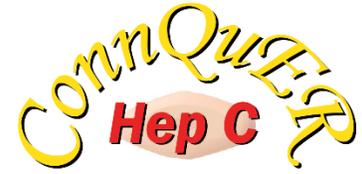
Project Echo

- Joined existing HIV/HCV ECHO
- All sites attended monthly & presented 2x during project

AETC

- All sites received AETC Curriculum training – Provider and non-prescribers
- Patient training across all sites
- Roll out of Educational Phone App





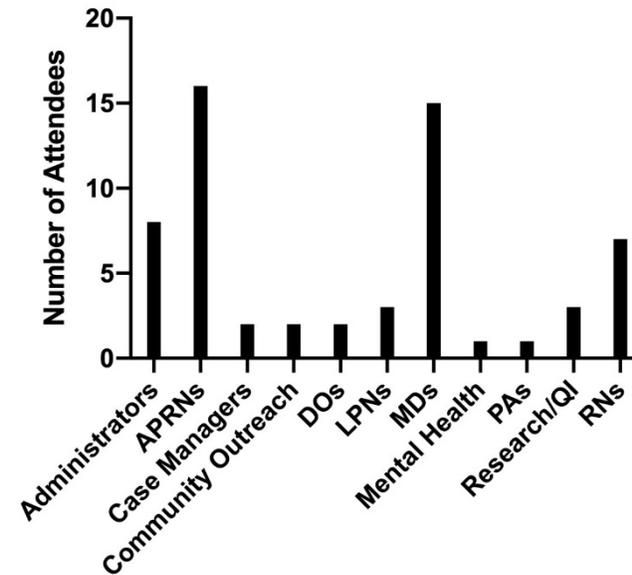
Training/Education Highlights

Project ECHO Data

- Project ECHO established via Community Health Centers, Inc.
- Project ConnQuER HEPC partnered with Project ECHO
 - All sites required to attend at least once per month
 - Each site presented at least 1 case per year
- 726 hours of training for 61 attendees (11/2018– 8/2020)



Number of Attendees by Profession



ConnQuER HEPC Website

To serve as mechanism for dissemination of:

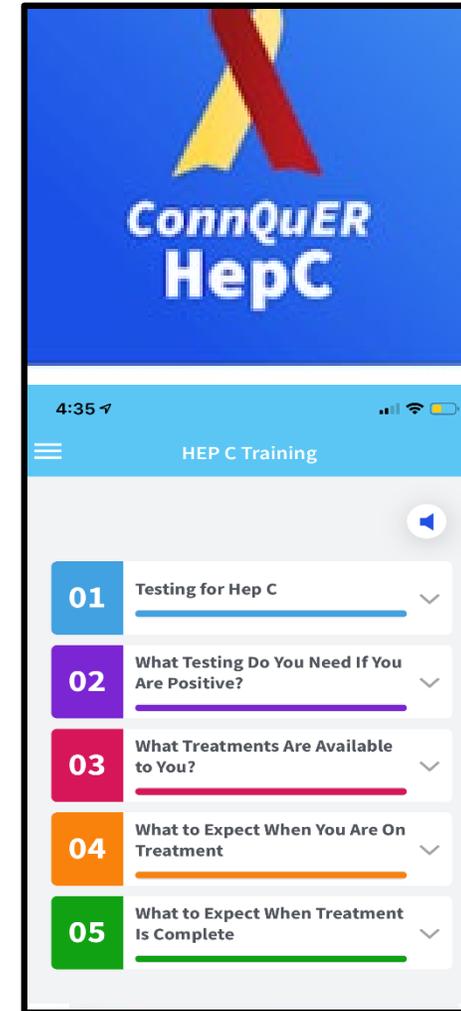
- Project Findings
- Training Resources
- Tools Developed

The screenshot shows the homepage of the ConnQuER HEPC website. At the top, there is a navigation bar with links for 'ABOUT US', 'FACULTY', 'RESOURCES', 'CONNQUER HEPC', and 'TRAININGS'. The main header features a person holding a sign that says 'ConnQuER Hep C'. Below this, a section titled 'Curing Hepatitis C Among People of Color Living with HIV' provides a brief overview of the project's focus. A 'What is Project ConnQuER HEPC?' section lists the project's goals, such as curing Hepatitis C in persons with HIV (PW) in Connecticut, improving partnerships with key stakeholders, and improving surveillance mechanisms statewide for HIV/Hep C co-infection. The website also highlights its collaboration with the Yale School of Medicine and the CT Department of Public Health (DPH). Four key areas of focus are listed: EDUCATION, SURVEILLANCE, CLINICAL, and SUD/SSP. The footer includes the AETC logo, a 'Join our Mailing List' button, and a copyright notice for 2020.

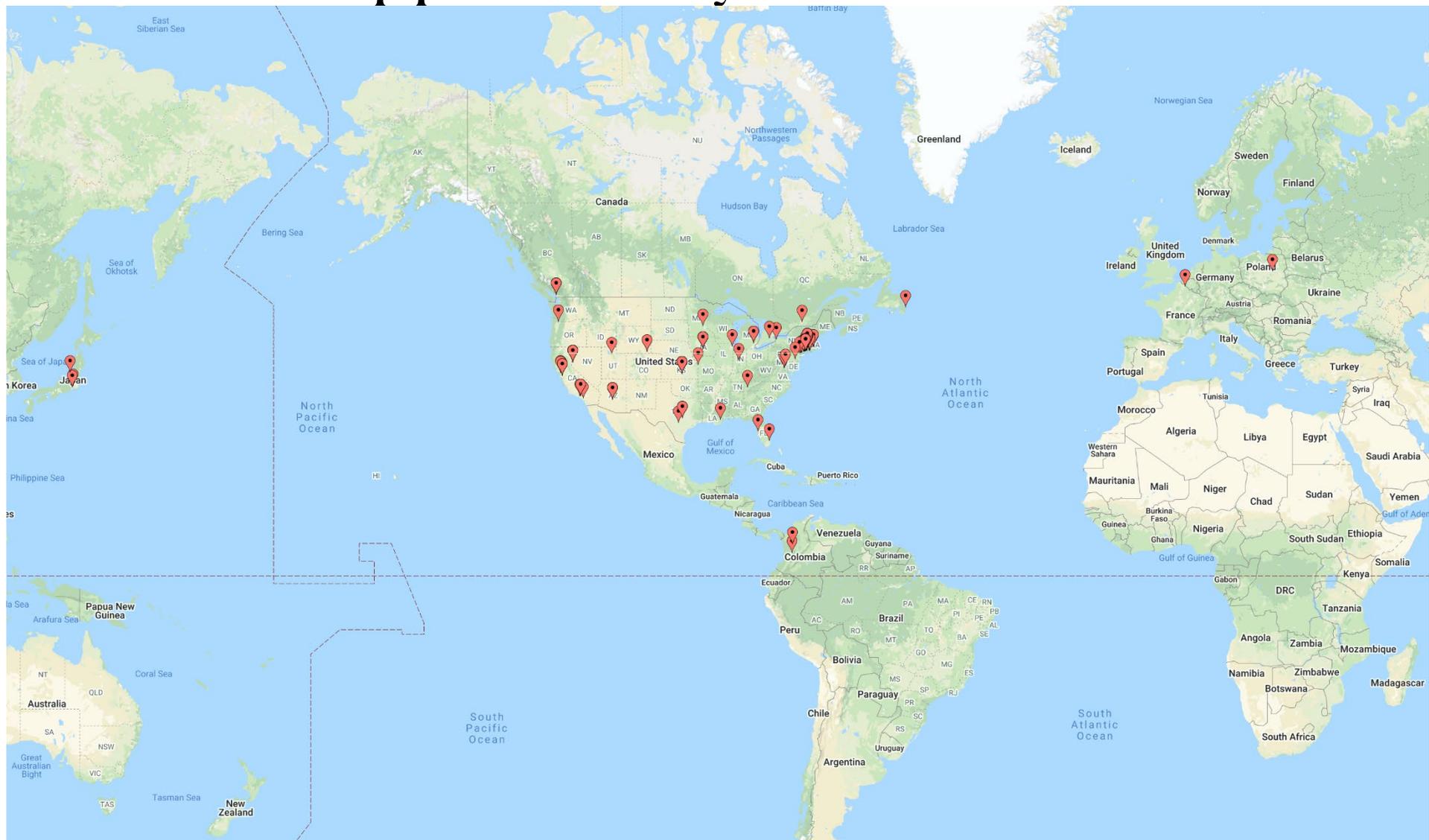
ConnQuER HEPC App

- Mobile application developed to educate clients of community-based organizations about the importance of Hep C screening and treatment
- Released November 2019
- Currently in use in 6 countries and 56 cities around the world
- Website portal created for alternative access:

<http://tinyurl.com/connquerhepc>



App Users by IP Address



App Roll-Outs to Local Clinics will Include Interactive Game

JEOPARDY!

Testing, testing...	Going Viral	Live(r) Free, Or Else	Just Say Yes to Hep C Drugs	\$\$	Hep Cats
<u>100</u>	<u>100</u>	<u>100</u>	<u>100</u>	<u>100</u>	<u>100</u>
<u>200</u>	<u>200</u>	<u>200</u>	<u>200</u>	<u>200</u>	<u>200</u>
<u>300</u>	<u>300</u>	<u>300</u>	<u>300</u>	<u>300</u>	<u>300</u>
<u>400</u>	<u>400</u>	<u>400</u>	<u>400</u>	<u>400</u>	<u>400</u>
<u>500</u>	<u>500</u>	<u>500</u>	<u>500</u>	<u>500</u>	<u>500</u>

FINAL

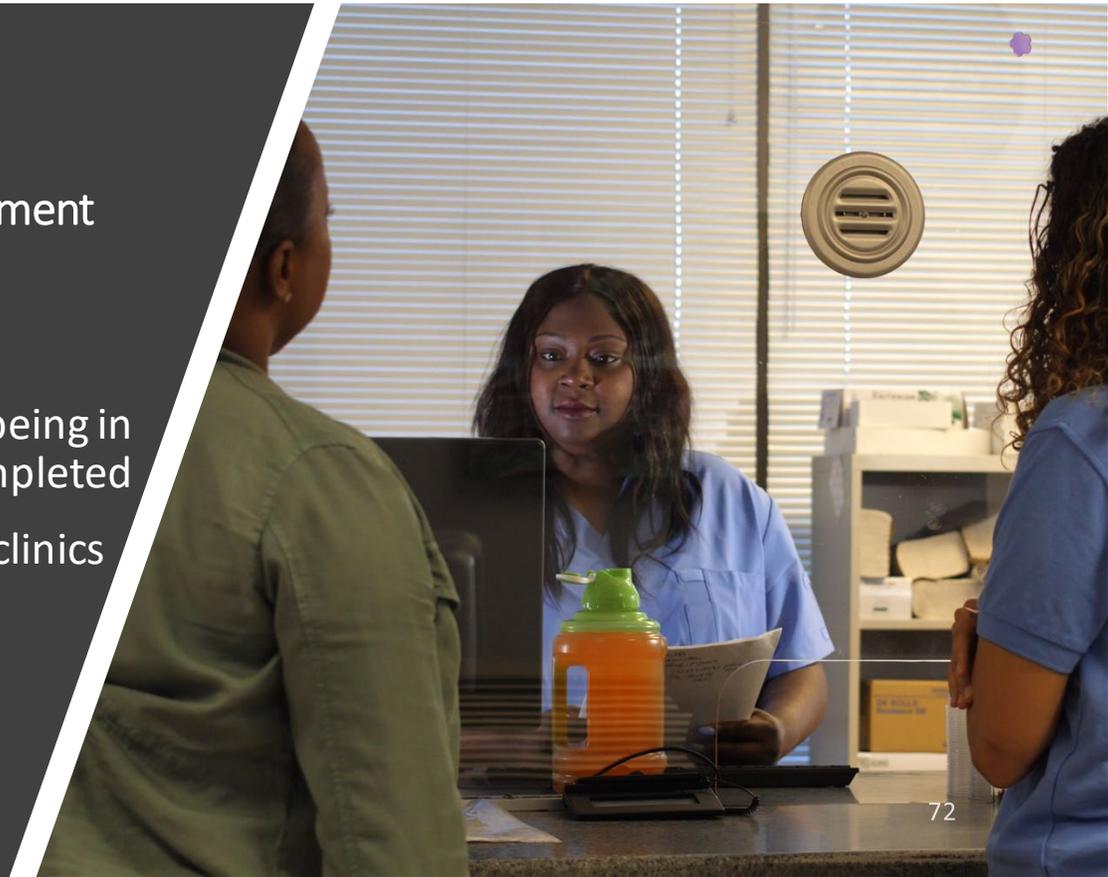


Educational Video 1

Methadone Referrals Demystified: A Patient Journey into Methadone Treatment

Format and Goals

- Illustrate patient's experience while being in treatment and after treatment is completed
- Interviews with medical staff at SUD clinics
- Patient's interviews
- Staged scenarios



Educational Video 2

Syringe Services Programs

Community Building, Testing and
Stigma

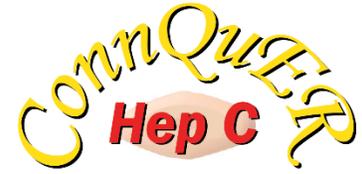


Format and Goals

- Improve linkage to care
- 4 animated videos (approx. 5 minutes each)
- Introductory videos by the staff members from each of the SSPs

Overall Project Goals

1. ***Cure Hepatitis C (HCV) in persons with HIV (PWH) in CT, particularly persons of color through improvements in the HCV cascade of care***
2. Improve partnerships with key stakeholders
3. ***Improve surveillance mechanisms statewide for HIV/HCV coinfection***



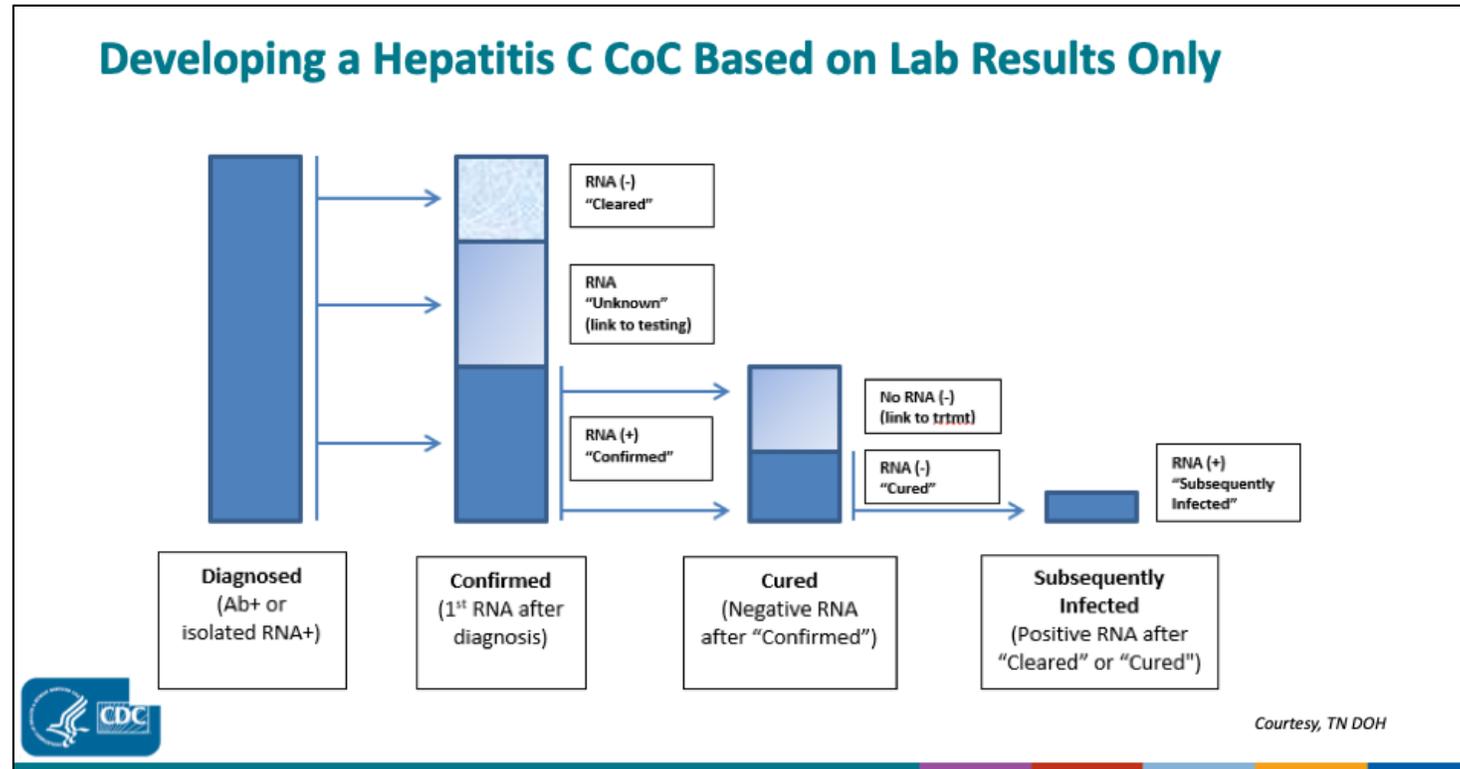
Local Evaluation Plans

LEPs

- LEP #1: Approach to HCV Re-testing of HIV+ Persons with HCV Seronegative History (Targeted vs. Universal)
- LEP #2: Creating a Statewide HCV Treatment Cascade for HIV/HCV Co-infected Persons Using Surveillance Data
- LEP #3: Efficacy of Using Disease Intervention Specialists (DIS) to Re-engage Out of Care HIV/HCV Co-infected Persons into HCV Treatment
- LEP #4: Analysis of Patient and Provider Factors Associated with Non-Receipt of HCV Care Among HIV/HCV Coinfected Persons

LEP #2: Creating a Statewide HCV Treatment Cascade for HIV/HCV Co-infected Persons Using Surveillance Data

CDC Methodology vs Reality



- Similar to the cascade we created but more simplified
- In reality, a lot of pre-cascade work takes place before we can get to this point
 - Updating surveillance cleaning data, matching surveillance databases, processing lab & patient information, and developing rules/definitions

LEP #2: Creating a Statewide HCV Treatment Cascade for HIV/HCV Co-infected Persons Using Surveillance Data

Updating the Surveillance data (CTEDSS)



- Updated CTEDSS with backlog of paper labs from 2016-2018
- When this effort began in July 2018, there were roughly 20 of these banker boxes full of paper labs that needed to be looked up in the database and entered.

March 2019
(right before temps started)



May 2019

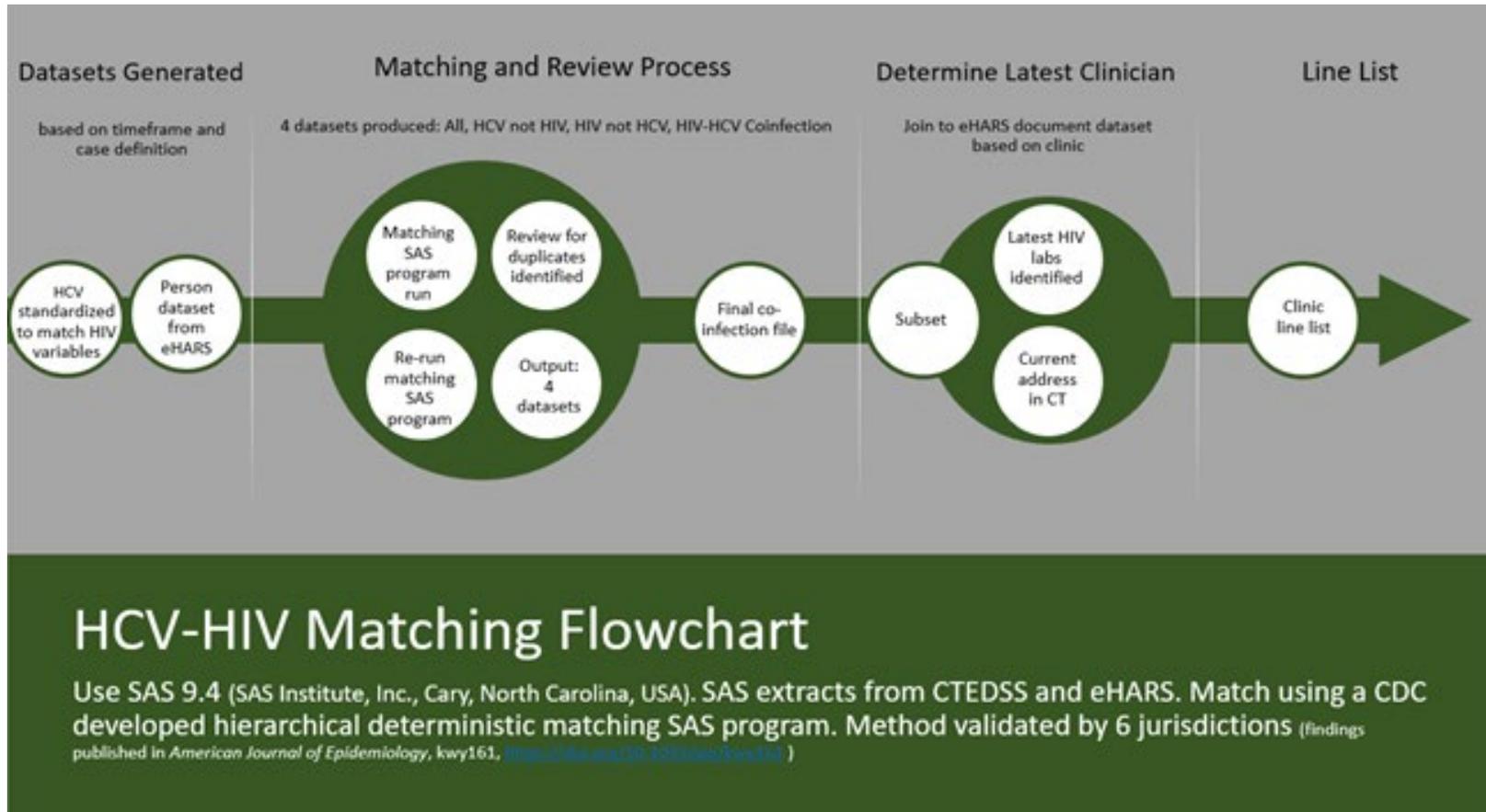


June 2019



LEP #2: Creating a Statewide HCV Treatment Cascade for HIV/HCV Co-infected Persons Using Surveillance Data

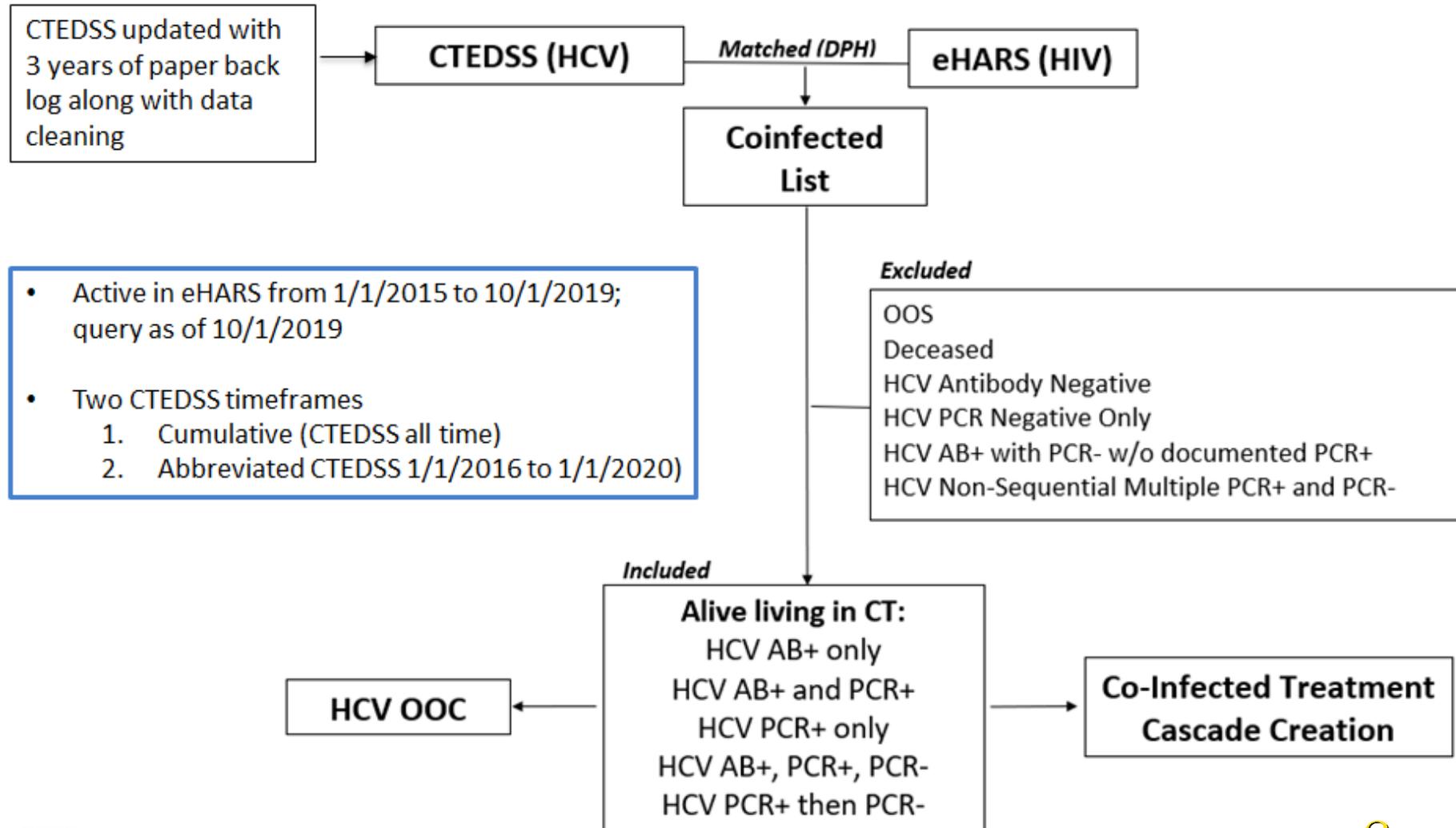
Surveillance Data Matching at the DPH



*We created a Master List from all CTEDSS cases (HCV surveillance since 1994) matched to eHARS patients active from 2009-2018

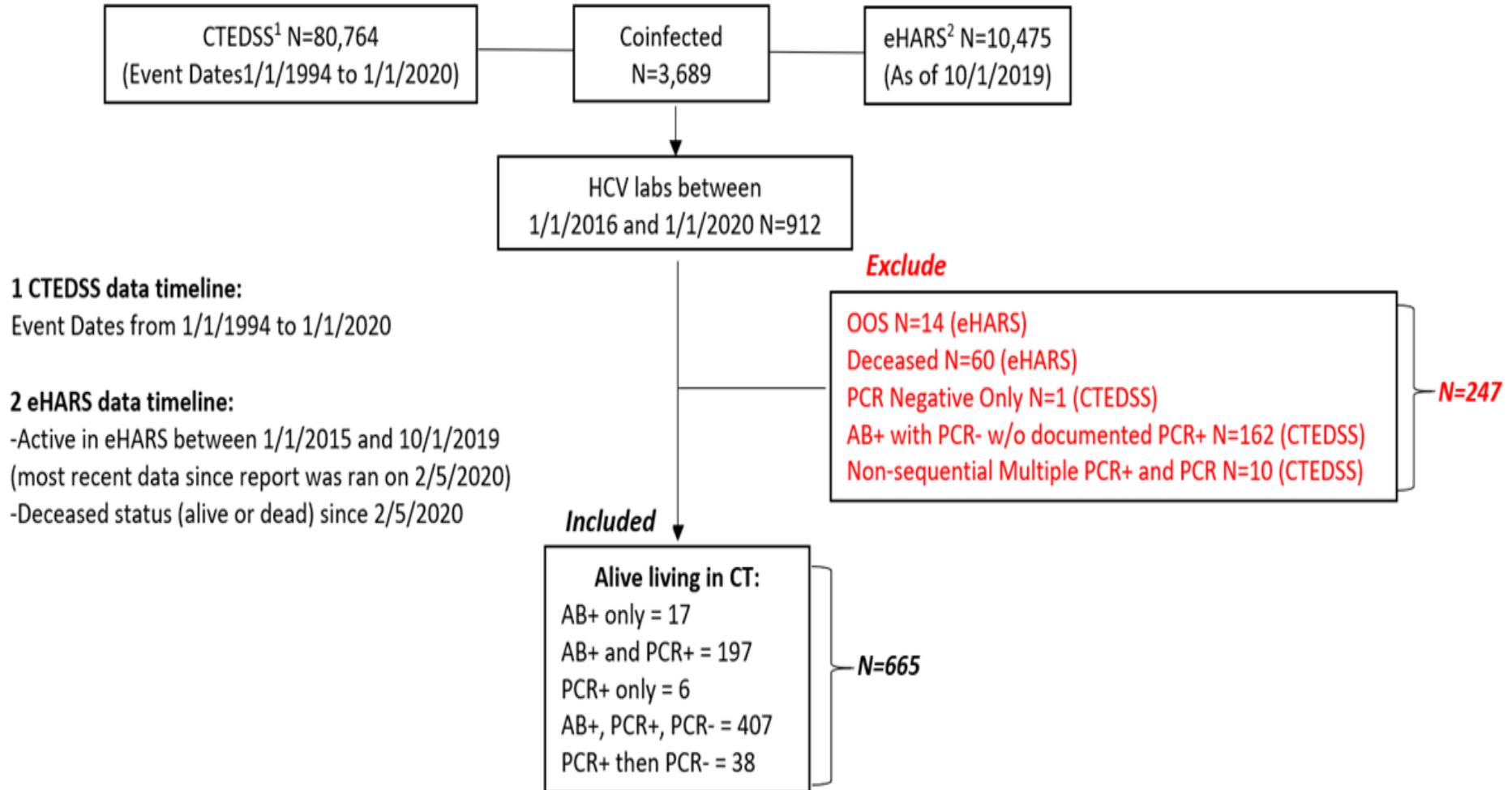
LEP #2: Creating a Statewide HCV Treatment Cascade for HIV/HCV Co-infected Persons Using Surveillance Data

Overall Flow



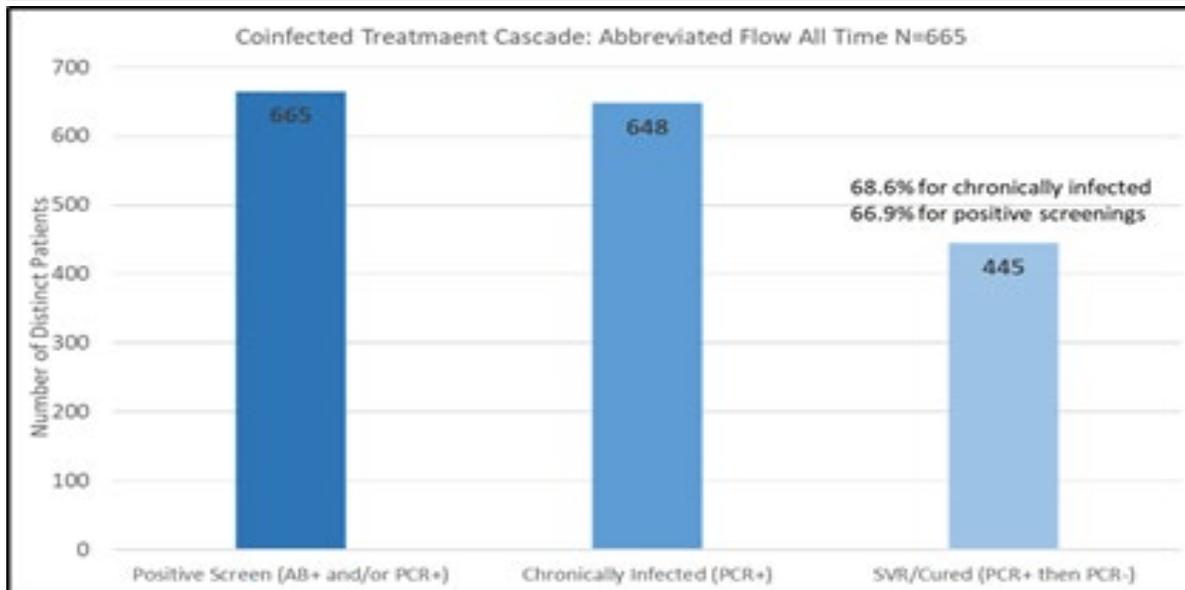
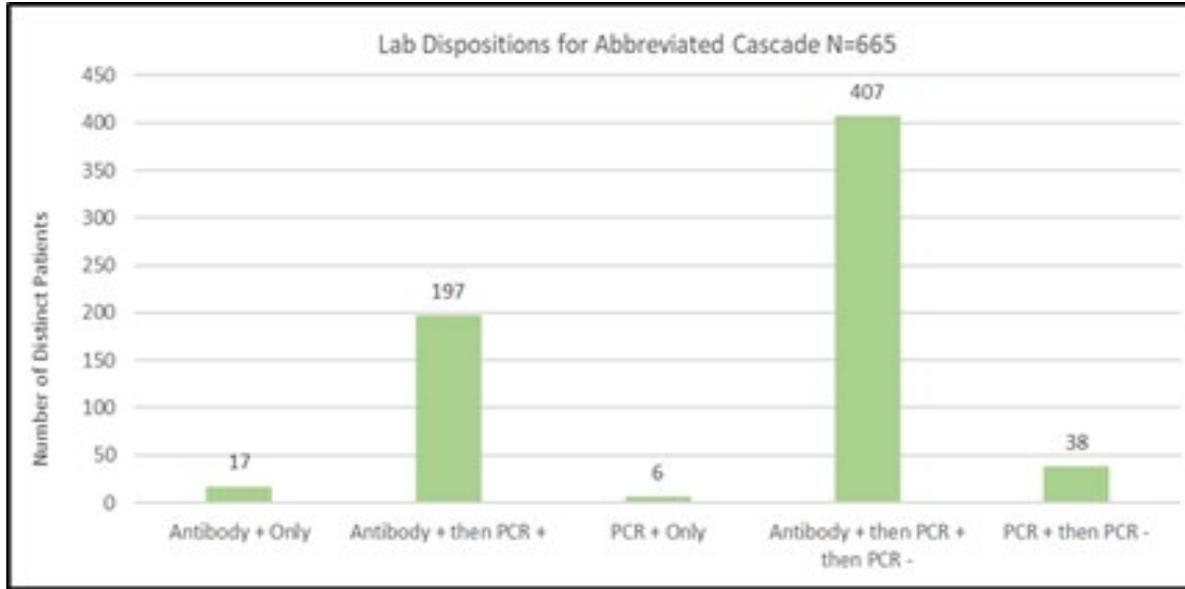
LEP #2: Creating a Statewide HCV Treatment Cascade for HIV/HCV Co-infected Persons Using Surveillance Data

Flow for Cascade Creation



LEP #2: Creating a Statewide HCV Treatment Cascade for HIV/HCV Co-infected Persons Using Surveillance Data

Cascade Results



Discussion:

- 2016 HCV case definition change (increased HCV PCR testing); ELR reporting of negative PCRs in 2018; DAA availability (treatment adherence); Improvements in testing efficiencies
- Timeframe more accurately represents the HCV care status of the current co-infected population – should be used in future studies
- Those who look OOC from cascade followed up using methodology presented in LEP 3

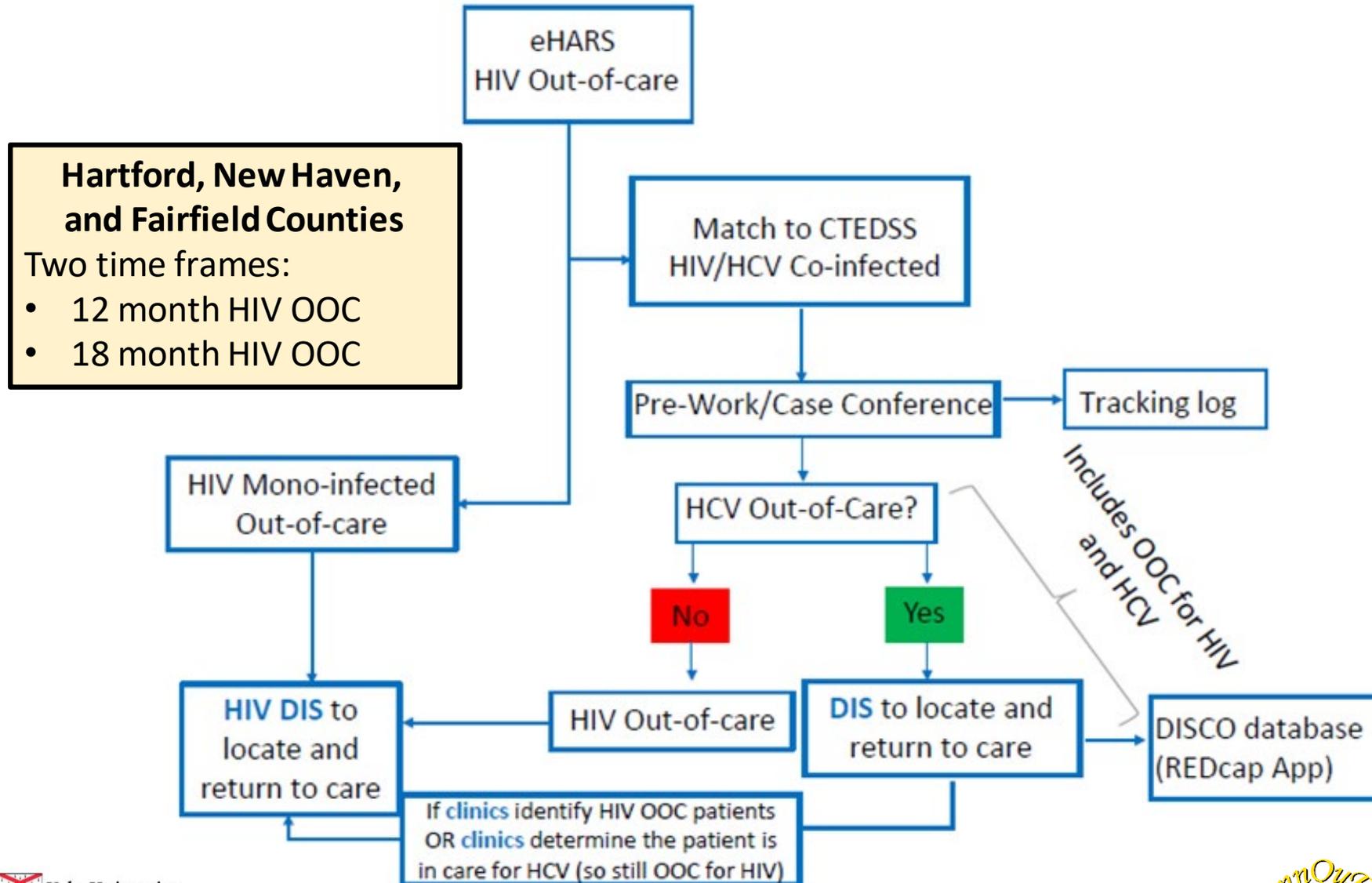
LEP #2: Creating a Statewide HCV Treatment Cascade for HIV/HCV Co-infected Persons Using Surveillance Data

Statewide Abbreviated Treatment Cascade SVR vs Not SVR for Total Screened					
Variable	Categories (N, %)	SVR (N=445)	Not SVR (N=220)	X ² p-value	Odds Ratio(95% CI)
Birth Cohort <small>(Baby boomer includes 8 cases that are older)</small>	Baby Boomer (448, 67%)	323 (72.6%)	125 (56.8%)	<0.0001	2.01 (1.4-2.8)
	Younger than Baby Boomer (217, 33%)	122 (27.4%)	95 (43.2%)		Ref
Gender	Male (474, 71%)	323 (72.6%)	151 (68.6%)	0.29	*
	Female (191, 29%)	122 (27.4%)	69 (31.4%)		
Race/Ethnicity	White (160, 24%)	107 (24%)	53 (24.1%)	0.97	*
	Black (219, 33%)	145 (32.6%)	74 (33.6%)		
	Hispanic (281, 42%)	190 (42.7%)	91 (41.4%)		
	Other (5, 1%)	3 (0.7%)	2 (0.9%)		
HIV Transmission Mode	Heterosexual Contact (60, 9%)	43 (9.7%)	17 (7.7%)	0.67	*
	MSM (46, 7%)	31 (7%)	15 (6.8%)		
	MSM and PWID (29, 4%)	18 (4%)	11 (5%)		
	PWID (500, 75%)	330 (74.1%)	170 (77.3%)		
	Other/Unknown (30, 5%)	23 (5.2%)	7 (3.2%)		
HIV Viral Load Level <small>(SVR N=438, Not SVR N=208)</small>	High (>10,000) (31, 5%)	10 (2.3%)	21(10.1%)	<0.0001	Ref
	Low [200-10,000] (46, 7%)	21 (4.8%)	25 (12%)		1.76 (0.68-4.56)
	Undetectable [<200] (569, 88%)	407 (92.9%)	162 (77.9%)		5.28 (2.43-11.45)

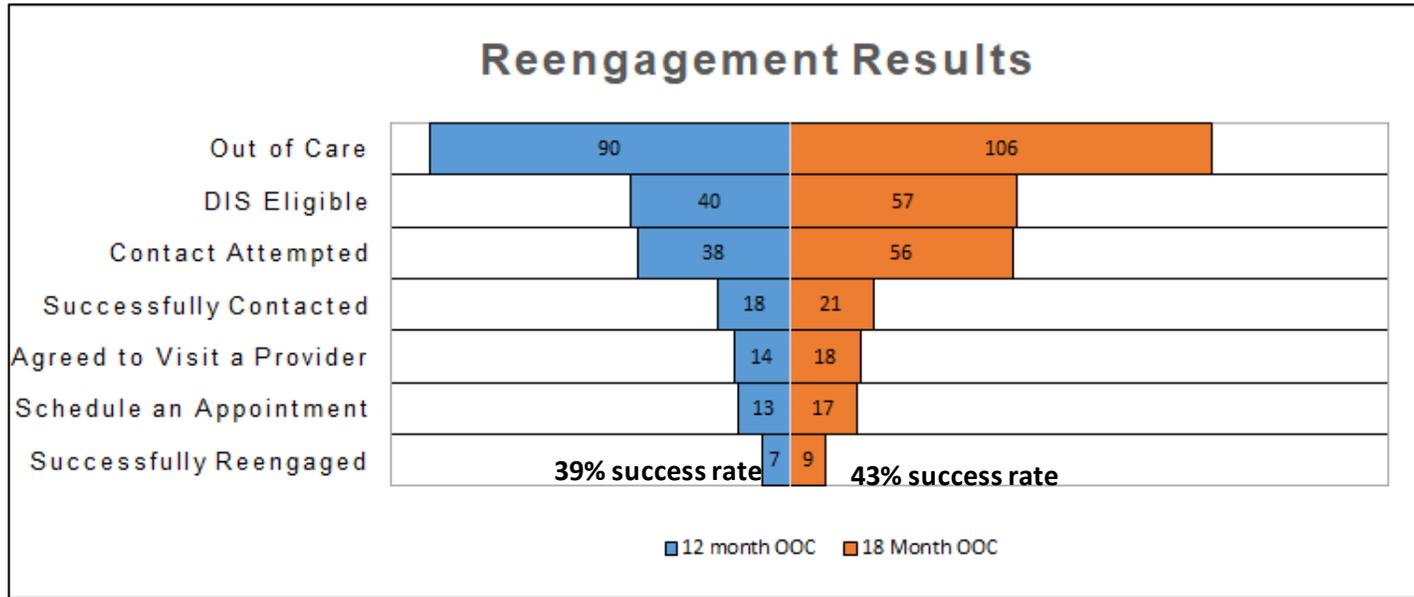
This population is primarily:

Baby boomers, Males, Persons of color, HIV Transmission – PWID, and HIV VL- Undetectable

LEP #3: Efficacy of Using Disease Intervention Specialists (DIS) to Re-engage Out of Care HIV/HCV Co-infected Persons into HCV Treatment



LEP #3: Efficacy of Using Disease Intervention Specialists (DIS) to Re-engage Out of Care HIV/HCV Co-infected Persons into HCV Treatment



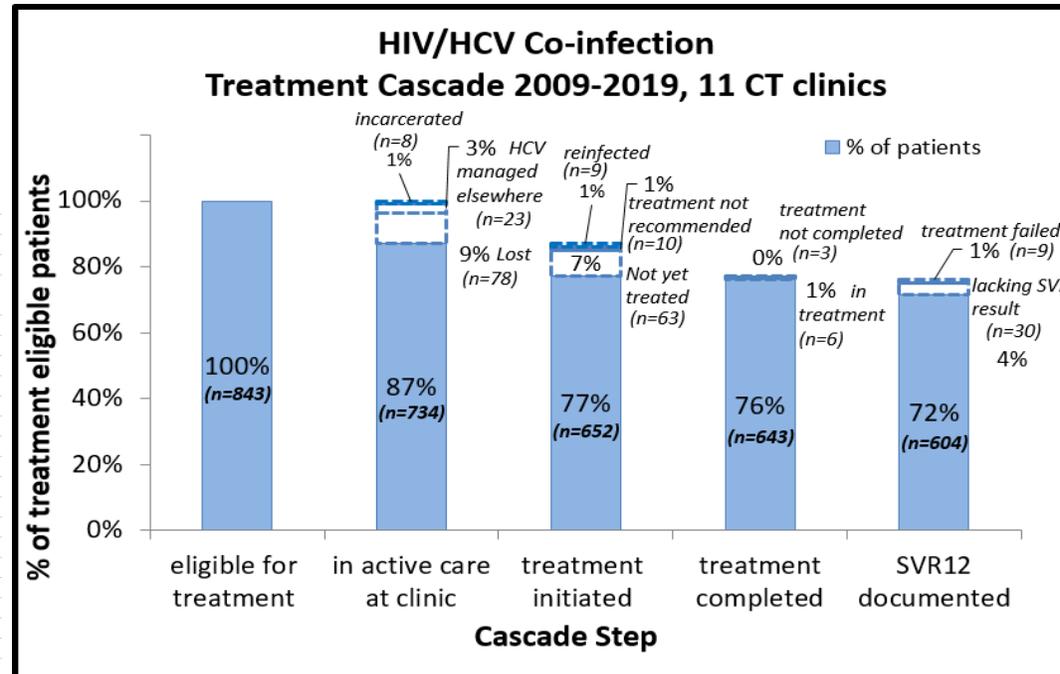
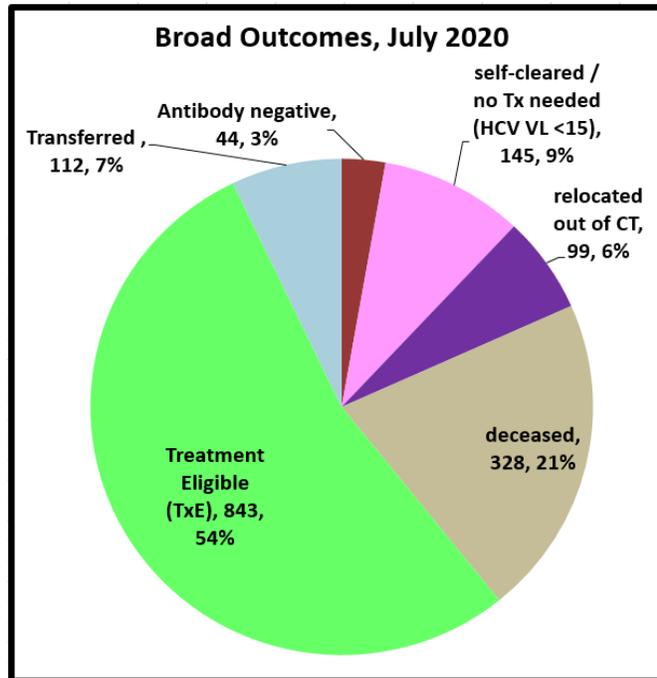
- ### Conclusions
1. Results are promising; number reengaged was small
 2. Time consuming
 3. OOC population hard to find and reengage
 4. Use what we learned to reengage the OOC from LEP 2

Out of Care and Workload Results for each study group

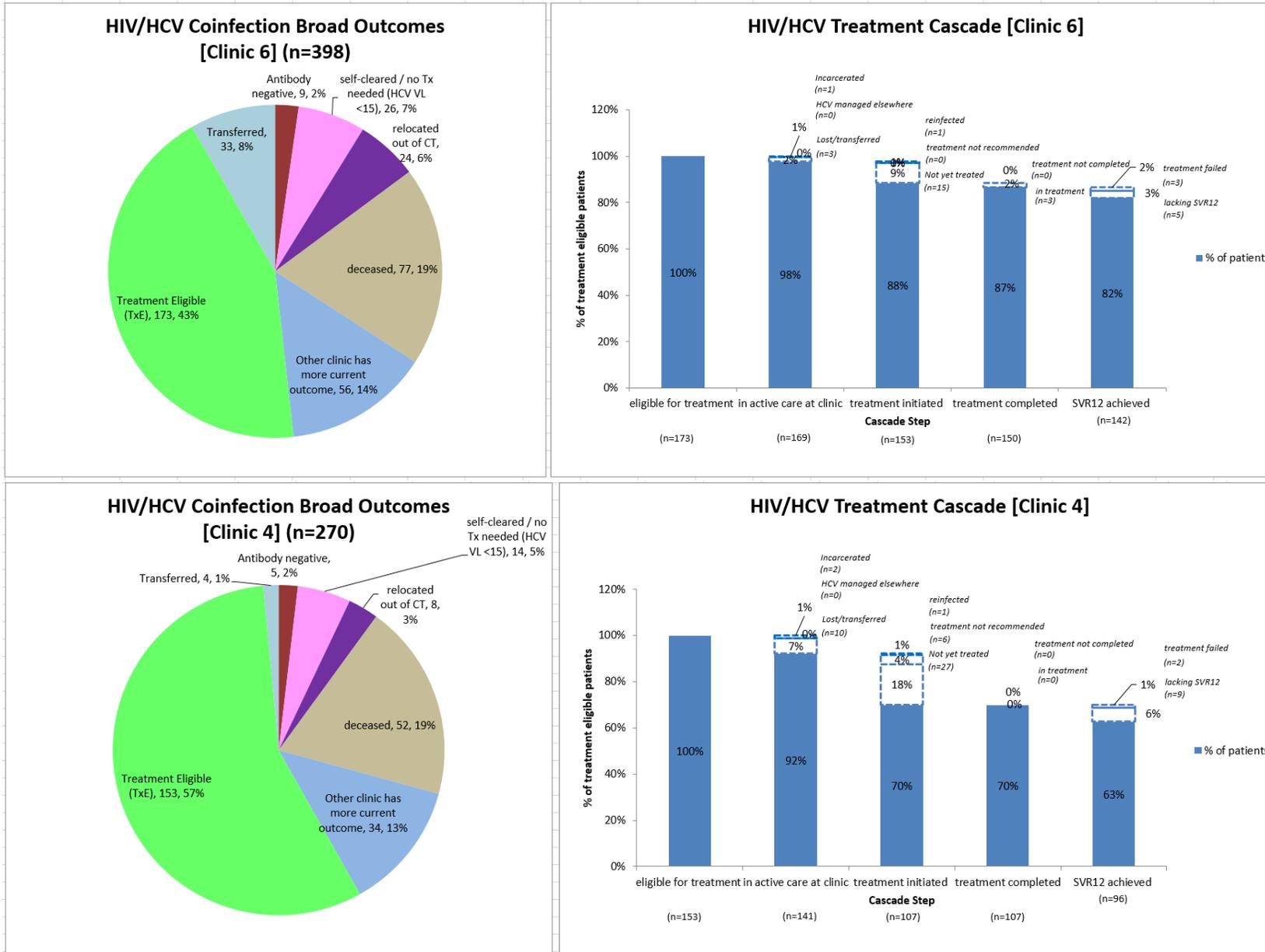
Result Types	Variables	12 month OOC	18 month OOC
Who is most likely to be OOC	Non-Baby Boomers	✓(0.05)	✓(0.02)
	Detectable HIV VLs	✓(0.04)	✓(0.002)
	Hispanic and Black		✓(0.04)
Workload for Successful Contact	Average days (range)	7 (4-11)	12 (8-18)
	Total Phone Calls	75	74
	Total Field Visits	31	36

Multi-Site Project

- Summary: 10 years (2009-2019), 11 clinics, 1571 coinfecting patient outcomes
 - Initial cascade created July 2019 (n=1496)
 - Regular refinement cycles (6 cycles to July 2020)
 - Vital records, DIS OOC (LEP3), Tx init & SVR, Care Transfer (eHARS)



Sample Clinic Cascades



Characteristic Comparison of Treatment Initiated vs Not Yet Treated Patients

Characteristic	Category	Initiated treatment (SVR12 & currently in treatment/SVR12 pending)	Not yet initiated treatment	p-value
Age (median, IQR)		44 (38-49)	43 (38-50)	0.955
Age ><50yo	≤50yo ≥50yo	481 (76.6%) 147 (23.4%)	56 (72.7%) 21 (27.3%)	0.452
Gender (gender at birth)	Male Female	445 (70.6%) 185 (29.4%)	45 (58.4%) 32 (41.6%)	0.029 OR 1.71, 95% CI 1.05-2.77
Race	Asian Black Hispanic White Other (5 <u>multirace</u> , 73 unknown)	3 (0.5%) 224 (35.6%) 179 (28.4%) 144 (22.9%) 80 (12.7%)	0 36 (46.8%) 18 (23.4%) 10 (13.0%) 13 (16.9%)	0.12
Minorities	White Minority (<u>Asian, Hispanic, Black</u>)	144 (25.9%) 413 (74.1%)	10 (15.4%) 55 (84.6%)	0.064
Hispanic Race	All others Hispanic	378 (67.9%) 179 (32.1%)	47 (72.3%) 18 (27.7%)	0.466
Black Race	All others Black	333 (59.8%) 224 (40.2%)	29 (44.6%) 36 (55.4%)	0.019 OR 1.85, 95% CI 1.1-3.096
MSM	Not MSM MSM	554 (87.9%) 76 (12.1%)	73 (94.8%) 4 (5.2%)	0.046 OR 0.399, 95% CI 0.142-1.1
IDU	No IDU IDU	133 (21.1%) 497 (78.9%)	11 (14.3%) 66 (85.7%)	0.160
VL suppression (<20)*	Suppressed Not suppressed	458 (72.7%) 172 (27.3%)	40 (51.9%) 37 (48.1%)	<0.001 OR 2.46, 95% CI 1.52-3.98

*For last VL below at time of detection at time of test

Overall Project Goals

1. Cure Hepatitis C (HCV) in persons with HIV (PWH) in CT, particularly persons of color through improvements in the HCV cascade of care
2. Improve partnerships with key stakeholders
3. Improve surveillance mechanisms statewide for HIV/HCV coinfection
4. ***NEW GOAL: *Analyze barriers and facilitators to HCV treatment****

LEP #4: Analysis of Patient and Provider Factors Associated with Non-Receipt of HCV Care Among HIV/HCV Coinfected Persons

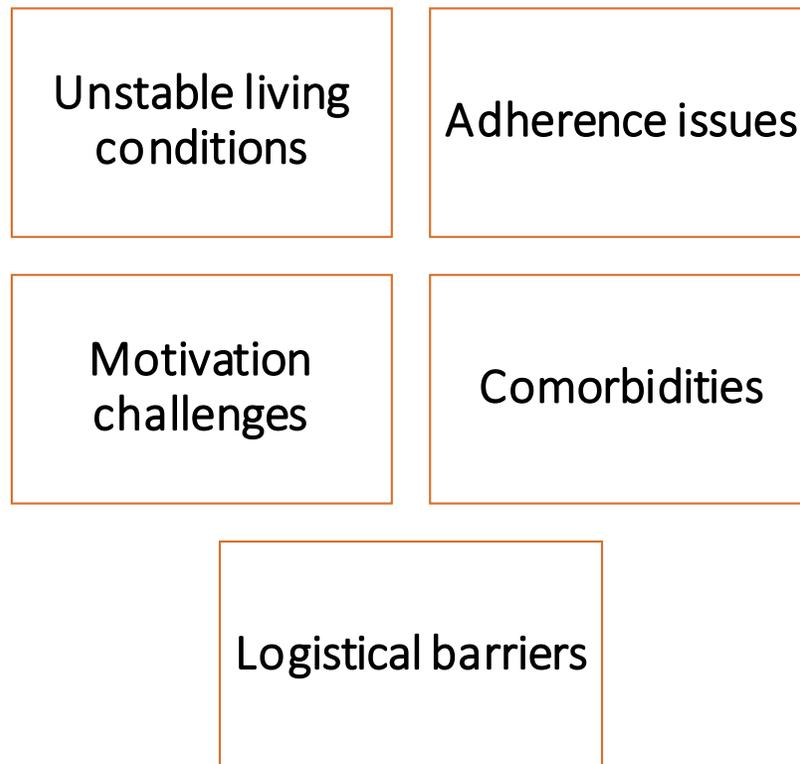
Virtual provider focus groups (2x)

17 Qualitative patient interviews (via phone)

LEP #4 Provider Focus Group (Nominal Group Technique)

From provider perspective, what gets in the way of HIV/HCV co-infected patients getting HCV treatment?

Major themes:



LEP #4 Provider Focus Group (Nominal Group Technique)

From provider perspective, what would need to change in order to increase the number of patients with HIV who get treated for HCV?

Major themes:

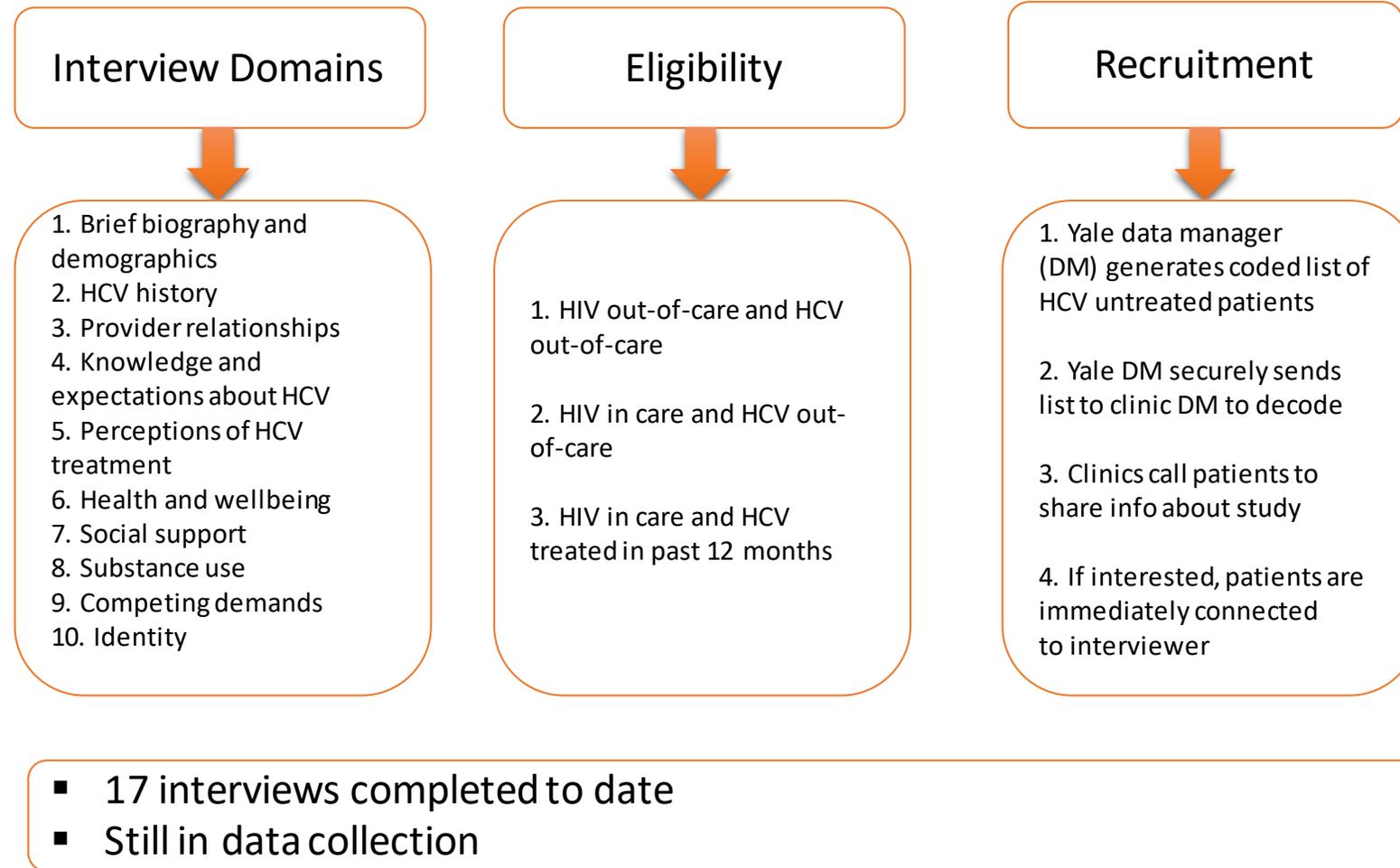
Delivery of
clinical care

Improved
knowledge

Addressing
clinical logistical
barriers

Increase patient
engagement

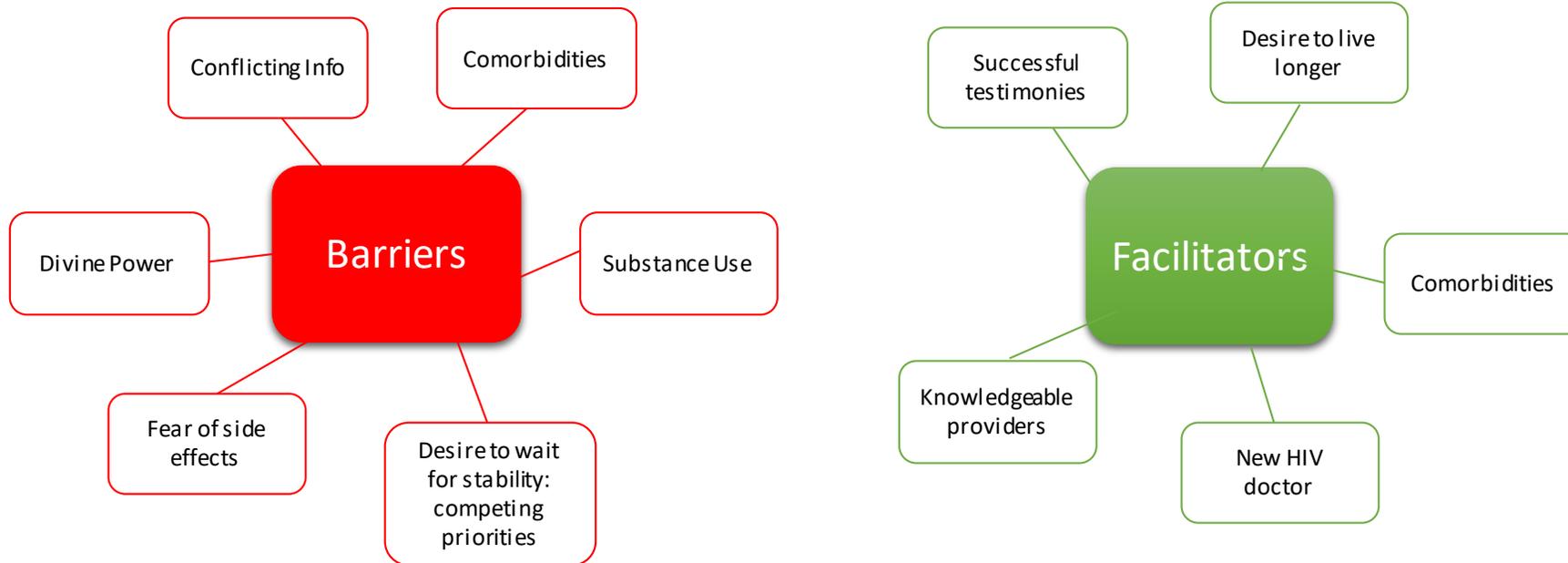
Qualitative Interviews



LEP #4 Patient Interviews

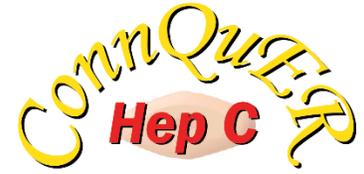
Barriers and Facilitators to HCV treatment among HIV/HCV clients

Preliminary Themes



Overall Project Goals

1. Cure Hepatitis C (HCV) in persons with HIV (PWH) in CT, particularly persons of color through improvements in the HCV cascade of care
2. ***Improve partnerships with key stakeholders***
3. Improve surveillance mechanisms statewide for HIV/HCV coinfection
4. *NEW GOAL: Analyze barriers and facilitators to HCV treatment*

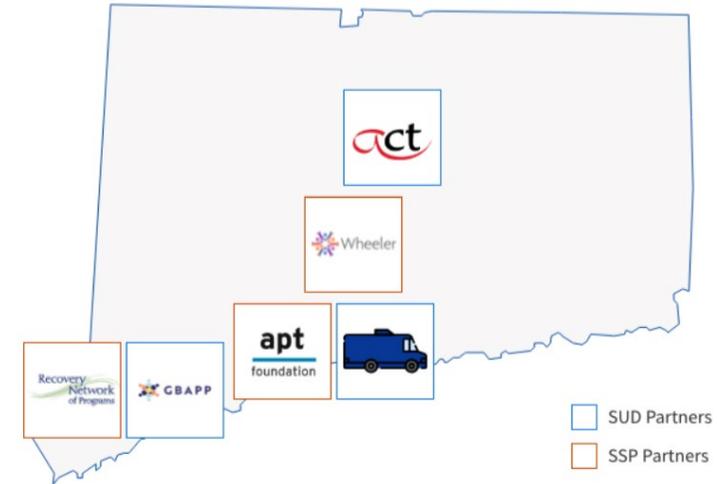


SUDs / SSPs

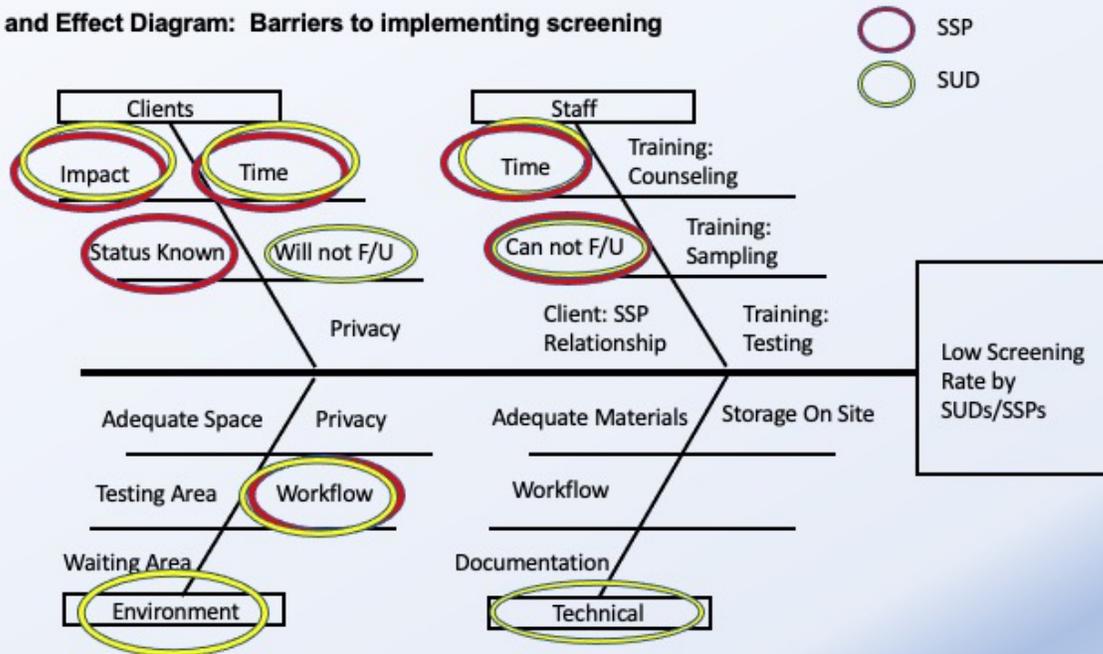
Screening challenges faced by SUDs/SSPs

- SUDs/SSPs had low testing rates.
- Cause and Effect Analysis allowed for clear identification of contributing factors

ConnOuER SUD/SSP Partner Map

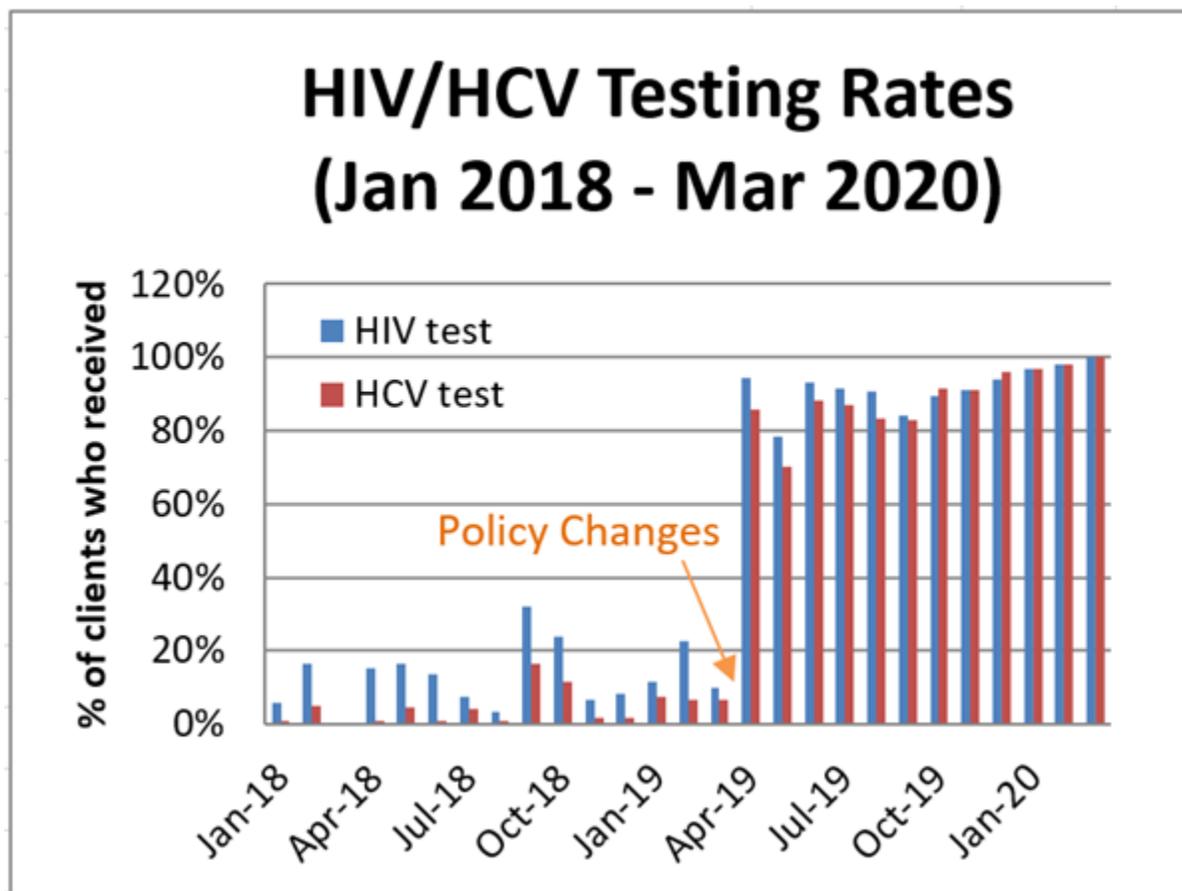


Cause and Effect Diagram: Barriers to implementing screening



SUD/SSP Partner Successes

- One site made improvements to intake procedures and policies based on the project recommendations



Detailed Results & Bi-directional Referral and Linkage

- Apr 2019-Mar 2020, 927 clients admitted (MAT program)

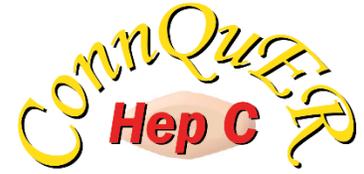
HIV:

- 842 (90.8%) tested for HIV
- 17 (2%) confirmed POSITIVE
 - All previously knew
 - 15 were already in HIV care
 - 2 were previously in care, but had stopped
 - These 2 re-engaged

HCV:

- 812 (87.6%) tested for Ab
- 292 (36%) POS HCV Ab
- 128 (15.8%) POS Ab + POS PCR
 - 97 Previously knew
 - 16 in treatment
 - 52 Tx Referrals made
 - 6 New treatment starts

- 10 patients POS for HIV & HCV Ab → 2 with HIV & POS HCV PCR → Referred to treatment
- Partner engaged 2 clinics in bi-directional referrals
 - 1 co-located and 1 external



Conclusions and Next Steps

Overall Project Goals: Accomplishments

- ✓ Cure Hepatitis C (HCV) in persons with HIV (PWH) in CT, particularly persons of color through improvements in the HCV cascade of care
- ✓ Improve partnerships with key stakeholders
- ✓ Improve surveillance mechanisms statewide for HIV/HCV coinfection
- ✓ *NEW GOAL: Analyze barriers and facilitators to HCV treatment*

Other Accomplishments

- Present findings at conferences:
 - IAS
 - SYNC 2020
 - National Ryan White Conference 2020
 - IAPAC
 - ID Week
 - Local/Regional
- 5 Anticipated Manuscripts

Next Steps

CT DPH

- Continue to regularly update and check quality of CTEDSS
- Continue the reporting of PCR negatives
- Increase the number of hospitals & labs reporting through ELR
- Increase VL/PCR testing in CT
- Devote staff to manage CTEDSS and activities developed during this project

Clinic Partners

Multisite
Eval.
Clinics
(N=11)

SSPs
SUDs
(N=6)

- SSPs - improve testing rate; home testing initiative
- SUDs - testing and referral system efficiency
- Multi-site clinics/SUD bi-directionality
- Complete LEP 1
- LEP 4 qualitative interviews coding and analysis

Training/Education

- Rollout new educational activities for project partners
- Disseminate APP
- Disseminate website

HRSA 077 – Leveraging a Data to Care Approach to Cure Hepatitis C within the RWHAP

2-Year Capacity Building Project: 9/1/2020 - 8/31/2022

Health Dept. Jurisdictions:

- CT
- RI
- KY
- NV
- AZ
- FL Orange County
- Puerto Rico

Goals:

- Improve existing collaboration between jurisdictional HCV surveillance systems and RWHAP care providers
- Link people with HCV within RWHAP to care by leveraging public health surveillance and clinical data systems

Acknowledgements



CT Dept. of Public Health

- Suzanne Speers
- Deborah Gosselin
- Heidi Jenkins
- Marianne Buchelli

SSPs

- Community Healthcare Van
- GBAPP
- ACT

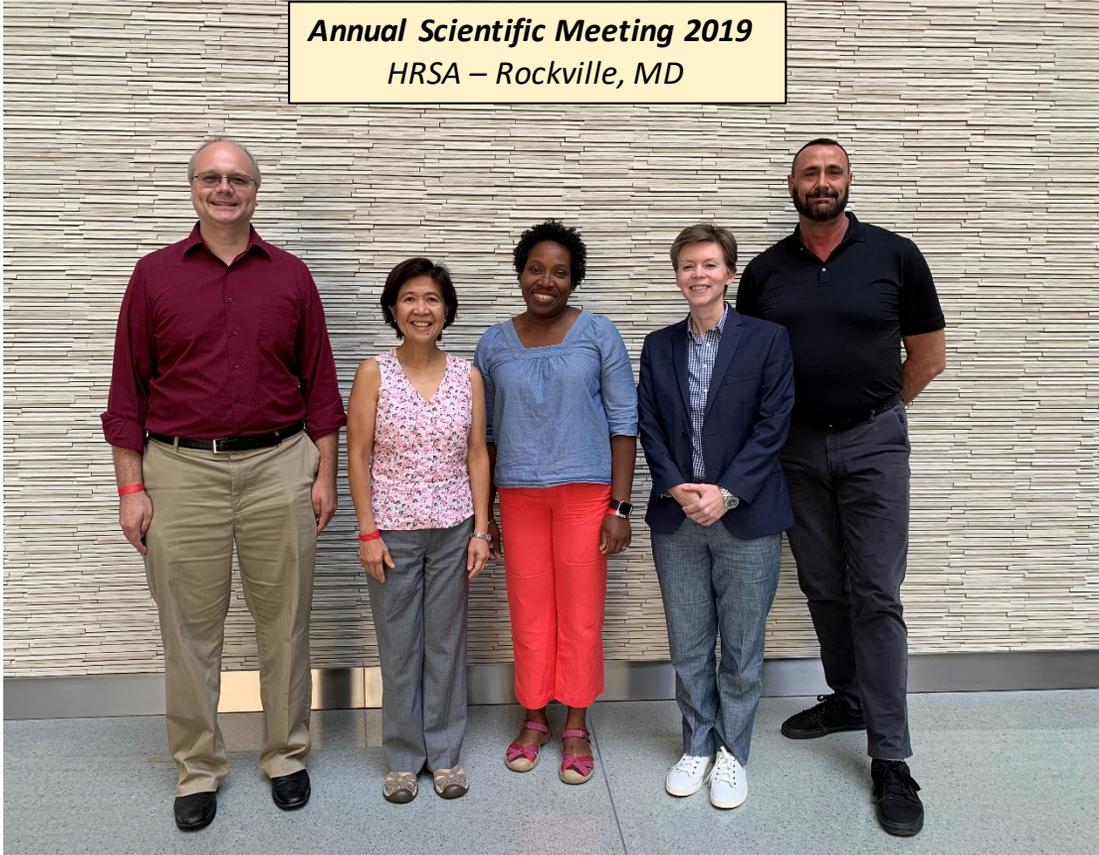
SUDs

- Recovery Network of Programs, Inc.
- APT Foundation
- Wheeler Clinic

Multisite Clinics

- YNHH Nathan Smith Clinic
 - YNHH Haelen Center
 - Cornell Scott Hill Health Center
 - Waterbury Hospital ID Clinic
 - StayWell Health Center
 - Circle Care Center
 - Optimus Health Care
 - Southwest CHC
 - Norwalk CHC
 - Lawrence & Memorial (NEMG)
 - Anchor Health Initiative
-

Annual Scientific Meeting 2019
HRSA – Rockville, MD



Special Thanks!

- HRSA Project Officers:
 - Sara Woody
 - John Hannay
- RAND Corporation
 - Peggy Chen
 - Lisa Wagner
 - Vivian Towe
- Yale University Team
 - Merceditas Villanueva
 - Lisa Nichols
 - Ralph Brooks
 - Maximilian Wegener
 - Robert Sideleau
 - Tequetta Valeriano
 - Katarzyna Sims
 - Sharen McKay
 - Christina Rizk
 - Janet Miceli
 - Sarah Brothers
 - Libby DiDomizio
 - Divya Chandra
 - Frederick Altice
 - David Vlahov





HRSA-047 Grant Collaborating Partner

Southwest Community Health Center

Bridgeport, Connecticut

Gary F. Spinner, PA, MPH, AAHIVS

Southwest Community Health Center

A Federally Qualified Health Center in
Bridgeport, CT.

- 46 Albion Street
- [510 Clinton Avenue](#)
- [968 Fairfield Avenue](#)
- [1020 Fairfield Avenue](#)
- [1046 Fairfield Avenue](#)
- 762 Lindley Street



46 Albion Street

Gary F. Spinner,
PA, MPH, AAHIVS

- An HIV Specialist caring for patients with HIV since 1983.
- 11 years at Southwest Community Health Center, building an HIV practice in Bridgeport that now serves 450 PLWH.
- Never having treated HCV prior to 2014, but since treated or have currently in treatment all co-infected patients and many hundreds of mono-infected patients.

Connecticut- The First State to Eliminate HCV?

- When CT Medicaid placed restrictions limiting who could treat HCV and the severity of liver disease as a barrier, I was one of 3 clinicians to meet with the Medicaid medical director, and as a result, drafted guidelines that led to treatment of all Medicaid patients with HCV by any licensed prescriber.
- I believe this policy will make CT the first state in the U.S. likely to meet HCV elimination by 2028 (see next slide).

Timing of HCV Elimination in the U.S.: Estimating the year each state will achieve WHO Elimination targets.

Table 1. Annual Number Needed to Treat Between 2020 and 2030 to Achieve Elimination by 2030

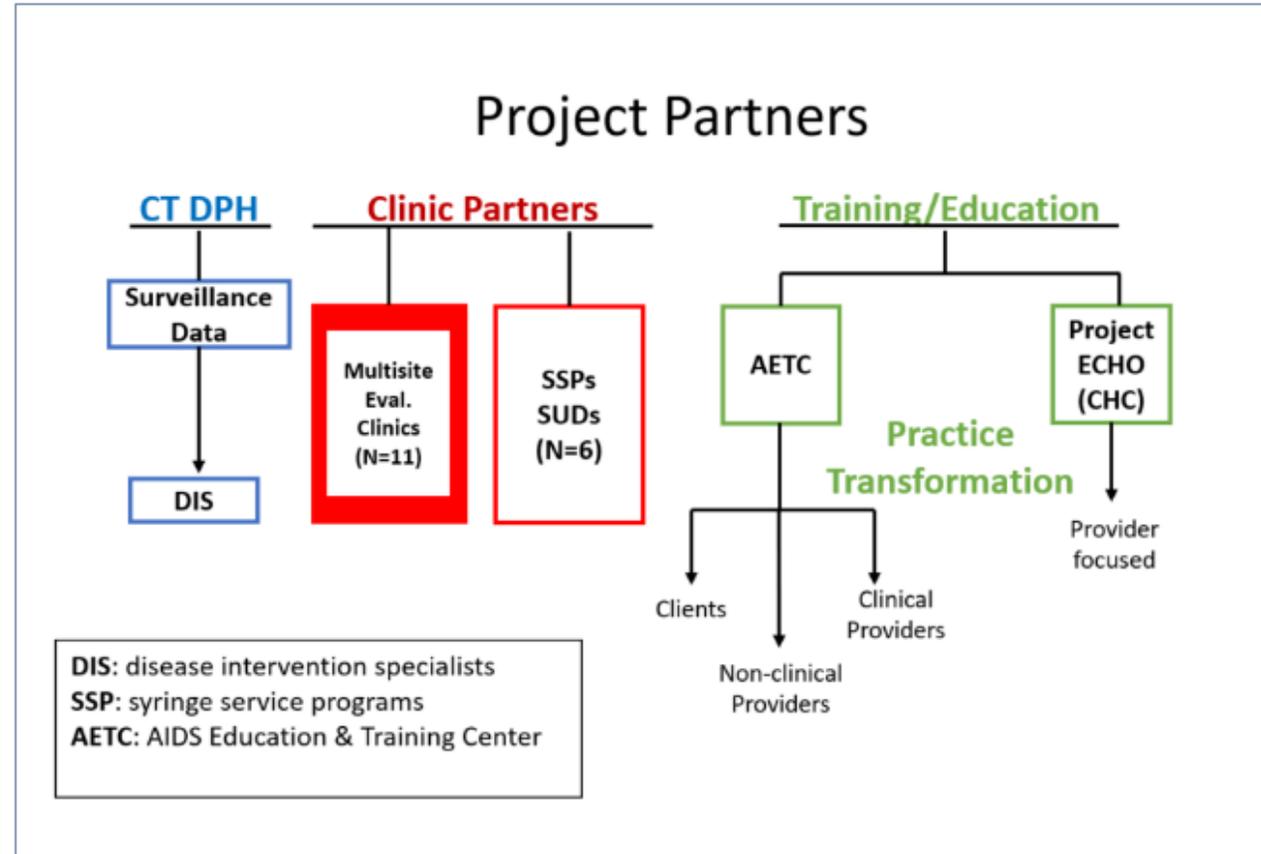
State	Year in Which Individual WHO Elimination Targets Will Be Met				Year of HCV Elimination	Annual Number of Treatments over 2020–2030 Necessary for 2030 Target	Treatment Restrictions by Fibrosis Stage in 2017
	Incidence	Liver-related Death	Diagnosis	Treatment			
AK	2033	2020	2024	2029	2033	380	None
AL	2034	2020	2025	2031	2034	1922	F2
AR	2039	2020	2025	2032	2039	2078	F3
AZ	2037	2020	2028	2034	2037	6322	None
CA	2039	2020	2030	2035	2039	29147	None
CO	2042	2021	2028	2039	2042	3551	None
CT	2028	2019	2026	2026	2028	1639	None
DC	2039	2020	2043	2032	2043	749	None
DE	2038	2021	2026	2034	2038	733	None
FL	2031	2019	2028	2028	2031	13350	None
GA	2039	2019	2026	2030	2039	3608	None
HI*	>2050	2049	2045	>2050	>2050	51	None
IA	2036	2020	2026	2032	2036	443	F2
ID	2034	2020	2025	2030	2034	313	None
IL	2044	2022	2027	2042	2044	3905	None
IN	2040	2021	2025	2037	2040	2264	None
KS	2031	2019	2027	2028	2031	766	None
KY	2045	2025	2026	2045	2045	4505	None
LA	2041	2021	2024	2038	2041	2469	None
MA	2032	2019	2026	2029	2032	4760	None
MD	2034	2020	2028	2031	2034	3648	F1
ME	2037	2021	2031	2034	2037	629	None
MI	2042	2023	2026	2041	2042	7113	None
MN	2032	2019	2025	2027	2032	930	F3
MO	2037	2020	2025	2034	2037	2584	None
MS	2031	2019	2025	2028	2031	943	None
MT	2040	2021	2025	2035	2040	428	F3
NC	2032	2019	2026	2029	2032	4564	None
ND*	>2050	2045	2028	>2050	>2050	122	None
NE	2047	2025	2024	2047	2047	430	F2
NH	2036	2020	2025	2032	2036	393	None

Connecticut likely to eliminate HCV by 2028



Yale's Project ConnQuER HEPC

- HRSA SPNS (Special Project of National Significance)
- “Curing Hepatitis C Among People of Color Living with HIV”
- Two recipients
 - University of TX, San Antonio
 - Yale University
- GOAL: Create a HCV cascade of care in PLWH



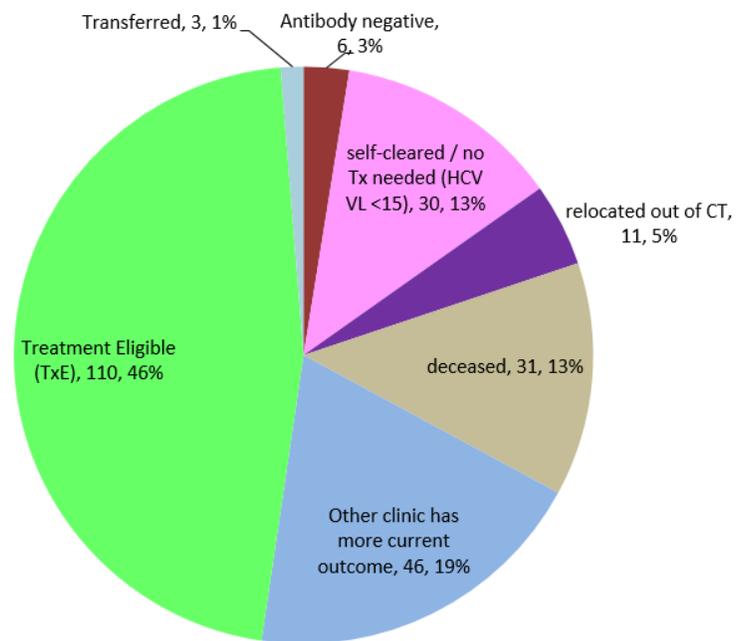
**Project ConnQuER is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling \$2,300,000 with no percentage financed with nongovernmental sources. The contents presented above are those of the author and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.*

The Project

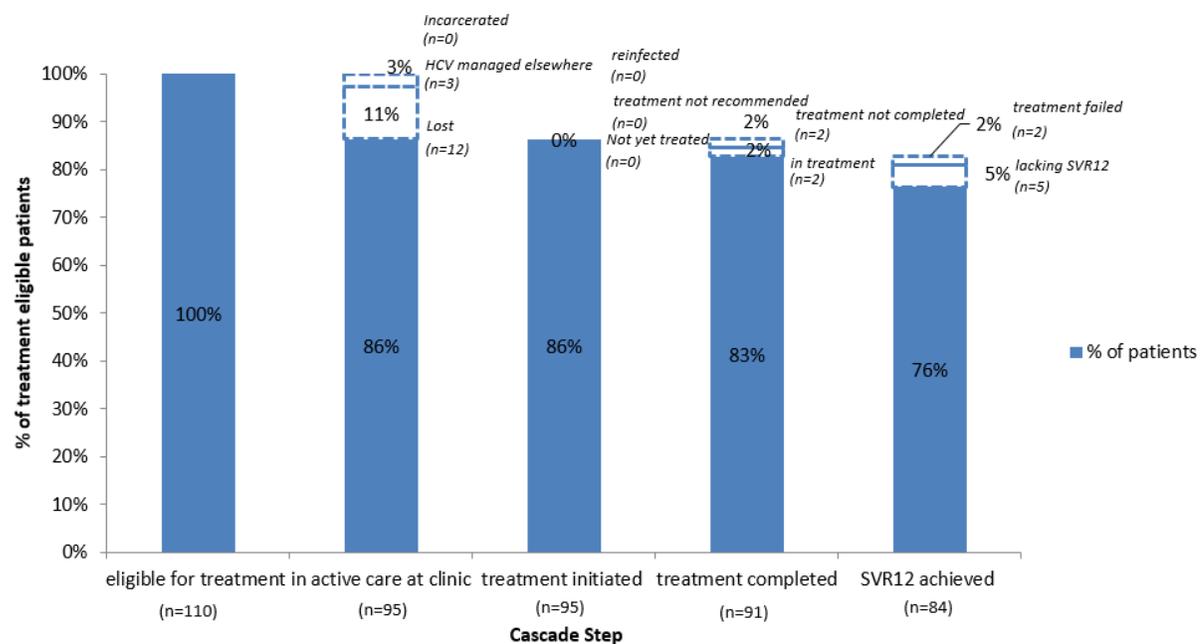
- Lacking a state-wide cascade of care for HCV, and a care cascade for my own FQHC, the project brought together an array of HIV/HCV clinicians to meet monthly.
- Discussions at these meetings have allowed sharing of best practices and development of consensus on what evidence-based and innovative practices look like in treating our co-infected patients.
- Through data sharing, a cascade of care was developed for my FQHC.
- Comparisons to other organization's data was reinforcing that my own institution was doing an excellent job of treating patients.
- I have shared the ConnQuER app with patients to educate them about HCV.

Current Clinic HIV/HCV Cascade of Care

Preliminary HIV/HCV Coinfection Broad Outcomes [Southwest] (n=237)



Preliminary HIV/HCV Coinfection Treatment Cascade [Southwest]



Development of a Collaborative Group

- Monthly meetings led to a collaborative working group who developed appreciation for each other, and the challenges faced collectively in treating co-infected people who are marginally housed or who are homeless, those with serious mental health conditions, those with active substance use disorders, etc.
- Project ECHO allowed less experienced clinicians to share cases with each other to get valuable input on how best to proceed with certain patients.

Covid-19 and HCV Treatment

- When lockdowns started in CT in March, our meetings maintained their value by allowing us to share how we were continuing to treat our patients with HCV using telemedicine.
- In my own practice, many patients for whom I have yet to meet in person, were successfully treated for their HCV using telemedicine, or telephone encounters.

Sustaining the Momentum

- We will continue to meet as a collaborative group to discuss HIV and HCV issues related to our patients.
- Southwest CHC will continue to maintain the cascade of care going forward.
- At the most recent monthly meeting of clinicians, it was agreed by all participants that the meetings contained value beyond the lifespan of the grant.
- Future meetings to allow collaboration and information exchange will continue for this working group.

Lunch Break

LUNCH – 45 Minutes



Targeted Access to
Community Knowledge,
Linkage to treatment and
Education for HIV/HCV in
people of color (TACKLE
HIV/HCV in people of color)



UT Health

San Antonio

TACKLE Program

OBJECTIVES

- Review TACKLE HIV/HCV goals, partnerships, data flow, and year 1 accomplishments
- Detail TACKLE HIV/HCV implementation findings
 - HIV/HCV Extension for Community Healthcare Outcomes (ECHO) Facebook and website impact
 - HIV/HCV surveillance
 - Fibroscan
 - TACKLE provider and staff focus groups
 - Opioid overdose training
 - AETC national HIV/HCV co-infection curriculum distribution
 - Knowledge assessment responders
 - Community events and knowledge
- Describe TACKLE HIV/HCV sustainability, dissemination, next steps

TACKLE HIV/HCV Overview

Waridibo Allison MD PhD

Principal Investigator/Program Director

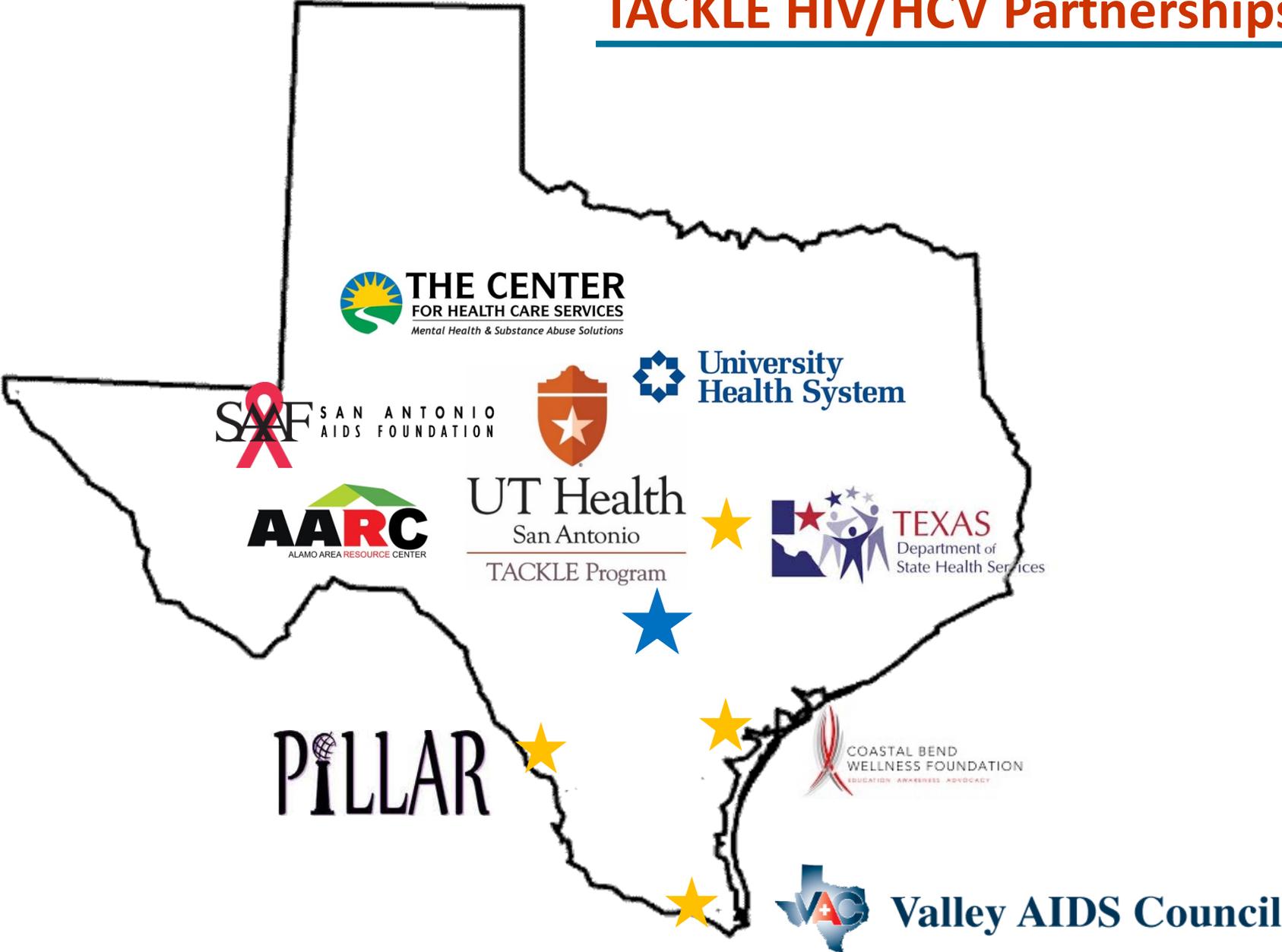


PROGRAM GOALS

GOAL 1 - Establishment of a model of integration of HCV services into HIV services and support of substance use disorder/mental health services	GOAL 2 - Provision of provider support including non specialist provider support for HIV/HCV co-infection management and treatment	GOAL 3 - Education about and screening for HIV/HCV in communities predominantly composed of people of color	GOAL 4 - Sentinel surveillance for acute and chronic HCV in people living with HIV (including people of color)
<p><i>Clinic HIV/HCV care model</i></p> <p><i>Fibroscan</i></p>	<p><i>(AETC) National HIV/HCV curriculum dissemination</i></p>	<p><i>Community education and screening events</i></p>	<p><i>Enhance TX DSHS acute HCV surveillance</i></p>
<p><i>SUD/Depression screening and linkage to support/treatment)</i></p> <p><i>Pilot opioid overdose program</i></p>	<p><i>ECHO (Extension of Community Health Outcomes) model</i></p>	<p><i>HIV/HCV Education App</i></p>	<p><i>Pilot chronic HCV sentinel surveillance program</i></p> <p><i>Pilot data to care</i></p>

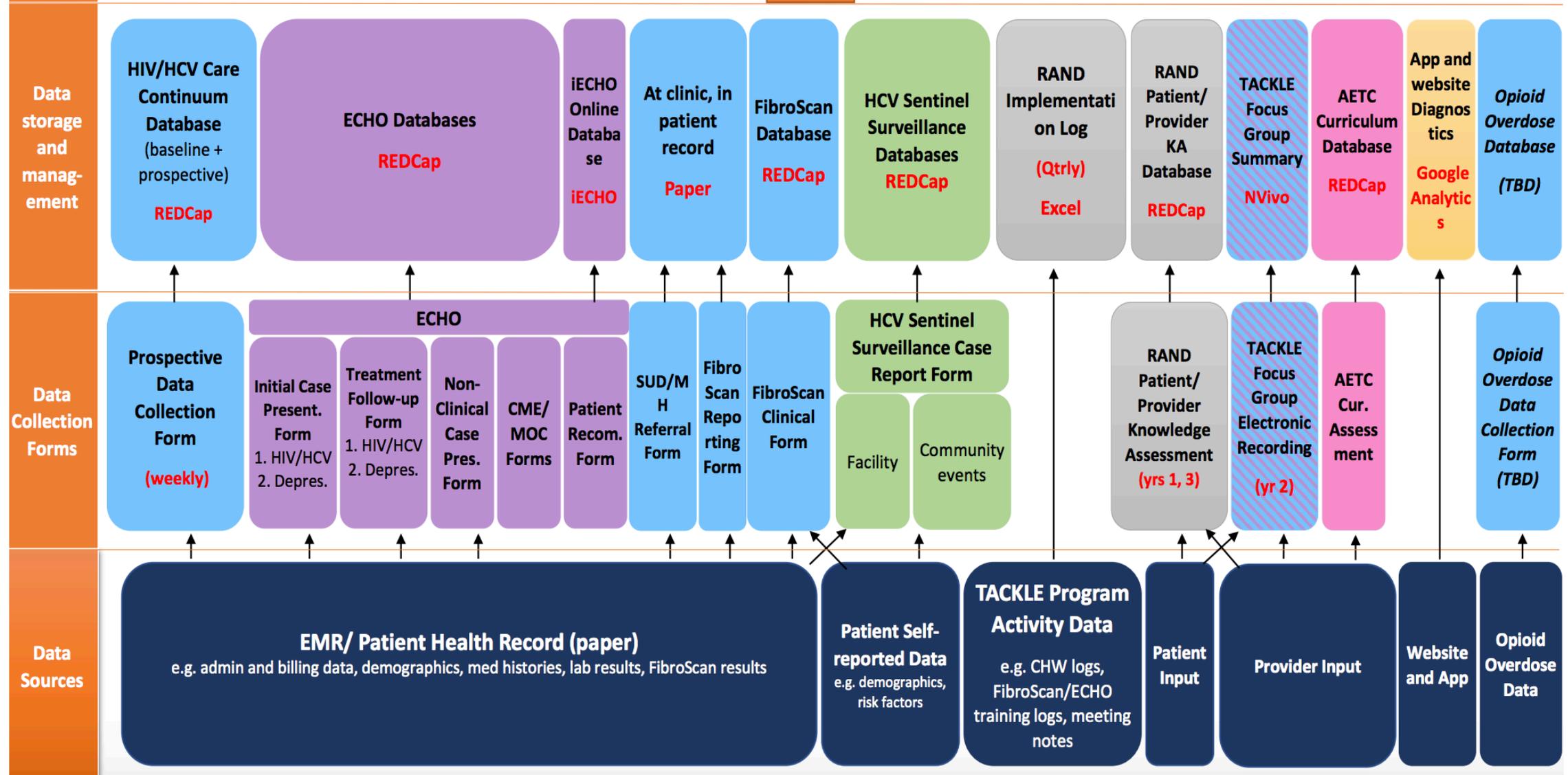
EVALUATION – FOCUS ON PROCESS EVALUATION (vs. IMPACT/OUTCOME EVALUATION)

TACKLE HIV/HCV Partnerships



Legend: ■ Clinical and SUD/MH Component ■ Surveillance Component ■ Community Outreach Component
■ ECHO Component ■ Workforce Development Component

(1) Reporting to Grantor (2) Process/Outcome Evaluation (3) Publications



Year 1 Accomplishments

- Established HIV/HCV ECHO, create a promotional video + obtain MOC/CME accreditation, train staff and partners
- Constructed websites for TACKLE and ECHO
- Detailed needs assessment, project implementation + local evaluation plans
- Produced protocols/forms and databases to unify project implementation with partners' input
 - ECHO protocol, case presentation and recommendations forms
 - Bidirectional referral processes: clinic \leftrightarrow SUD/MH
 - Fibroscan clinical reporting guidelines and pricing
 - HIV/HCV drug interaction and side effects + DAA drug access protocol
 - Reporting of acute HCV
 - Distribution of AETC HIV/HCV Co-infection Curriculum
 - HIV/HCV educational app
 - Surveillance – Clinic and community



UT Health San Antonio ECHO (Extension for Community Healthcare Outcomes)

Andrea Rochat MFA

Sr. Research Coordinator

ECHO Facilitator – Coordinator



HIV/HCV ECHO

Multidisciplinary hub experts

- 3 Infectious disease specialists
- 1 Hepatologist
- 2 Pharmacists (Faculty and Community-based)
- 2 Psychiatrists & addiction medicine specialists
- 1 Community Health Worker (CHW)

Support staff

- Non-specialist facilitator
- IT support technician
- Coordinator

No cost Continuing Medical Education (CME) and
Maintenance of Certification II (MOC II)



UT Health San Antonio HIV/HCV ECHO Didactics

Epidemiology of HIV/HCV Co-infection in the US
Screening, Testing, Diagnosis & Clinical Evaluation of Chronic & Acute HCV among PLWH
Hepatitis C Virus Treatment among People Living with HIV (PLWH)
The Role of Community Health Workers in HCV Care
NASH, NAFLD, and Chronic Liver Disease"
Overcoming Barriers Related to HCV Care- Stigma
Hepatitis C Virus Drug Regimens among Persons Living with HIV (PLWH)
Medication Adherence
Managing HCV Treatment Failures
Brief Overview of the Need to Address Alcohol Use and Chronic Hepatitis C (HCV) Infection
Introduction to Opioid Use Disorder for Community Health Workers
Beyond the Liver: Extraintestinal Manifestations of Hepatitis C
The Language of Addiction
Managing Depression and Anxiety
Long-Term Outcomes After HCV Treatment

Resources:



UT Health San Antonio HIV/HCV ECHO Didactics

Patient Education Strategies and Resources
HCV Treatment in Injection Drug Users
Opioid substitution therapy and the HCV-provider
Care for patients with Cirrhosis
Protocols for Direct Acting Antiviral (DAA) medication access
Hepatitis B Vaccination
History of hepatitis C pharmaceuticals
Addressing barriers for coinfecting people of color: Provider patient interactions
Prevention: Secondary Prevention of Viral Hepatitis and Treatment as Prevention
Prevention: Risk behavior harm reduction
HIV mutation & orientation to the HIV drug resistant database
Recommendations for subpopulations: Pregnant and post-partum coinfecting women
Covid-19 Implications for People with HIV and HCV
Recommendations for subpopulations: Neurocognitive disorders and mental illness
Addressing barriers for coinfecting people of color: Health literacy & Access to Care



UT Health San Antonio HIV/HCV ECHO

N ECHO sessions	38
N cases presented	45
Total number of attendees	923
Average number of attendees per session	24
Number of PLWHIV reached	3,226
Number of HIV/HCV clients reached	82



Outreach & sustainability

UTHSA ECHO Website (launched Oct 2018)

◦ www.uthscsa.edu/echo

UTHSA ECHO Facebook 

◦ [@UTHealthSAECHO](https://www.facebook.com/UTHealthSAECHO)

Spoke engagement and recruitment

Partnership with UT Health San Antonio
AETC Local Performance Site



Facebook and Website Impact

Keito Kawasaki MPH

Research Associate



UT Health

San Antonio

TACKLE Program

Facebook (10/2018-8/2020)

Posts: 204

Page views: 3,780

Likes: 115



UT HEALTH SAN ANTONIO
ECHO



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About See All

San Antonio, TX 78229

Case-based learning, innovative technology, adaptive didactics, and a rich collaboration for guided medical practice. Are you part of the ECHO?

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UT Health San Antonio ECHO 16h · 

To join, contact us at: <https://wp.uthscsa.edu/echo/about/contact/>

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Medical & Health · Education

UT Health San Antonio ECHO August 18 at 5:09 PM · 

We will host our next HIV/HCV Co-infection ECHO session on Friday, August 28 at 11:00am-12:00pm CST. We will be discussing "Overcoming Barriers Related to HCV Care Stigma". Please consider participating in our ECHO session!

To join, contact us at: <https://wp.uthscsa.edu/echo/about/contact/>
#ProjectECHO #HIV #HCV #coinfections



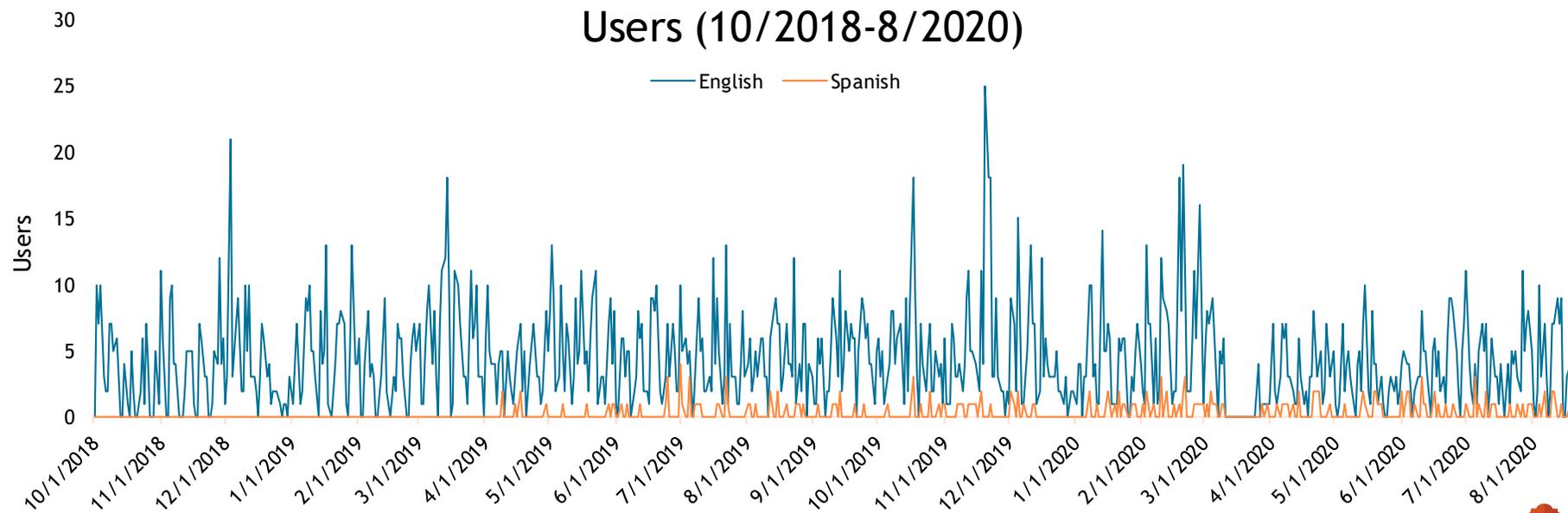
Raudel Bobadilla, Ariel Gomez and 2 others

Like Comment Share

Write a comment...

UT Health San Antonio ECHO added an event.

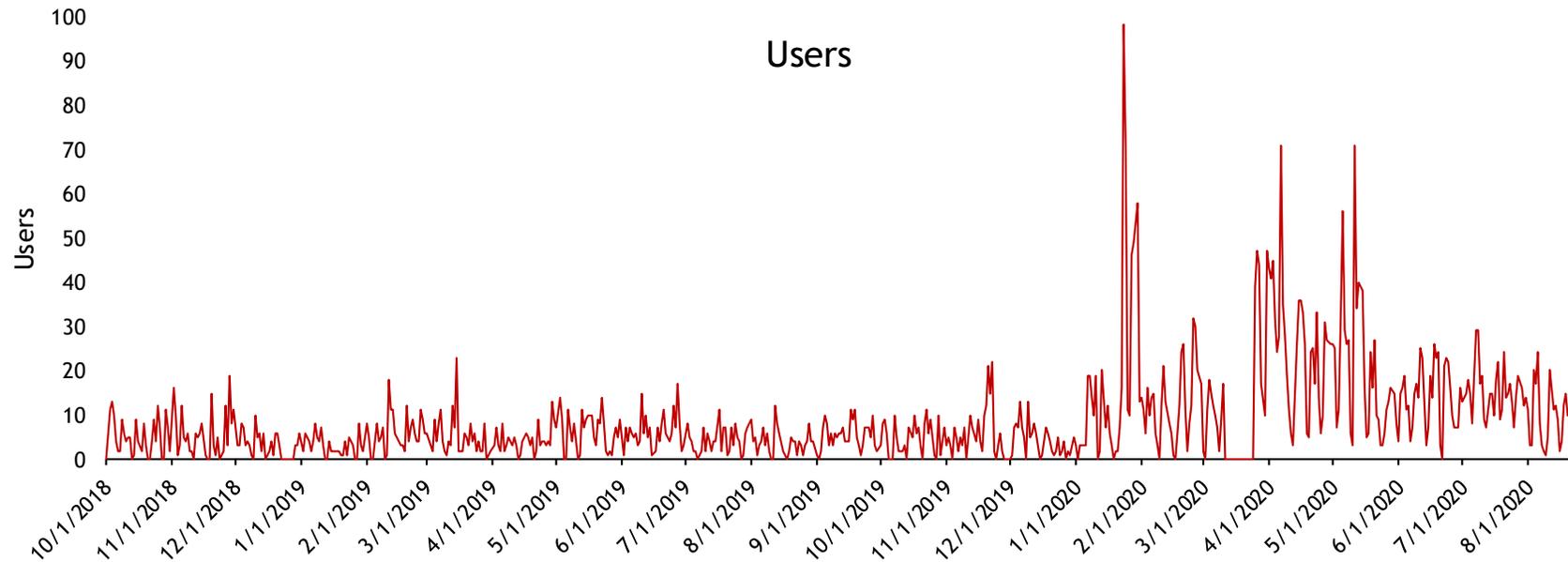
TACKLE Website (10/2018-8/2020)	English	Spanish
Users	2,143	149
Page Views	9,634	796
Sessions	3,421	214
Avg. Session Duration	02:47	03:31



ECHO Website (10/2018-8/2020)	
Users	4,420
Page Views	16,954
Sessions	6,670
Avg. Session Duration	02:16



What is the ECHO Model?



HIV/HCV Surveillance

Trisha Melhado MPH

Sr. Research Scientist



UT Health

San Antonio

TACKLE Program

HCV Case Definition

HCV INFECTION TYPE		DATE OF DIAGNOSIS
1 <input type="checkbox"/> Probable Chronic* <input type="checkbox"/> Confirmed Chronic* <input type="checkbox"/> Acute		1 _____
2 <input type="checkbox"/> Probable Chronic* <input type="checkbox"/> Confirmed Chronic* <input type="checkbox"/> Acute		2 _____
<p>*Definitions:</p> <p>PROBABLE CHRONIC HEPATITIS C: Chronic condition with no available evidence of clinical and relevant laboratory information indicative of acute infection and with items from columns 1 and 3</p> <p>CONFIRMED CHRONIC HEPATITIS C: Chronic condition with no available evidence of clinical and relevant laboratory information indicative of acute infection and at least one item from columns 2 and 3</p>		
1	2	3
<ul style="list-style-type: none"> • Anti-HCV positive 	<ul style="list-style-type: none"> • NAT for HCV RNA positive (including genotype) • HCV antigen positive 	<ul style="list-style-type: none"> • No report of test conversion (documented negative anti-HCV, HCV NAT, or HCV antigen result followed within 12 months by a positive result)

Overview of TACKLE clients from five clinical sites

Screened for HCV	2,566
HCV Ab+	262
Probable HCV	86
Confirmed HIV/HCV coinfection	120
SUD/MH referral	30

Demographics of probable (N=86) and confirmed HIV/HCV coinfecting cases (N=120)

	Probable	Confirmed
Age mean, (SD)	50, (11)	47, (10)
Gender	N (%)	N(%)
Male	69 (80)	88 (73)
Female	16 (19)	28 (23)
Transgender	1 (1)	4 (3)
Race/Ethnicity		
Hispanic	56 (65)	71 (59)
N-H White	23 (27)	26 (22)
N-H Black	6 (7)	20 (17)
N-H Other	1 (1)	3 (2)

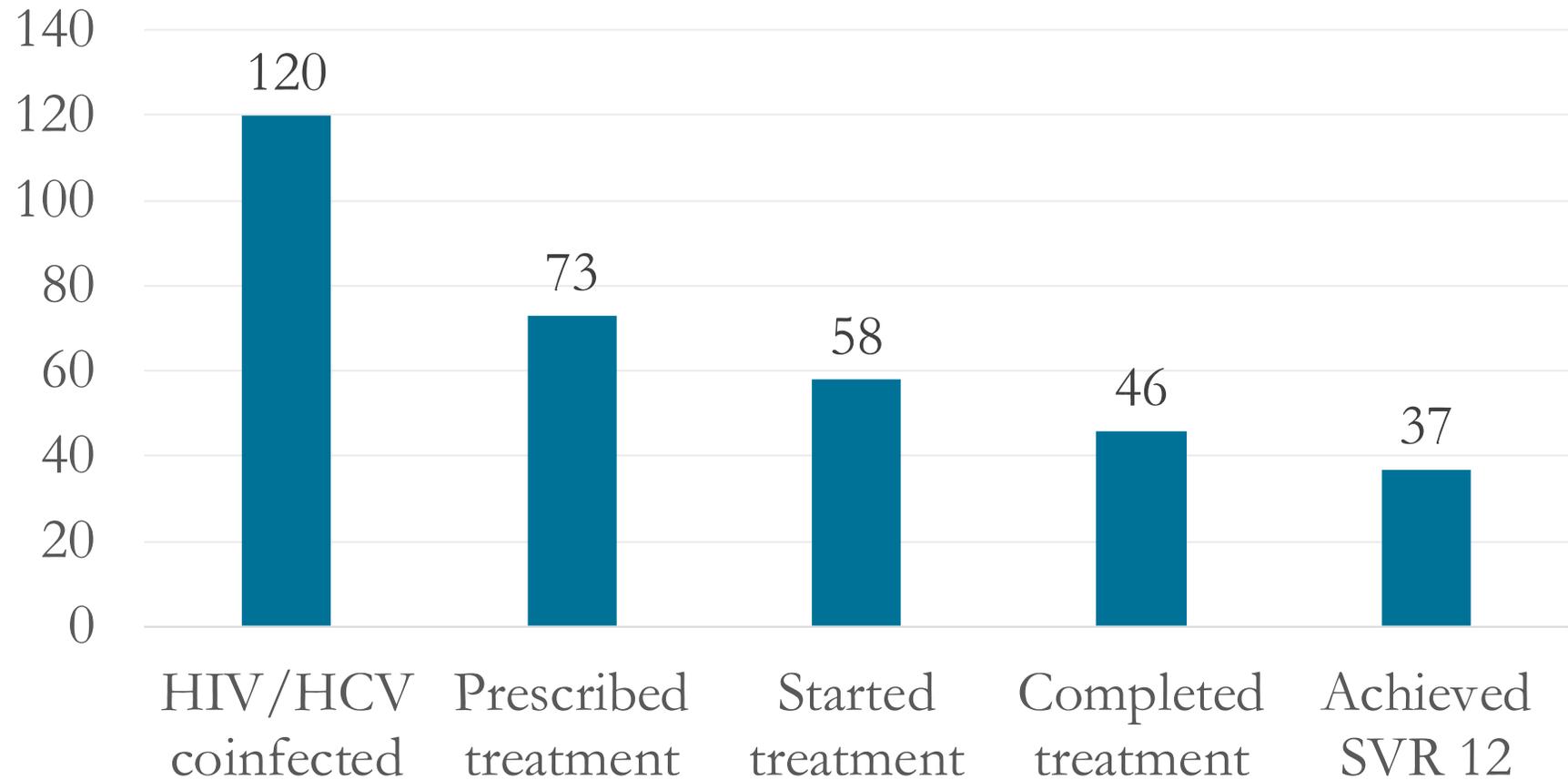
Characteristics of probable (N=86) and confirmed HIV/HCV coinfecting cases (N=120)

Insurance	Probable N (%)	Confirmed N (%)
None	42 (49)	77 (64)
Private	28 (33)	17 (14)
Medicare	7 (8)	8 (7)
Medicaid	9 (10)	13 (11)
Carelink	0	5 (4)
Injection drug use		
Never used	51 (59)	62 (52)
Current user	0	10 (8)
Used but not current user	6 (7)	41 (34)
Non-injection drug use		
Never used	41 (48)	43 (36)
Current user	7 (8)	31 (26)
Used but not current user	10 (12)	39 (33)
History of mental health disorder	32 (37)	51 (43)

Risk factors among probable (N=86) and confirmed HIV/HCV coinfecting cases (N=120)

Risk factors	Probable N (%)	Confirmed N (%)
One or more male sex partners	7 (8)	48 (40)
Incarceration	5 (6)	47 (39)
Used non-injected street drugs	11 (13)	58 (48)
Treated for a sexually-transmitted disease	12 (14)	46 (38)
Tattoo (non-commercial setting)	4 (5)	31 (26)
One or more female sex partners	4 (5)	37 (31)
Body piercing (non-commercial setting)	2 (3)	11 (9)
Injected drugs or cosmetic products not prescribed by a doctor	3 (4)	25 (21)
Contact with person who had hepatitis	1 (1)	13 (11)

TACKLE HCV Care Cascade*



*n=21 loss to follow-up, patient moved, incarceration, pregnancy, death

Fibroscan

Trisha Melhado MPH

Sr. Research Scientist



Fibroscan

- Number of HIV/HCV clients receiving Fibroscan – 73
- Number of HIV or HCV mono-infected clients receiving Fibroscan – 295
- Analysis plan
 - Identify the demographics of persons receiving Fibroscan and their score
 - Check for concordance between Fibroscan, APRI, and FIB4 scores
 - Compare Fibroscan scores among HIV/HCV coinfecting clients with HIV mono-infected and HCV mono-infected clients

TACKLE Provider and Staff Focus Groups

Trisha Melhado MPH
Sr. Research Scientist



Focus group findings

- *Participants*
 - Two pharmacists and three physicians
 - Four coordinators, three LCDCs, three CHWs, and two administrators
- *TACKLE Benefits*: having a community health worker and increased capacity to treat more patients
- *TACKLE Challenges*: structural issues and patient comorbidities
- *ECHO Benefits*: indirect benefit to patients by having providers participant and learn through ECHO, having access to specialists and different perspectives, learning about other clinics' cases/case management
- *ECHO Challenges*: scheduling physician time/logistics

Opioid Overdose Training Program at PILLAR

Trisha Melhado MPH

Sr. Research Scientist



UT Health

San Antonio

TACKLE Program

Table 1a: Opioid Overdose Prevention Trainee Characteristics (N=82)	
Age Mean (SD)	35 (12)
Language	N (%)
English	73 (89%)
Spanish	9 (11%)
Gender	
Male	31 (38%)
Female	51 (62%)
Education	
High School	21 (26%)
Undergraduate	38 (46%)
Graduate	19 (23%)
Missing	4 (5%)
Ethnicity	
Hispanic	81 (99%)
Missing	1 (1%)

Table 1b: Opioid Overdose Prevention Trainee Roles (N=82)	
	N (%)
Friend/Family of Injection Drug User	22 (27%)
Counselor (8), Social Worker (1), SUD Prevention Specialist (1)	10 (12%)
Health Technician (7), Medical Assistant (1)	8 (10%)
Promotora (3), Health Educator (5)	8 (10%)
Recovering Addict (8)	8 (10%)
Case Manager	6 (7%)
Administrative	5 (6%)
Epidemiologist	2 (2%)
Police Officer	2 (2%)
Other	11 (14%)

Opioid Overdose Knowledge Scale (OOKS) assessed four overdose related domains: opioid overdose risk factors, signs, actions to be taken in an overdose situation, and naloxone use including effects, administration, adverse effects, and aftercare procedures

Table 2: OOKS Paired T-Test Knowledge Change (N=82)

	Mean Pre-Test	Mean Post-Test	P-value
Risk	5.63	6.46	0.0244
Signs	6.44	7.46	<.0001
Action	8.51	9.8	0.0001
Naloxone Use	12.09	11	0.0166
Overall OOKS	32.67	34.73	0.0472

Opioid Overdose Attitudes Scale (OOAS) assessed three overdose management domains: competence (self-perceived ability to manage an overdose), concerns on dealing with an overdose, and readiness (willingness to intervene in an overdose situation)

Table 3: OOAS Paired T-Test Knowledge Change (N=78)

	Mean Pre-Test	Mean Post-Test	P-value
Competence	30.01	39.81	<.0001
Concerns	24.82	30.91	<.0001
Readiness	23.28	26.50	<.0001
Overall OOAS	78.12	97.22	<.0001



AETC National HIV/HCV Co-infection Curriculum Dissemination Results

Keito Kawasaki MPH

Research Associate



Table of Contents

Curriculum Home

About The Curriculum

Section 1: Epidemiology

Section 2: Prevention

Section 3: Screening, Testing, and Diagnosis

Section 4: HCV Treatment

Section 5: Recommendations for Subpopulations of HIV/HCV Co-infected Persons

Section 6: Addressing Barriers for Co-infected People of Color

HIV/HCV Co-infection: An AETC National Curriculum

The goal of this curriculum is to provide an evidence-based online curriculum for healthcare providers and trainers of healthcare providers

to increase their knowledge on human immunodeficiency virus (HIV)

and hepatitis C virus (HCV) co-infection among people of color in the United States and its territories.

Topics covered include 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.



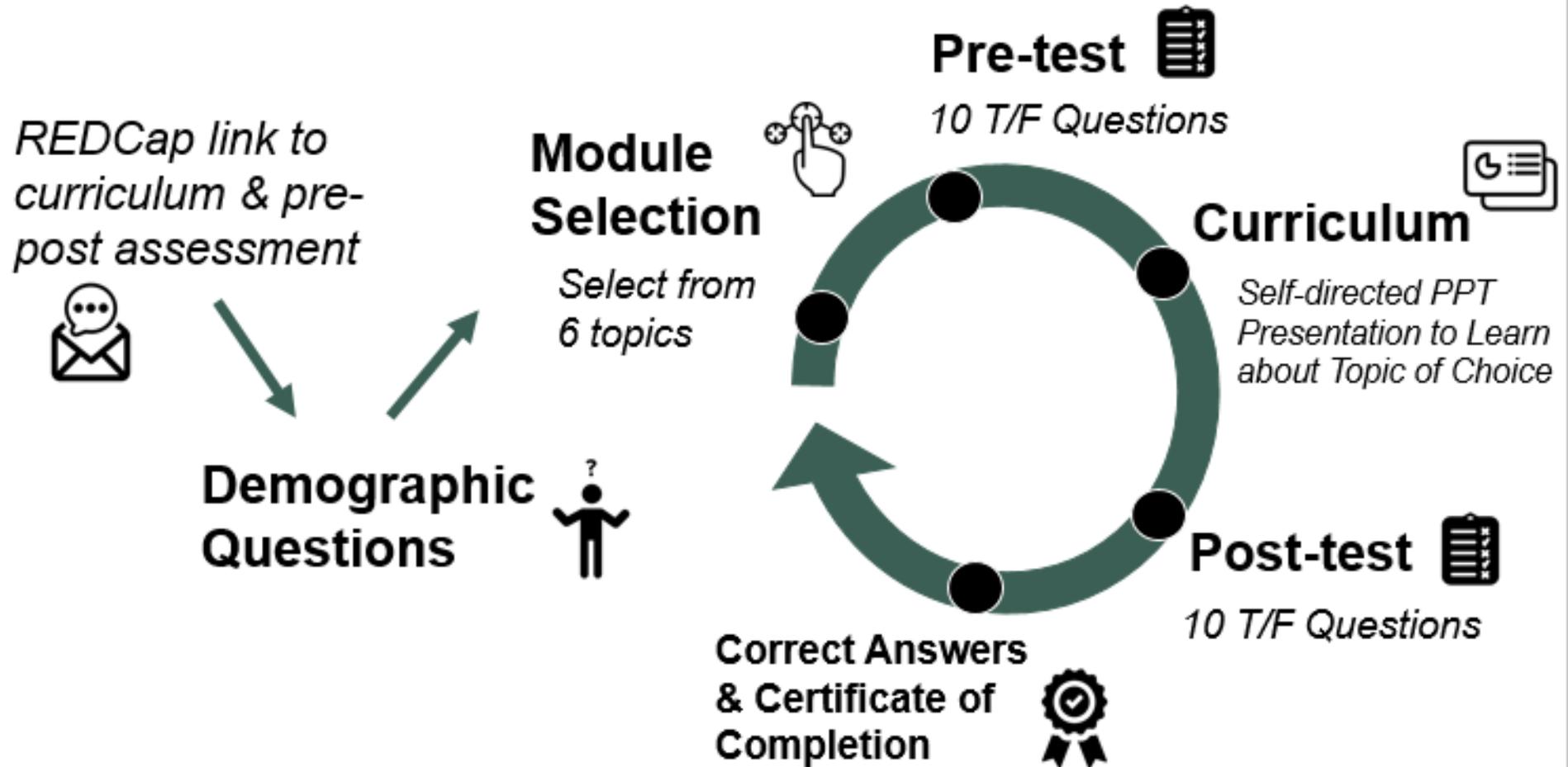
A team of AETC Program faculty and staff identified six core competencies for providers treating co-infected people living with HIV (PLWH). Within each topic area, there are multiple lessons.

To earn **free continuing education credits** (CME or CNE), you must register and complete the course modules on the Rutgers University Center for Professional Development website.

If you are not interested in receiving CE credits, you may view the all course module content on this website.

Link to AETC National HIV/HCV co-infection curriculum: <https://aidsetc.org/hivhcv>

METHODS: Data Collection



METHODS

Curriculum distribution

Year 1

- 4 VAC/AETC supported regional and national conferences and workshops
- Providers at TACKLE clinical and SUD/mental health sites

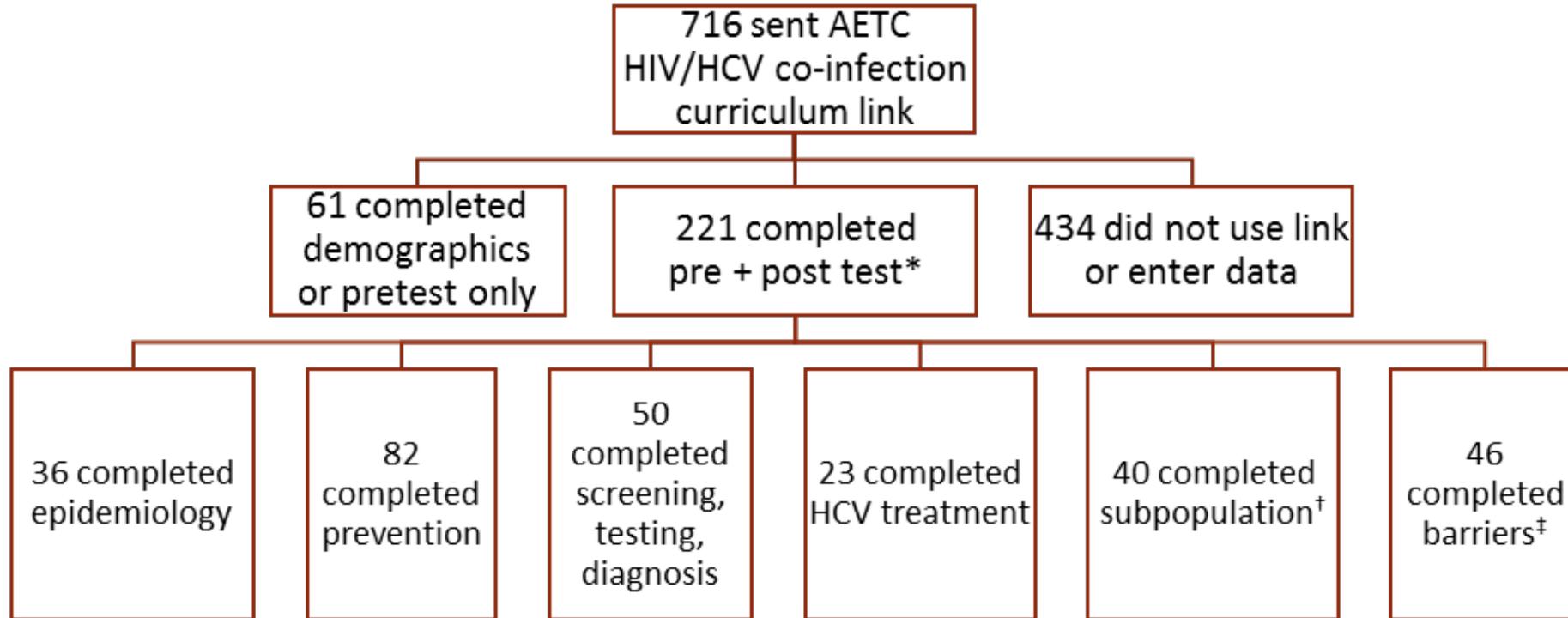
Year 2

- 3 VAC/AETC supported regional and national conferences and workshops

Data Analysis

- Descriptive – Assess demographic characteristics of respondents
- Paired sample t-tests – Assess short term knowledge changes before and after the curriculum, overall and for each of the six AETC modules

RESULTS: Year 1 Responses

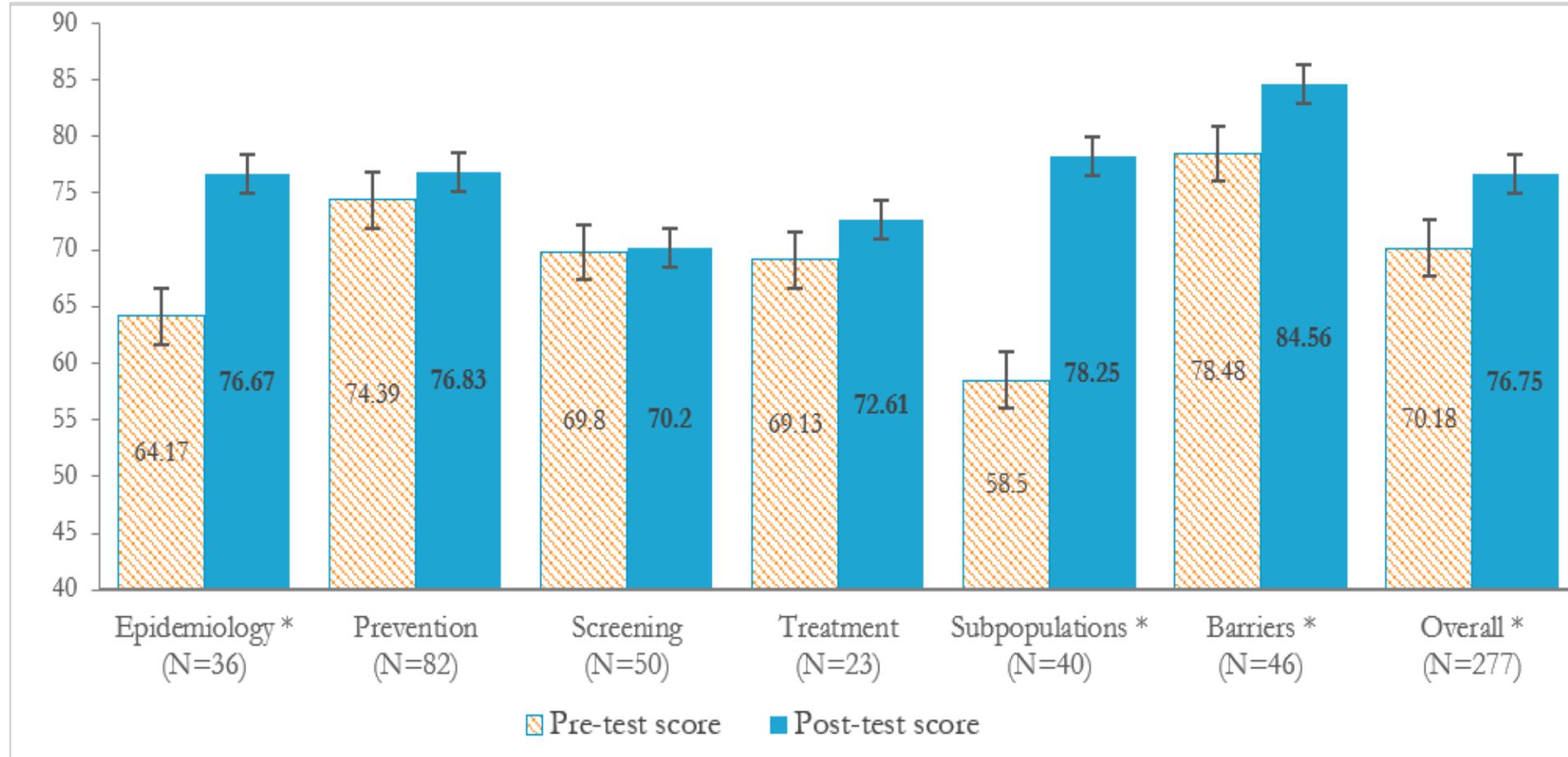


*Responders are able to complete more than one module

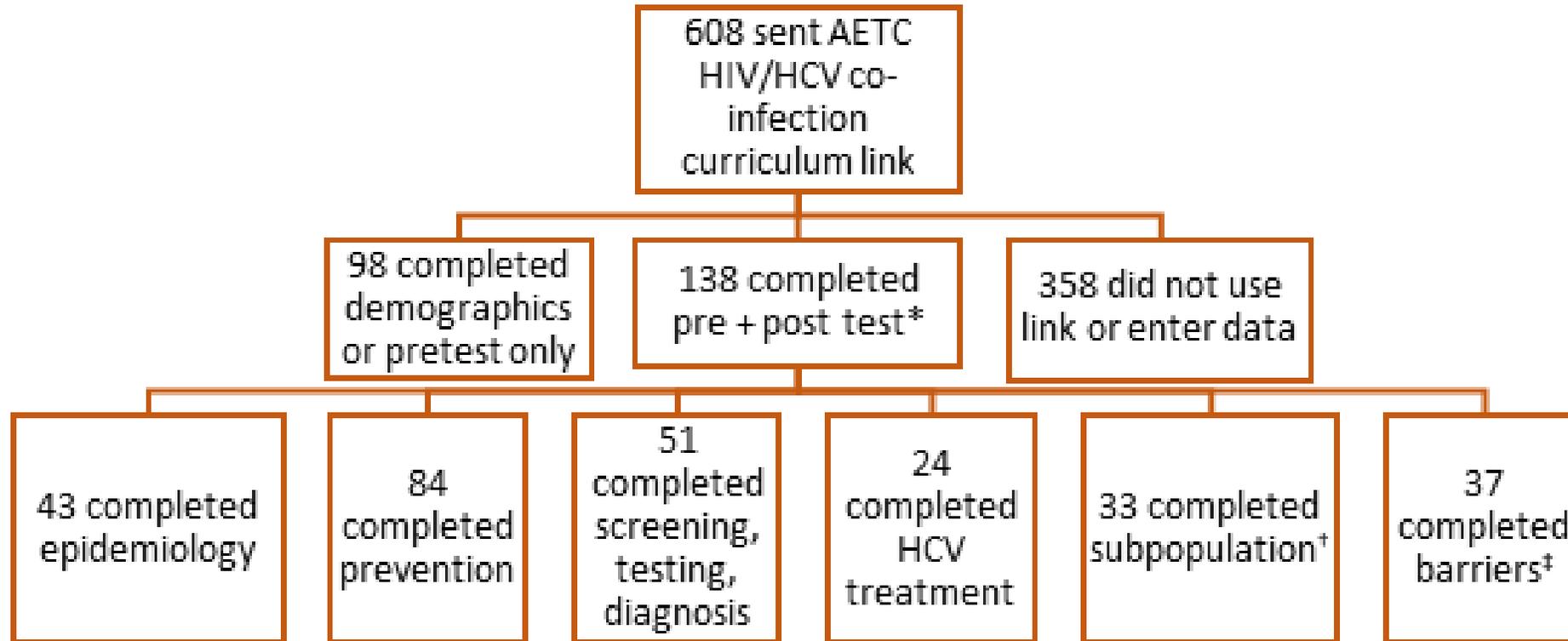
†Subpopulation = Recommendations for Subpopulations of HIV/HCV Co-infected Persons Barriers module

‡Barriers = Addressing Barriers for Co-infected People of Color module

RESULTS: Mean Pre-Post Scores Year 1



RESULTS: Year 2 Responses

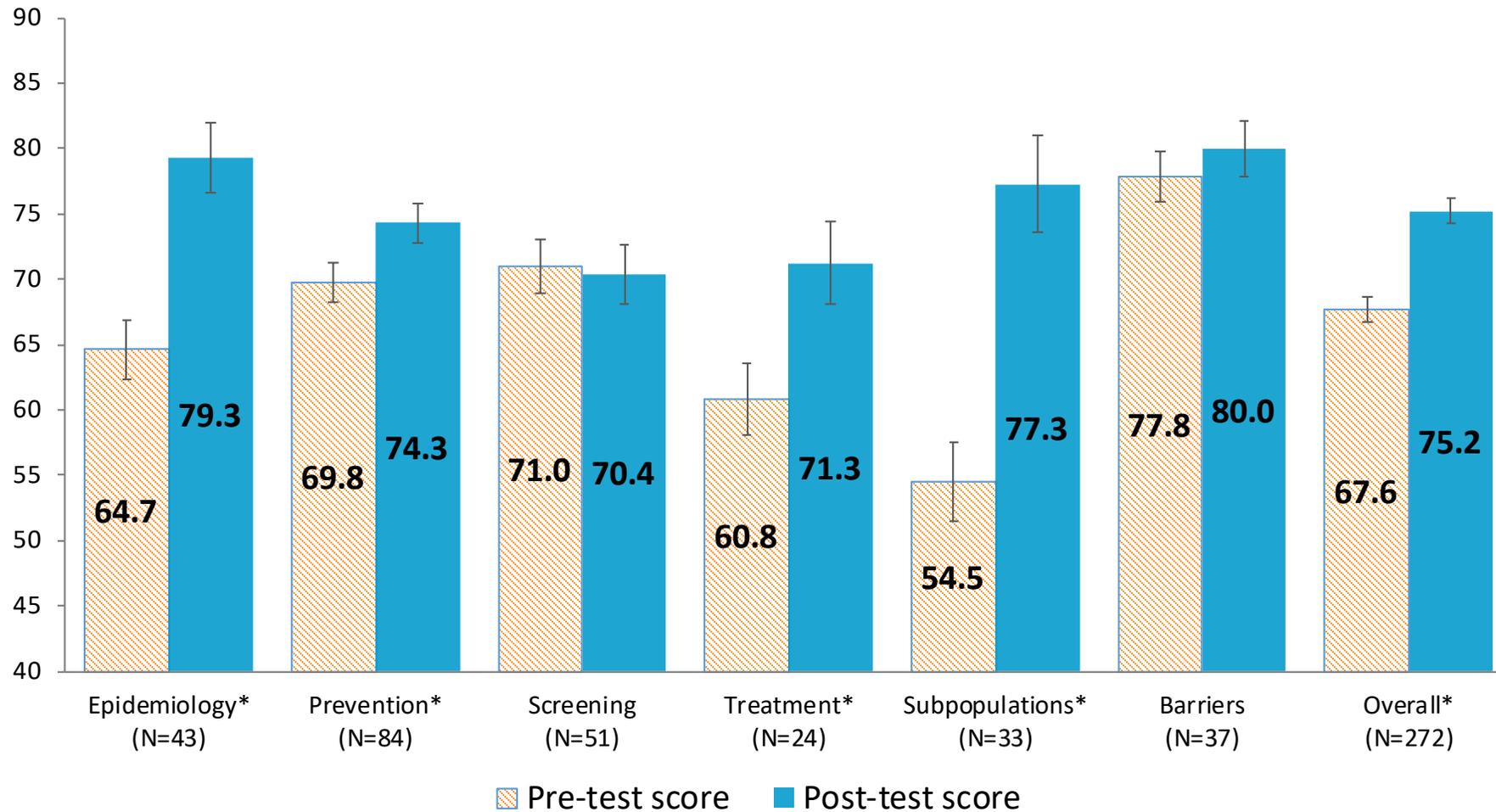


*Responders are able to complete more than one module

†Subpopulation = Recommendations for Subpopulations of HIV/HCV Co-infected Persons Barriers module

‡Barriers = Addressing Barriers for Co-infected People of Color module

RESULTS: Mean Pre-Post Scores Year 2



Upcoming distribution of AETC HIV/HCV co-infection curriculum

- September 24th – Valley AIDS Council/AETC Virtual Health Equity Conference
- November 16th – HIV/HCV/SUD AETC Symposium
- December 4th – Texas Department of State Health Services HIV/STI Conference
- April 2021 – National Latinx HIV/HCV/ SUD Conference

Patient and Provider Knowledge Assessments

Trisha Melhado MPH
Sr. Research Scientist



Patient Knowledge Assessment Results

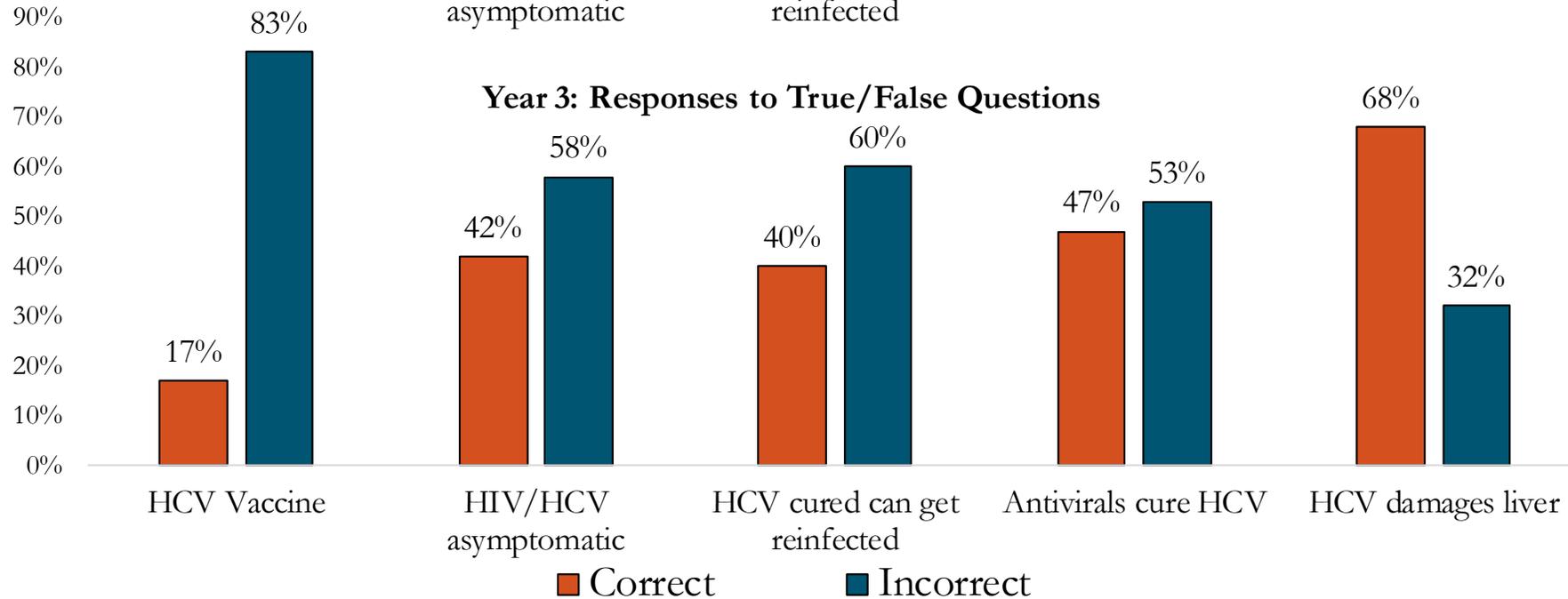
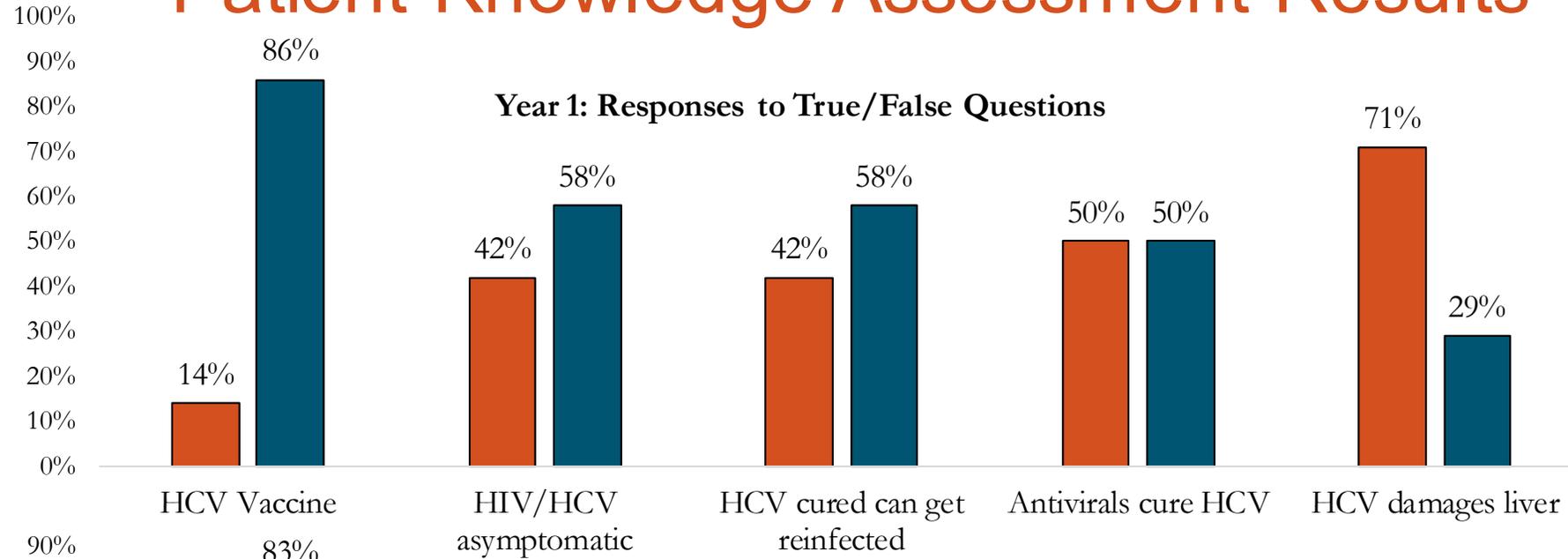
Patient KA Year 1					
	Total Eligible	Total Approached	Total Refused	Total Surveyed	Response Rate
Overall	467	382	35	353	92%

Patient KA Year 3					
	Total Eligible	Total Approached	Total Refused	Total Surveyed	Response Rate
Overall	441	443	23	318	72%

Patient Knowledge Assessment Results

Responder Characteristics	Year 1 (N=353)	Year 3 (N=318)
Gender (Male)	255 (72%)	241 (76%)
Education (HS diploma or GED)	102 (29%)	94 (30%)
Ethnicity (Latinx)	267 (76%)	233 (70%)
Language (English)	266 (75%)	264 (83%)
Insurance (RW/ADAP)	186	160
Age Mean (SD)	44.6 (12.6)	46 (12.9)

Patient Knowledge Assessment Results



Provider Knowledge Assessment Results

	Provider KA Responders Yr 1				Provider KA Responders Yr 3			
	Responded		Total	Response Rate	Responded		Total	Response Rate
	Yes	No			Yes	No		
Totals	176	36	212	83%	134	46	180	74%

Provider Characteristics	Year 1 (N=176)	Year 3 (N=134)
Age, mean (SD)	43 (13)	-
Gender (Female)	116 (66%)	79 (59%)
Race (Latinx)	124 (71%)	83 (62%)
Profession (counselor/ social worker)	63 (47%)	73 (42%)

Provider Knowledge Assessment Results

Mean responses to vignettes: how likely to start HCV treatment on HCV PCR confirmed patient – 52 years old, diagnosed HIV 12 years ago, no HCV risk factors...	N	Mean	SD
White male, homeless	13	3.77	1.17
Black male, homeless	29	4.03	1.12
White male, severe depression history	14	3.71	.99
Black male, severe depression history	16	3.31	1.01
White male	22	3.95	.90
Black male	21	3.38	1.16

- 1 Very likely
- 2 Somewhat likely
- 3 Neither likely nor unlikely
- 4 Somewhat unlikely
- 5 Very unlikely

Community Events

Raudel Bobadilla MPH, CHW

Senior Research Coordinator



UT Health

San Antonio

TACKLE Program

TACKLE HIV/HCV Community Events Summary

Number of events	4
People in attendance (est.)	1,100+
N screened for HIV/ HCV/ Syphilis	91/ 81/ 89
Flyers distributed	220
N educated with app	123

Characteristics of community event attendees screened for HIV, HCV, and educated with app

Demographics	HIV screened (N=91)	HCV screened (N=81)	Educated with app (N=123)
Age	N (%)	N (%)	N (%)
18-25	64 (70)	59 (73)	44 (36)
26-35	9 (10)	9 (11)	12 (10)
>35	15 (17)	3 (4)	11 (9)
Missing	3 (3)	10 (12)	56 (46)
Gender			
Male	38 (42)	32 (40)	23 (19)
Female	48 (53)	45 (56)	36 (29)
Transgender	2 (2)	2 (2)	7 (6)
Non-binary	0 (0)	2 (2)	0 (0)
Missing	3 (3)	0 (0)	57 (46)
Ethnicity			
Hispanic	72 (79)	63 (78)	54 (44)
N-H White	5 (5)	7 (9)	8 (7)
N-H Other	11 (12)	11 (14)	2 (2)
Missing	3 (3)	0 (0)	59 (47)

Self reported risk factors among community members screened for HCV (N=81)

Risk Factor	N (%)
One or more male sex partners	46 (57)
Tattoo (n=3 jail/ home)	34 (42)
Body piercing (n=3 home)	31 (38)
One or more female sex partners	24 (30)
Used non-injected street drugs	9 (11)
Finger stick at home	7 (9)
Injected drugs or cosmetic products not prescribed by a doctor	5 (6)
Incarceration	5 (6)
Treated for a sexually-transmitted disease	3 (4)

Community HIV/HCV Knowledge

Raudel Bobadilla MPH, CHW

Senior Research Coordinator



UT Health

San Antonio

TACKLE Program

App

 **UT Health San Antonio**



What is Hepatitis C?

Hepatitis C virus (HCV) is a liver infection. HCV infection causes few symptoms for many years.

Most people with HCV have no idea that they have it.



It is important to know, because it can seriously hurt your liver.

There is a cure for HCV and most people can be cured.

Back **Next**

 **UT Health San Antonio**

QUICK QUESTION

What part of your body can Hepatitis hurt?

Stomach **Bones**

Liver **Eyes**

Back

Flyer

TREAT HEP C BEAT HEP C

Targeted Access to Community Knowledge, Linkage to treatment and Education for HIV/HCV
(TACKLE HIV/HCV)



What you should know about HIV and Hepatitis C

WHAT IS HIV?

- » HIV is a virus.
- » HIV attacks immune cells in the body, so it can't fight infection.

WHAT IS HEPATITIS C?

- » Hepatitis C is a viral infection.
- » Hepatitis C virus (HCV) damages your liver. Your liver:
 - helps your body use the food you eat
 - filters your blood
 - helps blood clot
 - fights infections

WHAT IS HIV/HCV CO-INFECTION?

- » HIV/HCV co-infection is when a person has both HIV and HCV infection at the same time.
- » Both HIV and HCV are viruses and are transmitted in similar ways.
- » If you have both HIV and HCV infection at the same time, you are more likely to get liver damage from HCV.

WHY SHOULD I GET TESTED FOR HIV AND HCV?

- » The only way you know for sure whether you have HIV and/or HCV is to get tested.
- » If you get tested, you can get treated.
- » There is no cure for HIV infection but people on HIV treatment can live a healthy, normal life.
- » There is a cure for HCV infection.

WHERE CAN I GET TESTED FOR HIV AND HCV?

- » Your primary care provider can test you for HIV and HCV.
- » Search for a testing site near you by accessing CDC's online locator: gettested.cdc.gov
- » TACKLE HIV/HCV offers free HIV and HCV screening at community screening events. For details, visit online: uthscsa.edu/tackle/events

HOW ARE HIV AND HCV TREATED?

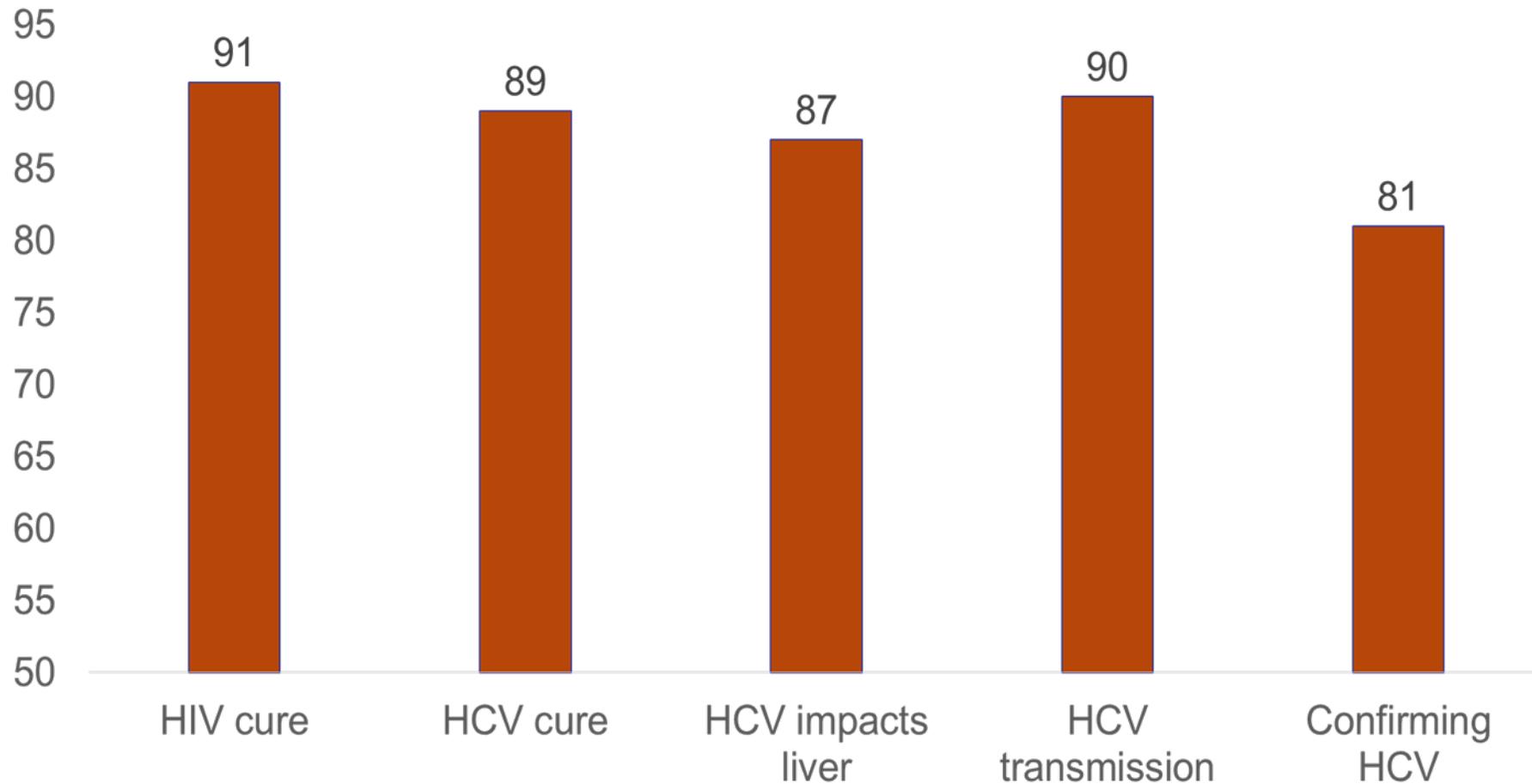
- » There are very effective drugs available today to treat both HIV and HCV infections.
- » HCV infection can be treated and cured in most cases with one pill a day for 8-12 weeks.
- » HIV infection can be treated in a lot of cases with one pill a day, but HIV treatment is life-long.



FOR MORE INFORMATION, VISIT: UTHSCSA.EDU/TACKLE OR CONTACT: TACKLEADMIN@UTHSCSA.EDU

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Percent correct responses to teach back questions in app
(N=123)



TACKLE HIV/HCV Sustainability, Dissemination, and Next Steps

Waridibo Allison MD PhD

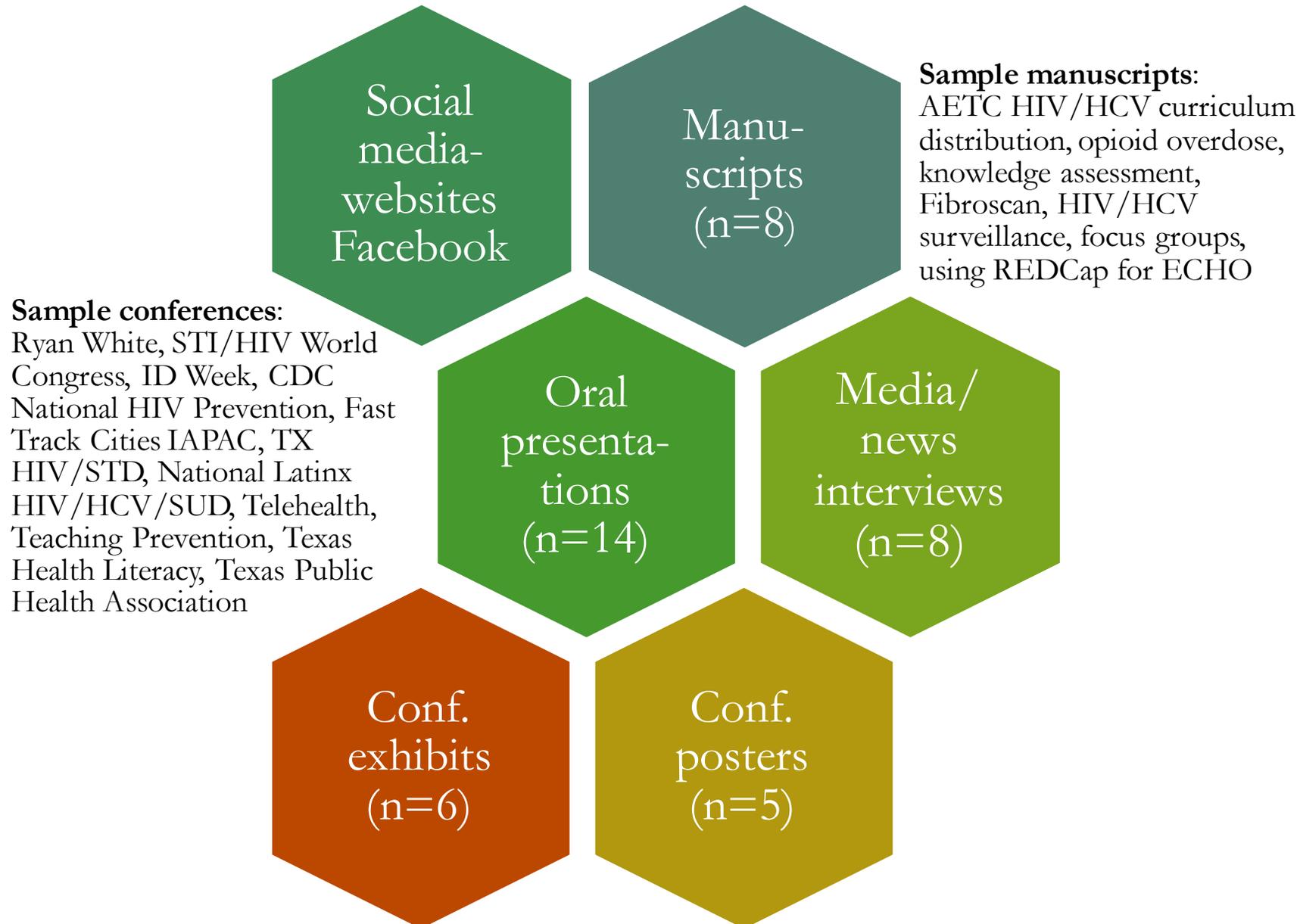
Principal Investigator/Program Director



Sustainability

- Partners overwhelmingly agree about the positive impact of the HIV/HCV ECHO and plan on continued participation
- Sites find the project materials (ex. bidirectional referral processes, forms, protocols, bilingual materials) helpful and plan to use them beyond the end of TACKLE
- Fibroscan at the clinical sites is viewed as an asset for patient management – saves patients time and sustains retention in care
- A few sites will retain the community health worker (CHW) role since it positively impacted patient management
- When possible, partners will implement HIV/HCV screening and education community events
- PILLAR will continue opioid overdose trainings

Dissemination



Next Steps

- Create an observational database for HIV/HCV coinfection cases
- Provide Texas Department of State Health Services (TX DSHS) with a staff member to compile and clean their existing chronic HCV data
- Development of a mobile application to support HIV providers to treat HCV
- UT Health San Antonio South Central AETC HIV/HCV workshops
- Continue to offer UT Health San Antonio HIV/HCV ECHO as a resource to primary care providers who want to treat HIV/HCV coinfection

Acknowledgements - Core TACKLE Team

UTHSA ID Division/ReACH

Andrea Rochat MFA
Kesi Williams MPH
Raquel Romero MD
Keito Kawasaki MPH
Anmol Desai MPH
Raudel Bobadilla MPH
Jim Bridges BS
Aro Choi MS
Paula Winkler MEd
Ariel Gomez MPH
Celeste Rodriguez MPA
Kelli Williams MA
Trisha Melhado MPH
Shreya Prasanna B.P.Th M.Sc

UTHSA Faculty/Consultants

Hope Hubbard MD
Joel Tsevat MD MPH
Barbara Taylor MD MS
Ruth Serrano MD
DeWayne Davis PharmD
Margaret Adjei Pharm D
Carlos Tirado MD MPH FBAM
Isela Werchen MD
Wari Allison MD PhD



Contact/Interact with Us

TACKLE HIV/HCV Website:

www.uthscsa.edu/tackle

UT Health San Antonio ECHO Website:

www.uthscsa.edu/echo



Find us on Facebook: @UTHealthSAECHO

For general inquiries about UT Health San Antonio ECHO:

echoinfo@uthscsa.edu

Program Director/Principal Investigator - Wari Allison MD PhD

allisonw@uthscsa.edu  **@waritalks**

The logo for PILLAR features the word "PILLAR" in a bold, black, serif font. The letter "I" is replaced by a stylized globe icon. A thin purple horizontal line is positioned below the text.

PILLAR



September 16, 2020

The logo for PILLAR features the word "PILLAR" in a bold, serif font. The letter "I" is replaced by a stylized globe icon. The logo is centered within a white rectangular box that has a thin purple border. The background of the slide is a dark purple gradient with a magenta vertical bar on the right side.

PILLAR

- ▶ **MISSION:** The mission of PILLAR is to provide readily accessible, quality mental health and substance abuse addiction care for men, women, youth, and families in an atmosphere that promotes compassion, respect and well being for all.
- ▶ PILLAR was founded in 2010 to service the youth of the community of Laredo and surrounding areas who are victims of bullying, have attempted suicide, or are struggling with suicidal thoughts.
- ▶ Today, PILLAR has grown into a behavior health center, outpatient substance abuse treatment center, STI testing and treatment clinic and drug testing facility. We service any person five years of age and above.
- ▶ <https://www.pillarstrong.org/>

PILLAR SERVICES

- ▶ HIV Prevention
- ▶ Office of Governors Grant
- ▶ SAMHSA Project BRIDGES
- ▶ Methodist Health Care Ministries
- ▶ SAMHSA Communities in Motion
- ▶ ESPYR
- ▶ Tele-Psychiatry Unit
- ▶ PILLAR Counseling Services
- ▶ Thrift Store
- ▶ STD and Drug Testing Services
- ▶ Community Service
- ▶ Webb County Jail
- ▶ Migrant Head Start
- ▶ LISD
- ▶ Municipal Court
- ▶ Federal Probation
- ▶ 406th Drug Court
- ▶ Webb County Youth Village



&

PILLAR

MAIN CONTACTS

- ▶ Aramazti Canales M.A., LPC
- ▶ Araceli Perez. Community Health Worker
- ▶ Manuel Sanchez, CEO
- ▶ Arturo Diaz, Director
- ▶ October 2017 – CLHD
 - ▶ SUD/Mental Health Implementation
 - ▶ Recruitment for co-infected clients
 - ▶ Outreach Testing
 - ▶ Parks, Plazas, Streets, Shooting galleries, Truck Stops
 - ▶ 794 HIV Tests
 - ▶ 525 HCV
- ▶ ECHO Meetings
- ▶ Medical Provider & SUD/MH Meetings
- ▶ Opioid Monthly Meetings

Project Successes

- ▶ Opioid Overdose Pilot Project
 - ▶ TONI trainings & distribution of Narcan kits
 - ▶ Recruitment
 - ▶ Newspaper, TV, radio, billboards, networking
 - ▶ 85 participants



- ▶ Community event
 - ▶ Over 20 community partners
 - ▶ 200 + attendees
 - ▶ Testing stations
 - ▶ Free medical check ups

Project Challenges & Barriers

1. Lack of co-infected client referrals
2. No identification of co-infected clients
3. Cultural barriers
 - ▶ misconception
 - ▶ lack of awareness
4. COVID – 19
 - ▶ Limited outreach efforts
 - ▶ Postponed community events
 - ▶ Limited Opioid trainings

Future Direction:

- Continued efforts to identify and provide evidence based treatment for co-infected clients and substance use clients.
- Community Fair

NARCAN Project

- Continue recruiting gatekeepers
- Continue providing NARCAN trainings to families of substance users from our community.

Policy Changes

- ▶ Local Police Department will begin implementation of Narcan trainings for police officers
- ▶ The Drug Court Program changed policy to provide Narcan to eligible participant's

Sustain Improvements

- ▶ Community Events
- ▶ Community Outreach
- ▶ Continue HIV and Hep C Testing
- ▶ Continue Training on Narcan
- ▶ Continue identification of Co-Infected Clients

Valley AIDS Council dba Westbrook Clinic

DORA MARTINEZ, MD
DIEGO HUERTA
MELISSA HERNANDEZ
AMY GONZALES



About us...



- ▶ Valley AIDS Council (VAC) is the primary provider of HIV prevention, education, and testing services and the only Ryan White funded agency providing medical care and supportive services for people living with HIV in the 3-county area that stretches from the lower Rio Grande Valley on to the US/Mexico border.
- ▶ **Mission** - VAC is a non-profit HIV service organization that delivers culturally appropriate sexual health and wellness services in South Texas and advocates for the Latinx population at the local, state and national level.



Services Offered – “one stop shop”



- ▶ **Now with Curbside Services**
- ▶ **Telemedicine/Telehealth**
- ▶ Medical
- ▶ Mental Health Counseling
- ▶ Substance Use Counseling
- ▶ Dental Care
- ▶ HOPWA – Housing
- ▶ HIV/STD Testing
- ▶ Transportation
- ▶ Nutritional Advice
- ▶ Case Management
- ▶ Pharmacy
- ▶ Medical Case Management
- ▶ Support Services
- ▶ PreP & PEP
- ▶ Transgender & HRT Care
- ▶ Community events/health fairs



New Dual Diagnosed Client Pathway

- ▶ Client labs indicate that they are HCV AB+
- ▶ HCV RNA will be ordered at their medical appointment and TACKLE staff will speak to them about HCV after their CM appointment
- ▶ If labs come back with a positive viral load, client is then transitioned into the TACKLE program
- ▶ CHW will be the main point of contact and act as their case manager throughout HCV treatment until SVR 12
 - ▶ Any support services needed by the client will be handled by our CHW
- ▶ During the initial assessments by the CHW, a warm handoff was made to introduce the LCDC to the client.
 - ▶ We encouraged all the clients to meet the LCDC briefly so she could introduce herself and review her services.



WHAT IS HEPATITIS C?

Hepatitis C is a contagious liver disease that ranges in severity from a mild illness lasting a few weeks to a serious, lifelong illness that attacks the liver.

It results from infection with the Hepatitis C virus (HCV), which is spread primarily through contact with the blood of an infected person. Hepatitis C can be either "acute" or "chronic."

HOW IS HCV SPREAD:

Hepatitis C is usually spread when blood from a person infected with the Hepatitis C virus enters the body of someone who is not infected.

Today, most people become infected with the Hepatitis C virus by sharing needles or other equipment to inject drugs. Before 1992, when widespread screening of the blood supply began in the United States, Hepatitis C was also commonly spread through blood transfusions and organ transplants.

TREATMENT:

The aim of treatment is to CURE Hepatitis C. Treatment can vary from 6, 12, or 18 months depending on the severity of the liver damage. Having HIV makes hepatitis C more serious and harder to treat. Westbrook Clinic Providers are experienced in treating clients that are co-infected with HIV and Hepatitis C.

ACUTE HEPATITIS C VIRUS INFECTION

is a short-term illness that occurs within the first 6 months after someone is exposed to the Hepatitis C virus. During this time, the body can sometimes get rid of the virus on its own, without treatment. For most people, acute infection leads to chronic infection.

CHRONIC HEPATITIS C VIRUS INFECTION

is a long-term illness that occurs when the Hepatitis C virus remains in a person's body. Hepatitis C virus infection can last a lifetime and lead to serious liver problems, including cirrhosis (scarring of the liver) or liver cancer. You may not notice any symptoms for several years as hepatitis C develops slowly.



PEOPLE CAN BECOME INFECTED WITH THE HEPATITIS C VIRUS DURING SUCH ACTIVITIES AS:

- ▶ Sharing needles, syringes, or other equipment to inject drugs
- ▶ Needlestick injuries in health care settings
- ▶ Being born to a mother who has Hepatitis C

LESS COMMONLY A PERSON CAN ALSO GET HEPATITIS C VIRUS INFECTION THROUGH:

- ▶ Sharing personal care items that may have come in contact with another person's blood, such as razors or toothbrushes
- ▶ Having sexual contact with a person infected with the Hepatitis C virus



TACKLE Staff

Community Health Worker



- ▶ Case management duties:
 - ▶ Met with patient immediately after provider
 - ▶ Assist with PAPs and medication adherence (HIV/HCV)
 - ▶ Care plans, assessments, acuity, eligibility
 - ▶ **Had an agency cell-phone to be available with clients outside of agency hours**
 - ▶ Documentation using ARIES/eClinical Works (documentation/forms are transferred from ARIES to eCW – information needs to be identical)
 - ▶ Transportation (taking clients to appointments), home visits (lost to care) and deliver medications
 - ▶ Co-facilitate support groups
 - ▶ Assist Linkage to Care Department with intakes (new patients)
 - ▶ Assist case managers when needed
 - ▶ Commute from Harlingen to McAllen locations to see patients

LCDC

- ▶ **Individual and group counseling sessions**
- ▶ Created curriculum for group/individual sessions
- ▶ Created evaluation survey for sessions
- ▶ **Participate in support groups – TACKLE clients are part of these groups – this helps to continue to build rapport with clients and open to individual sessions**
- ▶ Assist with transportation
- ▶ Commute to Brownsville and McAllen from Harlingen office – to meet with clients
- ▶ **Met clients during initial medical visit when referred to TACKLE program with CHW – introduced themselves and provided information about services**
- ▶ Work on presentations for conferences/meetings
- ▶ Participate in workshops/health fairs/community events

Project Coordinator

- ▶ Planning Committee for the National Latinx HIV/Hep C/SUD and our annual Local Client Conference
- ▶ Update Electronic Medical Records and ARIES to identify TACKLE clients
- ▶ **Run ECW reports to identify clients that are dual diagnosed to enter onto the Patient Tracker and REDCAP Database**
- ▶ Coordinate tabling at community events
- ▶ Assist with client's CM and transportation needs as needed
- ▶ Assisted with fibroscan reporting



TACKLE Data

TACKLE Successes

- ▶ The TACKLE Specialist team shared recommendation forms that allowed us to assist clients that had insurance but had a low Fibrosis score so they could obtain treatment
- ▶ Hosted health fairs in our 1st and 2nd grant year to raise awareness about Hep C and provided testing services to the community
- ▶ Were able to provide the support for a few clients to obtain treatment and encouraged them to stay linked to care
 - ▶ TACKLE allowed us to be flexible to meet our clients' needs

Difficulties encountered

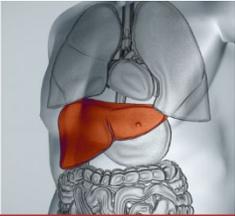
- ▶ We had an MOU with Tropical Texas to assist them with mono-HCV clients.
 - ▶ The Behavioral Health Center was able to cover expenses for labs and PCP costs for the clients.
- ▶ Clients' readiness to begin treatment
 - ▶ Some of our clients have basic needs that need to be met before considering treatment (e.g. job, health, finances, homeless, etc.)
- ▶ Insurance Hurdles - ID or GI requirements for clients with Insurance
- ▶ Limited assistance for Individuals that only have Hep. C
- ▶ Clients in the Justice system did not receive treatment, we could only encourage them to follow-up with us once they were released
- ▶ COVID 19 made it difficult for some clients to stay adherent to their lab appts and medication – our interactions with clients are now mostly over the phone unless we're assisting them with a direct need

WHAT IS THE LIVER? WHAT DOES IT DO IN THE BODY?

The liver is the largest solid organ in the body, about the size of a football, and weighing three to four pounds.

The liver serves as the body's filter and warehouse, with more than 1.5 quarts of blood pumping through it every minute. This allows the liver to effectively remove toxins and waste products from the blood stream.

It also acts as a warehouse to hold onto substances like vitamins, minerals and glucose that the body will need later. The liver helps to manage cholesterol, hormones and sugar. It also regulates fat storage and blood clotting factors.



THINGS THAT CAN HARM THE LIVER:

▶ **MEDICATIONS** Acetaminophen (Tylenol®) is usually well tolerated at prescribed doses, but overdose is the most common cause of drug induced liver disease and acute liver failure worldwide.

▶ **INFECTIONS** Inflammation of the liver (Hepatitis.) Common causes are the viruses Hepatitis A, B, C.

▶ **NON-ALCOHOLIC FATTY LIVER DISEASE** Fatty liver disease affects approximately 30% of the population worldwide and is commonly seen in people with diabetes and obesity. People with fatty liver disease may progressively damage their liver to an extent that requires a liver transplant.

▶ **SOME HERBAL AND ALTERNATIVE REMEDIES** ▶ **ABUSE OF ALCOHOL**

SYMPTOMS OF LIVER DAMAGE can include:



FIBROSCAN

is a non-invasive test that helps assess the health of your liver. It works by emitting a pulse of energy, which you may feel as a slight vibration on your skin, and it sends back a clear picture that is then used by your provider to determine the degree of fibrosis or scarring that may be present.

WHAT DOES THE FIBROSCAN EXAMINATION CONSIST OF?

You lie on your back, with your right arm raised behind your head. Your technician or nurse applies a water-based gel to the skin and places the probe against your skin with a slight pressure. The examination includes 10 consecutive measurements made at the same location. The procedure is painless and takes about 15 minutes.

HOW TO PREPARE

It is important to have the examination on an empty stomach; you should not eat or drink anything 3 hours before the examination. Wear comfortable clothes that can partially expose your skin on the right side above the waist along your rib cage.

Future Directions with TACKLE

- ▶ It would be great if more resources were made for clients such as bilingual short informational videos on Pill Burden, Treatment Food Requirements, Severity of HCV and the stages of fibrosis,
- ▶ We will not be able to keep the Hep C CHW position as a permanent role
 - ▶ We will continue to assist clients that need HCV treatment
- ▶ Planning to grow our Counseling Services
 - ▶ Our LCDC position would become permanent to continue to work with any clients on their needs
- ▶ Hepatitis C outreach efforts with our Education department
 - ▶ Our Education staff now provides Hep C tests for any community members that meet state requirements

Thank you!



Break

BREAK – 10 Minutes





Policy Considerations

Demonstration Sites' Perspectives

September 16, 2020

Sara Woody

Management Analyst, HIV/AIDS Bureau, Division of Policy and Data

Health Resources and Services Administration (HRSA)

Vision: Healthy Communities, Healthy People



Demonstration Sites' Perspectives

- More resources are needed for collecting data for chronic HCV surveillance. *(CDC)*
 - What strategies or plans does CDC have to address gaps in HCV surveillance?
 - How is CDC increasing the number of public health agencies and laboratories engaged in Electronic Lab Reporting (ELR)?

Demonstration Sites' Perspectives

- Substance Use Disorder (SUD) policies are needed that incentivize federally-funded SUD clinics to test and report data to funder. (*SAMHSA*)
 - Existing policy calls for clinics to test and treat/refer, but the reality on ground is different; How is SAMSHA addressing these challenges?
 - Has SAMSHA considered incorporating either more requirements (e.g., tie funding for methadone clinics to reported data) or incentives, (e.g., tie increased funding for improved data reporting)?

Demonstration Sites' Perspectives

- How can people with HCV-only, who are uninsured, access care and treatment services? (*BPHC*)

Demonstration Sites' Perspectives

- The current HRSA performance measure relevant to HCV is only for single time screening. (*HAB*)
 - Is it possible to update this performance measure to reflect more frequent screening in persons at ongoing risk?
 - Is it possible to have a performance measure(s) related to HCV treatment initiation, SVR documentation, maintenance of SVR?
 - Has HAB considered modifying CAREWare to accommodate HCV specific fields such as those proposed above?

Closing Thoughts and Wrap Up

- Closing Thoughts and Meeting Wrap Up
 - Courtney Gidengil, MD, Senior Policy Researcher, RAND
 - Antigone Dempsey, Director, Division of Policy and Data, HAB





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