Replicating Innovative HIV Care Strategies in the Ryan White HIV/AIDS Program

Innovative HIV Care Strategies Using a Comprehensive Approach to Address the Needs of Priority Populations

June 7, 2024

Agenda

- *Project Overview*
  - About the Special Projects of National Significance (SPNS) Program & Integrating HIV Innovative Practices (IHIP) Project – presented by: Shelly Kowalczyk (MayaTech)
- *Intervention Overview*
  - ***The Black Women's Project*** – presented by: Mr. Erik Moore, the front-line Team, & Dr. Gwen Davies, with Positive Impact Health Centers, Atlanta, GA
  - ***Curing Hepatitis C Among People of Color Living with HIV*** – presented by: Dr. Merceditas Villanueva & Mr. Ralph Brooks, with the Yale School of Medicine AIDS Care Program, New Haven, CT
- *Q&A*
- *Participant Feedback*

About Integrating HIV Innovative Practices (IHIP)

- **Funding/Administration**: The Ryan White HIV/AIDS Program (RWHAP) Part F: Special Projects of National Significance (SPNS) Program administered by HRSA's HIV/AIDS Bureau (HAB).

- **Purpose:** To support the coordination, replication, and dissemination of innovative HIV care strategies in the RWHAP through the development and dissemination of implementation tools and resources.

Framework for RWHAP SPNS RWHAP

DEMONSTRATE OR IMPLEMENT	EVALUATE & DOCUMENT	COORDINATE, REPLICATE, & INTEGRATE
Fund recipients to respond to emerging needs of people with HIV using evidence-based, evidence-informed, and emerging interventions	Use an implementation science framework to identify effective interventions to improve HIV outcomes among Ryan White HIV/AIDS Program clients	Develop guides and manuals, interactive online tools/toolkits, publications, and instructional materials that describe how to coordinate, replicate, and integrate interventions and strategies for RWHAP providers
Fund special programs to develop a standard electronic client information data system to improve the ability of recipients to report data	Evaluate and document specific strategies for successfully integrating interventions in RWHAP sites	Streamline access to materials and promote replication through the Best Practices Compilation

Key Support to RWHAP Providers

- Implementation tools and resources
  - Featuring interventions implemented by RWHAP grant recipients/subrecipients
- Capacity building technical assistance (CBTA) on featured interventions
- Support in the development and dissemination of implementation tools and resources
- Email Helpdesk (**ihiphelpdesk@mayatech.com**)

Check out TargetHIV.org/IHIP

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Sevyn Jones	Nothing to Disclose
Dr. Merceditas Villanueva	Nothing to Disclose
Ralph Brooks	Nothing to Disclose

Black WomenFirst

POSITIVEIMPACT HEALTH CENTERS

CHAMBLEE · DECATUR · DULUTH · MARIETTA

Beautifull F. Devynne
Letitia Burr, MSW
Sevyn Jones
Erik Moore, MSW
Gwen Davies, PhD

June 7, 2024

Disclaimer (1)

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U90HA39764 SPNS Black Women First Initiative, awarded at $180,000 over 3 years with non-governmental sources used to finance the project. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Front Line Presenters

Beautifull F. Devynne:
Beautifull is a Community Health Worker with decades of experience working with the transgender community and individuals living with HIV.

Gwen Davies, PhD:
Gwen is a Licensed Psychologist and acted as the Principal Investigator for the Black Woman's Project. She has over 20 years of experience working with individuals living with HIV.

Letitia Burr, MSW:
Letitia is an Intensive Case Manager with 24 years of experience working with clients experiencing Domestic Violence and Mental Health needs.

Sevyn Jones, MPH:
Sevyn is a Data Analyst and a current MPH candidate with over 7 years of experience working in HIV patient and health advocacy.

Erik Moore, MSW:
Erik is Medical Case Manager with 12 years of experience working with homeless populations and people living with HIV. This is the second SPNS Initiative that he has managed.

Project Overview

- Black Women's Project was supported by a RWHAP Part F: SPNS Grant "Black Women First Initiative."
- Other funding that supports clients in the program included: RWHAP Parts A, B and C, and 340B Ryan White Pharmacy Program
- AIDS United funding of TransLife Care Initiative
- The priority population is Black women (cis and trans) with HIV
- This program specifically serves Black women with high need for wraparound care in order to maintain overall health and undetectable HIV viral load

Overview: Recipient-Sites

POSITIVE IMPACT HEALTH CENTERS

Positive Impact Health Centers (PIHC) is an HIV services agency with three site locations, in the metro Atlanta Georgia area, serving 10,000 people per year with HIV care and prevention services. PIHC improves health outcomes through coordinated HIV care, behavioral health services, substance use counseling, case management and peer navigation services.

Our mission is Patient-centered care for the HIV community to create a life worth loving.

Overview: Black Women First Initiative

The Black Women First Initiative is based on substantial evidence that Black cisgender and transgender women are disproportionately affected by HIV. According to the Centers for Disease Control and Prevention (CDC), black cisgender women make up 57% of all cisgender women newly diagnosed with HIV. Transgender women have the highest rate of HIV prevalence with some estimates as high as nearly 50 times that of other adults. The Black Women First Project focused special priority on the Transgender population at PIHC.

Reasons for these poor outcomes include:

- HIV stigma
- Need for childcare
- Higher levels of depression and trauma
- Poverty
- Effects of institutional racism

Project Goals and Outcomes

The overall goal of the Black Women's Project was to provide **90%** of the clients with bundled interventions such as:

- Trans-Life Care
- Intensive Case-management
- Cognitive Process Therapy

During the program **90%** of retained clients achieved viral suppression

- The Black Women's Project served **113** clients with case management and a minimum of one other bundled intervention
- **58** Black transgender women living with HIV received trans-specific services through Trans-Life Care
- **76** Black cisgender and transgender women living with HIV received mental health services that include cognitive processing therapy (CPT) for PTSD

Intervention

Bundled interventions offered in the Black Women's Project include:

Peer/Patient Navigation

Provided by case managers and CHWs

IPV/Domestic Violence (DV) Interventions

Provided by case managers and outside IPV/DV providers

Self-Efficacy

TransLife Care services are provided by the internal Gender Inclusivity Team

Trauma-Informed Care

Provided by behavioral health and well-being clinicians

When applied as a bundle, these interventions work together to:

- **Increase** engagement in HIV care
- **Reduce** stigma
- **Achieve** and maintain viral suppression

Intensive case management:

- **Reduces** barriers to care
- **Satisfies** unmet needs
- **Increases** overall well-being by reducing traumatic distress and providing a path to recovery from substance abuse and IPV

Intervention: Based on Patient Experience

Patient comes to PIHC

1. She is identified by rapid entry, a case manager, medical provider, or a mental health provider, as a high-need/acuity Black woman.
2. She is referred to the BWP program.
3. She meets with intake person to get consent, receive description of the program, and do intake.
4. She meets with intensive case manager to reduce barriers to care and connect and coordinate to other needed services.
5. She receives other needed services: peer navigation, trauma informed care (therapy/medication), IPV/DV services, and/or TransLife Care.

Intake and Eligibility Process

Centralized Intake/Eligibility Screening for Program

- Eligibility criteria (Black cis/trans women)
- HIV+
- In need of 2 or more bundled services
- Meets RW FPL income restrictions

Assigned Case Manager

- Biopsychosocial assessment
- Referrals to appropriate internal and external services
- Individual Service Plan (ISP) developed in collaboration with the client

IPV/DV Services

- Safety Planning
- Abuse Assessment Screen
- Trauma Informed Care
- Referrals to DV Shelters

Housing

- Housing Assessment
- Homeless Diversion
- Emergency Hotel Lodging
- Permanent Housing

Behavioral Health

- Therapy
- Psychiatry
- PTSD Assessment

Substance Abuse

- SA Addiction Screening Tool
- Assessment and treatment
- Harm reduction group
- Intensive outpatient program

Employment/Income

- Benefits Application(s)
- Employment Referrals

Clinical Care

- Linkage for newly Dx to services
- Formerly Incarcerated
- Pilot Screen – HIV Treatment Drop Out
- Re-engagement of Lost to Care
- Rx ART
- Viral Load Suppression
- Other medical care needs (Pap, Co-morbidities, etc.)
- Community Health Worker
- Access to Hormone Therapy

Social Supports/Education

- Groups – Safe Space and Youth
- Volunteering
- Faith Community
- GED/Continuing Education

Intervention Bundles

All services have Trans-Life Care built into the interventions

Intervention Challenges

- **Recruitment and Retention** – Recruitment was not a challenge, however; we did have some minor retention issues as Atlanta can be a transient city where clients often come and go and fall out of care without warning

  Solution: By helping clients anticipate barriers, case managers helped avoid this barrier by providing transportation and telehealth options

- **Developing an integrated CAB** - Clients preferred to keep separate groups (transgender/cisgender) to maintain the content of the meetings to their specific concerns

- **Transportation -** Atlanta is a sprawling car-dependent metro area and many of our clients do not have access to their own, reliable transportation

  Solution: To provide Rideshare options, telehealth options, gas cards and MARTA cards utilizing other funding (RWHAP/340B)

- **Impact of COVID-19** - Adapting to virtual only access was difficult with patients without consistent Wi-Fi or cell phone data

  Solution: On a limited basis the agency provided cell phones and tablets with data

Intervention Successes

1. ***Culturally Tailored Approach:*** A deep understanding of the cultural norms, beliefs and values of Black women
2. ***Community Involvement:*** Engaging influential figures within the Black transgender community to create a sense of trust
3. ***Accessible and Equitable Services:*** Ensuring accessible free or low-cost services
4. ***Insurance Navigation*****:** Assist with obtaining health insurance and co-pay/premium assistance so that being insured doesn't result in a new barrier to care
5. ***Peer Support and Mentoring:*** Implementing the trans-life group where Black women who have successfully managed HIV can offer encouragement and practical advice
6. ***Comprehensive Education:*** Providing comprehensive education about HIV treatment, IPV prevention and recovery options, trauma-informed care and self-care to empower Black women

Intervention Successes and Outcomes

- ***Intersectional Approach:*** Acknowledging and addressing the intersectionality of identities
- ***Holistic Health Support:*** Incorporating mental health, sexual health, reproductive health and gender-affirming care (access to HRT) into the intervention
- ***Stigma Reduction:*** Implementing initiatives to reduce HIV-related stigma within the community of Black women
- ***Personalized Care Plans for High Acuity Clients:*** Tailoring the intervention to meet individual needs and preferences
- ***Long-Term Follow-up:*** Establishing a system for long-term follow-up and support to ensure continuity of care and sustained positive outcomes

Outcomes – Bundled Interventions

Bundled Interventions and Encounters Per Client: (Peer/Patient Navigation, Trans-Life Care, Trauma-Informed Care, DV/IPV Services)	Number	Percent
Clients engaged in 2 or more bundled interventions	107	93%
Clients engaged in 3 or more bundled interventions	50	44%
Number of clients engaged in Peer/Patient Navigation services	115	100%
Number of clients engaged in Self-Efficacy / Trans-Life Care services	66	57%
Number of clients engaged in Trauma-Informed Care services	85	74%
Number of clients engaged in IPV Interventions services	25	22%
Average Number of Encounters per client	10.21	

Outcomes – Trans-Life Care

TransLife Care Fact Sheet – Past 12 Months

Over the past 12 months, the Gender Inclusivity Team has implemented TransLife Care Interventions with the below noted accomplishments and outcomes. The team provided services to 40% of the BWP enrollees.

- Launched TransLife Care Drop in Center
- 77% Viral Load Suppression Rate amongst the cohort
- 70% Accessing HRT Services
- Developed support groups and a safe space
- Expanded Staff – Bi-Lingual Case Manager
- Established community outreach efforts at the community ballroom scene

Client Testimonial

POSITIVE IMPACT HEALTH CENTERS

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Case Study

Ms. Jordan:

- A transgender woman who came to the BWP through an internal referral from a provider at one of our clinics.
- The provider stated multiple barriers to care, as noted below.
- Ms. Jordan was viremic, living with her sister's family and about to be evicted.
- Sister was taking her rent money but not paying the rent.
- No employment or transportation.
- No familial or community support.
- Disability – Cystic Fibrosis.

Case Study Results

Engaged in PIHC Services:

- Trans-Life Care Peer Support Groups
- Case Management and CHW Peer Support
- Housing
- Behavioral Health

Results:

- Obtained her own housing
- Employer provided her with a car, and she drove for the first time –self-taught
- Met a romantic partner
- Currently virally suppressed

Sustainability

What has worked?

- Dedicated program staff working as a team, (e.g. Case Manager, Community Health Worker, Mental health providers and trans-life care specialists)
- Meeting regularly to consult on cases
- Having staff that mirrored the population

What do you plan to discontinue and why? All interventions were needed to support patients, however, the research component will end

What do you plan to support and why? All interventions will be continued. We are seeking agency buy-in to create a dedicated Care Team to serve high-need Black cis/trans women with HIV

What kind of funding is required to sustain? PIHC will use 340B revenue to sustain staff and some services

Sustainability (con’t)

PIHC has recently become certified as a Patient Centered Medical Home (PCMH). In PCMH there is an integrated team, just as in the Black Women's Project, which maintains collaborative contact with each patient assigned to the team.

In effect, the interventions offered are bundled, with each team having a medical provider, a Medical Case Manager, a Behavioral Health Clinician acting as a consultant/provider, and access to a CHW.

Lessons Learned

Greatest contributor to success is PIHC as a “one stop shop” for HIV medical and social services with a large client population
Rapid entry clinic

- Case management and peer support
- Pharmacy
- Mental health and substance abuse services
- Food assistance
- Dental clinic

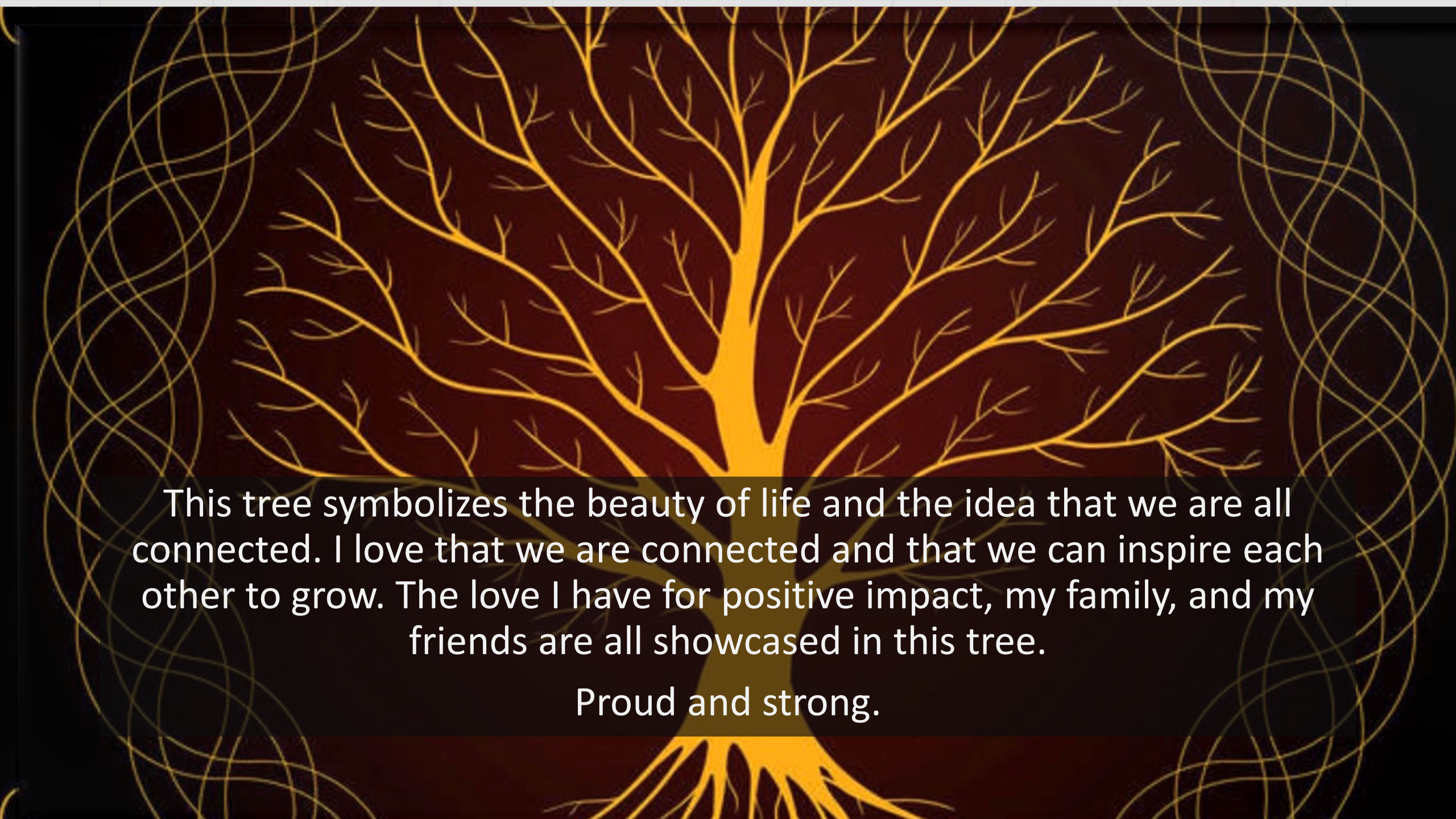
Access to services on this level, and all under one roof, invariably leads to greater retention in care as well as increased medical adherence

Lessons Learned (con’t)

- The company's culture and environment play an integral role in ensuring client satisfaction and retention.
- The welcoming and supportive atmosphere at PIHC sets it apart and makes a significant impact on client outcomes.

Ideally, an agency seeking to replicate our program would be:

- A larger-scale clinic that offers similar services and
- Strong community ties and
- A reputation for inclusivity and social justice


This tree symbolizes the beauty of life and the idea that we are all connected. I love that we are connected and that we can inspire each other to grow. The love I have for positive impact, my family, and my friends are all showcased in this tree.
Proud and strong.

References (1)

Division of HIV Prevention, National Center for HIV, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention (CDC), *HIV and Women*. February 16, 2023. Available at: https://www.cdc.gov/hiv/group/gender/women/

Human Rights Campaign Foundation. n.d. Transgender People and HIV: What We Know. Available at: http://www.hrc.org/resources/transgender-people-and-hiv-what-we-know

Contact Us

You may contact us with any questions related to program design/management or client/community engagement:

Erik Moore, (Program Design) : Erik.Moore@PIHCGA.org

Gwen Davies, (PI) : Gwen.Davies@PIHCGA.org

Sevyn Jones, (Data Management) : Jamal.Jones@PIHCGA.org

Letitia Burr, (Case Management) : Letitia.Burr@PIHCGA.org

Beautifull Devynne, (Community Outreach) : Beautiful.Devynne@PIHCGA.org

Replicating Innovative HIV Care Strategies in the Ryan White HIV/AIDS Program: Creating and Using a Clinic Cascade of Care for HCV Treatment

Merceditas Villanueva, MD
Ralph Brooks, MS
Yale School of Medicine

June 7, 2024

Yale University
School of Medicine

Disclaimer (2)

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U9039341 SPNS Project, awarded at $2,000,000 over 3 years with 0% non-governmental sources used to finance the project. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Merceditas S. Villanueva, MD

Dr. Villanueva is a Professor of Medicine at Yale School of Medicine and Director of the Yale Medicine AIDS Care Program. She is an infectious disease specialist with a clinical focus on HIV. Dr. Villanueva has served as the principal investigator for the New Haven Ryan White HIV Continuum grant, a collaboration between clinics and community organizations that promotes service coordination to improve quality of care for persons with HIV. Her research focuses on optimizing models of care for persons with HIV and Hepatitis C, with particular interest in partnerships between public health, medical and community stakeholders including Data to Care approaches. She has published on innovative approaches to promoting HIV-centered client re-engagement, retention and viral suppression and promoting HCV cure in HIV/HCV coinfected persons.

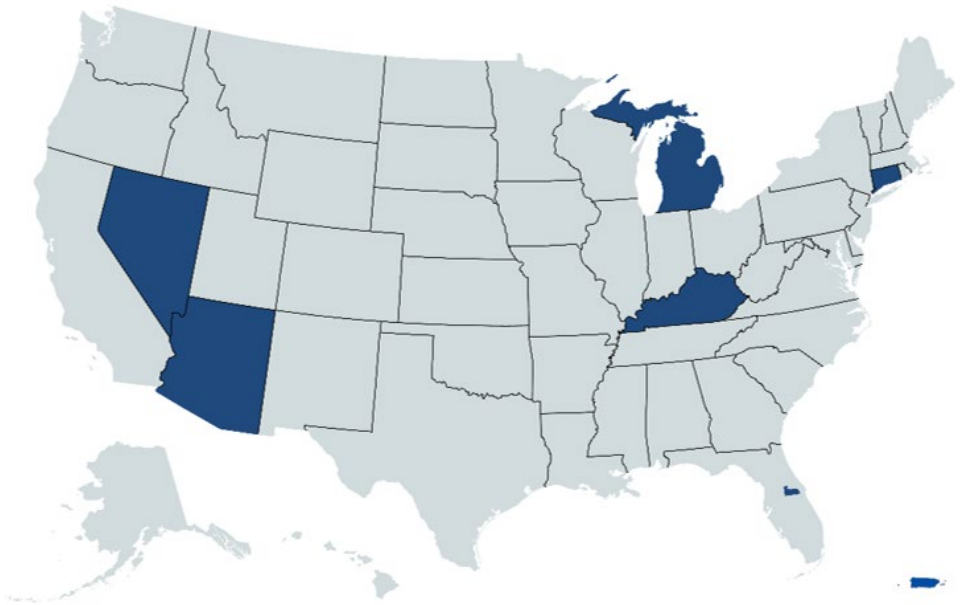
Ralph Brooks, MS

Ralph Brooks, is a data manager with the Yale School of Medicine AIDS Care Program. Since 2008, his work has focused on the syndemic intersection of HIV, Hepatitis C, and substance use, as well as TB, in both in the United States and international resource limited settings.

Objectives

- Brief overview of the grant goals and participants
- Discuss importance of creation of HCV care cascade
- Demonstrate the case conferencing tool intervention
- Provide a real-world example of the utility of using the tool
- Summarize lessons learned

HRSA 077 Project Overview: Leveraging a Data to Care Approach to Cure HCV Within the RWHAP: A Multisite Partnership



- HRSA HAB Special Projects of National Significance initiative (9/1/2020-11/29/2023)
- Yale School of Medicine served as the Technical Assistance Provider (TAP)
- 7 participating jurisdictions
- 18 Ryan White Clinics

Jurisdictional Partners: Arizona, Connecticut, Florida (Orange County), Kentucky, Michigan, Nevada, Puerto Rico

RWHAP Clinics Participating in HRSA 077

Nevada: SNHD Community Health Clinic

Florida: Sunshine Clinic (Orange County HD Clinic)

Arizona:

- El Rio Health
- North Country Healthcare
- Valleywise Community Health Center

Michigan:

- Beaumont Medical Center
- Corktown Health Center
- Sunshine Family Care Clinic

Connecticut:

- Brownstone Clinic
- Charter Oak Health Center
- Generations Family Health Center
- Trinity Health of New England

Kentucky:

- Bluegrass Care Clinic
- LivWell Community Health Services

Puerto Rico:

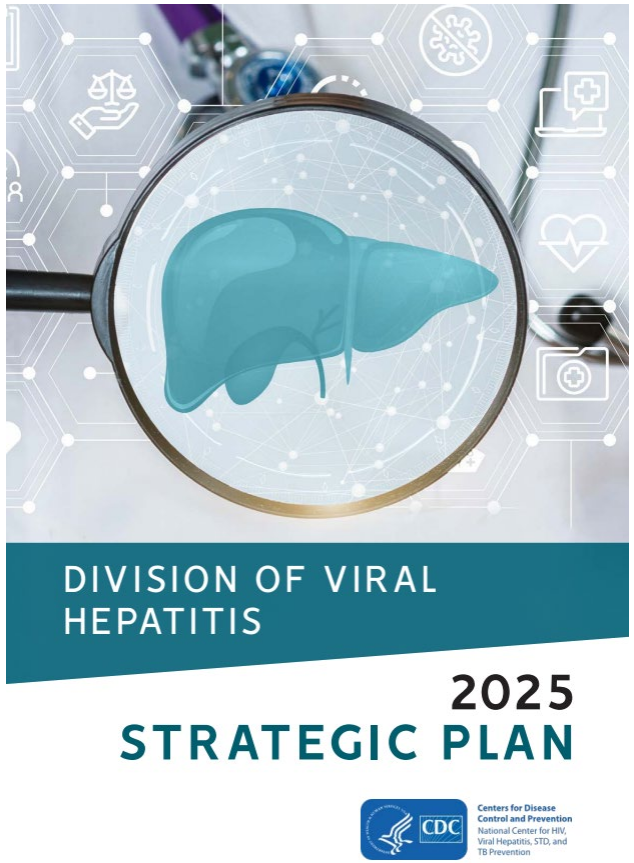
- Bayamon HD Medical Center
- Caguas HD Clinic
- CLETS
- Programa Vida

Two Main Project Components

1. HCV Clearance Cascades for Co-Infected Individuals

2. Outreach and Linkage to Care

Significance: HCV Viral Clearance Goal >80%



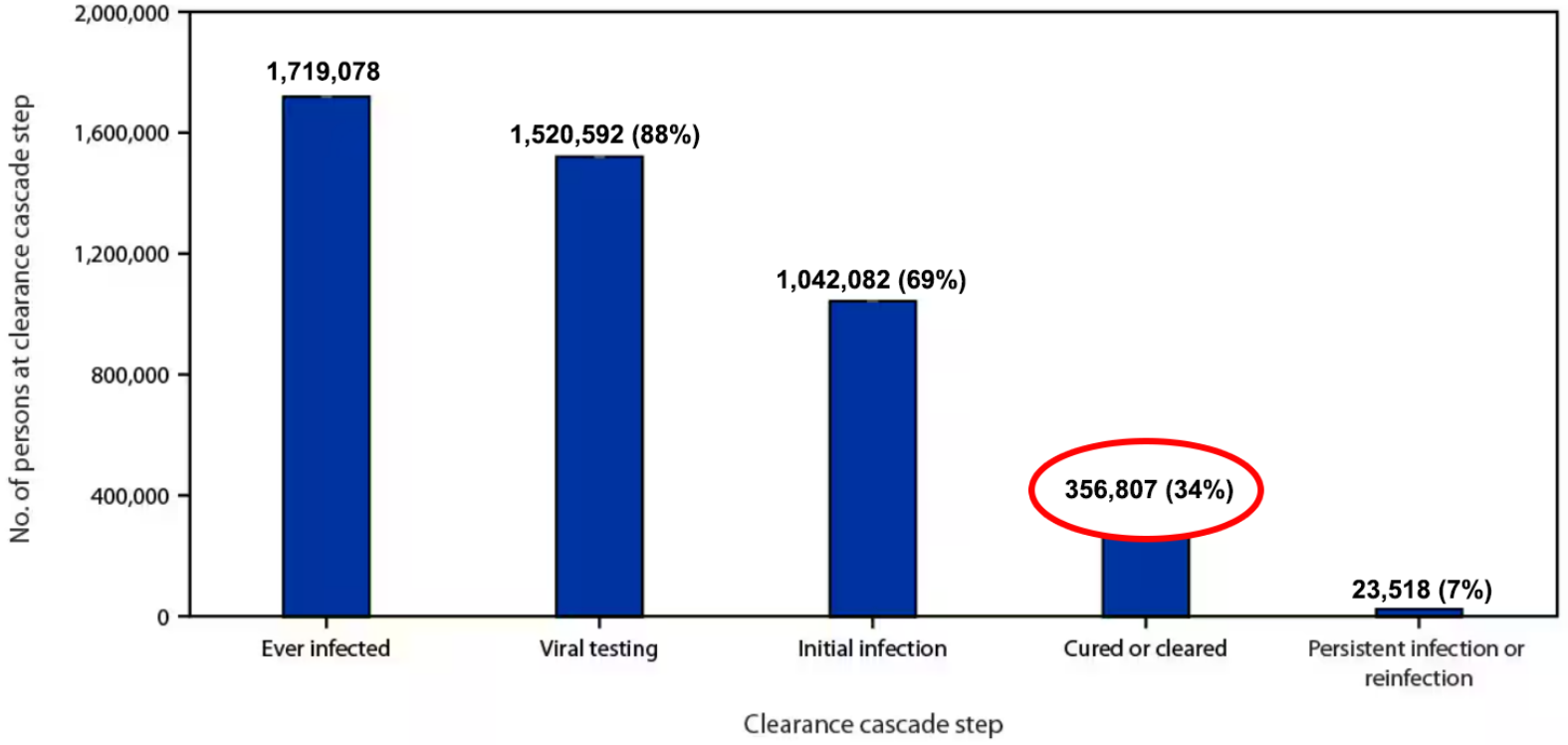
Why the HCV Clearance Cascade is Important

- Clearance cascade is a TOOL to help visualize diagnosis and treatment milestones
- Identify gaps in care
- Monitor elimination efforts
- Key step in 2025 National Hepatitis Strategy

Source: MMWR, 2023
Carolyn Wester, MD; Ademola Osinubi, MS; Harvey W. Kaufman, MD; Hasan Symum, PhD; William A. Meyer III, PhD; Xiaohua Huang, MS; William W. Thompson, PhD
https://www.cdc.gov/mmwr/volumes/72/wr/mm7226a3.htm

Why the HCV Clearance Cascade is Important (con't)

FIGURE 1. Hepatitis C virus clearance cascade using national commercial laboratory data — United States, 2013–2022



Source: Quest Diagnostics (January 1, 2013–December 31, 2022).

Source: MMWR, 2023
Carolyn Wester, MD, et. al
https://www.cdc.gov/mmwr/volumes/72/wr/mm7226a3.htm

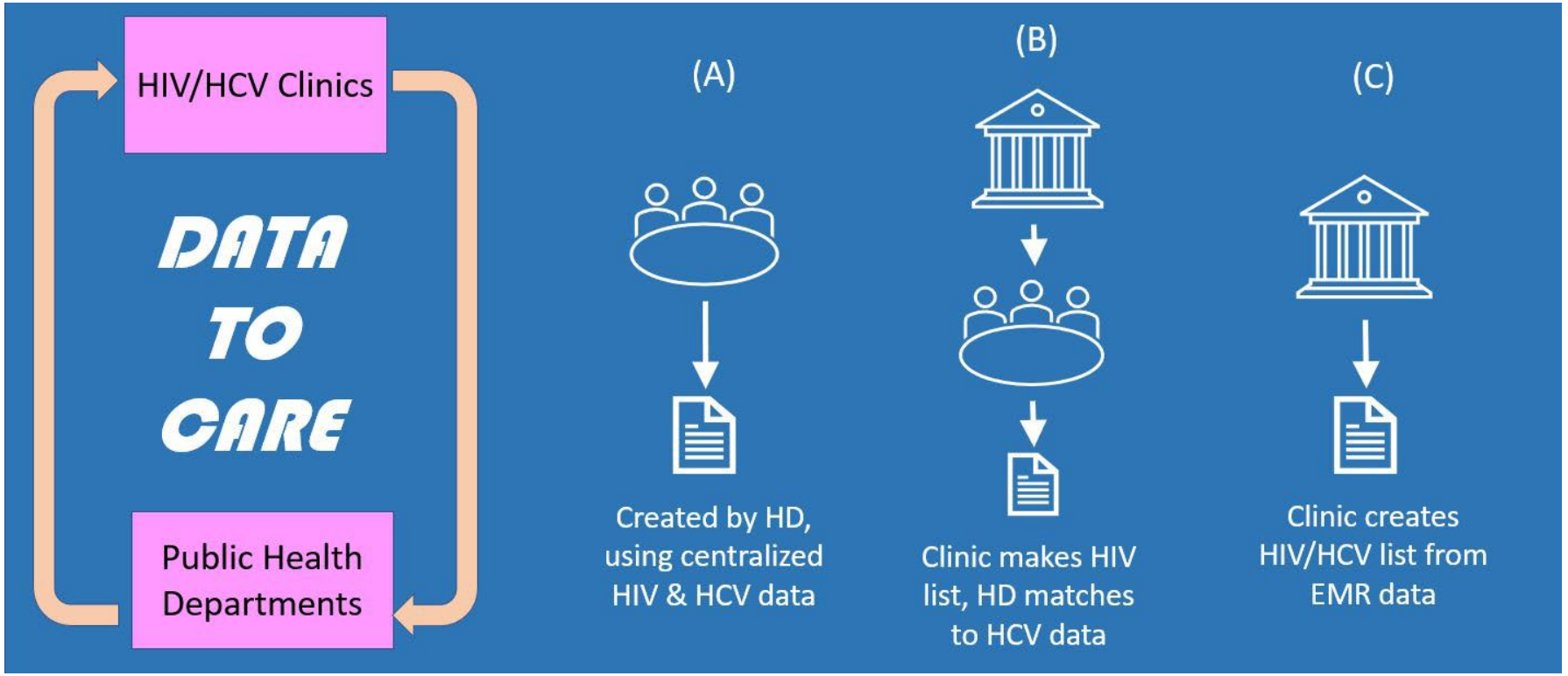
Creating a Clinic Cascade of Care

Promoting Outreach and Linkage to Care

1. HCV Clearance Cascades for Co-Infected Individuals

2. Outreach and Linkage to Care

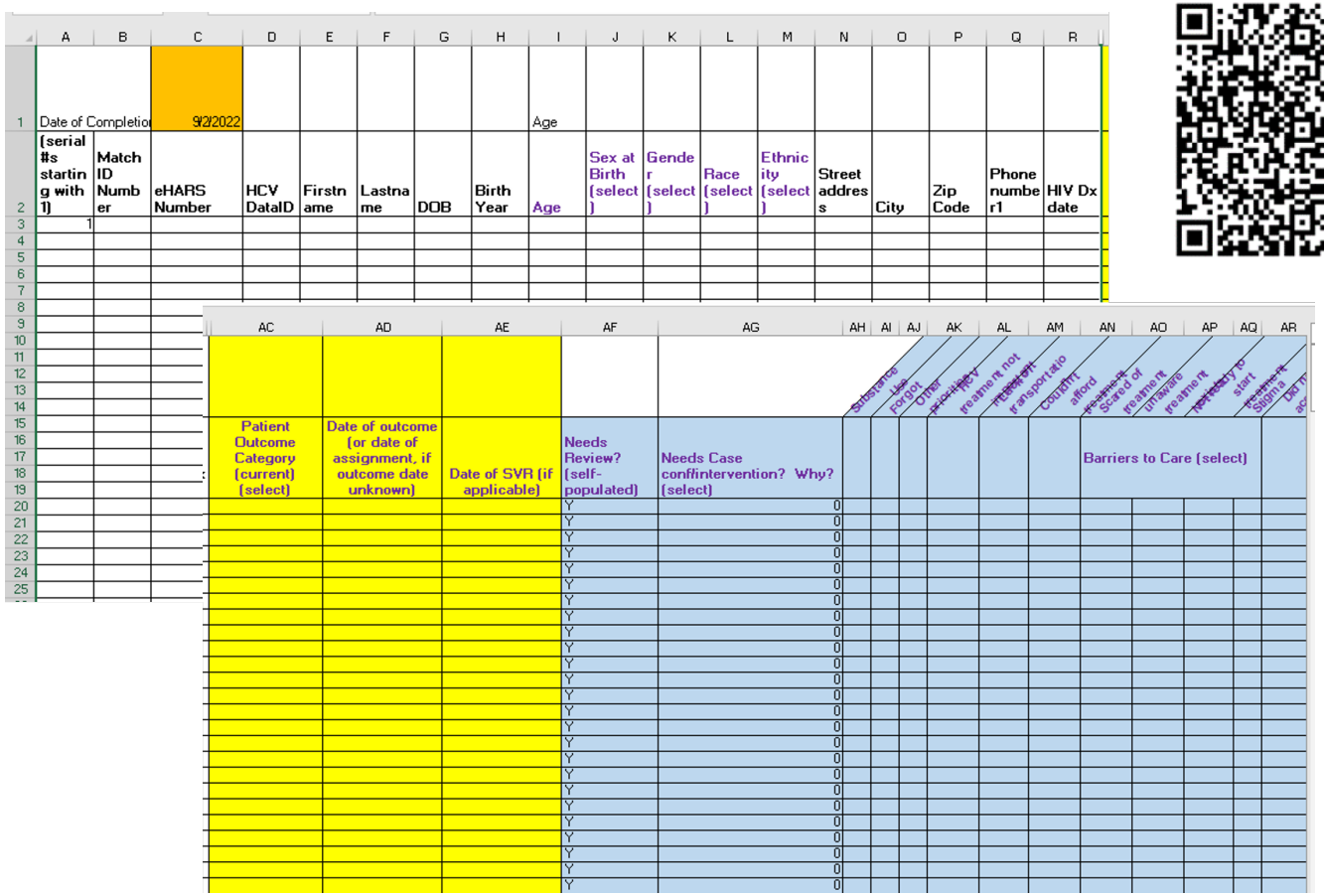
Creating a Clinic Cascade of Care: Does the Clinic Have A Working Partnership With The Local Health Department?



Create HIV/HCV Co-infected List: Different Models

Case Conferencing Data Tool

- Case Conferencing Data Tool
  - Demographics (for ID matching),
  - Treatment Status
  - Barriers to Care
- Data Tool automatically generates cascades
  - More granular than CDC viral clearance cascades
  - Details of status
- Yellow fields are minimum needed for cascade creation



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Date of Completio		9/2/2022						Age									
2	(serial #s starting with 1)	Match ID Number	eHARS Number	HCV DataID	Firstname	Lastname	DOB	Birth Year	Age	Sex at Birth (select)	Gender (select)	Race (select)	Ethnicity (select)	Street address	City	Zip Code	Phone number1	HIV Dx date
3	1																	

	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR
	Patient Outcome Category (current) (select)	Date of outcome (or date of assignment, if outcome date unknown)	Date of SVR (if applicable)	Needs Review? (self-populated)	Needs Case confintervention? Why? (select)	Substance	Use	Forgot	Other	[illegible]	[illegible]	[illegible]	[illegible]	Barriers to Care (select)		
20				Y	0											
21				Y	0											
22				Y	0											
23				Y	0											
24				Y	0											
25				Y	0											

https://targethiv.org/sites/default/files/media/documents/2023-08/HCV_D2C_Case_Conferencing_Tool.zip

Module 4: Case Conferencing

Module 4

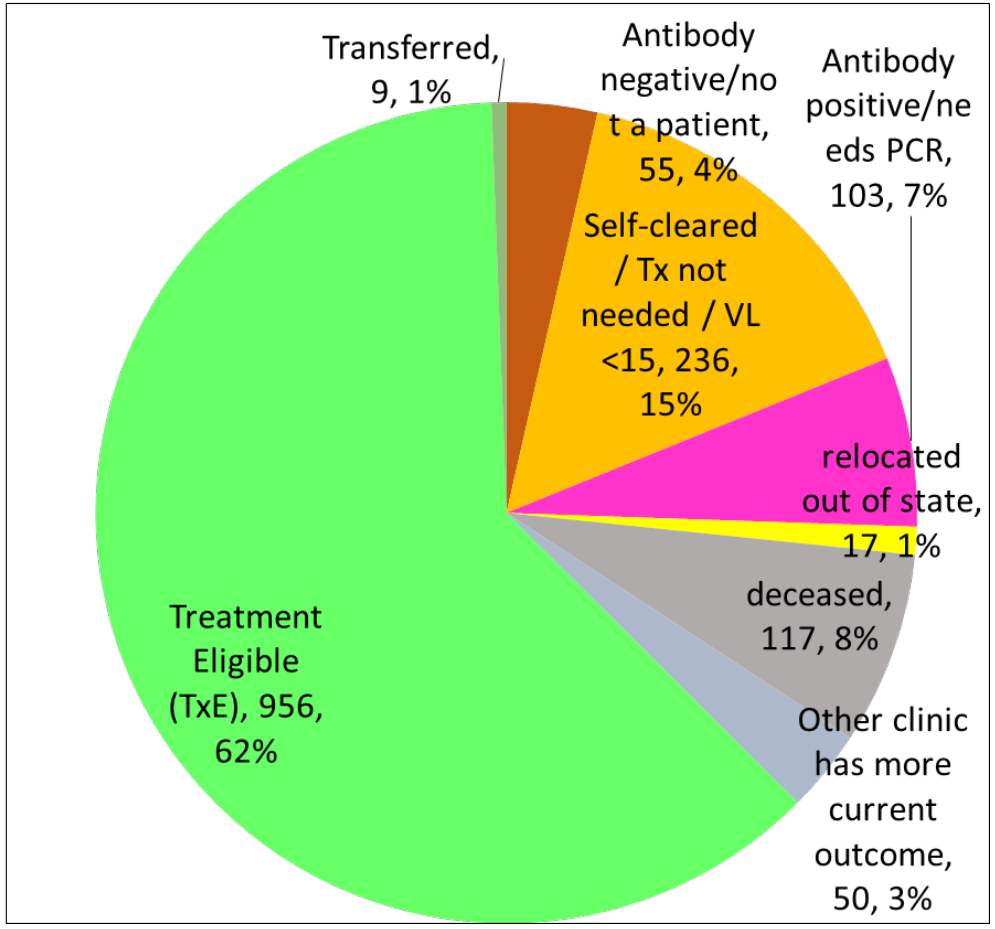
- Video 1: The Case Conferencing Tool
- Video 2: Create the HIV/HCV Co-infected List
- Video 3: Implement the Case Conference
- Video 4: Generate and Use the Clinic Care Cascade

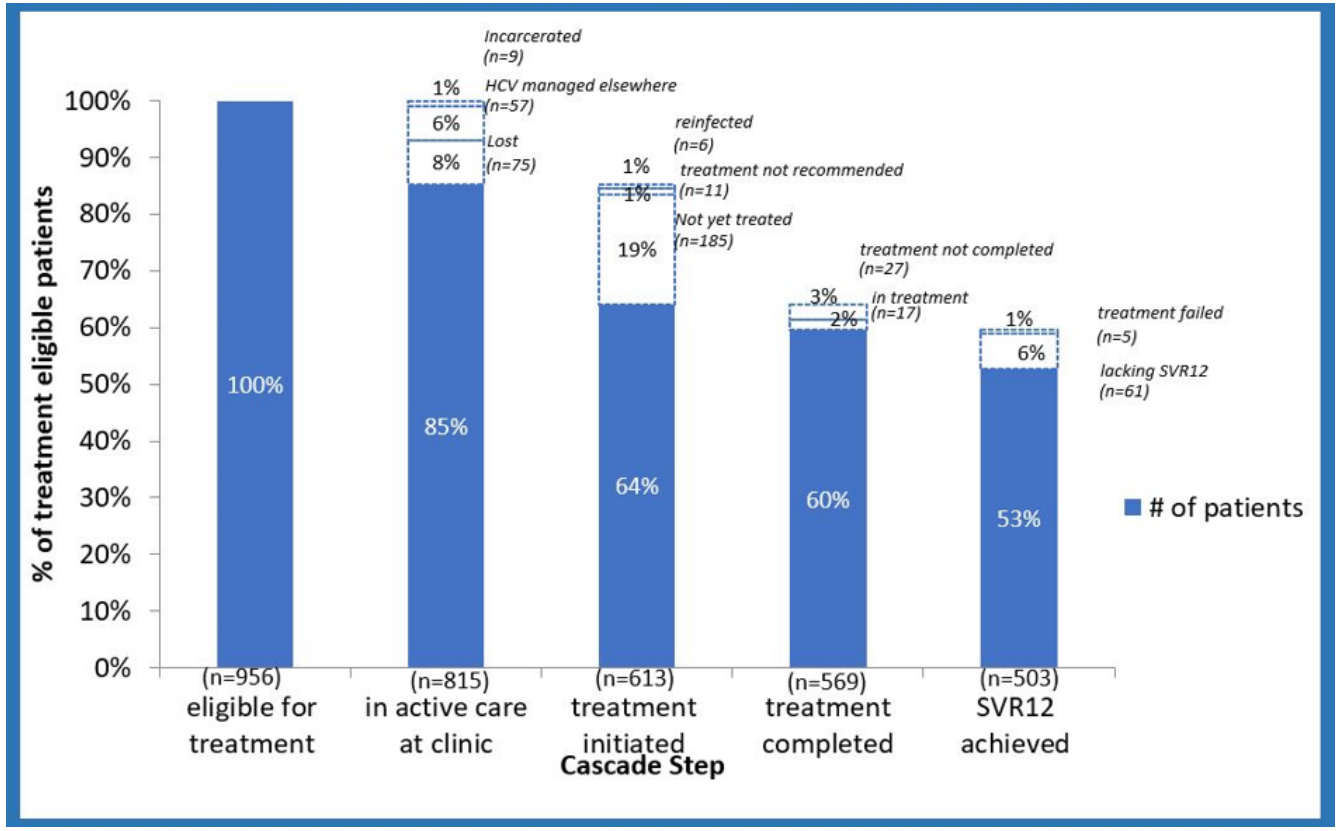
Mini eLearning Module 4: Video Excerpt

How to Create Hepatitis C Virus (HCV) Care Cascades for Persons with HIV/HCV Coinfection: A Written Companion to the Mini-Module Video Training Series for Health Departments and Clinics

http://targethiv.org/spns-hcv-dtc

Example of Aggregate Results: 14 Clinics as of 11/30/2021 (N=1,543)





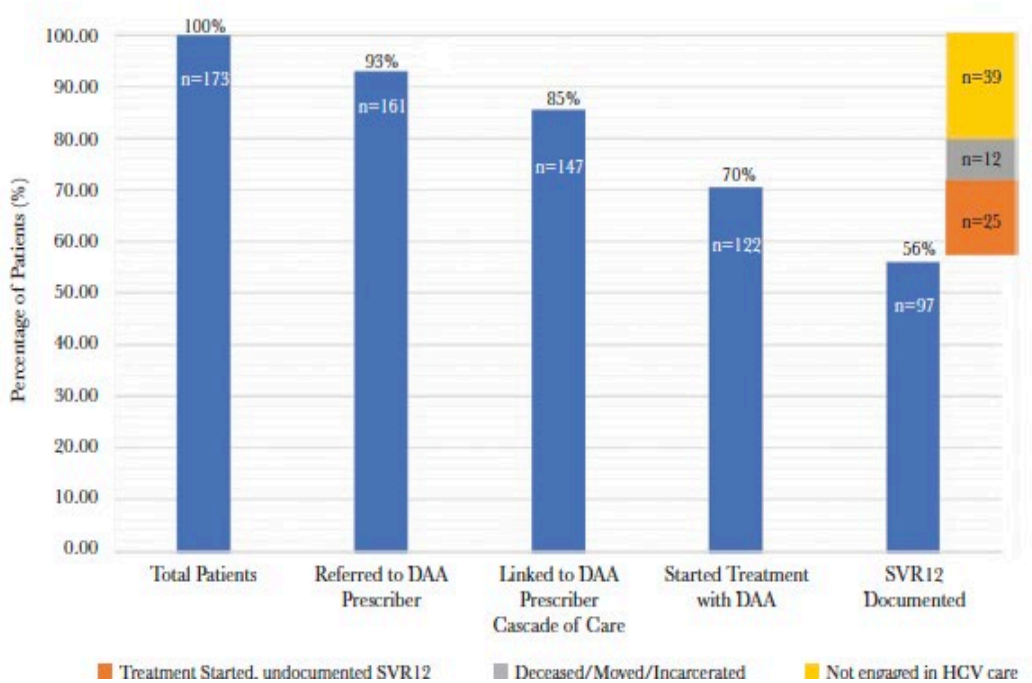
Real Life Clinic Example: RW-funded HIV Clinic in New Haven, CT: Status of HCV Treatment Among Cohort as of 8/31/2018

Open Forum Infectious Diseases

MAJOR ARTICLE

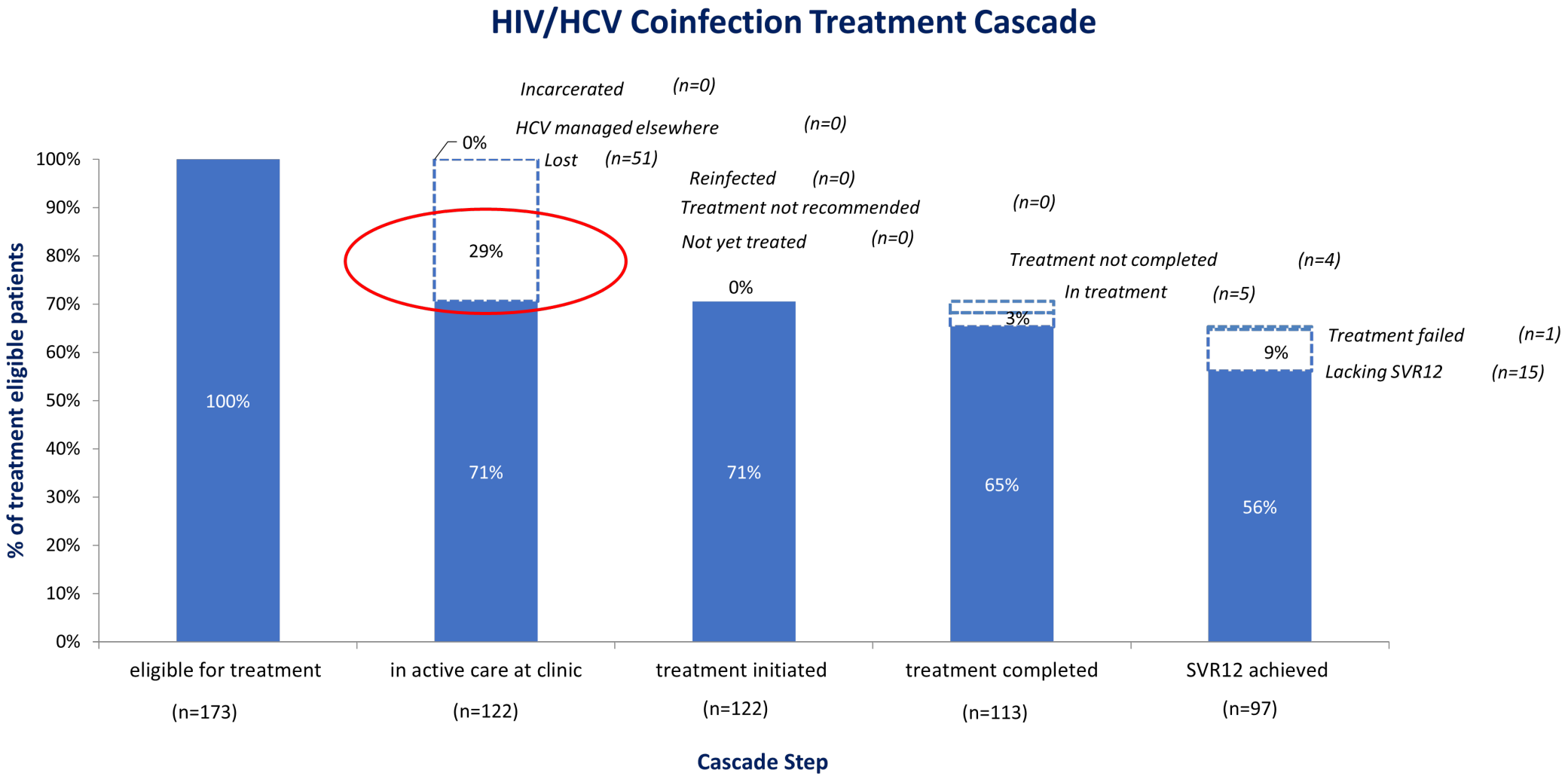
Implementing a Comprehensive Hepatitis C Virus (HCV) Clinic Within a Human Immunodeficiency Virus Clinic: A Model of Care for HCV Microelimination

Christina Rizk,[1] Janet Miceli,[1] Bethel Shiferaw,[2] Maricar Malinis,[1] Lydia Barakat,[1] Onyema Ogbuagu,[1] and Merceditas Villanueva[1]

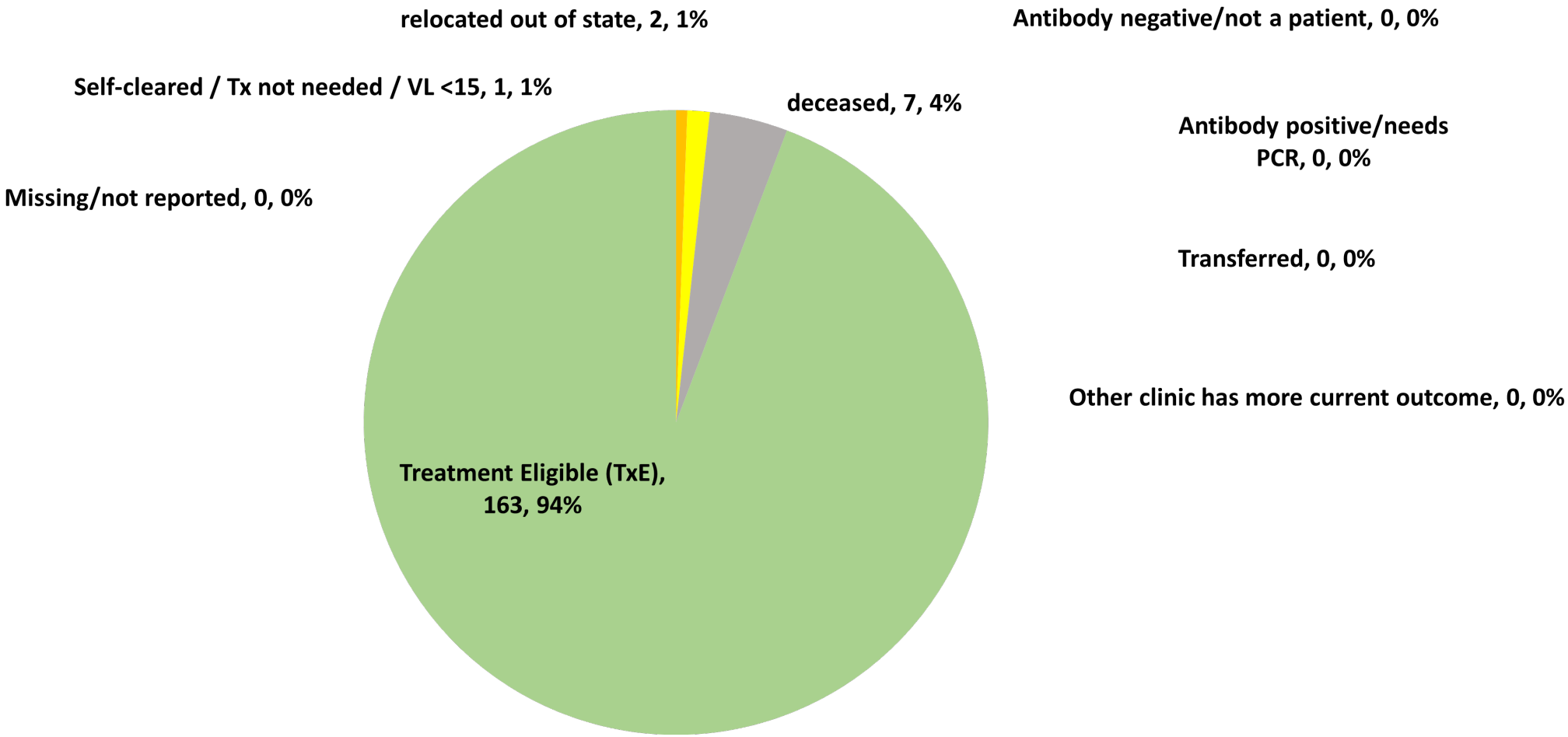


- Clinic created the HIV/HCV Coinfected List (Model C)
- Labor intensive
- Lack of detail among “not engaged in care”

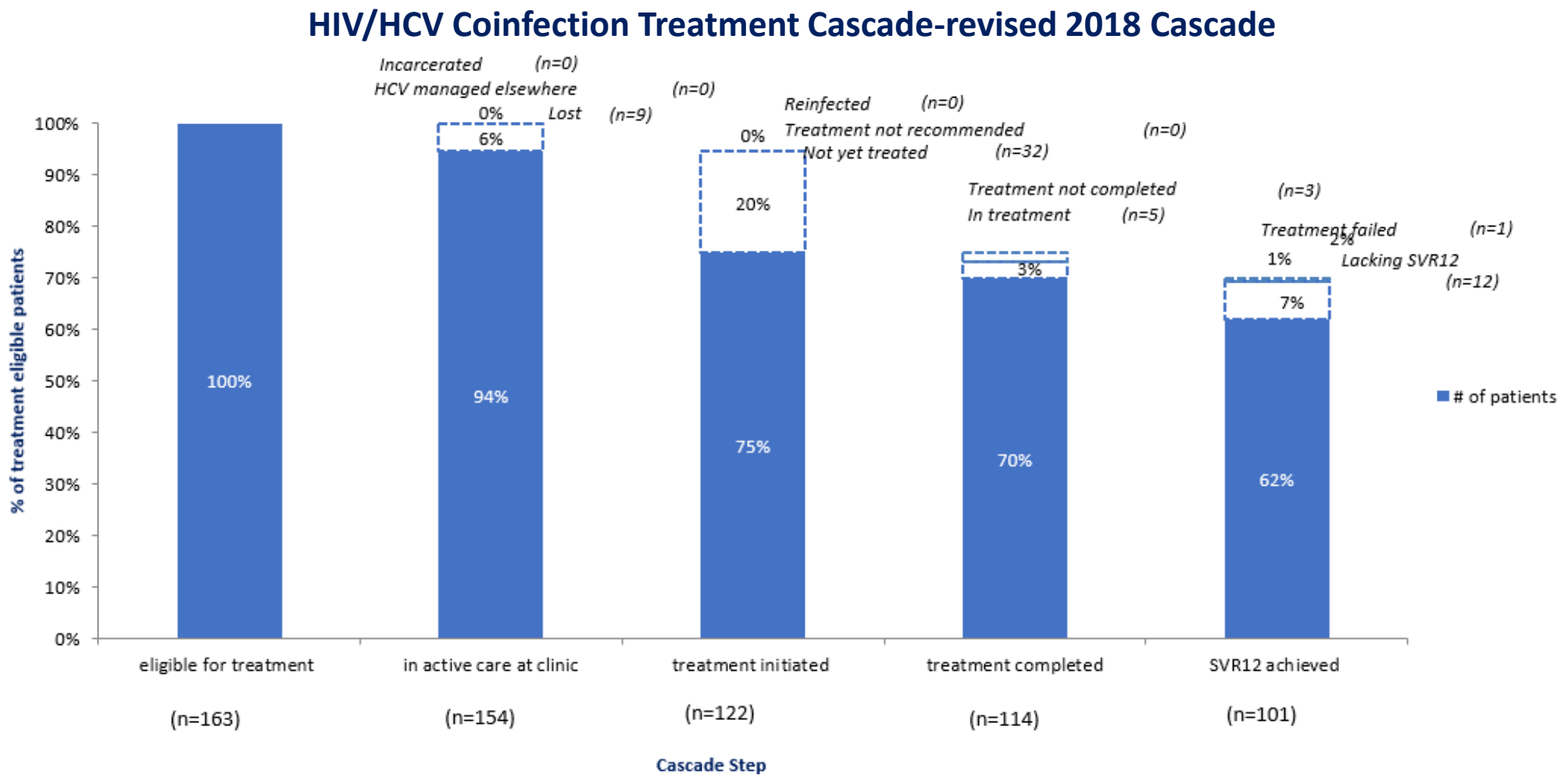
Real Life Clinic Example: Using the Tool for the Original Data



Real Life Clinic Example: Using the Tool for the Original Data-Revising Denominator and Enhanced Definitions



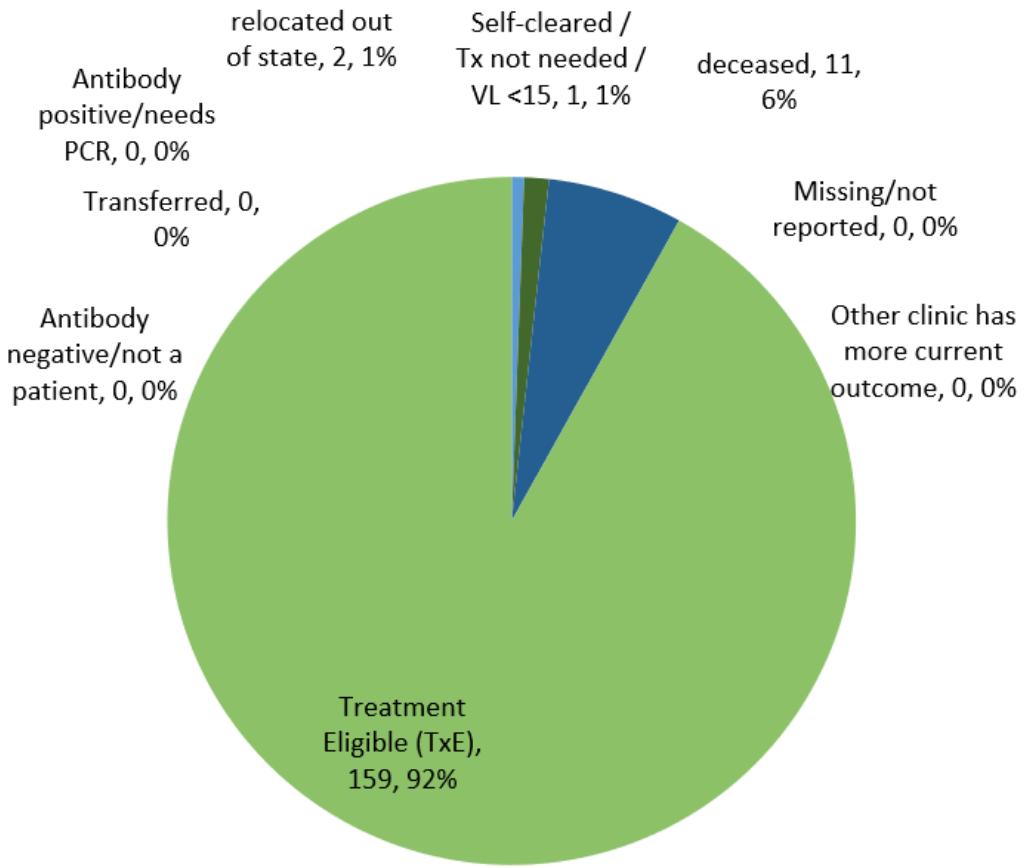
Real Life Clinic Example: Using the Tool for the Original Data- Revising Denominator and Enhanced Definitions (con't)

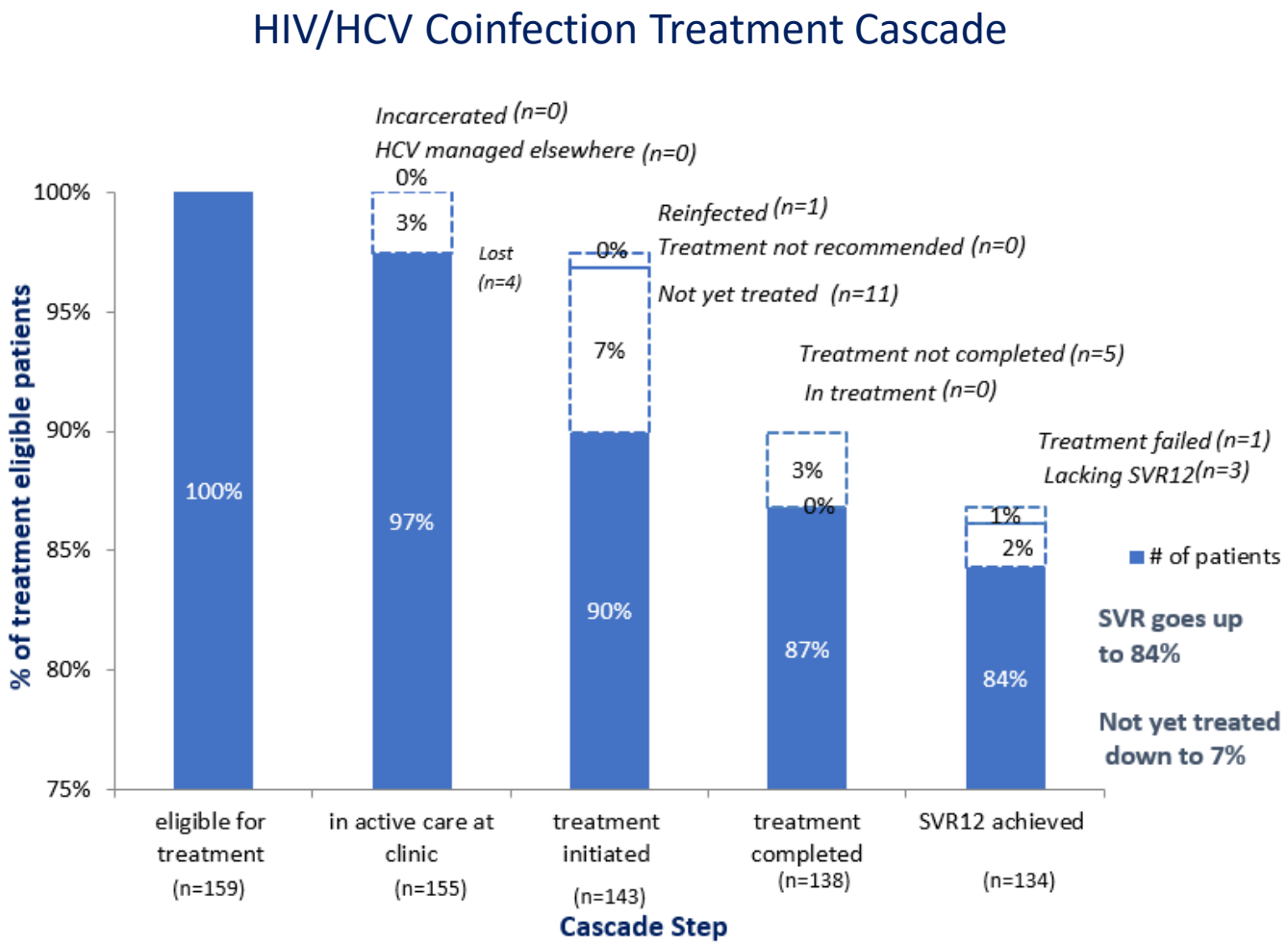


Analysis Not Yet Treated Group in 2018: Chart Review

Reason	Number
Active SUD	11
Not Ready (Competing priorities or other)	7
Comorbidities HCC (n=2) Decompensated (n=1) Multiple (n=3)	6
Refused	3
Mental Health	1
Unclear	4
Total	**32**

Updated Cascade Using the Tool: 2024





What Accounts for the Improved SVR Rate in Our Clinic: Best Practices

- Treatment within long-term care settings
  - Leeway Residential
  - Jail
- Initiation of Treatment for SUD (e.g. MOUD)
- Models of Care:
  - Ongoing Monitoring with Referrals to HCV treatment team
- Assessing Readiness for Treatment in ongoing fashion
- Use of Specialty Pharmacy

Sustainability (3)

- Training modules on HRSA Target Web Site
- Ongoing presentations to key stakeholders

Some Lessons Learned

Using the Case Conferencing Tool

- The Case Conferencing Tool is your friend!
- Ensure persons completing the list understand HCV
- Have dedicated staff knowledgeable about data
- Create regular updating sessions
- Implement the results: outreach to clients who have not successfully been treated

Some Lessons Learned (con't)

Outreach and Linkage Services

- Use multiple methods for outreach and linkage if possible
- Leverage HD jurisdictional DIS staff if possible
- Check with DIS and HD staff re: more up to date data on "lost" clients
- Use multidisciplinary support staff to address client barriers
  - Refer to long term care facilities
  - Address active SUD issues
- Designate specific clinic champion(s) in a comprehensive QI effort

References (2)

TargetHIV page with project information and resources:
https://targethiv.org/spns/hiv-hcv-dtc

- Recorded webinars
- Implementation Manual with steps and lessons learned to support replication
- Videos and companion text
- Clearance cascade and case conferencing tools

Contact Information

Dr. Merceditas Villanueva

Associate Professor of Medicine, Yale School of Medicine

Director of the Yale Medicine AIDS Care Program

Merceditas.villanueva@yale.edu

Ralph Brooks

Data Manager

Yale School of Medicine AIDS Care Program

Ralph.brooks@yale.edu

Participant Feedback

Please use the following link to give your feedback

https://www.surveymonkey.com/r/June72024

Stay Connected!

Sharing Information & Strategies

CBTA questions, email:

IHIPhelpdesk@mayatech.com

To access IHIP tools/resources and join the IHIP listserv:

https://targethiv.org/ihip

iHiP Contact Information

Natha Bakayoko, MHA
Program Manager
Division of Policy & Data (DPD)
HRSA HAB
Nbakayoko@hrsa.gov
http://hab.hrsa.gov

Shelly M. Kowalczyk, MSPH, CHES
IHIP Project Director
The MayaTech Corporation
Silver Spring, MD 20910
skowalczyk@mayatech.com
http://www.mayatech.com