2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Successful Hepatitis C (HCV) Strategies within the Ryan White HIV/AIDS Program (RWHAP)

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Learning Objectives

At the conclusion of this activity, the participant will be able to:

1. Explain the importance of treating HCV in PLWH while discussing key facilitators and barriers to HCV care for PLWH.
2. Identify potential RWHAP eligible individuals who are not able to access affordable treatment and create a streamlined application process to improving their access to medication.
3. Understand at least two replicable activities to address HCV in the RWHAP and identify three existing HCV resources within the RWHAP for providers.

Obtaining CME/CE Credit

If you would like to receive continuing education credit for this activity, please visit:

http://ryanwhite.cds.pesgce.com

2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

HIV/HCV Resources

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Disclosures

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Commercial Support was not received for this activity.

AETC Program

- In 2016, the AETC National Coordinating Resource Center (NCRC)was funded to coordinate and facilitate the development of a national curriculum to be used for self-directed learning by health care providers as well as by trainers of clinical teams across the United States and its territories.

- The AETC NCRC partnered with the regional AETCs associated with each of the Part A and B jurisdictional sites to develop the curriculum.

- The 5 regional AETCs were: MidAtlantic AETC, New England AETC, Northeast/Caribbean AETC, South Central AETC, and Southeast AETC.

Core Competencies

- HIV/HCV experts from the 5 regional AETCs and the NCRC, developed 6 core competencies to address with the curriculum.
- These core competencies are the basis of each of the 6 modules of the curriculum:
  - Epidemiology
  - Prevention
  - Screening, Testing, and Diagnosis
  - HCV Treatment
  - Recommendations for Subpopulations of HIV/HCV Co-infected Persons
  - Addressing Barriers for Co-infected People of Color

The Curriculum

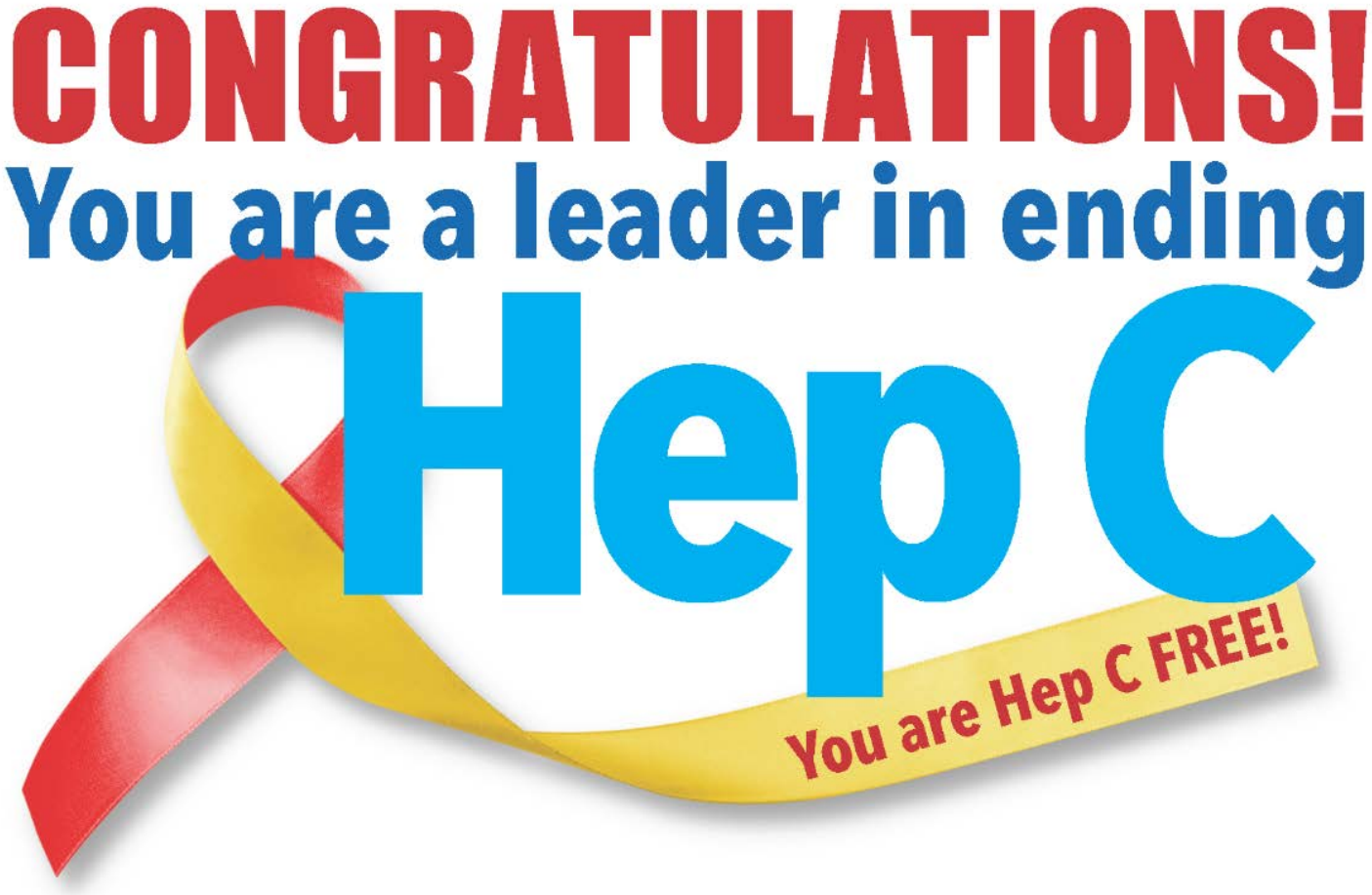
- In July 2017, ***HIV/HCV Co-infection: An AETC National Curriculum*** was launched on the AETC NCRC website: **aidsetc.org/hivhcv.**
- This curriculum can be used for free self-directed learning, continuing education units, and by faculty and trainers to educate healthcare providers and health profession student.

HIV/HCV Co-infection:
An AETC National Curriculum

First Year Stats (7/2017 – 6/2018)

- 18,917 Pageviews
- 14,538 Unique Users
- Epidemiology module most reviewed

Patient-Provider Resource 1



Back of Patient-Provider Resource 1

Re-infection can occur IF YOU ARE NOT CAREFUL.

To avoid re-infection and to stay healthy, it is important that you:

- ✓ **DO** continue to see your healthcare provider(s) on a regular basis and discuss risks for re-infection (i.e. new sexual partner or recent drug use)
- ✓ **DO** continue taking your HIV medications
- ✓ **DO** continue seeing your mental health or substance use recovery providers
- ✓ **DO** use condoms for anal and vaginal sex to avoid infection with hepatitis C or sexually transmitted infections
- ✓ **DO NOT** share needles, syringes, straws, or other equipment to inject or sniff drugs
- ✓ **DO NOT** share another person's razors or toothbrushes since they may spread hepatitis C
- ✓ **DO NOT** get a tattoo and/or piercing from an unregulated person or place (the ink and/or needles may be contaminated with hepatitis C)

AETC AIDS Education & Training Center Program
National Coordinating Resource Center

This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U10HA28686, AIDS Education and Training Center Program for $1,500,000.00. 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.

Rev May 2018

Patient-Provider Resource 2

Pharmacy Information:

Clinic Information:

Clinical Team:

What are my HIV medication(s)?

What are my other medication(s)?

What is coinfection?

Coinfection is when a person living with HIV (PLWH) is also infected with the hepatitis C virus (HCV).

HIV/HCV coinfection is a common scenario because of shared risk factors of the virus.

HIV/HCV coinfection increases the risk of liver disease, organ failure and other serious health issues.

Treatment of HCV in PLWH should be a priority.

What kind of HCV do I have? (circled below)

There are 7 different HCV genotypes (types). A genotype is the strain of the virus you have in your body.

You have genotype: 1a, 1b, 2, 3, 4, 5, 6

What stage of liver disease do I have?

Liver disease is "staged" based on the amount of scar tissue or fibrosis in the liver:

- ❑ Mild Fibrosis (Stage 1)
- ❑ Moderate Fibrosis (Stage 2)
- ❑ Bridging Fibrosis (Stage 3)
- ❑ Cirrhosis (Stage 4)
- ❑ Decompensated Cirrhosis (Stage 5)

What is my HCV load after starting HCV meds?

0-4 Weeks _____

12 Weeks _____

24 Weeks _____

What was my last HIV viral load and CD4?

VL _____ Date _____

CD4 _____ Date _____

Which HCV medications am I on?

❑ Daklinza® (daclatasvir) 1 tablet by mouth daily
❑ 90mg ❑ 60mg ❑ 30mg

❑ Epclusa® (sofosbuvir/velpatasvir) 400mg/100mg
1 tablet by mouth daily

❑ Harvoni® (ledipasvir/sofosbuvir) 90mg/400mg
1 tablet by mouth daily

❑ Mavyret® (glecaprevir/pibrentasvir) 100mg/40mg
3 tablets by mouth daily with food

❑ Ribavirin® 200mg
tablets twice daily with food

❑ Sovaldi™ (sofosbuvir) 400mg
_____1 tablet by mouth daily

❑ Vosevi® (sofosbuvir/velpatasvir/voxilaprevir) 400mg/100mg/100mg
1 tablet daily with food.

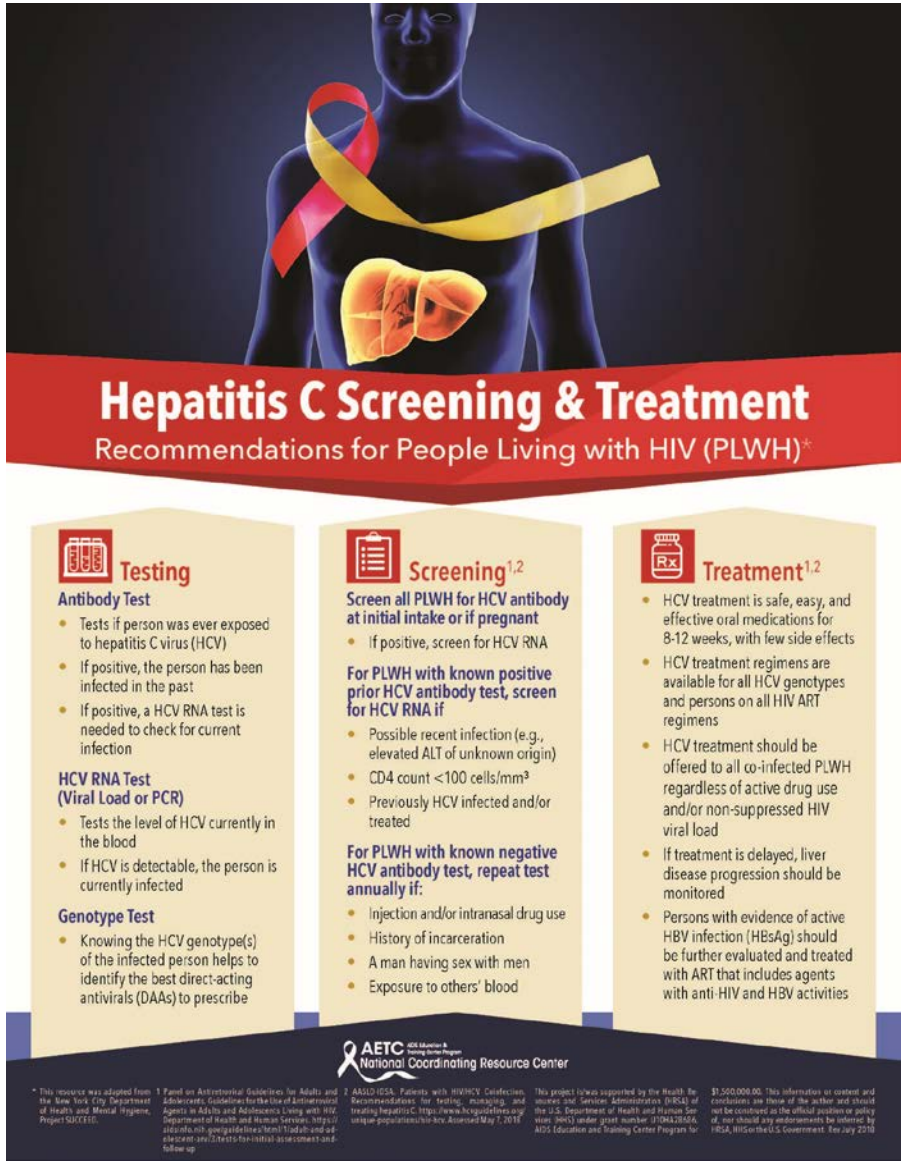
❑ Zepatier® (elbasvir/grazoprevir) 50mg/100mg
1 tablet by mouth daily

How long is the HCV treatment?

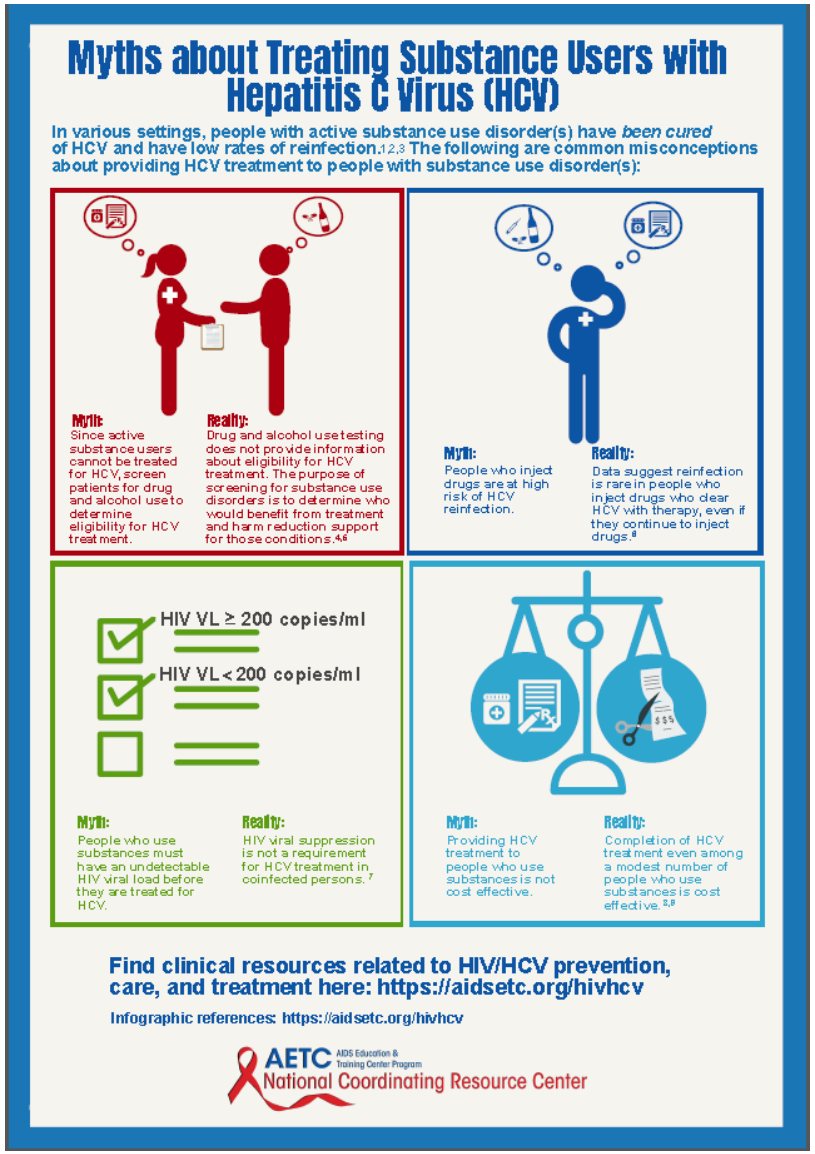
❑ 8 weeks ❑ 12 weeks ❑ 16 weeks ❑ _____ weeks

AETC National Coordinating Resource Center

Provider Resource



Infographic



Provider Awareness

THANK YOU

nelsonj3@sn.rutgers.edu (email)

aidsetc.org/hivhcv (curriculum and resource page)

2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Jurisdictional Approach to Curing Hepatitis C Among HIV/HCV Co-Infected People of Color (HRSA-16-189) & Curing Hepatitis C among People of Color Living with HIV (HRSA-17-047)

Lisa Wagner

Senior Project Analyst, RAND Corporation

Disclosures

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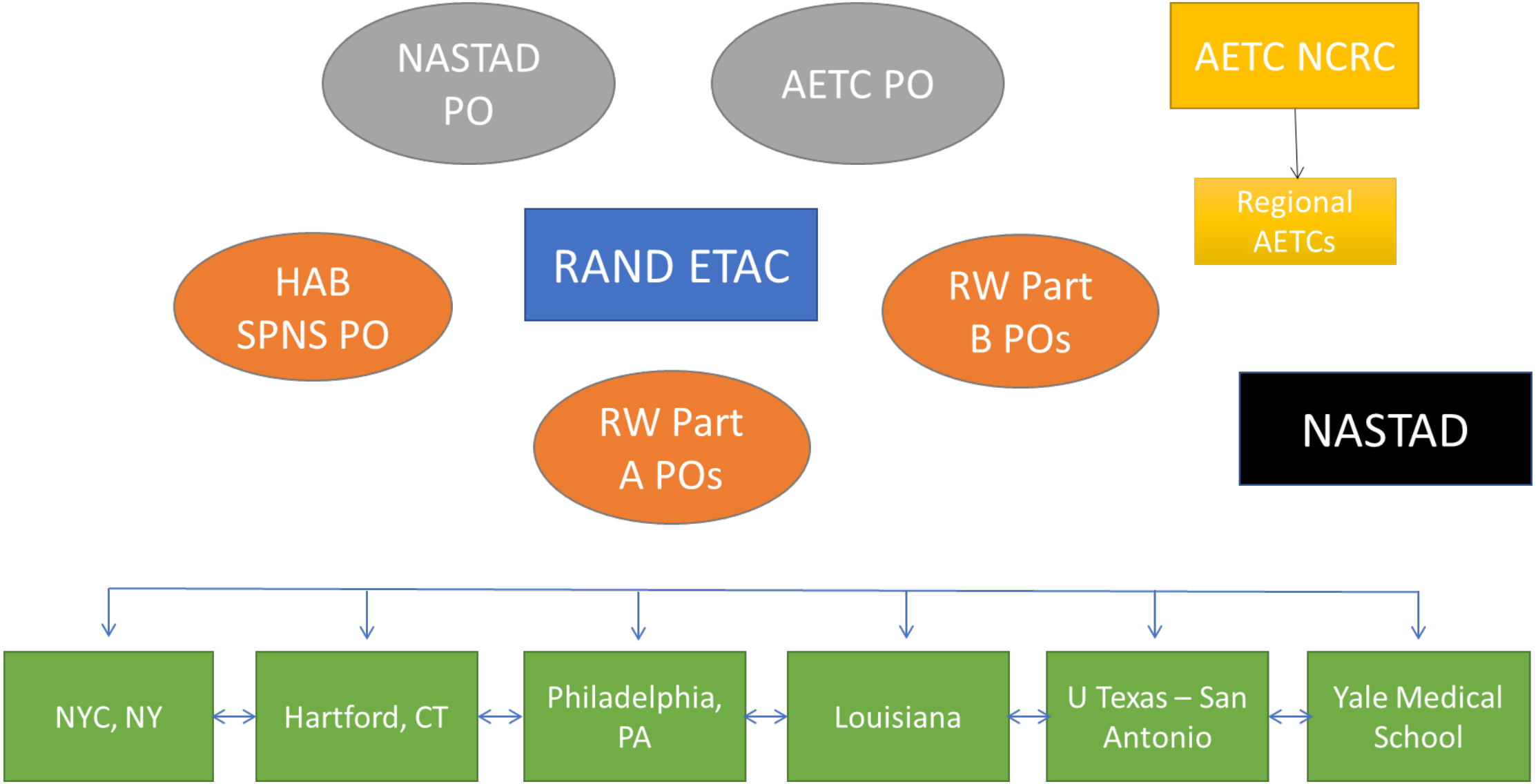
Project Goals

- Increase capacity to provide comprehensive screening, care and treatment of HCV among HIV/HCV coinfected people of color
- Increase numbers of HIV/HCV coinfected people of color who are diagnosed, treated, and cured of HCV infection
- To better understand the HCV Continuum of Care
- Improve coordination with SAMHSA-funded SUD treatment providers to expand the delivery of behavioral health and substance use treatment*
- Enhance health department surveillance systems to increase their capacity to monitor acute and chronic coinfections of HIV and HCV*


NASTAD PO
AETC PO
AETC NCRC
Regional AETCs
HAB SPNS PO
RAND ETAC
RW Part B POs
RW Part A POs
NASTAD
NYC, NY
Hartford, CT
Philadelphia, PA
Louisiana
U Texas – San Antonio
Yale Medical School

Roles & Responsibilities:

Performance Sites

Develop comprehensive jurisdiction-level HCV screening, care, and treatment systems for HIV/HCV coinfected people of color

Three phases:

- Project Pre-Implementation (Assessments, Develop Project Implementation Plan, etc.)
- Project Implementation (Establish Communities of Practice and Learning, etc.)
- Publication & Dissemination (Sustainability& Local Evaluation Plan)

Work with ETAC to receive TA/CBA and participate in multisite evaluation

Collaborate with HRSA, NCRC, and regional and local AETC partners

Roles & Responsibilities:

HRSA Project Officers

Active participation in the planning, development, management and technical performance of all phases of the project

Coordination of the partnership and communication with other federal agencies' personnel and other funded capacity building entities

Provision of ongoing review of curriculum, documents, activities, procedures, evaluative measures and tools to be established and implemented, including project information prior to dissemination

Participation in meetings, monthly conference calls and site visits to be conducted;

Provision of information resources and facilitating partnerships with other RWHAP recipients and stakeholders

Participation in the dissemination of project findings, best practices and lessons learned

Roles & Responsibilities:

RAND ETAC

Design and implement multisite evaluation

Provide TA and capacity building to jurisdictions

- Comprehensive jurisdiction-level HCV screening, care and treatment system planning, implementation and sustainability,
- Human Research Subjects Protection and Institutional Review Board applications
- Participation in multisite evaluation and implementation of local evaluation

Collaborate with the AETC/NCRC to develop a National Provider Competencies and Curriculum for HCV screening, care, and treatment

Lead and coordinate publication and dissemination efforts

Roles & Responsibilities:

NASTAD

Identify and engage Part B recipients (Louisiana and North Carolina*)

In year 1, coordinated with ETAC to:

- Conduct Patient Knowledge Assessment and Provider Assessment
- Develop Project Implementation Plan
- Establish workforce capacity
- Implement a local evaluation plan

In years 2 and 3, support Part B recipients to:

- Develop sustainability plan
- Implement the local evaluation
- Publish and disseminate findings from the project

Roles & Responsibilities:

AETC NCRC

Identify, develop, and disseminate national HIV/HCV core competencies for healthcare professionals

- Facilitate a workgroup of national, interprofessional HIV/HCV experts and AETC Program grant recipients
- Develop evidence-based online curriculum components for healthcare providers and healthcare provider trainers (AETC Program) to address each of the core competencies to use to increase HIV/HCV coinfection prevention efforts, screening, diagnosis, and treatment.
- Identification of effective online platform to host the completed curriculum
- Participate in collaborative calls between NCRC and each of the Part A and B recipients

2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Massachusetts RW Part B & Hepatitis C: Testing, Linkage to Care, Treatment & Cure

Annette Rockwell

Massachusetts Dept. of Public Health

Bureau of Infectious Disease & Laboratory Sciences

Office of HIV/AIDS

Disclosures

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History

- Funding for HCV included in state budget HIV/AIDS Line
- Bureau of Infectious Disease & Laboratory Sciences (BIDLS) determines how to utilize resources based on epidemiologic data and needs assessment
- 2013 HIV/AIDS State Plan incorporated hepatitis C (HCV) prevention and care objectives
- 2016 HIV/HCV/STI/TB Prevention, Linkage, Treatment Completion, and Retention in Care and Treatment Request for Response (RFR) includes HCV testing and linkage to care and treatment
- *MA HIV/AIDS Integrated Prevention and Care State Plan 2017-2021* strengthens Massachusetts's response to HCV infection, including strategies to enhance programmatic efforts for the prevention, care, and treatment of HCV infection, with a focus on persons who inject drugs

Current Activities

- State Public Health Laboratory (SPHL) co-tests all HIV blood samples for HIV and hepatitis C (HCV)
- Availability of HCV NAAT
- State Viral Hepatitis Coordinator works in collaboration with Office of HIV/AIDS
- Clinical provider education through NEAETC
- Working with Medicaid to provide education through new ACO model (HCV Affinity Group)
- Development of “Treatment at a Glance”
- Capacity building for non-clinical providers in development

ADAP

- Massachusetts HIV Drug Assistance Program (HDAP) has an “open formulary” and will cover all treatments for HIV and “HIV-related conditions.”
- Convened Scientific Advisory Board in fall of 2013 to address covering new, highly effective treatments for HCV coming onto the market.
- Recommendation from group was to cover drugs despite costs due to the fiscal stability of the program at that time.

ADAP Cont.

- In FY18 (7/1/17-6/30/18):
  - Full pay = $444,850.56
  - Unduplicated clients = 5
  - Copay = $1,399.82
  - Unduplicated clients = 11
- Medicaid requirement around fibrosis scores was removed in 2016 following the example of NY & Washington state.
- Since many HDAP clients are also enrolled in Medicaid, and because many pharmacies forgo Medicaid copays, HDAP does not process claims

Conclusions

- High level of commitment to HCV treatment and access to care at the Department of Public Health.
- What is on paper doesn't always lead to action.
- Access to HCV treatments under most payers, including Medicaid & ADAP.
- Continued reluctance on the part of providers to treat certain populations, or belief that only gastroenterologists & infectious disease MDs can treat.

2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Integrating HCV Treatment into RW Part A Medical Care

Nora S. Holmquist

RW Lead Consultant

Hudson County NJ TGA

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History of the HCV Co-Infected Clinic

- At the Hudson TGA's largest Part A medical program (JCMC CCC) in June 2014 nearly 40% of HIV positive patients on antiretroviral therapy (ART) were co-infected with HCV
- JCMC CCC requested Part A funding to utilize .25 of an existing Nurse Practitioner and .25 of an existing LPN to provide dedicated HCV treatment, education, and adherence counseling
- The Co-Infection Clinic was fully operational in FY2015, and detailed screening and treatment criteria were developed, consistent with national guidelines
- The Clinic was designed to also serve non-JCMC CCC patients that were RW eligible from all areas of the TGA, especially the uninsured (20% of the TGA's PLWH due to our large undocumented population) for whom access to HCV treatment is difficult

Components of the HCV Co-Infected Clinic

- Screening for HCV annually as clinically indicated (a TGA Standard of Care) results in between 1% and 3% positive HCV screening tests; all Hep C antibody + patients are included as possible candidates for HCV Treatment
- Once the diagnosis of chronic HCV infection has been made, the Nurse Practitioner conducts a Hepatitis Specific Medical Visit that incorporates an evaluation of potential HCV treatment with patient counseling on Safe Sex, Transmission Risks, Education on abstaining from alcohol, Vaccination against the Hepatitis A and Hepatitis B if appropriate
- The HCV clinic recognized the need for a comprehensive approach during evaluation for HCV treatment, including management of medical and social issues that may prohibit treatment, support needed during treatment, and careful monitoring and management of treatment responses and treatment complications
- The patient's assigned Part A Medical Provider in collaboration with the HCV Nurse Practitioner addresses health issues that may make treatment more difficult or less effective (e.g. poorly controlled diabetes with insulin resistance), and any conditions that are current contraindications

Components of the HCV Co-Infected Clinic (cont.)

- The HCV Nurse and Nurse Practitioner jointly complete the lengthy approval process to get access to HCV medications.
- The patient's assigned Part A Medical Case Manager and HCV Nurse help to ensure that the social and psychological determinants of adherence are addressed to optimize patient tools for success and eliminate barriers (e.g. depression, substance abuse issues)
- Medical Case Manager(s) are an integral part of the HCV clinic, charged with assisting patients with accessing on-Site Psychiatry and other supportive resources, scheduling referrals and medical appointments and providing supportive counseling to the HCV/HIV co-infected patient
- The multidisciplinary team follows the HCV co-infected patient from Assessment though Discharge with ongoing medical monitoring for patients started on HCV treatment, through discharge from treatment as cured or not completing treatment; patients deemed not ready for HCV Treatment are continually reviewed.

Hepatitis C Clinic Outcomes Measures March 1, 2015 – February 28, 2016

Indicator #1: Testing for Chronic Hepatitis C-confirmation of Hepatitis C Viremia AMA-PCPI

Target: 100% of patients aged 18 years or > with a diagnosis of Hepatitis C seen for an initial evaluation will have HCV RNA testing ordered or previously performed.

Outcome: 100%

Indicator #2: Antiviral Treatment Prescribed

Target: 100% of patients aged 18 years or > with a diagnosis of chronic hepatitis C will receive HCV therapy within the 12-month reporting period

Outcome: 67%

Hepatitis C Clinic Outcomes Measures (cont.)

Indicator #3: Third party treatment regimen approval within 2 weeks of Rx

Target: 85% of patients aged 18 years or > who were prescribed a treatment were approved within 2 weeks of prescribing.

Outcome: 18%

Indicator #4: Immunizations

Target: 85% of patients diagnosed with Hepatitis C will have Hep A and B vaccination as appropriate

Outcome: 78%

Indicator #5: Counseling Regarding Risk of Alcohol Consumption

Target: 85% of patients aged 18 years or > with a diagnosis of hepatitis C will be counseled about the risk of alcohol use at least once within 6 months

Outcome: 100%

Conclusion

- Integration of HCV care into Part A HIV care was recognized as a need due to a high percentage of HCV/HIV co-infected patients already in RW Care
- In it's first full year the HCV clinic evaluated 149 co-infected patients with 100 receiving HCV treatment and of those 98 completed HCV treatment with 94 cured
- The use of existing RW medical and MCM staff facilitated the integration of the HCV co-infected clinic and HIV services are already provided using a multidisciplinary model
- HCV clinical outcomes are tracked along with HIV clinical outcomes as part of the Part A clinic's CQM program.

Acknowledgements

RWJ Barnabas Health, Jersey City Medical Center, Center for Comprehensive Care:

Whitney Bracco, Administrator

Tri Nguyen, Quality Improvement Coordinator

Hudson County Department of Health and Human Services

Office of HIV/AIDS Services (OHAS):

Darice Toon, Director and Ryan White Part A Recipient

Jonique Mosley, RW Supervising Program Analyst

2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Affinity Health Center Rock Hill, SC

Heather McCutcheon, J. Craig Charles, MD

Associate Director, Affinity Health Center, Medical Director, Affinity Health Center

Disclosures

Presenter:

J. Craig Charles, M.D., Medical Director

Advisory Board: Gilead Regional Advisory Boards for Hepatitis C treatment and HIV treatment

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Heather McCutcheon BSW, Associate Director

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Affinity Health Center

- Affinity Health Center (AHC) is a Federally Qualified Health Center committed to our mission, guided by our values and inspired by our vision for a healthy and vibrant community where all people have access to exceptional and comprehensive healthcare.
- AHC started as a not-for-profit HIV service organization (Catawba Care Coalition) in 2000, committed to caring for people living with HIV in York, Chester and Lancaster counties in South Carolina.
- In 2014, AHC expanded services to include primary care for uninsured, underinsured and low-income residents of York County. In 2015, we rebranded as Affinity Health Center, and became a federally qualified health center.
- In 2017, we started treating HCV.

Hepatitis C: Testing, Linkage and Treatment

- One stop shop approach for HCV care and services from testing to cure
  - Rapid testing program for HIV/HCV
    - On-site and off-site rapid testing
  - Referrals coordinated by our Linkage Coordinator
  - Universal screening for HIV/HCV for all new patients
  - Assess and address barriers to treatment
  - Linkage to internal/external resources

Hepatitis C: Testing, Linkage and Treatment

Discussion of system level strategies:

- Board approved policies
  - Opt-out testing for HIV/HCV through primary care new patient intake process
- Leadership and Provider buy in for universal screening
- FOCUS funding 2016-2018 through Gilead
- On-site pharmacy in our new facility- July 2018

Hepatitis C: Testing, Linkage and Treatment

Discussion of clinical approach:

- Universal screening
- Bundled labs
  - Streamline the process
  - Provider ease
  - Consistency with labs ordered

Hepatitis C: Testing, Linkage and Treatment

Discussion of clinical approach:

- Patients testing positive for HCV
  - Referred to ID physician within 2 weeks of testing positive for further tests including viral load, genotype and fibrosis score
  - Primary Care Providers can obtain HCV-specific labs at the first follow up visit if they so desire, thus accelerating the ability to order HCV Rx at first visit with ID physician
  - Medication Access Coordinator assists patients with enrollment in patient assistance programs; prescription sent to on-site pharmacy if insured
  - Patients are notified when medications arrive, adherence visit completed with medication pick up, monitoring labs completed after one month of medications
  - Final proof of cure labs obtained 12 weeks after final dose of medication taken

Hepatitis C: Testing, Linkage and Treatment

Discussion of support staff, strategies and internal resources:

- Linkage to Care Coordinator
- Nursing visit for adherence
- Medical Case Management services
- Mental Health Counselor
- Medication Access Coordinator
- Medication tracking, labs, adherence
- On-site pharmacy

Questions

2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Project SUCCEED: A Data to CURE Project

Amber J Casey, MPH, Deputy Director/Project SUCCEED Director

HIV Care & Treatment Program, NYC Dept of Health and Mental Hygiene

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Data to Care

CDC-developed public health framework

Promotes use of Health Department surveillance and other data to identify people living with HIV (PLWH) and link to them to medical care and other services

Multiple methods:

- Health Department-initiated
- Health care provider-initiated
- Combined approach

The NYC Health Department has applied this framework to HIV and hepatitis C (Hep C) coinfected individuals in a HRSA funded project, locally called **Project SUCCEED**

Project SUCCEED Model

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

Provider Education & Training

Practice Transformation

Case Investigation & Linkage to Care

NYC Health Department
HIV and Hep C Surveillance Registries

Reportable to the NYC Health Department:

HIV surveillance registry (Provider and Laboratory Reporting)

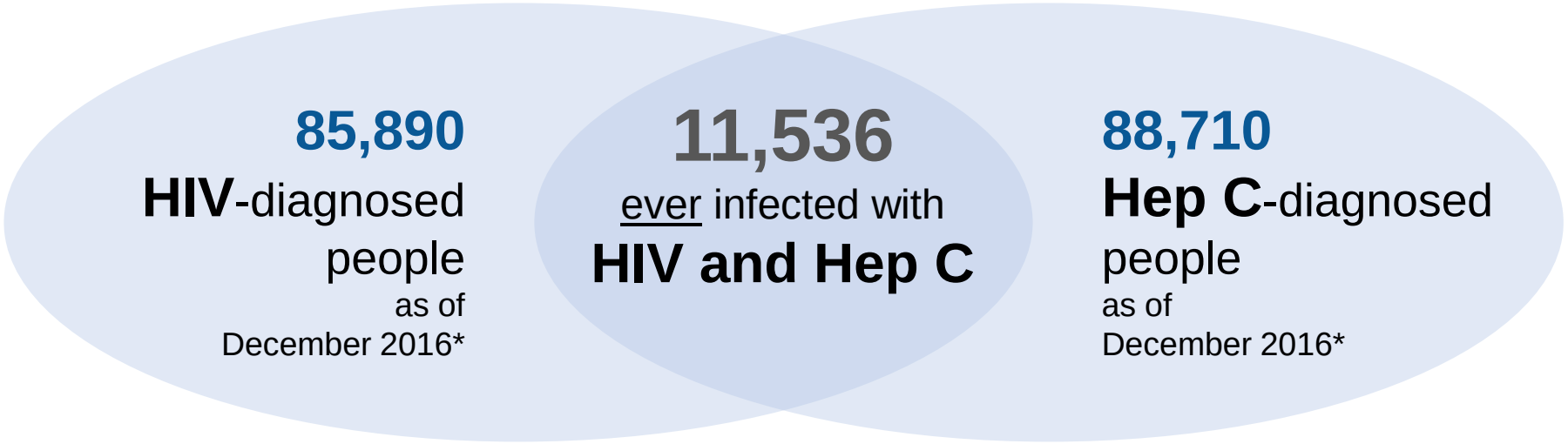
- All HIV diagnosis, viral load, CD4 count, and HIV genotype test results
- Demographic data available

Hep C surveillance registry (Laboratory Reporting)

- Positive antibody, positive and negative RNA, and genotype test results
- Negative antibody tests and Hep C rapid tests results are not reported
- Minimal demographic data available

HIV and Hep C Estimates for NYC

HIV and Hep C surveillance data were matched in May 2016 and May 2017 to estimate prevalence of co-infected population:



4,200 people currently co-infected with **HIV and Hep C** (May 2017)

*To better account for out-migration and deaths, the number of individuals considered to be diagnosed and living in NYC has been restricted to people who had at least one HCV or HIV lab test reported since 2014 and weren't known to have died prior to 2017.

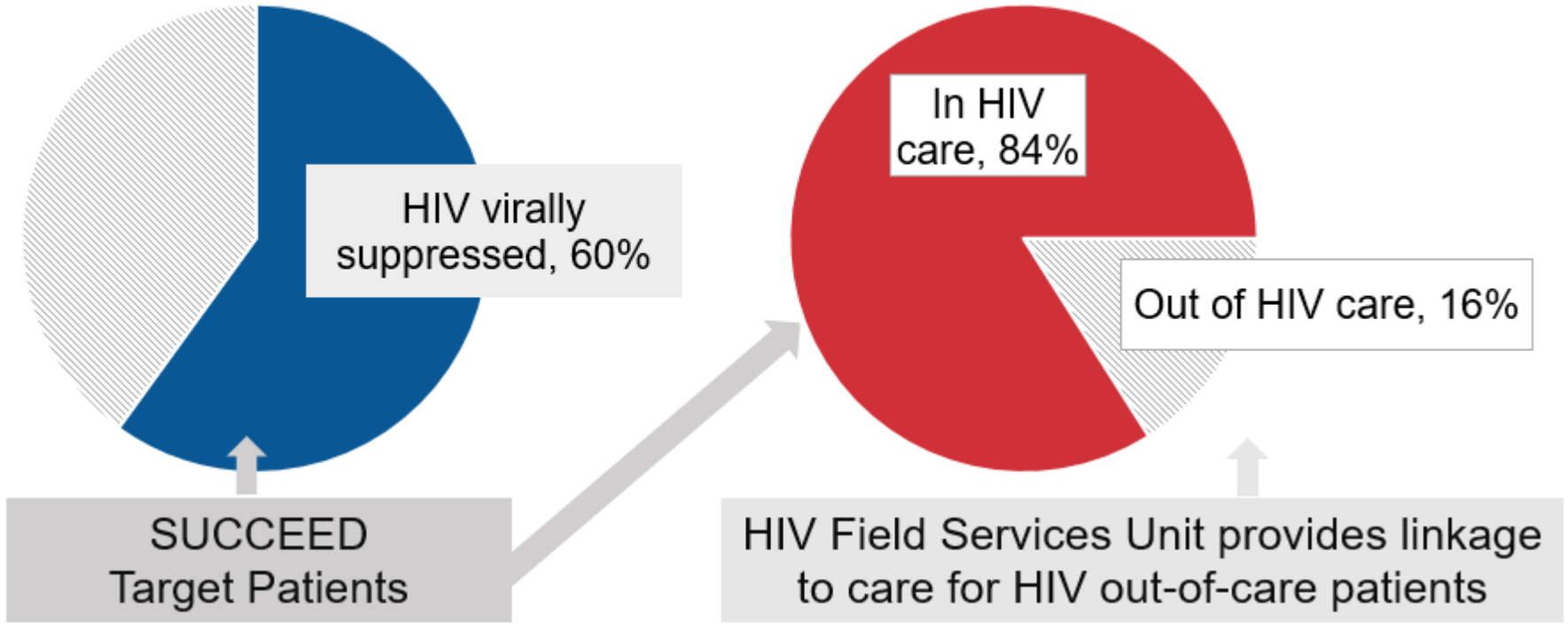
Data to Care Approach

Matched HIV and Hep C surveillance data findings were used to:

1. **Assess patient care status**
2. **Identify facilities** with the highest burden of HIV and Hep C co-infection
3. **Create Hep C dashboards** for HIV health care facilities
4. **Create lists of co-infected patients** for linkage to care or return to care
5. **Conduct a Practice Transformation intervention** with high burden facilities
6. **Monitor** project progress towards Hep C elimination

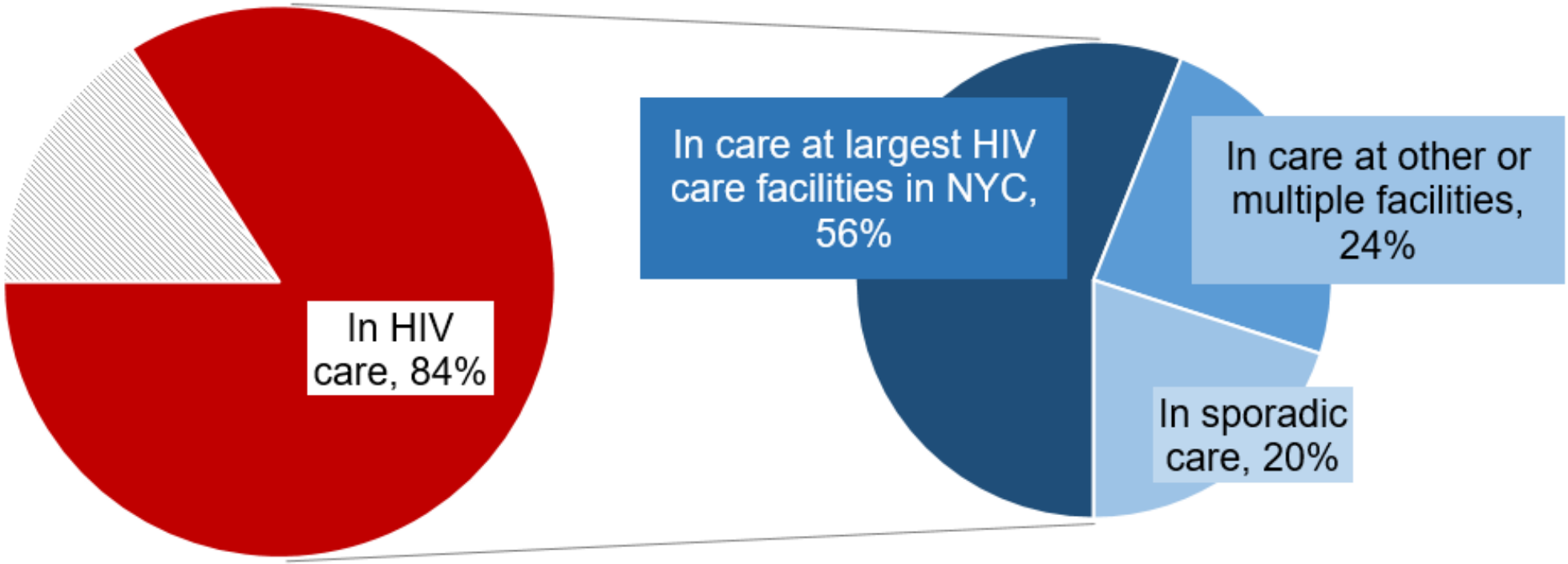
Assessing HIV Care Status to Plan Intervention

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



Care Status of Co-Infected People in NYC

Of the 84% in HIV care:

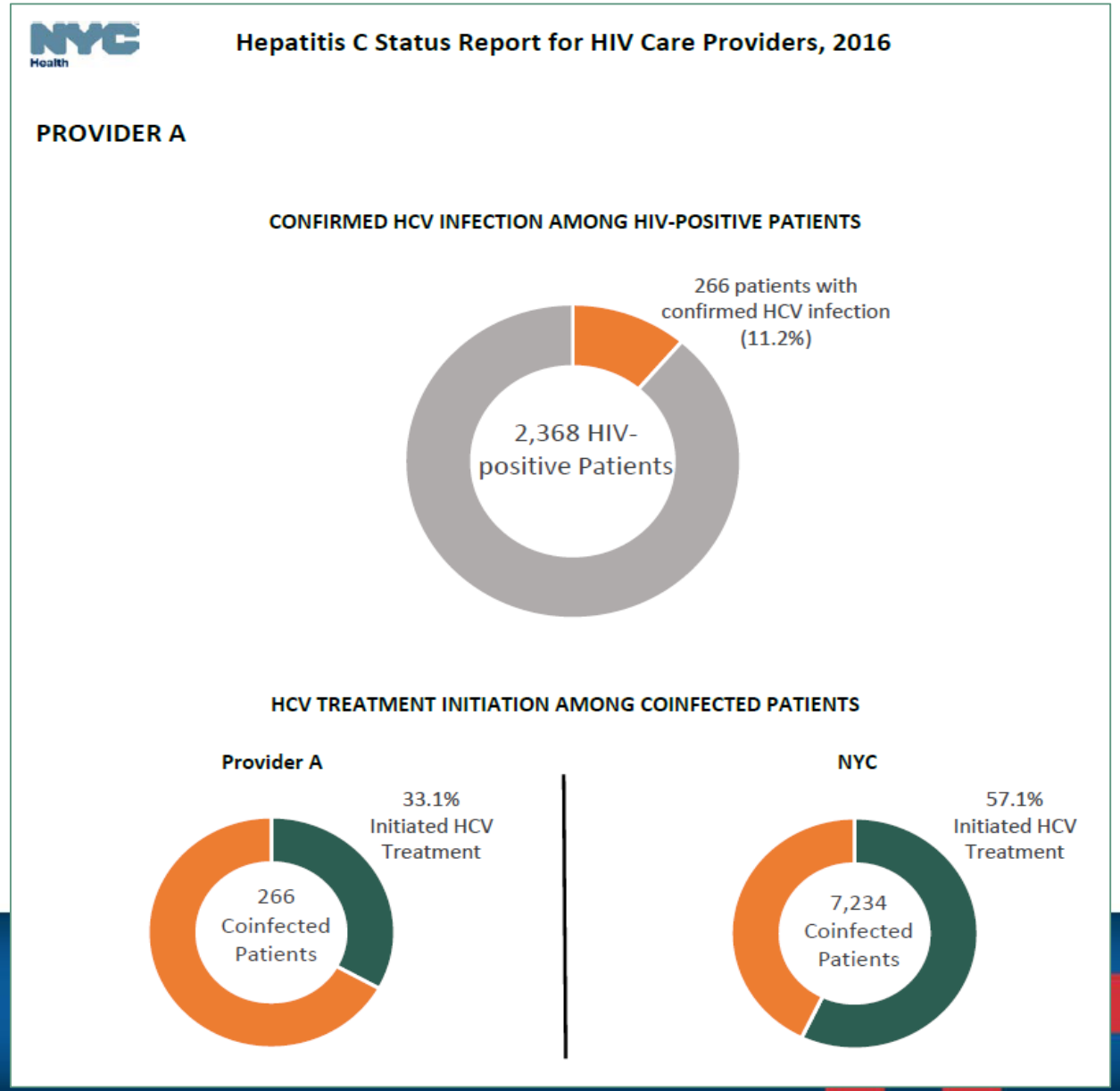


Hep C Dashboards for HIV Care Providers

Dashboards were created for **47** HIV health care facilities, showing:

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

These clinics were offered surveillance based lists of their own co-infected patients to promote Hep C treatment.



Distributing Patient Lists

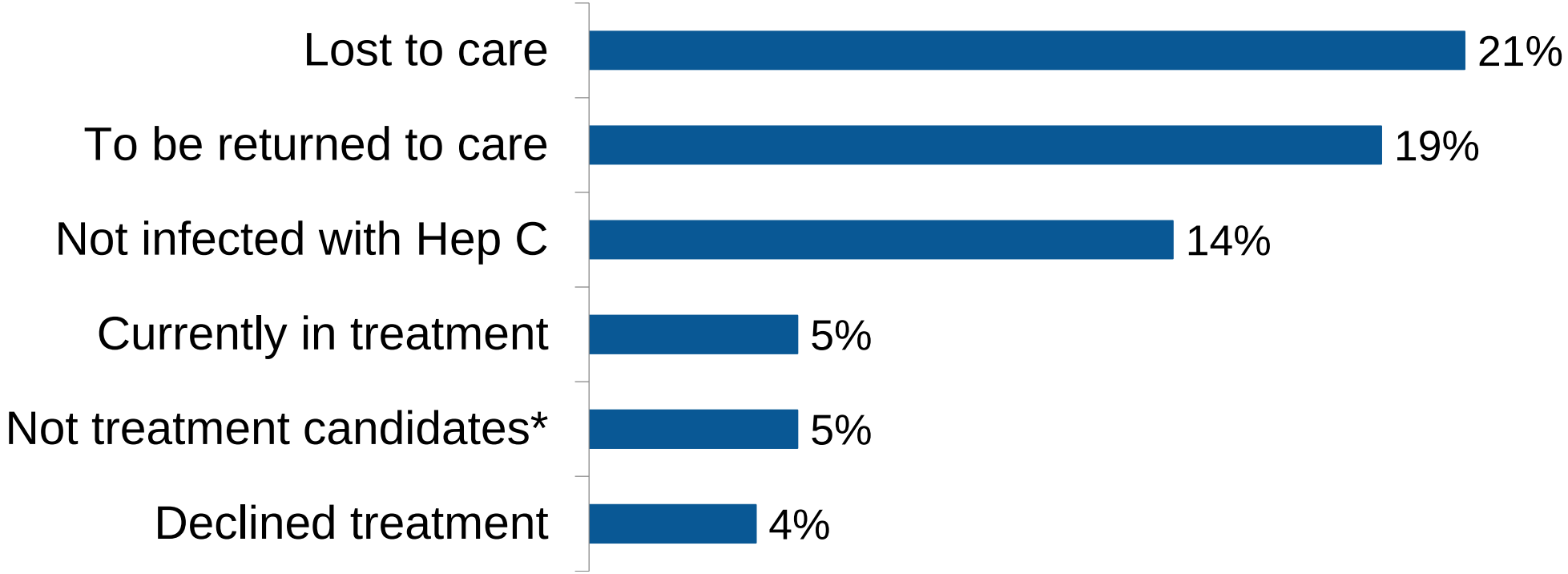
23 facilities accepted a list of their co-infected patients (799 patients in total)

Facilities were asked to:

- Review list and promote Hep C treatment
- Return the list to the Health Department with patient status (i.e. Hep C care status of each patient, treatment barriers)

Patient List Outcomes

12 facilities returned patient lists (406 patients total), of these:



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

Provider Training

Health care providers across NYC were invited to participate in training on patient navigation, care and treatment for Hep C patients. Since November 2017:

109 service providers participated in a full day Hep C Navigation Training.*

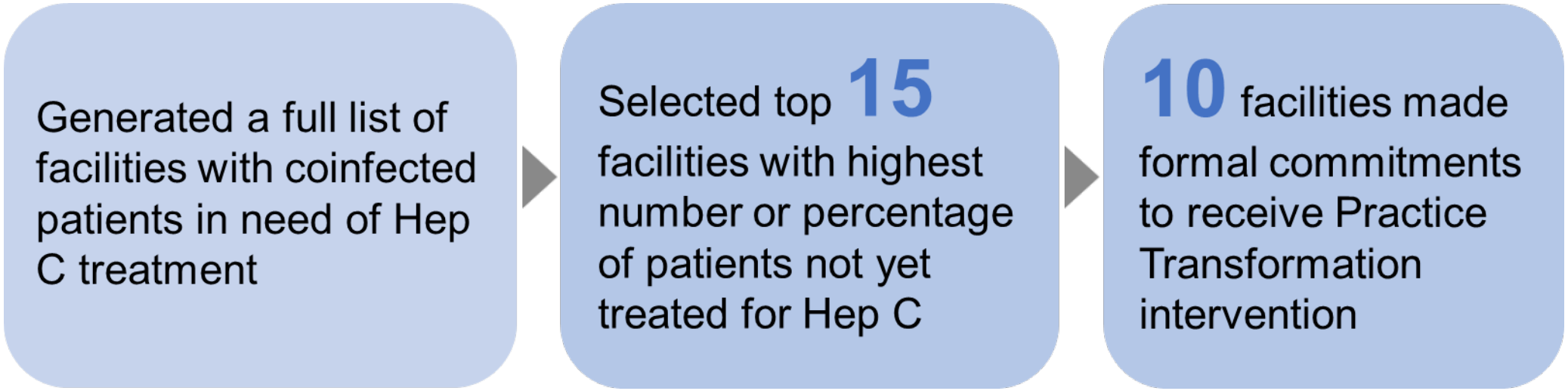
53 HIV clinical providers completed a 10-CME comprehensive online training on Hep C evaluation, care, treatment and monitoring.*

6 HIV providers participated in a half-day preceptorship at a liver clinic.

*Training topics included Hep C medication coverage/prior authorization/patient assistance programs, HIV/Hep C treatment, and co-occurring mental health and substance use disorders.

Practice Transformation Model

Using surveillance data, Health Department identified and recruited facilities



Health Department supports facilities to:

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

Practice Transformation Project

EHR Query Support

Facility runs query to assess baseline, monitor progress and generate up to date patient lists:

- Number and rate of PLWH screened for Hep C
- Number of PLWH who are in need of Hep C treatment
- Generate lists of patients in need of screening or treatment

Hep C Service Improvement Plan

Health Department supports facility to create the plan at baseline

Facility submits interim progress report and final report with sustainability plan

Practice Transformation Methods & Tools

Methods

- Introductory presentation and call
- Brief needs assessment
- Three site visits
- Training
- Technical assistance

Project Tools

- Organization profile
- Screening report
- Hep C service and workflow description
- Hep C Service Improvement planning worksheet (SMART)
- Electronic Health Record Query Tool

Hep C Services Improvement Plans (7 Facilities)

1. Staff Support

- Training and motivation
- Hire staff to fill service gaps (e.g. Hep C testing)
- Clinical mentoring to promote treatment in PWUD (facilitated by a clinical expert)

2. Enhanced Case Management

Use EHR query to update lists of cases in need of screening and treatment

Set up regular case conferences

Develop community outreach capacity (e.g. phone calls, home visits, community health workers)

Identify and utilize case finding tools to return lost patients to care

Hep C Services Improvement Plans (Cont'd)

3. Improve Utilization of Existing Facility Resources

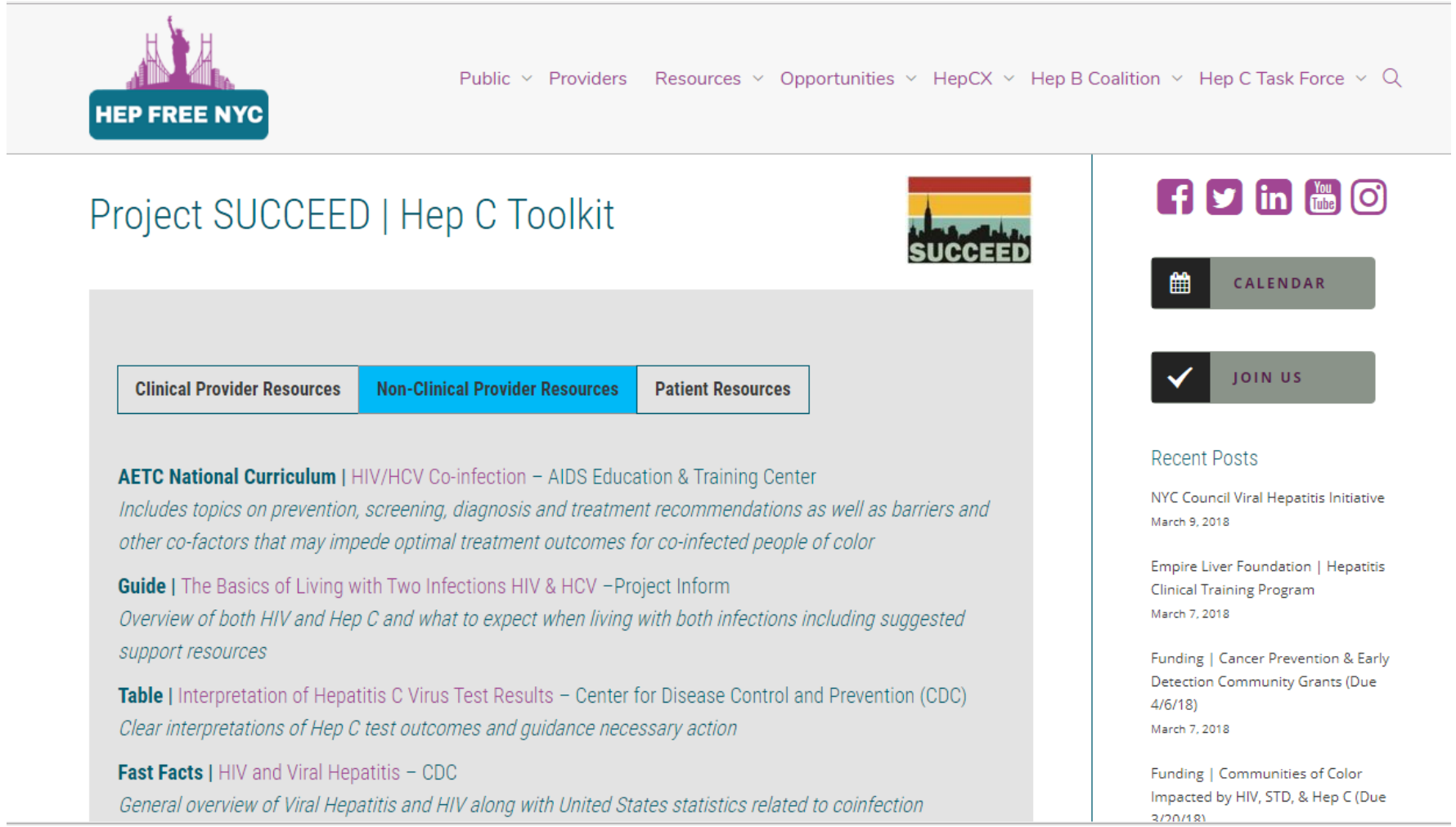
- Support referral to HIV or Hep C navigation, case management and care coordination programs available at the facility
- Leverage 340B to support Hep C navigation staff
- Utilize incentives and other priority resources to promote engagement in care

4. Systems Changes

Develop and implement QI tools to monitor patient status/outcomes and provide feedback to staff

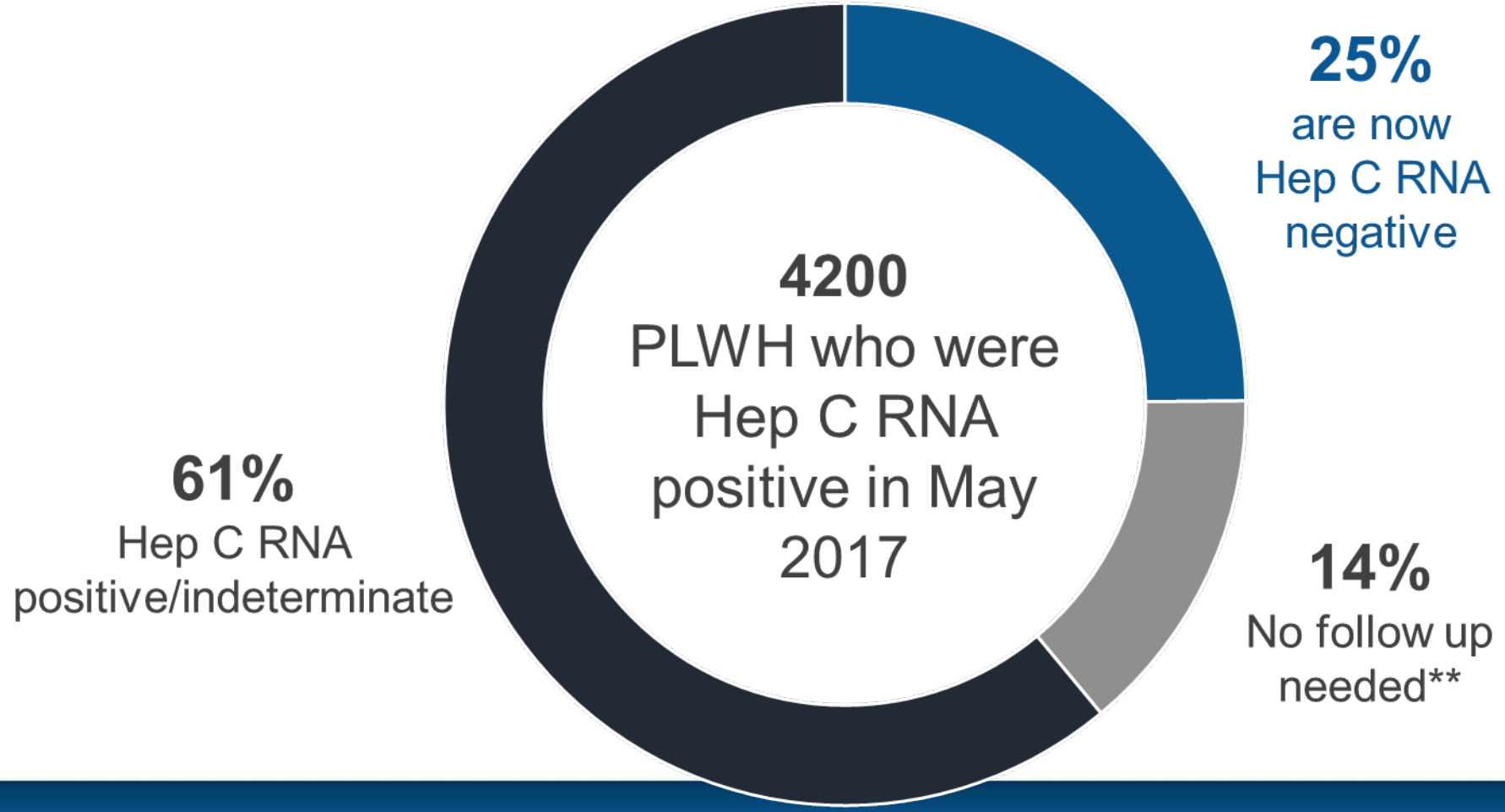
Improve EHR systems (alerts, order sets, auto ordering, patient panels)

Hep C Toolkit



www.HepFree.NYC/ProjectSUCCEED

Progress Eliminating Hep C in PLWH, NYC*
May 2017 – August 2018



*Result at the time of their last test, as of August 30, 2018.
** Deceased, found to be uninfected with HIV or HCV, now living outside of NYC

Outstanding Hep C Elimination Needs Identified through Project SUCCEED

Increased resources for Hep C surveillance

- Enhance surveillance system capacity to enable receipt of negative Hep C antibody test results (to assess screening rates)
- Case investigation resources (to assess demographics and risk)
- Generate surveillance based tools for data to care projects (dashboards, patient lists, facility lists)

Case finding resources

- Tools to assist with finding patients who are lost to care
- Community outreach, navigation and retention in care

Interventions to improve health care facility and provider capacity to provide care for people who use drugs

Disclaimer:

This initiative is funded through the U.S. Department of Health and Human Services (HHS) Secretary's Minority AIDS Initiative Funding (SMAIF) and administered through the Health Resources and Services Administration (HRSA)'s HIV/AIDS Bureau (HAB) through the Special Projects of National Significance (SPNS) Program (Grant number U90HA30517). This information and its conclusions are those of the authors and should not be construed as the official position or policy of HRSA or the U.S. Government. Responsibility for the content of this report rests solely with the named authors.

THANK YOU!!

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INCREASING MEDICATION ACCESS FOR HIV/HCV CO-INFECTED INDIVIDUALS IN LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

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DISCLOSURES

Presenter has no financial interest to disclose.

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PESG, HRSA, and LRG staff as well as planners and reviewers have no relevant financial or nonfinancial interest to disclose.

Commercial support was not received for this activity.

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WHAT IS LA HAP?

- The Louisiana Health Access Program (LA HAP) is the ADAP for the state of Louisiana.
  - LA HAP provides drug assistance for uninsured individuals and premium/cost share assistance for insured individuals
  - Clients eligible for Medicaid are not eligible for LA HAP benefits
- LA HAP is available to applicants who:
  - Are HIV positive
  - Live in Louisiana
  - Have an income below 400% of the Federal Poverty Guideline (FPL)
  - Do not have full Medicaid benefits nor are eligible for full Medicaid

HISTORY

- Medicaid expanded in Louisiana July 1st 2016
  - Population of LA HAP clients was cut in half
  - In early 2017, LA medical providers voiced concern over Medicaid's limited coverage of Hepatitis C treatment regimens
  - Individuals were denied treatment until they entered an advanced stage of the disease
  - Appeals to Medicaid to reconsider HCV treatment policy were unsuccessful due to financial strain on state Medicaid program
  - Due to this financial strain eligibility requirements were stringent
- LA HAP worked with HRSA to create the LA HAP HCV program for HIV/HCV co-infected individuals with limited cost assistance options for HCV treatment

LA HAP HCV PROGRAM

- In February 2017 LA HAP began accepting applications for limited services for:
  - Co-infected individuals with HIV & HCV
  - Currently enrolled in full Medicaid
  - Not eligible for HCV treatment through Medicaid

APPLICATION PROCESS

1) **Applicant submits completed two page LA HAP HCV application**
   - **Required: Denial letter from Medicaid provider indicating that they have been denied coverage of an HCV treatment regimen**
2) **Medical provider completes the Supplemental Form for Hepatitis C Regimens**
   - **Required: laboratory results**

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LA HAP HCV APPLICATION

1) General eligibility information
   - Client attests to being co-infect HIV/HCV individual, currently enrolled in full Medicaid, & applying for assistance with HCV medications only
2) Contact Information
3) Demographic Information
4) Income & Household Size
   - Self reported only, no documentation required
5) Provider/Case Manager Information
6) Client Responsibilities and Release of Consent

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SUPPLEMENTAL FORM FOR HEPATITIS C REGIMENS

1) One page form completed by Medical Provider with laboratory results confirming
   - Baseline complete blood count
   - Hepatitis C Genotype
   - Baseline Hepatitis C RNA viral load (within the last 3 months)
   - CD4 count (within the last 6 months)
   - HIV viral load (within the last 6 months)
2) Pharmacy from a specified network is chosen by client/provider
3) Ramsell, the contracted PBM (pharmacy benefits manager) for the LA HAP program, reviews the appropriateness of therapy
   - If therapy is approved by Ramsell Clinical Department the prior authorization is forwarded to the pharmacy/prescriber

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REVISED DOCUMENTATION REQUIREMENTS

- **Received feedback that obtaining a Medicaid denial was a major barrier for patients obtaining treatment**
  - Due to financial strain on LA state Medicaid additional tests were added for treatment access
- **After conversations with Medicaid, providers, HRSA, & Ramsell we were able to ease some eligibility requirements**
  - October 2017: in lieu of Medicaid denial letter LA HAP accepts FibroSure test results as an indication of presumed treatment coverage denial
- **If a patient's FibroSure test result indicates a fibrosis stage of:**
  - F0-F1 or F1-F2: LA HAP will presume client will be denied treatment by Medicaid and LA HAP will NOT require a Medicaid denial letter
  - F3-F4: Coverage of their treatment by Medicaid is likely and LA HAP will continue to require a denial from Medicaid

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RESULTS OF LA HAP HCV PROGRAM (3/3/17-4/1/18)

Characteristics	n	%
Total	42	100%
Gender		
Female	14	33%
Male	27	64%
Transgender	1	2%
Ethnicity/Race		
Black	25	60%
Hispanic	2	5%
White	15	36%
Age		
13-24	1	2%
25-44	15	36%
45-64	26	62%

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CONCLUSION

- **Streamlined application components and benefits**
  - Eliminating Medicaid denial documentation requirements
  - Eliminating income documentation requirements
  - Two page application & 1 page supplemental form

- **Moving forward**
  - As of July 2018 Medicaid announced the removal of Fibrosis staging documentation for treatment

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http://ryanwhite.cds.pesgce.com

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QUESTIONS?

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