2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

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Jurisdictional Approach to Curing Hepatitis C Among HIV/HCV Co-infected People of Color

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Background

- SMAIF funded Special Project of National Significance (SPNS)
- Three-year project (September 30, 2016 – September 29, 2019)
- Louisiana joined the project in the middle of year 1

Participants & Agencies

- **Health Resources and Services Administration, HIV/AIDS Bureau (HRSA/HAB)**
- **The RAND Corporation** – Evaluation & Technical Assistance Center (ETAC)
- **NASTAD** – Oversees and assist Part B jurisdiction participants
- **Part A Jurisdictions** – Hartford, CT, New York, NY, and Philadelphia, PA
- **Part B Jurisdictions** – Louisiana and North Carolina
- **AETC National Coordinating Resource Center (AETC NCRC) –** manages AETC participation

Goals & Objectives

- **Goals**
  - Cure HCV among co-infected PLWH, focusing on people of color
  - Establish a sustainable HCV care cascade

- **Objectives**
  - Increase jurisdiction-level capacity to provide comprehensive HCV screening, care, and treatment
  - Increase providers'/clients' HCV knowledge
  - Decrease structural/system-level barriers to screening, care, and treatment

Approaches

- Provider and Client Knowledge Assessments
  - Assessed knowledge, attitude, and perception
- Pilot clinic sites selected to increase access to screening, care, and treatment
- Educational programs for clients and providers
  - Conducted by the local AETC and clinic site staff members
- Communities of Practice and Learning (CPL)
  - Convening of expert HCV providers and trainee providers from clinic sites

Evaluation Activities

- RAND developed a multi-site evaluation plan that included formative, process and outcome evaluation. Data sources include:
  - Project Implementation Plan
  - Quarterly activity logs
  - Pre/post provider and client assessment
  - Pre/post provider and client focus groups
  - Jurisdictional site visits
  - Client-level data
- All jurisdictions were also encouraged to develop a local evaluation plan
- NASTAD supported agencies in meeting multi-site evaluation requirements as well as development and implementation of local evaluation activities
  - Customized support to each jurisdiction based on needs

Evaluation Activities

- Debriefed with providers about HCV Report Cards
  - Determined what data was actually measuring
  - Identified data gaps and other data quality issues
- Supported providers in mapping required data elements from three electronic health records (EHRs)
  - Developed simplified crosswalk to identify how data were collected
  - Documented final decisions to support data export
- Reviewed HCV screening decision support in EHRs
  - Identified needed enhancements
  - Provided peer-to-peer resources to support implementation of needed changes

Evaluation Activities

- Implementing CAREWare changes to support monitoring and evaluation of project activities
  - Leveraged work completed by other jurisdictions (Philadelphia and Hartford)
  - Developing protocol/instruction manual for data changes and data collection
  - Adding non-Ryan White contracts to capture Bridge Counselor/Patient Navigator activities
  - Adding in custom variables, custom tabs, custom subforms and custom reports
- All activities intended to not only support project implementation, but sustainability as well
  - Continue to support project implementation
  - Determine impact of project activities
  - Ensure that any implemented changes are sustainable after project end

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Elimination of Hepatitis C Among PLWHIV in Louisiana: Building a Care Pathway and Prioritizing Access

Emilia Myers, ***Viral Hepatitis Coordinator Louisiana Department of Health***

Outline

- Health Disparities
- Gaps (patient-, provider-, system-)
- SPNS Project Framework
- Tool
- Mindset
- Developing a Movement Mindset
- Lessons Learned
- Future Needs

Health Disparities in Louisiana

State Ranking[1]

Health care, 47th

Education, 49th

Economy, 44th

Opportunity, 50th

Infrastructure, 44th

Crime & Corrections, 48th

Fiscal Stability, 48th

Quality of Life, 42nd

Persons Living with HIV/HCV Co-Infection (n=1,143)[2]

- **68%** of dual diagnoses are black. Only **32%** of the state population is black.
- Rates in black males are **4.6 times** higher than in white males.
- **52%** of dual diagnoses indicated injection drug use as mode of HIV transmission.

1 US News & World Report 2018 Rankings
2 Louisiana 2016 HIV/HCV Co-Infection Surveillance Data

Gaps

System-level barriers:

- HCV treatment cost
- Provision of HCV treatment under Medicaid guidelines
- Case ascertainment (existing co-infection among PLWHIV)
- Communication between data systems and EHR needs

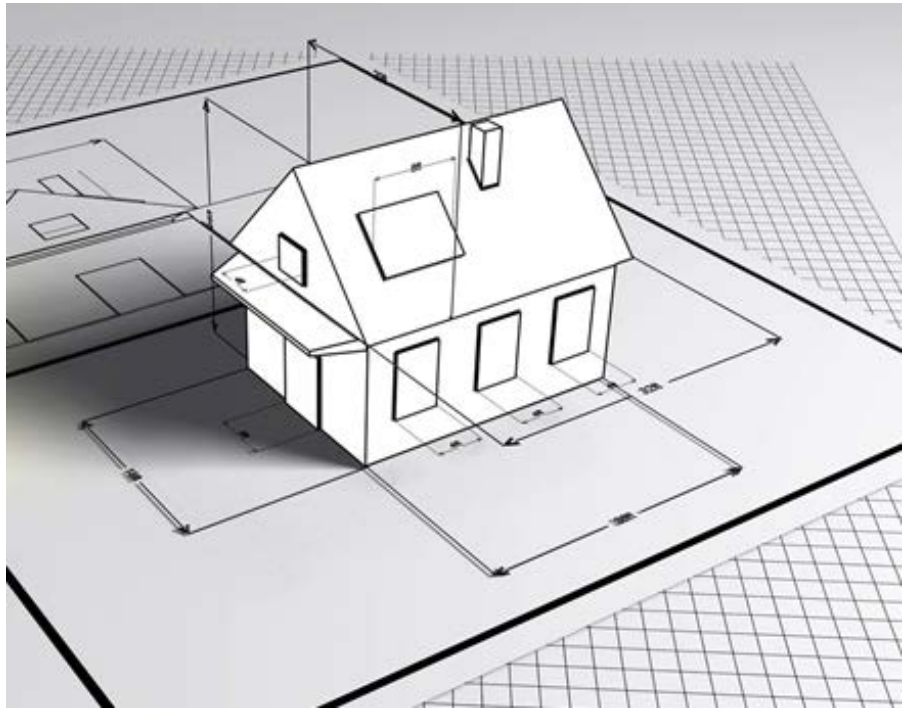
Provider-level barriers:

- Treatment guideline confusion
- Attitudes towards social and behavioral determinants of health
- Provision of harm reduction services
- Gatekeepers

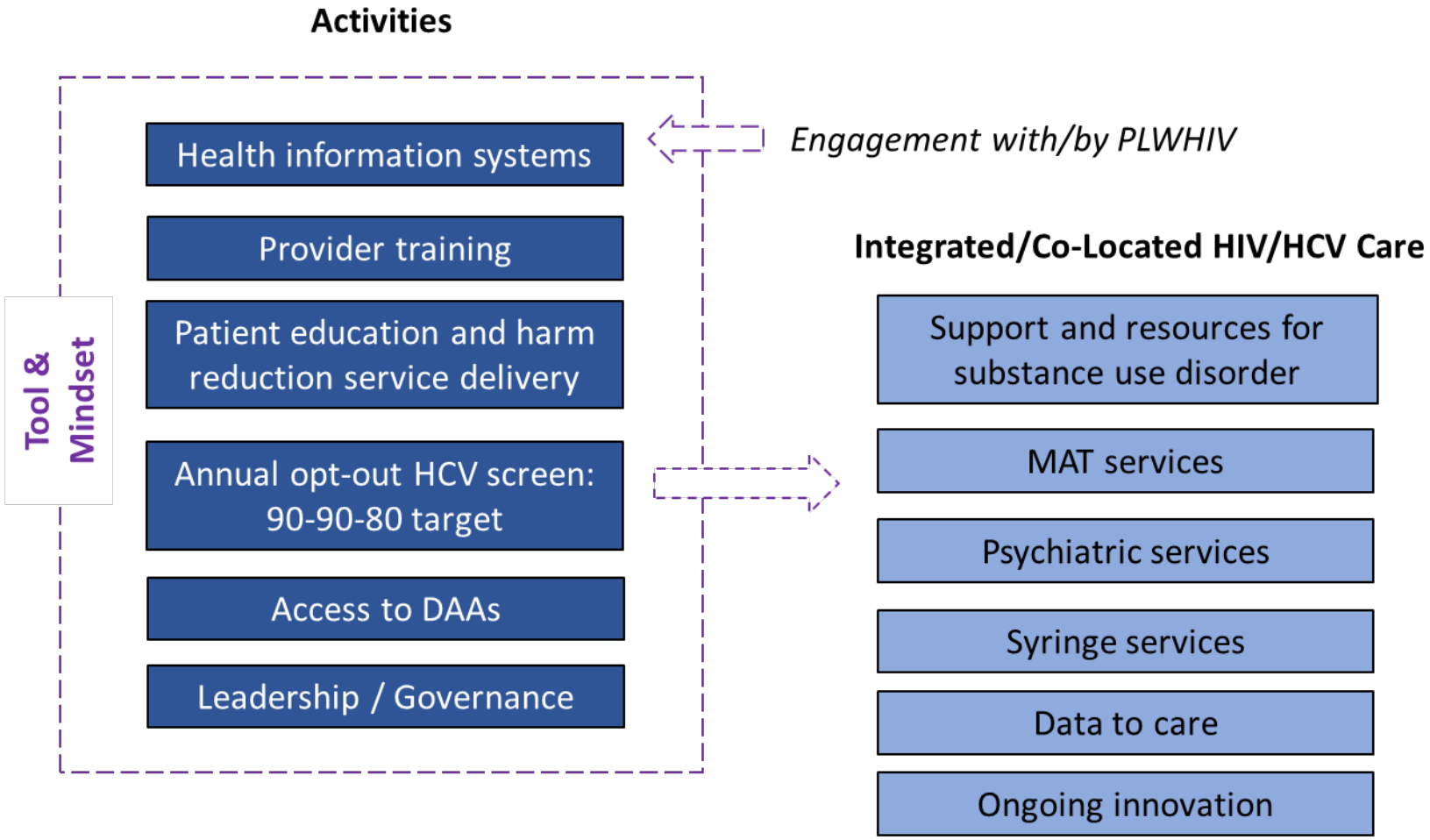
Patient-level barriers:

- Accessing HCV services and healthcare in general, especially around substance use disorder
- Knowledge of HCV symptoms and treatment

How does a State Health Department support development of a Hepatitis C care pathway to achieve cure?

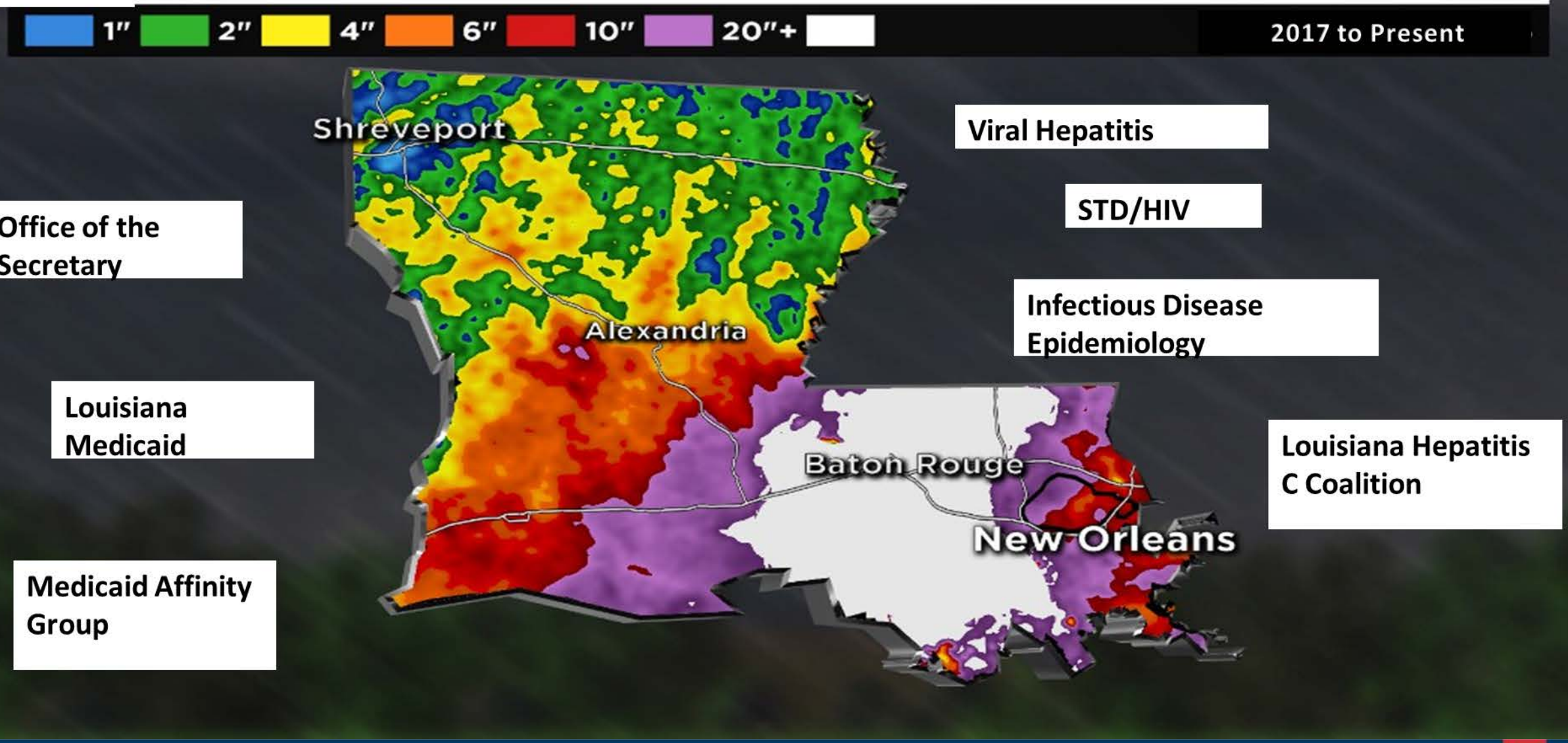


Louisiana SPNS Project Framework



LOUISIANA DEPARTMENT OF HEALTH

PERFECT STORM OF OPPORTUNITY AND COLLABORATION



Office of the Secretary

Louisiana Medicaid

Medicaid Affinity Group

Viral Hepatitis

STD/HIV

Infectious Disease Epidemiology

Louisiana Hepatitis C Coalition

Tool - *Policy*

Ryan White Part B/ADAP Service Delivery: Louisiana Health Access Program (LA HAP)

- Expanded pharmacy eligibility to cover HCV medications
- Removed inefficient processes Medicaid providers went through to submit the request for the HCV cure

90-90-80 Target

- Clinic HCV screening practices
- EHR investment

Louisiana Medicaid Prior Authorization

- Eliminated nonmedical barriers to access (sobriety requirements)
- Removed fibrosis score for HIV/HCVco-infection
- Removed prescriber limitations

Mindset – *Hearts and Minds*

How to go from:

- "I can't treat this issue so I'll just defer on it"
- "I can treat this issue, but it is going to take extra time and work and I'm already overwhelmed"
- "We should refer for Hep C to help manage it"
- "There are so many programmatic changes, I can't keep up with them AND the medical advances/changes in HCV treatment"

To:

- "We can eliminate HIV/HCV co-infection and it is our *obligation* as HIV providers to do so"

Mindset – *Hearts and Minds*

- Hep C Champion
- Provider Trainings
- HCV Report Card and Quality Improvement Meetings
- Hot-topic webinars during Grand Rounds
- Provider and Patient Relationships = patient education, prevention and harm reduction
  - Trust, safety, respect, health, time

Curing HIV/HCV Co-infection Project

[redacted] February 1, 2017 - January 31, 2018

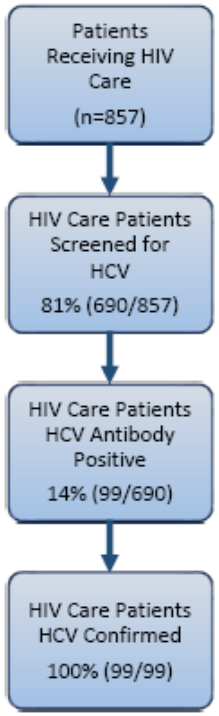
Progress towards meeting 90 90 80 goals:

90% of HIV+ clients screened for HCV in last 12 months

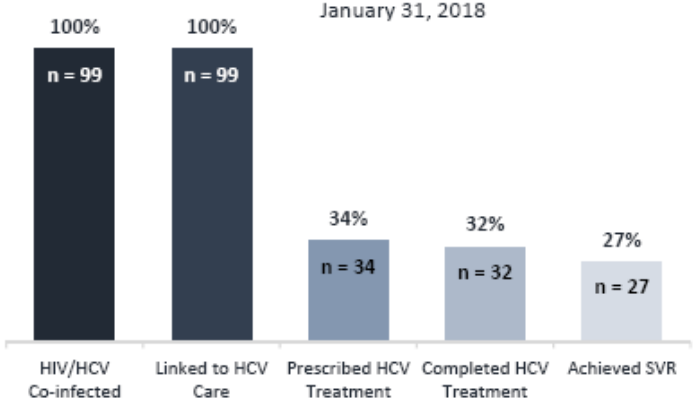
90% of HIV/HCV co-infected clients linked to HCV Care within 90 days of positive HCV RNA test

80% of HIV/HCV co-infected clients completed HCV treatment

Steps to Identify HIV/HCV Co-infected Clients



HCV Care Cascade for HIV/HCV Co-infected Patients at Open Health Care Clinic, February 1, 2017 - January 31, 2018



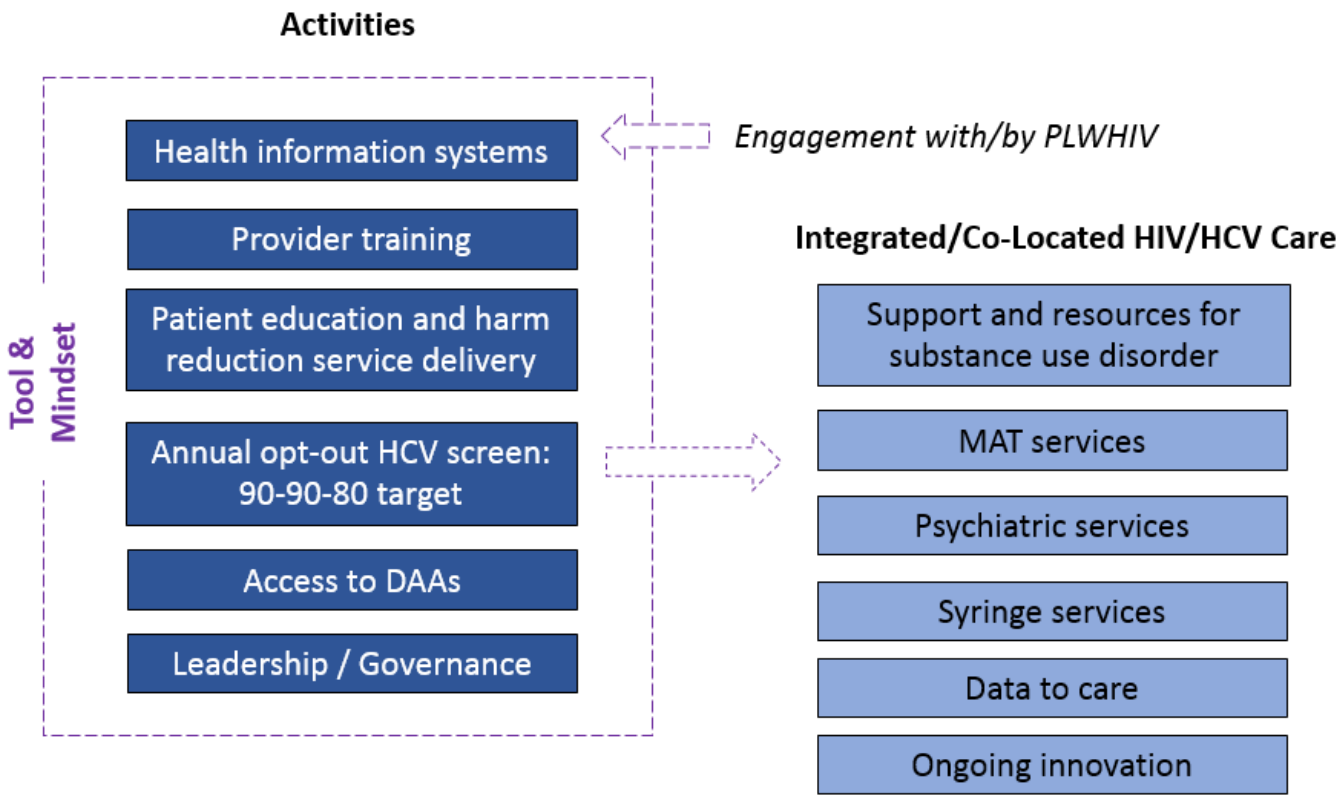
Steps of the HCV Care Cascade

1) HIV/HCV Co-infected: Patients receiving HIV+ care at clinic who are confirmed positive for HCV by RNA testing

2) Linked to HCV Care: Patients who attended initial visit with a HCV medication prescriber within 90 days of first positive HCV RNA test

3) Prescribed HCV Treatment: Patients prescribed HCV treatment
4) Completed HCV Treatment: Patients completed HCV treatment
5) Achieved SVR: Patients who achieved SVR (sustained virological resonse) 12 weeks after completion of HCV treatment

Priorities for Action



System-level barriers:

- ✓ *HCV treatment cost*
- ✓ Provision of HCV treatment under Medicaid guidelines
- ✓ Case ascertainment (existing co-infection among PLWHIV)
- ✓ Communication between systems and EHR infrastructure needs

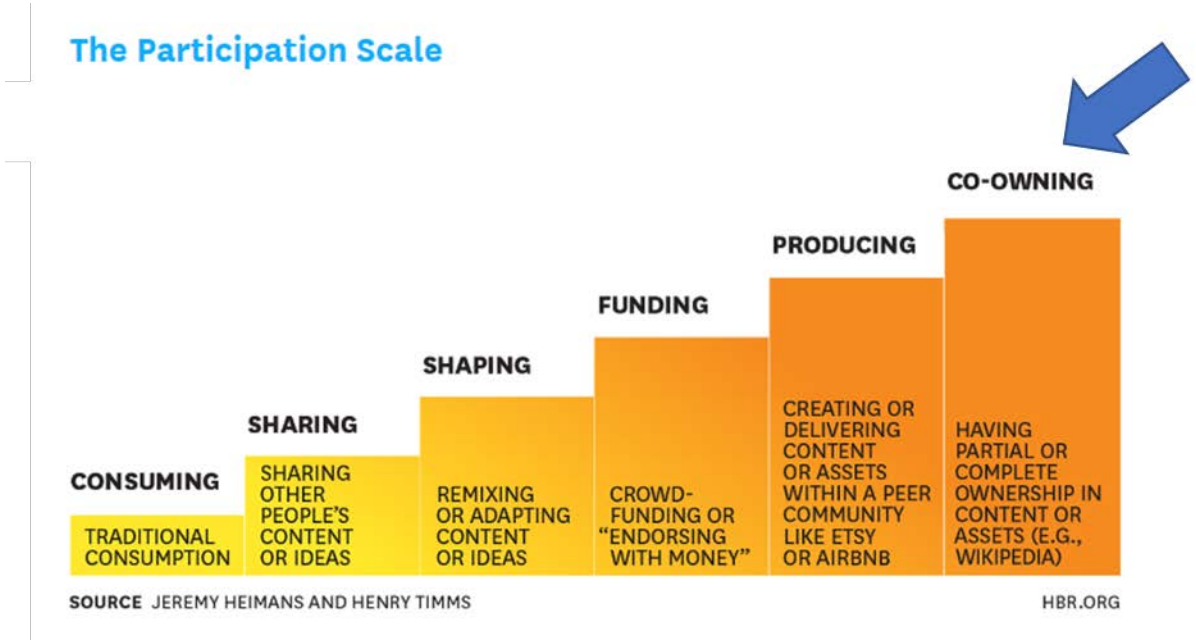
Provider-level barriers:

- ✓ *Treatment guideline confusion*
- ✓ *Attitudes towards social and behavioral determinants of health*
- ✓ *Gatekeepers*
- ✓ *Provision of harm reduction services*

Patient-level barriers:

- ✓ Accessing HCV services and healthcare in general, especially around substance use disorder
- ✓ Knowledge of HCV symptoms and treatment

Developing a Movement Mindset



"We can eliminate HIV/HCV co-infection and it is our *obligation* as HIV providers to do so"

Low-Barrier Asks

- Data sharing and QI monitoring 1x every 6 months
- Non-medical provider trainings
- Engaging PLWHIV on HCV education and harm reduction services

Mid-Barrier Asks

- Hot-topic webinar with CE
- MAT waiver training

High-Barrier Asks

- Annual HCV screen policy
- Time-intensive medical provider trainings
- Participation in external QI/CPL groups
- Development of a stigma indicator

Lessons Learned

Tool v. Mindset… strength in persistence, encouraging buy-in (state and clinic)… be prepared to adapt and modify approach.

- **Develop genuine partnerships with people living with HIV/HCV** and consult them on the design and operation of health services.
- **Acknowledge the potential disconnect** between the lived experience of HIV/HCV and the assumptions of health professionals and policy makers.
- **Integration of HCV services** with HIV and harm reduction services is critical to EtE.
- **Identifying and cultivating the right connected connectors** (Hep C Champion) is often the difference between takeoff and fizzle.
- Focus on long term HIV/HCV co-located care model, but also on smaller building blocks to build momentum… **lower the barriers, flatten the path.**
- **Sustainability efforts:** what happens when funding dissolves?
  - Invest in EHR, data to care, and integration of HCV patient education/wrap-around services

Future Needs

- Generate an **evidence-base** for which HIV/HCV interventions work vis-à-vis policy and practice brief

- **Expand flexibility of federally funded HIV programs** to support integration with HCV programs

- Raise and prioritize the profile and understanding of **stigma** as it relates to HIV/HCV care

We can eliminate HIV/HCV co-infection and it is our ***obligation*** as HIV providers to do so.

Questions?

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