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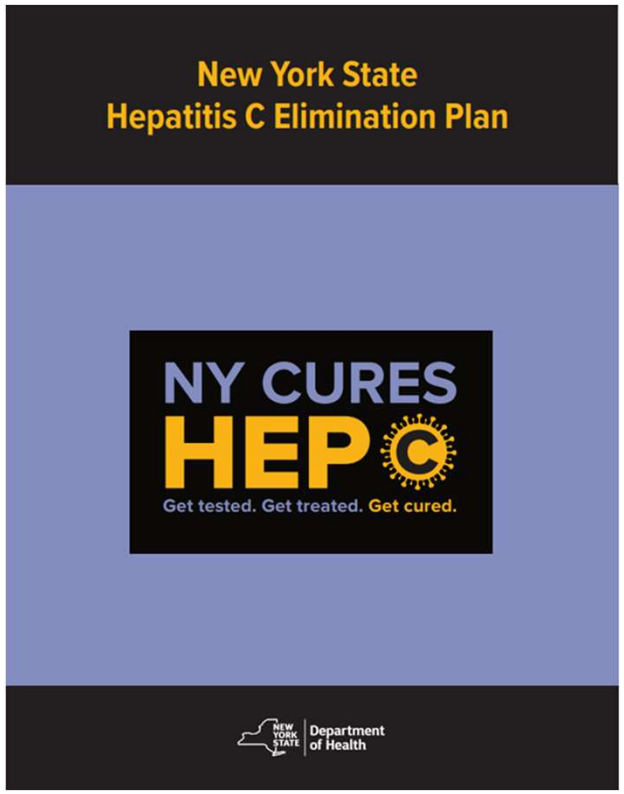
Innovative strategies to identify and link people with hepatitis C to care and treatment

Innovative and Promising Practices for Hepatitis C Elimination

May 15, 2024

New York State Hepatitis C Elimination Plan



- Identified **priority populations** that will be most impacted by implementation of recommendations.
- Identified **priority settings** that will lead to successful implementation of elimination recommendations.
- Outlined **recommendations** to expand the reach of health care settings.

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Recommendations Outlined to to Expand the Reach of Health Care Settings

- Facilitate screening and diagnosis through electronic medical records systems (TLC4)
- Design screening, linkage to care and treatment delivery models to better engage complex patient populations (TLC8)
- Expand patient navigation and outreach programs (TLC10)
- Increases resources for vulnerable population and address patient barriers to treatment (CTA2, CTA5)
- Increase use of telehealth to reach underserved populations (CTA6)
- Improve access to health care at syringe exchange programs (SDH4)
- Focus efforts on key populations who the health care system has historically not engaged (SDH7)

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Innovative strategies to identify and link people with hepatitis C to care and treatment

Innovative and Promising Practices

- **Data Analysis of Hepatitis C Testing and Treatment to Meet Elimination Goals**
  Dr. Aarathi Nagaraja, MD, CPH, Mary Correa, and Aldonza Milian, Sun River Health

- **Utilizing Telehealth for Hepatitis C Treatment within a Syringe Exchange Program**
  Miraf Kassew, BS, Lauren Estby, MSW, and Brian Hennessey, MPH, Housing Works

- **Community Health Worker Facilitated Hepatitis C Telehealth Model**
  Reginald Idlett, REACH Program, Mount Sinai Hospital

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Data Analysis of HCV Testing and Treatment to Meet Elimination Goals.

Dr. Aarathi Nagaraja (Arthi) - Quality Medical Director HIV/Hepatitis Programs

Aida Milian - AVP Grant Funded services

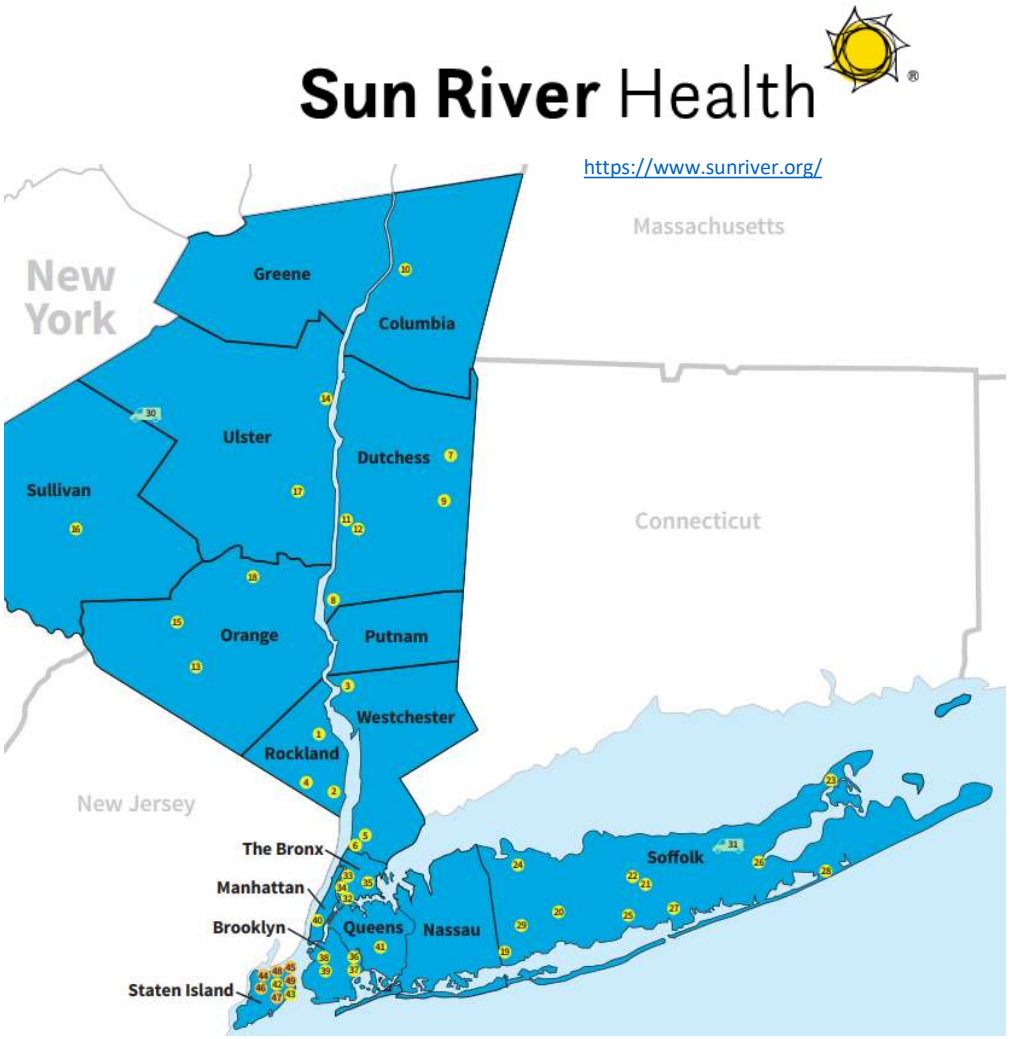
Mary Correa - Senior Director of RAP and HCV initiatives

Sun River Health, FQHC in NYS.

Sun River Health

Large FQHC in NYS, serving 16 counties in NYC, Hudson Valley, and Long Island regions

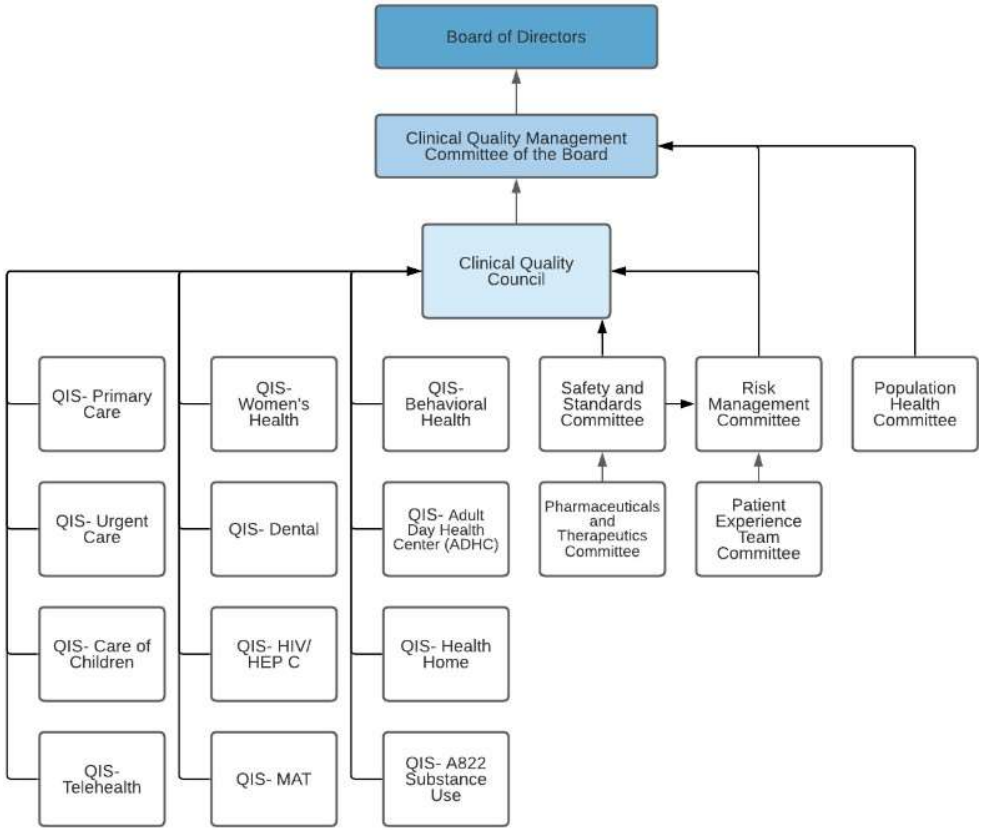
53 clinics in total, 16 of them provide integrated HIV/HCV/HBV/STI/PrEP/MAT care within a primary care settings. The latter is referred to internally as the Genesis program to decrease unintended or subconscious bias and stigma.



QUALITY PROCESS

The Genesis Program is an integrated component of the Sun River Health Clinics.

Sun River Health has a robust Quality Management Program that oversees grant deliverables, and other quality measures that are important clinically and fiscally for the organization.



HCV testing

Testing is done in various ways –to minimize blood draw, improve on obtaining confirmatory results.

- Brick and Mortar Sun River clinics
  - Primary care visit
  - Specialty visits – HIV/MAT/PrEP/STI
  - Women's health – OB and GYN
  - Mental Health clinics
  - Urgent care
  - Telemedicine and in person hybrid models are offered for all of these services
    - If telemed – lab draw visits are scheduled with the help of nursing or front desk teams
- Outreach testing
  - Mobile vans and off-site testing
  - Inpatient and outpatient detox and rehab programs (standing orders and order sets shared)
  - Methadone clinics
  - Shelters
  - Syringe Exchange Programs
  - Homeless Shelters
  - Housing programs and pantries
  - DOH events/Health fairs
  - Target Youth: Job Corps, colleges
  - Group education on harm reduction and HCV treatment given by care teams at these outreach sites
- Link to improve population health
  - Outreach to the criminal justice system
  - Overdose vigils
  - Advertise that Community-based case management
  - Naloxone training to all staff, and offered at onboarding to new staff
  - Point of care testing is also done at outreach

HCV testing

- As part of the USPTF recommendation to expand screening to all adults from 18 to 79 years in 2020 and to align with HCV elimination goals for NYS:
- QI initiative was started around 2020, midst of COVID-19.
- We advertised to use of Order sets – which had HCV ab reflexed to viral load.
- If the antibody was positive in the past, providers were advised to order viral load alone
- EMR and informatics data platforms already existed for baby boomers and those with HIV, and we changed the denominator to capture all those 18 years of age or older.
- This integration allowed us to drill down regional, site, and patient level data.
- Testing was discussed as aggregate in leadership meetings and in regional and site level quality meetings at monthly to quarterly intervals.
- Site medical directors were encouraged to do PDSA projects.
- In 2023, we rolled out patient-specific alerts in our EMR, which notifies providers on the day of the visit that an HCV test is needed for an individual patient. The templates and order sets allow the provider to order the HCV Antibody reflex to the VL test with a singular click in the progress note. Thus, we have significantly increased our screening.
- Thus far, 70% of our active population has been screened, of which 55% were screened after incorporating the above alerts and order sets in the past four years.
- Informatics maps to pull all HCV orders: antibody, antibody reflex to viral load, viral load alone, hepatitis panels, STI panels, and prenatal panels.

HCV testing

- EMR is linked to an informatics platform at regional, site, and patient levels. Data can be drilled down.
- Thus far, 70% of our active population has been screened.
- In sites with large MAT, HIV, and PrEP burdens, the screening reached close to 80 to 85%.
  - However, these sites, have higher risk populations, need to continue to screen annually
  - Number of HCV individuals screened over the last few years – see attached table

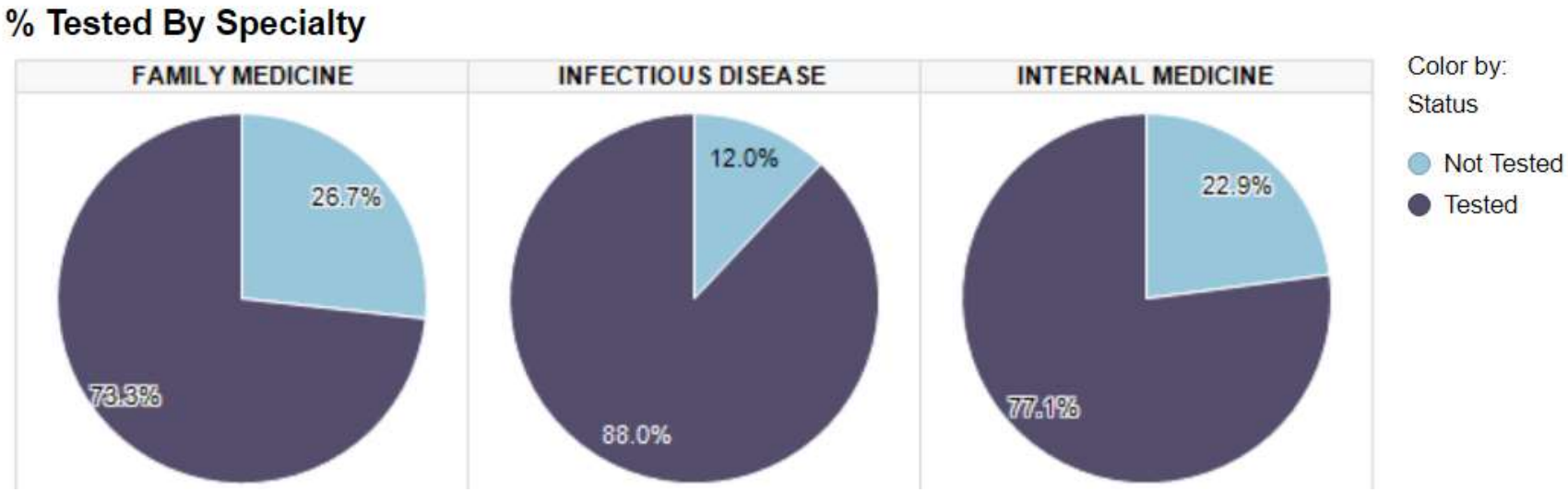
Year	No of clients screened
2020	537
2021	796
2022	896
2023	1683
2024	338

HCV treatment

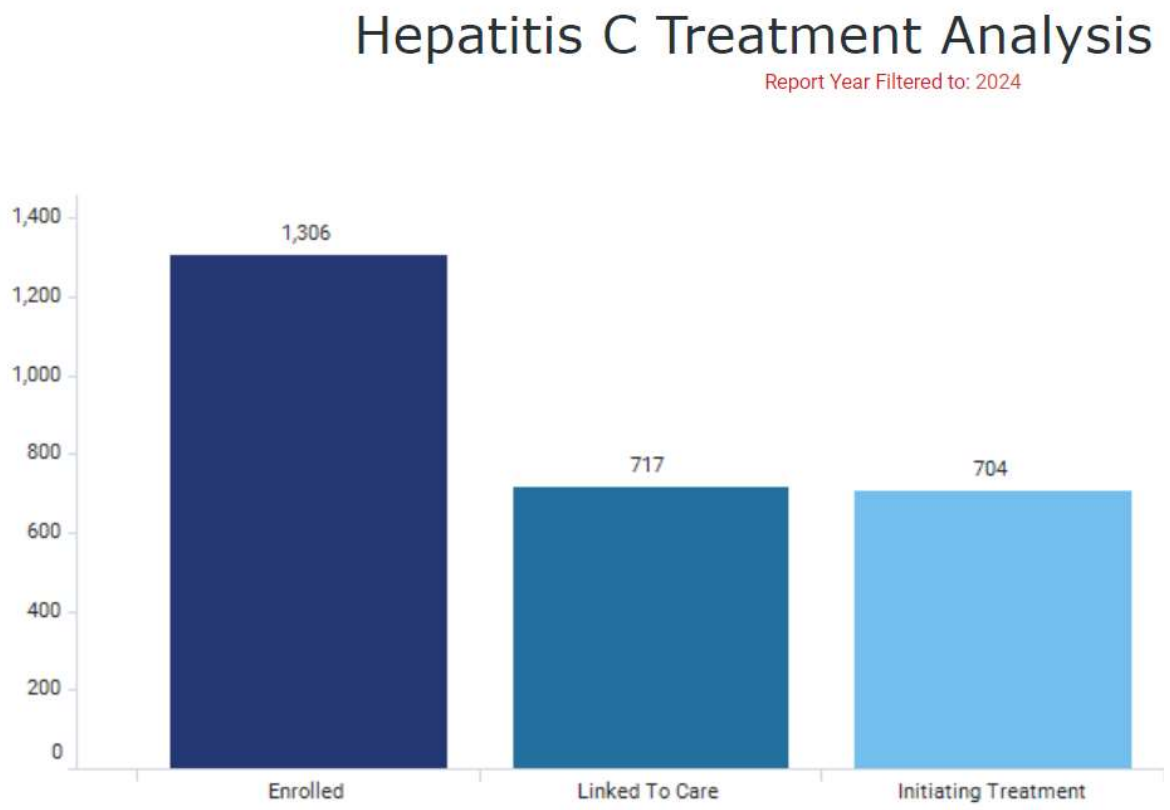
In the last four years, 1013 individuals from 20 to 89 years of age had positive HCV viral load. 40 individuals had low viral loads or self-cleared and thus were monitored. 343 did not start treatment. 192 started treatments but fell out of care, 469 were prescribed/responded to treatment with an undetectable viral load. 9 are currently still in treatment. So, 70% (469) of individuals in care responded to treatment. Many, especially those out of care, had barriers related to social determinants of health, such as mental health, housing, or substance use, and outreach attempts were made through phone or letters.

Row Labels	Count of Treatment
Linked To Care	**670**
Treatment started	**670**
Response To Treatment	469
Response to treatment not yet accessed_to complete treatment	9
Response to Treatment_Not accessed _out of care	192
Linked to care_Out of Care	**343**
Treatment Not Started	**343**
Treatment Not Started	343
Grand Total	**1013**

Example of HCV testing data extraction



Example of HCV treatment dashboard



HCV treatment

- This level of EMR and informatics integration allows for patient-level data to be tracked.
- Data integration has been built over the last few years, but for this submission, manual chart audits for accuracy were done and were required, as SVR rates are hard to capture. So, for this data, we used response to treatment instead of SVR, meaning having a UD viral load after prescribing meds, and most of these were four weeks after medications.
- Manual audits also allow care teams to increase outreach efforts and integration with other providers in mental health, pediatrics, and women's health.
- These dashboards also allow for better case management and provider interface.

Successes and Challenges

Success:

- Collaboration is paramount between administration, quality leads, providers, health center directors, and case management.
- Telemedicine for HCV treatment is well-received by clients
- Most clients remain engaged in care throughout treatment and then move on to other Primary care, MAT or general health care needs.
- Patient education and incentives provide support, enable patients to attend appointments without financial burden, and reduce barriers to care.
- Direct Observation Therapy has proven effective in supporting unsheltered and/or transient patients in remaining retained in care and adherent to medication.
- The Innovative Models of Care targeted, such as mobile vans, outreach events, and HCV treatment in non-traditional settings, has helped.
- Extensive community outreach and partnerships with drug treatment programs and Syringe exchange programs are used to retain and cure individuals

Challenges:

- Maintaining contact with clients who move (phone number, address).
- Gain buy-in from internal care teams.
- Not all sites are equal - aggregate data needs to be looked at the site level because individual sites can underperform while others perform well.
- There are limitations with capacity, phlebotomy, provider, nursing, case management, insurance coverage, SDOHs.
- Competing priorities in any health care model.

Special thank you to our teams

Dr. Aarathi Nagaraja – Quality medical Director for HIV/Hepatitis Care Sun River Health
Dr. Sonia Punj – Quality lead for NYC, Infectious Disease
Dr. Vasanthi Arumugam – Quality lead in Long Island, Infectious Disease
Mary Correa – Senior Director of RAP and Hepatitis C initiatives
Iris Arzu – Manager of Informatics
Nilav Kulkarni – Informatics Analyst
Aldonza Milian – AVP of grant funded clinical services, Sun River Health

Case management teams – Hudson Valley, New York City and Suffolk County

Laura *Marissa Savage, Gloria Baker, Jennifer Zupan, Jamel Bailey, Medesa Garrett, Sarah Usher, Alex Ortiz, Carl Tyler, Shannon, Kelly Riordan, Dawn Walters and Denise Williams, Cara DeFilippis, Melvin Skinner, Jacqueline Pabon, Kerri Richmond, Christine Papa*

And all the providers who provide HCV care across the regions.

Utilizing Telehealth for Hepatitis C Treatment Within a Syringe Exchange Program

Presented by:
Lauren Estby
Brian Hennessey
Miraf Kassew

About Us

Housing Works is a healing community of people living with and affected by HIV/AIDS. Our mission is to end the dual crises of homelessness and AIDS through relentless advocacy, the provision of lifesaving services, and entrepreneurial businesses that sustain our efforts.

SERVICES

- Primary Care
- Sexual Health Services
- Behavioral Health & Substance Use
- Case Management

HEALTHCARE CENTERS

Park Ave Health Center
1751 Park Ave, New York, NY

HEALTHCARE CENTERS

Westside Health Center
326 W 48th St
New York, NY

HEALTHCARE CENTERS

Downtown Brooklyn Health Center
57 Willoughby St, Brooklyn, NY
718-277-0386

HEALTHCARE CENTERS

East New York Community Health Center
2640 Pitkin Ave, Brooklyn, NY
718-277-0386

HEALTHCARE CENTERS

Keith D. Cylar Community Health Center
743 E 9th St, New York, NY
718-277-0386

HEALTHCARE CENTERS

Housing Works - Positive Health Project
301 W 37th St #3, New York, NY 10018

Federally Qualified Health Centers in Manhattan and Brooklyn

Harm Reduction Sites

Housing Works HCV Care and Treatment Program

6/1/2021 - 5/1/2026

- AIDS Institute initiative to support primary care-based integrated models of HCV care and treatment health care facilities that will: 1) increase the number of people living with HCV who are linked to care; 2) increase HCV treatment initiation and completion rates; and 3) increase the number of people cured of HCV.

- Accomplished by conducting targeted outreach and recruitment, linkage and care coordination for those currently underserved and socially disadvantaged with HCV and HIV/HCV in accessing timely HCV medical care and appropriate supportive services.

- Focus on building relationships with external community-based organizations with patients at high risk for Hep C who are not connected to PC services

Case Conferences

Adherence Support

Peer Support

Hep C Education/ Reinfection Counseling

Incentives

Care Planning

Referrals to Harm Reduction/ Case Management

Mental Health Referrals

Integrated Model of Care to Achieve Cure

Care team includes Medical Provider, Patient Navigator, Nursing, Case Management, Hep C Peer and Nursing working in tandem to support client through treatment and to cure

Standard of Care for Hep C Care and Treatment

HCV Care and Treatment Program Timeline

1st

Hep C Initial Medical: Initial meeting with provider and navigator + lab work

2nd

Lab Review and Case Conference: 2 weeks after initial visit

3rd

Treatment Initiation: 3 weeks after initial visit; client will pillbox weekly

4th

SVR visit: 3 months post treatment completion

HCV Telehealth Pilot for Harm Reduction Clients

- To expand Hep C treatment across the agency and strengthen internal partnerships, the Hep Care and Treatment program began providing primary care telehealth services to eligible harm reduction clients treatment.

- This initiative launched on 6/1/2023 with a goal to eliminate obstacles to treatment, such as the need to travel to a medical facility to see a provider in person. Now, clients can receive both harm reduction services and treatment without having to leave their location

- Pillboxing is provided on-site, and prevention navigators travel to the client's harm reduction location to provide in person support for televisits and care coordination services

HCV Telehealth Workflow

Identifying clients:

Intake

SEP client presents for program intake. HCV rapid performed by SEP Navigator

+ rapid

Harm Reduction Nav record results and assist in client completing HCV bloodwork (standing order)

+ bloodwork

-Brooklyn Hep C Navs will coordinate f/u televisit with DBHC or ENY Provider (televisit)

Enrollment :

Televisit/COMP

-Televisit completed at SEP with Brooklyn based provider

-Brooklyn Nav will be on site for intake, case conference and gift card distribution.

Pillboxing

-Client will pillbox at SEP for 8-12 weeks

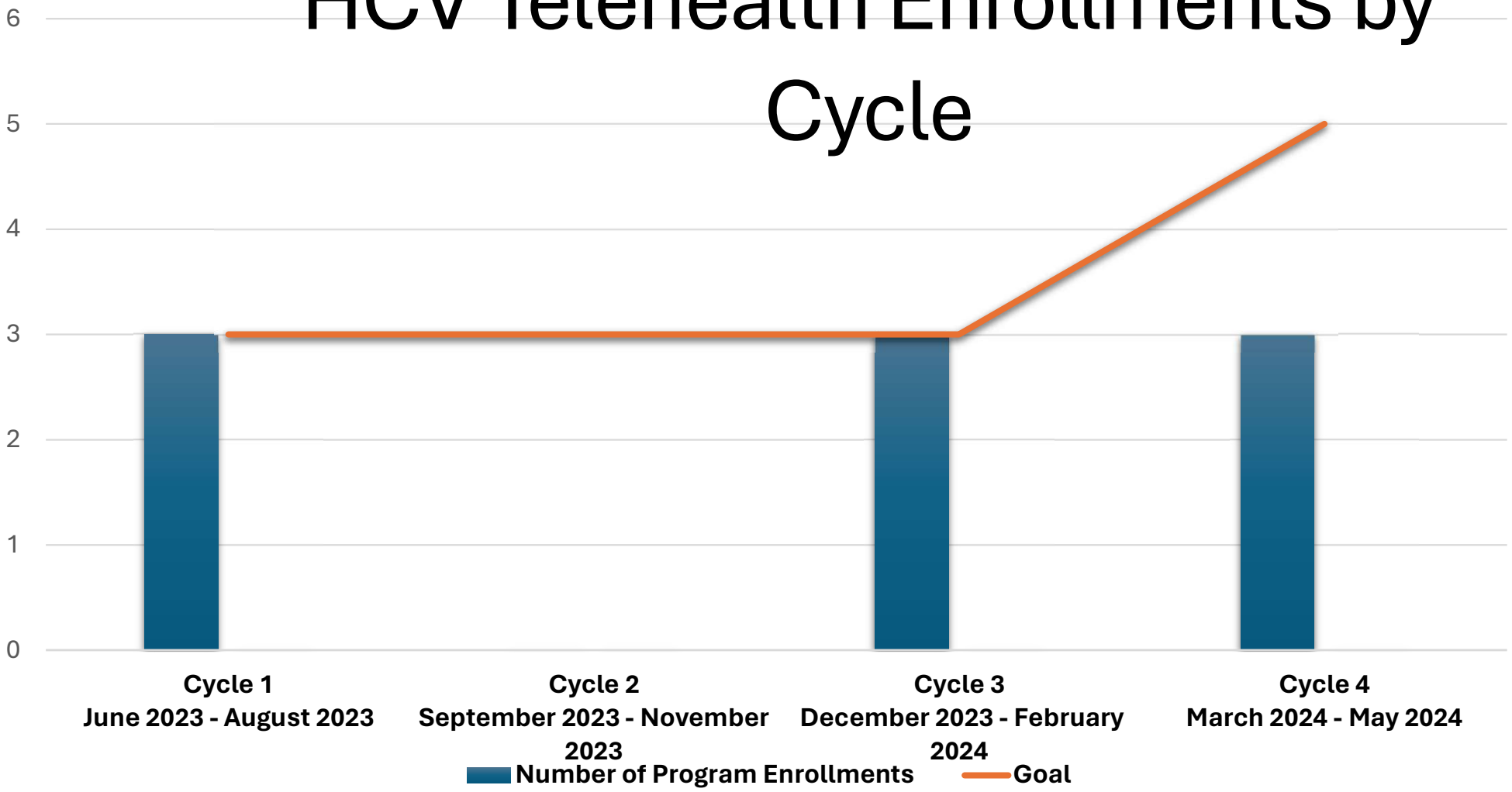
-Brooklyn Nav will provide navigation services for clients both in-person and remotely

SVR Televisit and final labs

-Client will present for 3-month televisit with Provider and perform HCV RNA labs with MA.

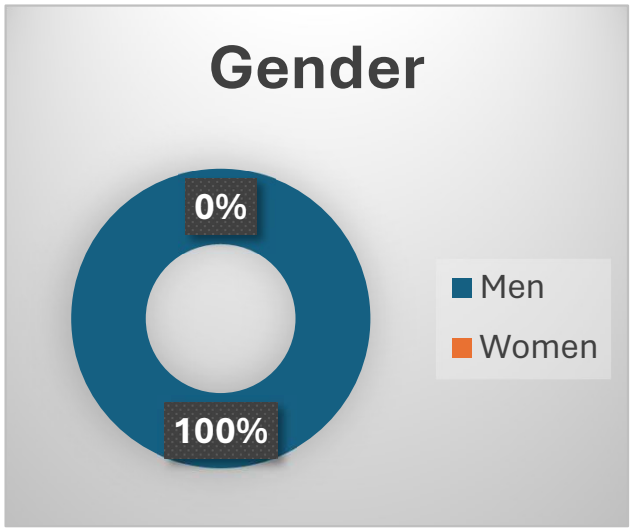
- Program completion

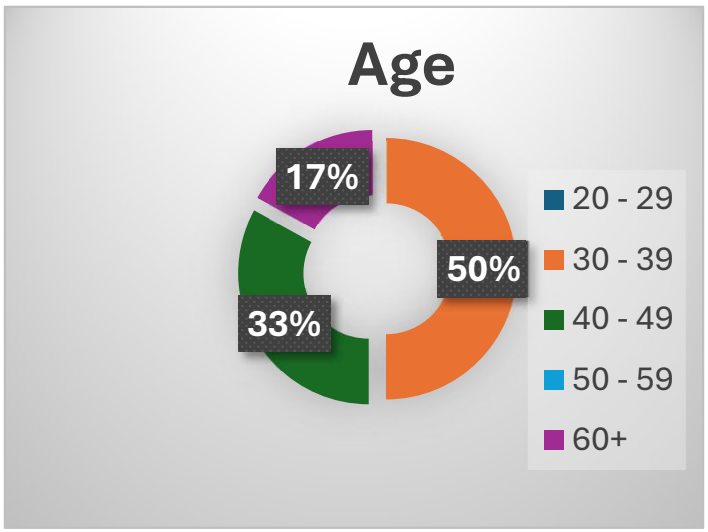
HCV Telehealth Enrollments by Cycle

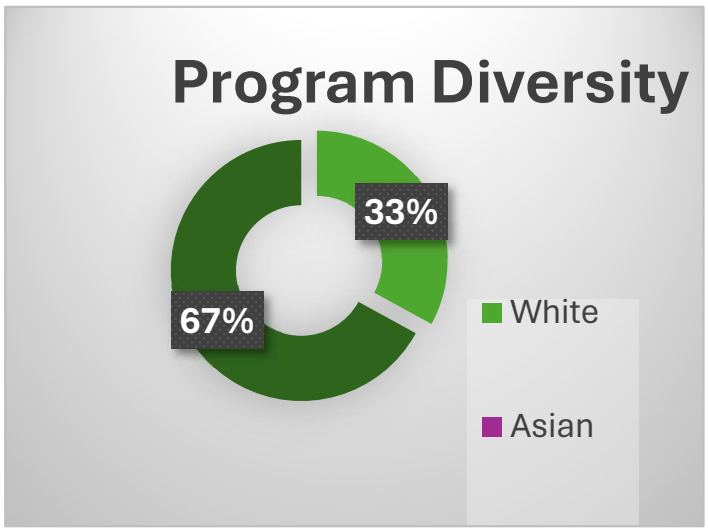


HCV Telehealth Pilot Treatment Cascade

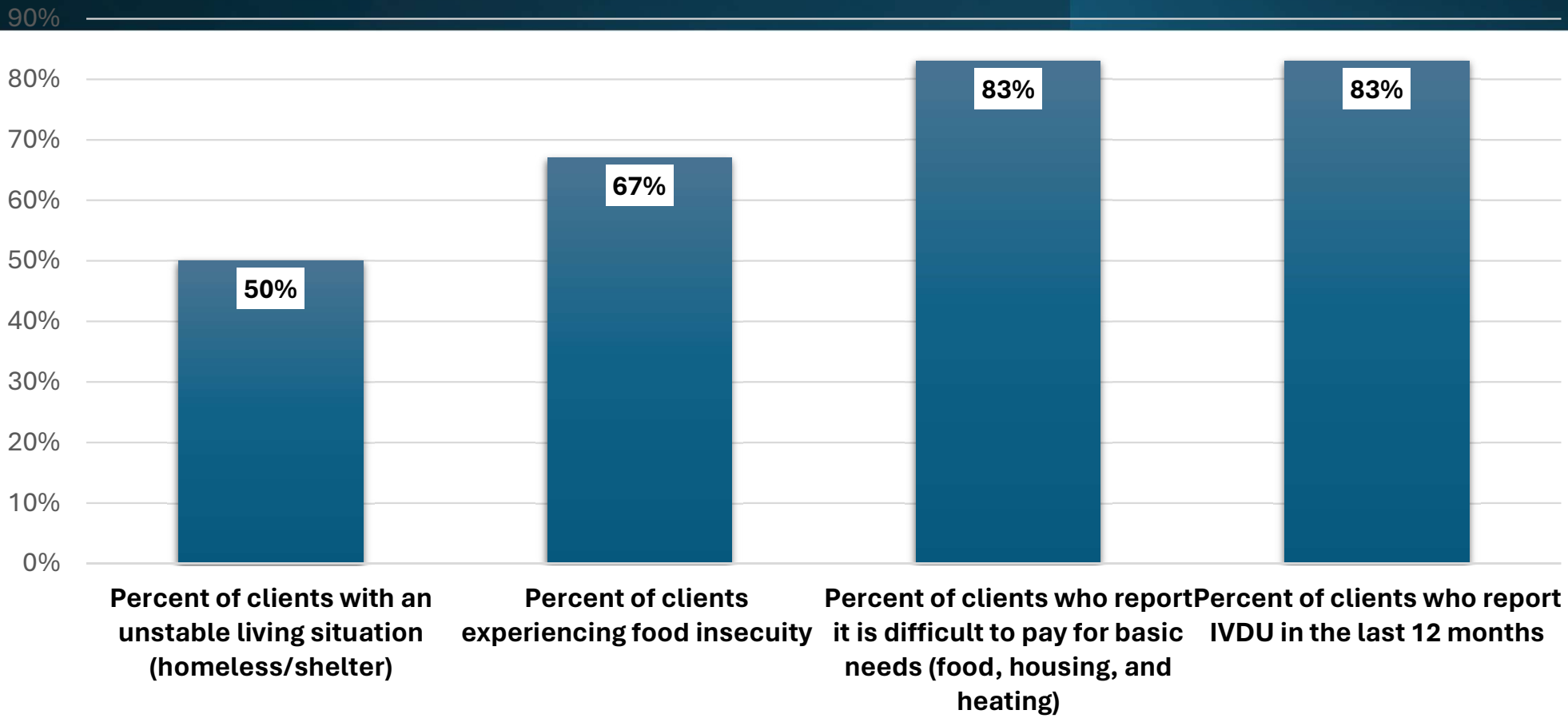
Client Demographics







Social Determinants of Health Assessments



Program Barriers and Success

Successes:

1. **Client Identification**– 12 positive clients have been identified between the two Manhattan SEP locations. 11 of those clients have been linked to a Primary Care provider to complete a Hep C COMP visit. 82% of those clients have been enrolled in the treatment program.
2. **Treatment Initiation** – 88% of clients enrolled in the telehealth pilot have initiated treatment.
3. **Care Coordination** - 100% of enrolled clients have a completed care coordination plan complete within 30 days of enrollment.
4. **Cure Rate –** 33% of clients have completed treatment, with current engagement the program has a projected cure rate of 78% for the enrolled clients.

Barriers:

1. **Engagement –** Despite 88% of clients initiating treatment we have struggled to keep clients engaged with the treatment team. Competing SDOH barriers have caused a disruption in treatment for some clients, resulting in them becoming lost to care or extending their treatment timeline.

Next Steps - Leveraging Partnerships with Internal Programs to Enhance Engagement

1. Phone Pilot Project

- Launched February 2024 to address the barriers of engagement. Clients are loaned cellphones for the 5-6 months they are enrolled in the program. Clients can use the phone to complete televisits, connect with their care team, and personal use.

- To test the efficacy of phone on engagement the cohort of clients who received phones will be compared to the clients who were enrolled prior to this intervention.

2. Nonfinancial Incentives

- Supplies including hygiene kits, clothing, and program swag distributed throughout enrollment to increase client engagement

Thank You

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Lauren Etsby
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Miraf Kassew
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Community Health Worker Facilitated Hepatitis C Telehealth Model

Reginald Idlett

May 15, 2024

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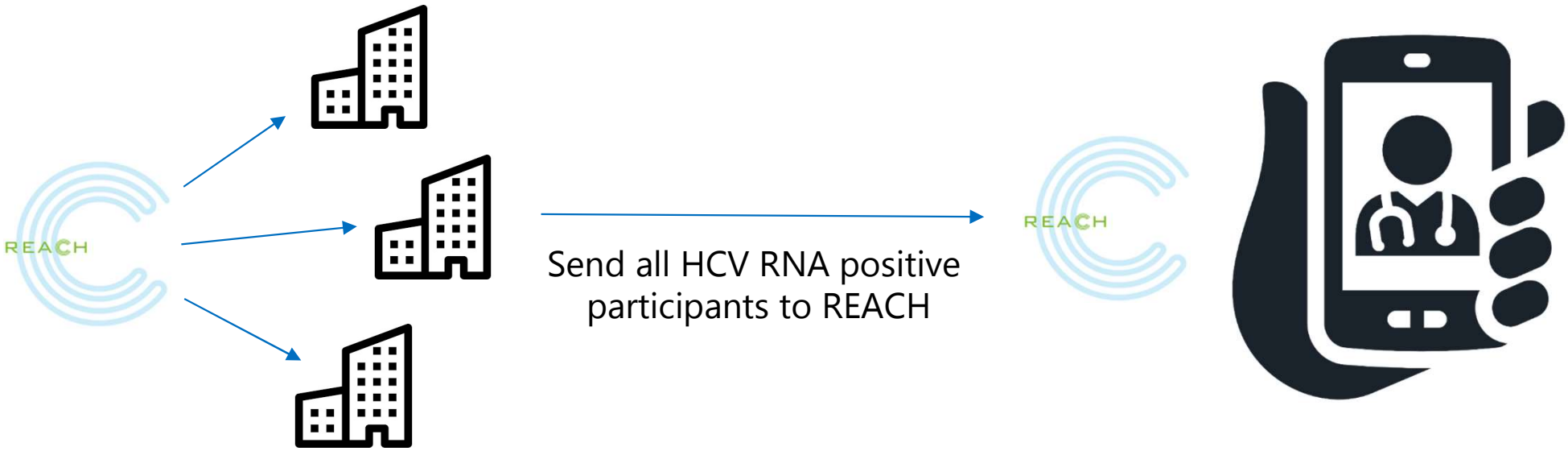
Mount Sinai

Initial telehealth model of care: no clinician onsite to collaborate with the REACH telehealth provider and the majority of care coordination is done remotely



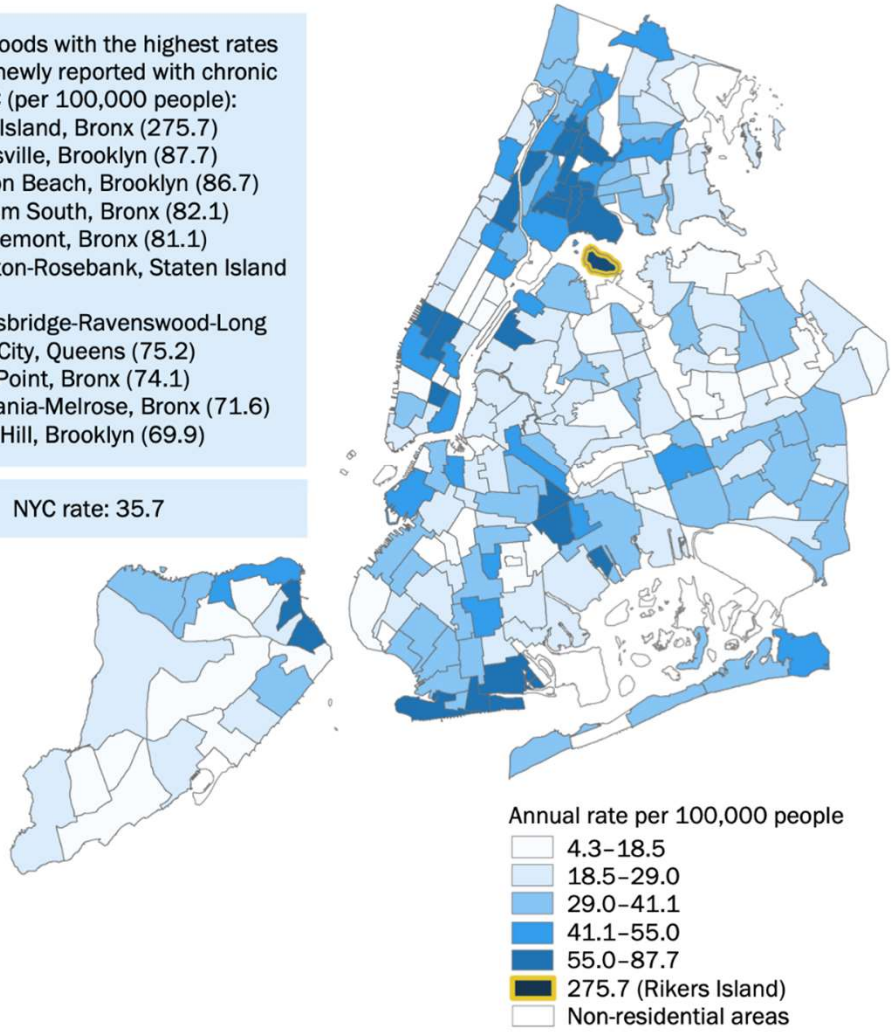
Chronic Hepatitis C: Geographic Distribution

Figure 16. Rate of people newly reported with chronic hepatitis C in NYC by NTA,[20] 2021

Neighborhoods with the highest rates of people newly reported with chronic hepatitis C (per 100,000 people):

1. Rikers Island, Bronx (275.7)
2. Brownsville, Brooklyn (87.7)
3. Brighton Beach, Brooklyn (86.7)
4. Fordham South, Bronx (82.1)
5. East Tremont, Bronx (81.1)
6. Stapleton-Rosebank, Staten Island (75.9)
7. Queensbridge-Ravenswood-Long Island City, Queens (75.2)
8. Hunts Point, Bronx (74.1)
9. Morrisania-Melrose, Bronx (71.6)
10. Ocean Hill, Brooklyn (69.9)

NYC rate: 35.7



HCV Collaborative Sites

Moving to Community Health Worker (CHW) Facilitated Telehealth

- REACH introduced the CHW in December 2022 to have an in-person liaison to connect our services with clients and staff at our partner programs with the goals of:
  - Increasing the number of referrals of HCV RNA+ patients to REACH
  - Increasing successful linkage to HCV Treatment Services

Integration of CHW at Partner Sites

- CHW co-credentialed at partner site and has access to EMR | labs | case notes | discharge plan | TEAMS | email | floor access
  - Required a physical, OASAS background check, drug testing, and respective HR onboarding for each inpatient substance use treatment program (ISUTP)
- CHW onsite to facilitate telehealth with the REACH Provider

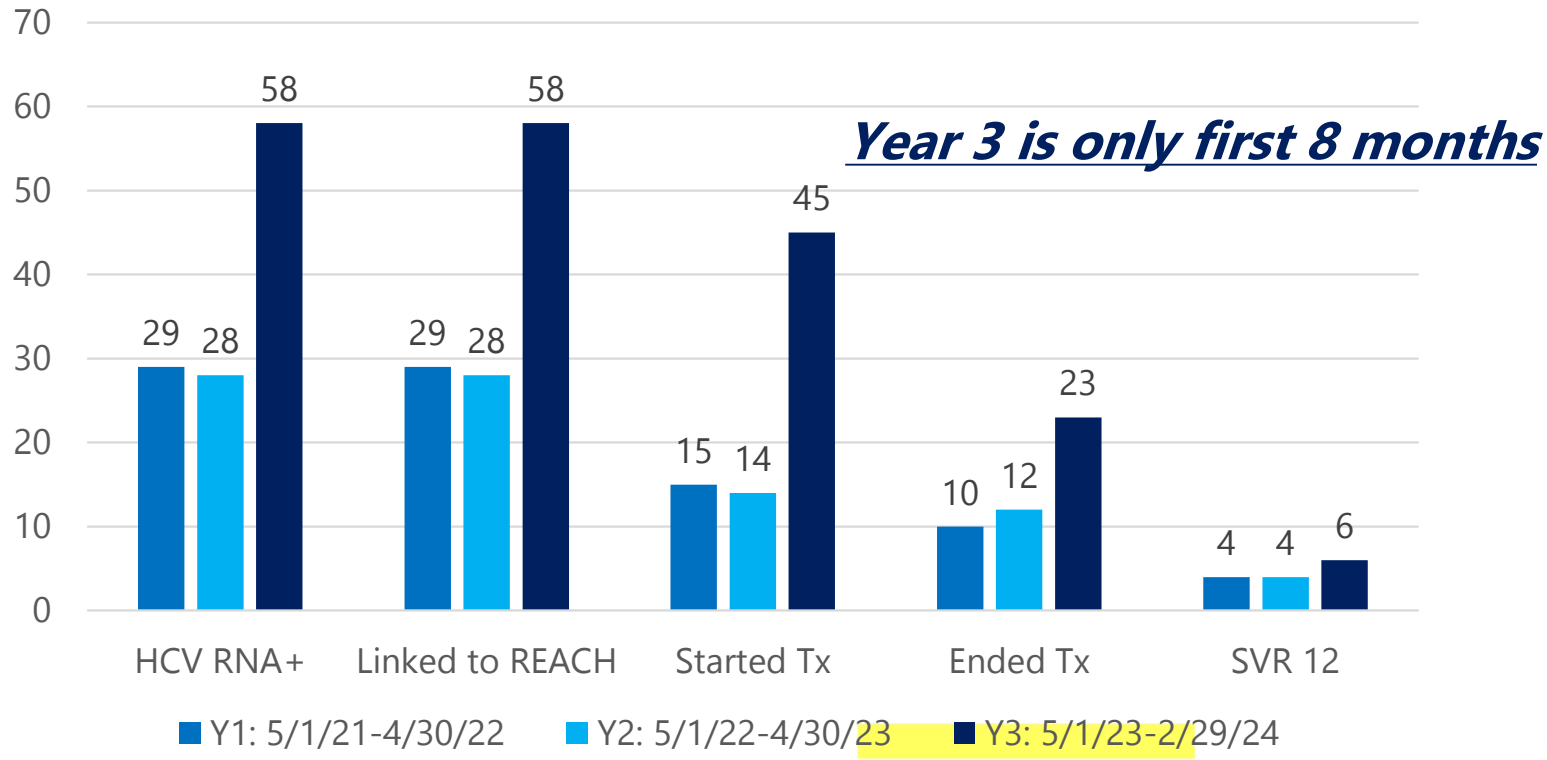
CHW Responsibilities

- Identifies HCV RNA positive clients by chart review in addition to staff referral
- Meets with clients onsite for HCV treatment education
- Develops care plan with client onsite
- Consents client, reviews social determinants of health assessment, and completes new patient registration forms
- Uploading labs and medical history to REACH electronic health record
- Verifies insurance and prescription coverage
- Schedules Initial HCV Evaluation/ Treatment initiation/ Follow up appointment
- Coordinates and/or facilitates confidential telemedicine appointment at ISTUP on laptop or iPad
- Our integration and routine sessions at these programs allow us to meet, schedule and start treatment for clients within a week of identifying them

Inpatient Substance Use Treatment Programs

- What are these spaces like?
  - Restricted physical access, additional layers of privacy protections, limited communication
  - Approximately 10% of clients are HCV RNA+
- 71% Male, 53% Black/AA
- 31%18-39, 44% 40-54 years old.
- 23% reported injection drug use over the last year.
- 70% reported unhoused.
- Each program has a census of 50-70 clients at a time.
- Rapid turnover; short length of stays.

Care Cascade of Linkage HCV Patients Linked to The REACH Program (Years 1-3)



CHW Effectiveness in Role

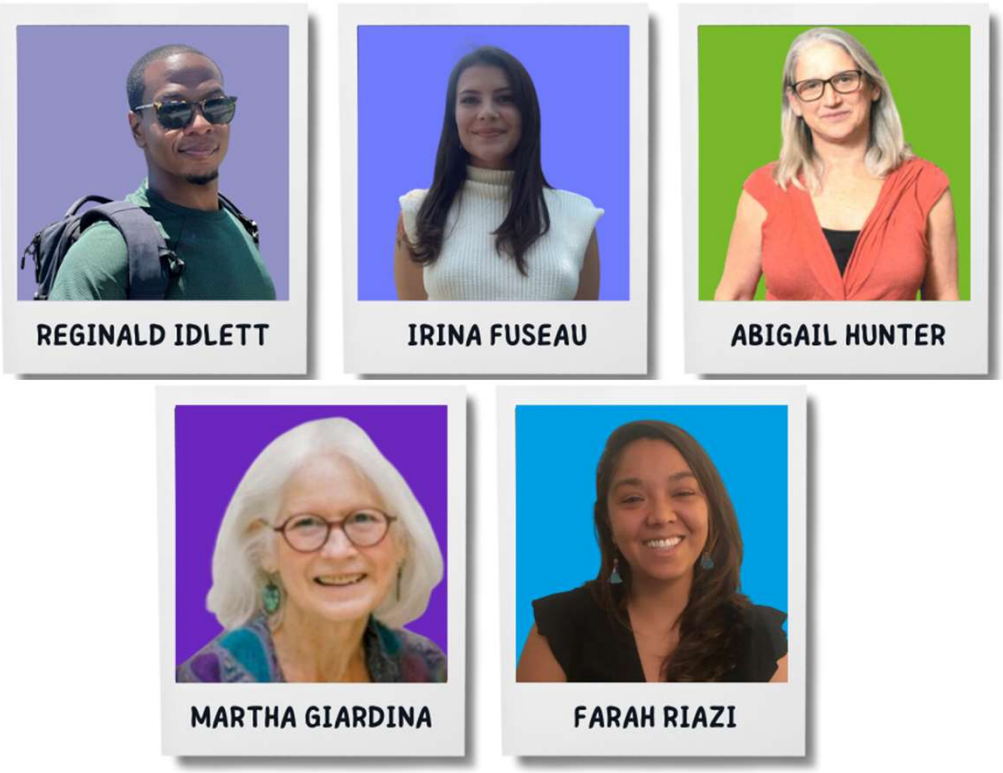
- Lived experience
- Racial/ cultural concordance
- Strategies to avoid being the 'Hep C guy'
- Relationship building
  - With staff
  - With clients
  - Motivational Interviewing
- Flexible!

CHW Lessons Learned

- Asking questions to learn about other systems and **constantly** refining the process
- Physical Access – Directly and routinely building rapport with agency staff and clients.
- Laptop + WiFi hot spot + confidential space = Good to go
- Importance of internal communication – Microsoft Teams for confidential and real time access
- How to review charts to effectively identify referrals (current labs, previous admissions, and diagnosis codes)
- Skills sharing across multiple work settings – LabCorp link

Grant Support

The REACH HCV program receives funding from the New York State Department of Health AIDS Institute and is a subcontractee through Public Health Solutions on CDC: Integrated Viral Hepatitis Surveillance and Prevention Funding for Health Departments (IVHSP)



Discussion

Thank you!

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