2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Project ACCESS

Achieving Comprehensive Coverage Early, Systematically and Sustainably

Jurisdictional Approach to Curing Hepatitis C among HIV/HCV Coinfected People of Color

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Disclosures

Presenter(s) has no financial interest to disclose.

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OUTLINE

- Discuss the implementation of jurisdictional approach toward curing HCV among PLWH of color
- Describe two integral components of our initiative:
  - Evolution of surveillance leveraging clinical data
  - Implementation of Project ECHO
  - Utilizations of clinical data to identify new HIV/HCV clients

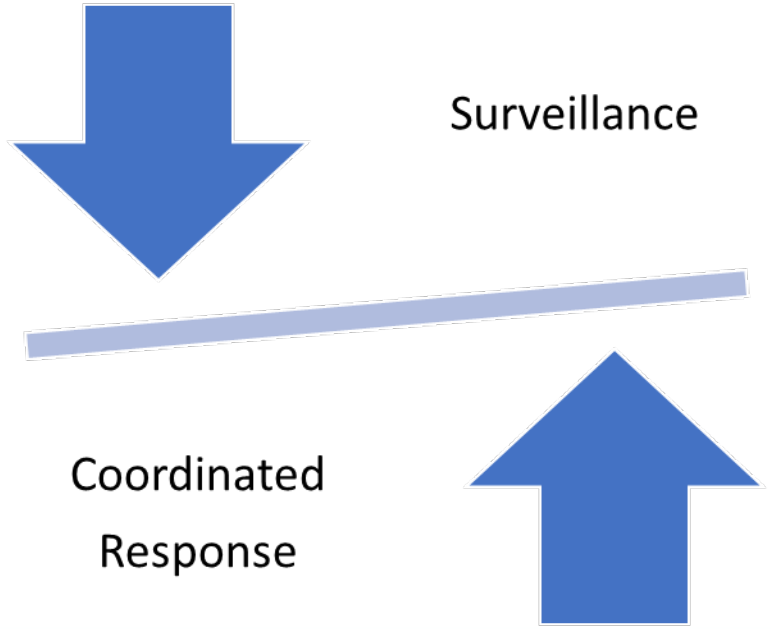
BACKGROUND

- The Hartford TGA has 3,428 individuals living with HIV/AIDS in three counties: Hartford, Middlesex and Tolland
- Providing services across 12 categories through a partnership with grantees. These include hospitals, federally qualified health centers, and community based organization
- Our HIV/HCV SPNS project, Achieving Comprehensive Coverage Early, Systematically and Sustainably (ACCESS), supports services for 631 individuals in 7 medical sites across the jurisdiction

PROJECT OVERVIEW

7 Ryan White Clinics enrolled to implement patient navigation, medication adherence and provide ID care for low income individuals co-infected with HIV/HCV throughout the Hartford Transitional Grant Area.

Implementation decision based to managed competing barriers:



ACCESS GOALS

- ***Localization of HCV surveillance in CAREWare***. Project ACCESS will use surveillance data to identify, select, and prioritize patients at 5 Ryan White funded HIV health service facilities and assigned to patient navigation and HCV care and treatment. In conjunction with a QM Nurse and ad-hoc quality management advisory group, Project ACCESS staff will provide training and tailored technical assistance to improve HCV screening, diagnostic testing, linkage to care, and treatment rates at these sites. Additional CAREWare measures (HCV RNA, HCV Medication Initiation, HCV Treatment Referral, HCV Medication Adherence, Achievement of SVR, Post SVR12 Follow-up) were added to collect this information.
- ***Implementation of Project ECHO.*** Project ACCESS will adapt the National AETC curriculum into a telehealth mentoring program that provides remote HCV education to HIV providers in a collaborative community of practice utilizing video conferencing and case-based learning. provide HCV care technical assistance and training to HIV providers. The cohort of providers meets bi-weekly and each intervention site is responsible for presenting at least 3 de-identified clinical cases.
- ***Engagement of Patient navigation.*** Project ACCESS will provide HCV clinical training for HIV clinical providers and HCV basics and patient navigation training for non- clinical providers to improve HCV screening, diagnostic testing, linkage to care, and treatment rates jurisdiction-wide. 6 patient navigators are being funded at 6 of the intervention sites to provide patient outreach, linkage to care, adherence support and community education.
- ***Direct patient outreach education*****.** Project ACCESS will create culturally relevant patient education materials and coordinate peer group activities to address disease stigma and access to treatment.

PROJECT IMPLEMENTATION PLAN

PILLARS		
	INFORMATICS & EVALUATION	TRAINING, EDUCATION & COMMUNITY MOBILIZATION
	ENHANCED SCREENING & LINKAGE	INTEGRATED COORDINATION

Intervention sites implementing:

- Patient Navigation
- Medication Adherence
- Treatment Management

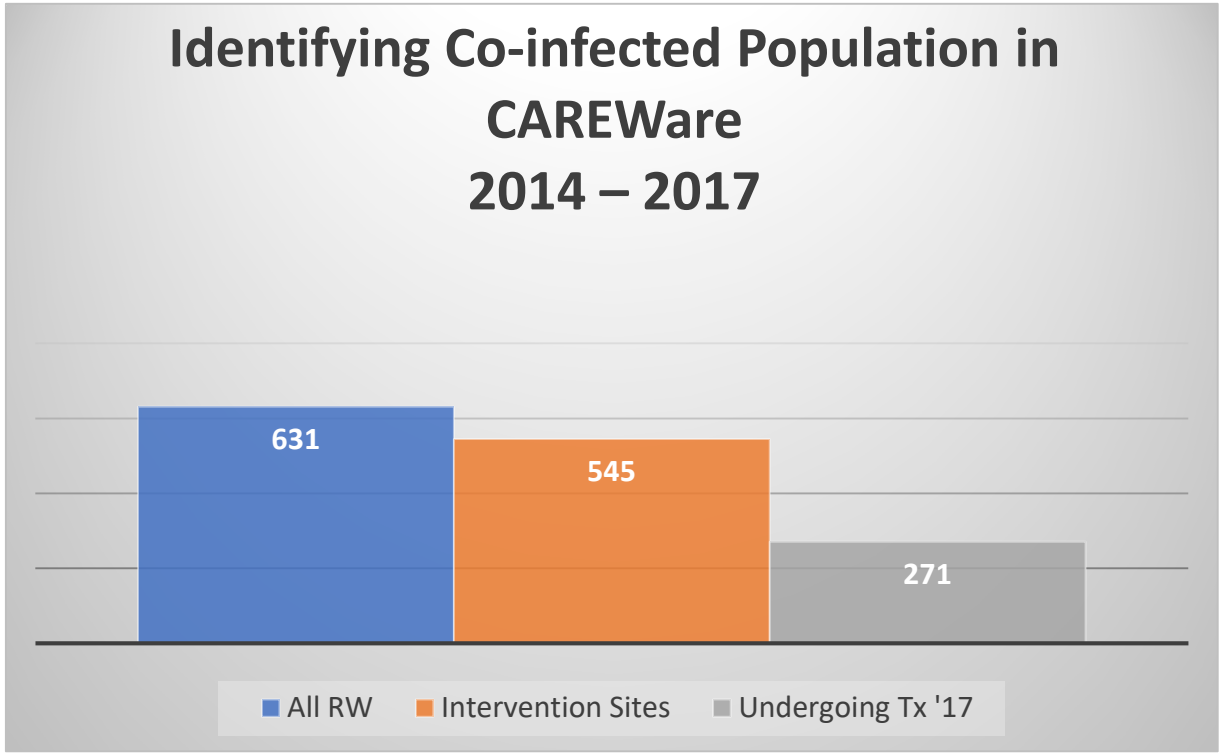
Jurisdiction-wide implementing:

- HCV workforce development
- Community awareness

Evolving Surveillance

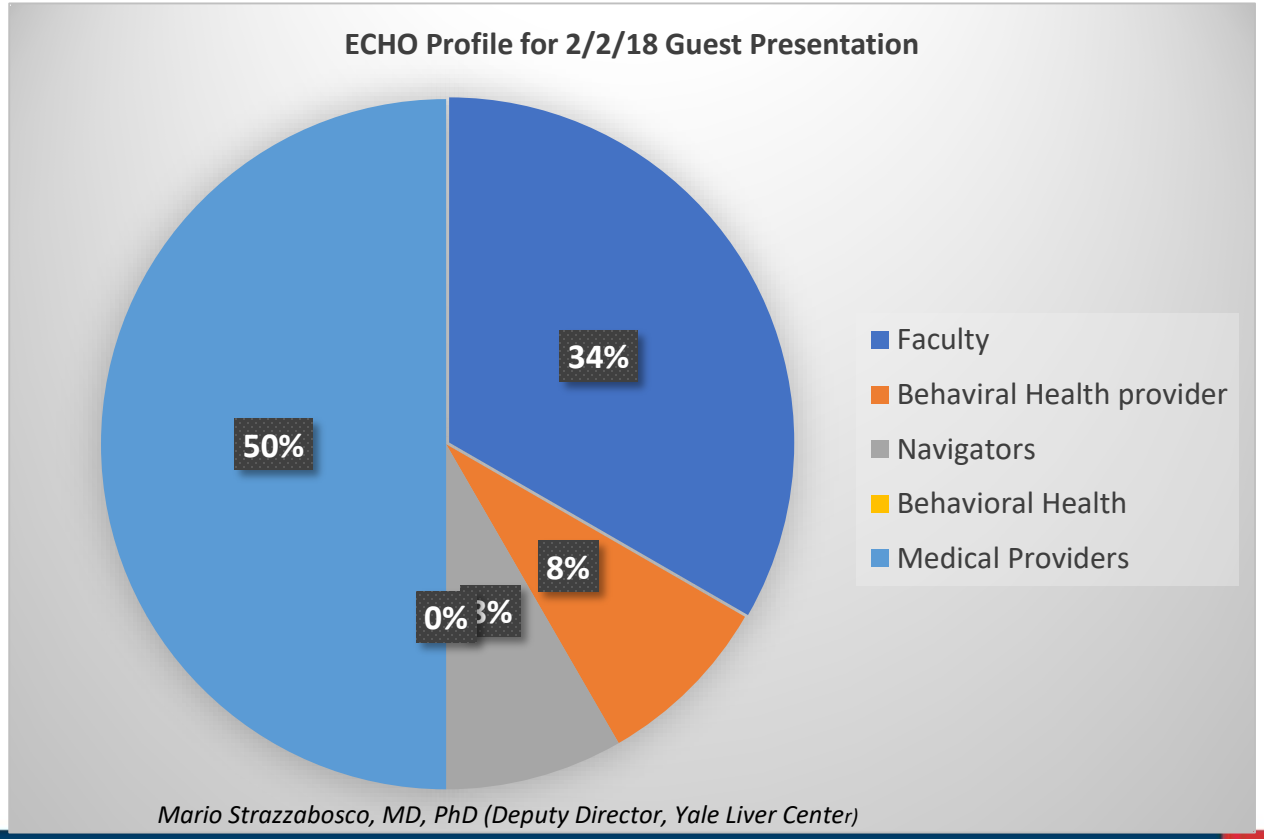
The Viral Hepatitis Action Plan benchmarks **2015** for the national HCV surveillance project

The Hartford TGA benchmarks **July 1, 2016** for its CAREWare HCV surveillance project



Coordinated Prevention through Telehealth

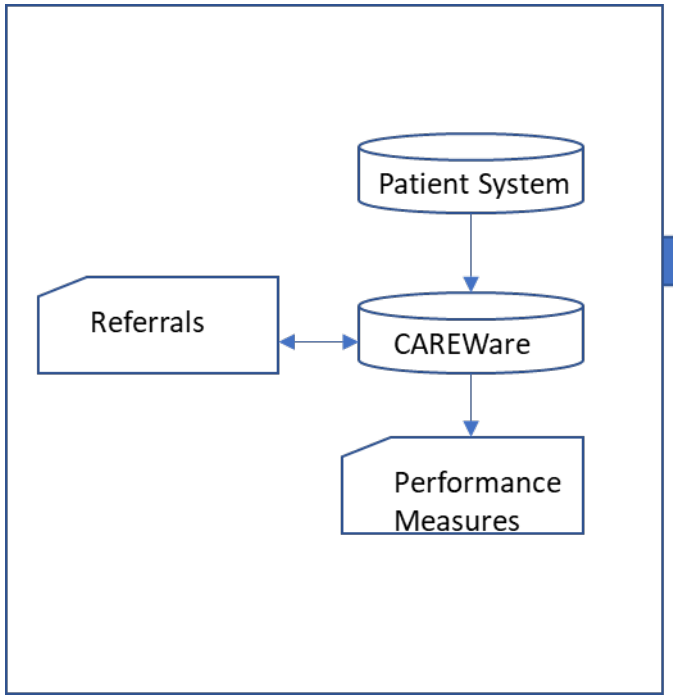
We are implementing the AETC curriculum through Project ECHO in partnership with the Weitzman Institute at Community Health Center, Inc. which meets bi-weekly and offers guest lectures quarterly on treatment guidelines and emergent issues in hepatology and HIV, cultural competency.



Mario Strazzabosco, MD, PhD (Deputy Director, Yale Liver Center)

How Data was Used to Locate & Facilitate Linkage to Care

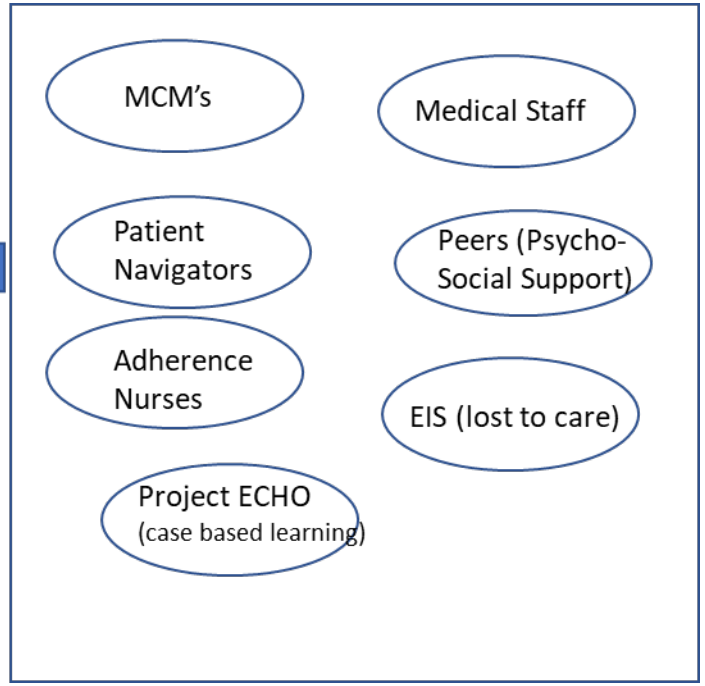
Data Provided by Systems



Functions

- Identification of co-infected individuals
- Identification of patient complexities (active SA, MH issues, homelessness, not virally suppressed, etc.)
- Track patients (being worked up; in treatment; cured; lost to care)
- Monitor performance measures for gaps
- Identify pops. at risk for reinfection and individuals within those populations

Data Provided by Care Team

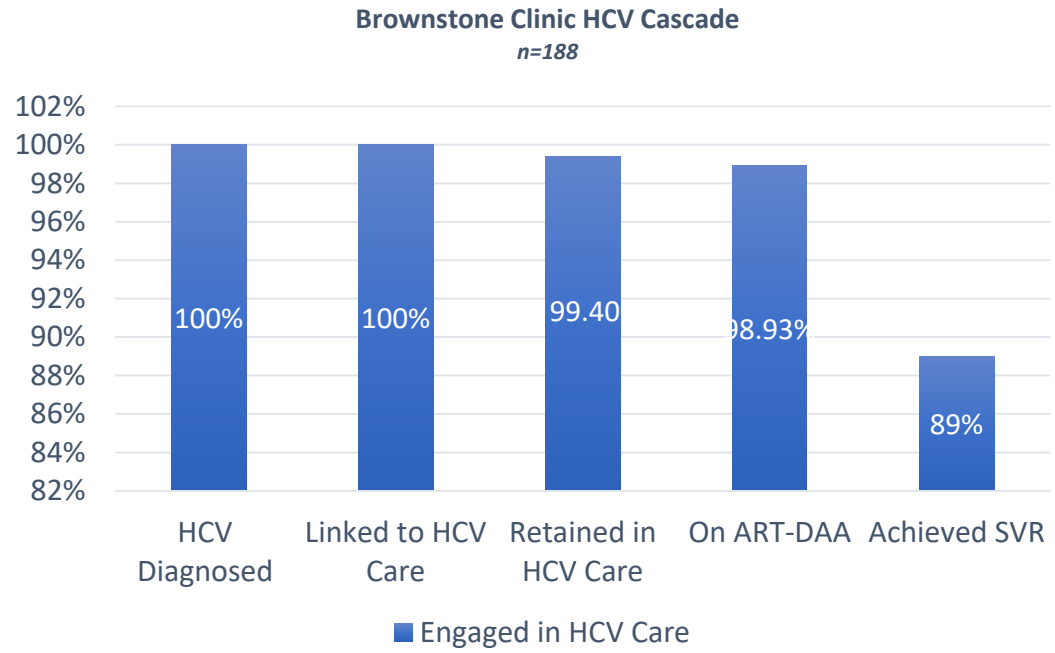


Identifying, Linking, Supporting Patients

Step 1: Integrated HCV surveillance between CAREWare and EHRs from data migration to identify co-infection through HAB measures.

Step 2: Enhanced CAREWare with additional HIV/HCV subservices fields to track patients along the care continuum.

Step 3: Developed clinical performance indicators as part of comprehensive quality management plan



Identifying, Linking, Supporting Patients, Cont'd

CAREWare had to be changed to reflect the HCV care continuum for reporting and quality management by establishing indicators and subservice categories

Measure	Definition	Sources	Subservices
Screening	*% total of patients in the denominator receiving 1 Reactive HCV Ab test in the measurement period* **Denominator:** Number of People living with HIV receiving and/or eligible for Ryan White services[1]	*HAB 08 (HBV Vaccine)* *HAB 09 (HCV screening)* *HAB 17 (HBV screening)* ***OR ICD 10*** *B16 – B19* ***OR EHR/Lab/Pharmacy*** *Hepatic Panel* • ***HCV RNA/Viral Load***	*HIV/HCV_Outreach* *HIV/HCV_Screening* *HIV/HCV_Initial Face to Face*
Linkage	*% total of patients in the denominator with first HCV RNA (>15c/mL) within 9 months of reactive recent HCV Ab test[2]* **Denominator:** Number of people with documented HIV diagnosis and reactive HCV Ab receiving and/or eligible for Ryan White services	***ICD 10*** *B16 – B19* ***OR EHR/Lab/Pharmacy*** *Hepatic Panel:* • *Liver function* • *HCV Genotype* • *HAV/BV Screening* • *HAV/BV C Vaccine* *HIV Labs*	*HIV/HCV_Initiatal Face to Face* *HIV/HCV_Adherence Assessment* *HIV/HCV_Patient Education* *HIV/HCV_Care Coordination* *HIV/HCV_Treatment Initiated*
Retention	*% total of patients in denominator with second viral load/medical appointment within 4 weeks of beginning treatment[3]* **Denominator**: Number of people with HCV viral load (>15 c/mL) linked to treatment receiving and/or eligible for Ryan White services	***ICD 10*** *B16 – B19* ***OR EHR/Lab/Pharmacy*** *Hepatic Panel:* • *Liver function* • *HCV Genotype* • *HAV/BV Screening* • *HAV/BV C Vaccine* *HIV Labs*	*HIV/HCV_Patient Education* *HIV/HCV_Referral Services* *HIV/HCV_Case Conference* *HIV/HCV_Adherence Advocacy* *HIV/HCV_ID Services Face to Face*
Sustained Virologic Response (SVR)	% total of patients in denominator with documented last HCV viral load (<15c/mL) 12 weeks after completing treatment **Denominator:** Number of people retained in care with at least 1 HCV medical visit since first treatment prescription receiving and/or eligible for Ryan White services	***ICD 10*** *B16 – B19* ***OR EHR/Lab/Pharmacy*** *Hepatic Panel:* • *Liver function* • *HCV RNA*	*HIV/HCV_Care Coordination / Education* *HIV/HCV_Referral Services* *HIV/HCV_Treatment Completed* *HIV/HCV_Post Treatment Follow-up 1/2*

Disclaimer:

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THANK YOU!!

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