Project ACCESS

COMBATING HEP C THROUGH COMPREHENSIVE COVERAGE

ACHIEVING COMPREHENSIVE COVERAGE EARLY, SYSTEMATICALLY AND SUSTAINABLY

Presented by: Angelique Croasdale Mills

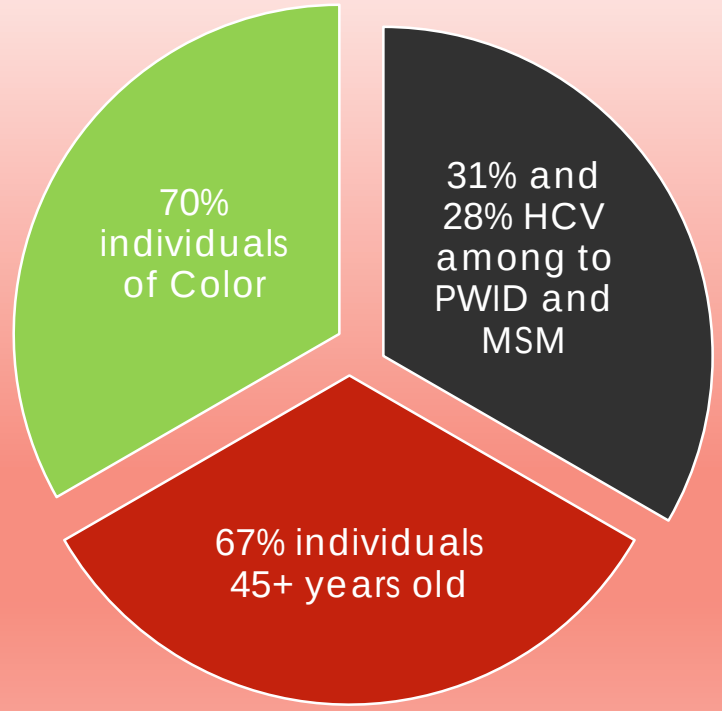
PRESENTATION OUTLINE

- The Hartford Jurisdiction
- Implementation Overview
- Program Outcomes
- Local Evaluation Findings
- Project Sustainability Plan

THE HARTFORD TGA

- The Hartford TGA has 3,652 individuals living with HIV/AIDS in a three county area: Hartford, Tolland and Middlesex.
- Providing services across 13 categories through a partnership with 16 sub-recipients. These includes hospitals, federal qualified health centers, and community based organizations
- Project ACCESS (Achieving Comprehensive Coverage Early, Systematically and Sustainably) supports 631 HIV/HCV co-infected individuals partnering with 7 medical sites

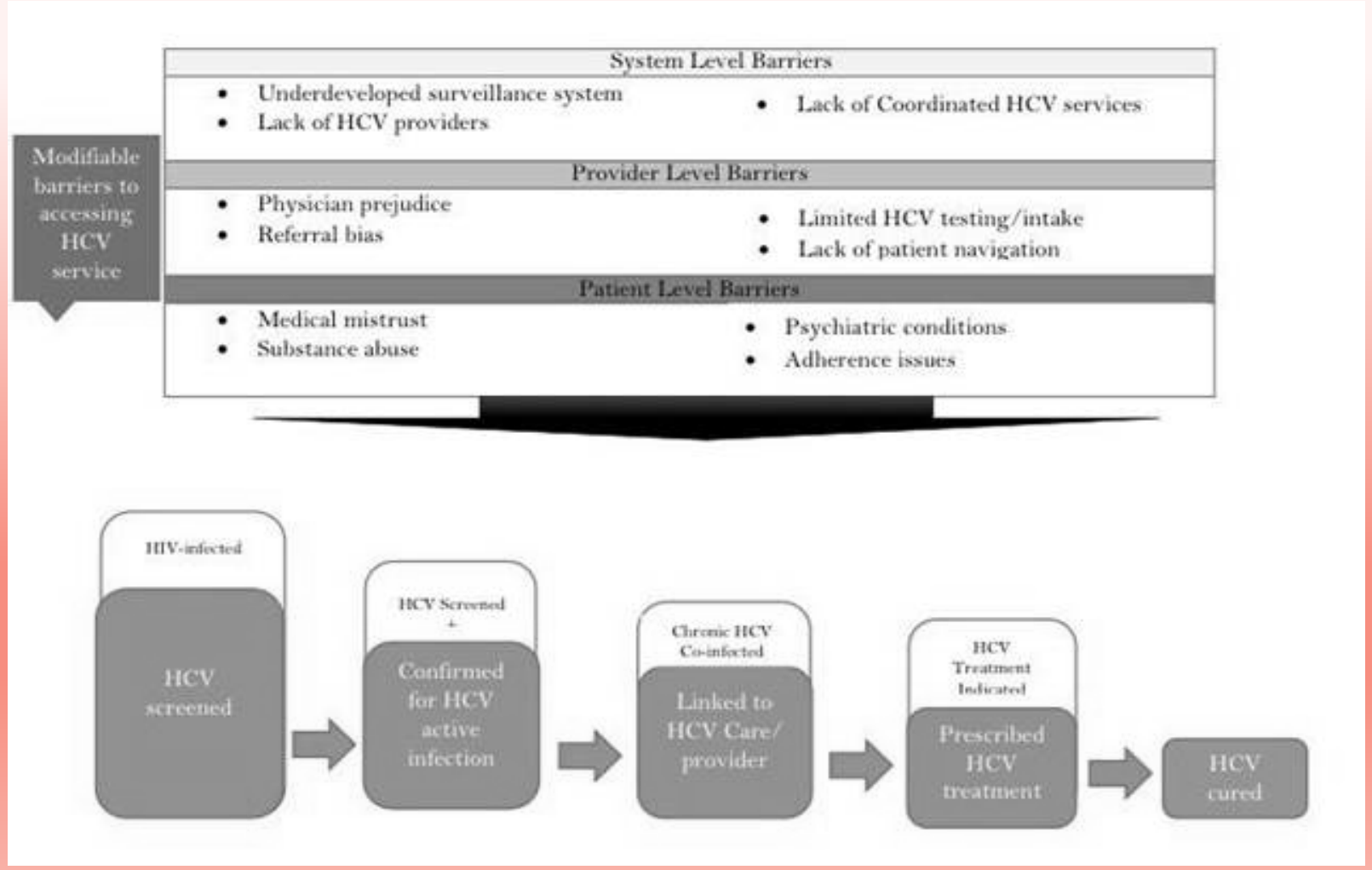
Baseline HIV/HCV Co-infection: 17%



PROJECT OVERVIEW

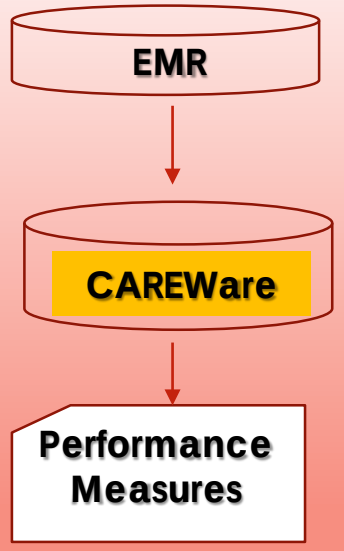
PROJECT ACCESS CO-INFECTION PROGRAM OVERVIEW

The goals for the grant were to introduce a jurisdictional approach to improve HCV provider and patient education, expansion of screening and linkage to care and systems transformation.



SURVEILLANCE

Data Provided by Systems



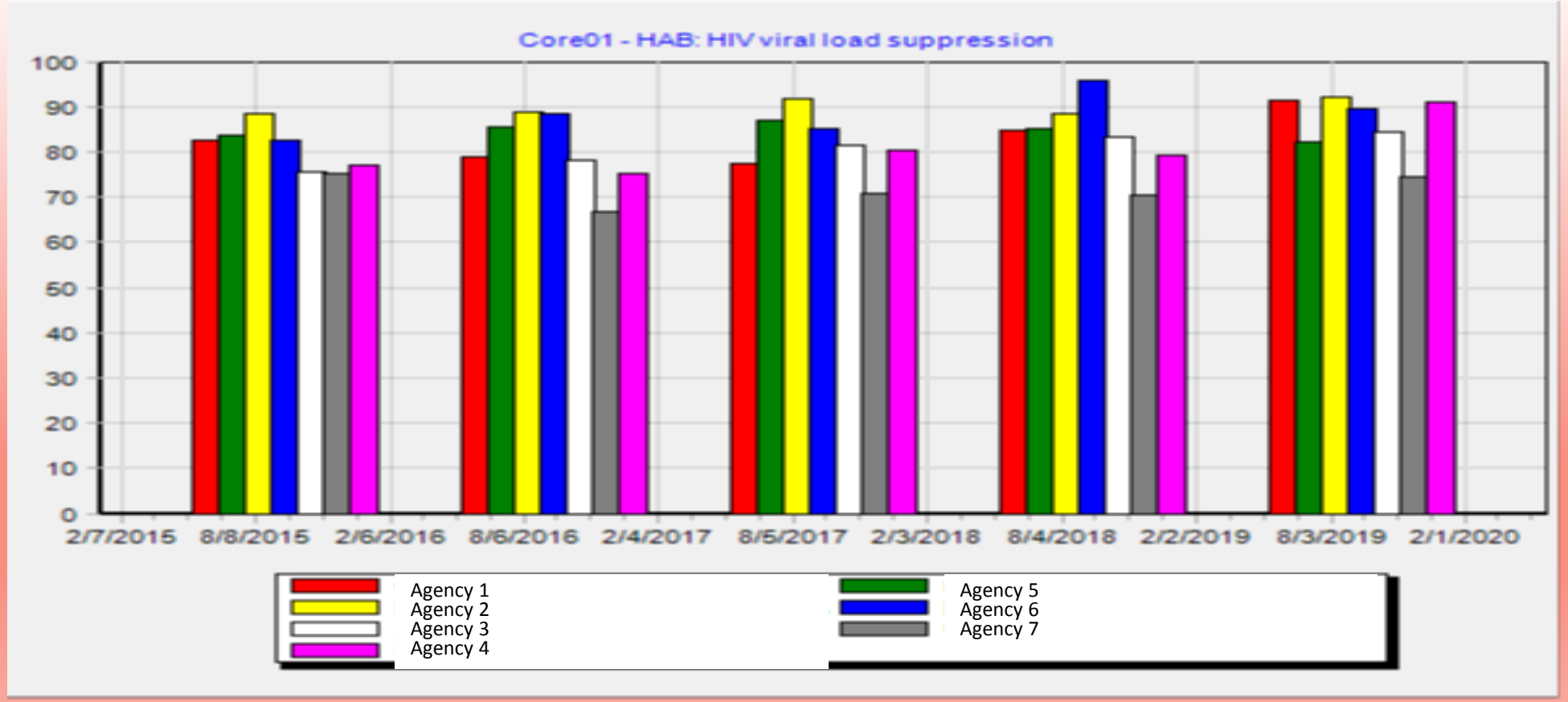
Functions

- 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

- Medical Staff
- MCM's
- Patient Navigator
- Adherence Nurses
- Peers
- EIS (lost to care)
- Project ECHO (case based learning)

IF WE CAN DO THIS FOR HIV, WE CAN CURE HCV



IMPLEMENTATION PLAN

IMPLEMENTATION COMPONENTS BARRIERS

- **Activities (NOFO Requirements)**

- **HCV Screening**
- Uncoordinated among OTL, FQHCs, Shelters and Substance Treatment Centers
- No testing protocols for corrections and supportive housing programs

- **Provider Training**
- Small ID department staff
- Provider bias against HIV/HCV treatment (esp. PWUD)
- Inconsistent treatment recommendation due to advances in DAAs

- **Patient Education**
- Interpersonal Stigma
- Low reading comprehension (education attainment & ethnicity)
- Lack of culturally sensitive material with deference to CT

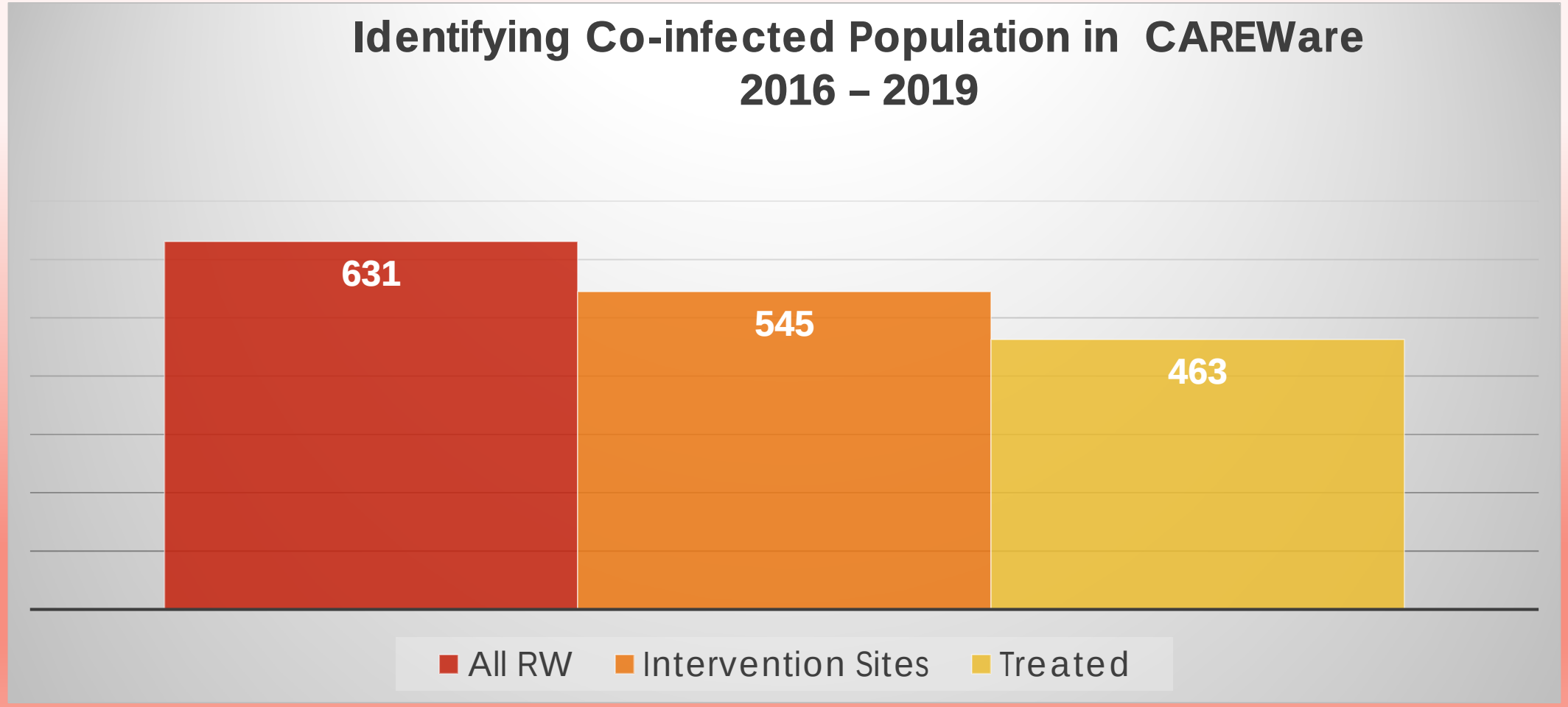
IMPLEMENTATION COMPONENTS BARRIERS

- **Clinical Practice Transformation**
- Fragmented HIT systems (CAREWare v EHRs)

- **Healthcare Access**
- Lack of HCV patient navigation
- ADAP delays in adopting HCV DAAs
- Lack of providers in Rural Areas
- Lack of medical transportation

- **Medication Adherence Support**
- No funding for HCV adherence support
- Provider bias working with HIV/HCV patients
- Patient housing instability (primarily due recidivism in corrections)

OUTCOMES


Identifying Co-infected Population in CAREWare
2016 – 2019
631
545
463
All RW
Intervention Sites
Treated

PATIENT OUTCOMES

91% Screened

89% Linked to Treatment

87% Retained in care

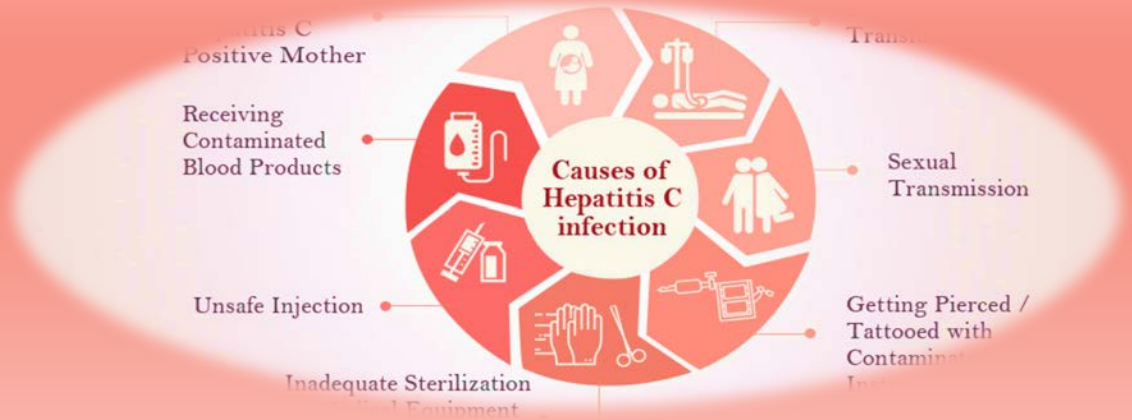
85% cured

SCREENING

10 **batch testing events, initiating 926 tests**

Trained 30 new HIV/HCV testers **deployed in community programs**

ACCESS clinics tested 100% of their patients for HCV upon enrollment, **initiating repeat testing according to the AALSD and CDC guidelines for at-risk populations**



PROVIDER TRAINING AND EDUCATION

90 ***hours of accredited CME units***

42 **Echo Training Sessions**

11 **educational dinner meetings**

20 hours in continuous education for Patient Navigators

3 **HCV Summits**

HEALTH CARE ACCESS

4 new **HCV/screening treatment locations:**

Vernon First Choice Satellite

Community Renewal Team

Latino Community Services

Greater Hartford Harm Reduction Coalition Inc.

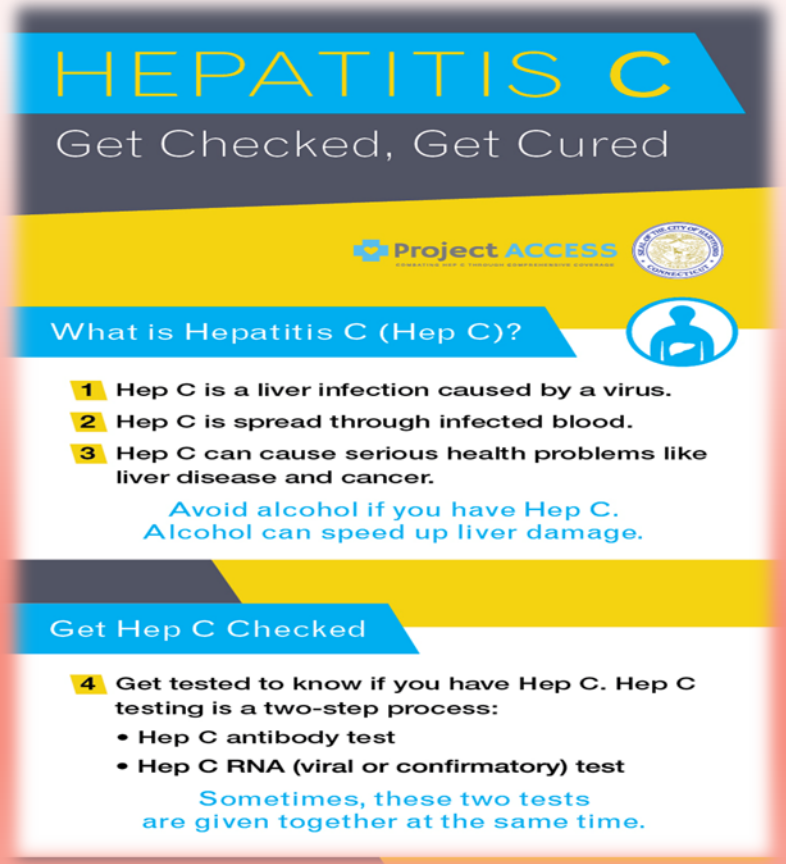
Added 2 **treatment providers expanded treatment capacity within Federally Qualified Health Centers**

9 referral sites!!!

PATIENT & CONSUMER EDUCATION

- Clients integrated into Ryan White Continuum of care through psychosocial support, Early Intervention Services and medical case management.
- Hepatitis C Street Lamp Post Campaign in high targeted areas

SHARING THE MESSAGE



PRACTICE TRANSFORMATIONS

Created 3 new performance measures in CareWare for HCV monitoring:

1. HCV01- Linkage to Care
2. HCV02- Retention in Care
3. HCV03- SVR

LOCAL EVALUATION PLAN OVERVIEW

- Mixed methods approach
- Consumers (15-17), non-medical providers (8-10), medical providers (10-12)
- Include brief surveys and in-depth individual interviews.
- Determine medical and support services being offered for co-infected communities.
- Patient Navigation, Insurance, Stigma, Facilitators/Barriers, Medication Coordination, Media

LOCAL EVALUATION PLAN METHODS

- **Recruitment**: participating organizations
- **Screened**: contacted the PI and complete screener, schedule appointment.
- **Consumers and non-medical providers**:
  - **Brief survey and in-depth interviews**
    - Demographics, HCV knowledge, beliefs
    - Services provided/received
- **Medical providers**:
  - Survey only
    - Demographic, HCV knowledge, beliefs

LOCAL EVALUATION PLAN FINDINGS

- **Consumers:**

Demographics:

  - 70% cismale, 20% cisfemale, 10% transwoman; ages 35-70 (M=57, SD=12)
  - 50% identified as Black/AA, 50% identified as Latinx
- HCV tx as important when HIV VL is undetectable
- Insurance is not a problem
- General lack of support services related to HCV

- **Non-medical providers:**

Demographics:

  - 100% cisfemale; ages 52-65 (M=56, SD=5)
- 40% Black/AA, 10% Latinx
- Providing services between 7 months and 10 years
- No HCV specific services offered
- Peers are not always viewed as competent by staff
- Funding cuts are detriment to services

LOCAL EVALUATION PLAN IMPLICATIONS

- **Consumers:**
  - Need for increased HCV-specific services, including social support and events
  - Need for more education out in the communities affected by HCV
  - Address stigma, particularly out in communities affected most
  - Increase providers communication about HCV, screening and cure

- **Providers:**
  - Increase peer support services and create inclusive environment
  - Funding needed – reduced funding negatively impacting orgs
  - Increase HCV education with providers and consumers

SUSTAINABILITY

- ***Data :*** *we have standardized HCV reporting.* Automated data import *between CAREWare and EMRs. Incorporated the additional 3 HCV Performance measures into the Part A Standard of Care, quality management plan, Early Identification of Individuals with HIV/AIDS and Hepatitis Plan and provider contract language.*
- ***Contracts:*** *we will leverage RW and HOPWA continuum to ensure seamless continuation of services. Peer workers, case managers, early intervention services workers and adherence nurses will assume key components from the patient navigation program.*
- ***Quality Management****. Integrated HCV PDSAs into the HTGA's Quality Management Plan*
- ***Provider Education:*** *We have leveraged our Project ECHO infrastructure to update the New England AETC databases with both our video offering and provider electronic directory for continuing education offerings.*

SUSTAINABILITY CONT..

Community Mobilization: we have tasked the RW Planning council continuum of care committee, (CCC) and the Hartford Planning Committee on HIV/AIDS, (HPCHA) to incorporate HCV activities within their charge.

- *CCC oversees the activities of TGA's EIIHA Plan, now called Early Identification of Individuals with HIV/AIDS/HCV, (EIIHAH)*

we will continue to partner with American Liver Foundation, pharmaceutical companies, CT HIV Planning Consortium, AETC, etc.

RECOMMENDATIONS

- **HAB should adopt standardize HCV performance measures in CAREWare**
- **CDC should support states in developing HCV elimination plan**
- **State health department should offer technical assistance FQHC-look-alikes implementing HCV, especially for special populations (PWID, pregnant women, MSM)**
- **More culturally sensitive patient education materials**

NEXT STEPS FOR PROJECT ACCESS

ACCESS clinics prioritized HCV elimination within the Ryan White continuum of care; we will continue to focus on the following entities to expand outreach efforts:

- **Private HIV clinics**
- **Local health departments** *(New Britain, East Hartford, Vernon.)*
- **Community Health Centers** *(First Choice, Wheeler Clinic, Intercommunity, St Francis Community Clinic).*

We will consider sharing best practice model, and resources with these entities.

NEXT STEPS

- **Work with the State of CT to create a micro-elimination HCV elimination Plan**
- **Expand HCV training for frontline RW/HOPWA staff who will be assuming ACCESS components**
- **Continue to treat newly infected individuals, treat re infected individuals and reengage those not previously ready for treatment.**
- **Provide patient education addressing stigma and HCV service providers**
- **Share *Lost to Care* protocol with non-RW providers**

Questions?

SPECIAL THANKS

Key Clinics: *CHC, CHS, Charter Oak Health Center, THOCC, Hartford Hospital, St. Francis, UCONN*

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