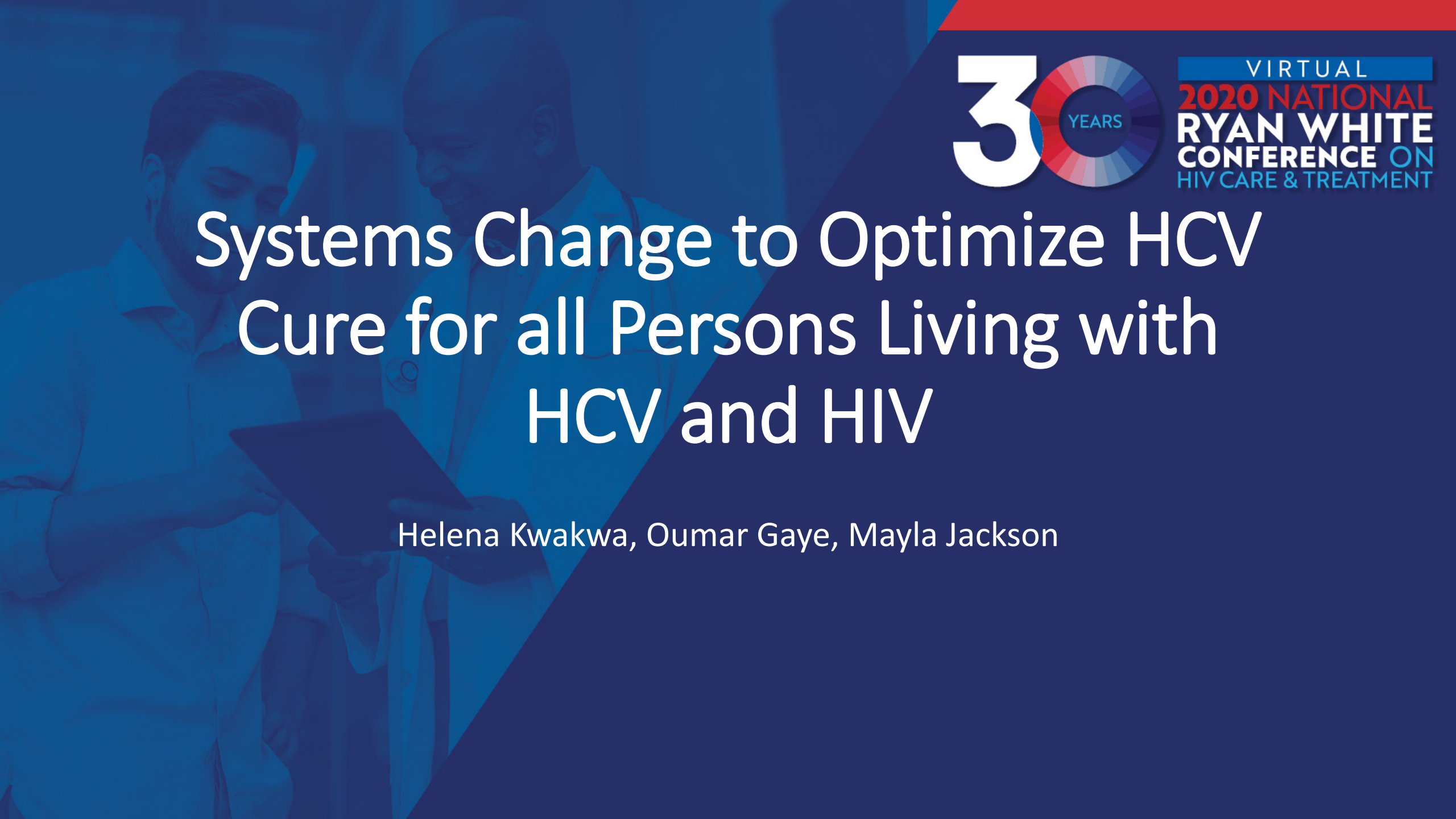


VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Systems Change to Optimize HCV Cure for all Persons Living with HCV and HIV

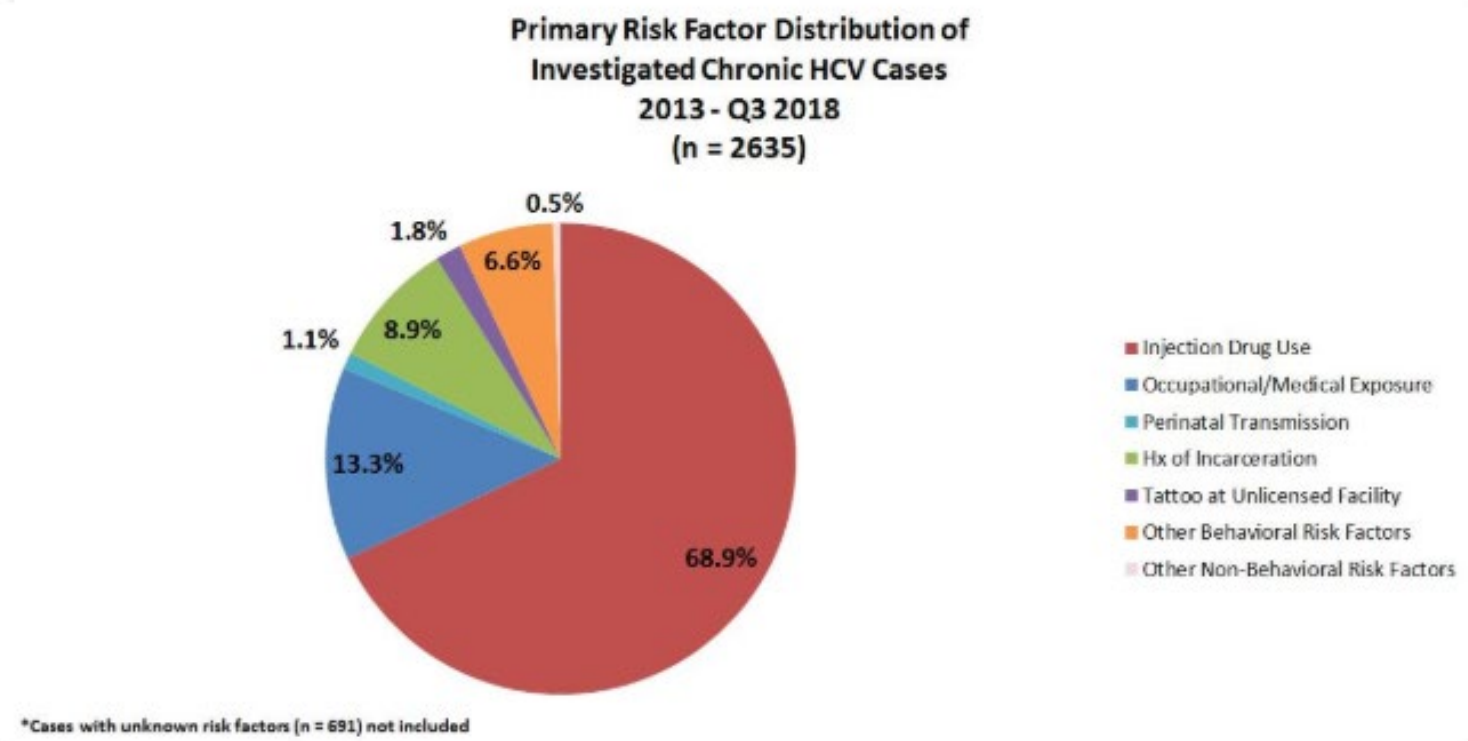
Helena Kwakwa, Oumar Gaye, Mayla Jackson

Overview

- Background
  - HCV/HIV in Philadelphia
  - Setting and HCV treatment strategies at Project start
- Systems collaborations
- Sequential cure strategies and outcomes
- Successes
- Challenges

Background

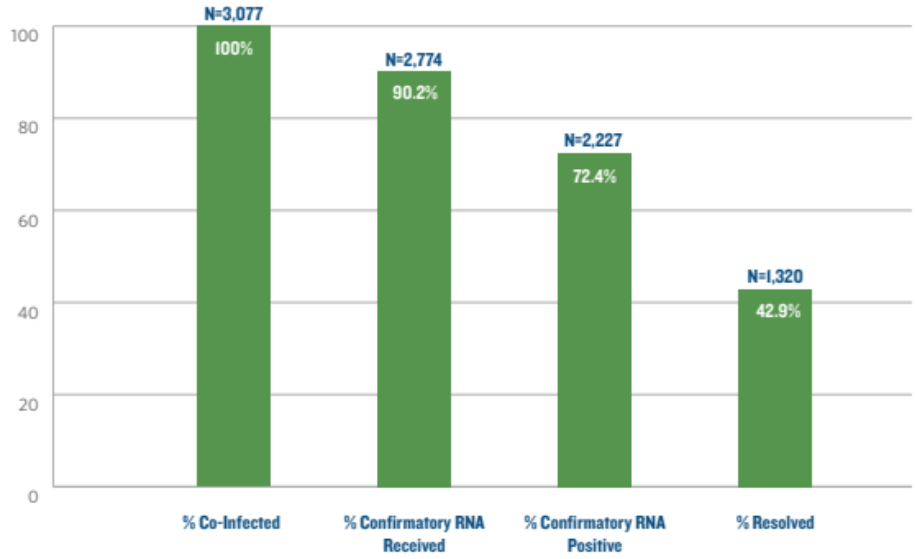
Transmission risk for HCV, Philadelphia, 2013-2018



HCV Care Continuum among PLWH - Philadelphia, 2018

FIGURE 7

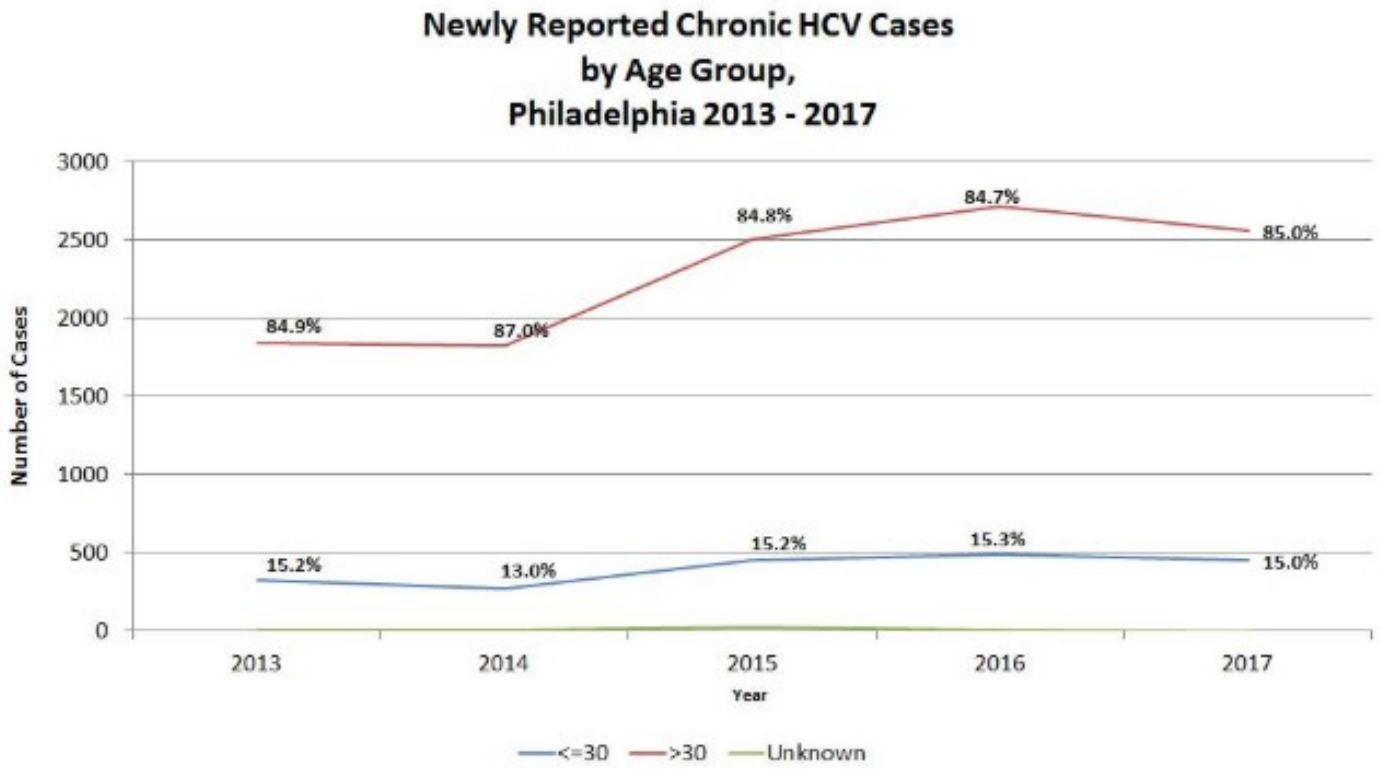
Hepatitis C Virus (HCV) Care Continuum among Persons Living with HIV, 2018



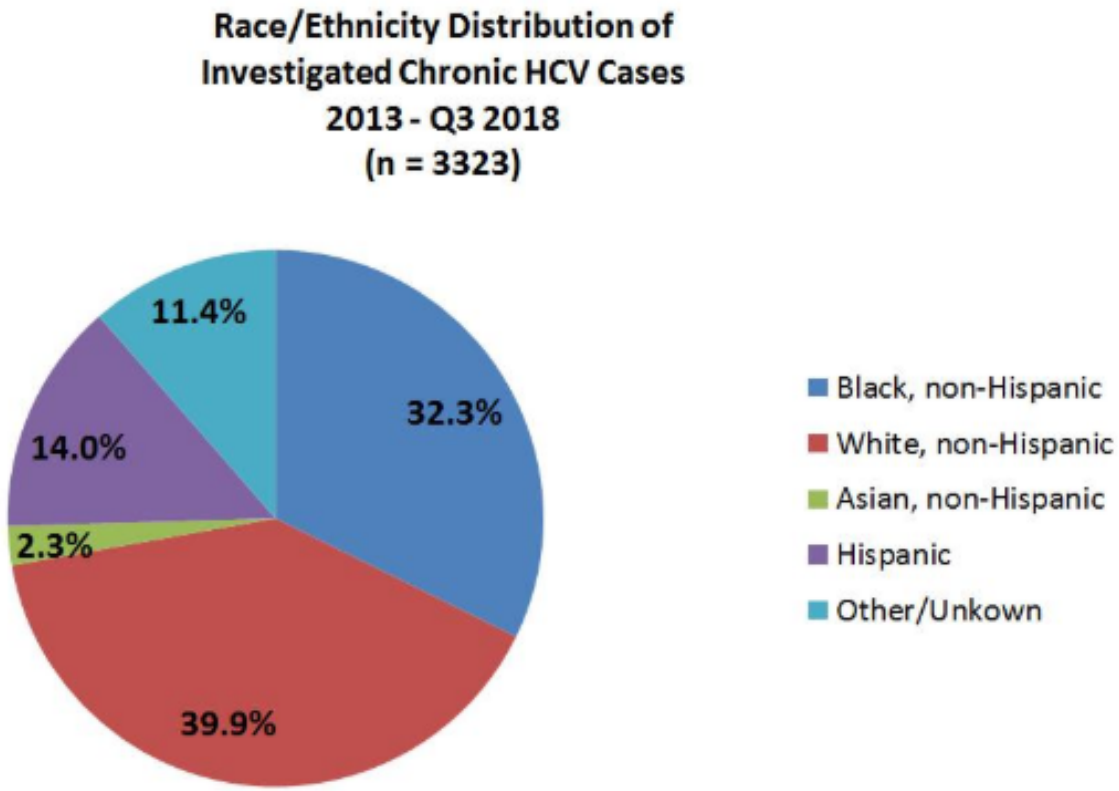
Note Resolved refers to the percentage of people with a negative HCV RNA result following a previously positive HCV RNA result.

Source Philadelphia Department of Public Health, AIDS Activities Coordinating Office; Philadelphia Department of Public Health, Division of Disease Control, Viral Hepatitis Program

Chronic HCV by age group - Philadelphia, 2013-2017



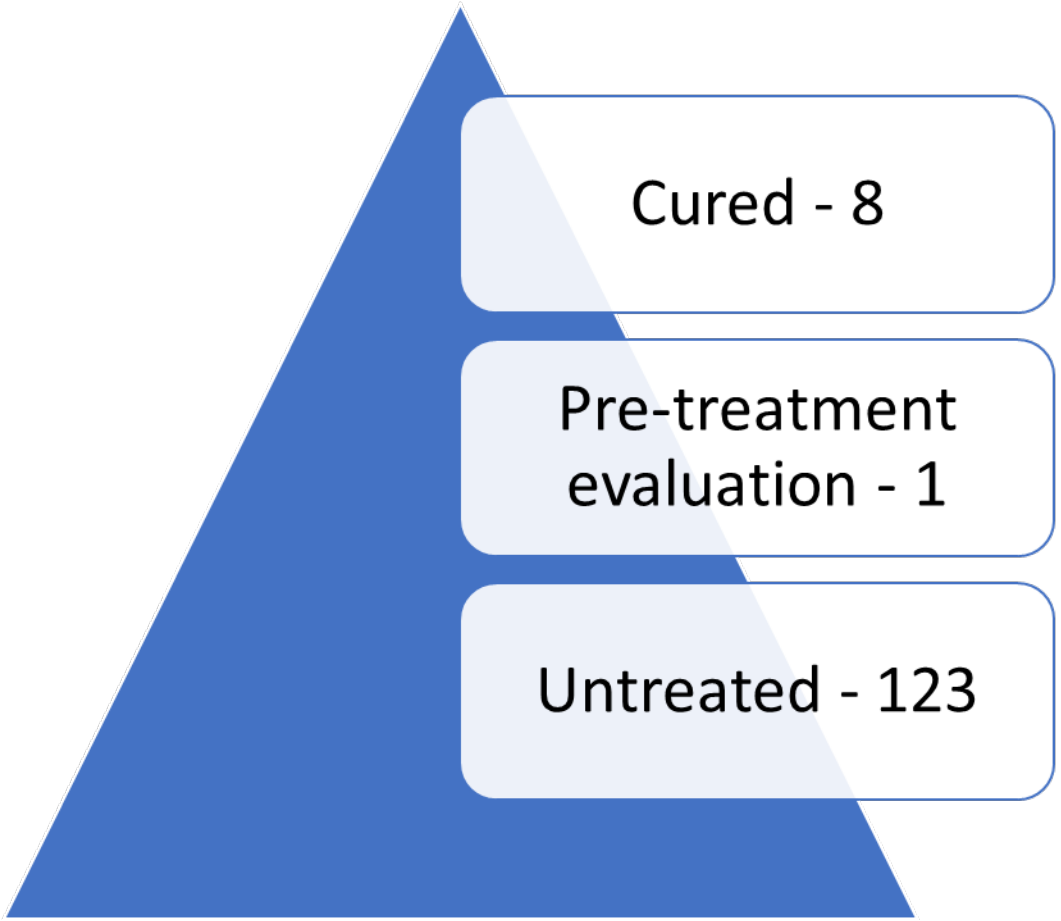
HCV/HIV in Philadelphia by race & ethnicity, 2013-2018



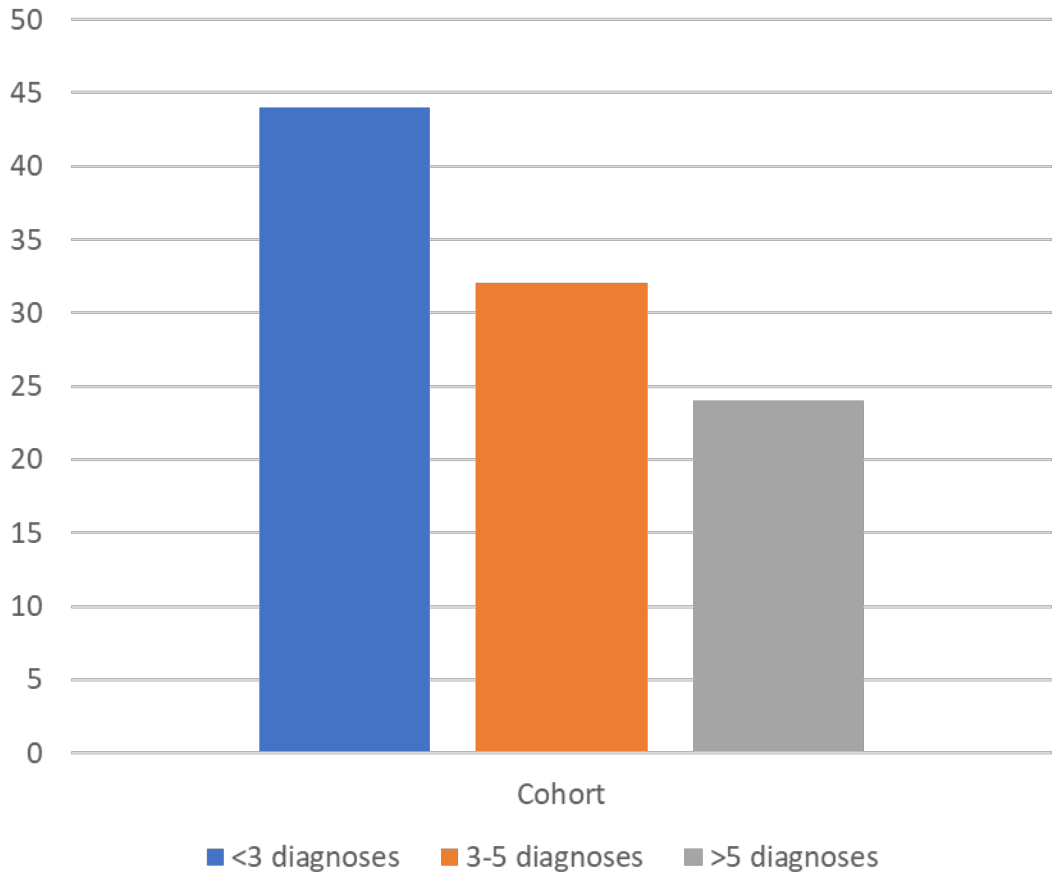
Setting – Ambulatory Health Services (AHS)

- 8 FQHC and FQHC look-alike facilities
- In the neighborhoods of Philadelphia
- Each center has an HIV Clinic
- Each center conducts HCV testing
- Each center offers MAT
- Each center has on-site Behavioral Health Counseling

Status of HCV cure at project start



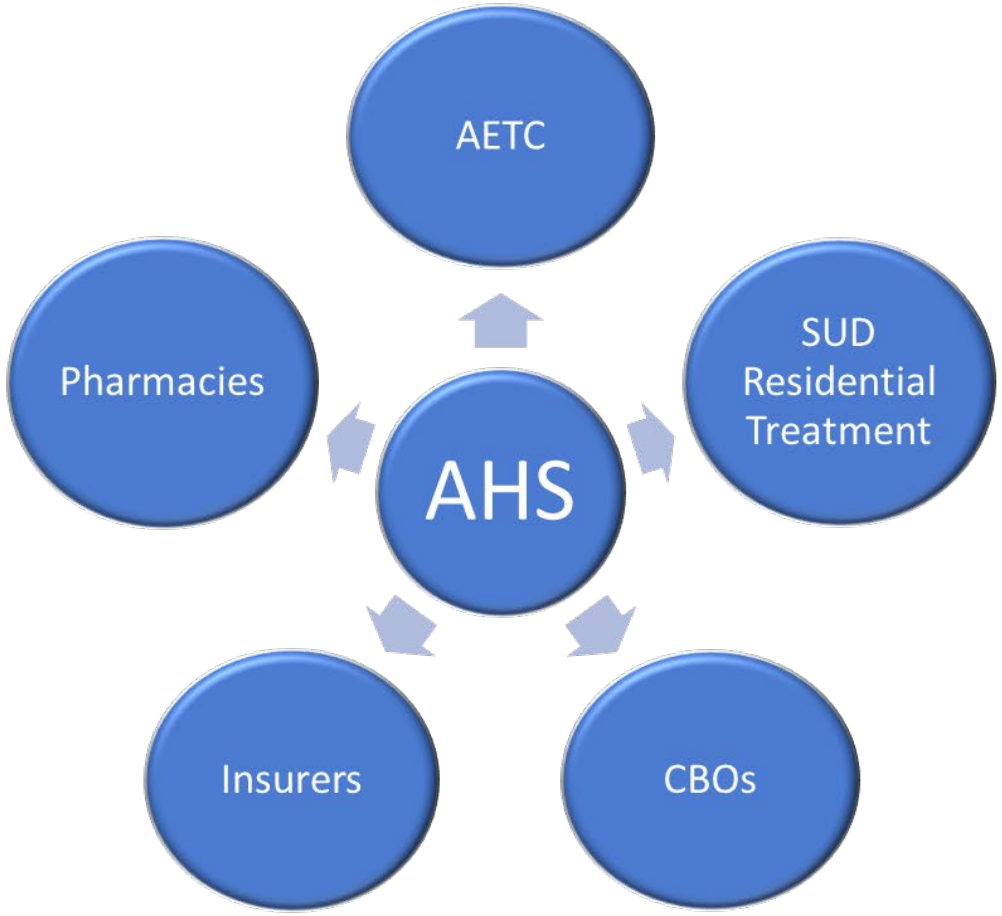
Documented co-morbidities of cohort at baseline



- Most frequent concurrent diagnoses
  - Hypertension (59%)
  - Obesity (38%)
  - COPD (32%)
  - Diabetes (31%)
  - CKD (18%)
  - CAD (11%)

Systems Engaged

Systems engaged



At baseline

- Patients referred to area GI and/or ID specialists
  - Current infection confirmed
  - All specialists in hospital systems
  - Preference for centers with experience treating persons with both HCV and HIV
  - Consult notes scanned into EMR
- Uninsured patients referred also
  - AHS contracts with area hospitals for uninsured patients

Sequential Cure Strategies and Outcomes

Engaging systems at AHS

- Staff
  - Integrating training into ongoing training series
- Administration
  - Facilitating inter-center care
- Clerical
  - Facilitating appointments (new and follow up)
- Laboratory
  - Minimizing missed orders, incorrect processing of specimens, incorrect translation of orders
  - Expediting results when possible
- Patient Assistance Program
  - Access to manufacturers' assistance programs

Training and education

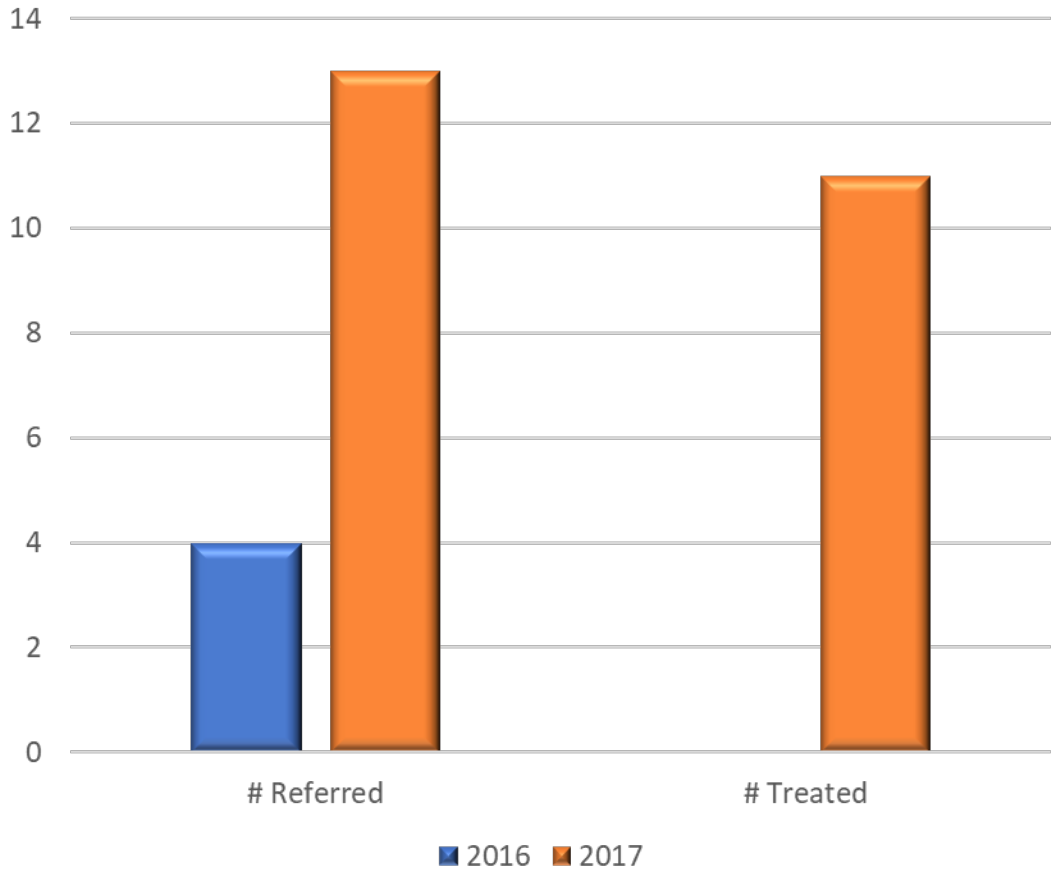
- Pennsylvania Mid-Atlantic AETC
  - Annual training for HIV program providers and staff
    - Additional Summer training provided
    - Local and national speakers with HIV/HCV treatment experience
- Patient education (patient groups, visits)
    - Availability of HCV treatment at AHS
    - Newer DAA treatment options
    - Potential for cure for many patient types

Training and education outcomes

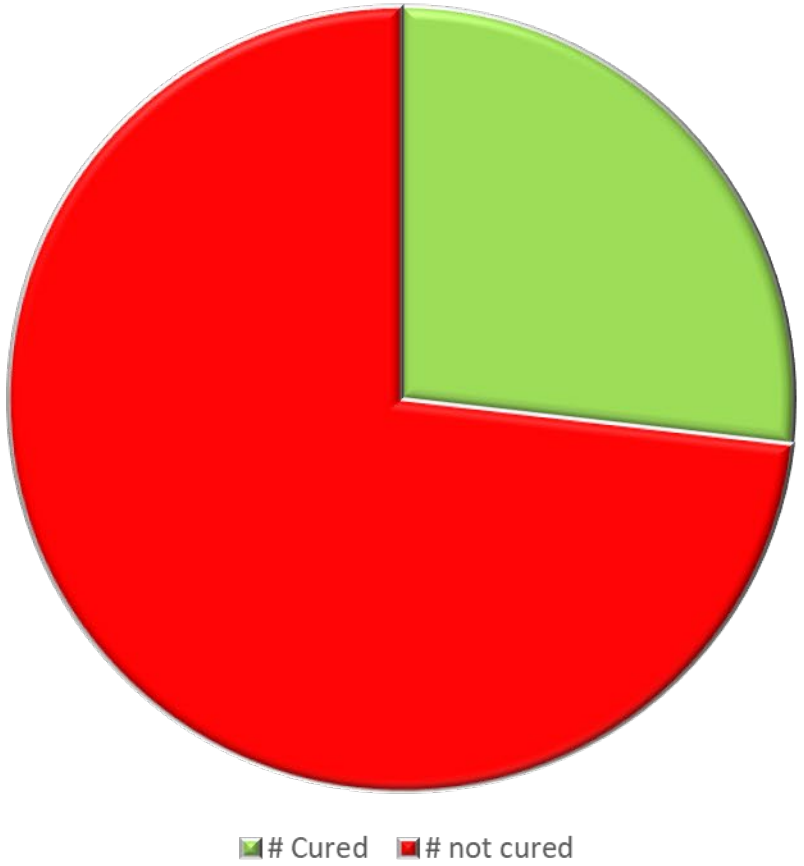
- All providers, nurses trained on HCV treatment in context of HIV
  - 1-3 times a year
  - Case-based
- Institutional protocol developed based on hcvguidelines.com and available resources
- Of 8 providers, 3 began treating HCV
  - The 3 providers covered all 8 centers
  - Intra-center referrals encouraged
- All other HIV Program staff trained on HCV treatment needs
  - Navigators (ensure pre-treatment labs, follow up appointments)
  - Social Workers, Medical Case Managers (assist with linkage to mental health, housing, SUD treatment and other supports)
  - Nurses (baseline, interim and cure labs, counseling on adherence, preparing for visits)

Training and education outcomes

- Increased referrals
- Improved support for patients on treatment
- Number treated by referral
  - 2016 – 4
  - 2017 - 13
- Number treated on-site
  - 2016 – 0
  - 2017 - 11



Progress to HCV cure of all persons living with HIV/HCV, 2016



Intra-center referrals

- Number one reason for lack of treatment
  - Referral not completed
- Number one reason for incomplete referrals
  - Reluctance to seek services at referral hospital
- Intra-center referrals established
- Inter-center referrals also established

Referrals

- External
- Preferred list of providers compiled with HIV experience
- Direct contact information for providers obtained
- Support services at AHS continued in collaboration with treatment team
- HIV treatment at AHS continued

- Internal
- To one of HCV-treating providers
- Mostly intra-center referrals
- Occasionally inter-center referrals (permission obtained for this)
- Provider – provider communication
- Team – team communication

HCV team meetings

- Quarterly report of candidates for treatment by health center
  - From CAREWare
- Discussed barriers for each patient with care team
- Reviewed where they were on the treatment spectrum
- Developed plan for each patient

Most common barriers

- Substance use disorder with active use
- Clinical instability
  - Frequent ED visits, hospitalizations
  - Worked with providers around ongoing alcohol use, active SUD
- Social instability, eg unstable housing
- Awaiting surgery, intensive treatment
- Loss to HIV primary care

Case study: A long road to cure

- 62yo man with HIV and HCV diagnosed in 2014
- DM diagnosed in 2016
- Excellent HIV control, HCV untreated, poor DM control
- Convinced to undergo HCV treatment
- 2 weeks into treatment, he was hospitalized with markedly elevated glucose
- Resumed HCV treatment 1 year later – he was convinced that his hospitalization was a result of his HCV treatment
- His ex-wife convinced him otherwise and supported him through treatment

Strategy 2: Enhanced support for on-site treatment

- Patients overwhelmingly preferred on-site treatment for HCV
  - Even if with a provider other than their PCP
  - No new care delivery system to navigate
- Data sharing seamless
- Team-team communication seamless, occurred in real time
- Appointments facilitated, reducing wait times
- Support staff often shared across teams

Provider barriers

Insurance

- Prior authorization
- Laboratory requirements

Pharmacy

- Restrictions
- Lapse in med supply
- Communication

Active alcohol use

- Discomfort with treatment
- Also active substance use

Insurance barriers

- Centralized assistance with prior authorizations
  - Kept up with evolving requirements
    - Medicaid
    - Medicare
    - Private insurers
    - Manufacturers' assistance programs (on-site at health centers)
    - ADAP (on-site at health centers)
  - ID physicians on team supported the process
- Central team provided support eg ordering labs, following up with patient for adherence support, ensuring follow up

Insurance barriers

- Timing can be frustrating for team as well as for patient
- Consistent follow up with carriers
  - Call to ensure request received
  - Direct number of main contact preferred
  - Inform patient they may hear from carrier
- Some prior authorization requests – up to 22 pages
- Choice of medication may not be preferred by carrier
  - Balance likelihood of completing treatment vs ease of obtaining medication
  - Pt education is key to achieving this balance
- Uninsured patients – ensuring documentation important

Pharmacy

- Central team established link with one pharmacy preferred by Medicaid HMOs
  - Maintained contact with dedicated person at this pharmacy
  - Sent pharmacy medication list for each patient to minimize drug-drug interactions
- Delivery arranged to specific health center for each patient, or to patient's home or CBO of choice

Active alcohol or substance use

- Covered in training
- Discussed with providers
- Cessation strongly advised to all such patients and support offered, but HCV treatment offered to all patients
- For active substance use, treatment programs recommended
  - HCV cure for this population preferred in residential treatment programs
- Link established with 1 local residential treatment facility

Patient support

- RWHAP support services
  - Medical Case Managers
  - Patient representatives
  - Health System Navigators
- Team RN
- Provider
- Central support team

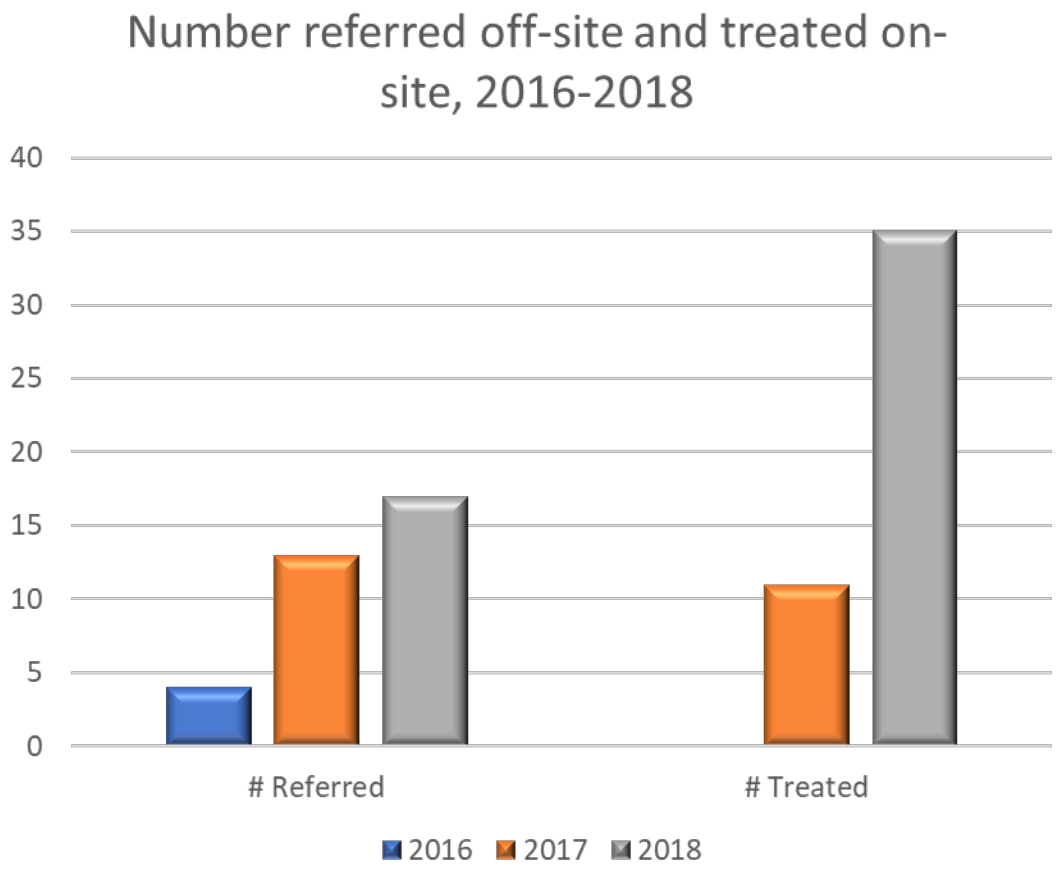
Community-based organizations

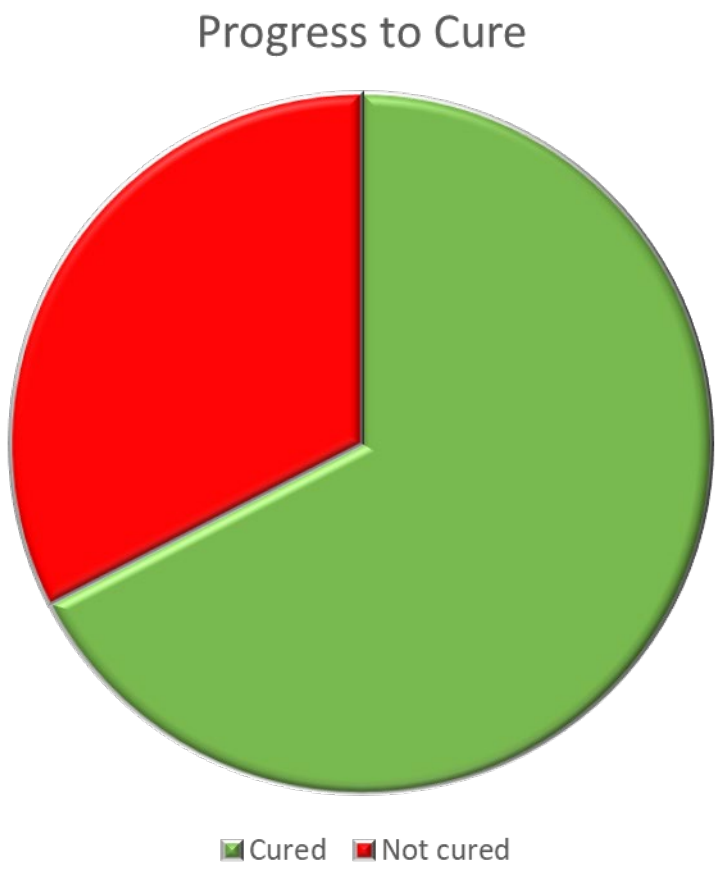
- Some patients very closely linked to specific CBOs
  - Food bank
  - Behavioral Health Counseling
  - Medical case management
  - Drop-in
  - Receive mail
- Delivery of meds to CBO arranged for some such patients
- CBO staff excellent partners in ensuring follow up, communicating with patient, medication delivery

Community-based organizations

- Temporary housing (6 months) for patients to span facilitated evaluation and treatment when needed
  - In collaboration with local CBO
  - Patients paid $150/month for rent and utilities - for a room with a lock and shared common spaces – 2-3 to a unit
  - Weekly check-in by CBO
- 4 patients utilized this option in 2018

Strategy 2: Outcomes





2018 review

- More patients referred to area hospital systems but not completing referrals
  - Many with more complicated HCV cases
  - Some with prior experience at the designated hospital
- Reasons for not completing referrals
  - Insurance instability
  - Forgot appointment
  - Lacked transportation to/from appointment
  - Received medication but never started
  - Unknown

Strategy 3: Enhanced support for external referrals

- RWHAP support services teams
  - Medical Case Managers
  - Patient representatives
  - Health System Navigators
- Access to electronic health records of some area hospital systems
- Reminder calls to patients
  - Appointments (ensure transportation available)
  - Laboratory visits
  - Adherence checks and support
- Support for internal referrals maintained

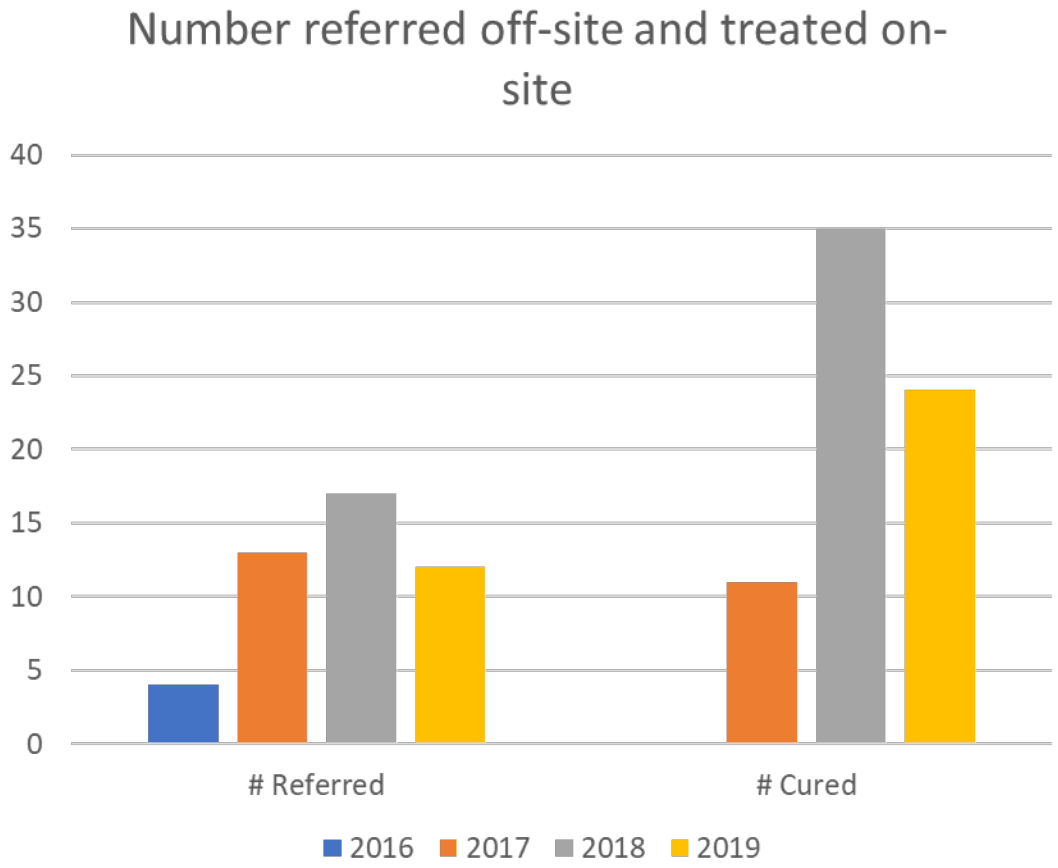
Internal referrals

- Additional provider began to treat, enhancing capacity for on-site treatment

Strategy adjustment

- Hybrid strategy
- External referral partner at community site with experience treating HCV/HIV
  - Familiar to health center staff and some patients
- Doubled referral completion rate

Outcomes: Strategy 3, Hybrid Strategy



Case study

- 61yo woman with multiple co-morbidities, cirrhosis
  - DM with multiple complications, hypertension, osteoporosis, COPD, major depression, chronic back pain , hypothyroidism, SUD with active use
  - Medical coverage - Medicare
- Multiple attempts to treat were unsuccessful because of medical instability
  - Never completed authorization process before change in medical status
- Worked with patient and daughter to get her into residential treatment
  - Used pharmacy of patient's choice
  - Completed HCV treatment 2 months ago

Case study

- 34yo man with HCV/HIV, evaluated for treatment
  - Commercial insurance
- Prior authorization obtained on second appeal
  - Monthly co-pay > $6,000
- Manufacturer's assistance program recommended some foundations
  - 2 foundations covered his co-pay and enabled him to complete treatment and cure

Remaining persons to be cured

- 8
- 5 in process of pre-treatment evaluation and/or prior authorization
- 3 medically unstable
- New patients to system prioritized for cure (11 over project period, 10 cured)

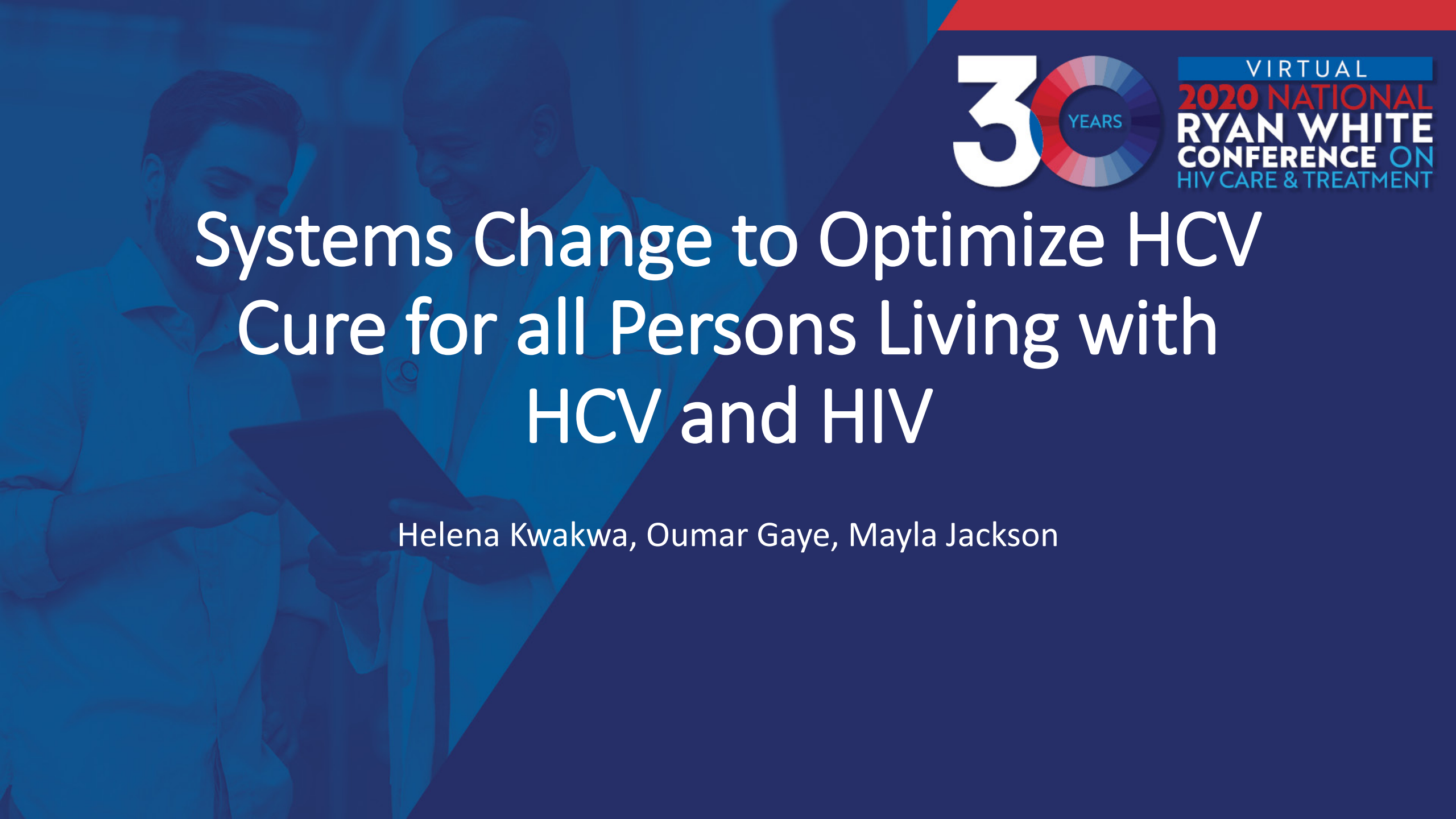
Successes and Challenges

Successes

- Steady progress over 4 years to cure a cohort facing multiple seemingly intractable barriers to cure
- Engaging multiple unrelated systems in support of cure for the cohort
  - Beginning with our own internal systems
- Relationships built endure for future patients, and for other projects as well
- Treatment (and treatment-related support) served as stabilizing factor for some patients who have since been more stable

Challenges

- Treatment increased in difficulty as we proceeded
  - Challenges presented seemed more intractable
- Medically and socially complex cohort
- Managing patients' perceptions and motivations
- Engaging some systems without additional funding to allocate to other systems was sometimes tricky
  - Had to find innovative ways in which partners would benefit
- Major challenge was navigating insurance carriers



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