

# C an Impact

*Using Data Integration Strategies to Track Progress  
Towards Hep C Elimination in the Philadelphia EMA*



City of  
Philadelphia

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# ACKNOWLEDGEMENT OF SUPPORT

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# Learning Objectives

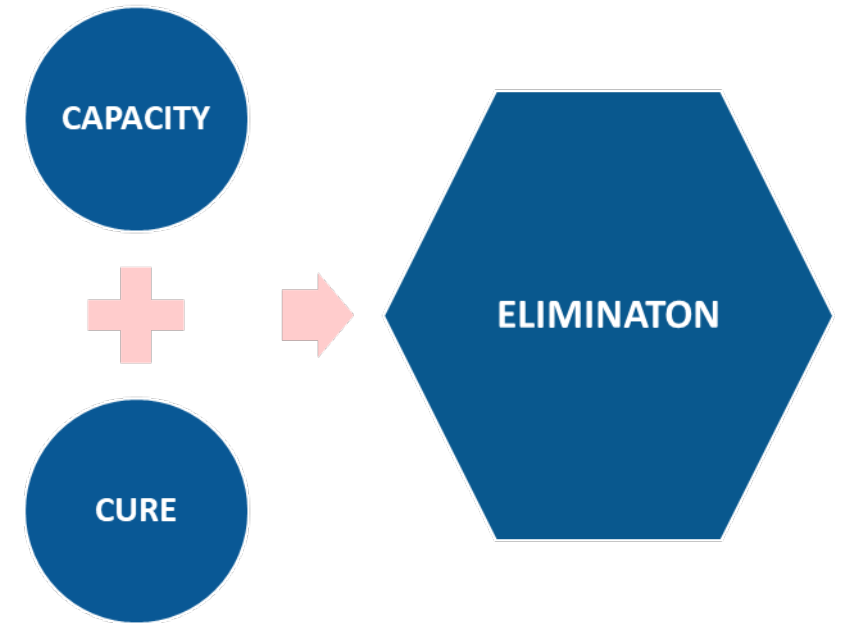
By the end of this presentation, Philadelphia's C Ya team hopes you will be able to...

- Champion hepatitis C elimination as a feasible goal among PLWH
- Understand the importance of data and surveillance in hepatitis C elimination efforts
- Identify areas where hepatitis C could be integrated into Ryan White programs and services

# C YA:

## Philadelphia's Plan to Connect our Co-infected Community to a Cure

- 3-year SPNS project (9/16 – 9/19)
- **Goals:**
  - Increase **capacity** to provide hep C screening, care and treatment in the HIV service system
  - Increase **number** of HIV/HCV co-infected people who are diagnosed, treated and cured of hep C



# C Ya: Philly's Plan to End Hep C in PLWH

## Data & Evaluation

- C Who is Co-Infected

## Training & Capacity Building

- Cross train staff to address hep C

## Re-Engagement in Care

- Connecting PLWH to HCV Cure

## Service Integration

- Continuity & Sustainability

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# Data & Surveillance

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*HIV and hepatitis surveillance capacity is critical to hep C elimination among PLWH: better data helps Ryan White programs develop targeted and measurable strategies to integrate hep C into an existing service system*

# Philadelphia's Data Sources

## QUANTITATIVE

*Illustrate progress & gaps  
along the HCV Continuum*

### Surveillance Databases:

- Hepatitis Registry
- EHARS
- CAREWare

### Data Activities:

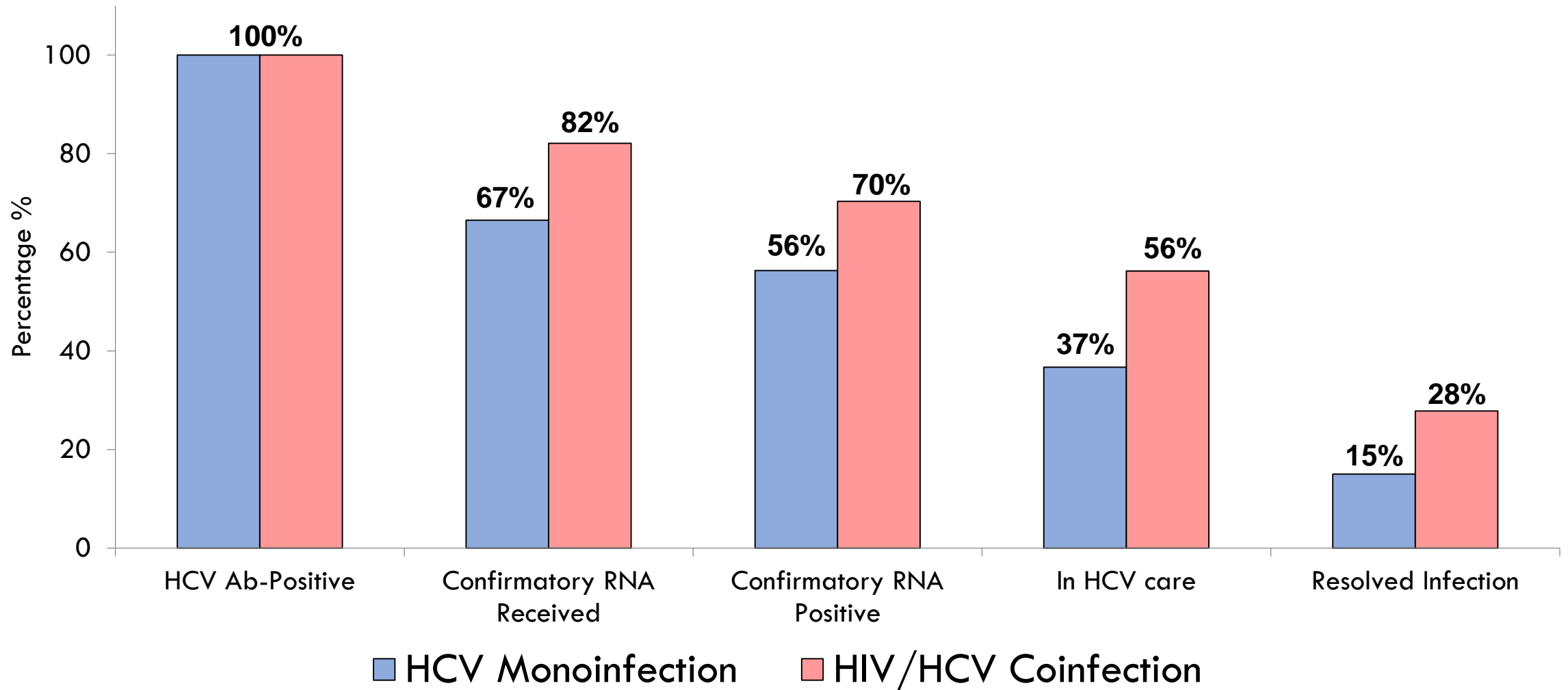
- Routine Monthly Matches
- Data-To-Care Integration (CoRECT)
- CAREWare Measures
  - QI Plans, Feedback Reports

## QUALITATIVE

*Describes why gaps exist &  
where project might have impact*

- **20** Clinical Site Visits
- Regular HepCAP & Community Meetings
- Focus Groups
- Training Feedback
- Data to Care Case Conferences
- Cross-Program Meetings

# HIV Infrastructure Boosts HCV Outcomes In PLWH

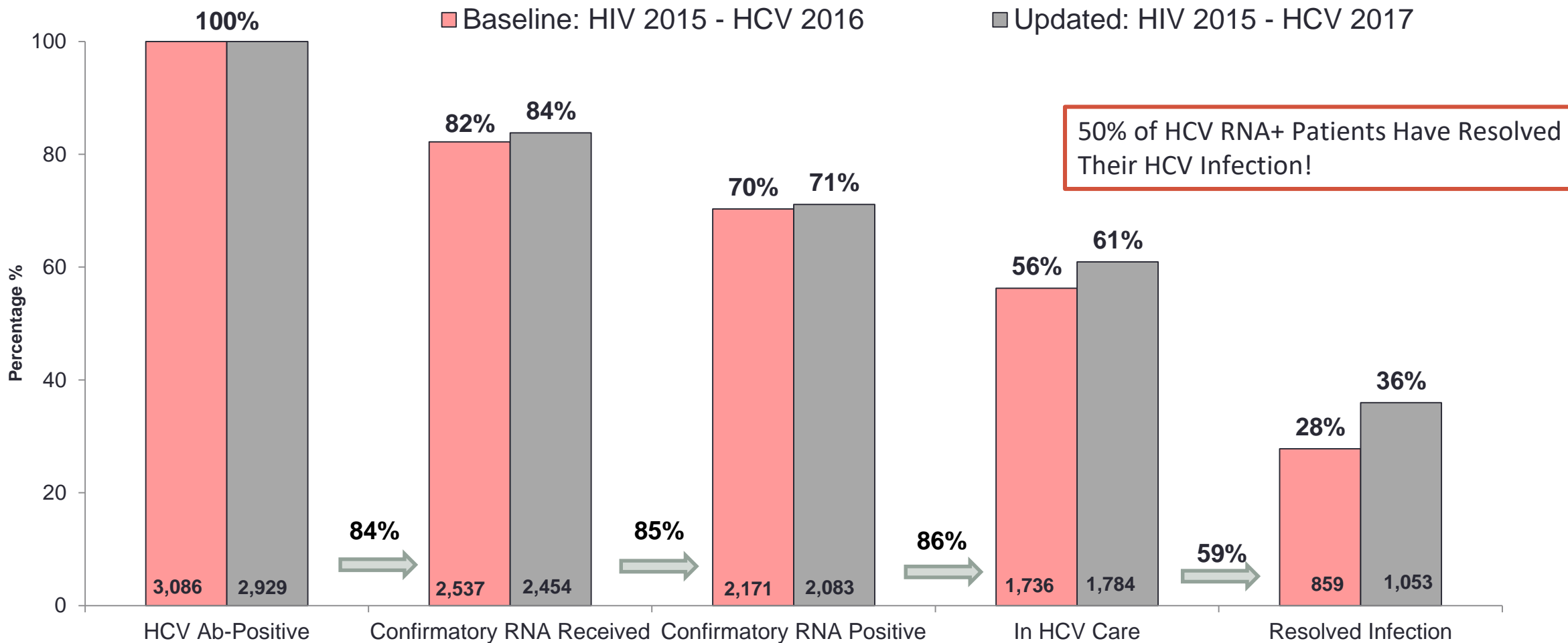


Source: Philadelphia Department of Public Health, AIDS Activities Coordinating Office & Viral Hepatitis Program



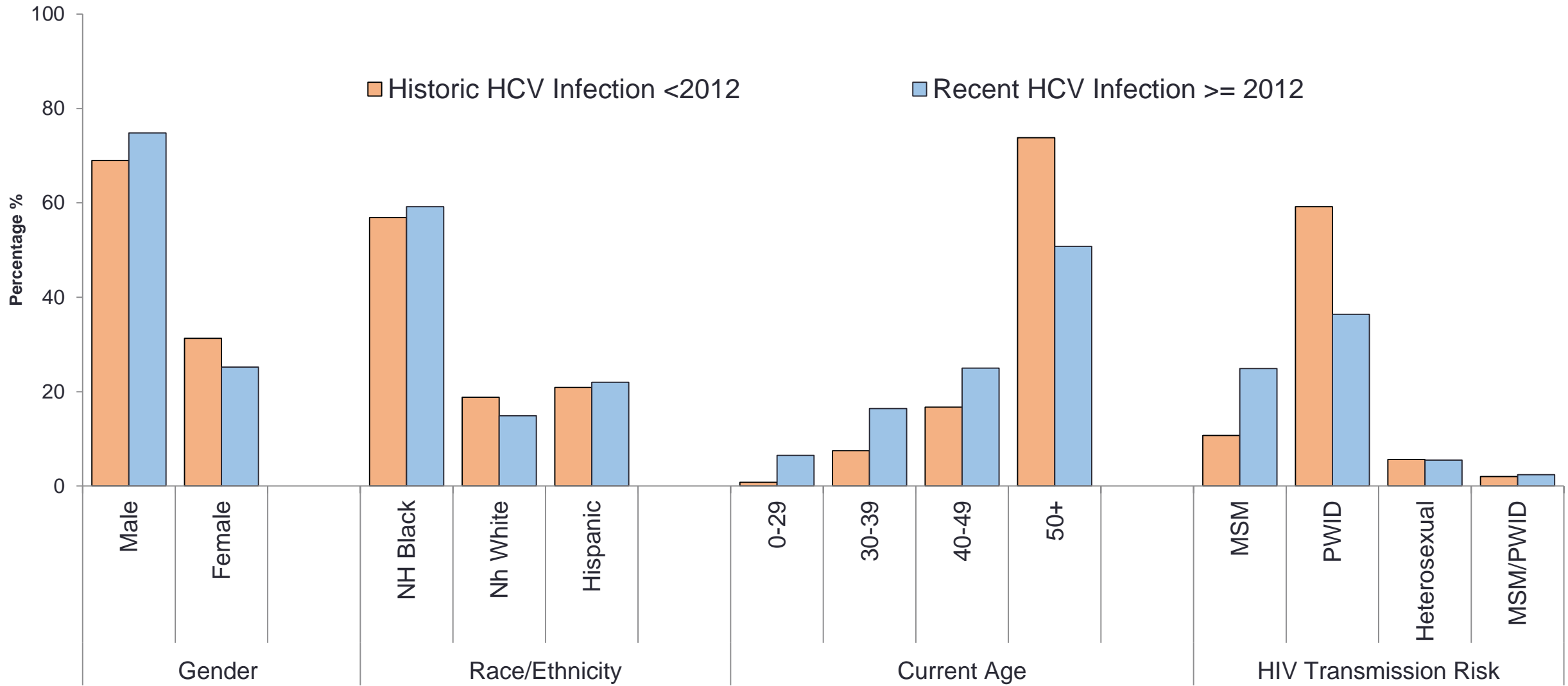
# HCV Continuum is Improving for Philadelphia PLWH in DAA Era

Ability to create & update a local HCV continuum for PLWH helps us target activities & track improvements



Source: Philadelphia Department of Public Health, AIDS Activities Coordinating Office & Viral Hepatitis Program

# Data Integration Helps Us Monitor New HCV Co-infections



# Enhancing Local HCV Measures in RW System

## Why?

- Current HRSA measure limited in what it tells us about co-infection in RW system
- Would local CAREWare measures help us identify high and low performing sites?
  - Which care sites have already integrated HCV services and applied best practices?
  - Which sites need additional support to build HCV capacity?

## Current RW HAB Measure:

HAB09	Hepatitis C Screening (HAB)
Definition	Percentage of clients for whom Hepatitis C (HCV) screening was performed at least once since the diagnosis of HIV infection
Numerator	Number of HIV-infected clients who have documented HCV status in chart
Denominator	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year
Exclusions	None

# Enhancing Local HCV Screening Measure

## How?

- New HCV measures in EMA's CAREWare help evaluate site-specific outcomes
- Made HCV screening an **ANNUAL** measure
  - Get a better sense of local HCV prevalence and ongoing transmission patterns
    - Assess whether annual screening improves identification of new HCV infections
    - Identify emerging risk populations that may be missed in "risk" based screening

## PHL's HCV Screening Measure:

PHL10	Hepatitis C Screening
Definition	Percentage of patients, regardless of age, with a diagnosis of HIV for whom Hepatitis C (HCV) <u>screening was performed at least once during the measurement year</u>
Numerator	Number of eligible patients with a documented HCV antibody or HCV RNA screening during the measurement year
Denominator	Number of patients with a diagnosis of HIV who had a medical visit at least once during the measurement year
Exclusions	Patients who were deceased or inactive, or are Not Medically Indicated (NMI) for an annual screening due to no sexual activity since last screening and no history of substance use

# Enhancing Local HCV Diagnosis & Treatment Measures

- **How?**
  - Set hepatitis C screening and treatment as 2017 quality improvement measures

## PHL's HCV Diagnosis & Treatment Measures:

PHL11	HCV RNA Performed if HCV Antibody Positive
Definition	Percentage of patients, regardless of age, with a diagnosis of HIV and positive Hepatitis C antibody who had an HCV RNA performed
Numerator	Number of eligible patients who had an HCV RNA test performed on the same day or after the last positive HCV antibody result
Denominator	Number of patients, regardless of age, with a diagnosis of HIV and at least one medical visit during the measurement year who had a positive Hepatitis C antibody at last screening
Exclusions	Patients who were deceased or inactive

PHL12	HCV Treatment Prescribed
Definition	Percentage of Patients with a diagnosis of HIV who are currently co-infected with HCV and have received HCV treatment
Numerator	Number of eligible patients who received HCV treatment on the same day or after the last positive HCV RNA result
Denominator	Number of patients with a diagnosis of HIV, ages 12 and over, with at least one medical visit in the measurement year and a positive HCV RNA test at last screening
Exclusions	Patients who were deceased or inactive
Notes	This measure will not include patients who have been successfully treated and is intended only to assist the program in following up on patients who may be eligible for treatment—it will not be collected for the purposes of monitoring and evaluation

# Impact of Data Integration Activities

## Successes & Benefits:

- Full-time HIV/HCV Epi is an essential team member
  - Matches cross-program data & translates it for project team & partners
- Buy-in from AACO leadership to add new CAREWare measures
- Provider flexibility adapting to new HCV measures
- QI process allowed us to monitor HCV services and provide feedback to care sites

## Challenges & Next Steps:

- Tracking outcomes for clients getting care from non-RW providers
- Ability to assess local trends once we have more than 1 year of data
  - Can we create a more timely feedback loop with clinical partners & use HCV data more proactively?
  - What type of data report would be useful for care sites?

# Data to Care

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*Building hepatitis C into existing HIV data to care programs helps prioritize untreated co-infected patients for care re-engagement*

# Building HCV into an Existing D2C Project

## **Create a new hep C linkage program for PLWH or use an existing project?**

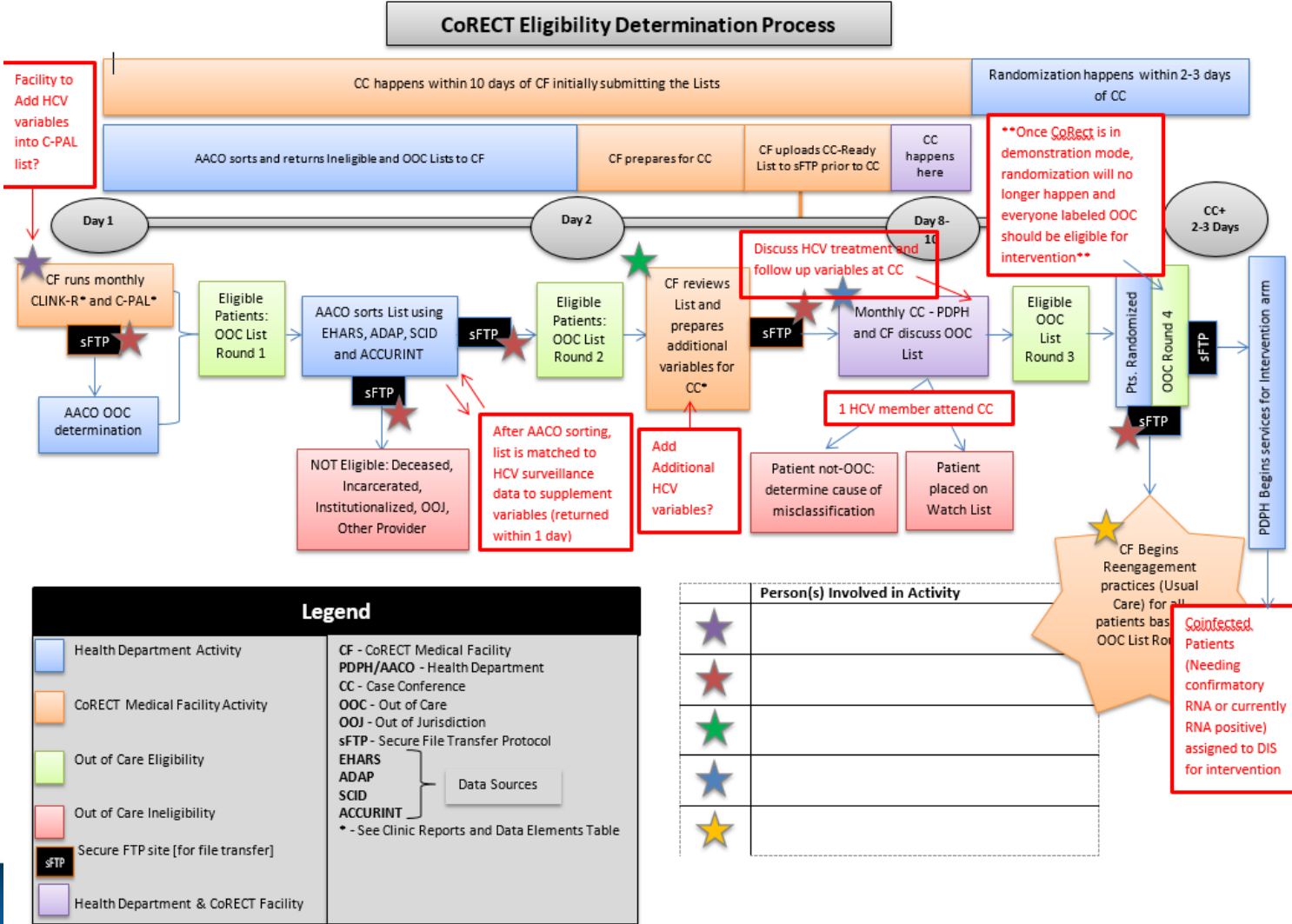
- Isn't it more sustainable to build hep C into CoRECT, a CDC-supported project?
  - Partnership between AACO, STD, and 7 HIV care sites
- Uses data, provider feedback, and DIS to identify, locate, and re-engage lost to care patients

## **C Ya & CoRECT teams collaborated to:**

- Develop codes & process to match monthly CoRECT lost to care lists with HCV data
- Adapt outreach forms and program protocols to collect information relevant to HCV care
- Cross trained DIS who do patient outreach and care re-engagement using ARTAS model



# Is Hep C Integration in Data to Care as Hard as it Looks?



# Points of Hep C Integration in D2C Activities

## Data

- Monthly data uploads and matches between care sites and AACO
- Routine SAS Coding to generate reports and identify high priority patients
- Track care retention and HCV treatment outcomes among re-engaged co-infected patients

## Discussion

- Monthly case conferences with all care sites (in-person and by phone)
- **Pros:** Info about complexity of cases; opportunity to build relationships with care sites
- **Cons:** Time consuming and resource heavy

## DIS

- STD DIS have been cross-trained on hepatitis C
- **Major Limitation:** DIS can get folks back in the door, keeping clients engaged long enough for hep C to be cured falls on other pieces of HIV system

# Impact of Data to Care Integration

## Successes & Benefits:

- Hep C integrated into process at 6 out of 7 current CoRECT sites
  - All sites treat hep C; once re-engaged patients can get HIV and hep C treatment at same clinic
- Cross-trained staff and built HCV fluency across programs

## Challenges & Next Steps:

- Even if providers are “drug user friendly”, is the practice welcoming and accommodating?
  - Ex: DIS get a patient in active use gets back in the door, but what happens next?
- Share & scale up models of harm reduction from front desk to exam room
  - “Meeting people where they are at and not leaving them there”
  - Identify and share strategies to keep clients engaged when there are competing priorities
    - Addiction, housing, work, childcare, mental health...
    - How can coordination between systems that “touch” clients be improved?

# From Integration to Elimination

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*What needs to be done to keep tracking progress and ensuring PLWH are being moved swiftly through the HCV continuum?*

# Evaluating C Ya's Impact

## Research Questions:

- Will C-YA improve HCV care continuum outcomes among co-infected patients in the Philadelphia EMA?
- How will C-YA develop and promote best practices that lead to sustainable improvements to the HCV care continuum?

## Tracking Outcomes:

- *Patient-Level Outcomes:* # PLWH tested and moved along HCV continuum
- *Facility-Level Outcomes:* Availability and utilization of hep C services and best practices
- *Project Implementation Outcomes:* Impact of C Ya on improving Client/Facility outcomes

# Using Data to Guide Next Steps

- **Now that we've collected data, share it!**
  - Update analyses to identify where HCV outcomes have improved, where gaps remain
  - Share findings locally:
    - Empower HIV providers to focus on elimination at their practice
    - Share info with hep C community to highlight best practices for micro-elimination
  - Share findings nationally: contribute to growing body of HCV elimination publications
- **Identify Opportunities for Sustainability**
  - What activities have had most impact towards hep C elimination?
    - What resources would it take to sustain until elimination achieved?
  - What hep C integration opportunities need to be explored more?
    - Ex: Strategies to incorporate hep C in case manager role
  - In midst of opioid crisis, use cross-program collaboration to address drug user health
    - Outbreak planning with other program areas: HEP, STD, Opioids, etc.

# THANK YOU!

## Philadelphia Dept of Public Health

- Viral Hepatitis Team
- AIDS Activities Coordinating Office
- C Ya, CoRECT & C Change Teams

## Community Partners

- HepCAP
- Mid-Atlantic AETC
  - Philadelphia Performance Site at Health Federation
- Philly's HIV Service Providers
- Philadelphians living with HIV & hep C

## National Partners

- HRSA & RAND



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