Strengthening the HCV Continuum of Care

Fabienne Laraque, MD, MPH, Medical Director
Viral Hepatitis Surveillance, Prevention and Control
Bureau of Communicable Diseases Control, NYC DOHMH
March 18, 2014
Disclosures

• None to report
Epidemiology of HCV in NYC

- Estimate of HCV infection prevalence based on surveillance data: 2.4% or 146,500 persons (≥20 years)*
- In 2012, in NYC, there were 7,643 were newly-reported cases (compared to 10,846 in 2009)
  - 64% males
  - 51% born between 1945–1964
- Based on enhanced surveillance project (2009–11)**
  - 50% born in the US/PR, and 3% from the Dominican Republic and Haiti, 2% from Russia and Pakistan
  - 33% Hispanics, 33% blacks
  - 43% had a history of injection drug use and 34% of intranasal drug use
  - 5% already had cirrhosis and 12% had HIV

*Balter et al, Epi Infect 2013
** Drezner, PHR 2013
HCV Surveillance – Newly Reported Patients, NYC, by zip code, 2012

Areas With Highest Rates

Highbridge–Morrisania
Central Harlem
Hunts Point
East Harlem
Trends of Age-adjusted Death Rates per 100,000 Population of the Multiple Cause Mention of HIV and Hepatitis C: NYC 1999 to 2011* (All Events Occurring within NYC)

*Contributing cause data for 2011 was obtained from the OVS statistical file and are preliminary.

Source: NYC Bureau of Vital Statistics / NCHS Multiple Cause Files for NYC
Rev. 3/12/13
Gaps in Care, NYC

Based on enhanced surveillance, of newly reported persons, 2009–11:

• 47% were tested for HCV because of risk factors, 29% because of abnormal LFTs
• Only 61% counseled on transmission and 61% on alcohol use
• 34% had no RNA test done despite follow-up by DOHMH (most in primary care or drug treatment programs)
• Only 13% on antiviral treatment
NYC HCV Estimated Treatment Cascade

Prevalence estimates among persons ≥20 years: Balter et al, Epidemiol Inf 2013
Summary of Institute of Medicine HCV Assessment and Strategic Plan

The Problem

- 0.8–1.4 million people are chronically infected with hepatitis B virus (HBV) in United States
  - 3,000 deaths each year are due to hepatitis B-related liver disease
- 2.7–3.9 million people are chronically infected with hepatitis C virus (HCV) in United States
  - 12,000 deaths each year are due to hepatitis C-related liver disease
- Over 150,000 deaths due to hepatitis B and hepatitis C are projected to occur in next 10 years

Underlying issues

- Lack of Public Awareness
- Lack of Provider Awareness
- Lack of Public Resource Allocation

Consequences

- At-risk people do not know that they are at risk or how to prevent becoming infected
- At-risk people may not have access to preventive services
- Chronically infected people do not know that they are infected
- Many medical providers do not screen people or know how to manage those infected
- Infected people often have inadequate access to testing and medical management
- Inadequate disease-surveillance systems underreport both acute and chronic infections

Recommendations

- Improved Disease Surveillance
- Improved Provider and Community Education
- Integration and Enhancement of Viral Hepatitis Services

Outcomes

- Screening is widely used as a part of good primary care
- At-risk people and communities actively seek testing, preventive services, and appropriate medical management
- Better information leads to
  - Improved understanding of hepatitis B and hepatitis C
  - More effective and targeted prevention programs
  - More research on effective vaccination and treatment options
- Infected people have better health outcomes
- Decreased transmission leads to fewer carriers of HBV and HCV and fewer cases of hepatitis B and hepatitis C

FIGURE 1-2 The committee’s approach to its task.

A Public Health Approach to HCV Control

The NYC DOHMH developed a Strategic Plan for HCV infection

• Primary goal: significantly reduce illness and death from HCV infection in NYC with primary and secondary prevention

• Key strategies:
  o Use surveillance and other data for action
  o Increase provider awareness and change their behavior
  o Promote HCV screening
  o Research and promote linkage to care
  o Improve treatment outcomes
  o Prevention
  o Leverage existing resources, seek new funding, promote relevant policies and increase community awareness
Use Surveillance and Other Data for Action

• Current activities:
  o Identify gaps and disparities (enhanced surveillance project)
  o Identify neighborhoods with a high rate of HCV infection
  o Use surveillance data to evaluate RNA testing practices

• Newly started or planned activities:
  o Identify persons with no RNA test
  o Monitor linkage to care
  o Monitor treatment uptake
  o Use surveillance data to link to care
Increase Provider Awareness and Change their Behavior

Using the Pathman-PRECEED model for behavior change (Davis, BMJ 2003), we aim to educate providers to increase screening and treatment capacity, by

• Predisposing health professionals to learning about HCV screening and management
  o Grand rounds, guidelines distribution, peer-to-peer learning,

• Enabling providers to apply best-practices through active learning
  o Tool kits, provider assessments, mentoring, public health detailing,

• Reinforcing new provider practices through feedback mechanisms
  o Provider/clinic assessments, Quality Improvement
New York State HCV Testing Law

Every individual born between 1945–1965
• Who receives health services as an inpatient in a general hospital or
• Who receives primary care services
  – Shall be offered a hepatitis C screening test or hepatitis C diagnostic test
Promote HCV Screening

• Implement the NYS Testing Law
• Increase screen: in primary care settings, in jail, and in drug treatment programs, particularly RNA testing
• Systems changes:
  o EHR alerts
  o Incorporate routine screening into clinic workflow and implement by non-clinical staff
  o Develop screening indicators and share with individual clinics and providers
• Educate the public and persons at risk
Research and Promote More Effective Linkage to Care

• Use surveillance and other data for linkage to care
  o Evaluate phone vs text-based linkage
  o Facility-led linkage starting from surveillance data
  o Send feedback to providers on linkage to care rates
  o Use Medicaid and other payers data for feedback
  o Use Electronic Health Records for feedback

• Collaborate with clinical providers and community-based organizations

• Collaborate with payers of care
Improve Treatment Outcomes

• Care Coordination
  – Navigation: assistance to obtain health insurance and benefits and schedule and keep clinical appointments
  – Treatment readiness assessment
  – Help address social issues and co-morbidities, mental or drug use issues: assessments and referrals; health promotion; community support
  – Medication adherence education and support

• Multi-disciplinary team for care

• Mentoring/telemedicine to increase treatment capacity
  • HIV and ID providers
  • Primary care, nurse practitioners and physician assistants
  • Shared care?
Prevention

• Primary prevention among young substance users
  – Monitor HCV infection rates
  – Investigate drug use patterns

• Strategies:
  – Collaboration with substance abuse programs, syringe exchange, and harm reduction programs
  – Treatment to prevent transmission
  – Education in schools
  – Safe injecting education in pharmacies
Challenges

- Lack of awareness among providers, persons at risk and the community at large
- Lack of funding
- Uninsured individuals unable to afford HCV care
- Co-morbidities
- Providers still reluctant to screen and treat
- Cost of new treatments:
  - One of the greatest barriers?
  - A human rights issue?
Thank you

Fabienne Laraque, MD, MPH, Medical Director
Viral Hepatitis Surveillance, Prevention and Control Program
flaraque@health.nyc.gov
<table>
<thead>
<tr>
<th><strong>Moderator</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mario U. Mondelli, MD, PhD</td>
<td>University of Pavia Pavia, Italy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Presenter</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fabienne Laraque, MD, MPH</td>
<td>The New York City Department of Health and Mental Hygiene New York, NY, USA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Discussants</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Kosh Agarwal, MD</td>
<td>King’s College Hospital London, England</td>
</tr>
<tr>
<td>Jeffrey Kwong, DNP, MPH, ANP-BC</td>
<td>Columbia University New York, NY, USA</td>
</tr>
<tr>
<td>Federico G. Villamil, MD</td>
<td>British Hospital of Buenos Aires Buenos Aires, Argentina</td>
</tr>
</tbody>
</table>