UNLOCKING HCV CARE IN KEY SETTINGS

HepNET
Hepatitis Network for Education and Testing

NASTAD

NVHR
National Viral Hepatitis Roundtable

Syringe Services Programs
2:30 – 4:00 pm ET

Implementing and Scaling-Up Routine, Bundled HIV/HCV Testing in Syringe Services Programs

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IDEA Miami Syringe Services Program

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Disclosures

Financial Relationships:

Dr. Bartholomew receives grant funding from Gilead Sciences and ViiV.

The FOCUS Program is a public health initiative that enables partners to develop and share best practices in routine blood-borne virus (HIV, HCV, HBV) screening, diagnosis, and linkage to care in accordance with screening guidelines promulgated by the U.S. Centers for Disease Control and Prevention (CDC), the U.S. Preventive Services Task Force (USPSTF), and state and local public health departments.

FOCUS funding supports HIV, HCV, and HBV screening and linkage to the first appointment after diagnosis. FOCUS partners do not use FOCUS awards for activities beyond linkage to the first appointment.

Number of reported cases* of acute Hepatitis C virus infection and estimated infections† — United States, 2014–2021

Risk Behaviors/Exposures†	Risk Identified*	No Risk Identified	Risk Data Missing
Injection drug use	820	629	3,574
Multiple sexual partners	142	397	4,484
Surgery	158	661	4,204
Men who have sex with men§	69	218	3,061
Sexual contact¶	61	289	4,673
Needlestick	50	701	4,272
Household contact (nonsexual)¶	14	336	4,673
Occupational	8	866	4,149
Dialysis patient	68	916	4,039
Transfusion	2	819	4,202

Year

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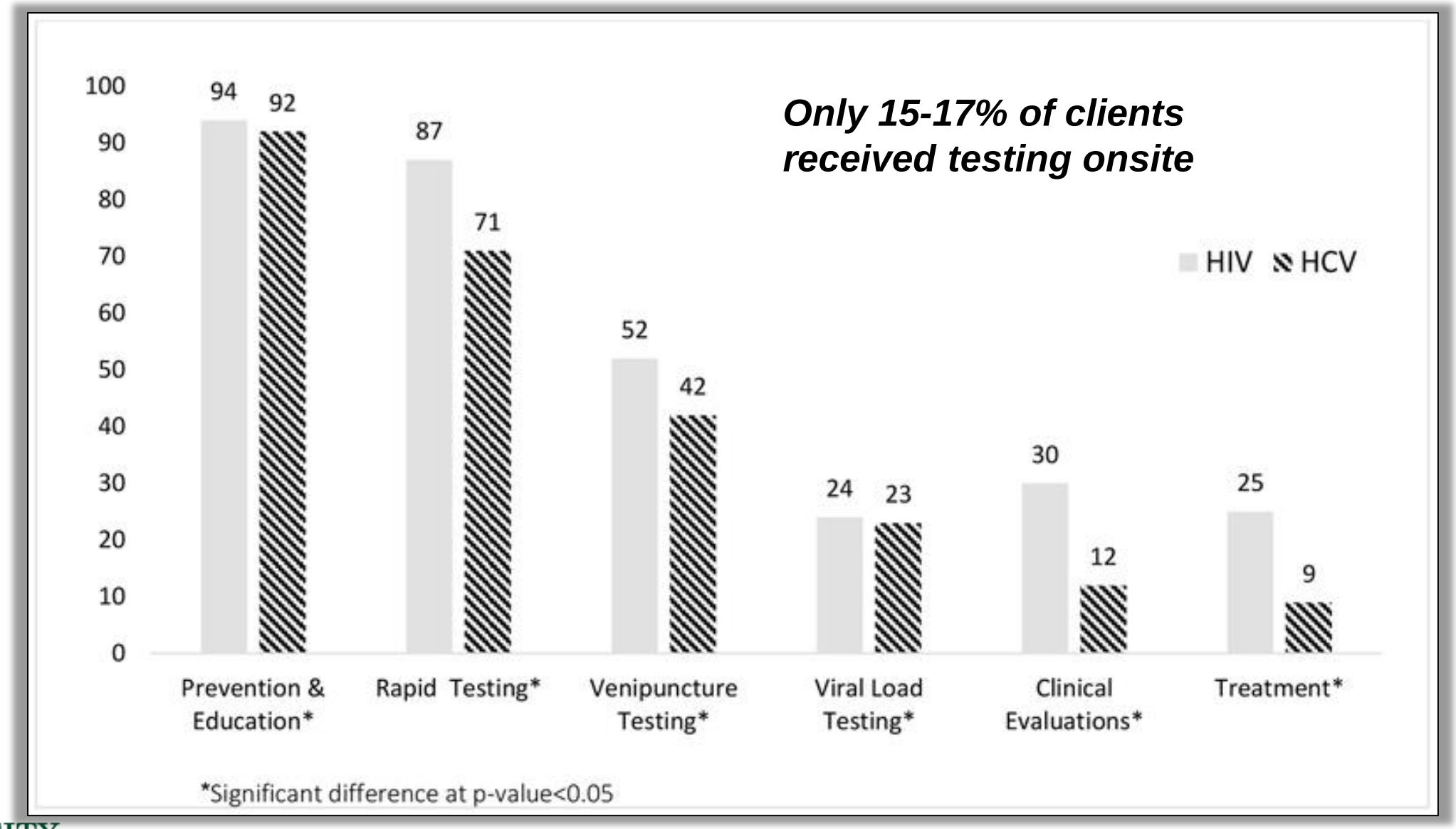
1. The traditional healthcare system has failed PWID

2. SSPs are community-driven, non-stigmatizing programs frequented by PWID

3. PWID engaged in SSPs are more likely to be tested for HCV

However, testing uptake remains low among SSP clients

Bull-Otterson et al., 2020; Heinzerling et al., 2006; Bayani et al., 2020; Hayes et al., 2014; Latham et al., 2019



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Behrends et al., 2018

Opt-Out HIV/HCV Screening Approach

- Testing is offered as part of routine/standard of care and clients can actively decline if they do not wish to be tested.
- Example language: *"HIV/HCV testing is part of routine care that we provide but you have the right to object or decline either test. Do you have any questions regarding HIV/HCV or testing?"*
- CDC has recommended opt-out testing for HIV across medical settings since 2008 to streamline identification of infection.
- Makes testing routine, systematic, and destigmatizes testing

CDC, 2020; Young et al., 2009; Zang et al., 2020

- Effective 07/01/2016
- Authorized the University of Miami syringe exchange pilot program
- Possession, distribution, or exchange of needles and syringes not a violation of the law.
- Provide sterile injection equipment throughout Miami-Dade County

- Retrospectively gathered administrative records data from the IDEA Miami SSP between December 2016 – January 2020 (37 months)

All data are collected electronically using REDCap

Opt-In Testing Policy Period (15 months)	Opt-Out Testing Policy Period (22 months)
512 SSP participants	**547 SSP participants**
↓	↓
Monthly Testing Reach Estimates	Monthly Testing Reach Estimates

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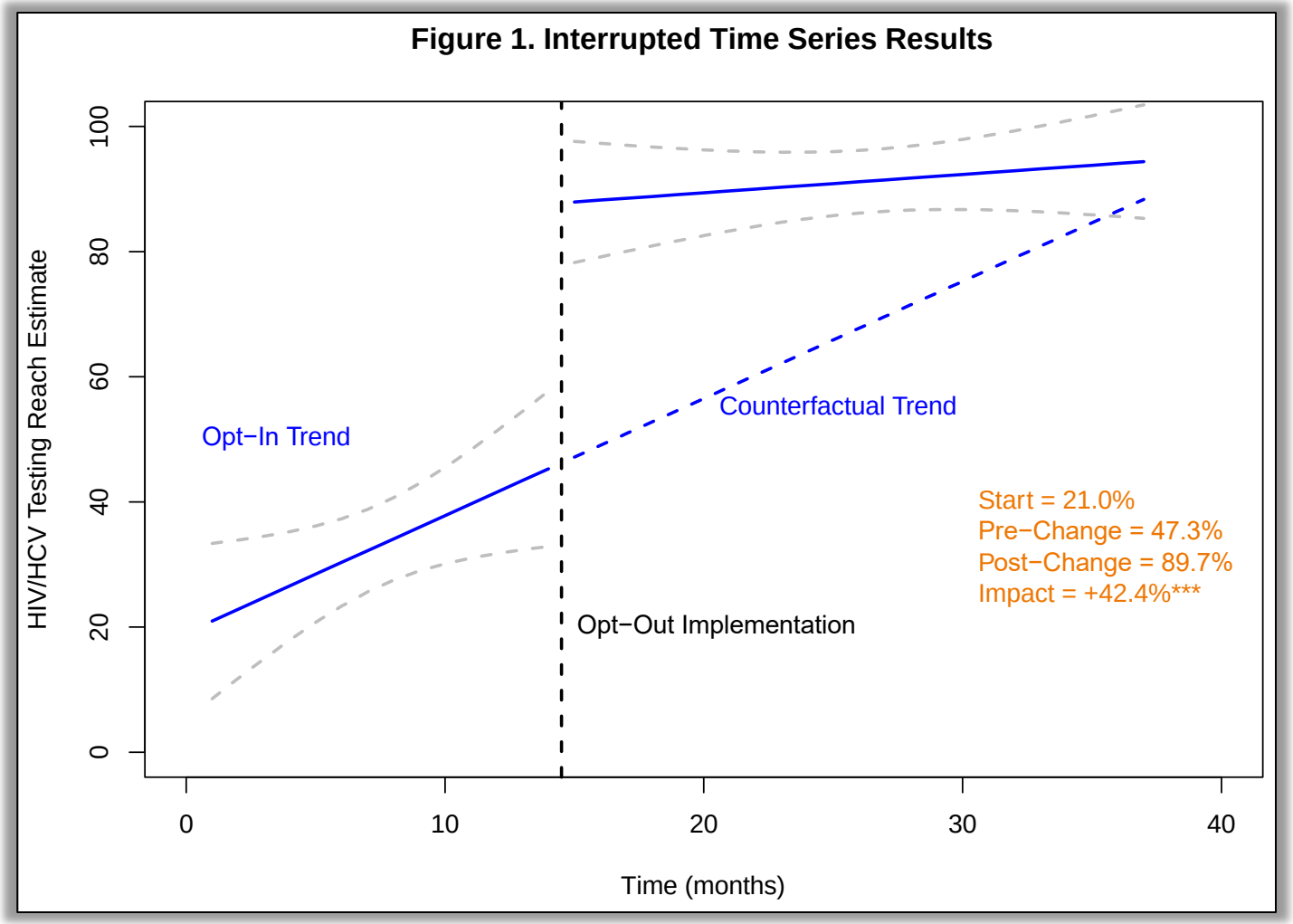
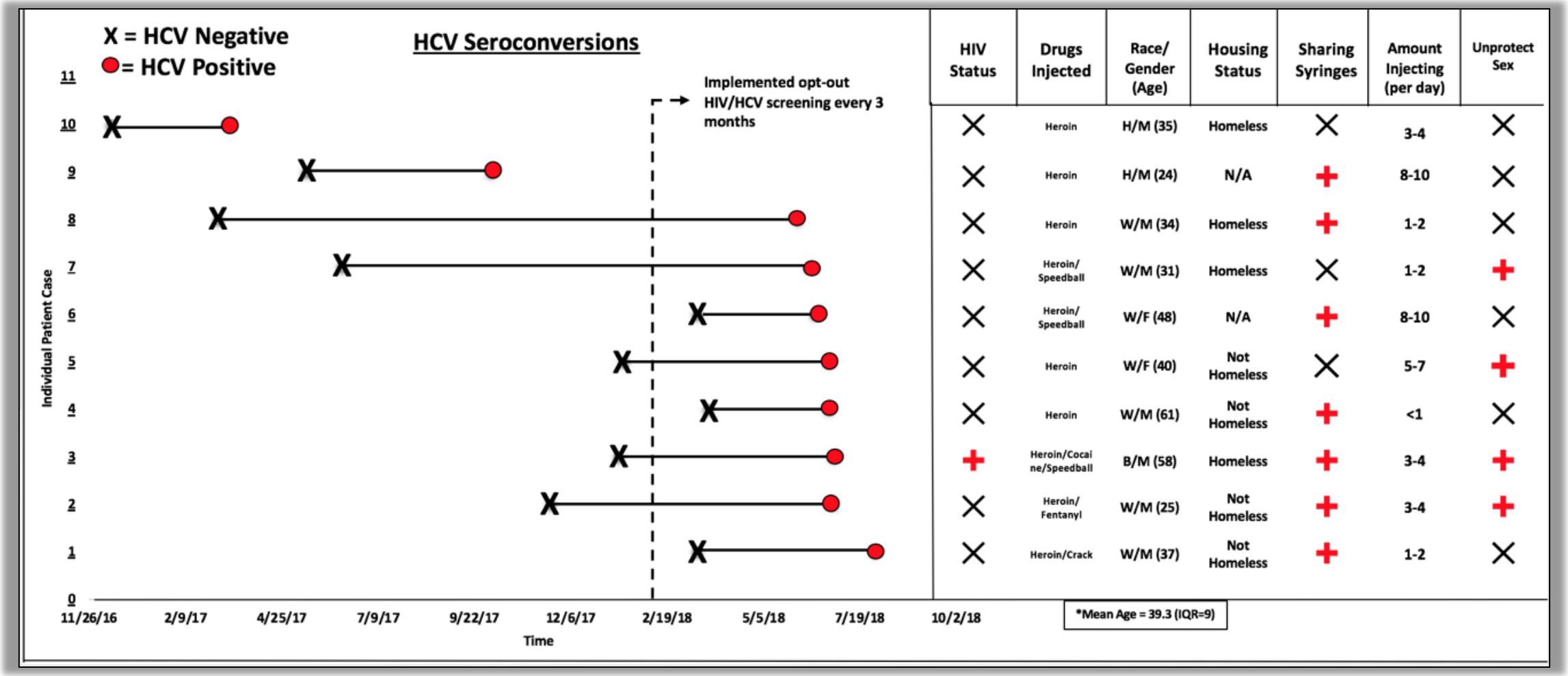
Reach = # of SSP clients tested / # of SSP clients who should have been tested



Regression	Beta	95% CI	*p*-value
Intercept	20.96	8.55, 33.38	0.002
Opt-in testing policy trend	1.87	0.25, 3.50	0.030
Immediate effect of opt-out testing policy	42.35	26.21, 58.49	<0.001
Change in trend during opt-out testing	-1.58	-3.35, 0.20	0.080

Bartholomew et al., 2020



HIV Status	Drugs Injected	Race/ Gender (Age)	Housing Status	Sharing Syringes	Amount Injecting (per day)	Unprotect Sex
X	Heroin	H/M (35)	Homeless	X	3-4	X
X	Heroin	H/M (24)	N/A	+	8-10	X
X	Heroin	W/M (34)	Homeless	+	1-2	X
X	Heroin/ Speedball	W/M (31)	Homeless	X	1-2	+
X	Heroin/ Speedball	W/F (48)	N/A	+	8-10	X
X	Heroin	W/F (40)	Not Homeless	X	5-7	+
X	Heroin	W/M (61)	Not Homeless	+	<1	X
+	Heroin/Cocaine/Speedball	B/M (58)	Homeless	+	3-4	+
X	Heroin/ Fentanyl	W/M (25)	Not Homeless	+	3-4	+
X	Heroin/Crack	W/M (37)	Not Homeless	+	1-2	X

*Mean Age = 39.3 (IQR=9)

AIDS and Behavior (2020) 24:246–256
https://doi.org/10.1007/s10461-019-02680-9

ORIGINAL PAPER

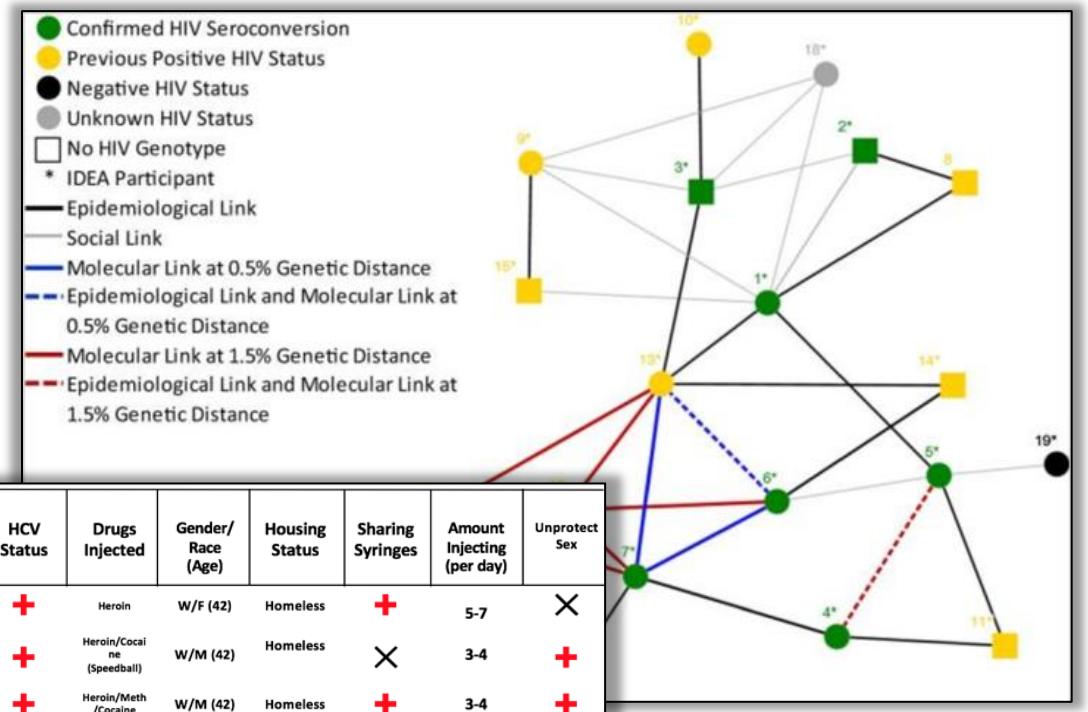
Rapid Identification and Investigation of an HIV Risk Network Among People Who Inject Drugs –Miami, FL, 2018

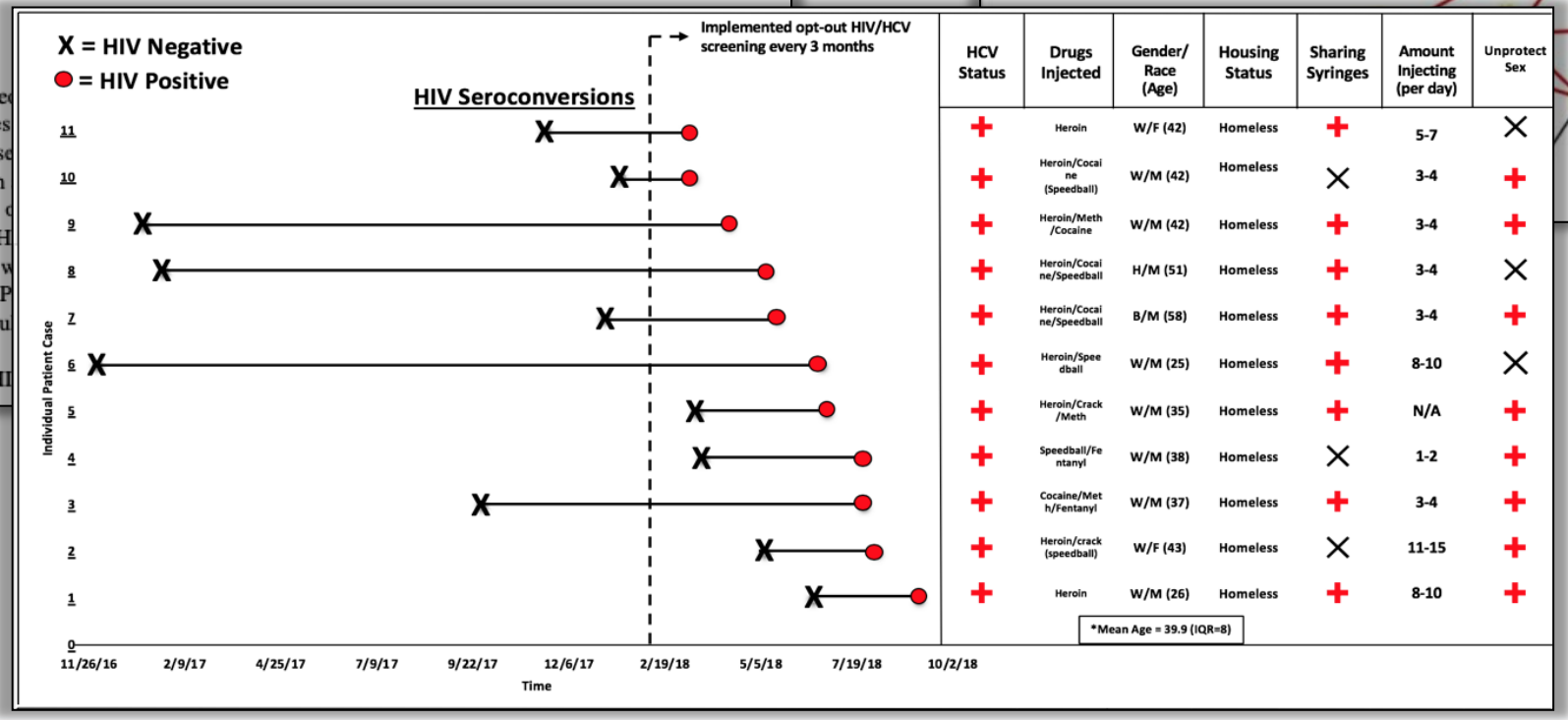
Hansel Tookes[1] · Tyler S. Bartholomew[1] · Shana Geary[2] · James Matthias[3,2] · Karalee Poschman[4,2] · Carina Blackmore[2] · Celeste Philip[2] · Edward Suarez[1] · David W. Forrest[1] · Allan E. Rodriguez[1] · Michael A. Kolber[1] · Felicia Knaul[1] · Leah Colucci[1] · Emma Spencer[2]

Published online: 25 September 2019

Abstract
Prevention of HIV outbreaks among pe
States. The first legal syringe services
identification of ten anonymous HIV s
epidemiologic investigation. All seven
viral suppression (mean 70 days). Six
other seroconversions. Analysis of the H
distance. We identified a risk network w
methods or molecular analyses alone. P
sive linkage and patient navigation, cou

Keywords People who inject drugs · HI





HCV Status	Drugs Injected	Gender/ Race (Age)	Housing Status	Sharing Syringes	Amount Injecting (per day)	Unprotect Sex
+	Heroin	W/F (42)	Homeless	+	5-7	X
+	Heroin/Cocaine (Speedball)	W/M (42)	Homeless	X	3-4	+
+	Heroin/Meth /Cocaine	W/M (42)	Homeless	+	3-4	+
+	Heroin/Cocaine/Speedball	H/M (51)	Homeless	+	3-4	X
+	Heroin/Cocaine/Speedball	B/M (58)	Homeless	+	3-4	+
+	Heroin/Speedball	W/M (25)	Homeless	+	8-10	X
+	Heroin/Crack /Meth	W/M (35)	Homeless	+	N/A	+
+	Speedball/Fentanyl	W/M (38)	Homeless	X	1-2	+
+	Cocaine/Meth/Fentanyl	W/M (37)	Homeless	+	3-4	+
+	Heroin/crack (speedball)	W/F (43)	Homeless	X	11-15	+
+	Heroin	W/M (26)	Homeless	+	8-10	+

*Mean Age = 39.9 (IQR=8)

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Tookes et al., 2020

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention

PREVENTION RESEARCH SYNTHESIS

Structural Interventions

Best practices that use structural approaches to improve HIV outcomes

OPT-OUT HIV/HCV SCREENING

Evidence-Informed Structural Intervention

INTERVENTION DESCRIPTION

Intended Population
- People who inject drugs (PWID) participating in a syringe services program (SPP)

Goals of Intervention
- Increase HIV testing
- Increase Hepatitis C (HCV) testing

Brief Description

Opt-Out HIV/HCV Screening is a structural intervention designed to provide access to HIV/HCV testing in an acceptable venue for PWID. The intervention involves a change from an opt-in testing policy to an opt-out testing policy where participants are informed that bundled HIV/HCV testing is part of routine care upon their enrollment at the SSP. Participants can decline testing. If clients accept the testing, both results of each test are recorded. Point-of-care tests for both HIV/HCV are offered using a blood sample collected via fingerstick. Results are reported to the participant immediately with appropriate post-test counseling and education. For those who tested reactive, active linkage to care is offered.

Theoretical Basis
- None reported

Intervention Duration
- Ongoing

Intervention Settings
- Syringe services programs (SSP)

Deliverers
- SSP staff

Structural Components
- Access – HIV testing
  - Increased access to HCV/HIV testing and linkage to HIV medical care
- Policy/Procedure – Institutional policy/procedure
  - Implemented opt-out HCV/HIV testing in SSP

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Thank You

Code for opt-out testing in SSP paper

Email: tsb61@miami.edu

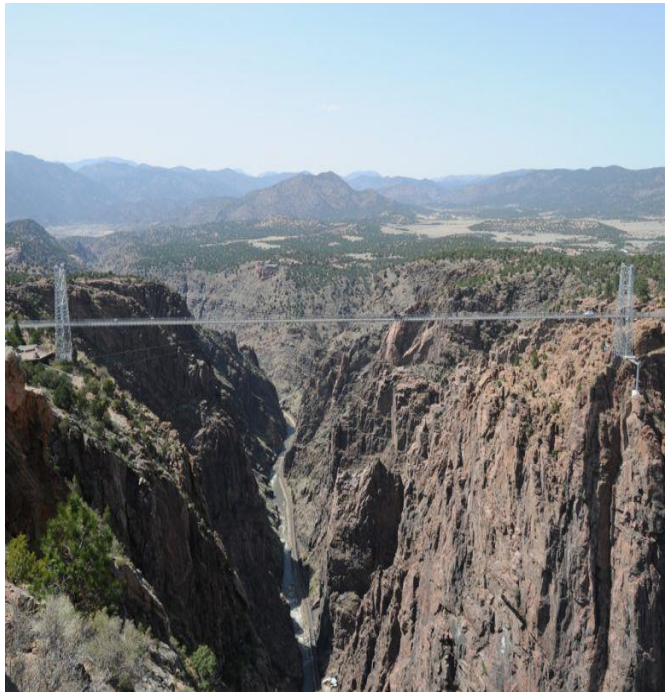
VOCAL-NY + Mount Sinai Cures Innovative Models Project

Abigail Hunter, FNP-BC, MSN, MPH
Clinical Program Manager
Mount Sinai

HCV Therapeutic Divide

HCV TREATMENT

- Almost universal efficacy of DAAs
- Minimal side effects
- Short treatment duration
- All oral medication



HCV DISEASE STATE

- HCV infections continue to rise due to ongoing opioid epidemic
- Up to 50% unaware of HCV infection
- Shortage of treatment providers

Barriers to Hepatitis C Treatment Uptake

Patient

- Lack of HCV knowledge
- Stigma
- Feelings of not deserving treatment
- Mistrust of health care system
- Competing priorities
- Lack of phone number

Provider

- Concerns regarding adherence, reinfection
- Management of coexisting mental health diagnoses
- Lack of support to coordinate care
- Believes that a specialist should treat

Systems

- Insurance
- Discrimination
- Fragmented Care
- Drug User Health Expertise across disciplines (e.g. phlebotomy)

Clinical Models to Improve Linkage to HCV Care and Treatment Uptake

Conventional Referral

- System is difficult to navigate for many
- Need a multidisciplinary approach
- Utilization of case managers
- Peer navigators

Telehealth

- Useful to deliver services to any setting (prison, rural, substance abuse clinics)
- Provide specialty care where not otherwise available
- COVID has increased access and billable options

Colocalization

- One-stop shopping
- Multiple services offered in one location
- Minimizes loss to follow-up
- Streamlines care

Participant challenges

- **Housing:** Participants are often undomiciled.
- **Substance use:** Many participants are not engaged in MOUD treatment
- **Competing Priorities**: Participants often have with many medical and psychosocial competing needs and are often not engaged in primary care.
- **Communication**: often participants do not have a phone.
- **Lack of apparent symptoms with HCV**: Not much urgency to get treated.

VOCAL-NY + Mount Sinai Cures

Combining expertise of harm reduction agency + academic medical center

Onsite HCV Testing + Community outreach as part of Peer Delivered Syringe Exchange (PDSE) services

Hybrid in-person (NP) + telemedicine model

Care coordination and peer services

Incentivized HCV treatment

VOCAL-NY+ Mount Sinai Cures testing sites

Provide testing on-site at VOCAL-NY in Brooklyn (300 Douglass Street) a harm reduction agency that provides syringes, a drop-in center, laundry, showers, groups, care coordination, food pantry.

Partner with the PDSE program at VOCAL-NY to provide testing on outreach in various neighborhoods in Brooklyn.

Test at shelters/in parks/at CHIPS (local food provider nearby)

VOCAL-NY + Mount Sinai Cures clinic

VOCAL-NY staff at a testing event

Strategies to Overcome Challenges

- Flexible model of In-person & Telehealth Services tailored to client needs and preferences
- Nurse Practitioner joins outreach team
- Providing telephones and incentives to clients on treatment
- Intensive peer engagement of clients to address social determinants of health needs
- Escorting clients to local lab for blood draws, HRA and medical appointments
- Onsite clinic at VOCAL-NY will open very soon

Tele-harm reduction model

Tele-harm reduction is a telehealth enhanced harm reduction intervention delivered within a harm reduction-oriented non-traditional healthcare setting.

Settings for tele-harm reduction model

Low threshold/low barrier to treatment programs

- Syringe services program
- Other harm reduction agencies
- Shelters
- Soup kitchens/pantry

Roles and responsibilities for Tele-harm Reduction Model

Preparation & Screening	Hepatitis C screening	HCV peer navigator in non-traditional setting
	Laboratory testing	Care coordinator in non-traditional setting
Hepatitis C Telehealth Implementation	Care coordination	HCV peer navigator in non-traditional setting
	Baseline (initial) medical evaluation	Telehealth provider
	Order hepatitis C medication	Telehealth provider
	Treatment initiation clinical visit	Telehealth provider
	Track medication refill/adherence	Non-traditional healthcare setting staff
	On-treatment monitoring visit(s)	Telehealth provider
	End-of-treatment visit	Telehealth provider
	SVR12 visit	Telehealth provider
Post-treatment	Follow-up for potential reinfection	Non-traditional healthcare setting staff

Developed in collaboration with:

Clinical Education Initiative (CEI)

Jacobs School of Medicine and Biomedical Services, University at Buffalo

New York City Department of Health and Mental Hygiene Viral Hepatitis Program

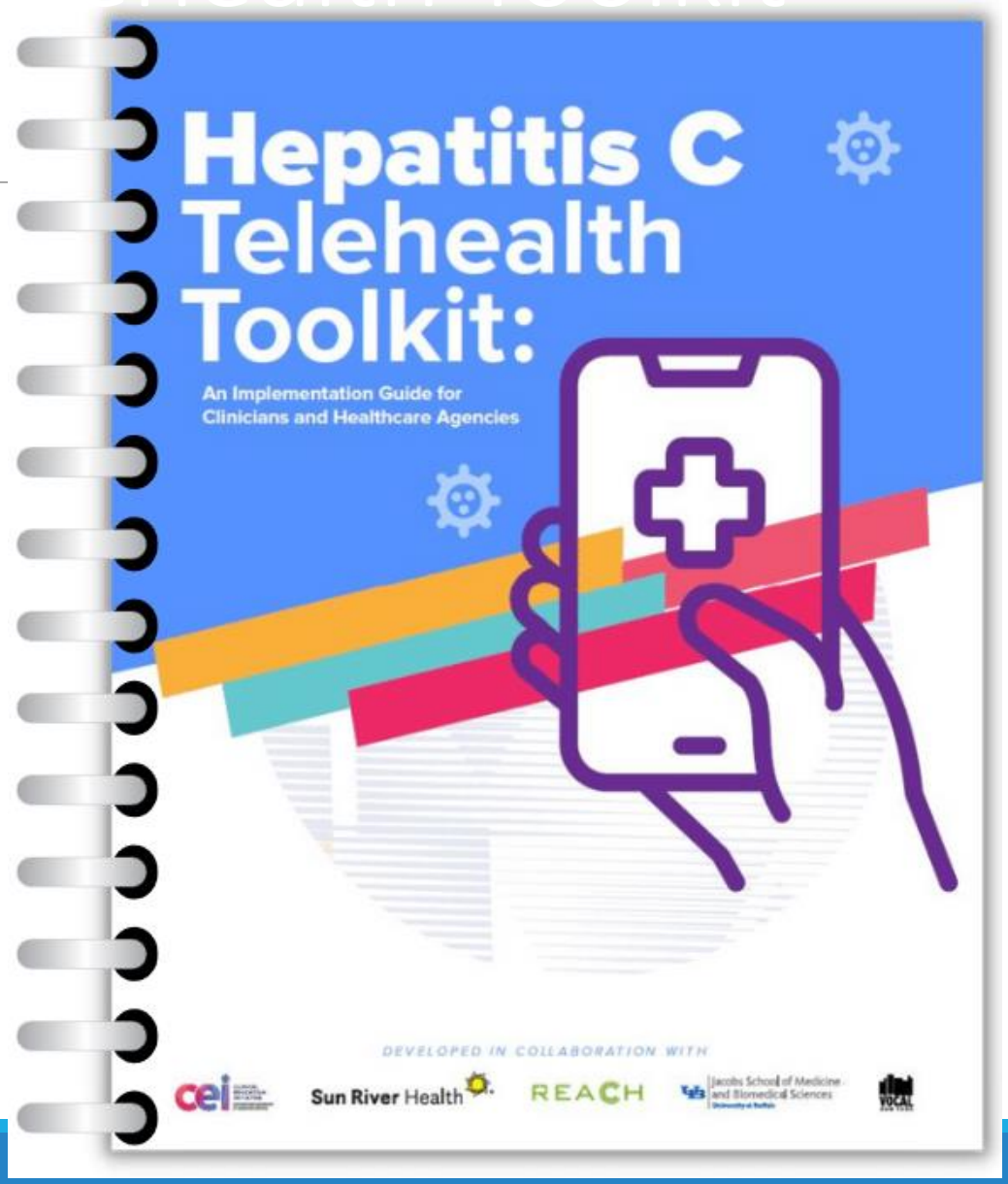
New York State Department of Health AIDS Institute Bureau of Hepatitis Healthcare and Epidemiology

New York State Office of Addiction Services and Supports (OASAS)

Respectful and Equitable Access to Comprehensive Healthcare (REACH) Program at Mount Sinai

Sun River Health

VOCAL-NY



Hepatitis C Telehealth Toolkit

Practical guide to the implementation of HCV telehealth

Supports both traditional and non-traditional settings interested in providing HCV treatment via telemedicine

Best practices and minimum requirements

Billing considerations

https://ceitraining.org/documents/HCV_Telehealth%20Toolkit_FINAL2023.pdf

Case Study: Tele-harm Reduction

54 year old user of a peer-delivered syringe service program is rapid tested by an HCV peer navigator (HCVPN) for HCV antibodies and a dried blood spot (DBS) which will be send to a lab for analysis. Assessment of social determinants of health (SDH) will be conducted; SDH needs may need to be addressed prior to treatment initiation. Prep-C can be used to measure treatment readiness.

DBS results will be given to participant by HCVPN on outreach. If the participant would like treatment, a phone may be provided along with referral to telehealth provider (THP). Insurance information and paperwork will be signed and collected. Telehealth sessions can happen during outreach.

After initial telehealth session, participant escorted to lab for pre-treatment analysis by HCVPN.

THP to contact participant with lab results to discuss next steps.

Case Study: Tele-harm Reduction, Part 2

THP orders medication and sends paperwork to specialty pharmacy.

Once medication arrives, HCVPN brings it on outreach and treatment initiation telehealth session occurs.

If treatment labs can be conducted, HCVPN escorts participant to lab.

THP to check treatment status via phone or additional telehealth sessions throughout treatment cascade.

Second (or third) box of medication provided to participant by HCVPN on outreach.

Incentives are also provided on outreach.

End of treatment labs and SVR conducted with another escort to the lab.

VOCAL-NY + Mount Sinai Cures Team

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VOCAL NEW YORK

Mount Sinai

Grant Funding Provided by the New York State Department of Health AIDS Institute

Virginia Harm Reduction Coalition

Ariel Johnson MSW, Supervisee of Social Work, QMHP-A
Patient Navigation Director | *VHRC*
Operations Director | *MHC Warming Center*

Who We Are. What We Do. Why We Do It.

Virginia Harm Reduction Coalition (VHRC) is a 501(c)(3) nonprofit, peer-run organization whose mission is to **improve the health of the community** it serves by advocating for, developing, and **implementing evidence-based solutions** to address the adverse effects of drug use. We address health inequities faced by people who use drugs (PWUD) by providing **outreach to marginalized, stigmatized, and criminalized populations, advocating for health policies that address their specific needs**, and collaborating with other agencies to effectively meet those needs.

Services:

- Benefit enrollment services
- Case management/ patient navigation
- HCV antibody testing
- Overdose education and Naloxone distribution
- Sterile use supplies to prevent infection
- Peer support
- Advocacy
- HIV Testing
- Focus Partnership- Minority AIDS Support Svcs, INC

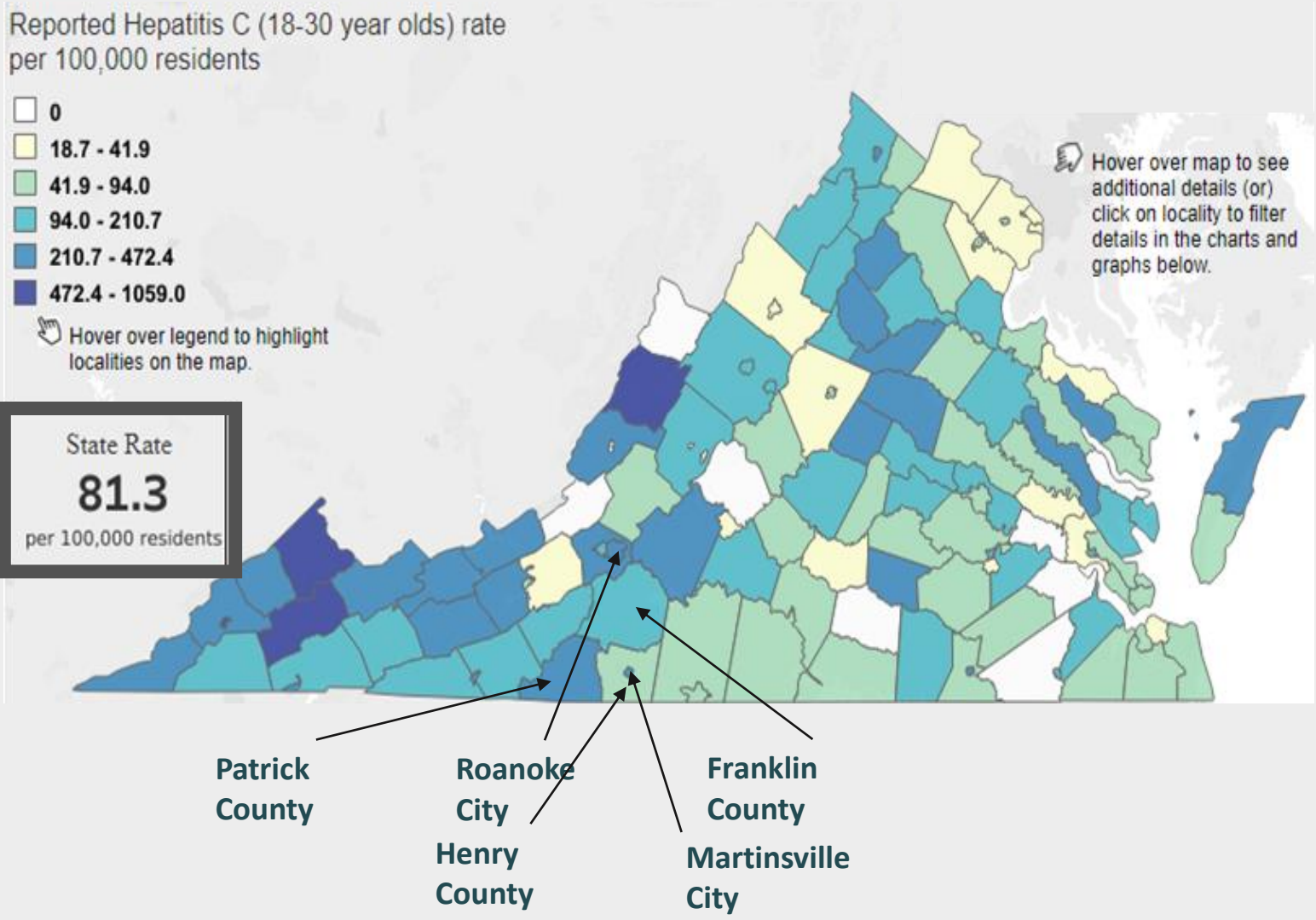
Mission:

To improve the health of the communities we serve by advocating for, developing, and implementing evidence-based solutions to address the adverse effects of drug use.

Virginia Harm Reduction Coalition
In 2022

- Disposed of 845 lbs of used syringes, which translates to approximately 110,000 syringes
- Distributed 19,416 doses of naloxone
- Trained 134 PWUD on how to administer naloxone
- Distributed 273,170 sterile syringes to PWUD
- Served 1,586 unique participants over 7,791 interactions
- Provided critical vaccinations to 337 participants
    - Hep A (292 Participants)
    - HEP B (123 Participants)
    - COVID-19 (285 Participants)
    - Hep B (123 Participants)
- Patient navigation services provided to 110 participants
    - Supported 24 participants to SUD Treatment
    - Helped 14 participants to get vital documents
    - Provided housing case management to 34 participants
    - Provided domestic violence services to 14 individuals
    - 26 participants assisted through HCV treatment navigation
    - 25 participants connected to medical care for STI screens and treatment
- In addition to this, participants reported reversing 2,032 overdoses in 2022

VIRGINIA-EPIDEMIOLOGY HEPATITIS C VIRUS

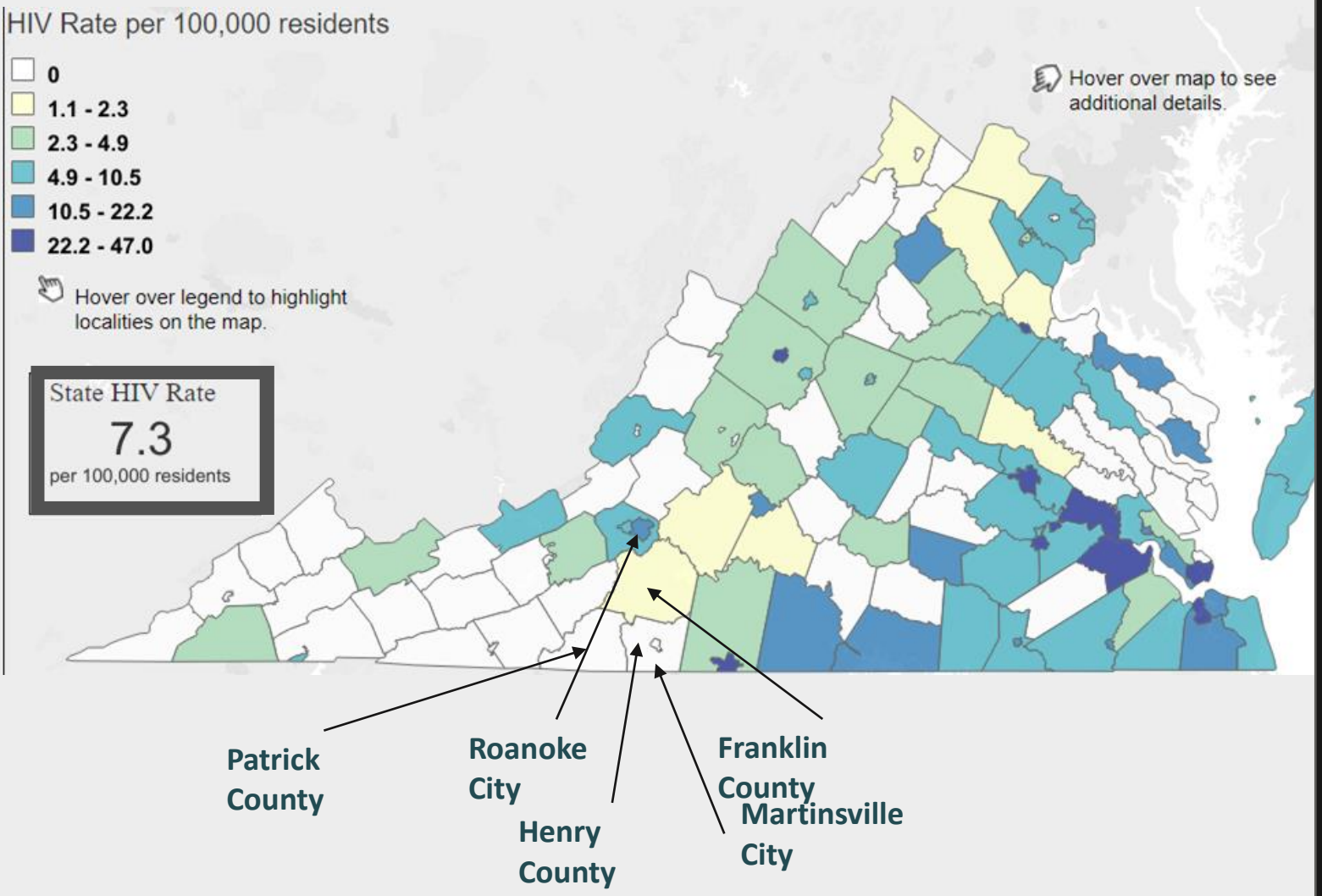


In 2020, The Reported HCV Rate *(per 100,000 residents)*

- Roanoke City, 328.9
- Henry County, 90.8
- Martinsville City, 212.5
- Franklin County, 116.2
- Patrick County, 345.7

Source: https://www.vdh.virginia.gov/drug-overdose-data/hepatitis-c-hcv/

VIRGINIA-EPIDEMIOLOGY-HIV



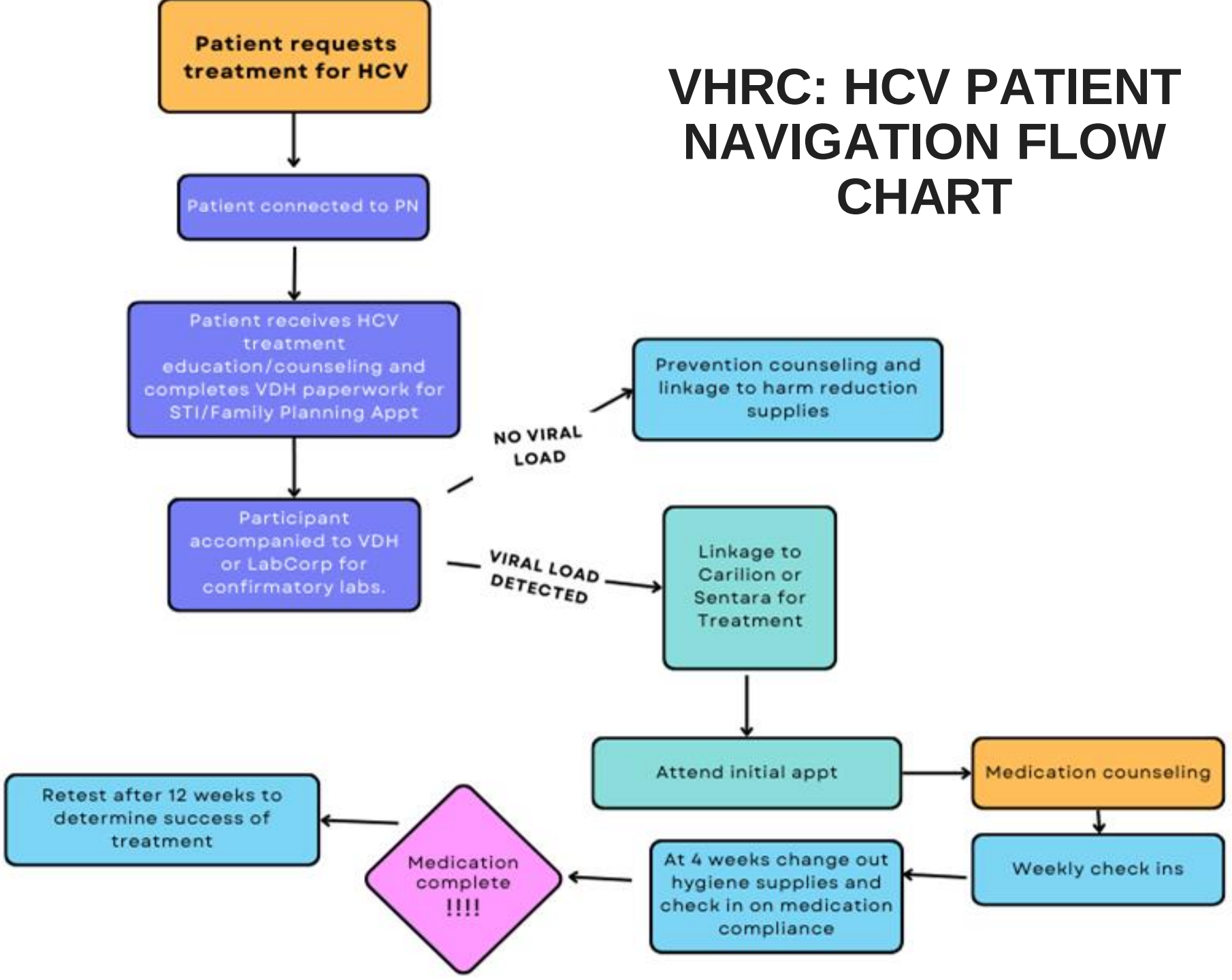
In 2020, The Reported HIV Rate *(per 100,000 residents)*

- **Roanoke City**, was **15.1**
- **Franklin County** was **1.8**

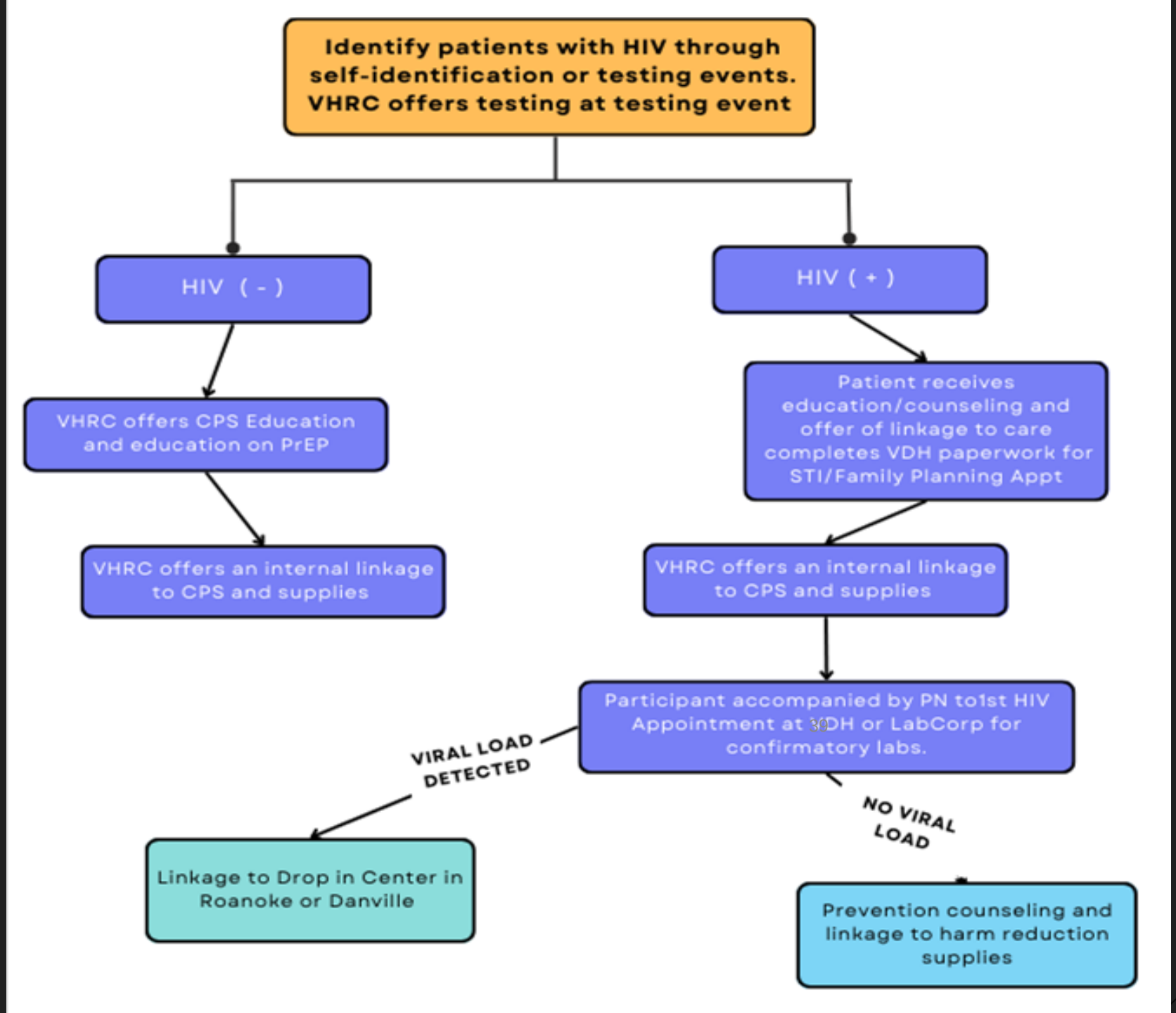
87% of VHRC's clients inject drugs, and **91%** of those are not in monogamous relationships who had intercourse in the past **3** months use condoms less than half the time.

Source: https://www.vdh.virginia.gov/drug-overdose-data/hiv/

VHRC: HCV PATIENT NAVIGATION FLOW CHART



VHRC: HIV PATIENT NAVIGATION FLOW CHART



VHRC

Virginia Harm Reduction Coalition

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Discussion, Q&A

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Thank you!