INNOVATION AND EQUITY: Navigating HCV Care in VA

Rachel Gonzalez and Angela Park
Hepatic Innovation Team Collaborative Leadership Team
Veterans Health Administration
No conflicts of interest to disclose
OBJECTIVES

• Describe the VA population & identified barriers to accessing HCV Care
• Define assessment used to identify strategies to address barriers
• Review action plan & tailored strategies developed
• Examine the impact of implementing strategies on patient access
• Learn how to connect with subject matter experts to inform strategies to increase patient access
VA POPULATION AND PRIORITY GROUPS

- Organized into 18 regions called Veteran Integrated Service Networks (VISNs)
- 130 Veterans Affairs Medical Centers (VAMCs), with 6-8 per VISN
- ~1000 community-based outpatient clinics (CBOCs), with 3-8 per VAMC
- Provide primary care, specialty care, and mental health services

- VA Priority Groups are **based on:**
  - Your military service history, **and**
  - Your disability rating, **and**
  - Your income level, **and**
  - Whether or not you qualify for Medicaid, **and**
  - Other benefits you may be receiving (like pension benefits)

- This may impact:
  - Copays – up to $50 for specialty appointments, up to $9/month for prescriptions
  - Eligibility for:
    - Certain Transportation Services
    - Nursing Home Services
    - Dental
HEPATITIS C INNOVATION TEAM COLLABORATIVE

Collaborative Leadership Team

- Program management and facilitation, including setting national goals
- Coaching Hepatic Innovation Teams (HITs) to improve processes
- Identifying low performers and pairing them with strong practices
- Advocating for patients and on behalf of the HITs
- Building community amongst the HIT members

Hepatic Innovation Teams

- Multidisciplinary, network-level teams led by a HIT Coordinator
- Work locally to contribute to national goals
- Participate in national calls and working groups
- Have monthly virtual meetings and annual face-to-face meetings
ELIMINATING HCV IN THE VETERAN POPULATION

<table>
<thead>
<tr>
<th></th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
<th>FY18</th>
<th>FY19 TD</th>
<th>Enduring Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Cohort Testing</td>
<td>68.8%</td>
<td>73.9%</td>
<td>80.1%</td>
<td>84.3%</td>
<td>84.8%</td>
<td>90%</td>
</tr>
<tr>
<td>Treatment Starts</td>
<td>30,138</td>
<td>38,074</td>
<td>28,636</td>
<td>17,537</td>
<td>82.5%</td>
<td>5,367</td>
</tr>
<tr>
<td>SVR12 Testing</td>
<td>55.4%</td>
<td>84.1%</td>
<td>87.6%</td>
<td>89.6%</td>
<td>90.2%</td>
<td>90%</td>
</tr>
</tbody>
</table>

77% of all Veterans in-care have achieved SVR
## RATES OF COMORBID SUBSTANCE USE DISORDERS IN THE HCV-POSITIVE VETERAN POPULATION

<table>
<thead>
<tr>
<th>Comorbid Condition (By Substance)</th>
<th>Number Ever Diagnoses</th>
<th>Percent Ever Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>96,076</td>
<td>55%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>44,693</td>
<td>26%</td>
</tr>
<tr>
<td>Opioids</td>
<td>38,438</td>
<td>22%</td>
</tr>
<tr>
<td>Stimulants</td>
<td>61,037</td>
<td>35%</td>
</tr>
<tr>
<td>Tobacco</td>
<td>115,626</td>
<td>66%</td>
</tr>
<tr>
<td>Other/Unspecified Drug Use</td>
<td>74,472</td>
<td>43%</td>
</tr>
</tbody>
</table>

## Hepatitis C Virus Testing and Prevalence Among Homeless and Non-Homeless Veterans

<table>
<thead>
<tr>
<th>Group and Sex</th>
<th>In VA Care in 2015</th>
<th>HCV Testing</th>
<th>HCV Testing Rate, %</th>
<th>Laboratory Confirmed HCV</th>
<th>HCV Tested Prevalence, %</th>
<th>Problem List or Laboratory-Confirmed HCV</th>
<th>HCV Population Prevalence, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless</td>
<td>242,740</td>
<td>189,508</td>
<td>78.1</td>
<td>29,063</td>
<td>15.3</td>
<td>29,311</td>
<td>12.1</td>
</tr>
<tr>
<td>Female</td>
<td>26,966</td>
<td>19,792</td>
<td>73.4</td>
<td>1,047</td>
<td>5.3</td>
<td>1,062</td>
<td>3.9</td>
</tr>
<tr>
<td>Male</td>
<td>215,774</td>
<td>169,716</td>
<td>78.7</td>
<td>28,016</td>
<td>16.5</td>
<td>28,249</td>
<td>13.1</td>
</tr>
<tr>
<td>Non-homeless</td>
<td>5,424,685</td>
<td>3,227,554</td>
<td>59.5</td>
<td>144,964</td>
<td>4.5</td>
<td>148,079</td>
<td>2.7</td>
</tr>
<tr>
<td>Female</td>
<td>408,481</td>
<td>255,924</td>
<td>62.7</td>
<td>4,995</td>
<td>2.0</td>
<td>5,112</td>
<td>1.3</td>
</tr>
<tr>
<td>Male</td>
<td>5,016,205</td>
<td>2,971,630</td>
<td>59.2</td>
<td>139,969</td>
<td>4.7</td>
<td>142,967</td>
<td>2.9</td>
</tr>
<tr>
<td>Total</td>
<td>5,667,425</td>
<td>3,417,062</td>
<td>60.3</td>
<td>174,027</td>
<td>5.1</td>
<td>177,390</td>
<td>3.1</td>
</tr>
</tbody>
</table>

SVR RATES AMONG GT-1 HCV-INFECTED VETERANS: IMPACT OF MENTAL HEALTH

<table>
<thead>
<tr>
<th>Mental health diagnosis</th>
<th>%</th>
<th>n/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>91.6</td>
<td>(5,201/5,679)</td>
</tr>
<tr>
<td>Yes</td>
<td>89.8</td>
<td>(12,408/13,825)</td>
</tr>
</tbody>
</table>

| Mental health diagnosis, ever                  |       |                    |
| Anxiety                                       | 89.6  | (7,787/8,695)      |
| Bipolar                                       | 89.6  | (2,182/2,434)      |
| Depression                                    | 89.7  | (10,959/12,216)    |
| PTSD                                          | 89.7  | (5,522/6,158)      |
| Schizophrenia                                 | 89.7  | (1,606/1,791)      |

| Mental health diagnosis in past year          |       |                    |
| Anxiety                                       | 90.3  | (2,983/3,305)      |
| Bipolar                                       | 90.3  | (908/1,006)        |
| Depression                                    | 89.8  | (6,046/6,734)      |
| PTSD                                          | 89.3  | (3,558/3,985)      |
| Schizophrenia                                 | 89.7  | (689/768)          |

More than 70% of those treated had a mental health diagnosis
PERCEIVED BARRIERS TO ACCESSING HCV CARE
PATIENT-LEVEL BARRIERS

- Patient deferred or declined: 75%
- Non-adherent/no follow-up: 20%
- Patient-level barriers: 50%
- Unstable Physical Comorbidity: 31%
- Mental Health comorbidity: 19%
- Homeless, Unstable Housing: 18%
- Alcohol or Substance abuse: 61%
- Psychosocial Needs: 16%
- Deceased: 3%

Based on VA data collected from VISNs 3, 7, 8, 17, 19, 21, 22, & 23; July 2016
IDENTIFIED BARRIERS TO CARE

• Patient Determinants
  – Non-adherent to treatment; lost to follow-up (didn’t return to complete evaluation, initiation)
  – Patient Deferred or Declined

• Unstable Medical Comorbidity
  – Uncontrolled diabetes, cancer, etc.

• Psychosocial needs
  – Homelessness, housing instability
  – Uncontrolled/unstable mental health co-morbidity
  – Alcohol or substance use
  – Mental Health comorbidity
  – Transportation barriers
• Identified areas with opportunities to collaborate in order to optimize care within VA:
  • Office of Case Management & Social Work
  • National Center on Homelessness
  • National Mental Health Program, Policy
  • National Mental Health Program, Operations
  • Peer Support Program
  • Transportation Program
• Conducted Semi-Structured Interviews
QUESTION 3

• Raise your hand if you’ve:
  – Heard of Environmental Scan
  – Conducted an Environmental Scan
  – Used this process to strategically plan for HCV care

Environmental scanning is a process that systematically surveys and interprets relevant data to identify external opportunities and threats.
ASSESSMENT PHASE - HCV ENVIRONMENTAL SCAN 2017

• **Objective:** Complete a comprehensive internal and external scan related to Barriers to HCV Care

• **Approach:**
  – Complete interviews with external SMEs
  – Provide a brief overview of HCV, the HIT program and how they can help
  – Obtain names of other SMEs/Stakeholders who may broaden our understanding
  – Establish connections
  – Collect existing strong practices related to addressing/removing barriers to care
  – Collate strong practices/strategies into guide for field/VISN HITs
• **Office of Social Work**: We understand that there are many aspects of case management and social work…

• **National Center on Homelessness**: Our understanding is that there is a Homeless Program Coordinator at each medical center…

• **Substance Use**: Our understanding is that there may not be a Substance Use Treatment clinic at each facility…
  – How can we direct HITs/care teams to locate resources for Social Work, Homeless Program Coordinators, Substance Use Treatment coordinators…Where do they begin? With whom specifically? What is your recommendation for partnering with these programs locally?

• What is the best way to approach educating social workers, case managers, homeless coordinators, substance use treatment center personnel, etc. about HCV care?

• How can we best partner with….?

• Describe the organizational structure of….?

• Who are other national/local leaders, what add’l resources you can direct us to…?
• Compiled guidance for each sub-population
• Created a linked slide deck, including medical center-specific POCs
• Held virtual education session – recorded, posted slides and recording online
• Invited program office directors to an SME Q&A panel
• Turned Environmental Scan results over to a new working group - Social Work Working Group
• SW WG built on results & created a Social Work Resource Guide
EXAMPLE OF INITIAL RESOURCE DEVELOPED AND SHARED

National Mental Health Program (Policy); Substance Use Disorder

"I am concerned that my patient's substance use disorder (SUD) will be a barrier for starting/completing HCV treatment."

Overview:
- Opioid Treatment Programs (OTP)
  - 22 methadone-based Opioid Treatment Programs (OTP) in VA
  - All others are outpatient buprenorphine-based OTP
  - Every facility offers buprenorphine
- Organizational Structure:
  - SUD Program Director/Coordinator (to be through SUD, Psychology, Psychiatry, or MH)- reports to Chief of MH (could be part of SW) - VISN SUD Lead
  - VISN SUD Lead often a collateral duty; can be a facility SUD Program Director/Coordinator

Contacts:
- Karen Dickler, National MH Program Director
- Adam Gerson, Director of the Buprenorphine in VA initiative
  - SUD Program Locator (searchable map with POC information, updated every 2 years)
  - SUD POC (top right)
  - National and VISN POCs

SUD Program Locator

Clinics, local and national and resources

What to do next

Action Items:
- Engage the SUD Program Director/Program Coordinator & the prescriber at your facility
  - HCV care teams support Veterans' recovery and be willing to help
  - As an HCV provider eliminate requirement for extraordinarily long periods of abstinence* before treatment
  - Get the message out! SUD is a chronic illness
  - Consider partnership w/ Academic Detailing for Opioid use disorder programs this year

Facts:
- MH Program sees "tremendous potential" for concurrent treatment
  - Motivates patients when they can engage in clinically relevant treatment
  - Integrate HCV treatment in residential/inpatient SUD treatment settings
  - It may be more challenging to partner with SUD programs that do not have a prescriber
Social Work Resource Guide

The Social Work Resource Guide is being developed by the HIT Social Work Workgroup.

Table of Contents:

1. Homeless Services
2. Addiction/SUD
3. Mental Health
4. Transportation / Mobility Manager
5. Justice Involved Veteran Resources (added 3/2019)
6. Financial and Other Concrete Resources
7. Peer support / Emotional Support: Coming soon
8. End of Life Care
9. Transplant Services / Support: Coming soon

VA Hepatitis Innovation Team     Social Work Resource Guide

Alcohol and Substance Use Disorders

OVERVIEW
Alcohol and substance use is common among hepatitis C (HCV) infected patients; 55% have an Ever Diagnosis of Alcohol Use and 22% have an Ever Diagnosis of Opioid Use. Minimizing alcohol use is one of the most important factors in preserving liver health in patients with HCV. In patients with cirrhosis, complete abstinence from alcohol is recommended. For VA policy (Memo), abstinence from alcohol or drug use is not required before beginning HCV antiviral treatment. Patients with active substance or alcohol use disorders may be considered for therapy on a case-by-case basis, and care should be coordinated with SUD treatment specialists.

Screening and providing brief counseling interventions or treatment referral can decrease drinking and/or substance use and improve health outcomes. Brief counseling with specialty referral as indicated can be effective in reducing hazardous drinking and/or substance use. Some patients may require comprehensive treatment programs that include the services of medical providers, psychologists, psychiatrists to assist with comorbid psychiatric conditions, social workers, housing counselors, case managers, and substance abuse counselors. For more information, refer to the VA/DoD Clinical Practice Guideline on Substance Use Disorders.

SCREENING FOR ALCOHOL USE AND SUBSTANCE USE
Evaluate and treat at-risk and disordered alcohol drinkers with the 4 A's: Ask, Assess, Advise, and Assist.

- Ask about alcohol use, using AUDIT-C (see below)
- Assess for alcohol use disorders (see below)
- Advise all patients with liver disease, even those with no reported heavy drinking, that there is no known "safe" level of alcohol consumption.
- Assist patients with brief interventions and referral for treatment services such as Alcoholics Anonymous, cognitive-behavioral therapy, addiction specialists, and detoxification programs.

The following tools may be used to develop a better understanding of a patient's current state of alcohol use:

- Screening and Assessment Pocket Card Flow Chart
- The AUDIT-C (Alcohol Use Disorder Identification Test) is a validated 3-question screening tool for alcohol misuse and alcohol use disorders (AUD), including alcohol abuse or dependence. Patients with AUDIT-C scores of 24 for men and 15 for women...
## RESULTS PHASE – IMPACT ON ACCESS TO TREATMENT

<table>
<thead>
<tr>
<th></th>
<th>Veterans Tx since 2014 (n=115,389)</th>
<th>All Veterans (n=8,260,856)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>63.6</td>
<td>63.4</td>
</tr>
<tr>
<td>Sex (M)</td>
<td>111,355 (97%)</td>
<td>7,611,530 (92%)</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African-American</td>
<td>43,566 (38%)</td>
<td>1,248,489 (15%)</td>
</tr>
<tr>
<td>Caucasian</td>
<td>64,638 (56%)</td>
<td>5,709,598 (70%)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>6,506 (6%)</td>
<td>485,760 (6%)</td>
</tr>
<tr>
<td>HIV</td>
<td>3,400 (3%)</td>
<td>33,243 (&lt;1%)</td>
</tr>
<tr>
<td>MH dx ever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>35,690 (31%)</td>
<td>1,467,195 (18%)</td>
</tr>
<tr>
<td>PTSD</td>
<td>33,674 (29%)</td>
<td>6,723,714 (17%)</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>8,912 (8%)</td>
<td>160,348 (2%)</td>
</tr>
<tr>
<td>AUD</td>
<td>52,581 (46%)</td>
<td>945,154 (12%)</td>
</tr>
<tr>
<td>OUD</td>
<td>18,734 (16%)</td>
<td>117,915 (1%)</td>
</tr>
<tr>
<td>Urban</td>
<td>84,962 (74%)</td>
<td>5,455,405 (66%)</td>
</tr>
<tr>
<td>Rural</td>
<td>30,313 (26%)</td>
<td>2,805,171 (34%)</td>
</tr>
<tr>
<td>Homeless/housing instability</td>
<td>30,908 (27%)</td>
<td>50,1493 (6%)</td>
</tr>
</tbody>
</table>

Preliminary Analysis of Barriers to Care Data, April 2019
RESULTS PHASE - PROPORTION OF PATIENTS TREATED W/ POTENTIAL BARRIERS TO CARE

Preliminary Analysis of Barriers to Care Data, April 2019
SYNC CHALLENGE

• People at this meeting we have SYNC-ed with:
  – Corinna Dan
  – Alyssa Kitlas
  – Siddharth Raich
  – Emily Comstock

• Go out into the meeting & scan the SYNC environment for SMEs who can help you increase access for your HCV patients/provide insight or expertise

• Come find us after the last session (we really mean it!) of the HCV track, with your worksheets and tell us about your SYNC environmental scan experience!
ACKNOWLEDGEMENTS

- **VA HHRC Leadership:** David Ross, Maggie Chartier, Lorenzo McFarland, Marge Petrucci, Timothy Morgan
- **HIT Leadership Team**
- **HITs**
- **Veterans**