CHCANYS

Community Health Care Association of New York State

Building a Hepatitis C Demonstration Project:
Using Tele-Consulting to Improve Delivery of Care

Thursday, October 25th, 2012
Saratoga Springs, NY

Defining New Directions

Hep C: New York Landscape

Colleen Flanigan RN, MS
Director, Viral Hepatitis Section
New York State Department of Health
AIDS Institute

Current HCV Infrastructure in NYS

- Since 2010,thirteen NYSDOH grant funded programs funded statewide can serve all payors
  - 5 focus on HCV monoinfected persons
  - 8 focus on HIV/HCV coinfected persons
- Integrate hepatitis C care and treatment into primary care settings, including:
  - Community health centers
  - Drug treatment, including Methadone Maintenance (MMTP)
  - Hospital based clinics
- Core services include: primary care, HCV care and treatment, care coordination, peer & supportive services

Medicaid Redesign in NY
Hepatitis C Initiative

- Developed by Health Disparities Workgroup
- Promote Hepatitis C Care and Treatment Through Service Integration:
  - The 2012-13 Executive budget an initiative for HCV wrap around services to promote care coordination and the integration of hepatitis screening, treatment and supportive services in primary care settings including community health centers, HIV primary care clinics and substance use treatment programs.

Medicaid Redesign in NY
Hep C Initiative – Proposed Framework

- Develop a HCV disease management program within Managed Care Plans.
- Utilize health homes care coordination framework for eligible HCV infected Medicaid enrollees for client engagement, care coordination and peer education/support services. Expand Health home eligibility to include HCV mono infected population.
- Expand current HCV care and treatment infrastructure in primary care settings through the use of new technology, building upon emerging telemedicine infrastructure.

Medicaid Redesign in NY
Hep C Initiative – Benefits

- Reduction in HCV-related Medicaid expenditures through enhanced coordination, access to and adherence in treatment.
- Most of these services are independently covered by Medicaid.
- Sustainability of HCV-related services.

Challenges Ahead

- Restructuring of the current care delivery system through Medicaid Managed Care and Health Homes
- The AIDS Institute is focused on retaining key features of successful programs of integrated care
- Tailored disease focused programs have diminished in re-design yet specific issues must be addressed

Hepatitis C: 2012 Overview
and
Project ECHO

David Bernstein, MD
Chief of Hepatology
North Shore University Hospital
Long Island Jewish Medical Center

HCV Infection in the US and New York

- About 6 million persons chronically infected
  - Approximately 240,000 New Yorkers have HCV (~2% in US)
  - Underestimation since survey did not account for incarcerated or homeless persons
- Of every 100 persons infected with HCV, approximately
  - 75% to 85% will develop chronic infection
  - 60% to 70% will develop chronic liver disease
  - 5% to 20% will develop cirrhosis in 20 to 30 years
  - 1% to 5% will die from the consequences of chronic infection (liver cancer or cirrhosis)
- Progression associated with ETOH, HBV, HIV

http://www.cdc.gov/hepatitis/HCV/HCVfaq.htm#section2

HCV Progression

- HCV is the leading infectious cause of cirrhosis and liver cancer. It's the most common reason for liver transplant in the US
  - Approximately 25% of HIV infected persons are also infected with HCV
- Deaths from HCV nearly doubled between 1999–2007 to over 15,000/yr
- CDC Proposed Expansion of Testing Recommendations
  - All baby boomers (born between 1945-1965) receive a onetime only HCV test
  - 75% of those infected are baby boomers
  - Expansion would:
    - Identify an additional 800,000 HCV infections
    - Prevent 120,000 deaths[1]
- If treatment rates continue as they are, only 14.5% of liver related deaths would be prevented.

[1] **With appropriate care and HCV treatment**

Project ECHO

Background

- The Extension for Community Healthcare Outcomes model was developed by Dr. Sanjeev Arora, et.al. at the University of New Mexico (UNM) to improve access to care for underserved populations with complex health problems such as chronic HCV.
- With the use of video-conferencing technology, the ECHO program trains primary care providers to treat complex diseases.

Project ECHO

Method

- A prospective cohort study was conducted comparing treatment for HCV infection at the UNM HCV clinic with treatment by primary care clinicians at 21 ECHO sites in rural areas and prisons in New Mexico.
- A total of 407 patients with HCV infection who had received no previous treatment for the infection were enrolled.
- The primary end point was a sustained virologic response.

Project ECHO

Results

- 57.5% (84 of 146 patients) treated at the UNM HCV clinic had a sustained viral response (SVR)
- 58.2% (152 of 261 patients) of those treated at ECHO sites had a SVR
- Among patients with HCV genotype 1 infection
  - 45.8% (38 of 83 patients) at UNM HCV clinic had a SVR
  - 49.7% (73 of 147 patients) at ECHO sites had a SVR
- Serious adverse events occurred in 13.7% of patients at the UNM HCV clinic and in 6.9% of patients at the ECHO sites

Project ECHO

Conclusions

- The results of this study show that the ECHO model is an effective way to treat HCV infection in underserved communities.
- Implementation of this model would allow other states and nations to treat a greater number of patients infected with HCV than they are currently able to treat.

Video Conferencing Sessions

- Monthly one hour sessions
  - 15 minutes of didactic learning
  - 15 minutes to review previous cases
  - 30 minutes for case conferencing new patients
  - Promotes collaboration with other providers across the state

CHCANYS Collaborative Process

Kathy Alexis, MPH
Assistant Director
Quality Improvement Program
CHCANYS

CHCANYS Collaborative Process

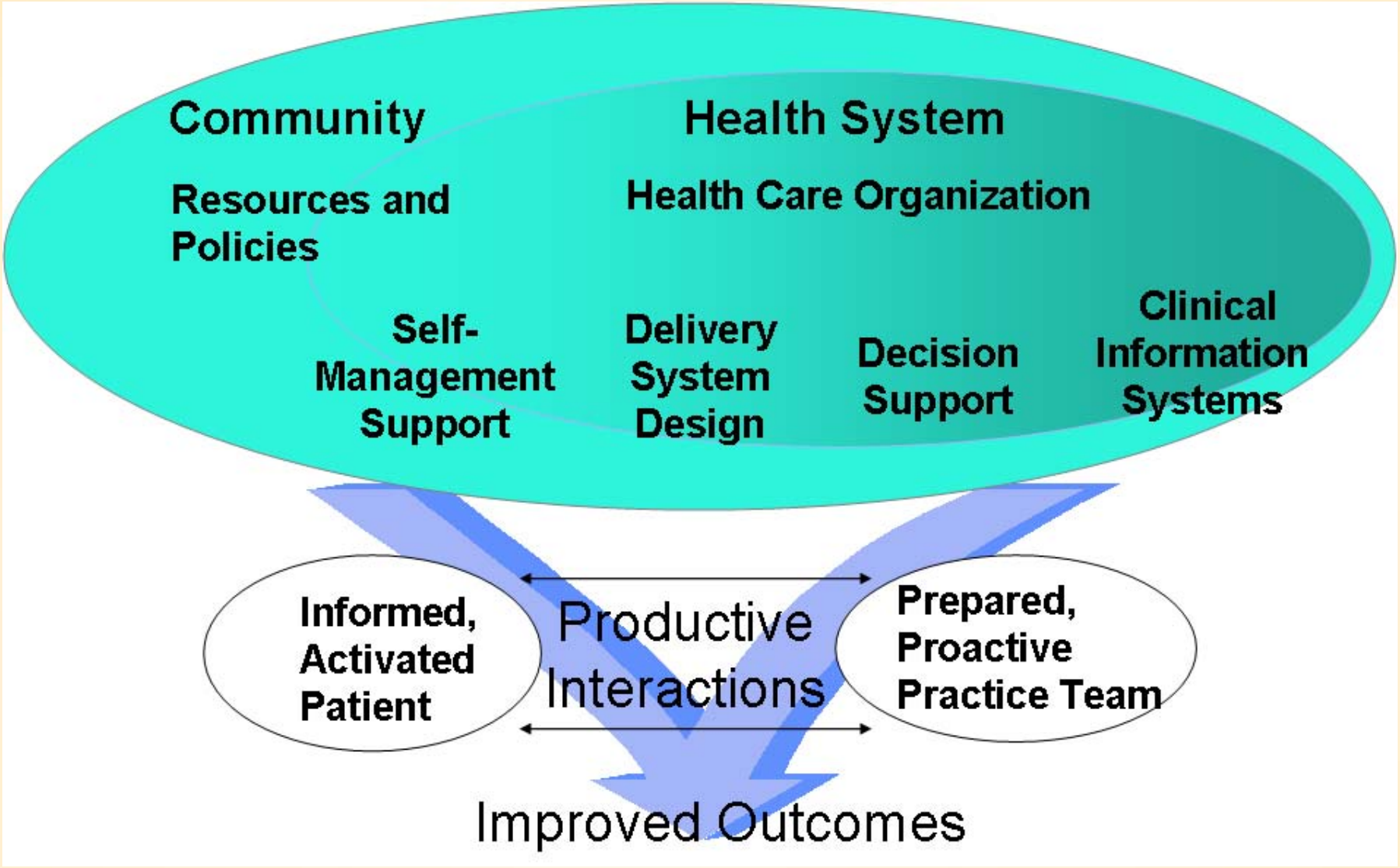
- Focus on quality improvement
- Form teams at participating health centers
- Orientation (kick-off meeting)
- Learning sessions (webinars or team calls)
- Data collection, monitoring and analysis for core measures and PDSA cycles
- Site visits to health center teams
- Year-end/harvesting meeting
  - Share best practices

Broad Changes that Improve Care

- Better use of non-clinical team members
- Modern self-management support
- Care management for the high risk
- Links to effective community resources
- Clinical guidelines integrated into care
- Enhancements to information systems

Care Model

- Identifies essential elements of a health care system that encourage high quality chronic disease care
- Uses evidence-based change concepts to foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise
- Results in healthier patients, more satisfied providers and cost savings


Community
Health System
Resources and Policies
Health Care Organization
Self-Management Support
Delivery System Design
Decision Support
Clinical Information Systems
Informed, Activated Patient
Productive Interactions
Prepared, Proactive Practice Team
Improved Outcomes

Model for Improvement

- Tool for accelerating quality improvement
- Use Plan-Do-Study-Act (PDSA) cycles to test changes in your health center
- PDSAs should be designed to produce immediate results geared toward specific defined outcomes
- Desired result = Encourage spread
- Undesired result = additional PDSAs

Measures and Data Collection

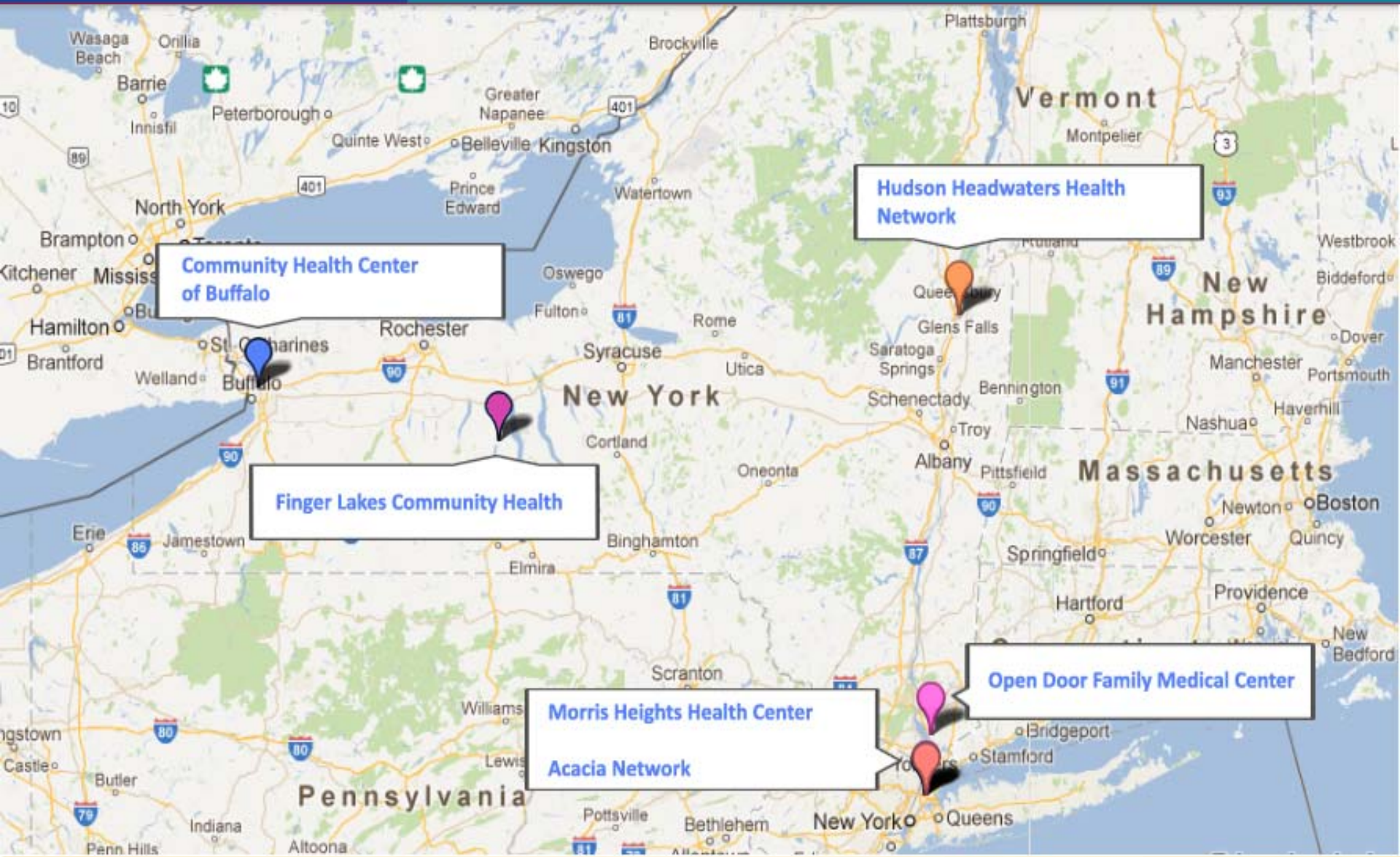
- Population of focus for each team is defined
- Core and Optional measures
- CHCANYS Data Collection Tool (DCT)
- Monthly data submission
- Follow-up and analysis on micro (team) and macro (initiative) level

Hep C Demonstration Project Overview

Kameron Wells, ND
Vice President, Clinical Affairs
CHCANYS

Hep C Demo Project Overview

- NYSDOH/Health Research Inc. (HRI) provided the first year of funding for a two year collaborative Hepatitis C pilot demonstration project in partnership with NYSDOH AI, NYCDOHMH-OVHC & HRC
- Project objective is to improve prevention, screening and treatment of HepC within FQHCs across NYS
- Focus on 5 NYS regions (1 – 2 FQHCs / region)
  - Western
  - Finger Lakes
  - North Country
  - Hudson Valley
  - Downstate


Hudson Headwaters Health Network
Community Health Center of Buffalo
Finger Lakes Community Health
Morris Heights Health Center
Acacia Network
Open Door Family Medical Center
Vermont
New Hampshire
New York
Massachusetts
Pennsylvania
Buffalo
Rochester
Syracuse
Albany
Binghamton
Scranton
New York
Queens
Bridgeport
Stamford
Hartford
Springfield
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Westbrook
Haverhill
Providence
New Bedford
Quincy
Newton
Pittsfield
Bennington
Williamsport
Bethlehem
Pottsville
Altoona
Indiana
Butler
Castle
Lewis
Williams

Comprehensive Viral Hepatitis Services

There should be five core components:

1. outreach and awareness;
2. prevention of new infections;
3. identification of infected people;
4. social and peer support; and
5. medical management of infected people

Institute of Medicine, *Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C. Washington, DC: The National Academies Press*, 2010

Project Aim Statement

- The Aim of the 2012-2014 Hepatitis C Virus (HCV) Demonstration Project is to increase the capacity within FQHCs to expand and improve HCV prevention, screening, diagnosis and linkage to treatment for all patients 18 years and older.

Acacia Network

David C. Collymore, MD, MBA

October 25, 2012

Health Center Background

- 6 Article 28 Health Centers located in the Bronx, including 3 FQHC's
- 1 Mobile Medical Unit
- Health Care, Substance Abuse, Housing, Economic Development
- NextGen – seamlessly integrated EMR/PMS
  - Implemented 2005
- 63% Latino; 32% African American
- Chronic Disease Focus:
  - Diabetes, Hypertension, Asthma, HIV, Hep C

Acacia Network

Initiative Population of Focus

- All provider panels for several sites
  - 3 sites; 8 primary care providers
  - Part-time Gastroenterologist
- Baseline Data
  - 2227 individuals screened
  - 148 diagnosis of chronic HCV
  - 66 initiating anti-viral HCV treatment

Acacia Network
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Team AIM Statement

- Among the patients ages18 and over of the Clay Ave Health Center, Claremont Family Health Center and the Charles A. Laporte Health Center, increase the percentage of individuals screened for HCV to 75% and increase the number of individuals with chronic HCV treated to 50% by March 31, 2013.

Acacia Network

Change Package Best Practices (CPBP)

- Self Management
  - Use of self management tools that are evidence based
- Decision Support
  - Implement clinical decision support tools for HCV screening
- Clinical Information System
  - Develop processes for use of registry (in the Electronic Health Record)

Acacia Network

Challenges to Implementing this Initiative

- Time / Competing priorities
- Customizing EMR
- Case Management Resources

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Initial Impact of Video-Conference Sessions

- Excitement!
- Technical Difficulties
- Timing / Location

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Changes to HIT Processes

- Template Development
- Clinical Decision Support Systems
- Developing Registry

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Next Steps

- Hepatitis C Treatment Support Group
- Continue Data Collection
  - Screening, Treatment, Post-Treatment
- Teleconference participation
- Hepatitis C Team Huddles

Acacia Network

Hepatitis C Demonstration Project

BUFFALO • NIAGARA FALLS

Your Partner for Quality Care

CHCB

COMMUNITY

HEALTH CENTER OF BUFFALO

Dr. Rebecca Simons, Medical Director

October 25, 2012

Who We Are

- **Primary care network of 3 Article 28 FQHCs providing medical, dental, family planning (Title X), onsite laboratory and radiology with major hospital system, 340 B Pharmacy, social work, and financial assistance**
  - **Locations: Buffalo, Niagara Falls, and Lockport**
- **New site for National HIV Treatment program led by Dr. Fann, Tampa, Florida**
- **New primary location opened in Buffalo, January, 2012: 66,000 square feet. Building new site in Niagara Falls**
- **Implemented third generation of electronic medical record (eCW) in April 2012**

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Population of Focus

- **Chronic HCV registry and HCV high risk registry**

- **Start small team at one location: 3 primary care providers, 2 medical assistants, 1 pharmacist (ESAP), 1 social worker for all Hep C patient needs. Weekly meetings work on tasks: template design, Rapid HCV testing protocols, high risk screening tools, system design and collaborative needs, etc.**

- **Consultant: New Director of ECMC GI will assist and be available for training and consultation**

- **Lab: One lab will be used for all testing. Medical Assistants will draw bloods onsite, lab will write off any expenses for uninsured**

- **System wide implementation after core policy and procedure is implemented and successful**

Team AIM Statement

CHCB will improve access to treatment for high risk patients diagnosed with Hepatitis C, ages 18 and older and those born between 1945-1965. The percentage of patients treated in-house will increase from 0% to 15% effective March 31, 2013. Three components of the CHCB plan includes:

- **Clinical Information System integration of a registry with CHCANYS performance measures, patient care reminders, and care planning tools**

- **Improved Delivery System design that integrates improved show rates, comprehensive care during the visit, harm reduction, social work, outreach, telephone calls, and home visits**

- **Improved Decision Support with evidence based guidelines, improved patient self management, and intensive staff training for core team**

Change Package Best Practices (CPBP)

Begin implementation for baseline Hepatitis C practice:

1. **Clinical Information System**
   - **Registry design**
   - **Use of registry for care planning tools**
   - **Registry used to provide feedback to care team and leaders**

2. **Decision Support**
   - **Embed guidelines into care delivery system**
   - **Establish linkages with key specialists for expert support**
   - **Provide training to clinical staff to support Hep C illness improvement**
   - **Improve patient education/self management**
   - **Collaborate with Pharmacy to set up ESAP**

3. **Delivery System Design (work with Data Management)**
   - **Set up roles and duties for multidisciplinary team**
   - **Designate staff for follow-up**
   - **Use community health worker programs for outreach**

Challenges to Implementing this Project

- **Finding time to work on project details outside of weekly meetings**
- **Creating EMR templates with accurate measurements for data collection**
- **Creating a case management design that uses available staff so that patients receive one stop shop care during visit**

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Initial Impact of Video-Conference Sessions

- **Effective format with case management, but getting everyone together to start on time can be challenging with patient service delivery issues**
- **Team conferences help us learn from each other**
- **Need basic learning concepts as we do not treat and have problems with patients coming back**
- **Prefer to learn from some best practices of team members who have demonstrated success in improved show rates, treatment successes, and getting patients to overcome treatment barriers**

Changes to HIT Processes

- **Working on ICD-9 Codes groups for all facets of care**
- **Develop structured data to save time in gathering information for reports**
- **Implement new screening tool in EMR to all high risk 18 year olds**

Next Steps

- **Attend all video conferencing sessions and monthly collaborative calls**
- **Train patient registration and MA staff on new screening tool**
- **Educate staff on Hepatitis C transmission and risk reduction**
- **Finish templates/order sets, finalize reports for data collection**
- **Staff training by ECMC GI Director and Pharmacy Reps**

Finger Lakes
COMMUNITY HEALTH

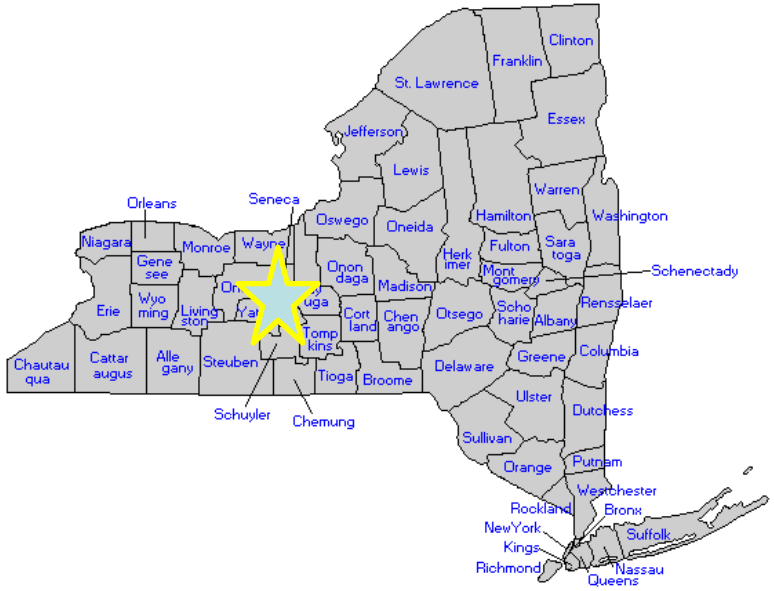
Hepatitis C Project Presentation

Lawreen Duel

October 25, 2012

About Us……

- Founded in 1989 to serve agricultural workers
- Primary care network of 8 Article 28 FQHCs
- ½ of patient encounters in 2011 provided to migrant community



Finger Lakes COMMUNITY HEALTH

Initiative Population of Focus

- **CHCANYS pilot project =**
  - **Chronic HCV Registry**
- **Registry of high risk**
  - **Drug users and HIV+**

Finger Lakes COMMUNITY HEALTH

Team AIM Statement

FLCH seeks to improve access to primary, specialty care, and preventive care for Dr. Eagleson's panel of patients diagnosed with and/or at-risk for Hepatitis C at Geneva Community Health using seven of the quality outcome measures listed below by March 31, 2013.

- **CHCANYS Performance Measures**
- **Decrease No Show/Cancellation**
- **Harm Reduction**
- **Prevention of transmission**
- **Decrease Barriers to Specialty Care**

Finger Lakes
COMMUNITY HEALTH

Change Package Best Practices (CPBP)

Clinical Information System

* Registry
* P&P of Registry Use
* Use registry in planning care

Delivery System Change

*Staff roles & responsibility
*Document core measures every visit

Self Management

*Goals
*Staff education
*Community resources

Finger Lakes COMMUNITY HEALTH

Challenges to Implementing this Initiative

Time & Resources Challenges

*Competing priorities

*Consensus on meeting times

Defining Roles & Responsibilities

*Care team

*Care coordinator

Patient Adherence

*No shows

*Maintaining scheduled appts

Finger Lakes COMMUNITY HEALTH

Challenges to Implementing this Initiative

Data Collection Challenges

* Scanned docs require chart review
* Difficulty getting info from outside agencies
* Need to create structured data/HCV template
* HRSB identifiers/coding
* How to include patients who have seroconverted
  (resolved infection from spontaneous or treated)

Finger Lakes COMMUNITY HEALTH

Initial Impact of Video-Conference Sessions

- Conferences with Dr. Bernstein informative
- Difficult to present case because we do not do treatment and information from specialists is sketchy
- Time constraints with providers schedule and participation (need archive)
- Team conferences beneficial – need all team members present to be effective
- Need learning modules to start

Finger Lakes COMMUNITY HEALTH

Changes to HIT Processes

- ICD-9 Codes were identified and groups created for reporting
- Reports have been developed in Bridge IT
- Using structured data to develop reports versus manual chart review
- Working with provider to ensure consistency in documenting in patient record

Finger Lakes
COMMUNITY HEALTH

Next Steps

- Continue working on goals to improving care
- Identify meeting times that will work with all schedules
- Encourage all team members to attend all video conferencing sessions
- Educate staff on Hepatitis C transmission and risk reduction

Finger Lakes
COMMUNITY HEALTH

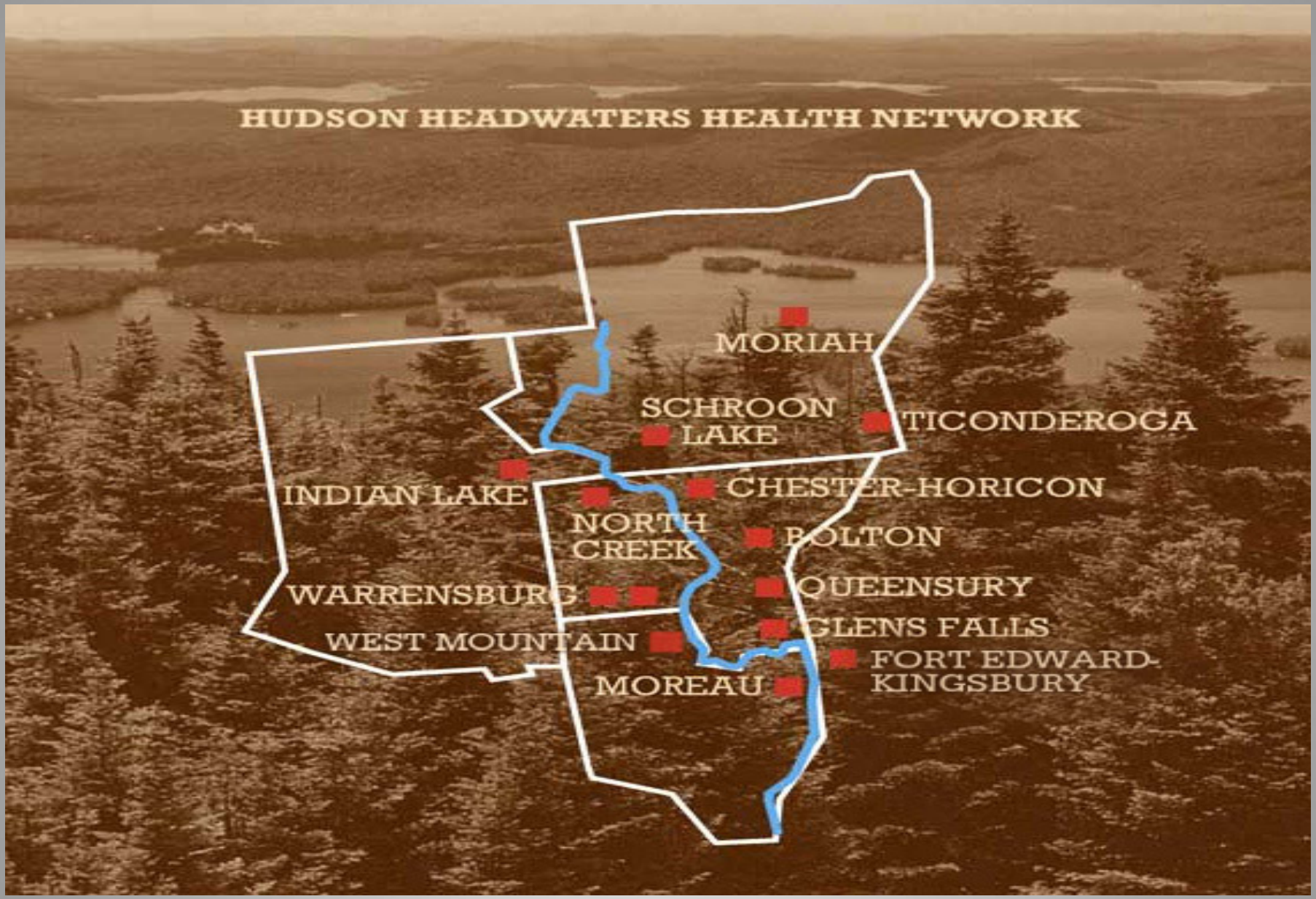
Hudson Headwaters Health Network

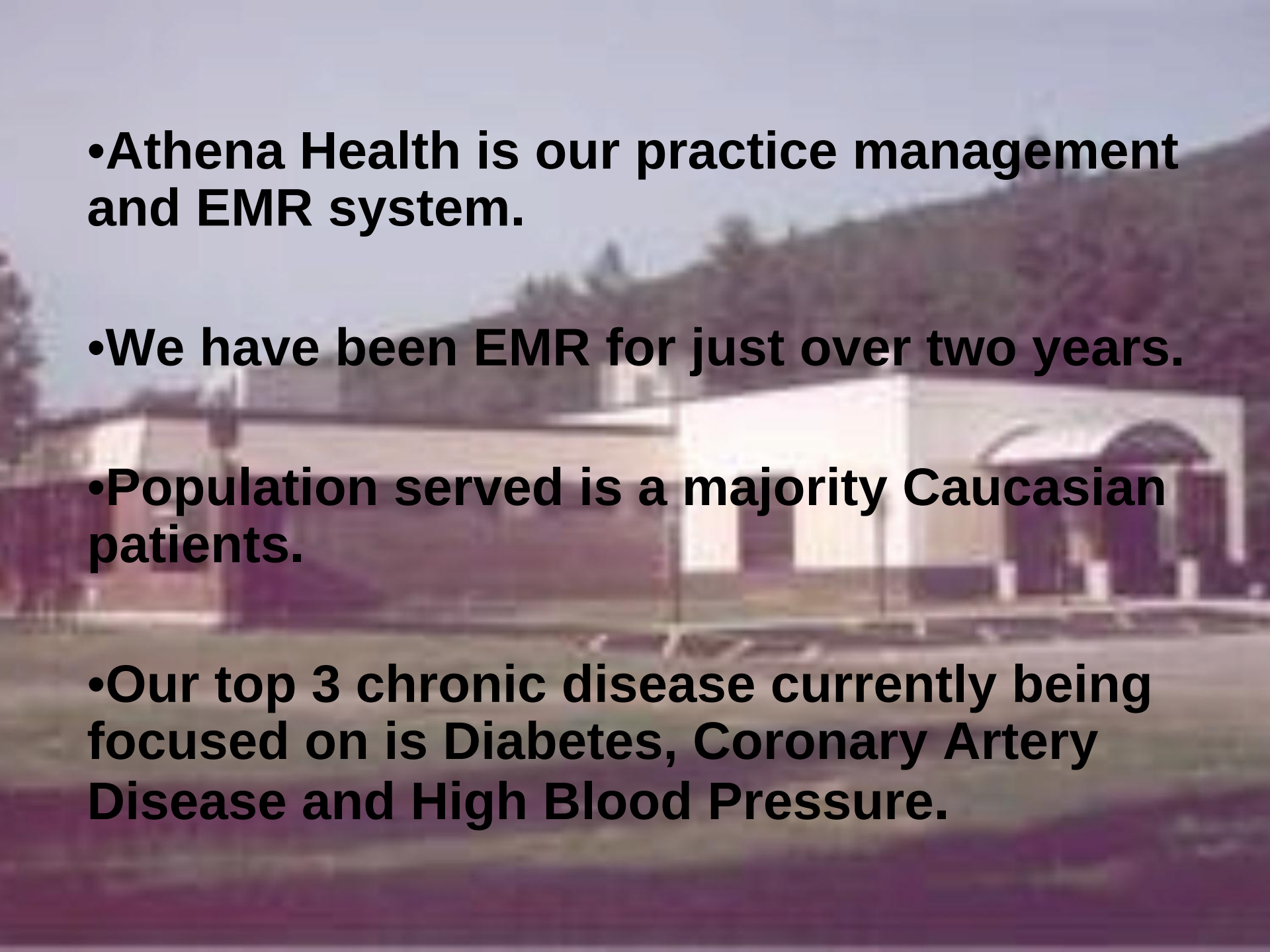
Dawn R. Loeffler

October 25, 2012

About Hudson Headwaters Health Network

- **We have been in operation for over 30 years.**
- **We provide services to mostly rural areas.**
- **We currently have a total of 15 health centers.**
- **Our centers stretch from Champlain to South Glens Falls. We offer dental ,urgent care, pediatrics, family practice, women's health, inpatient services, nursing home visits, home care, geriatric care and several other specialties.**


HUDSON HEADWATERS HEALTH NETWORK
MORIAH
SCHROON LAKE
TICONDEROGA
INDIAN LAKE
CHESTER-HORICON
NORTH CREEK
BOLTON
WARRENSBURG
QUEENSURY
GLENS FALLS
WEST MOUNTAIN
FORT EDWARD-KINGSBURY
MOREAU



- **Athena Health is our practice management and EMR system.**
- **We have been EMR for just over two years.**
- **Population served is a majority Caucasian patients.**
- **Our top 3 chronic disease currently being focused on is Diabetes, Coronary Artery Disease and High Blood Pressure.**

Initiative Population of Focus

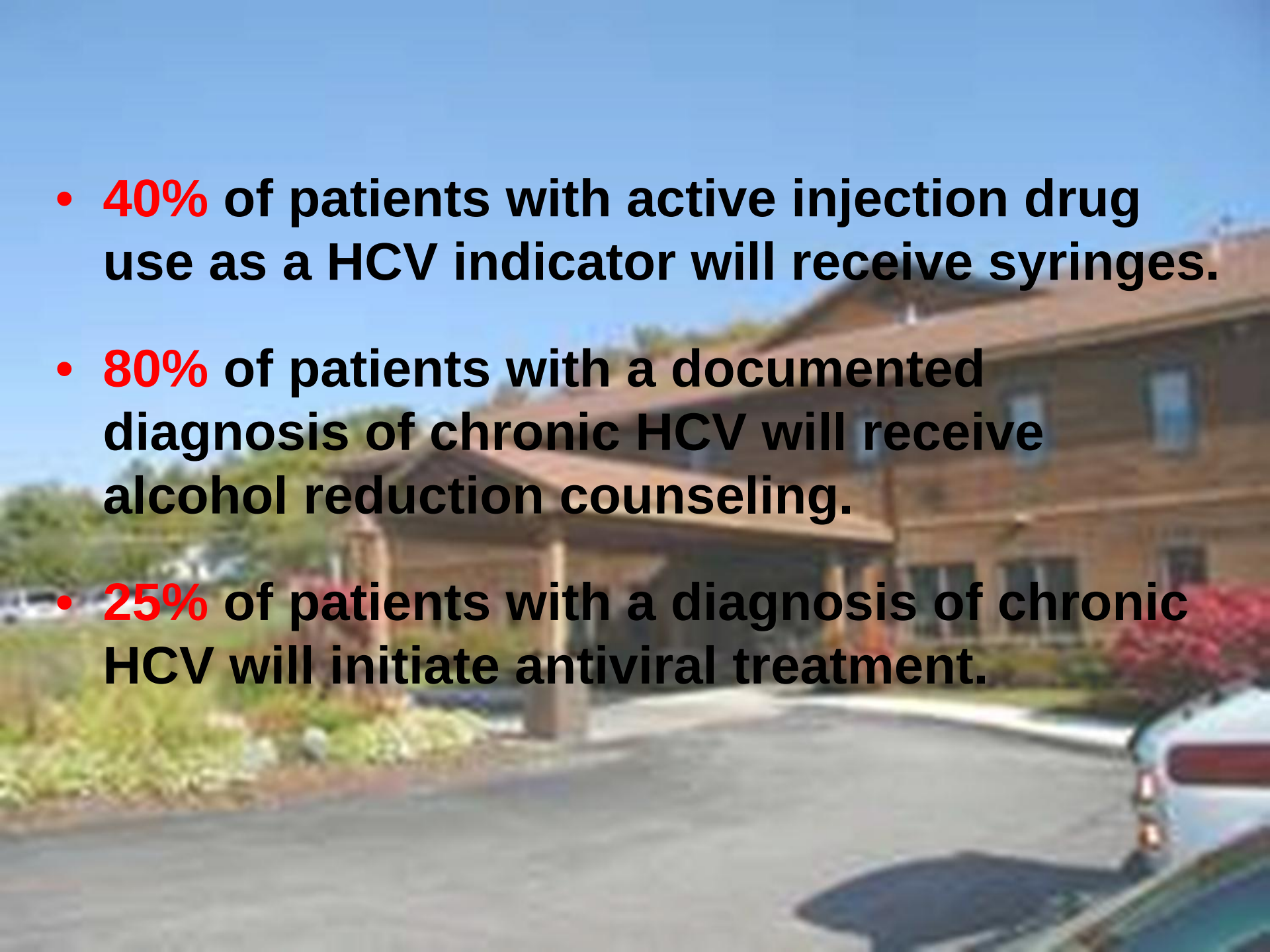
- **Our target population is approximately 277 patients seen in our Broad Street location for infectious disease.**
- **Brian McDermott, D.O. is our provider champion. His patient population is our target audience.**

HHHN AIM Statement

- **Among Dr. Brian McDermott's patient population at the Health Center at Broad Street, patients ages 18-100 who exhibit high risk behaviors will increase HCV screening to <u>20%</u> by March 2014.**

Intermediate AIMS include:

- **75% of patients ages 18-100 with an indicator for HCV exposure will be screened for HCV.**
- **80% of patients who screen HCV+ will receive HCV RNA testing.**
- **60% of patients with a +HCV RNA test will receive a diagnosis of chronic HCV.**



- **40%** of patients with active injection drug use as a HCV indicator will receive syringes.
- **80%** of patients with a documented diagnosis of chronic HCV will receive alcohol reduction counseling.
- **25%** of patients with a diagnosis of chronic HCV will initiate antiviral treatment.

Long Term AIM Goals:

Effective January 2013, each month an additional health center will be added to the collaborative.

Began on September 17th with Dr. Brian McDermott's patients at the Health Center on Broad Street.

Change Package Best Practices

- Use of self management tools that are based on evidence of effectiveness.
- Develop processes for use of the registry, including designating personnel to enter data, assure data integrity, and maintain the registry.
- Make sure senior leaders and staff visibly support and promote the effort to improve Hep C care.

Challenges to Implementing this Initiative

- **Adapting Computer Software to measure all required criteria. (IV Drug users, screenings, etc.)**
- **Re-education of staff to diagnose with either an acute or chronic disease state.**
- **Buy in from community and network to participate in the syringe exchange program.**

Process Changes

- **All patients in study, when presenting for office visit, are handed a questionnaire to complete.**
- **Questionnaire is reviewed to identify if any high risk behavior is noted.**
- **Screening is discussed with patient.**
- **Testing is ordered if patient consents.**

Changes to HIT Processes

- **Fields added to identify if patient was screened.**
- **Addition of IV Drug user field.**
- **System order sets established to select testing and patient education.**
- **Future plans to add a Hepatitis Flowsheet to gather and view at a glance Hep C specific testing and results.**

Next Steps

- **Continue to review the process and measurements.**
- **Identify areas for improvement and make necessary changes.**
- **Seek outside services available to assist our patients (i.e., treatment, behavioral health assistance, support groups etc.)**

Morris Heights Health Center

Azebe Etsubneh

October 25th, 2012

MHHC Background

- Level III Patient Centered Medical Home
- Participating in Meaningful Use
- 3 Primary care sites, 1 specialty site, 1 Women's Health Center & 12 SBHCs
- GE Centricity CPS (PM & EMR)
  - Fully implemented, 3 years

MHHC Population

- 66% Hispanic / 34% non-Hispanic
- 28% African American
- 0.5% Caucasian, 0.3% Asian/Pacific Islander
- Prevalent Conditions:
  - Hypertension, Heart disease, Obesity, Diabetes, HIV

Initiative Population of Focus

All patients 18 and over.

Team AIM Statement

- By March 31, 2013 Morris Heights Health Center will increase the percentage of patients aged 18 years and older that receive HCV screening from 33% to 75%. Of those testing positive we will enroll 95% into our team based Hepatitis C treatment program. We will do this by implementing evidence based guidelines, EMR template development and provider education.

MHHC Project Goals

- ≥ 30% of patients born between 1/1/1945 and 12/31/1965 will get a screening test for hepatitis c
- ≥ 75% patients with a positive screening test will receive a HCV RNA test
- ≥ 50% of patients with a positive HCV RNA test will receive an appointment with the Hepatitis C clinic within 3 months of diagnosis
- ≥ 10% of all patients with a positive HCV RNA test will receive will start treatment

Change Package Best Practices (CPBP)

- Decision Support
  - Embed evidence based guidelines in care delivery
  - Establish linkages with specialists so that PCPs have access to expert support
  - Skill oriented training to all staff

Change Package Best Practices (CPBP)

- Health Care Organizations
  - Senior leadership support & promote HCV care
  - HCV care is part of mission, goals, PI & business plans
  - Increase capacity to provide care: adding Tx provider

Change Package Best Practices (CPBP)

- Community
  - Provide lists of resources to patients, families & staff
  - Encourage participation in education & support groups
  - Raise community awareness through outreach & education

Challenges

- Meeting scheduling – provider champion availability during conference
- Financial viability of in house Hep-C clinic
- Increasing capacity of Hep-C treatment – adding providers
- Staffing to raise community awareness
- Promoting visibility and knowledge internally

Initial Impact of Video Conference Sessions

- Presented 2 clinical cases so far
  - Hepatologist feedback has been helpful
  - Better outcomes for patients
- Support staff education
  - Contributed to increased knowledge in interpreting lab results and assessing prognoses

Changes to HIT Processes

- Streamlining in-house Hep-C clinic referral process to ensure that all patients referred get an appointment
- Established Hep C screening template for PCPs

Next Steps

- Continue progress on Decision Support, Delivery System Design and Community outreach goals
- Ongoing review of monthly data, which tracks screening, diagnosis and treatment of HCV
- Internal support through Hep-C taskforce monthly meetings

Open Door Family Medical Centers, Inc.

Matthew Zeppieri, DO
Family Physician
October 25, 2012

Health Center Background

- Suburban location in Westchester County
- Four Total Sites
  - Ossining, Port Chester/SBHC, Mt. Kisco, and Sleepy Hollow
- EMR fully implemeted in 2006, eCW
- Approximately 60% Latino, 20% Caucasian, 10% African American,10% Other
- Top 3 chronic diseases:
  - Diabetes Type 2, Hypertension, Obesity

Initiative Population of Focus

- 1 provider panel with plans to expand to the entire Ossining site
- Provider panel
  - Matthew Zeppieri, DO – Family Physician

Team AIM Statement

- Increase the rate of HCV screening in patients 18 years or older who are at risk in our Ossining site.
- Of those infected, increase the rate of guideline-concordant care.

Change Package Best Practices (CPBP)*

- Embed evidence based guidelines in the care delivery system.
- Establish linkages with key specialists to assure that primary care providers have access to expert support.
- Assign roles and duties for planned visits to a multidisciplinary care team; Use cross training to expand staff capabilities

*Appendix D New York State Hepatitis C demonstration project

Challenges to Implementing this Initiative

- Cost of testing:
  - HCV cost
  - HCV oraquick?
- Once diagnosed:
  - Lost to follow-up
  - Arranging and maintaining treatment/therapy

Initial Impact of Video-Conference Sessions

- Case Discussions

Changes to HIT Processes

- Running proper filters in eCW to see which patients may be already at risk.

Next Steps

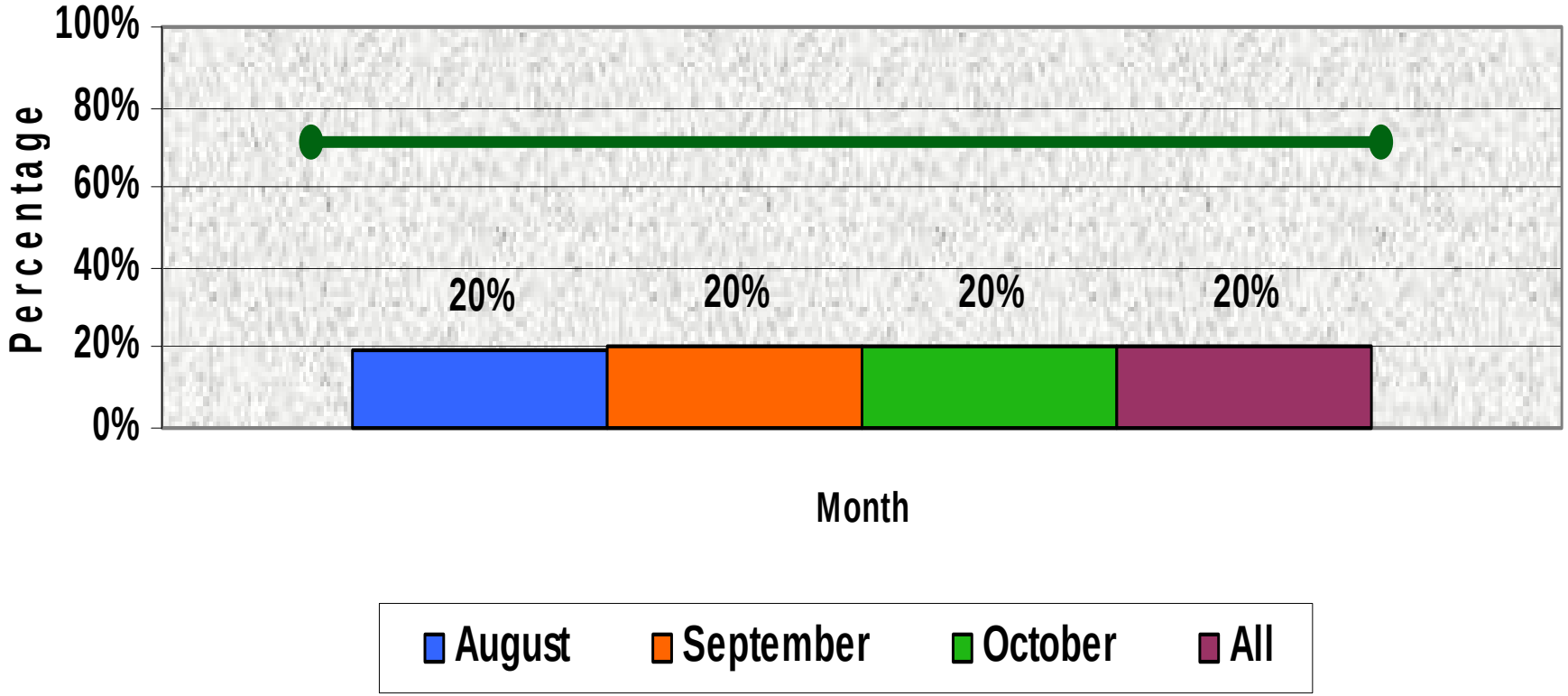
- Screening of at risk patients already in progress
- Coordination of care with Hepatitis clinic at Westchester Medical Center
- Consider HCV treatment training to make available at Open Door Facilities.

Current Project Data

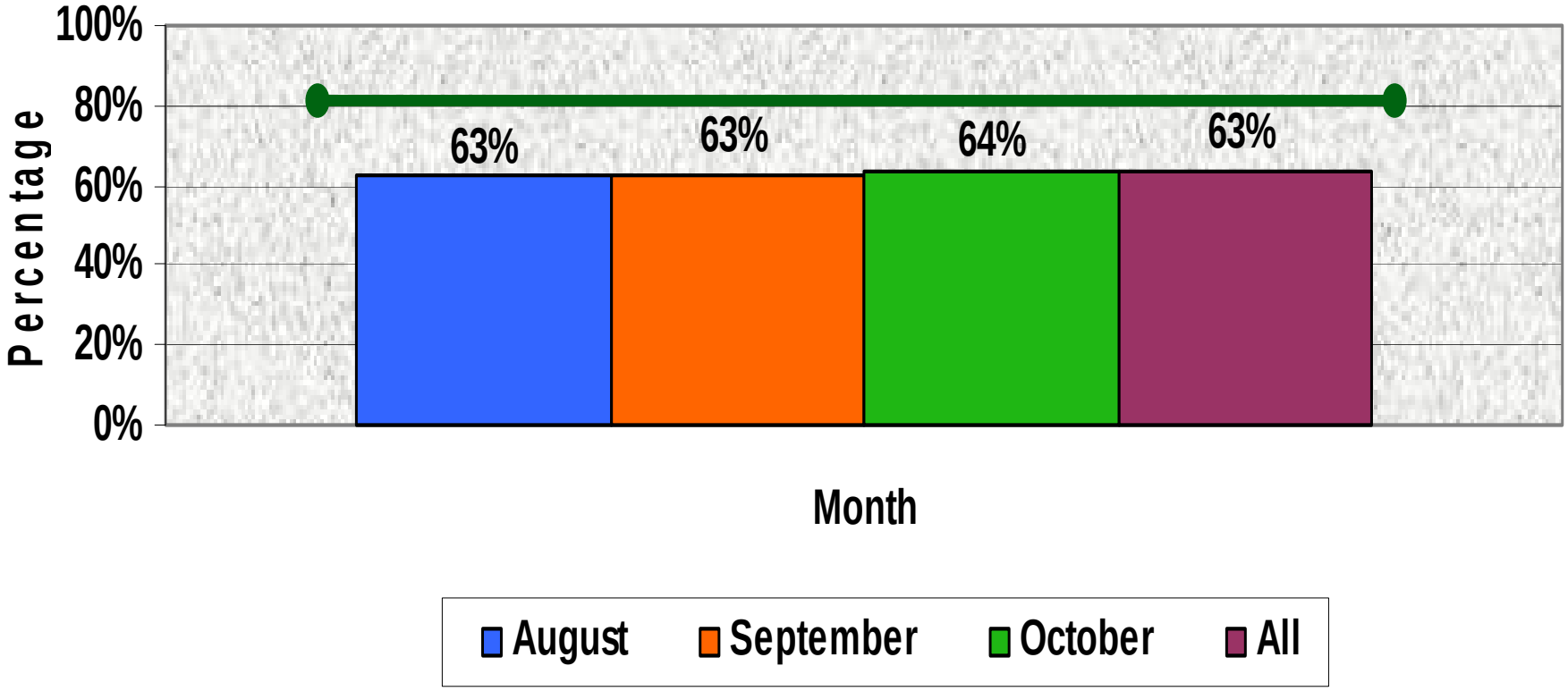
Performance Measures

- 75% of patients 18 years and older with an indicator for possible HCV exposure will be screened for HCV
- 80% of patients who screen HCV+ will receive HCV RNA testing
- 60% of patients with a + HCV RNA test will receive a diagnosis of chronic HCV
- 40% of patients with active injection drug use as a HCV indicator will receive syringes
- 80% of patients with a documented diagnosis of chronic HCV will receive alcohol reduction counseling
- 25% of patients with a diagnosis of chronic HCV will initiate anti-viral treatment

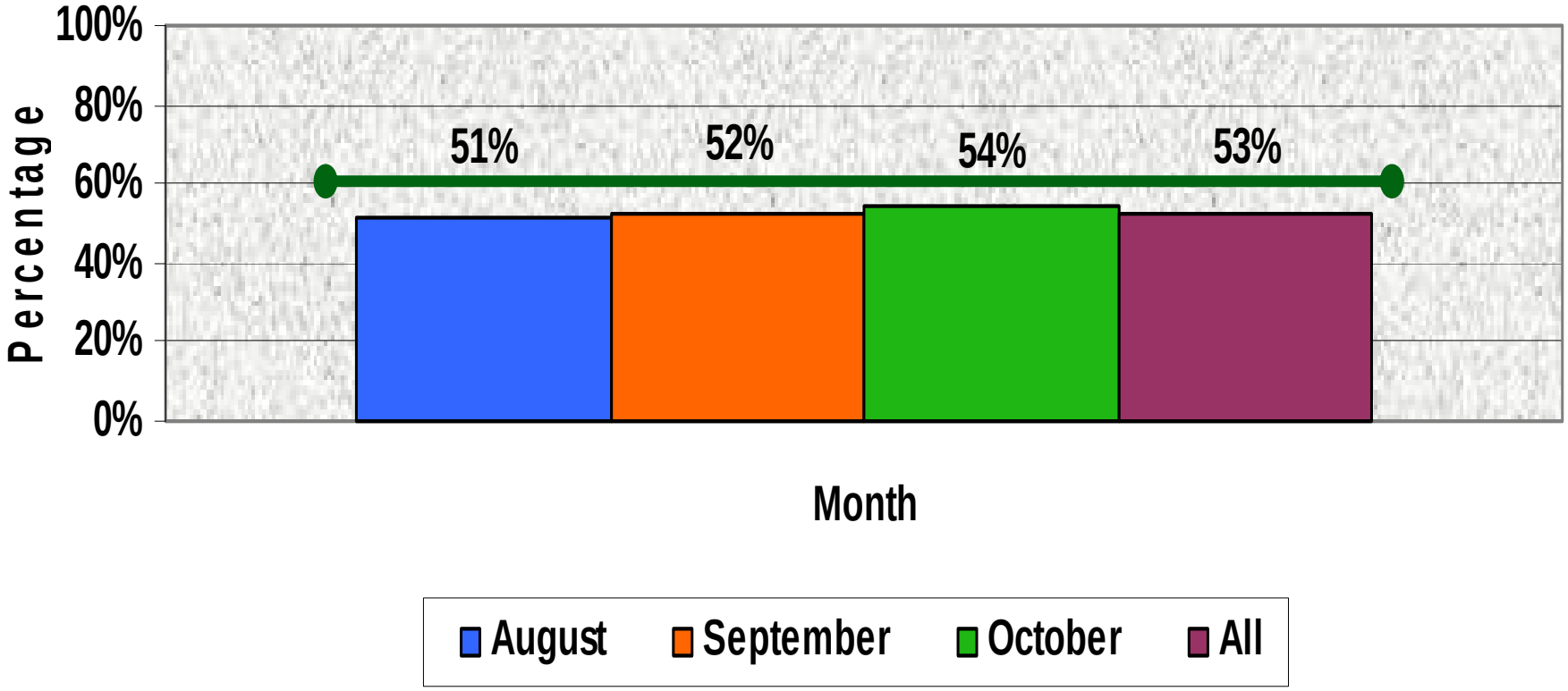
% of Pts 18 yrs+ with an Indicator for Possible HCV Exposure Screened for HCV



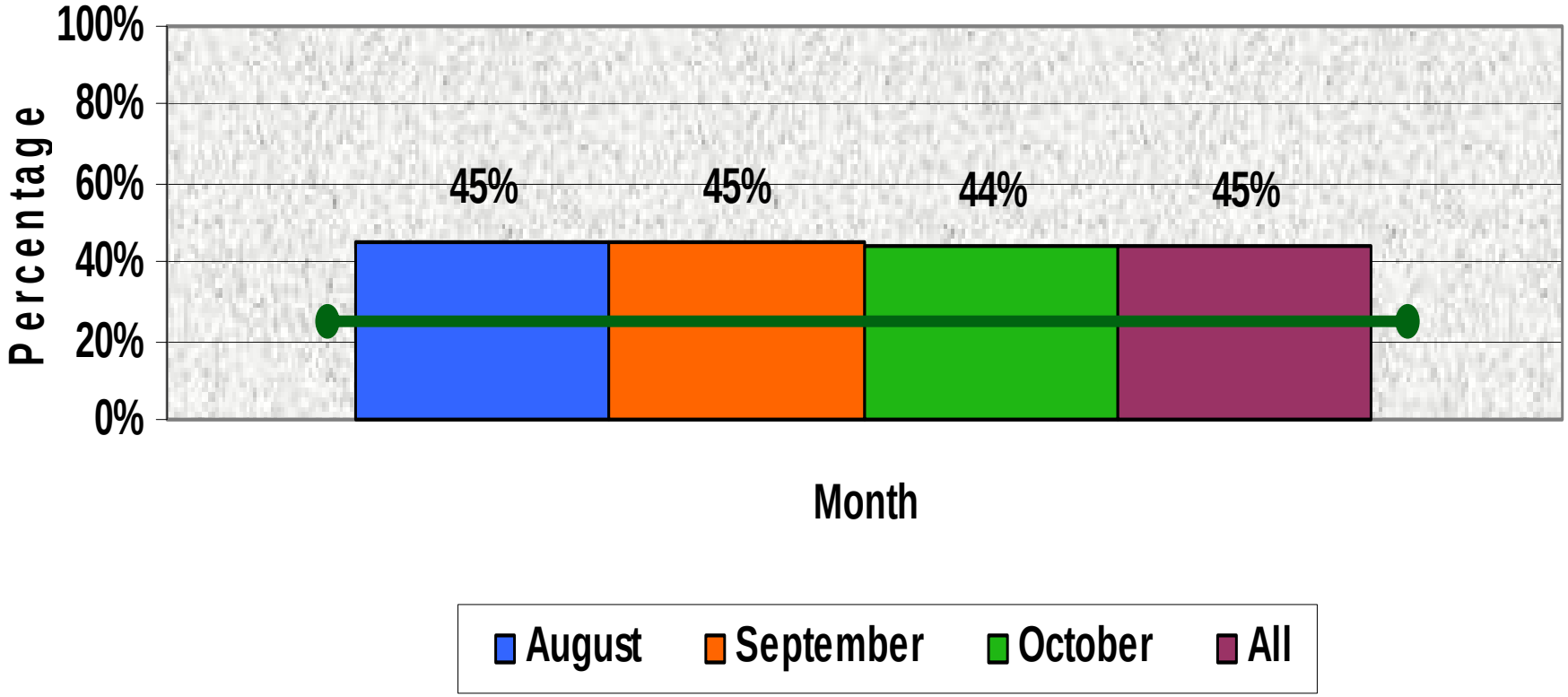
% of Patients with Positive HCV Screening Test Receiving HCV RNA Testing



% of Patients with a Positive HCV RNA Test Receiving a Diagnosis of Chronic HCV



% of Patients with a Diagnosis of Chronic HCV Initiating Anti-Viral Treatment



What's Next?

- Challenges to implementing tele-health model
- Resources available
  - Need cost neutrality (PMPM)
  - Access to specialists (Contracts)
  - Access to equipment
    - Finger Lakes Telehealth Network

Questions?