Innovative Roles for DIS

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Logistics

- This webinar will be recorded. The recording and slides will be made available to those who registered.

- Please mute your phone line or computer speaker.

Background

- DIS have been around for decades providing critical support to infectious disease detection and response
- Change and adaptation are crucial
- NASTAD and NCSD remain committed to providing support to state programs that wish to adapt, change and be innovative in the use of new tools and resources in the STD and HIV response.

Objectives

1. Describe Washington State's Hepatitis C Disease Intervention Specialist program and planning processes.
2. Describe Louisiana Department of Health's process in strengthening their DIS staff's culturally responsive care
3. Foster conversations on how your health department can adapt such information into your current work

Introduction

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Adult Viral Hepatitis Prevention Coordinator
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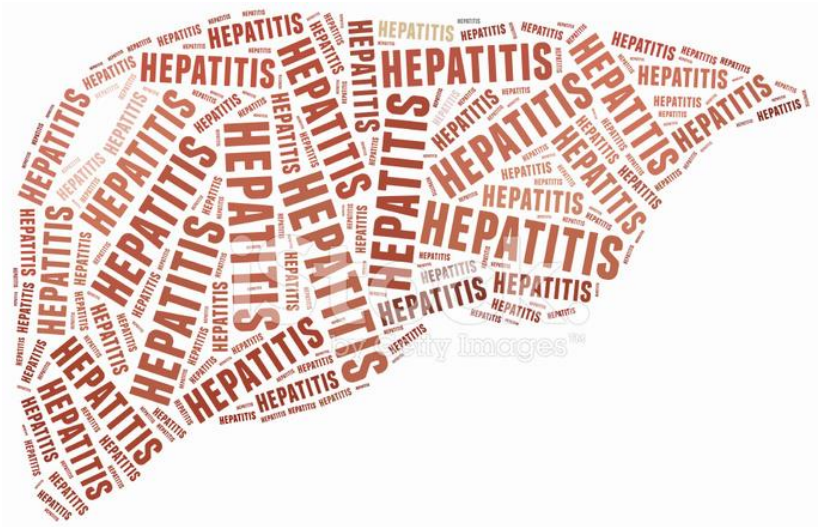
Viral Hepatitis – The Role of Disease Intervention Specialists

Key Learning Objectives

By the end of the session, participants will be able to:

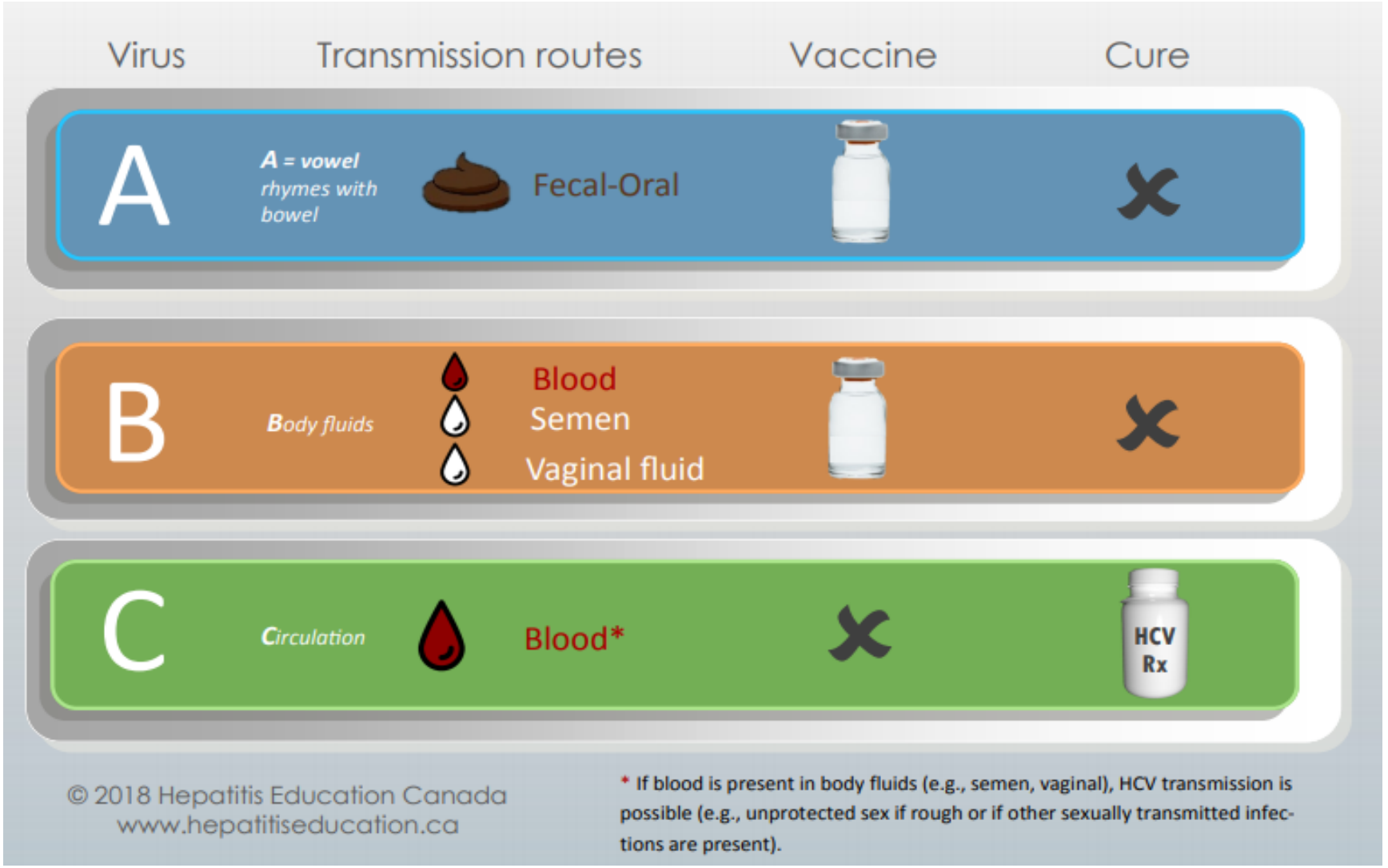
- Describe the impact of hepatitis C in Washington State;
- Identify the limitations and weaknesses to public health's ability to link those impacted by hepatitis C to care and treatment; and
- Describe Washington State's hepatitis C Disease Intervention Specialist Program and planning processes.

Hepatitis



- Inflammation of the liver
- In the U.S., the most common viruses that cause hepatitis are hepatitis A, hepatitis B and hepatitis C

A, B, C's of Viral Hepatitis

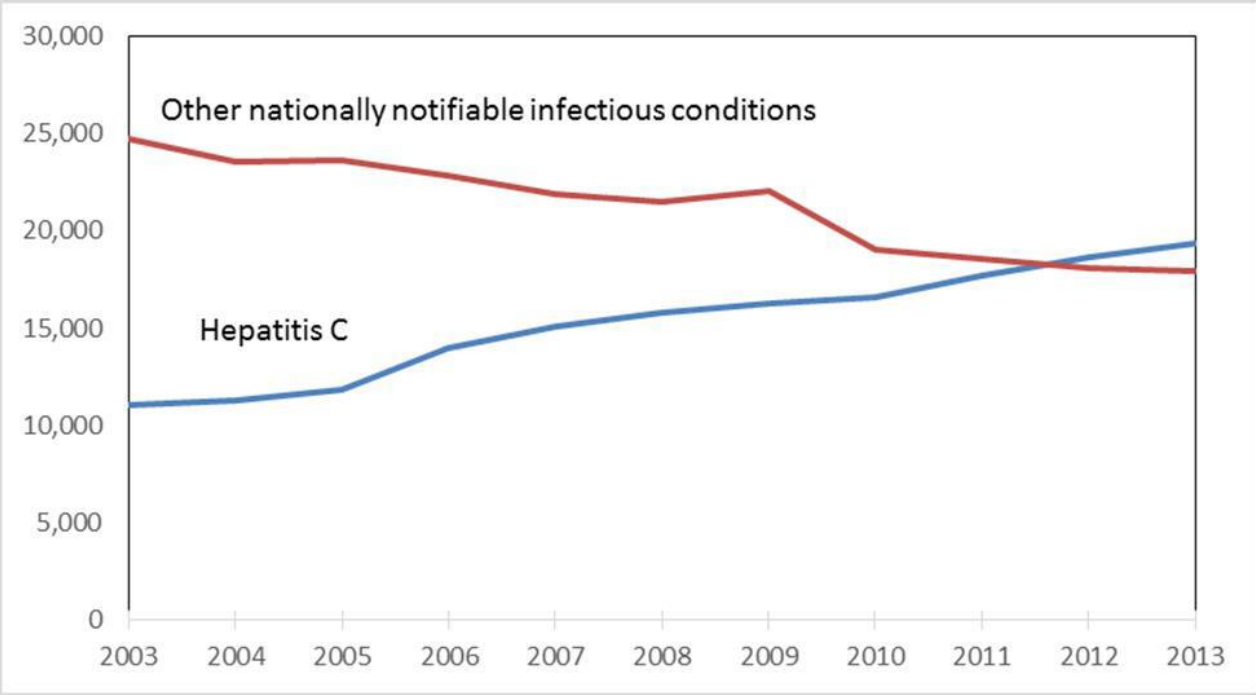


Source: http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/Hepatitis/Hepatitis%20A%20B%20C.pdf

Hepatitis C Virus (HCV)

- HCV is the most common bloodborne infection in the United States.
- In the US, it kills more people every year than all other 59 reportable infectious diseases combined.
- Rising death and morbidity in the aging Baby Boomer cohort (born 1945 through 1965).
- Leading cause of liver cancer and leading indication for liver transplant in the US.
- Hospitalization costs related to HCV in WA were $114 million from 2010 through 2014.
- While there is no vaccine to prevent HCV, new medications can successfully cure the infection in >90% of patients in 8-12 weeks with few side effects.

HCV Deaths Exceed Deaths from 59 Other Infectious Diseases Combined



Other notifiable infectious conditions include HIV, tuberculosis, and hepatitis B

Hepatitis C Surveillance in Washington State

- Hepatitis labs and cases reportable to each of the 35 local health jurisdictions (LHJs) in WA
  - Hepatitis C reporting became mandated in Dec 2000
- Labs and healthcare providers required to report positive test results for HCV (antibody/RNA)
  - Majority of reports come from labs; provider reporting rare
- WA DOH operates the state's electronic lab reporting system (PHRED), so state hepatitis staff have access to ELR data (but not hard copy lab reports)
  - Approximately 10,000 electronic laboratory reports (ELR) each month
  - ELRs account for 30-40% of total lab volume

Limitations of Hepatitis C Surveillance in Washington State

- **Lack of resources**
  - CDC only funds 14 states in the country for hepatitis surveillance; federal response very different from HIV/STDs
  - Most LHJ staff work on all communicable diseases; dedicated hepatitis staff at just 3 largest LHJs in WA
- **Unable to accurately track patients in the registry who have:**
  - Moved out of state
  - Died
  - Been cured
- **Other limitations include:**
  - ~75% of risk (and race/ethnicity) data among known chronic cases are missing
  - Diagnoses missed due to asymptomatic nature of disease
  - Limited in ability to conduct partner/contact investigations

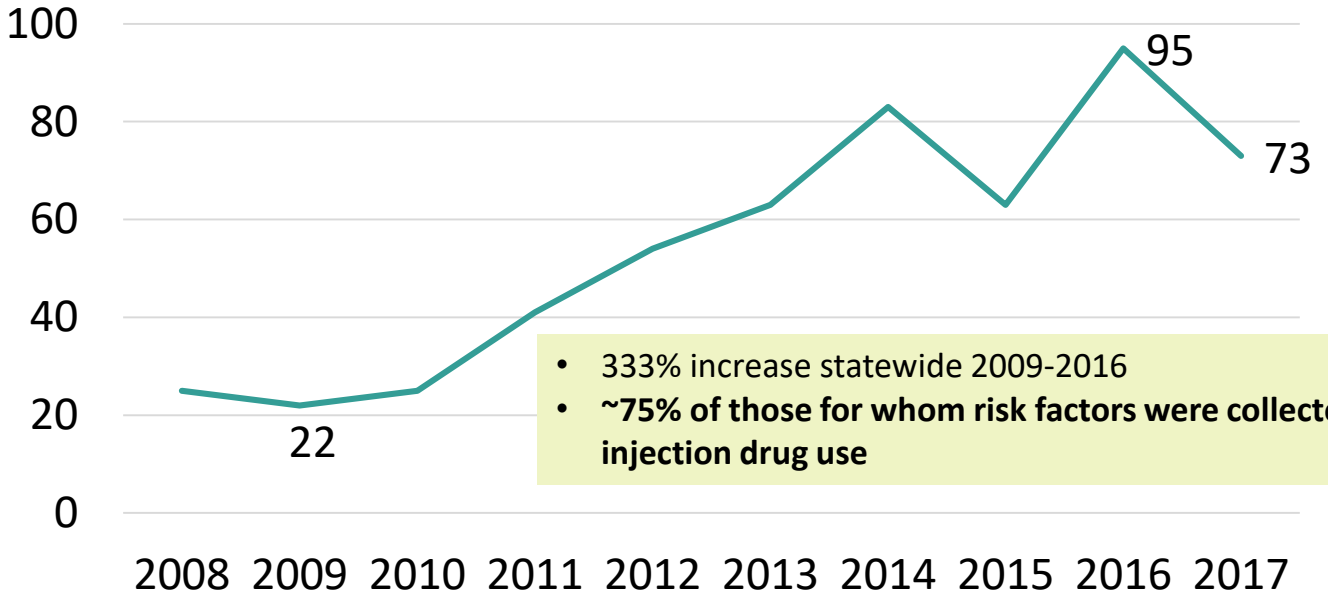
Hepatitis C Surveillance in Washington State

- In 2017:
  - 8,839 new reports of chronic infection
  - 543 deaths attributed to chronic HCV
  - 73 new reports of acute infection
- There are an estimated 65,000 Washingtonians currently living with chronic HCV.

Newly Reported HCV cases			
Year	**Acute**	**Chronic**	**Total**
2012	54	4,865	4,919
2013	63	4,438	4,501
2014	83	5,995	6,078
2015	63	7,085	7,148
2016	95	8,118	8,213
2017	73	8,839	8,912

Source: WA DOH Hepatitis Surveillance Records

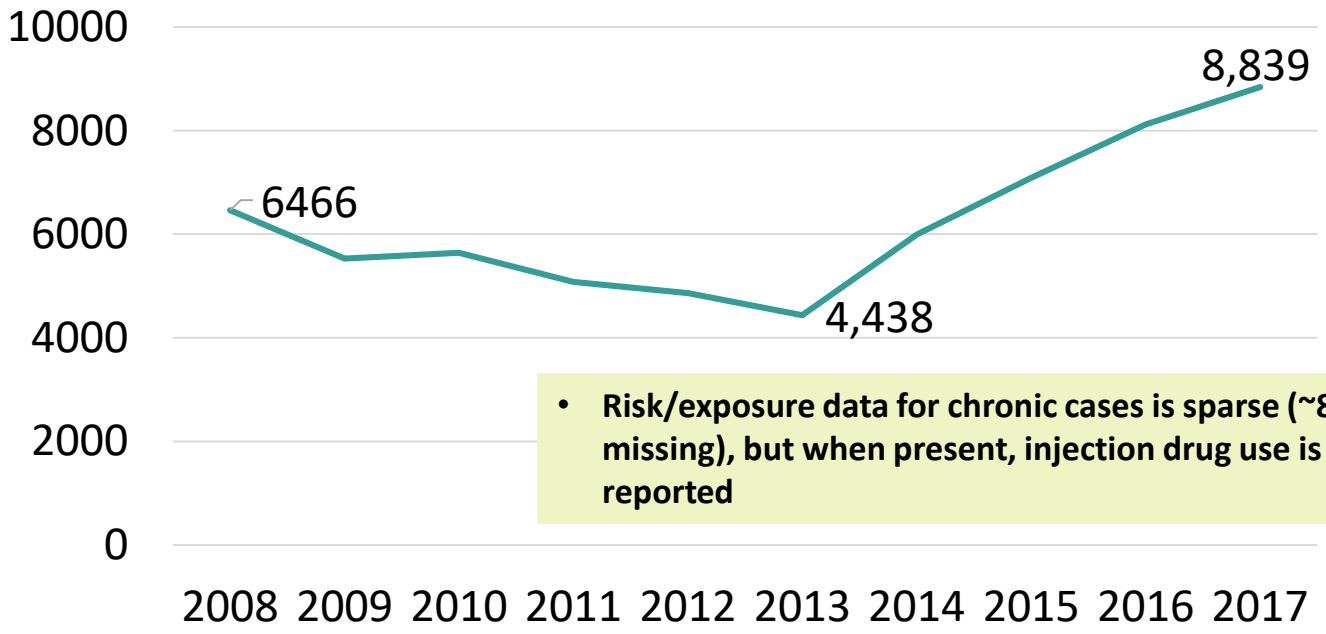
Acute HCV cases in Washington State, by year of report (2008 – 2017)



- 333% increase statewide 2009-2016
- **~75% of those for whom risk factors were collected report injection drug use**

Source: WA DOH Hepatitis Surveillance Records

Chronic HCV cases in Washington State, by year of report (2008 – 2017)

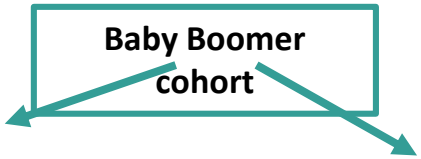


- **Risk/exposure data for chronic cases is sparse (~80% missing), but when present, injection drug use is often reported**

Source: WA DOH Hepatitis Surveillance Records

Age shift among chronic cases

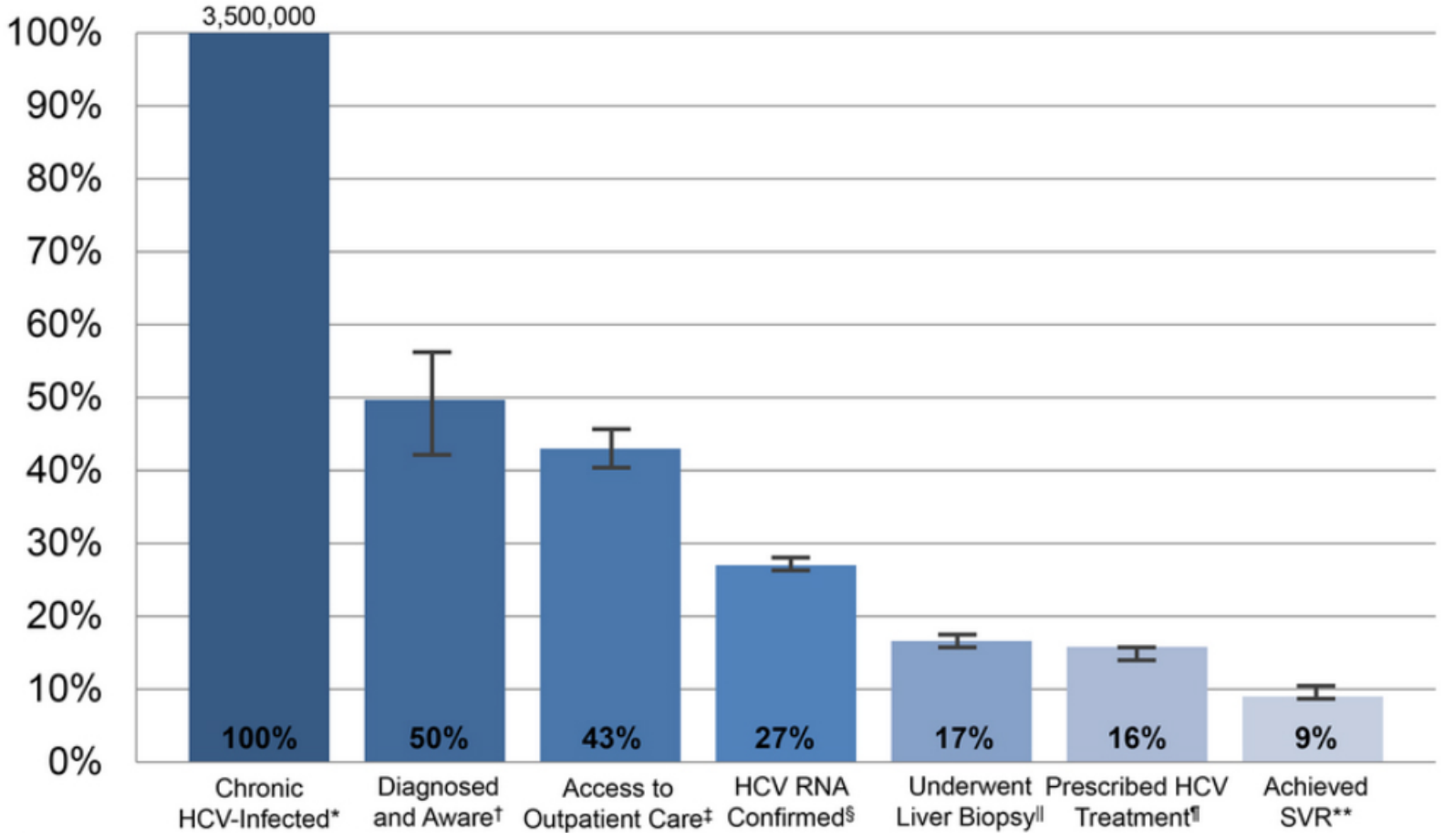
2007		
Age range	**#**	**%**
0-9	18	0.3
10-19	53	1.0
20-29	378	6.9
30-39	752	13.7
40-49	1701	31.1
50-59	2050	37.5
60-69	392	7.2
70-79	94	1.7
80+	36	0.7
unknown	22	
Total	5496	



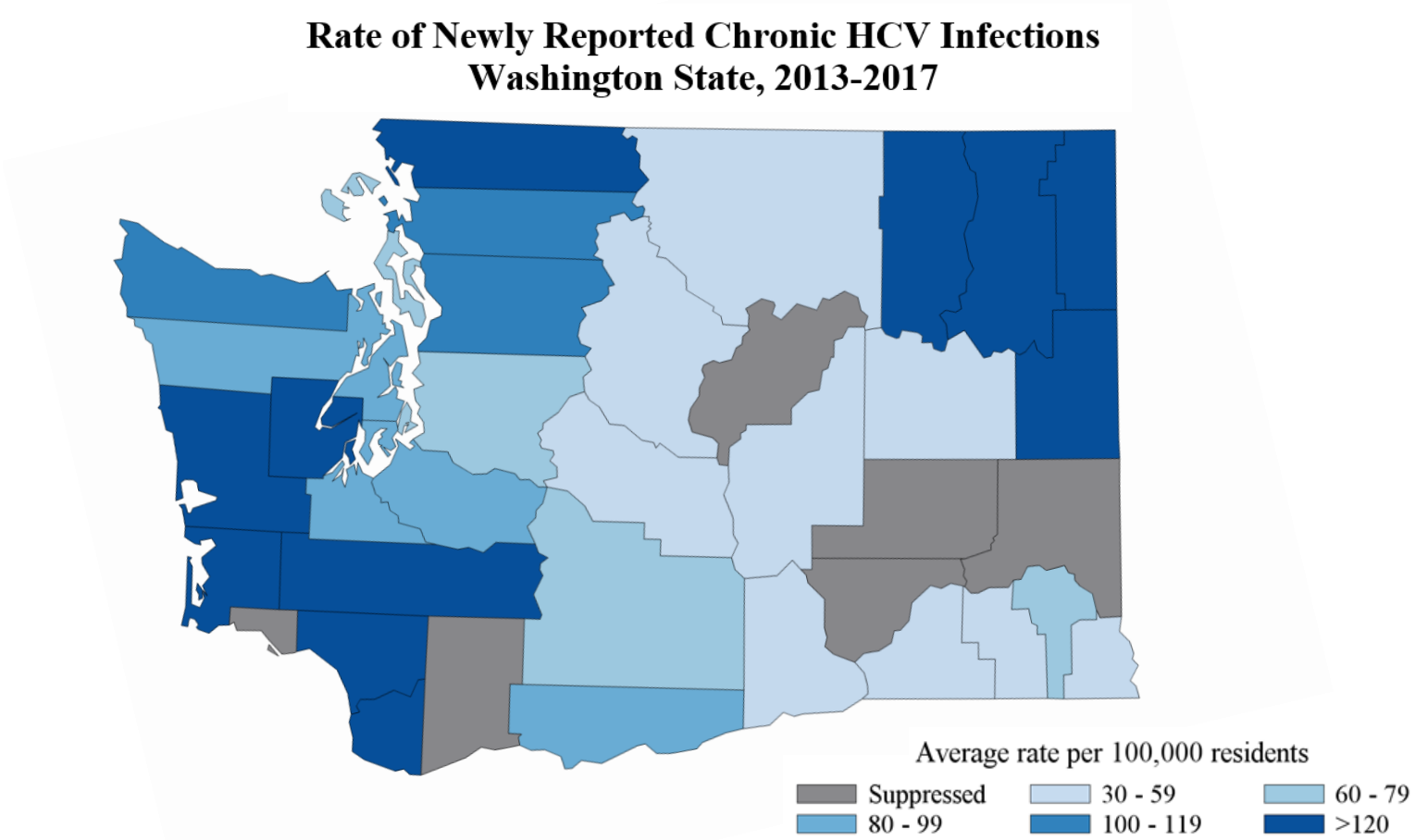
2017		
Age range	**#**	**%**
0-9	30	0.3
10-19	106	1.2
20-29	1255	14.2
30-39	1349	15.3
40-49	1097	12.5
50-59	2270	25.8
60-69	2294	26.0
70-79	353	4.0
80+	59	0.7
unknown	26	
Total	8839	

Source: WA DOH Hepatitis Surveillance Records

Treatment Cascade for Chronic HCV



Yehia, et al. Plos ONE. 2014


Rate of Newly Reported Chronic HCV Infections
Washington State, 2013-2017
Average rate per 100,000 residents
Suppressed
30 - 59
60 - 79
80 - 99
100 - 119
>120

WA DOH HCV Prevention Portfolio
Disease Detection & Provider Readiness

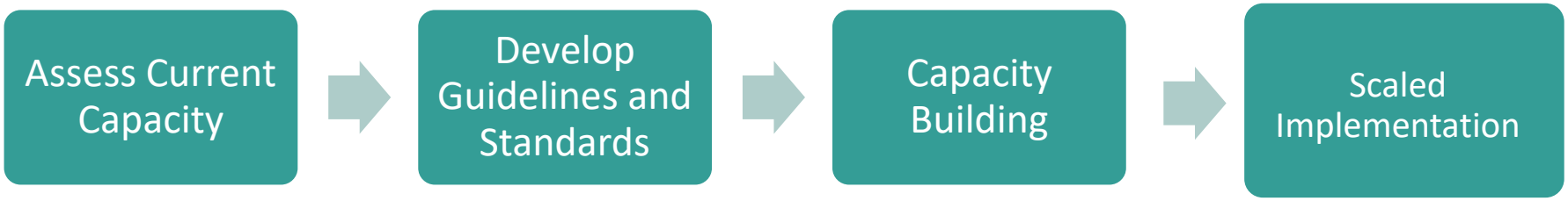
- ***Screening***: early adopters of rapid hepatitis C antibody screening technology
  - 2012, direct funding using General Fund State monies
  - Development of WA State Hepatitis C Rapid Screening Program
  - Community based organizations, local governmental health, health care entities, and jail screening programs.
- ***Provider Capacity Building***
  - UW Project ECHO
- ***Referral and Linkage to Care***
  - HCV case management program
  - Providers directory (drug user health focus)

Proposal for Strengthening HCV Surveillance in Washington – PS17-1703

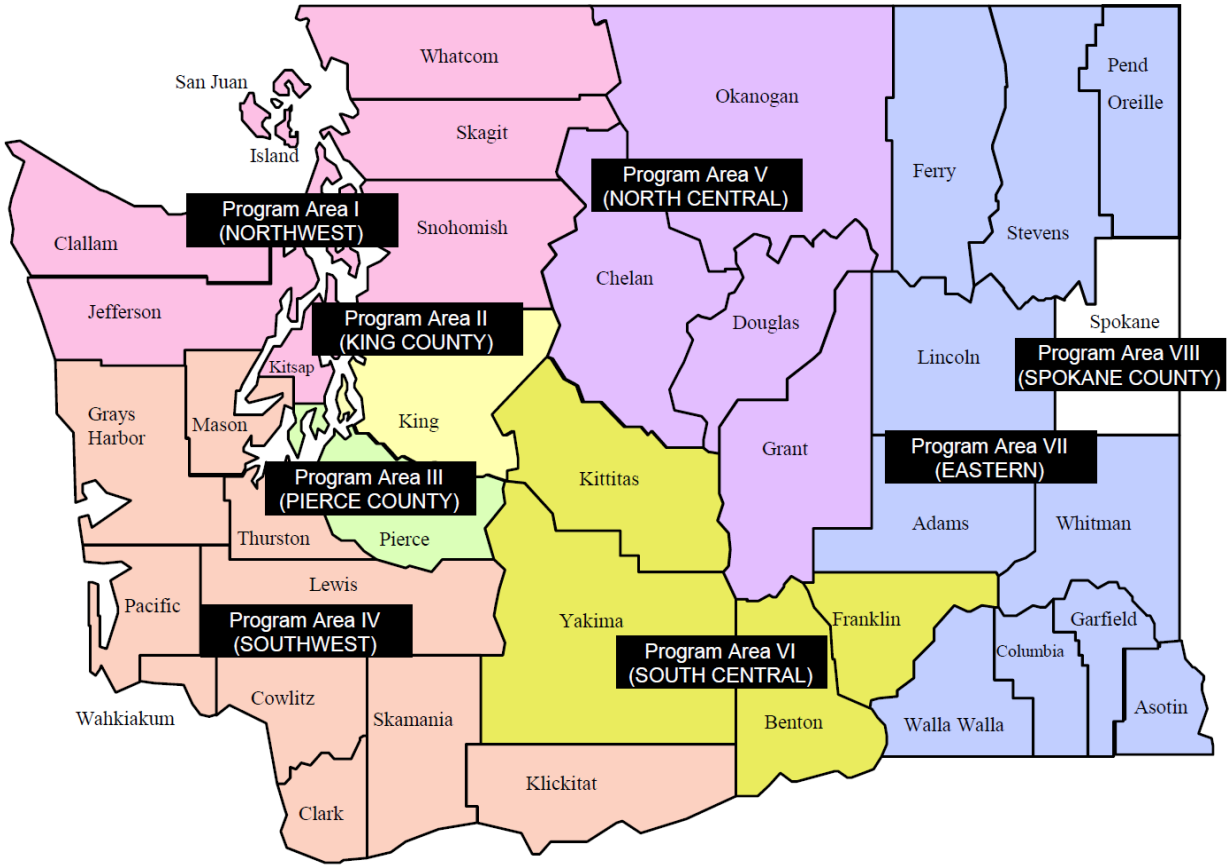
- Conduct active HCV surveillance
- Increase data completeness, quality and timeliness
- Improve surveillance data sufficient to recognize transmission patterns and need for linkage to care
- Stronger DOH-LHJ surveillance response to disease outbreaks
- Increased integrated approach to HBV and HCV surveillance

Hepatitis C DIS Program Planning Process

- **Goal**: Improve Surveillance , Interrupt Disease Transmission, Improve Access to Care and Supportive Services

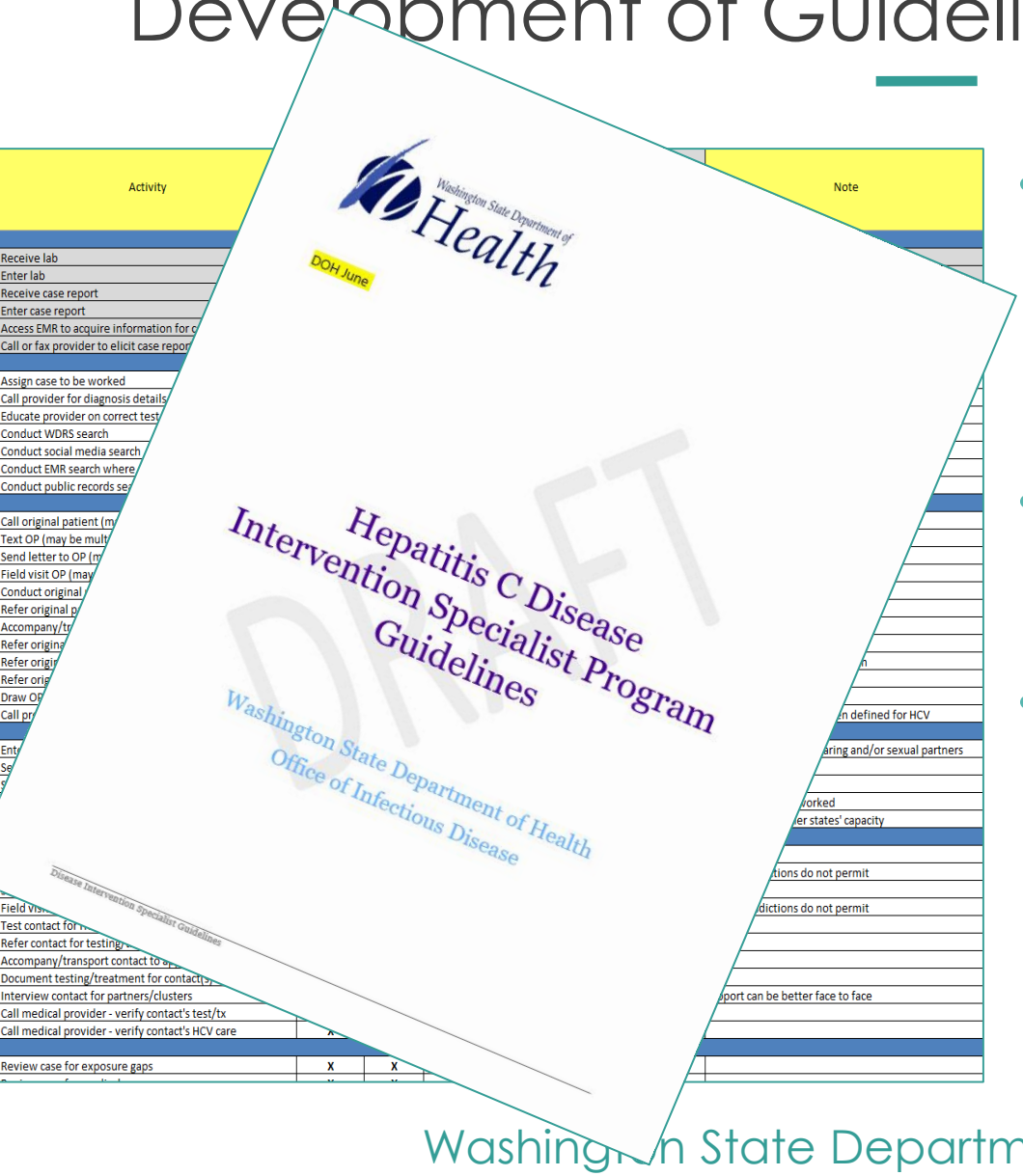


Assessing Current State DIS Models and Capacity



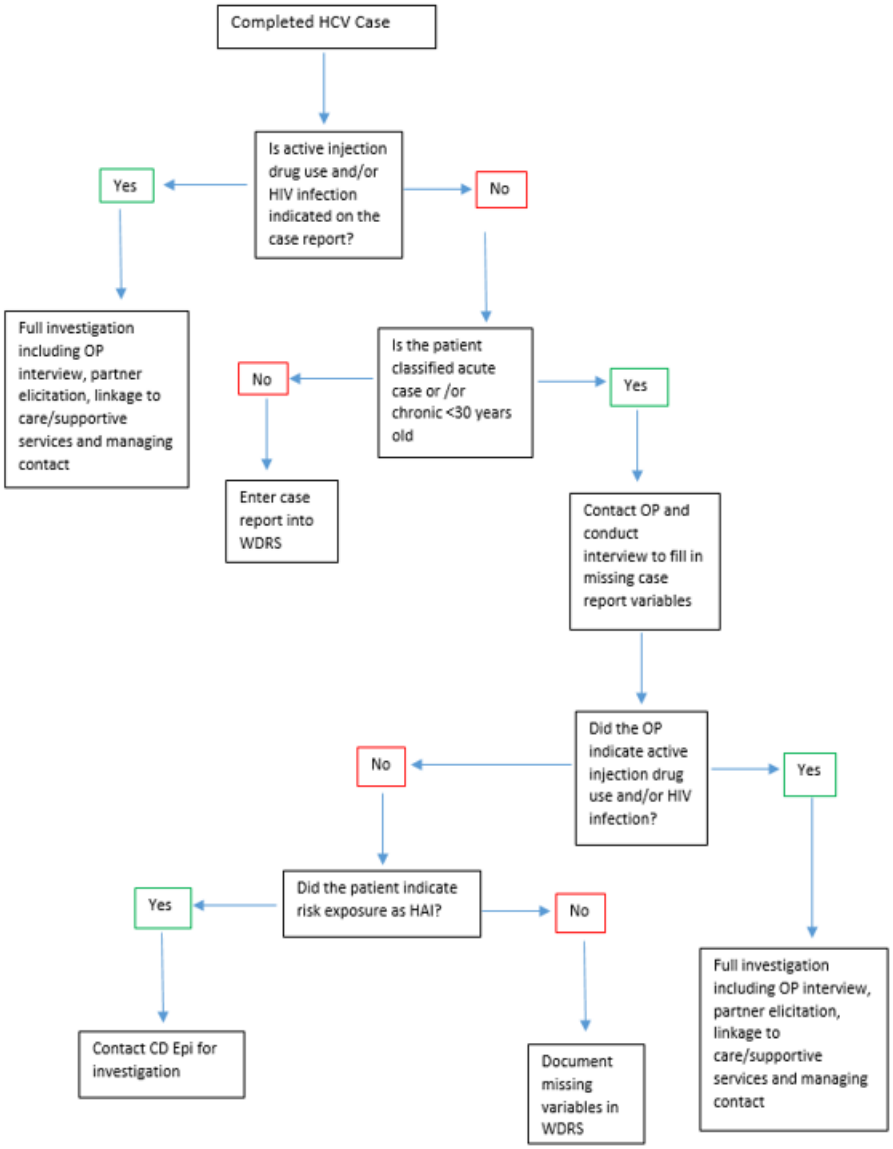
- STD/HIV DIS work is conducted both at the state and local level
- Local Health Jurisdictions – understaffed and work all infectious diseases.
- STD/HIV regional distribution model provides an example but may not be the answer for HCV work.

Development of Guidelines and Standards



- DIS activities; surveillance investigation, disease investigation, contact tracing & provision of services, case review and quality assurance.
- Standards; completed case, partner index, linkage to care, implementation efforts, etc…
- Things to consider; definitions, definitions, definitions, definitions…..

HCV DIS Prioritization



- Acute Cases
- Any indication of past or current injection drug use
- HIV coinfection

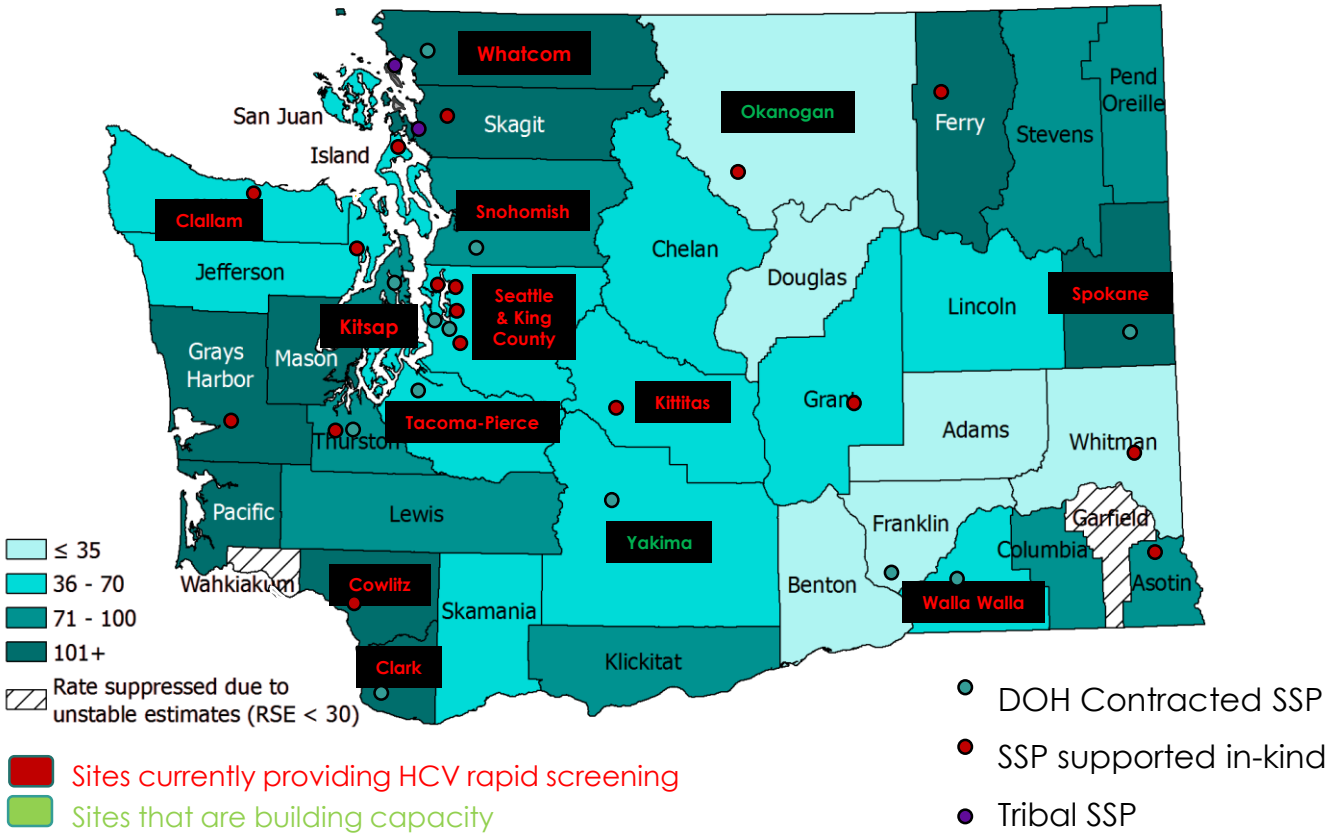
DIS Workforce Training

- Passport to Partner Services (CDC)
- Undoing Institutional Racism (The People's Institute NW)
- Job shadowing (State and/or LHJ)
- Motivational interviewing
- Connecting with state syringe service programs

Five-year rate of chronic HCV infections per 100,000 persons*

*among non-incarcerated residents—Washington State, 2010-2014

Washington State Syringe Service Programs & HCV Screening Sites



Implementation - HCV State Model

State – coordinates surveillance activities to identify prioritized cases using multiple data sources including; but not limited to; death records, EMR, LexisNexsis, DMV, and DOC.

Local Health Jurisdictions – coordinate investigation, contact tracing, and partner services activities.

Quality Assurance – coordination between both state and local health jurisdictions.

Reality?

- Phased approach at both the state and local level

Next Steps

- Finalize and publish WA State HCV Standards
  - Internal and external stakeholder review
- Update Washington Disease Reporting System (WDRS)
- Finalize implementation sequence
- Conduct and/or offer capacity building opportunities for local health jurisdictions

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Innovative Roles for DIS: An Institutional Analysis for Integrating Culturally Responsive Care

Rocky Block, STD/HIV Training Coordinator at the Louisiana Department of Health, STD/HIV Program (SHP)

LOUISIANA DEPARTMENT OF HEALTH
Public Health

Health Inequity 2016 Data

- 3rd in the nation for HIV case rates (24.6 per 100,000)
  - New Orleans ranked 2nd & Baton Rouge 3rd among large metropolitan areas
- 73% of all new HIV cases & 74% of all AIDS cases were black
  - Black people only make up 32% of the population
- Gay, bisexual men, and transwomen who have sex with men accounted for 61% of HIV diagnoses
  - 68% of these individuals were Black

Institutional & Structural Analysis

UNDOING RACISM®
The People's Institute for Survival and Beyond

- DIS, Health Department Staff, Community Based Organizations, Clinical Partners, and clients have the opportunity to participate
- Started in 2013 with the Care & Prevention in the U.S. Demonstration Project (CAPUS)
- *Undoing Racism*® by the People's Institute for Survival & Beyond
- *Deconstructing Homophobia & Transphobia* created by the California Prevention Training Center & the Center of Excellence for Transgender Health

California PTC

center of excellence for TRANSGENDER health

Elements of the Workshops

- To develop a shared understanding of the history of these oppressions, as well as shared language and analysis among the staff of each organization on how to address racism, heterosexism, and transphobia. To explore how Social Determinants (e.g., homophobia) can impede access to service within these populations.
- Examination of unearned privilege (white/heterosexual/cisgender)
- Historical context for how oppression has become part of our institutions
- Personal connection to people's experience with these oppressions
- Analysis of how these oppressions play out in our workplaces
- Understanding how these histories impact health outcomes and how our programs can be improved

Undoing Racism® & Deconstructing Homophobia & Transphobia

- From 2013-2018, more than 1,200 individuals participated in 47 combined workshops
- Pre & post surveys with overwhelming positive results on defining institutional vs individual racism/homophobia/transphobia and incorporating knowledge into the workplace
- California Prevention Training Center & the Center of Excellence for Transgender Health did a TOT for HD training team

"I will bring my knowledge to my organization to update our practices"

"This training gave me a more in-depth understanding of LGBTQ communities"

"This training will help address the needs of clients in our programs."

"This should be mandatory in community based positions"

Continuing the Work

- Ongoing Debrief sessions
- Sexual Positivity Workshop for DIS
- Health Equity Action Team (HEAT) uses a systemic analysis of racism and heterosexism for our programmatic activities. Focuses on improving access and quality of care for POC and LGBTQI individuals
- HIV/STI health equity is achieved when HIV & STI rates and access to care are improved & no longer predictable by race, sexual orientation, or gender identity

Some HEAT Highlights

- Built alignment among SHP staff on why addressing racism & heterosexism is essential for successful achievement of SHP's mission.
- Performed SWOT analysis of SHP units on timely access to services for LGBTQ & POC clients
- Changed trainings & orientation to include analysis of racism, homophobia, and transphobia
- Facilitated questions about race & gender within DIS survey.
- Created client satisfaction survey in regards to racism & heterosexism for funded partners.
- Conduct joint meetings with other divisions within LDH to increase equity collaboration
- Renewed commitment to CAB decisions making power and feedback on new projects.
- Shifted language in presentations, fact sheets, contracts and grant opportunities to become more humanizing.

Lessons Learned

- Organizational change can take time.
- Leadership involvement and staff buy-in are critical to the success of this work.
  - Relationship with PISAB & CAPTC critical
- Following up with teams and individual staff after these workshops is essential.
- Do not rush to solutions.
- Prevention efforts solely focusing on individual behavior must be coupled with an understanding of the systemic racism, transphobia, and heterosexism impacting clients' lives.

Thank You!

- For questions please contact, rocky.block@la.gov 504-568-8473

LOUISIANA DEPARTMENT OF HEALTH
Public Health

- http://www.pisab.org/ 504-301-9292

UNDOING RACISM®
The People's Institute for Survival and Beyond

- https://californiaptc.com/ 510-625-6000

California PTC

- http://transhealth.ucsf.edu/ transhealth@ucsf.edu

center of excellence for TRANSGENDER health

NCSD's DIS Community of Practice

- *Purpose:* facilitate DIS peer-to-peer resource sharing and communication via:
  - Webinars
  - Slack (online platform that can be used on any device via an app or your browser)
- Want to join Slack? The link is in the chat box and here: https://bit.ly/2CbsJM8. Email Leandra if you have questions.

Questions?

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