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U.S. Department
of Veterans Affairs

Focus on Health Equity and Action:

Treatment of HCV- ALD Among VHA Vulnerable Populations

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VA Informatics
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OVERVIEW

- Background and key definitions
- Cohort
- Data
- Challenges and Opportunities
- Discussion





ACKNOWLEDGEMENT

- Office of Health Equity
- VINCI
- Office of Clinical Public Health
- CIDER





THANK YOU VETERANS!



I CARE
DEPARTMENT OF VETERANS AFFAIRS



myVA
Putting Veterans First



- Five Priorities**
- Access
 - Employee Engagement
 - Best Practices and Consistency
 - Development of a High Performance Network
 - Restore Trust and Confidence



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- Veteran/Customer Experience
- Employee Experience
- Support Service Excellence
- Performance Improvement
- Strategic Partnership



AUDIENCE POLL QUESTIONS #1

What is your primary role?

- Veteran
- Researcher
- Clinician
- Management/policy maker
- Other





BACKGROUND: CHALLENGES TO EQUITABLE HCV CARE

1. Historically, there have been well documented disparities in HCV treatment, due in large part to patient and viral genotypes
2. Rapid pace of innovation in the development of promising new HCV treatments
3. Extremely expensive drugs, backlog of patients wanting treatment, constrained resources
4. Access to treatment is prioritized based on evidence of advanced liver disease (ALD), as indicated by:
 - a. Documented laboratory evidence of liver cirrhosis (Metavir fibrosis stage F4, Ishak fibrosis stage 5-6/6, FibroScan >15kPa)
 - b. Clinical evidence of cirrhosis





BACKGROUND: CHALLENGES TO EQUITABLE HCV CARE

6. Uneven dispersion of patients with ALD across VAMCs
7. Variable capacity across VAMCs
8. No clear process of navigation established to help patients, who may meet the criteria for treatment, but have not advocated for themselves or sought care from specialist
9. Rapidly changing political environment in which initially some patients were being referred to Choice providers





REFERENCES – VARIATIONS IN HCV CARE

- ❑ Moyer VA. Screening for hepatitis C virus infection in adults: U.S. Preventive Services Task Force recommendation statement. *Annals of internal medicine*. Sep 3 2013;159(5):349-357.
- ❑ Kramer JR, Kanwal F, Richardson P, Mei M, El-Serag HB. Gaps in the achievement of effectiveness of HCV treatment in national VA practice. *Journal of hepatology*. Feb 2012;56(2):320-325.
- ❑ McCombs J, Matsuda T, Tonnu-Mihara I, et al. The risk of long-term morbidity and mortality in patients with chronic hepatitis C: results from an analysis of data from a Department of Veterans Affairs Clinical Registry. *JAMA internal medicine*. Feb 1 2014;174(2):204-212.



OHE PROGRAM OFFICE SCOPE

□ Role of Program

- OHE champions the advancement of health equity and reduction of health disparities through 5 key focal areas*:
 1. Leadership
 2. Awareness
 3. Health Outcomes
 4. Diversity and Cultural Competency of the Workforce
 5. Data, Research, and Evaluation
- Strategic Alignments
 - VHA Strategic Plan Objective 1(e)—*Quality & Equity: Veterans will receive timely, high quality, personalized, safe, effective and equitable health care, irrespective of geography, gender, race, age, culture or sexual orientation*
 - Blueprint for Excellence strategies 2.2a, 3.2a and 7.2b

*VHA Health Equity Action Plan

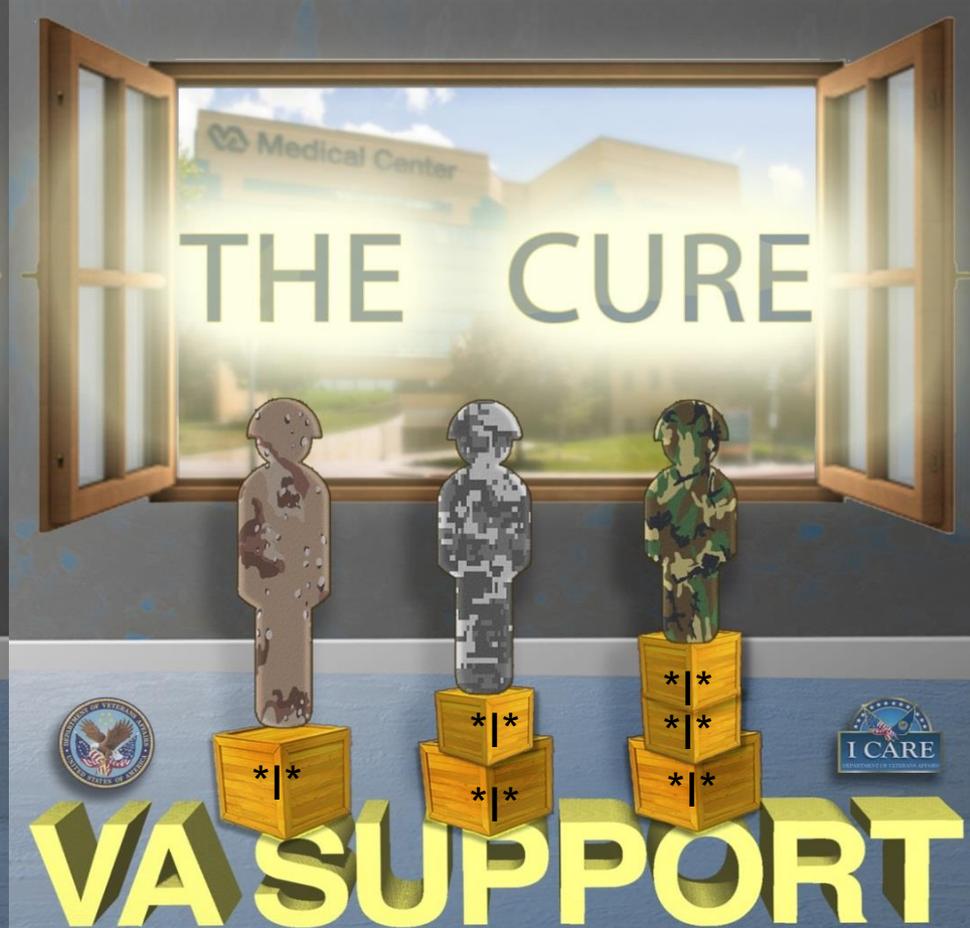
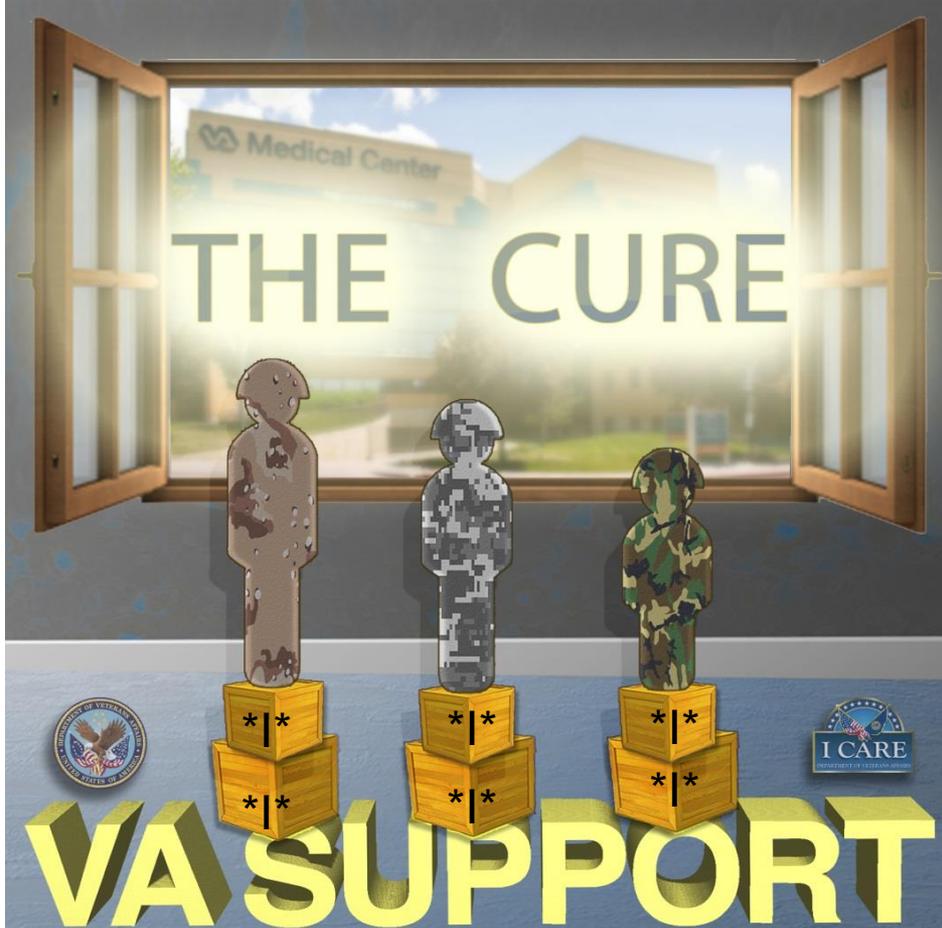




APPLYING AN EQUITY LENS

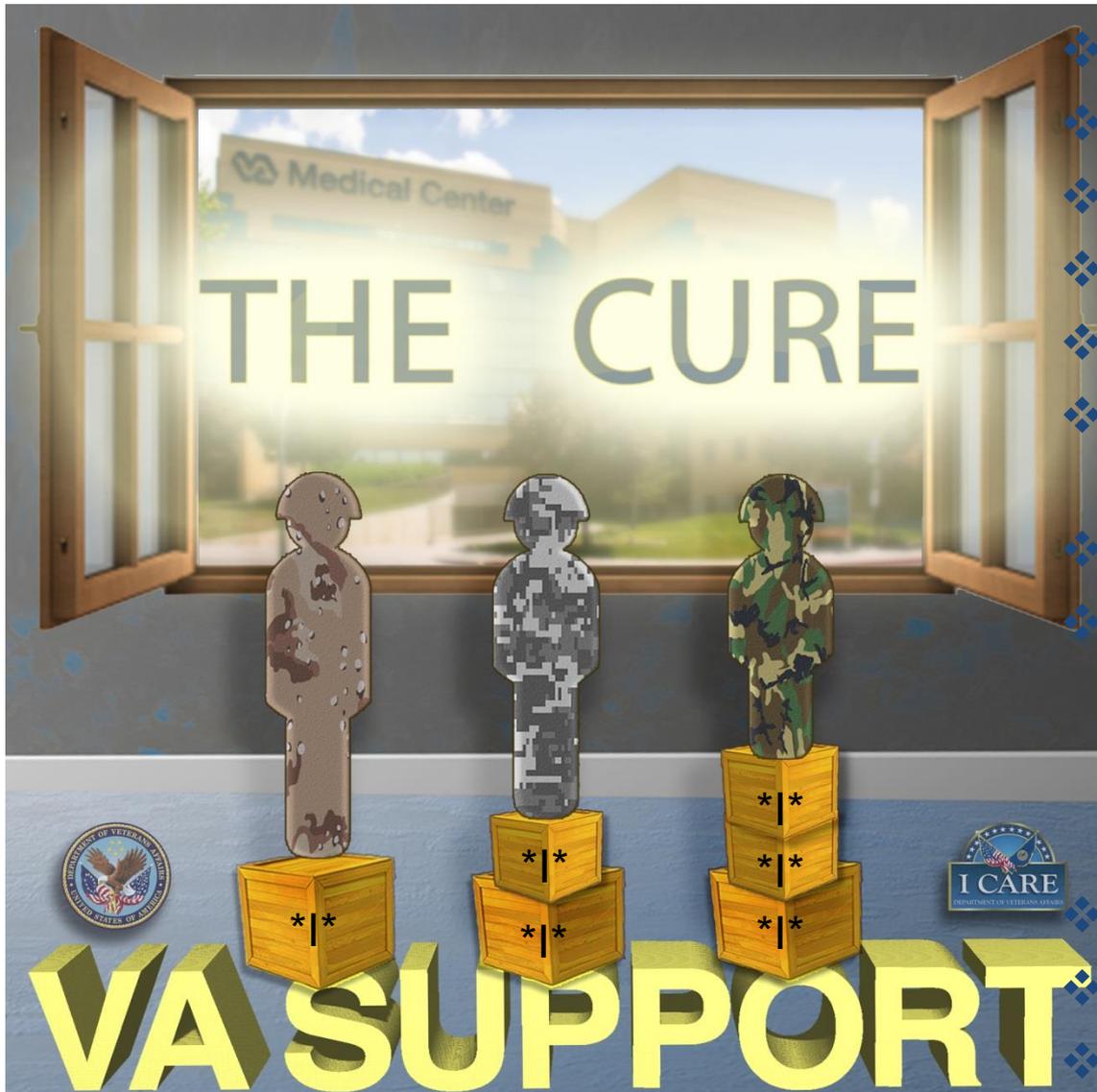
□ EQUALITY

□ EQUITY





APPLYING EQUITY - INTERVENTION



- ❖ Outreach
- ❖ Awareness
- ❖ Advocacy
- ❖ Care Coordination
- ❖ Cultural Competency
- ❖ Personalized Treatment/Health Plan
- ❖ Patient Activation
- ❖ Support:
 - ❖ Family
 - ❖ Community
 - ❖ Economic
- ❖ Policy
- ❖ Operations
- ❖ Resources

| = Intervention





POLL Q 1

Did you attend the November 2015 Cyberseminar on the Office of Health Equity HCV- ALD Disparities Dashboard and/or have you seen the dashboard or the data on data.gov

<http://catalog.data.gov/dataset/hepatitis-c-advanced-liver-disease-disparities-dashboard>

Yes

No



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HCV- ALD Veteran Cohort



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OHE HCV-ALD COHORT

- ❑ OHE obtained August 7, 2015 list provided to VISN and facilities by Office of Clinical Public Health - 38, 797 Veterans with HCV-ALD
- ❑ Corporate Data Warehouse used to identify vulnerable Veteran groups within the cohort as defined by age, gender, geography, military era/service and race/ethnicity
- ❑ Corporate Data Warehouse used to identify Treatment for the cohort
- ❑ Tracked treatment 38, 797 Veterans with HCV-ALD identified by VHA in August 2015
- ❑ Same cohort was subject of a prior seminar with break out by Vulnerable populations
- ❑ Current seminar explores treatment in the same cohort





COHORT DEFINITION – HCV-ALD

Inclusion criteria per list provided by the Office of Clinical Public Health*:

- Veterans selected for the Clinical Case Registry (CCR) as HCV infected
- Had ever had a detectable VHA HCV viral load – HCV RNA are identified by LOINC codes
- Was alive as of the end of the available data
- Was in VHA care during the past 365 days, defined as a record in the CCR of an outpatient visit in the past 365 days
- FIB-4 score used the age as of the day the report was run and the most recent electronically computable values for AST, ALT and platelets from national VHA lab data captured in the CCR.

Notes:

- Current VHA criteria differs from criteria when this cohort was created
- VINCI provided expert guidance for sorting the treatment/drug data

*Reports generated out of the CCR





OHE - VINCI SYNERGY

- ❑ Providing high quality, safe, and effective health care Veterans with HCV is a priority of VHA
- ❑ Several offices are involved in implementing policies and procedures to achieve that objective
- ❑ Different offices may approach the data with different lenses
- ❑ VINCI can provide analytic support to access data to improve the quality of VA healthcare





HCV GENOTYPE 1 MEDICATIONS*

Rapid pace of innovation in the development of HCV treatments:

- ❑ From 2001 to 2011, weekly IFN injections and twice daily oral ribavirin was the standard of care for HCV genotype 1.
- ❑ In 2011, two new protease inhibitors, boceprevir and telaprevir, were approved for combination therapy with IFN and ribavirin.
- ❑ In 2014, direct acting oral antivirals sofosbuvir (Solvadi), ledipasvir/sofosbuvir (Harvoni), ombitasvir, paritaprevir/ritonavir and dasabuvir (Viekira Pak).
- ❑ January 2016, Zepatier (Genotype 1a without baseline NS5A polymorphisms)

*New HCV drugs only



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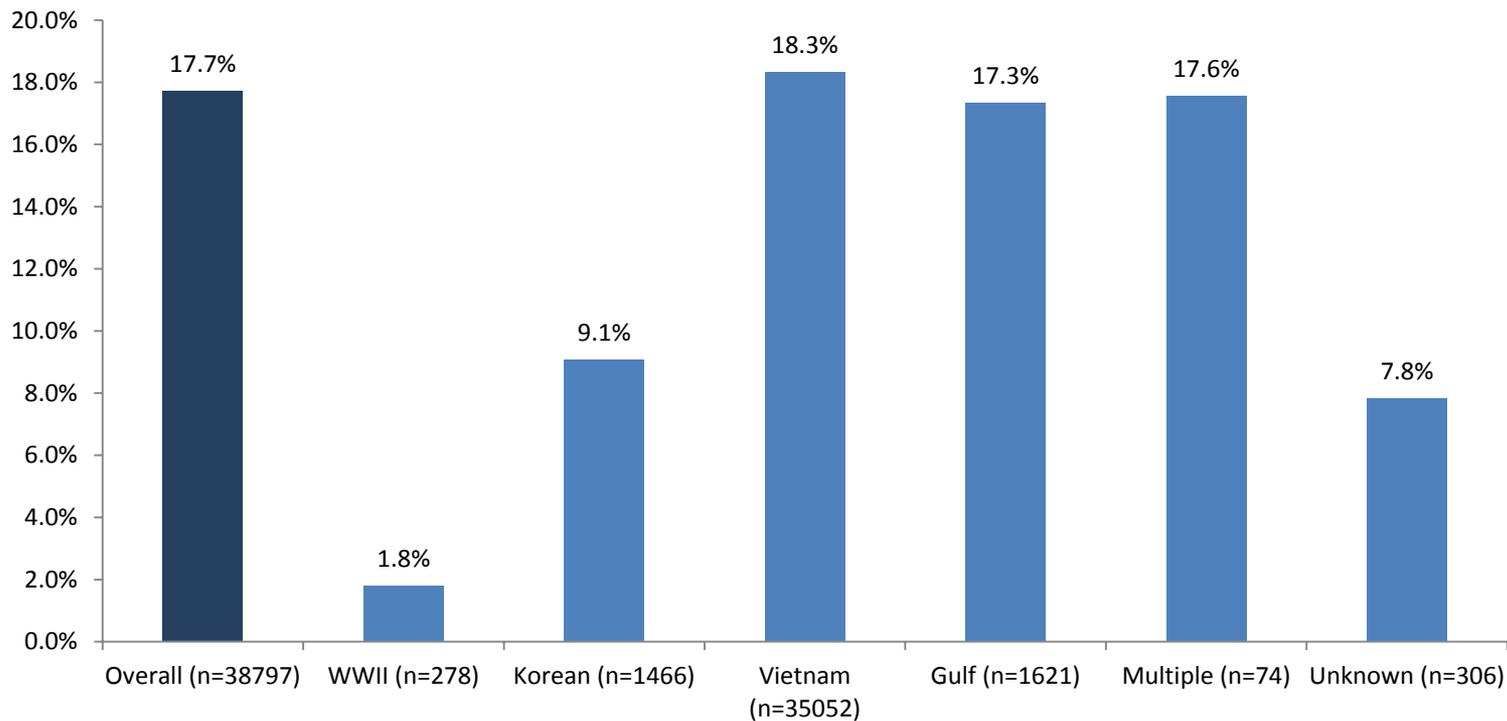
OHE HCV-ALD 2015 Cohort Treatment Data



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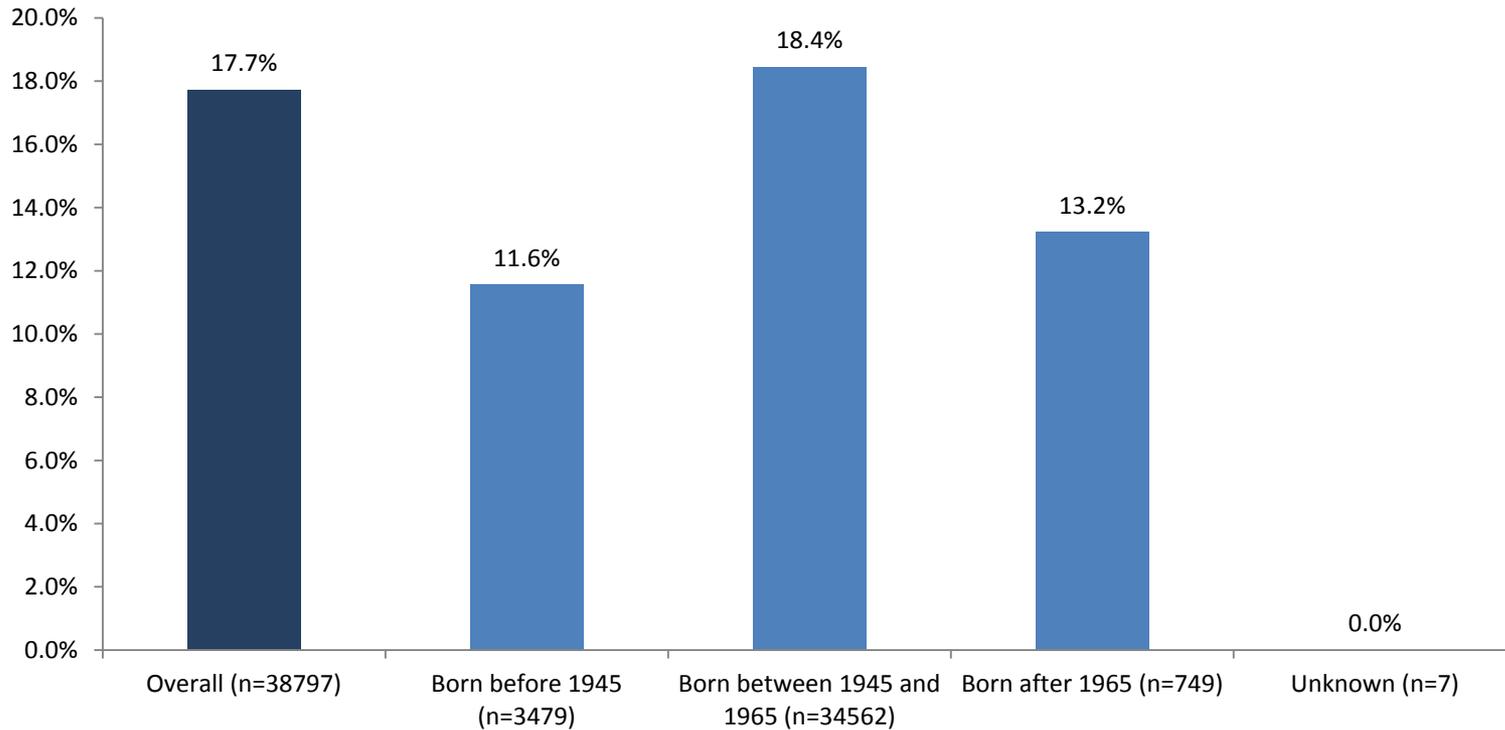
☐ % Treated – Period of Service





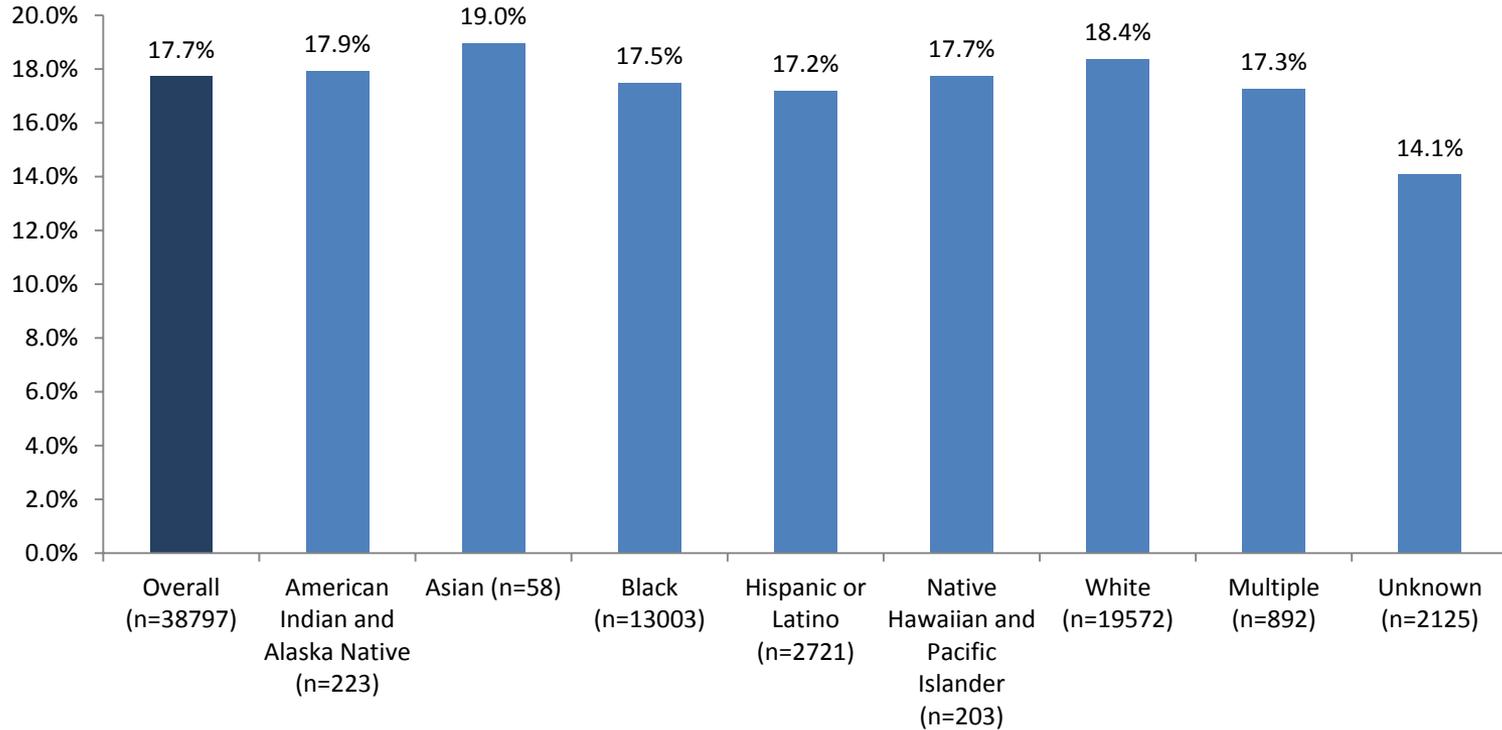
COHORT – TREATMENT OVERALL - BIRTH COHORT

☐ % Treated – Birth Cohort





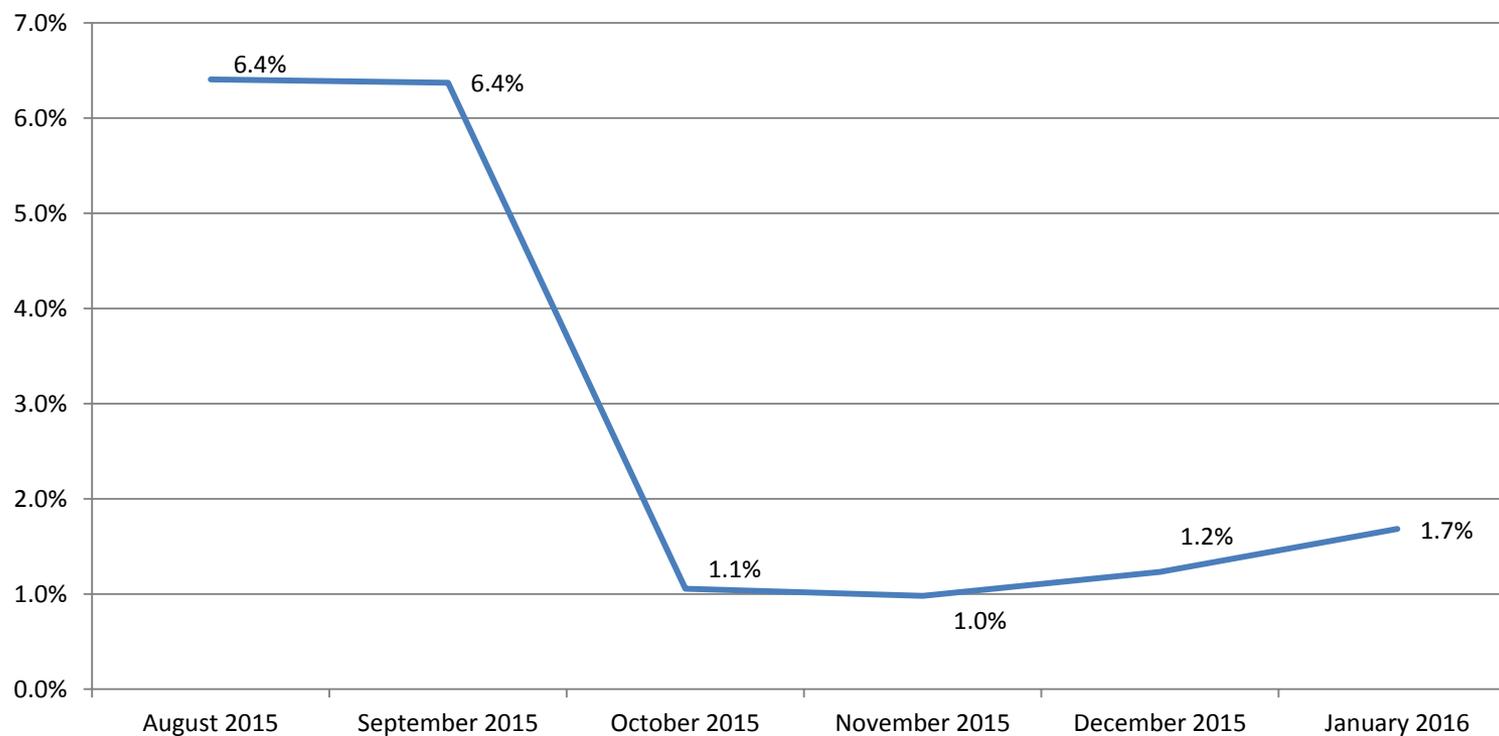
☐ % Treated – Race/Ethnicity





COHORT – TREATMENT ORIGINATED - ALL

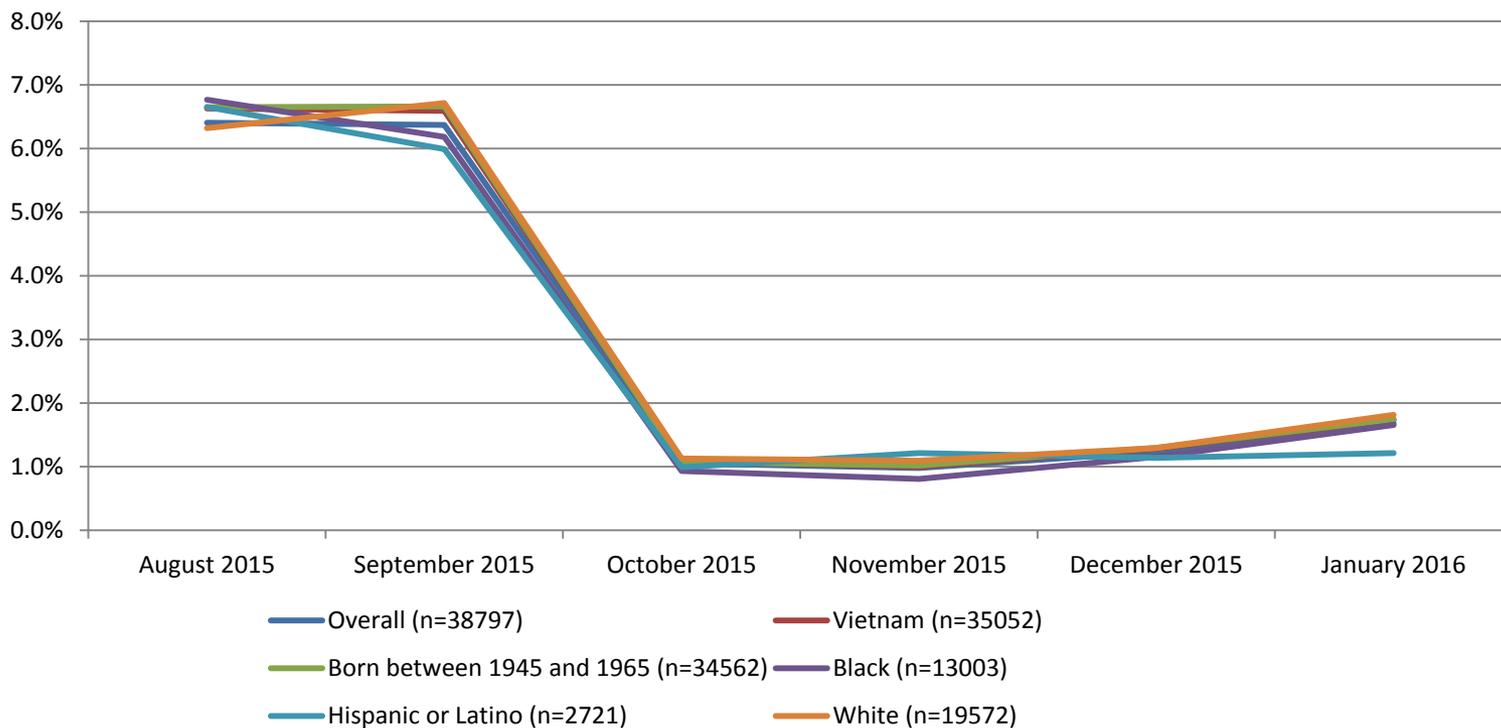
☐ % Starting Treatment – Overall





COHORT – TREATMENT ORIGINATED

☐ % Starting Treatment – Select Groups



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OHE HCV-ALD Cohort Treatment Data: Equity Vs. Equality

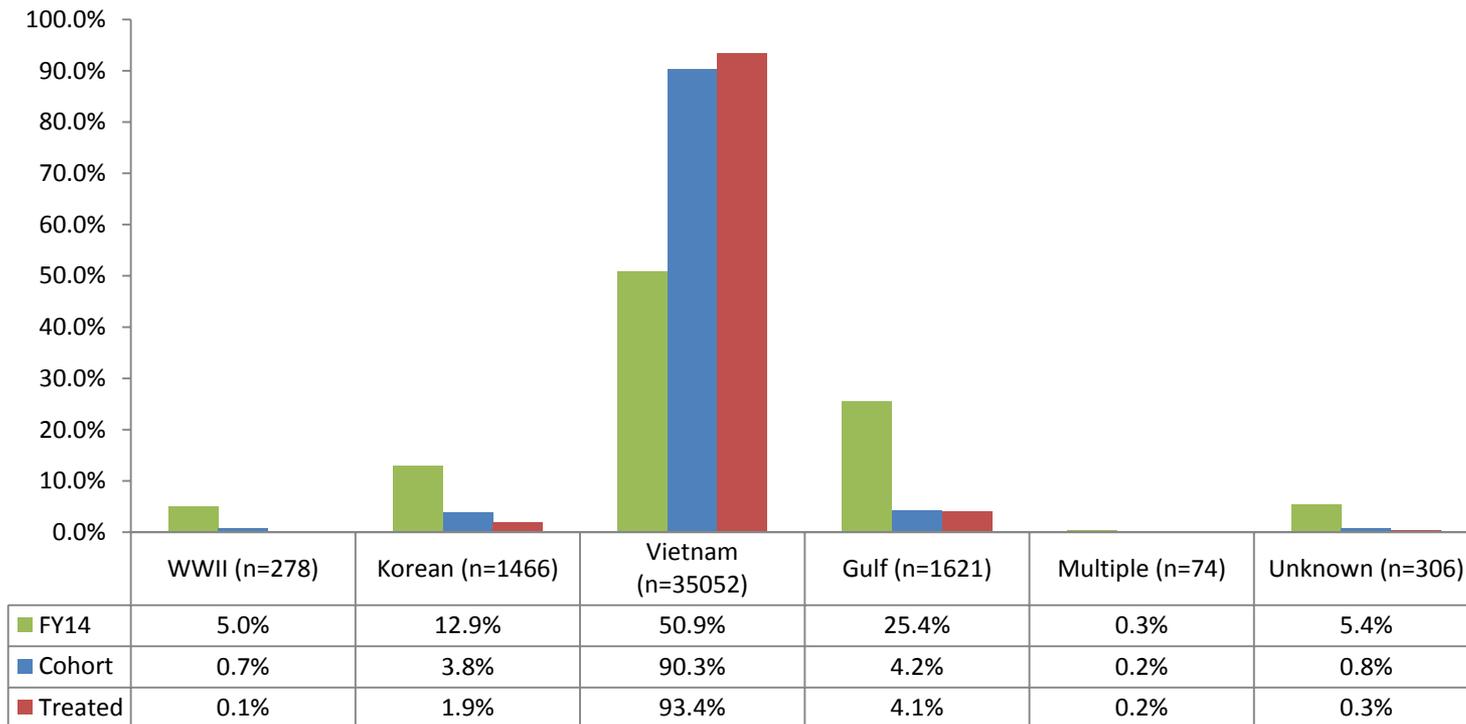


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COHORT – TREATMENT – EQUITY LENS

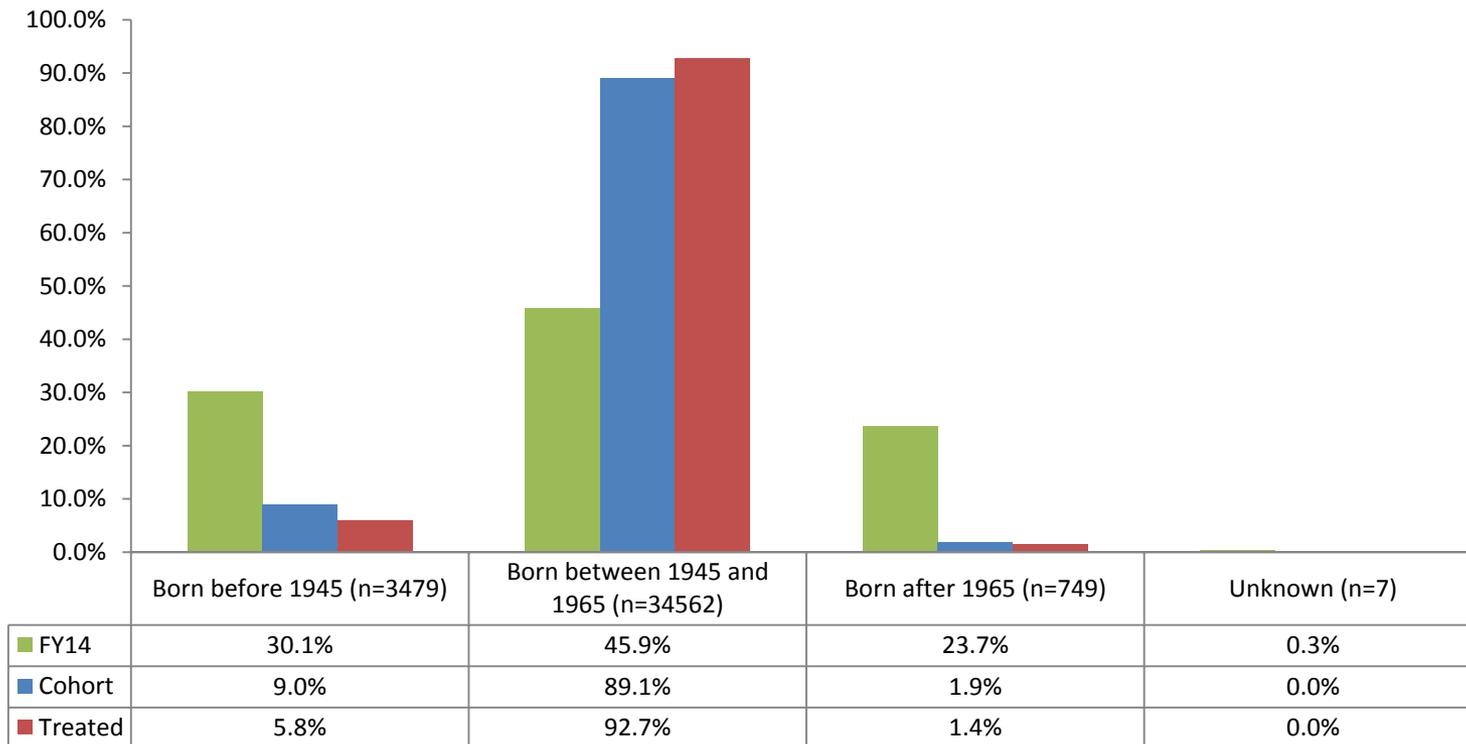
□ FY14, Cohort vs. Treated – Period of Service





COHORT – TREATMENT – EQUITY LENS

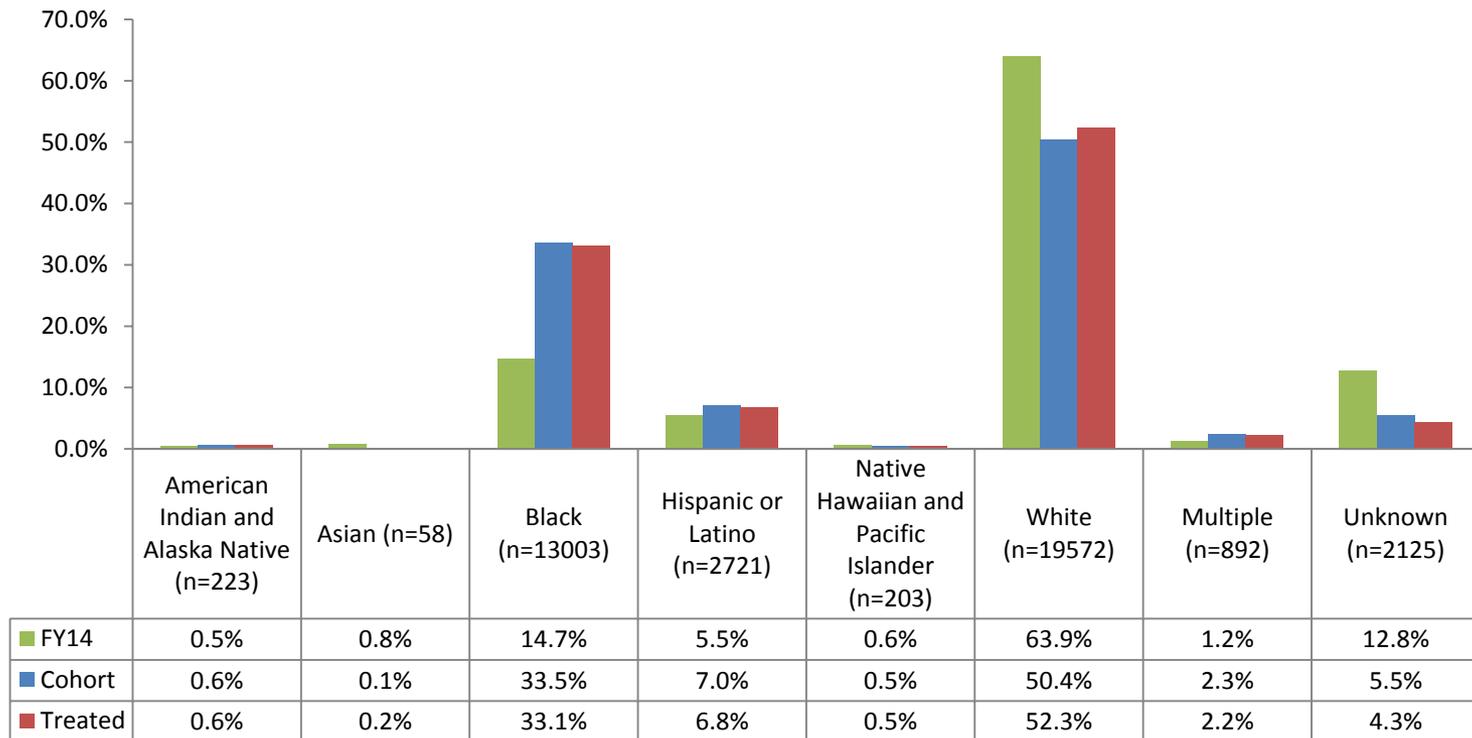
□ FY14, Cohort vs. Treated – Birth Cohort





COHORT – TREATMENT – EQUITY LENS

□ FY14, Cohort vs. Treated – Race/Ethnicity





DIFFERENCE/DISPARITY - EXAMPLES

Within Period of Service:

Vietnam Era Veterans in cohort $35,052 / 38,797 = 90.3\%$

Vs total treated $6,421/6,877 = 93.4\%$ (narrowing)

Race/Ethnicity:

• Black Veterans in cohort $13,003/38,797 = 33.5\%$

Vs. Total treated $2,275/6,877 = 33.1\%$

• Hispanic Veterans in cohort $,721/38,797 = 7\%$

Vs. total treated $468/,877 = 6.8\%$

Birth cohort:

• Born between 1945 and 1965 in cohort $34562/38797 = 89.1\%$

Vs. Total treated $6,376/6,877 = 92.7\%$ (narrowing)





COHORT – TREATMENT – EQUITY LENS

- ❑ Additional charts and table showed the FY14 data alongside the treatment data for the cohort
- ❑ Made crucial connection to the previously observed disparities discussed in the November 2015 OHE- HCV- ALD Cyberseminar
- ❑ While treatment appears equal and no disparities were observed in the distribution of treatment, the comparison with VA proportion of the vulnerable Veteran groups strengthen the fact that action is still needed so that we don't perpetuate the disparities observed
- ❑ Achieving the **highest level of health for all** would require that we narrow the gap
- ❑ These linkages underscore the importance of this work





WHAT CAN YOU DO?

Our lives begin
to end
the day we
become
silent about
things
that matter.

- Martin Luther King, Jr.



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Populations

Audience Poll Question #3
For Discussion



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DISCUSSION QUESTIONS

Please type your responses to the following:

1. Are there regional variations in access to new HCV treatments?
2. Are there variations in access by patient demographics?
3. What are some of the current challenges delivering equitable HCV care to Veterans?
4. Do you have a best or promising practice in engaging vulnerable Veterans for HCV treatment that you would like to share?





QUESTIONS AND COMMENTS



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GET INVOLVED!

- The pursuit of Health Equity should be everyone's business.
- It is a journey that takes time and effort.
- What can you do today in your area of influence to improve health equity?
- At a minimum - in all your actions - do not increase the disparity.
- Thank you!





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[VINCI http://www.hsrdr.research.va.gov/for_researchers/vinci/](http://www.hsrdr.research.va.gov/for_researchers/vinci/)



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FOCUS ON HEALTH EQUITY AND ACTION CYBERSEMINAR SERIES

- ❑ November 19, 2015 – Archived
- ❑ January 21, 2016 - Archived
- ❑ February 25, 2016 – Archived
- ❖ Mark your calendars and join us at 3-4PM EST for future sessions on the following Thursdays in 2016:
 - ❑ March 24, 2016
 - ❑ April 28, 2016
 - ❑ June 30, 2016
- ❖ For more details go to
http://www.va.gov/HEALTHEQUITY/News_Events.asp

