

TRANSCRIPT OF AUDIO FILE:

2015-06-16 13.00 SAMHSA MAI-CoC WEBINAR SERIES_ INTEGRATING HEPATITIS B_C SERVICES

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BEGIN TRANSCRIPT:

VICTOR RAMIREZ: Hi. Good afternoon everyone. Um, my name is Victor Ramirez, and I'd like to welcome you to today's webinar, "Integrating Hepatitis B & C Services into Behavioral Health Services." The webinar is brought to you by the SAMHSA-HRSA Center for Integrated Health Solutions.

Before we get started, I'd like to draw your attention to some important webinar logistics. (pause) Today's webinar is being recorded. An audio version of the entire webinar will be available on the MAI-CoC webpage on the CIHS website within 48 hours. And copies of all webinar materials are currently available on the website on the address—

MALE VOICE: (whispers) Go back [one slide].

VICTOR RAMIREZ: (long pause) —on the address that you see in your screen—on your screen. You can also download a copy of all the handouts, um, if you click on the "Handout" tab on your menu to the right of your screen.

You are currently in "listen only" mode. You're listening—if you're listening on your phone, please enter the audio pin number from the control panel on the right of your screen onto your phone's keypad.

You may send us questions for the speakers at any time during the webinar. Simply type your question into the dialog box to the right of your screen and send it to the organizer. Depending on the question, I may type an answer back to you, interrupt the speaker to ask it, or save it until the end. We will answer as many of your questions as time allows. [00:02:04]

If you experience technical difficulties at any point during the webinar, please call Citrix tech support at 888-259-8414. I'll repeat that number as 888-259-8414.

For today's webinar, the learning objectives are "to describe the impact of HBV and HCV on minority populations and people living with HIV/AIDS." Also, "to understand recommended staffing and training needs to establish HBC and HCV testing on site." In addition, "to describe a model for integrating HIV and hepatitis services into behavioral health services." And finally, "to identify models used to manage HBV and HCV/HIV co-infection."

So first, I would like to introduce, uh, Ms. Kelly Wagner. Ms. Wagner is currently the Senior Technical Vice President for Training and Technical Support, and Manager of Maya Tech Center for Technical Assistance, Training, and Research Support. And Ms. Wagner has over 14 years of specific experience providing programmatic and evaluation technical assistance and training. Her areas of expertise include HIV/AIDS, substance abuse prevention and treatment, women's health, minority health, epidemiology, and health disparity.

So, here is Ms. Wagner. [00:03:44]

KELLY WAGNER: Thank you, Victor. And thank you, everybody, for joining us this afternoon. Um, I'm going to talk a little bit at the beginning to focus on the learning objectives around the impact of HBV and HCV in people with HIV/AIDS and minority population—and then talk a little bit about the recommended screening and vaccination recommendations for implementing HBV and HCV screening and vaccinations.

So we'll talk about HBV a little bit first. Uh, currently, CDC estimates that there are 1.4 million people that are—have a chronic hepatitis B virus infection. These numbers are as of 2013. Um, in terms of acute infection, that means people that have been recently infected and have active virus in their blood. There were 3,000 reported cases. However, many HBV infections are asymptomatic or underreported. So the CDC estimates that we are actually looking at about 19,800 new hepatitis B infections per year. The last numbers are for 2013. And the rates are highest among males in this country, ages 25 to 44.

In terms of hepatitis C, the current epidemiology looks a little bit different. There are estimated nearly 4 million people that are infected with chronic HBV and an estimated nearly 30,000 new HBV infections per year. Again, you could see the difference between the reported cases and the estimated cases, and that's mostly due to asymptomatic infection and underreported.

In the United States, hepatitis C is most prevalent among people born between 1945 and 1965. So you may have heard comments around the birth cohort or Baby Boomers and HCV. This is the population that we're talking about being most, um—where a hepatitis C infection—chronic hepatitis C infection is most prevalent. [00:05:47]

Just quickly—to go over the differences, um, between hepatitis B and hepatitis C in terms of transmission—Hep B is transmitted through blood, semen, or other bodily fluids. Hep B does tend to be, um, transmitted more often through sexual contact with an infected, sharing of injection equipment or people that inject drugs, as well as needle sticks. Needle sticks tend to be more of a route of transmission for occupational exposure to hepatitis B. So nurses—other medical providers—potentially can contract hepatitis B through needle sticks.

In terms of hepatitis C—hepatitis C is transmitted through the blood. And so, sexual contact—uh, or sexual transmission of hepatitis C is much more rare. Um, hepatitis C is primarily transmitted through sharing of contaminated injection drug equipment.

When we look at the risk populations between Hep B and Hep C, you'll see there are some commonalities. The first commonality, um, would be people living with HIV. For hepatitis B, you're looking also as potentially sex partners of infected persons, um, persons who have multiple sex partners, as well as persons who have sexually transmitted infections—and men who have sex with men—are all identified as risk populations for hepatitis B.

For hepatitis C, the most common risk populations are people who inject drugs. And those are either current or former injection drug users, as well as people living with HIV.

If we want to talk a little bit about the impact of hepatitis B in this country, um, the hepatitis B virus is [500] (ph) to 100 times more infectious than HIV. So in terms of the ability of an infected person to pass on the virus to someone that is not infected, it is extremely more infectious than the H—um, than HIV itself. [00:07:57]

We have seen a decrease—a significant decrease in this country around acute hepatitis B infection—decreasing by 62 percent from 2000 to 2013. That is mostly due to implementation of vaccinations for hepatitis B. There was an increase between 2012 and 2013, and that increase was mostly seen between people ages 30 to 49.

When you look at the health implications of the impact, somewhere between 15 and 25 percent of people with chronic hepatitis B infection do move on to develop more serious liver complications. That could be liver damage. It could be hepatocellular carcinomas or liver cancers, cirrhosis, or liver failure. And approximately 3,000 people annually die from hepatitis B related liver disease.

In terms of the impact of hepatitis C in this country, hepatitis C is the most common blood-borne infection in the United States. And nearly (our estimates) between 45 and 85 percent of those people who are infected with hepatitis C are unaware of their infection. So that speaks very much to the importance of screening and testing, which is a key component of The Minority AIDS Initiative Continuum of Care Pilot Program.

We have seen a 250 percent increase in acute hepatitis C infection in this country between 2010 and 2013. There have been suggestions that that increase is mostly due to an increase in injection drug use—um, injection use of opioids for people that may have previously used prescription pill-based opioids but have seen difficulties in accessing pills due to crackdowns in terms of drug control and, um, more criminal justice control around prescription drug use. And so many people have moved on to injecting opioids-based, um—opioid-based drugs. [00:10:12]

So when we look at, um, development of disease progression for people that are infected with hepatitis B virus, up to 85 percent will develop a chronic infection, between 60 and 70 percent will develop chronic liver infection—so not just the chronic infection of the blood with the disease but actually hepatitis C infecting the liver. Between 5 and 20 percent will develop

cirrhosis. And between one and five people infected with hepatitis C virus will die from either liver cancer or cirrhosis.

When we look at the impact, um, in terms—in racial and ethnic minority populations, we could see that from 2000 to 2013, the rate of acute hepatitis B declined among all racial and ethnic populations except for a nearly 60 percent increase among American Indians from 2000 to 2000—uh, from 2001 to 2002; and then a nearly 11 percent increase among non-Hispanic whites between 2012 and 2013. In 2013, the rate of acute hepatitis B was lowest among Asian and Pacific Islanders and highest for non-Hispanic blacks. Nearly one per 100,000 non-Hispanic blacks were infected with acute hepatitis B in 2013.

As you can see from the slide, the rate of acute hepatitis C infection looks very different among racial ethnic populations when we're talking about hepatitis C. The rates for acute Hep C decrease among all racial and ethnic populations from 2000 to 2003. And from 2002 to 2010, the incidents of acute hepatitis C remain constant for American Indians and Alaska natives relative to all other ethnic populations where you'll see that in 2000—in that time frame, just about every other racial and ethnic population trend line does begin to see an increase in the incidents of acute hepatitis C infection. [00:12:23]

From 2011 to 2012—towards the end of this chart—acute Hep C rates increased by 86 percent among American Indians and Alaska natives; 100 percent between Asian and Pacific Islanders; 7 percent among non-Hispanic blacks; 36 percent among non-Hispanic whites; and almost 24 percent among Hispanic population.

From 2012 to 13, Hep C rates decreased, um, among American Indian and Alaska natives, but it continued to increase among non-Hispanic blacks from 30—uh, a 33 percent increase among non-Hispanic blacks, 28 percent increase among non-Hispanic whites, and almost a 5 percent increase among Hispanic population.

When we look at differences between, um, risk and exposure behavior for acute hepatitis B reports, we see that for the cases that included information around injection drug use, 23 percent indicated that injection drug use was part of their risk exposure. However, when we look at the number of cases that included information around, um, sexual preference or sexual practices, nearly 27 percent indicated that, um, having sex with another man was part of their risk—um, risk exposure category, and nearly 26 percent indicated that having two or more sexual partners was part of their risk exposure. So you'll see that the risk exposure for hepatitis B is more closely tied to, um, sexual contact and sexual risk. [00:14:08]

Next slide. (pause) Go back. [One more slide.] (ph) Sorry about that.

Um, when you look at hepatitis C, there is a marked difference. Nearly 61 percent of the cases that included information—the reports of acute hepatitis C infection in 2013—that included information around injection drug use did indicate that injection drug use was their primary risk exposure or behavior.

There is, um, significantly lower percentage of men who have sex with men and people that reported sexual contact with a confirmed or suspected Hep C infected individual identified that as their risk exposure or behavior.

So when we look at hepatitis among people who are living with HIV/AIDS in the is country, nearly 25 percent of the one—estimated 1.1 million people living with HIV/AIDS are co-infected with HCV and 10 percent are estimated to be co-infected with hepatitis B. 80 percent of people with HIV who actually do, um, also report injection drug use are co-infected with HCV.

Consequences of HIV and hepatitis C co-infection—um, co-infection of HIV and hepatitis B tends to affect the disease progression of the hepatitis B related issues more than the HIV disease progression. And so there are a couple of indications on the slide here of ways that co-infection does increase or, um, increase the progression or affect the response to treatment for hepatitis C. [00:16:00]

Very similarly, co-infection between HIV and HCV does also affect, um, the HCV co-infection more often. However, co-infection of HIV and HCV is the leading cause of morbidity and mortality among people living with HIV/AIDS. And co-infection leads to an increased chance of sexually transmitting hepatitis C—which we mentioned earlier tends to be more difficult to transmit sexually than hepatitis B typically. (pause) [(inaudible) a few minutes over.] (ph)

So I want to talk quickly about the screening recommendations for hepatitis B and Hep C. On the screen here, we have the recommendations from the CDC and the United States per—US Preventive Task Force, um, for people who should be screened for Hep B and Hep C. As I mentioned, hepatitis B people born between 1945 and 1965 should be screened for hepatitis C as well as people who inject drugs, and those that may have received, um, donate—organ donations or blood donations prior to 1992.

As you'll see, the vaccination recommendations only address hepatitis B. There is no current vaccine for hepatitis C, um, but the recommendations for vaccination for Hep B are on the screen. So that would be sexual partners of those infected with HBV, men who have sex with men, people who use injection drugs, all infants at birth, as well as people who are living with HIV/AIDS.

I've included—I want to wrap up rather quickly. I think I'm maybe a minute or two over, but I wanted to include a few recommendations for implementing a hepatitis C testing program. [00:17:54]

As you'll notice, I don't have a slide on implementing a hepatitis B testing program, and I'll address why in a second. However, currently, the only rapid testing technology that is available for hepatitis C is the OraQuick HCV Rapid Test. And that test can be administered either using whole blood, plasma, serum, or finger stick. And finger stick is the only waived screening technology to use with the OraQuick HCV Rapid Test.

If you are looking to implement a hepatitis C testing program, there are a number of recommended trainings. One would be to ensure that all staff that are implementing either the

program through testing or education receives training in Hepatitis C 101, training on delivering counseling messages around hepatitis, training again on conducting and interpreting the HCV rapid antibody test and controls, as well as specimen collection and disposal of biohazardous materials.

There are a number of other recommendations. If you were planning to implement a hepatitis C testing program, we do recommend that you have a quality control plan that includes the four items that are shown on the screen here, as well as very clearly written policies and procedures that address confidentiality, staff training and proficiency, quality control, counseling, record keeping, lab quality assurance, and the referrals and tracking for HCV diagnostic testing care and treatment. In the event that you are actually not providing treatment at your SAMHSA Grant place.

I did mention that I didn't include a slide for hepatitis B testing. The hepatitis B blood test is a three-part blood test that needs to be ordered by either a physician or another primary care provider. There are—there is no current rapid hepatitis B testing technology, and so the—you would need to do blood draw and have a lab with the ability to perform the panel test, which is called a Hep B blood panel and, as I mentioned, it looks for three different things. It looks for surface antigens, surface antibody, and core antibodies for the hepatitis B virus. [00:20:20]

Going to wrap it up quickly so that you can hear more from Dr. Himelhoch. The previous slide that was shown had a number of resources that you can access to gain more information on hepatitis B, it's impact among minority communities, and recommendations for staffing and training.

So, thank you very much.

VICTOR RAMIREZ: Thank you very much, Kelly. Um, at this point, we have five minutes for any questions or comments that grantees might have. If you look to the right of your screen, you will see on your (inaudible at 00:21:02) menu—you will see a little box for questions. Please type your questions or your comments there and, uh, we can ask Kelly. And again we'll have—we have, uh, five minutes. (long pause)

KELLY WAGNER: Well I either did an amazing job at explaining, or I've provided everyone with information that you already had.

VICTOR RAMIREZ: Okay. (pause) Uh, comment. Uh, grantee, uh, commenting on what a great job she did. Thank you very much.

KELLY WAGNER: And if we don't have any further questions right now, um, I will be available at the end for questions. So if you want to move on to Dr. Himelhoch, that would be (pause) great. (overlapping talking) [00:22:01]

VICTOR RAMIREZ: (overlapping talking) Okay. Uh, let's do that. We will have 10 more minutes at the end of the—of the, uh—of the webinar for, uh, more questions and answers. Uh, give me a second. (long pause) Okay. Um, so I'll jump ahead. And now I'll introduce Dr. Seth

Himmelhoch. Dr. Himmelhoch is Associate Professor and Director at the Division of Consultation Liaison Psychiatry in the Department of Psychiatry at the University of Maryland School of Medicine. He is Associate Residency Training Director for Research, a research investigator and faculty member in the Division of Psychiatry Services Research, and a research investigator affiliated with the Veteran's Affairs (VISN5) Mental Illness Research Education and Clinical Center.

Dr. Himmelhoch's clinical and research experiences have focused on access to care and treatment of co-occurring psychiatric and drug use disorders among individuals with HIV. He has published over 50 peer-reviewed publications and has received external funding from NIDA, NIMH, SAMHSA, and the Veteran's Affairs. He is also the Project Director for the University of Maryland's MAI-CoC project—Project STIRR-IT. Dr. Himmelhoch!

DR. SETH HIMELHOCH: Great. Well good afternoon, everyone. Thank you, Mr. Ramirez, for that very nice introduction. And thank you, Ms. Wagner, for doing a great job providing the background about the hepatitis B and hepatitis C infections in America. I also want to thank SAMHSA for inviting me today to provide a little bit of background about the [implementation] (ph) efforts that we are undergoing right now to provide co-located HIV and hepatitis C prevention and treatment in behavioral health settings.

Uh, next slide? [00:24:14]

So I want to present an overview of first STIRR-IT. What does STIRR-IT mean? So I want to be able to define that STIRR-IT means and what it does. Then I'd like to discuss why you're implementing STIRR-IT in Baltimore in particular. I then want to describe the implementation strategy in the behavioral health clinic. And then finally, I would like to provide some outcomes to date. At the very end I'll be happy to entertain questions.

Next slide?

So STIRR-IT—and if you do the next slide, we can discover what city this is. This is Baltimore city. Um, a lovely picture of where we're providing this service. Next slide?

So what does STIRR-IT mean? STIRR-IT is an acronym. And the acronym stands for Screening and Testing for HIV and Hepatitis C, Immunization for Hepatitis A and B viruses, and Risk Reduction Counseling that's linked to Integrated HIV Treatment.

Next slide.

Um, and now I'm going to explain what STIRR does now that we know what it is—what the acronym means. So first of all, we believe that STIRR is an evidence-based practice. If you go to the next slide—this is a study or a picture of the study that was published in Psychiatric Services in 2010. This was a study led by Dr. Stanly Rosenberg at Dartmouth, which we partnered with him, where we evaluated whether or not the STIRR model has an impact on providing best practices for blood-borne infections. And here we're talking about HIV and hepatitis C for

people with severe mental illness as who have—will often have co-occurring substance use disorders. [00:26:06]

Uh, next slide?

And what we found was that the STIRR model was in fact efficacious at providing the basic best practice package for these clients. And now I'm going to describe what that package involved.

Next slide?

So, STIRR provides HIV and hepatitis C screening and testing, immunization—again, hepatitis A and B immunization—and then followed up with risk reduction counseling. Now why is this important?

Next slide?

Uh, because of the CDC recommendations, and some of which, Ms. Wagner was hinting at earlier in her presentation. That first HIV screening is recommended for all persons age 13 to 64 in all healthcare settings in the United States—and that also includes behavioral health care settings.

Um, hepatitis C testing should be done for all people in the birth cohort of 1945 to 1965 as well as those who engage in injection drug use. And finally, vaccination with hepatitis C virus and hepatitis A virus should occur for those who engage in unsafe sex or risky drug use. (clears throat)

So, when we think about targeting a population that may be at risk, we want to be able to screen for HIV, screen for hepatitis C, provide immunization, and risk reduction counseling. And that package would all be, um, clearly in accord with what the CDC would recommend.

Next slide.

So, we've talked about that STIRR's an evidence-based practice. We've defined or described what STIRR does. But why are we focused on people that have serious mental illness? Or, I'm using the acronym SMI.

Next slide? [00:27:50]

That's because most people who have serious mental illness may be at higher risk for both of these blood-borne infections. In the table you'll see, in the first column, I've described the condition. In the second column is the prevalence of that condition among those with serious mental illness. And then for comparison, in the third column is the prevalence of these infections in the general population.

Um, in list—what you can immediately see is that those with serious mental illness are at strikingly higher risk for HIV as well as hepatitis C compared to the general population. Now

you may be wondering why there's such a wide range in the prevalence, um, and that has to do with several factors. One—many of these are convenience samples that were done in different parts of the country—some of which have higher incidents or prevalence, incidents of HIV or hepatitis C compared to others. Some were in outpatient settings. Some were inpatient settings. Some—we're looking at people with co-occurring substance use disorders. But even with all that said, it is still, you know, pretty striking that the risk in this population is so high.

Uh, next slide?

And this is critical because when we think about, um, the treatment cascade which many of you may be familiar with, many people in this country are infected—here we're showing with HIV—but may not know that they are infected. So that's our first step. And then among those that know, there are a smaller group that's actually linked to care, and then a smaller group that's in (inaudible at 00:29:22) in care, and an even smaller group that gets on the anti-retroviral medications that have been so successful in treating HIV, and then even fewer reap the benefits of being on that regimen.

And you could imagine that people with serious mental illness who may have to negotiate two systems of care. One—the mental health system of care for their chronic—for their mental—for their psychiatric and potentially substance use problems; but then also the somatic health care system for all their medical problems including here, for example, HIV. This could be quite difficult, and you could see how then people may fall off this kind of cascade of care and may not (A) even get diagnosed and (B) get into [cystine] (ph) treatment. [00:30:09]

Next slide. (pause) Oops, can you go back one slide? Thank you.

So, we've talked about that STIRR's an evidence-based practice, that it provides screening, immunization, and risk reductions counseling, that it targets people with serious mental illness and we've explained why that's important, and finally I want to draw your attention why it should occur in a behavioral health center.

Next slide?

So, one of the most important points is that even though people with serious mental illness may be at higher risk for HIV and hepatitis C, less than half the people at risk with serious mental illness—who have serious mental illness and may be at risk for HIV and hepatitis C actually receive testing for HIV and hepatitis C. So, when we think about cascade, again, there are many people that don't know that they may be infected.

The second point is that many people with serious mental illness rely on the mental health system to provide their basic medical care. Again, this issue that people may find it difficult—not all, but some: transitioning between the medical—the somatic health care system and the mental health care system. So it would make sense to maximize efficiency to—by ensuring people get into early treatment by allowing co-located treatment to occur in a behavioral health setting. That being, establishing testing, screening, and immunization right at the site of the behavioral health clinic, and then potentially—what we're going to talk about in a moment—having integrated

treatment occur there, as well. Again, to try to prevent that problem in the treatment cascade for people falling off and not ending up either knowing that they have an infection or getting treatment for it and sustaining their treatment.

Next slide. [00:31:54]

So, now that I've defined what STIRR-IT means and what it potentially does and why it's important, I now want to spend a few moments talking about why focus on Baltimore city.

Next slide?

So this is a, uh—this is a—clearly a picture of the continental United States with, I guess, a little image of Alaska and Hawaiian Islands at the bottom. And what I've circled here is the prevalence of, um—of HIV in Maryland, which is one of the highest in the country. So Maryland clearly has, you know, a very important—it's a very important state when it comes to HIV. But if you go to the next slide, when you look at the state of Maryland—and this is subdivided by counties—the lighter color means less prevalence of HIV—the darker reds mean higher prevalence of HIV. You can see that there are two counties that are—you know, have the highest HIV prevalence. I've circled there Baltimore County—um, is one of them. And then the second one is, um, to your—I guess to your left and down—is Prince George's County. But we're going to be focusing in Baltimore County because that's where we're locating our intervention, and it makes sense to target the area that has higher risks.

Next slide?

So one thing that we wanted to know was, “What is the risk for HIV and hepatitis C for people—for people who have serious mental illness who live in Baltimore or receive care in Baltimore, Maryland?” So we did a study of 153 people who had diagnosed with serious mental illness and were receiving mental health services in Baltimore, Maryland. And this is just to give you a feel for the risk in this population. Again, this is just one sample, but I think it reveals a lot.

[00:33:52]

About 25 percent of the people reported a history of injection drug use. And among those people who reported a history of injection drug use, nearly 92 percent reported sharing needles. As you know, sharing needles is one of the main conduits for both transmission of hepatitis C and HIV, as well as hepatitis B.

83 percent reported a history of unprotected sex. And among those who reported a history of unprotected sex, nearly 30 percent reported unprotected sex in the last six months. So again, the message about, you know, risk reduction clearly got through to some, but not all the people in this sample.

And finally, among those who reported having a history of unprotected sex, nearly 20 percent reported at least one encoun—one MSM encounter in the past.

So, again, you can see here that this missed population—uh, this sample, actually—may have a lot of risk factors that would lead them to potentially be infected with HIV/hepatitis C and/or hepatitis B.

Next slide.

Okay, so we've talked about what STIRR-IT is, what it does, and why we're thinking about—by Baltimore is so important. Now I want to talk a little bit about our implementation strategy and what I've shown you here as our graphic. This is our book that we developed to help people get the most out of their STIRR intervention. And then I just want to point out that the graphic, which we purchased—the image—but we liked it a lot because it didn't say that, you know, we're talking about potentially stigmatizing diseases like HIV or hepatitis C, but we're really focused on helping people think about their health and how to take better care of themselves, really focusing on the risk reduction elements of the intervention.

Uh, next slide? [00:35:49]

So let me tell you a little bit about the clinic that we're working in. So this is a mental health clinic in Baltimore city. And I just want to share some of the demographics of the people who attend this particular clinic. Over 80 percent self-identify as African American or black. The average age of a person who comes to the clinic is approximately 53 years old with the range of being 18 to 69 years old. So the—if the average age is around 53, again we're right in that birth cohort where, um, doing screening for hepatitis C is so important. Half the people are women. Over 70 percent have a diagnosis of a serious mental illness. And finally, the vast majority report a history or—of ongoing—or a history of substance use.

Next slide.

So, based on that, how did we compose our team to implement the STIRR intervention within this mental health—or behavioral health clinic? Um, so this is the STIRR-IT team that we've descri—that we are implementing. Um, it's nurse-driven, as you can see. So the main player[s] in this is the nurse and the peer navigator. The nurse delivers all elements of the STIRR intervention. So the STIRR intervention works over several visits. So the first visit, the nurse would assess the person, provide the background about, um, screening for hepatitis C and HIV. They would do the blood draw to screen for hepatitis C and HIV, with the person's consent, of course. And they would also take the hepatitis serology so that we can be informed about what immunizations—whether with B or with A or with both—are needed for that particular individual.

At the second meeting, the STIRR would—the [STIRR-ners] will provide the feedback regarding the results of the HIV and hepatitis C screening, and also then provide immunization with the Hep A, Hep B, or both—or potentially neither if the person has immunity. And then the next two—one or two visits are about following up with risk reduction counseling and finishing up the immunization pattern depending on what immunization the person needed. [00:38:14]

If a person is detected of having HIV or hepatitis C, the person then is referred to the nurse practitioner, which we'll get to in a moment, who then begins to provide onsite care if it's appropriate.

The next important person is the peer navigator. The peer navigator is a person that I like to think of as who has the PhD out of the streets; who knows what it's like to have potentially serious mental illness or a co-occurring substance use disorder; who may have been successful at getting care for either HIV or hepatitis C; and currently assists the people in the STIRR intervention with linkage to care, coronation of care, and even just being a helpful person in the intervention itself. So the peer navigator assists the nurse in the delivery of the STIRR-IT intervention—given that person's area of expertise.

So as I said, if a person has HIV or hepatitis C, then they get referred to the nurse practitioner who, again, is onsite at the behavioral health clinic. And then they begin the process of either, um, receiving treatment for HIV onsite, or being referred out for, um, hepatitis C treatment—or evaluation, actually; and then for more complicated cases, the nurse practitioner works with established HIV clinics throughout the city.

As many of you probably know, with the [start] (ph) studies information coming out, sort of suggesting that most people—independent of their CD4 count—should begin HIV treatment. This part of our intervention is going to become more and more, I think, important as we move forward. [00:39:57]

Finally, we have consultants. We have both an ID doctor, which is infectious diseases doctor, who, when we have challenging questions about whether or not to vaccinate somebody or not, they're available for backup. And then we have psychiatry as well to provide helpful information to the nurse or the nurse practitioner if the need arises.

Next slide?

And here, I just wanted to show the components of STIRR and how they line up with the RFA for this particular grant. And it just seemed like these were like really well-suited for each other. You can see that the STIRR intervention does the HIV and hepatitis C risk assessment, HIV testing, hepatitis C testing, hepatitis A and B immunizations, pre- and post-test counseling and referral to onsite medical care.

So we feel like this intervention—the STIRR-IT model—really completes the RFA key components, and we're excited that this matched so well with this particular grant.

Um, next slide?

So, when challenges—you know, when you have a new thing that you're trying to integrate into an ongoing system of care, there can be many challenges that may thwart that effort. And, um, we were fortunate enough to have very good working relations with this particular mental health clinic—or behavioral health clinic—that really facilitated the quick integration of this project. One—is we insisted on really considering our staff as being integrated within the larger health

system. We didn't want them to be like, you know, as kind of like walking in and doing research, or providing a service and walking out. We wanted them—the behavioral health system—to feel like we were there to stay and this could be maintained, hopefully, over the long run. [00:41:49]

Um, we also were fortunate to have an office that was accessible to the waiting room so that people didn't feel necessarily stigmatized or different if they chose to do this program. They would walk in to the clinic like anyone else to be seen by a clinician. So, again, they are not being taken to another site or another part of the building. It's all integrated right within the clinic itself.

Another thing that helped was that there was blood drawing facilities onsite. So, again, people weren't given like a [slip then said], "Go to another building or another clinic to get your blood drawn." Because, again, we know people will fall off even if it's a block away. So, um, I think that's helped tremendously, again, the notion of integrating right within the clinic structure. And the vaccines were stored—are stored and delivered onsite. So, again, no need for people to leave to another building to get this done. The nursing staff has the appropriate, you know, chain—the cold chain is established. All—all the important things that one has to do in terms of delivering vaccines is, you know, in place.

And finally, it's connected to an electronic medical record that allows all the therapists and all the clinical staff to see what the STIRR team is doing and look at the results and vice versa. So the STIRR team can see potentially, you know, how or what might be barriers or challenges for particular patients when they're meeting with [them.]

So again, this makes this highly, I think, achievable because there was this insistence at the very beginning to integrate so comfortably, I think, within the—this system of care itself.

Next slide?

So, but there're always challenges, and here—(chuckles) here are the ones we came up with. There are others, but these are the biggest challenges. Um, one was just the cost and types of vaccine. Um, you know, when we [initially] (ph) wrote the grant, we were quoted in one place for the vaccine, but then when we got the grant, the price changed. And so we've had some challenges about how to cover that cost. But the good news is that most, you know, insurance companies will cover the vaccine for people. So that's always, you know, an option. [00:44:08]

A problem there, of course, is establishing the cold chain to make sure the vaccine stays at the right temperature. That's been an interesting issue that we've been dealing with, but I think we've been dealing with it very successfully.

And then the second one is hiring the peer navigator. We work at a university and the university had never heard of a peer navigator, so they didn't know quite how to—how to post in that position. And because of that, there was a lot of back and forth on [Chris Nells] (ph) [00:44:37] in the human resources side to make sure that we were describing the position accurately. And then they—the human resources people—could then review it (inaudible) to give us people who were appropriate for this position.

Um, so we're still struggling with that a bit, but we're hopeful that in the next month we will have a peer navigator as part of our team.

Um, next slide.

And, so I wanted to share with you some of the outcomes because we were real excited about this part. Um, so—you know, we're able to successfully implement the model within the required timeframe, and that was great. We just had great partners all around and people who truly and strongly believed in the importance of this particular project.

So in the—since the end of February—so March, April, and May—we've seen 46 people who received the STIRR intervention. And then half of them completed the STIRR services. So, just so you know, um, that's not a low number. That's actually a pretty high number because some of the intervention can last a month to, uh, potentially six months depending on what type of vaccine pattern people need—so really good follow-up with all the people who have been in the program so far. [00:45:58]

Um, the vast majority of people have received immunizations. The reason the denominator's different—the 38 and the 46—is because this also includes people who've just finished their first visit. And again, as I said before, on the second visit is when people get their immunizations. So it doesn't count the eight people who had gotten the first visit that we're—when we got this data, they hadn't gotten their second visit, yet.

So 92 percent is really high. Um, the three people who refused just didn't want to be immunized on that day.

Um, the really important parts, I think, are the next three bullets or lines. Um, you know, 28.2 percent were found to be hepatitis C positive. And 20—or 4.3 percent, again, were found to be HIV positive. The two people who are HIV positive both knew it and we, um—but importantly, they needed some assistance with getting re-established with care. And that's why I can probably say at the very end that 100 percent of all these people fill—the people that were found to be HIV or hepatitis C—were appropriately referred to care and we were able to follow-up with that which was really exciting [stuff.] (ph)

Um, next slide.

And that's all I have. So, um, now I'm prepared for questions. And, again, I'm really happy that I had the opportunity to share, um, this implementation of the STIRR-IT model with you, and only can say that this is, um, an extremely important thing to do for this particular vulnerable population who may be at very high risk of, you know, being infected with HIV or hepatitis C.

VICTOR RAMIREZ: Thank you very much, Dr. Himelhoch—a lot of information that you provided [and I think that it's] a lot of very useful information for all the grantees. And, uh, for all the grantees, you have a question or you have a comment, please type it in your dialog box. [00:47:52]

Uh, we do have a couple of questions that came in late, um, right after Ms. Wagner's presentation. So, um—the first question: Is the reason for the spike among Native Americans—is that known?

KELLY WAGNER: Um, I think if you're talking about the spike—the early spike for hepatitis B, um—could you—actually, whoever asked that question, could you clarify which spike we're talking about. There was a spike in hepatitis—acute hepatitis B infections between 2001 and 2002, and I do not have an answer for kind of what that spike was due to. Um, it is around reported acute hepatitis B infection. I believe that there was a push to implement additional or expanded testing at that time, but I can't say for sure that that has been the reason or, you know, there has been a hypothesis that that would be related to the increase in acute hepatitis B infection at that point.

Um, in terms of hepatitis C, the spike that occurred around 2011 among Native Americans is indicative and similar to the spike among all populations. And I think that the current literature does speak to a relationship between—as I mentioned before—the increase in the injected drug use, especially among people who may have previously utilized pill-based opioids—and then moving into heroin which, unfortunately in many communities, has become a little bit easier to get than, um, oxycodone or OxyContin or some of the other prescription opioid.

VICTOR RAMIREZ: Okay. Uh, thank you. And second question that came in right after her presentation: Uh, should you always conduct a surface panel screening for HBV or should you only screen for one area? [00:50:04]

KELLY WAGNER: The hepatitis B blood test is a three-part blood panel test. So it's already an integrative test. And one of the main reasons that it looks at all three areas is because positivity for each of the areas actually indicates, um, a different condition. So, screening for the hepatitis B surface antigen—if that ends up being positive, then that does indicate that hepatitis B virus is present and the person that you have screened either has a chronic or an acute hepatitis B infection.

Screening for the surface antibody—if the surface antibody turns up as positive, then that indicates that the immune system has successfully developed a protective antibody against the hepatitis B vaccine. So it could indicate that the person was either previously vaccinated or had been infected with hepatitis B at some point and had naturally cleared the virus from their blood stream.

When you're looking at the third part of the panel—which would be the core antibody—um, a positive test there would indicate that the person may have been exposed to the hepatitis B virus. And that test is often used by blood banks. But the—the hepatitis B blood panel typically is integrated for all three components of the hepatitis B virus.

VICTOR RAMIREZ: Alright. Thank you. Uh, we have a couple of questions for, uh, Dr. Himelhoch: For the 100 percent who were referred to care, could you explain your referral

process when people need care from an outside HIV care site or primary care provider? What strategies did you use to support their connection to an engagement in primary care? [00:51:56]

DR. SETH HIMELHOCH: Thank you for that question. That's a very important question. Um, so part of, I think, what makes our system of care work well is that we have very good established relationships with the infectious diseases clinics who provide HIV treatment for our patients. And, um, so—you know, when call them up and we explain what we potentially need, they're able to help us out pretty quickly. The other important, and I think part of the reason for that is that we also have the integrated mental health care, so this is kind of the opposite of what I've been describing here—um, integrated mental health care within the HIV clinic. So, um, I think the HIV clinicians feel more supported and knowledgeable because they have the mental health expertise right there, as well.

That being said, the nurse practitioner has been trained through the HIV clinics to—through [preceptorships] (ph) with other nurse practitioners who work there to now do HIV treatment onsite at the behavioral health clinic for, as I said, uncomplicated cases. And I think, again, that reinforces that relationship between the HIV clinic on campus as well as our HIV treatment in the behavioral health center.

So, in a really, I think, nice way there's this integration of mental health on the HIV side, and now we're trying to do that reverse integration providing [somaticare] (ph) [00:53:29] of the behavioral health side. So I think all that really helps ensure that people are—you know, receive care and are, you know, can—I think, follow through pretty well.

VICTOR RAMIREZ: Thank you very much, Dr. Himelhoch. We have another question also for you, uh, from one of the grantees: We are in a community behavioral health facility that has been around for a long time. We're having quite a time getting our counselors on board with linking their clients to our testing for both HIV and HCV, and getting them into care. Do you have any suggestions? We are actually in different buildings, but also face the issue of changing someone's work pattern to include us. Any suggestions? [00:54:22]

DR. SETH HIMELHOCH: Wow, that's—so that gets to the integration and implementation. Um, one of the things that we did when we put together this model is that we—and you may have done this, as well—so I'm not saying anything that's novel—is that we ensured that we included leadership at the mental health clinic to be at the table when we developed the grant and implemented it. So, over the course of three or four months when we—after we received the grant and as we were implementing it, we created a team and we met almost weekly to go through every possible issue that we thought could come up that could be a barrier. You know, from our perspective, implementing the onsite delivery model; and from their perspective, how that model may interfere with the flow of their patients and getting their work done. And I think because we spent so much time working on that, we, I think, carefully assessed what the barriers might be and—you know, and now we have a very open relationship when things—or challenging things come up.

Now that being said, I think one of the things that we did early on was we began presenting the model at team meetings and allowing all the therapists and other people who we staff at the

clinic ask us questions, ask us about referrals, ask us, you know, things that we may not have thought about in order to ensure again this idea that we were integrating with them—that we weren't separate or unique. [00:55:53]

I think one of the challenges that you're facing is that being in a separate building—even that like one block or one—it could even be like literally one hallway away—can make a huge difference from a cultural perspective and also from, you know, an implementation perspective for patients. So anything you can do to break down that barrier or to provide evidence that this is really one big culture—that you're working together—I think will assist to make the implementation effort probably better.

KELLY WAGNER: This is Kelly. Um, I just wanted to add a couple of additional comments to that, um—to Dr. Himelhoch's response. Thank you very much for the response. Um, I think one of the—you mentioned definitely that challenge between being in two buildings. And if you are utilizing peer navigators or some other sort of peer support in your program, they may be able to assist with escorts back and forth. And so, that may be another way to break down that additional issue of being (inaudible at 00:57:00) get the clients between the two different buildings.

DR. SETH HIMELHOCH: This—this is, uh, I would highly—I mean, I highly agree with that, and that's one of the reasons we so desperately want to have a peer navigator work with us to help break down those challenges—especially if people decide to get care, for example, for HIV or Hep C off-site—that they could help people, you know, make those, um, building changes or whatever more possible. So, thank you for bringing that up. That's exactly right.

VICTOR RAMIREZ: Thank you. Um, an additional question: What—for you, Dr. Himelhoch—what is the gender breakdown for the—for participants in STIRR-IT? And does it follow the same as the clinic population? Are there any—(overlapping talking)

DR. SETH HIMELHOCH: (overlapping talking) That's—that's—

VICTOR RAMIREZ: — (inaudible) clients? [00:57:52]

DR. SETH HIMELHOCH: That's a great question and unfortunately I don't have the answers, but I certainly can get the answer to it. So at this point, I'm just going to say, "I don't know." (chuckles)

VICTOR RAMIREZ: Okay. Thank you. Again, for all grantees, if you have a question or a comment—do we still have a couple of more minutes? Please use the question feature on your, um—on your dialog box. (long pause) I mean, you can—for all the grantees, you can also continue to send us questions after the, um—after the webinar if, you know—or any comments—any of your experience so far. You can send it to MAI-COC-TA@mayatech.com or also to the integration@thenationalcouncil.org.

We are including the contact information for both of our presenters today—Ms. Kelly Wagner and also Dr. Himelhoch. If you have any specific questions—either related to, uh, you know, the

epidata or any of the information that was presented by Ms Wagner or any specific questions regarding the STIRR-IT project to Dr. Himelhoch—(long pause)

And, again, just a reminder that you will be—that an audio recording of this webinar will be available at the CIHS website. You can also find a lot of resources for integration at the TIA—at the SAMHSA-HRSA Center for Integrated Health Solutions—on their website. And, again, the e-mail—if you have any specific questions on any of the information presented at the website, you can [turn in] (ph) the e-mail—the National Council. [01:00:09]

And just to say thank you to everybody for joining us today. And at the end of the webinar, you will have the option to complete a survey. We highly encourage you to do so. Your feedback is very important—both for this webinar and also for future topics and for your—and for, you know, the webinars that we have coming up in the next few months.

So, just one last thing—please be on the lookout for information for the July webinar. We should be sending out information within the next couple of weeks.

Again, thank you to all the grantees for taking time off your day today. Uh, we hope that this webinar was very informative for you. And again, a special thank you for Dr. Himelhoch for giving us, you know, the time to present on STIRR-IT today and, you know, for being available as we plan this webinar. Dr. Himelhoch, thank you very much.

DR. SETH HIMELHOCH: Thank you.

VICTOR RAMIREZ: Alright, well thank you, everybody! And we hope to see you online next month.

[01:01:24]

END TRANSCRIPT