



NUMBERS FOR KNOWLEDGE
KNOWLEDGE FOR CARE 2-3



RAPID ORAL TEST AND IMED
CONSENT SIGNIFICANTLY
INCREASE HIV TESTING RATES 4-5



CITATIONS IN
PUBLIC HEALTH 6

VA PUBLIC HEALTH
PORTAL LINKS 6

CONTACT/COMMENTS 6

Public Health Matters

Public Health
Strategic
Health Care Group

▶ NEWSLETTER



Welcome to the inaugural issue of *Public Health Matters.*

The Public Health Strategic Health Care Group (PHSHG) in the Office of Public Health and Environmental Hazards intends to publish this newsletter twice a year. We will use it as a vehicle to provide important public health information to the VA provider community – especially information related to HIV, HCV, other bloodborne pathogens, emerging infectious diseases, influenza, and the public health consequences of tobacco use.

Our promise to you, our readers, is to strive to provide concise information that you will find useful in your daily efforts to improve veterans' health. In addition to a data-based article, each issue will share a "best practice" example from our diverse and talented pool of VA providers, as well as updates and announcements of public health interest.

As with any new venture, we hope to learn as we go. Therefore, we encourage you to let us know what you think about this issue, what was useful, what was not, and what you might like to see in future issues. You can send this feedback to publichealth@va.gov. We promise to carefully review your feedback before our next issue, due out in the Spring of '08.

Wishing you Good Health,

Ron Valdiserri

Ronald O. Valdiserri, M.D., M.P.H.
Chief Consultant, Public Health SHG

Mission:

The Public Health Strategic Health Care Group (PHSHG) is a key organizational component of the Office of Public Health and Environmental Hazards, U.S. Department of Veterans Affairs (VA). PHSHG's mission is to improve the health of veterans through the development of sound policies and programs related to several major public health concerns, including: HIV infection, HCV infection, seasonal influenza, smoking and tobacco use cessation, and emerging infections of public health significance – including health care-associated infections.



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PHSHG

Public Health
Strategic Health Care Group

Numbers for Knowledge Knowledge for Care

Larry Mole, Pharm. D.
James Halloran, R.N., M.S.N., C.N.S.
Lisa Backus, M.D., Ph.D.

Center for Quality Management
in Public Health, PHSHG

The availability of a comprehensive electronic medical record is a key factor in VA's widely recognized position as a leader in health care. In addition to allowing providers to access an array of information about individual patients, VistA/CPRS also supports population-based data collection to inform, plan, and assess how care is delivered. Building on this electronic medical record (EMR), the Center for Quality Management in Public Health (CQM), a unit of the PHSHG, provides and supports the Clinical Case Registry software (CCR). Installed at every Veterans Health Administration (VHA) facility in accordance with VHA Directive 2006-011, CCR provides access to data and tools for clinicians and administrators. At each facility, the disease-specific registry is maintained by a designated coordinator, and clinicians or administrators can generate a range of custom-izable local reports. In addition, data from each VHA facility is transmitted to a national clinical database, which is managed by CQM. A great deal of time and effort is required to assemble and maintain this national database. The rationale for doing all this work is not just to produce numbers, but to provide information useful in planning, delivering, assessing, and improving veteran care. In addition to the locally available reports, CQM periodically provides national reports compiled from data aggregated from all VHA facilities. These reports are designed to answer key clinical questions, as well as to provide insight into the population of veterans with hepatitis C in the VHA system.

Who are our veterans with hepatitis C?

Close to 210,000 veterans with hepatitis C enrolled in the registry received outpatient or inpatient care in FY06. The vast majority were male (97%), more than one-half were Caucasian (59%), and 57% were in their 50's (mean age 56 years). The graph on page 3 presents an overview of these hepatitis C patients receiving care in VHA and their status with respect to confirmatory testing, antiviral treatment, and advanced liver disease. More information on the CQM can be found at www.publichealth.va.gov/quality/index.asp.

▶ *“The rationale for doing all this work is not just to produce numbers, but to provide information useful in planning, delivering, assessing, and improving veteran care.”*



Where do veterans with hepatitis C get care? What kind of care do they get?

Caseloads for hepatitis C-positive veterans in FY06 range from 4,015 in VISN 2 to 22,000 in VISN 8. Twenty-one facilities report more than 3,000 veterans in care with hepatitis C in FY06, while 14 facilities saw less than 500. Median and mean of hepatitis C patients seen in FY06 were 9,581 and 10,314 at the VISN level and 1,416 and 1,771 at the facility level, respectively. Pharmacologic therapy can be reviewed in terms of those who have ever received therapy, those who received it during a target period, and those who received their first therapy ever in VHA in the target period. For those in care in FY06, more than 29,000 (14%) had ever received a prescription for anti-hepatitis C therapy (exclusive of investigational agents). The percent of veterans by VISN ever treated for HCV ranged from 9% to 21%. First ever treatment initiations in FY06 ranged from 87 to 367 at the VISN level. Although not a standardized measure of quality, when documented, the prescribing of anti-hepatitis C therapy does show that veterans are being screened for, then offered and prescribed such therapy. Overall sustained virologic response (SVR) rates for veterans initiating pegylated interferon/ribavirin therapy up to September 2005 were 23%, 60%, and 49% for hepatitis C genotypes 1, 2, and 3, respectively.

What clinical issues were seen among veterans with hepatitis C in FY06?

Co-morbid conditions were common in this group, with 55% having hypertension and 45% diagnosed at some time with depression. Substance use was frequently documented in these veterans' histories, including alcohol (45%), smoking (44%), and hard drug use (heroin, cocaine, and/or methamphetamine, 31%). Small portions have been diagnosed with hepatitis B (6%) or HIV (3.7%).

Rates of conditions related to chronic hepatitis C infection include 8.6% of patients in care with cirrhosis and 3.5% with a history of decompensated liver disease. Cases of

hepatocellular carcinoma were low (800 patients) but have increased by a hundred cases a year over the past few years.

How can I use this kind of data to assure the best care for veterans with hepatitis C?

The first step in providing optimal care is to understand the size and complexity of the population; the reports referenced above, along with those produced at the local level, can help you do that. Such data can help you plan how care is delivered, as well as assess important outcomes of that care at the population level. It can be helpful to compare numbers across facilities to get a sense of where your facility fits in with regard to population served or other aspects of care. For these reports there is no “magic number” that equals good care, as there are multiple reasons why numbers may vary across facilities. That said, a large difference on a measure can indicate a need to evaluate further. If you do see something that you wish to investigate, you can use your local CCR to run pertinent reports.

The local data used for CCR reports is updated daily, so changes that you make to improve care should be reflected in your reports. How long it will take for the effect of your changes to show up will depend on the specific issue you target. If your facility institutes reflex testing to improve rates of confirmatory testing, for example, the percentage of patients with documented confirmation

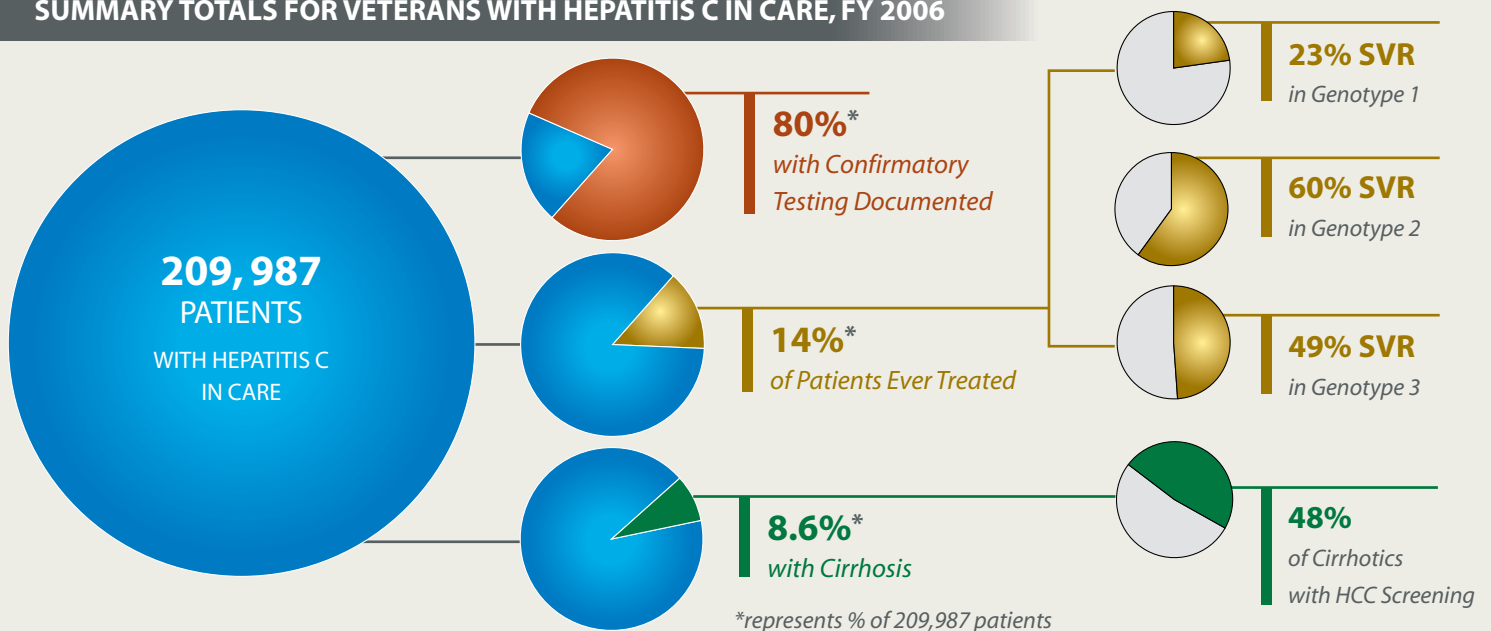
should increase fairly quickly. More complex issues may take longer, depending on the topic. For example, if you decide to institute an educational support group to increase adherence to prescribed treatment with a goal of increasing response rate, it would be necessary to wait several months to see if an effect develops.

Resources and support

For a wide array of information on hepatitis C for both providers and patients, be sure to check out www.hepatitis.va.gov where you will be able to access a wealth of information produced by PHSHG’s Hepatitis C Resource Centers. CQM and the VA National Training and Education Office (NT&EO) sponsor a monthly CCR support call using an open mic format where local coordinators or users can ask any questions about the CCR software. For more information about these calls, email Cathy Morgan at Cathy.Morgan@va.gov. Finally, the multidisciplinary CQM team is always available and willing to help you find ways to use the CCR and its reporting functions to help improve the process and outcomes of care. We strongly encourage you to share with us your ideas and successful strategies, and we will do our best to disseminate them across the VHA system. Please send your questions or suggestions via email to Lisa.Backus@va.gov or James.Halloran@va.gov.



SUMMARY TOTALS FOR VETERANS WITH HEPATITIS C IN CARE, FY 2006



Noreen Haren, M.P.H., B.S.N., C.S.

Rapid Oral Test and iMed Consent Significantly Increase HIV Testing Rates



New York Harbor Health Care System, New York Campus

The Under Secretary of Health's Letter 10-2005-017 recommended routine HIV risk assessment and testing for all veterans, particularly those seen in primary care, mental health, and substance abuse settings. As the HIV Clinical Specialist at the New York Harbor Health Care System Manhattan campus, I collaborated with Ms. Daragh Murphy, a nurse practitioner providing primary care in our Mental Health Clinic (MHC), to implement these recommendations in order to increase the number of MHC patients counseled and tested for HIV. Although our project focused primarily on MHC patients and providers, we promoted HIV awareness throughout the hospital and facilitated provision of iMed Consent electronic signature pads for any outpatient provider, encouraging primary care physicians to do their own counseling and testing. We also made the HIV rapid oral test (ROT) available in our HIV counseling clinic to provide same-day test results to veterans. The combination of these efforts resulted in a significant increase in HIV testing at our facility, but these gains were not achieved without encountering some barriers and learning several important lessons about implementing change in our local health care system.



Nursing Chronic Blood-borne Infection Project

In September 2006 we were awarded a grant from the VHA Public Health Strategic Health Care Group (PHSHG) and the Office of Nursing Services (ONS) to participate in the Nursing CBI (Chronic Blood-borne Infection) Project. The goal of the

Nursing CBI initiative is to provide an opportunity for a non-CBI nurse to partner with a CBI nurse and co-lead an initiative at their local facility to enhance the care of veterans with chronic blood-borne infections. The goal of our local project was to improve the identification and referral of veterans with undiagnosed HIV. Our target population consisted of the 5,900 veterans enrolled in the MHC. A random sampling of 100 patients revealed that less than one-third had ever been tested for HIV even though many had risk factors for infection, especially those enrolled in our Substance Abuse Relapse Prevention (SARP) program. When we initially wrote our proposal, the only providers in the MHC ordering HIV tests were Daragh Murphy and another MHC primary care nurse practitioner. Our plan was to expand testing within the MHC so that patients could be counseled by a provider with whom they had a pre-existing therapeutic relationship, such as their psychiatrist. The first major hurdle we faced was convincing providers that HIV counseling and testing does not need to be done by an HIV specialist. Understandably, many MHC providers were not used to ordering HIV tests. In order to raise awareness about HIV testing among patients and staff, my colleague, Ms. Maggie McGibbon (an HIV social worker), and I conducted an HIV Rapid Oral Testing Day in the MHC.



Detail of two human immunodeficiency virus (HIV) particles, or virions.

“The combination of these efforts resulted in a significant increase in HIV testing at our facility, but these gains were not achieved without encountering some barriers and learning several important lessons about implementing change in our local health care system.”

HIV rapid oral testing

The HIV rapid oral test had been available in NYC Department of Health clinics for over a year, and an increasing number of our veterans were requesting it. The approval process for use at our VA took almost a year and included the requirement to test 50 patients by both the oral method and standard ELISA testing to establish the accuracy of the test. This testing trial yielded 100 percent concurrence, and ROT was instituted in our HIV counseling clinic in August 2006. Maggie McGibbon and I, having had extensive training and many years' experience in standard HIV counseling and testing, were both trained in ROT, which is a simple test to perform. Initial training in rapid testing, which took approximately 2 hours, was provided by a specialist from a pharmaceutical company, and follow-up training was provided by industry. The cost of ROT kits is approximately \$305 for a box of 25 tests.



The HIV Rapid Oral Testing Day in the MHC was well advertised and promoted by Daragh Murphy. Mr. Herbie Hipp (another MHC nurse) also referred patients to us for testing. These patients were comfortable receiving care in the MHC, but while they were receptive to learning about HIV prevention, many had no idea that they could be tested for HIV in the VA. The event succeeded in raising awareness among patients and MHC staff about HIV testing. Mr. Hipp was so supportive of the project that he went on to be trained in HIV counseling and ROT. We held another HIV Rapid Oral Testing Day in the MHC on June 27th, which is National HIV Testing Day. Again, the event was well attended, with many MHC providers, including SARP staff, referring patients. Mr. Hipp, Ms. McGibbon, and I all performed ROT on that day.

Most patients admitted to our inpatient psychiatry and detoxification unit were also followed in the MHC, so we encouraged HIV testing by staff in this setting as well. We provided training in HIV counseling to nurses on the unit and advised them to contact Ms. Murphy or me to order HIV tests when there was no physician available on the unit. We oriented staff in the use of the iMed Consent pad, which

presents the standard HIV pre-testing counseling form in an electronic format on the computer. The patient and the provider can read the consent together and sign this form much as one would an electronic credit card pad in a retail store. The consent becomes a permanent part of the patient's electronic record and removes the barrier of providers having to fax the paper consent to the immunology lab where the test is performed. I am notified of all positive results by our immunology lab. I order confirmatory lab work, lymphocyte panel and viral load tests, and then arrange for expedited access to our Infectious Diseases Clinic, where we offer in-depth counseling to newly diagnosed patients. This allows new patients to enter specialty care without requiring them to come to our testing clinic first.


Outcome of the HIV testing project

As a result of our efforts, most inpatient house staff now perform their own testing. Primary care and specialty clinic providers have increasingly referred patients to us for ROT (patients can also self-refer), and they have also become more comfortable doing their own counseling and testing

“While we always welcome patients in our clinic, supporting others' efforts to provide HIV counseling and testing has fostered an excellent collaborative relationship with primary care and specialty clinic providers.”

on patients who may be reluctant to come to our testing clinic. In addition, two ER nurses were trained in ROT during the course of this project in the hope that they will offer testing to high-risk patients who may not otherwise return to the medical center for test results. Most encouraging is that, in the past two months, inpatient and outpatient psychiatrists have begun to do their own counseling and testing. Ms. Murphy has continued to raise awareness among other MHC providers by speaking to her colleagues individually and at MHC staff meetings. As a result, an increasing number of patients who come to our ID counseling clinic are MHC patients who have been referred by their providers.

We have achieved our goal of increasing HIV testing overall and have started to see an increase in the number of patients tested in the MHC. In the first nine months of our project (11/1/06-7/31/07), 736 patients were tested for HIV, with 261 of those by ROT. This represents a 36.3% increase over the 540 patients tested in the same time period last year, and many of the patients tested were MHC patients. Among the 736 patients tested during our project, 39 (5.3%) were HIV positive, less than the 45 (8.3%) HIV positive patients detected over the same time period last year. The reduction in the HIV prevalence rate may be due, in part, to implementation of these more routine testing procedures, resulting in a larger pool of veterans tested for HIV.

Ms. Murphy and I have both benefited by being able to learn from each other's expertise during the course of this project. While we always welcome patients in our clinic, supporting others' efforts to provide HIV counseling and testing has fostered an excellent collaborative relationship with primary care and specialty clinic providers. We have found this collaborative model to be beneficial for both veterans and providers and have since networked with nurses from other VA sites participating in the CBI project. 

Citations in Public Health

Retention in care for HIV

A retrospective cohort study of 2,619 veterans newly diagnosed with HIV infection during 1997–1998 demonstrated that, even in a system with few financial barriers to care, patients can have poor retention in care. Strategies to retain persons in care need to be developed and tested in order to maximize clinical outcomes.

Giordano TP, Gifford AL, White C, Suarez-Almazor ME, Rabeneck L, Hartman C, Backus LI, Mole LA, Morgan RO. Retention in care: A challenge to survival with HIV infection. *Clin Infect Dis*. 2007; 44:1493–1499.

Reducing smoking prevalence in NYC

In 2002, New York City began to implement a comprehensive tobacco control program, including increased taxation on cigarettes, legislation to establish smoke-free workplaces, public and health care provider education, cessation services, and evaluation, including cross-sectional telephone surveys. In 2006, the New York City Department of Health and Mental Hygiene implemented a broad-scale television-based media campaign to increase anti-tobacco public health messages. Following implementation of this comprehensive tobacco control program, the prevalence of smoking among adults in New York City decreased by 34.9% from 2002 to 2006.

CDC. Decline in smoking prevalence—New York City, 2002–2006. *MMWR* 2007; 56:604–608.

Hepatitis C treatment review

An outstanding overview of the standard medical therapy for chronic hepatitis C infection begins with a clinical case vignette. It contains a brief, albeit highly useful, discussion of major clinical studies, the clinical use of peginterferon and ribavirin therapy, and potential adverse effects. The article also addresses “areas of uncertainty” related to combination therapy for HCV.

Hoofnagle JH, Seeff LB. Peginterferon and ribavirin for chronic hepatitis C. *N Engl J Med*. 2006;355:2444–2451.

Expanded HIV screening

A recent cost effectiveness analysis uses data from published randomized trials, observational cohorts, national cost and service utilization surveys, and other sources to determine the impact of expanded HIV screening in the United States. The findings indicate that routine HIV screening of U.S. adults, using rapid testing technologies, provides benefits comparable to many commonly employed screening interventions for chronic disease.

Paltiel AD, Walensky RP, Schackman BR, Seage GR, Mercincavage LM, Weinstein MC, Freedberg KA. Expanded HIV screening in the United States: Effect on clinical outcomes, HIV transmission, and costs. *Ann Intern Med*. 2006;145:797–806.

VA Public Health Portal Links

- Public Health Strategic Health Care Group
www.publichealth.va.gov/about/pubhealth
- VA Smoking and Tobacco Use Cessation Program
www.publichealth.va.gov/smoking
- VA HIV/AIDS Website
www.hiv.va.gov
- VA Hepatitis C Website
www.hepatitis.va.gov
- Products available from the VA Hepatitis C Resource Centers:
www.hepatitis.va.gov/vahep?page=prin-con-hcrc-02

PHSHG Senior Staff

- | | |
|---|--|
| Ronald O. Valdiserri, M.D., M.P.H.
Chief Consultant | Mark Holodniy, M.D.
Director, Office of Public Health Surveillance and Research |
| Jane Burgess, A.C.R.N., M.S.
Deputy Chief Consultant | Larry Mole, Pharm. D.
Director, Center for Quality Management in Public Health |
| James Morrill, MA. Ed.
Chief Administrative Officer | David Ross, M.D., Ph.D.
Director, Office of Clinical Public Health Programs |
| Kim Hamlett-Berry, Ph.D.
Director, Office of Public Health Policy and Prevention | |

Contact/Comments

If you have any comments or suggestions, we welcome your feedback. We will read and consider all comments and suggestions but, due to the large volume of correspondence received, may not be able to reply to each individual directly. Comments about this newsletter can be addressed to: publichealth@va.gov.

John Davison, M.B.A., Ph.D. Managing Editor	Ronald Karstetter Assistant Editor
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Please look for the next issue of *Public Health Matters* in Spring '08.

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