HCV Linkage and Navigation to Cure

NASTAD's Hepatitis Testing Partnership

March 27, 2019

NASTAD's vision is a world free of HIV and viral hepatitis

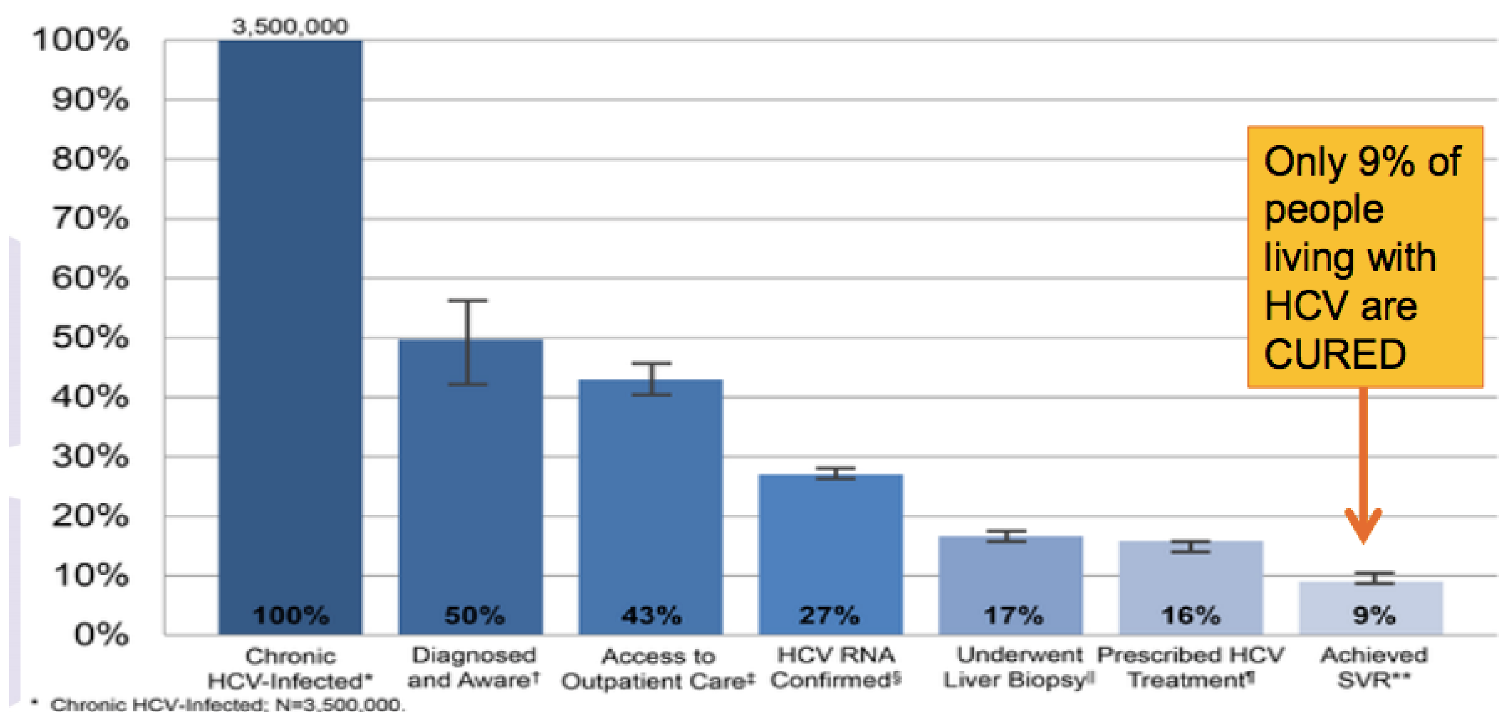
- NASTAD is a non-profit association that represents public health officials who administer HIV and hepatitis programs in the U.S. and around the world.

- We strengthen domestic and global governmental public health through advocacy, capacity building, and social justice.

Hepatitis Testing Partnership

- A diverse coalition of stakeholders working together to increase testing and linkage to care for hepatitis B and C
- Convenes through a listserv and quarterly webinars to share ideas, lessons learned, resources, and best practices

HCV Continuum in the US



* Chronic HCV-Infected; N=3,500,000.
† Calculated as estimated number chronic HCV-infected (3,500,000) x estimated percentage diagnosed and aware of their infection (49.8%); n=1,743,000.
‡ Calculated as estimated number diagnosed and aware (1,743,000) x estimated percentage with access to outpatient care (86.9%); n=1,514,667.
§ Calculated as estimated number with access to outpatient care (1,514,667) x estimated percentage HCV RNA confirmed (62.9%); n=952,726.
|| Calculated as estimated number with access to outpatient care (1,514,667) x estimated percentage who underwent liver biopsy (38.4%); n=581,632.
¶ Calculated as estimated number with access to outpatient care (1,514,667) x estimated percentage prescribed HCV treatment (36.7%); n=555,883.
** Calculated as estimated number prescribed HCV treatment (555,883) x estimated percentage who achieved SVR (58.8%); n=326,859.
Note: Only non-VA studies are included in the above HCV treatment cascade.

(Yehia et al, PLOS One, 2014)

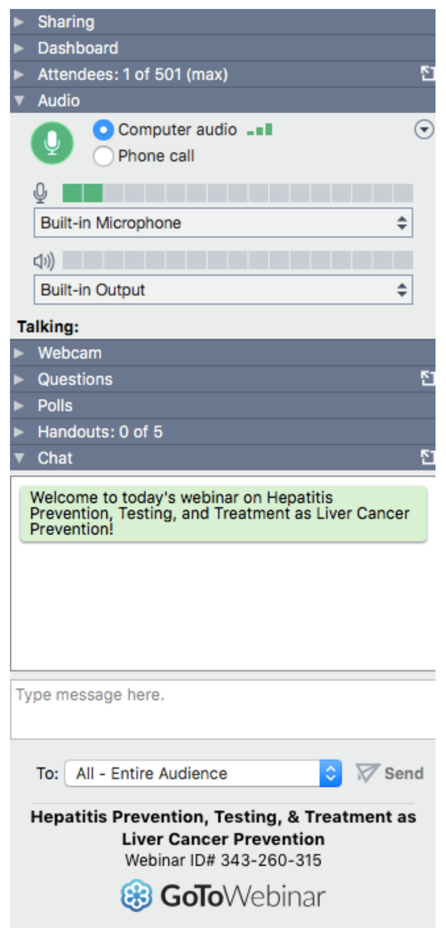
Phone/Audio Options

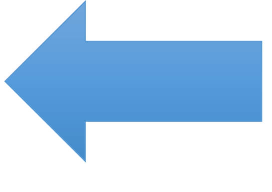
Call-In #: 1-562-247-8422

Attendee Access Code: 495-660-030

All attendees are muted.

Questions?





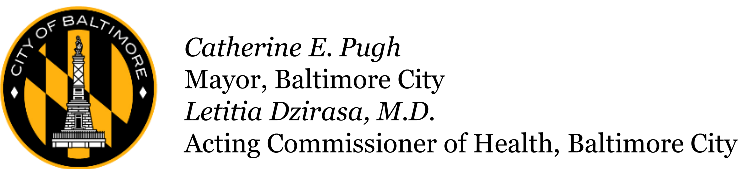
Questions? Submit questions in the chat box at anytime throughout the webinar.

Speakers

- Jaeson Smith, Baltimore City Health Department
- Lindsey Sizemore, Tennessee Department of Health
- Robert McGoey, Liver Health Connection
- Ashlee Knight, Hepatitis Education Project

HCV Linkage To Care

Jaeson Smith, MPH



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Mayor, Baltimore City
Letitia Dzirasa, M.D.
Acting Commissioner of Health, Baltimore City

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BaltimoreHealth
health.baltimorecity.gov

OUR TEAM & ROLES

- Started our HIV linkage to care program in 2005; integrated HCV linkage in 2016
- Our Team Layout
- ➢ 9 Care Linkage Specialist
- ➢ 1 Outreach Linkage Specialist
- ➢ 2 Disease Reactor Coordinators
- Disease Intervention Specialist model investigations
- Cross Training
- Community Passion Is Our Key

OUR PROCESS

1. RECORD SEARCH

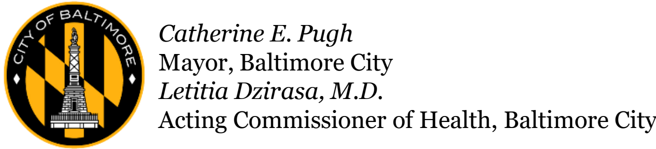
2. PHONE CALL

3. FIELD VISIT ADDRESSES (WITHIN 48 HOURS)

4. LINK PATIENT SAME DAY OR DETERMINE OTHER OUTCOME

Other Outcomes

- Unable to locate
-Already in care
-Did not attend appointment
-Refusal
-Deceased
-Move out of jurisdiction



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HCV Linkage Criteria

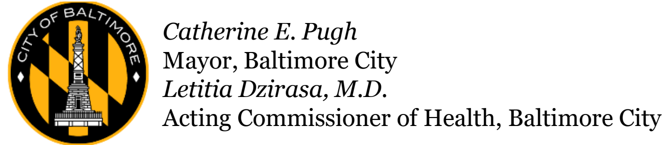
Our definition of a "linkage" - When we have encountered the client then verified the appointment has been completed; we will consider the client to be linked.

Linkage Eligibility

-A positive antibody test that need a confirmatory RNA.

-Fell out of care during treatment and need re-engagement

-Patients who have tested positive and have not returned in 6 months



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OUR RESULTS

2016

Already In Care	Attended Appointment	Deceased	Unable To Locate	Did Not Attend Appointment	Moved Out Of Jurisdiction	Refusals
93 - **17%**	222 - **39%**	27 - **5%**	139 - **25%**	56 - **10%**	8 - **1%**	18 - **3%**

Total Efforts - **563 Clients**

2017

Already In Care	Attended Appointment	Deceased	Unable To Locate	Did Not Attend Appointment	Moved Out Of Jurisdiction	Refusals
72 - **14%**	191 - **37%**	27 - **5%**	128 - **25%**	55 - **11%**	29 - **6%**	11 - **2%**

Total Efforts - **513 Clients**

2018

Already In Care	Attended Appointment	Deceased	Unable To Locate	Did Not Attend Appointment	Moved Out Of Jurisdiction	Refusals
69 - **12%**	172 - **28%**	43 - **7%**	163 - **27%**	75 - **13%**	55 - **9%**	20 - **3%**

Best Practices & Challenges

Best Practices

-Provider Access : Same-Day Appointment Slots

-Incentives

-Gaining Rapport

-Partnering with community providers

-Utilizing multiple locating resources

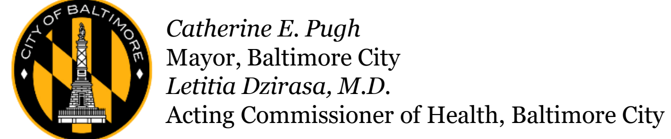
-Meeting patients where they are

Challenges

-Transient populations -Education

-Clinic Stigma -Complicated scheduling system

-Mental health -Substance abuse

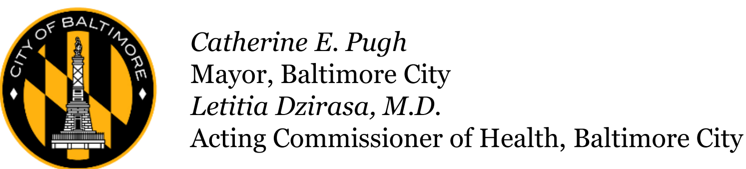


Thank you for your time! Questions?

Contact Jaeson Smith at

Jaeson.smith@baltimorecity.gov

if you have any questions.



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Linkage to Care and Treatment Services

HCV Linkage and Navigation to Cure Webinar

Lindsey Sizemore, Viral Hepatitis Program Director

HCV Continuum of Cure

HCV Surveillance

HCV Testing

Navigation to Care (HCV and PWUD)

HCV Treatment

HCV Surveillance

Newly Reported Cases of Chronic HCV in TN

Case Classification	2013	2014	2015*	2016	2017**
Confirmed	1,782 (44%)	3,385 (50%)	7,394 (59%)	10,442 (50%)	11,018 (50%)
Probable	2,234	3,421	5,244	10,496	10,992
Total (C + P)	4,181	6,866	12,213	20,513	21,264

***TDH Central office chronic HCV surveillance efforts augmented beginning 7/1/15**
****Chronic HCV laboratory reportable as of 1/1/2017**

TDH NBS, accessed August 1, 2018

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Acute & Chronic HCV Trends in TN, 2013-2017

409% increase in the number of newly reported chronic cases

Individuals < 45 years of age accounted for

- 50% of new chronic cases
- 80% of acute cases

Women accounted for

- 50% of acute & newly reported chronic cases among individuals < 45 years of age

HCV Testing

HCV Testing: Local Health Departments

- One time test for all patients that are:
  - Born from 1945 to 1965
  - Identified as high risk
  - Seeking evaluation and/or treatment for STIs
  - Requesting HCV testing or counseling
- Persons with ongoing risk for HCV infection may have repeat screening at intervals of ≥ 12 months, including:
  - Injection drug use (even once)
  - Illicit intranasal drug use (even once)
  - History of incarceration
  - Receipt of an unregulated tattoo
  - High-risk sexual behaviors (multiple sex partners, unprotected sex or sex with an HCV-infected person or an injection drug user)

HCV Testing in HD Clinics in TN (4/1/17 – 12/31/18)

60,459 = Total Tested

HCV Testing in HD Clinics in TN
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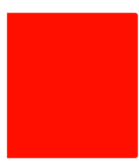
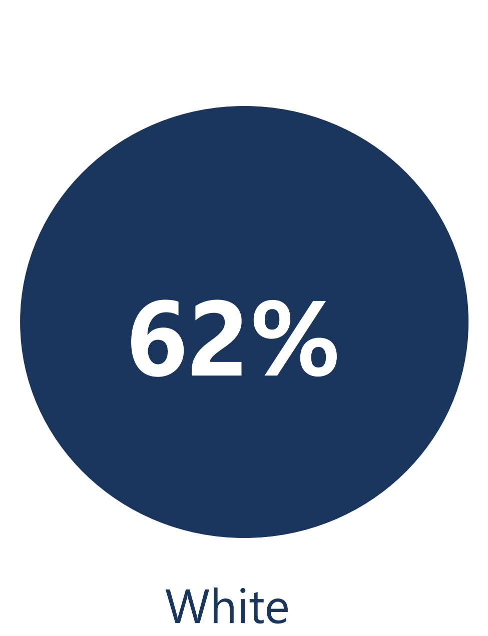
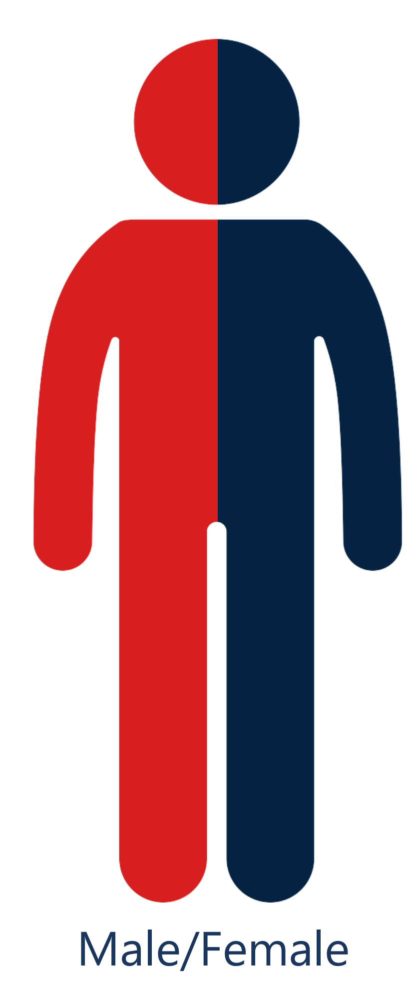


7.5% = HCV RNA +

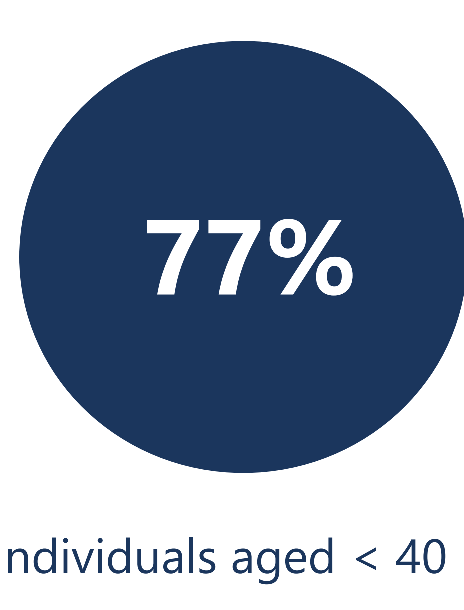
HCV Testing in HD Clinics in TN (4/1/17 – 12/31/18)



White

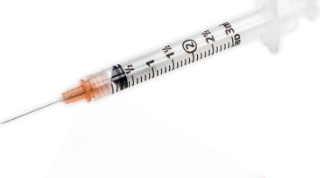
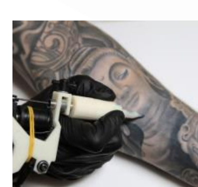


Male/Female



Individuals aged < 40

HCV Testing in HD Clinics in TN (4/1/17 – 12/31/18)

Self-Reported Risk Factor*



*Self-reported risk factors are not mutually exclusive

HCV Testing in HD Clinics in TN (4/1/17 – 12/31/18)

Self-Reported Risk Factor*	HCV Ab +	HCV Ab -
	65.9%	21.4%
	64.8%	5.1%
	62.2%	14.8%
	47.0%	20.1%
	2.6%	0.7%

*Self-reported risk factors are not mutually exclusive

HCV Testing in HD Clinics in TN (4/1/17 – 12/31/18)

Self-Reported Risk Factor	HCV Ab +	HCV Ab -
	10.8%	57.9%

Navigation to Care: Viral Hepatitis Case Navigators

Background

Viral Hepatitis Regional Responsibilities (Existing)

- Field and contact investigation
  - Perinatal HBV
  - Acute HAV, Acute HBV, Acute HCV

- **Viral Hepatitis Case Navigators (New)**
  - Began July 3, 2017
  - 12 new positions, covering all 13 public health regions

Steps in Navigation to Care

Identify

- HCV RNA clients seen at the Health Department, and/or
- Acute HCV clients identified via routine surveillance

Engage

- Contact clients through a variety of avenues and establish rapport

Refer

- Provide client with list of referral services and providers based on client centered goals and behaviors
    - HCV treatment, mental health services, substance use disorder treatment
- Identify steps to reduce barriers and increase access

Document

- Navigation efforts for all identified clients are documented in a REDCap project-specific database

Navigation to Care
(7/3/17 – 12/31/18)

Refer to HCV treatment and other services

- 4,316 clients identified for follow-up
- 2,611 (60%) clients were verbally contacted and referred*
  - 83% HCV treatment
  - 27% Substance use disorder (SUD) treatment
  - 16% Mental health (MH) services

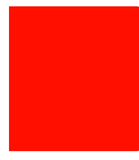
*Referrals provided are not mutually exclusive

Navigation to Care: Substance Use Resource Navigators

One Year CDC Opioid Overdose Crisis Funding

HCV Testing in HD Clinics in TN (4/1/17 – 12/31/18)

60,459 = Total Tested



11.0% = HCV Ab +

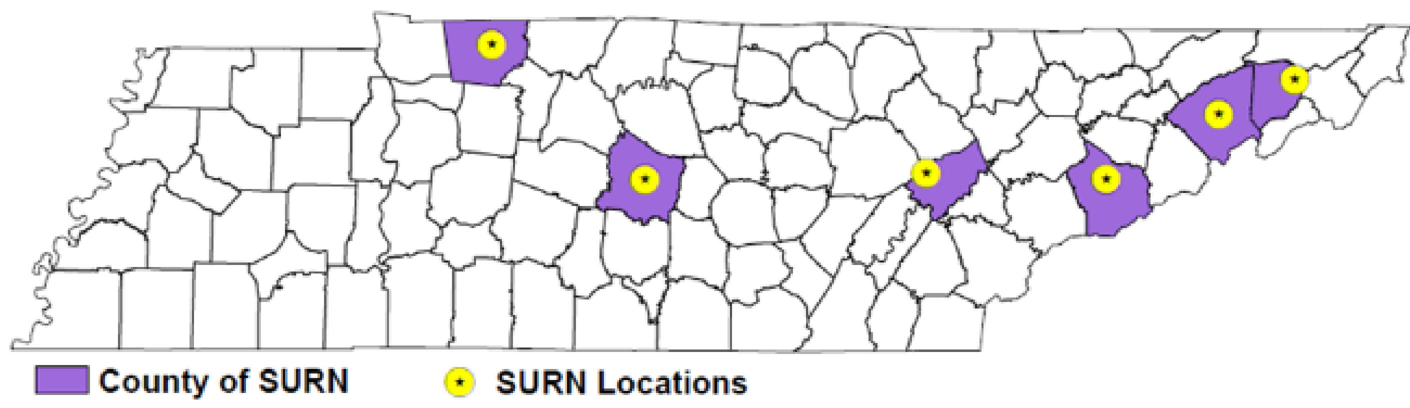
7.5% = HCV RNA +

An opportunity to investigate those that are HCV Ab+/RNA – and those that are HCV Ab- with a history of injection or intranasal drug use!

Navigation to Harm Reduction Services (11/1/18 – 08/31/19)

Substance Use Resource Navigators (SURNs) Pilot

- 6 nurses in county health departments
- 1 nursing manager located in Nashville (Central Office)



Navigation to Harm Reduction Services (Pilot) (11/1/18 – 08/31/19)

Priority Population #1

- Clients seeking any local HD service(s) and can benefit from harm reduction resources

Priority Population #2

- HD clients that are HCV Ab +/RNA – or HCV Ab negative and PWUD

Refer to harm reduction services

- Substance use treatment
- Mental health services
- Syringe service programs (SSPs)
- Local HDs
- Overdose prevention (access to naloxone)

Provide client with list of referrals based on client-centered goals and conduct 30-day follow-up

Navigation to Harm Reduction Services (Pilot) (11/1/18 – 08/31/19)

Conclusions

- A large proportion of clients who spoke to a navigator received a referral to an appropriate service
- Navigators can be critical components in assisting clients to access care
- Intensive efforts to provide linkage to treatment and supportive services are needed to increase access and reduce risk of disease progression and transmission

Thank you!

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Liver Health Connection's Patient Navigation Program

Rob McGoey, Patient Navigator

rmcgoey@liverhealthconnection.org

800-522-4372

Liver Health Connection

- Community-Based Organization
- Established 1995 as The Hep C Connection
- We provide:
  - Testing
  - Education for patients, providers and the community
  - Navigation
  - Advocacy

Patient Navigation

- Help patients identify and achieve their health goals
- Help patients identify and overcome barriers to care

Identifying Patients

3 main sources where clients come from:

- Referrals from other agencies
- Testing and field outreach
- The Helpline

Testing

- Free HCV & HIV rapid antibody testing in community settings
- Over 1,700 HCV tests in 2018
- Over 200 reactive HCV test in 2018
- Over 40 individuals identified who already knew their HCV status in 2018

The HelpLine

- The hub of the navigation program
- Colorado-focus but national in scope
- 1078 calls from 537 callers in 2018
- About 3/4th from Colorado
- Calls vary from basic questions to those needing ongoing support navigating treatment.

Treatment Map

1. Ab Test → 2. Confirmatory Testing → 3. Genotype Testing → 4. PCP Care → 5. Specialist Care → 6. Fibrosis Scoring → 7. Rx Medication → 8. Treatment → 9. SVR12

Tip #1: Provide Viral Load Testing

- Options for confirmatory testing
  - Blood draw on the spot after reactive Ab test
  - Clients can come to our office (or I go to them)
  - We order test & client goes to any Quest location

- How are we able to do this?
  - Standing orders from a physician
  - Utilize PALS (Patient Assistance for Lab Services)
    - www.pals-labs.org // 844-770-7257

Tip #2: Know your HCV Providers

- Look for providers who:
  - Don’t require a PCP referral
  - Understand PWID & don’t have sobriety restrictions
  - Accept self-pay or have financial assistance

Tip #3
Communicate what to expect

- Give patients a clear picture of the steps for treatment

- Understand Medicaid & insurer prior authorization criteria:
  - www.stateofhepc.org

- Understand how PAPs work

Challenges

- Limited options for uninsured
- Tension between scale/depth
- Capacity
- Loss to follow up; Bridging testing and navigation

Robert McGoey

www.liverhealthconnection.org

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Medical Case Management for PWID
Hepatitis Education Project (HEP)

Ashlee Knight, MA, LMHCA
Lead Medical Case Manager

1621 South Jackson St., Suite 201
Seattle, WA 98144

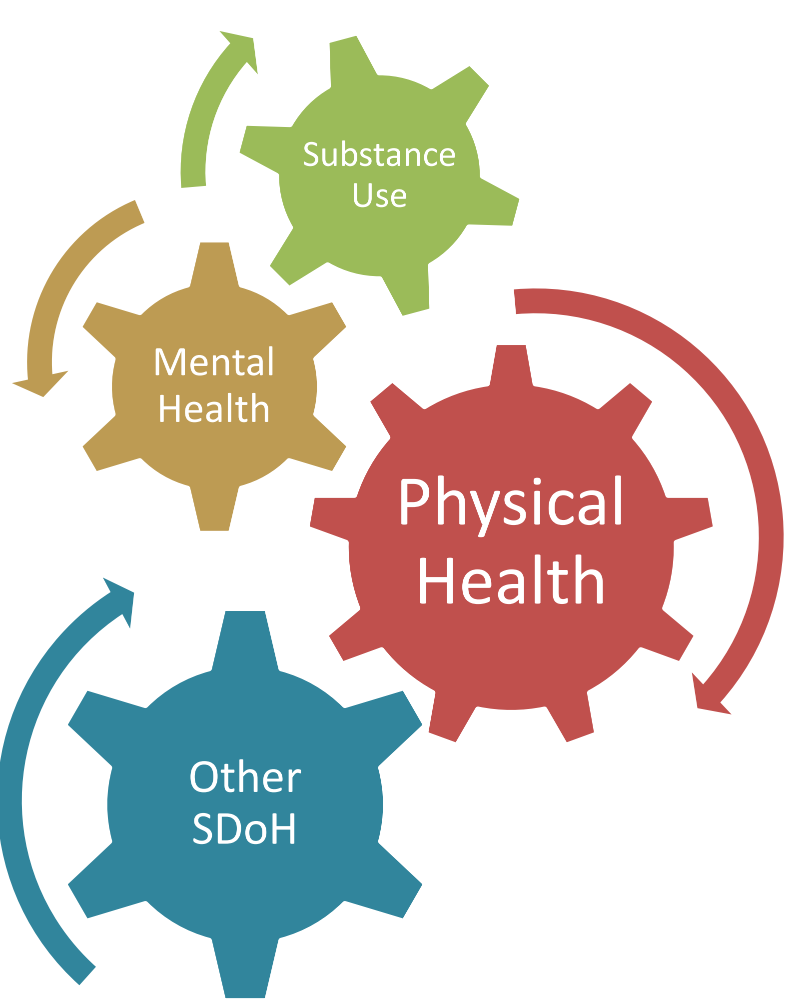
HEP's Programming

For the past 25 years, HEP has been supporting individuals disproportionately impacted by viral hepatitis through education and awareness, advocacy, low-barrier prevention, and testing and linkage to care services. We are a leading agency in supporting policy change to improve access to care and treatment and increasing city, state, and federal viral hepatitis funding. HEP's services include:

Medical Case Management

- Hepatitis Education Project began medical case management (MCM) services in 2014 through the CDC funded Test and Cure Grant
- Designed to improve the proportion of individuals who are successfully linked to care and complete curative HCV treatment, focusing on those who require bridge services to clinical care
- Nearly **80%** of the clients that HEP serves self-identify as homeless and/or unstably housed
- Currently **346** clients on the mcm team case load
- HEP's MCM team includes five full-time case managers and one MSW intern; two of the five case managers are Outreach Case Managers
- Since HEP began its MCM program services we have seen **149** clients reach SVR-12 cured, **700** clients have been case managed with over **22,000** encounters in our database

Whole-Person Care for PWID



Meeting people where they are at:

- HEP's MCM begins in the community, building relationships and trust
- Our medical case managers compassionately provide services and develop individualized care plans plan based on our clients needs
- We build goals and strategies to address social determinants of health, autonomy in decision making and self-empowerment
- During the intake process we assess barriers to care and readiness to begin the treatment process as we develop their treatment plan
- We support our clients in overcoming barriers to accessing care which includes providing wrap-around services and warm hand-offs and referrals for coordinated care

Whole-Person Care for PWID

SSP

Mental Health Services

Primary Care Services

Reproductive Health

Social and Housing Services

Vaccination HAV/HBV

Infectious Disease Screening and Treatment – HCV, HBV, HIV

SUD Treatment and OAT

Naloxone and Overdose prevention

PWID

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Seattle, WA 98144

Provider Network Development

- Our team works to de-stigmatize the health care experience for clients through:
  - Bridging provider-patient communication and educating care providers on how to create a safe, welcoming space for PWID
  - Discussing accurate and current HCV treatment guidelines with both clients and providers
- We develop strong relationships with HCV specialists and primary care physicians trained in treating HCV to provide warm hand-offs and trust-worthy referrals
- Crucial to have both agency and provider ROIs for all client related communication

Comprehensive (wrap-around) Services

Community and Social Factors

Health Care Readiness

Person-centered Care for HCV Medical Case Management

Individual Lived Experience

Harm Reduction Strategies

Navigating the Health Care System

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MCM Intensity Levels

Client A: High-Intensity

-First encounter: 11/3/17

-Extensive wrap-services including housing, cell phone, and behavioral health referrals

-Started treatment on 12/28/18

-Ended treatment on 3/22/19

-102 total encounters

Client B: Low-Intensity

-First encounter: 7/12/18

-Limited services required; client remained self-motivated

-Started treatment on 12/8/18

-Ended treatment on 3/2/19

-28 total encounters

Prevention

- Efforts to prevent infection and re-infection are a critical component of care at HEP. HEP's prevention services include:
  - Onsite clinic including vaccinations and wound care
  - Syringe Services Program
    - Among 199 SSP participants screened, 54% have evidence of acute HCV infection; of those, 47% have been diagnosed with HCV
  - Bi-weekly Low Barrier Suboxone Program
    - In partnership with a behavioral health agency and a primary care facility
    - Within six weeks of the program there have been 21 new patient inductions
    - Of these 21 inductions, 12 are HCV positive, and one is HCV AB positive
  - Health literacy education in the community and in the correctional system

Implementing a Medical Case Management Program

Step 1: Meeting the Client

Step 2: Intake and Assessment

Step 3: Linkage to Care

Step 4: Engagement in Care

Step 5: Post Treatment Support

Comprehensive services may be integrated at each step

Prevention → Testing → Linkage to Care → Treatment → Cure

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Step 1: Meeting the Client | Step 2: Intake and Assessment | Step 3: Linkage to Care | Step 4: Engagement in Care | Step 5: Post Treatment Support

Comprehensive services may be integrated at each step

Prevention → Testing → Linkage to Care → Treatment → Cure

Step 1: Meeting the Client

- Building rapport and connection with clients at outreach sites, in corrections, at HEP's SSP and low-barrier suboxone clinic
- Includes testing, prevention, vaccinations, and hand-off to medical case management when HCV diagnosis is confirmed
- Outreach Case Managers are able to provide onsite linkage to care

Step 2: Intake and Assessment

– Medical case managers consult with clients, gather demographic information, obtain client consent to enroll in services, and provide education about hepatitis C and harm reduction
– Assess readiness, intensity level, and create a person-centered care plan
– Discuss wrap-around services and options
– Administer Intake Client Survey with incentive

Step 1: Meeting the Client | Step 2: Intake and Assessment | Step 3: Linkage to Care | Step 4: Engagement in Care | Step 5: Post Treatment Support

Comprehensive services may be integrated at each step

Prevention | Testing | Linkage to Care | Treatment | Cure

Step 3: Linkage to Care

- Medical case managers link clients to medical care for HCV treatment
- Once a client has decided to pursue treatment, medical case managers support the client's connection to care by providing referrals, and assistance in scheduling an initial appointment with a medical provider
- A client is considered "linked to care" after attending their first appointment with a medical provider
- Medical case managers request records and/or contact the client's care team to confirm that a linkage to care has been made

Step 1: Meeting the Client	Step 2: Intake and Assessment	Step 3: Linkage to Care	Step 4: Engagement in Care	Step 5: Post Treatment Support

Comprehensive services may be integrated at each step

Prevention → Testing → Linkage to Care → Treatment → Cure

Step 4: Engagement in Care

- Medical case managers support the client in adhering to treatment with reminders about upcoming appointments, getting necessary lab work completed, providing emotional support, and accessing comprehensive or wrap-around services as needed
- Administer Client Satisfaction Survey with incentive once treatment begins

Step 1: Meeting the Client | Step 2: Intake and Assessment | Step 3: Linkage to Care | Step 4: Engagement in Care | Step 5: Post Treatment Support

Comprehensive services may be integrated at each step

Prevention → Testing → Linkage to Care → Treatment → Cure

Step 5: Post Treatment Support

- Medical case managers follow a client until they have achieved a sustained viral response for 12 or more weeks after the end of treatment (SVR-12)
- Post-treatment support also includes providing education on reinfection
- Administer final Client Satisfaction Survey with incentive

Building a Medical Case Management Team

- Qualified staff –both licensed and unlicensed—who provide support to clients along the care continuum
- Masters degrees in public health, social work, counseling psychology encouraged
- People with lived experience
- Core-skills for staff include:
  - Provide client-centered, harm reduction, low barrier approach; meeting clients where they're at
  - Empathic presence and compassionate listening
  - Dignity and respect
  - Provide accurate information and follow-up for clients on HCV testing, treatment, and linkage to care
  - Cultivate outreach and linkage to care resources
  - Use data collection and reporting tools effectively

Program Tracking

- Client satisfaction surveys
    - Incentives provided
    - Track client engagement and satisfaction at intake, when treatment begins, and when cure is achieved
- EMR platform
- HEP uses an Access database with Sequel on the back-end to capture:
    - Demographics
    - Encounter data
    - Lab results
    - Comprehensive services
    - Provider and treatment information
    - Vaccination records and comorbidities

Readiness Assessment Tool

Getting Started: Hepatitis C Medical Case Management Program Readiness Assessment Tool

Instructions

For each statement in the first column, mark the stage of change for your hepatitis C (HCV) medical case management (MCM) program:

- **Pre-Contemplation** — not yet providing HCV MCM
- **Contemplation** — interested in providing HCV MCM and beginning to assess staff buy-in and budget implications
- **Preparation** — starting to plan for staffing, protocols, linkage to care and services, data collection, data sharing, evaluation, and billing
- **Action** — starting to implement the HCV MCM program and monitor billing, staffing, policies and procedures, client tracking systems, quality improvement, and community partnerships
- **Improvement and Maintenance** — continuing to monitor the HCV MCM program efficiency and effectiveness, strengthening services

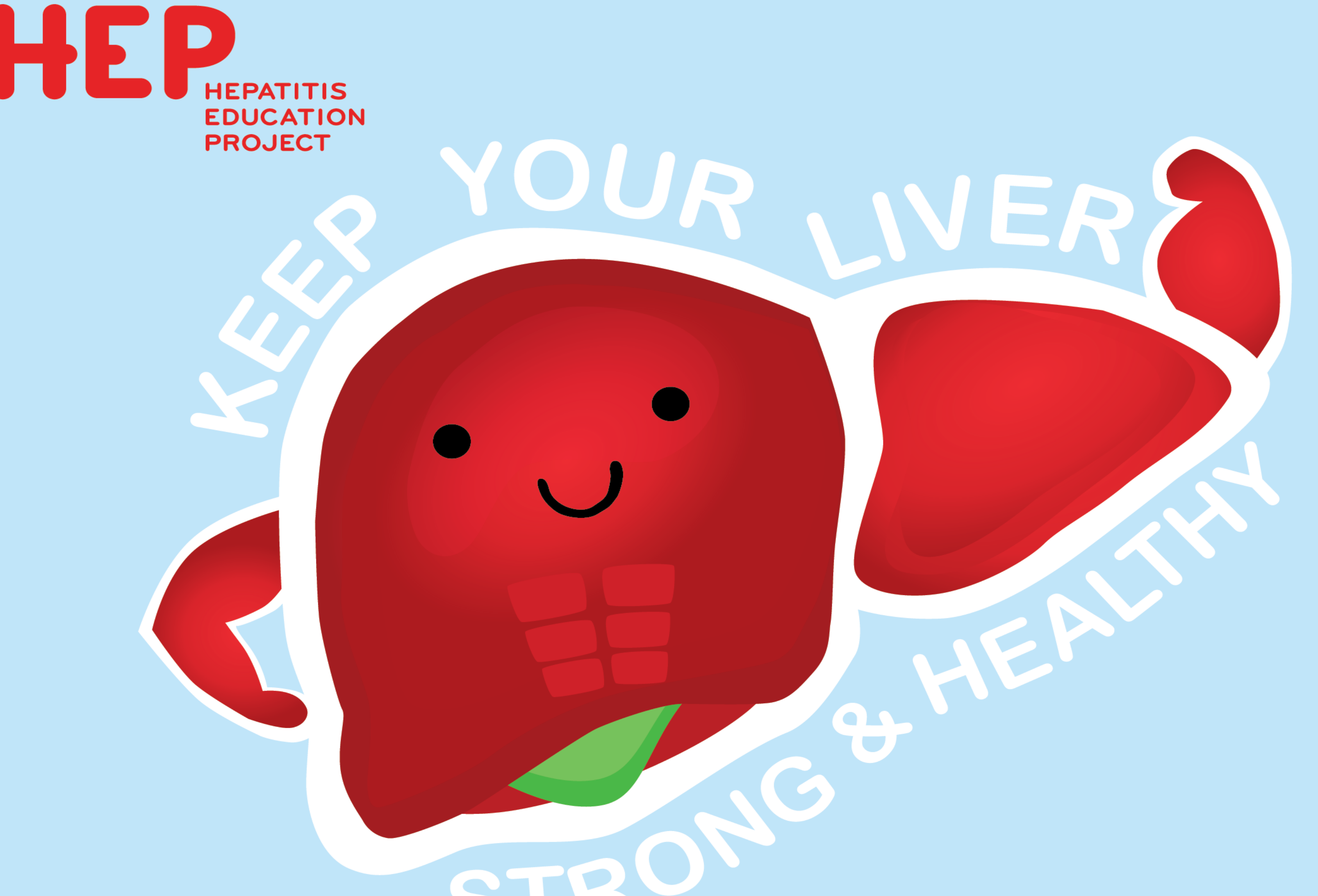
As you complete the tool, the score for each section will automatically appear to help you determine your organization's section-specific readiness for change. Compare the total score for each section with the key at the bottom of the page. In the last column, describe the next steps for moving your HCV MCM program forward.

A. Leadership Investment	Pre-Contemplation	Contemplation	Preparation	Action	Improvement & Maintenance	Score	Comments and Next Steps (Includes lead staff and action items)
Our leadership team is dedicated to implementing new programs to meet client needs.	◉	○	○	○	○	0	
Our leadership team is committed to making hepatitis C (HCV) medical case management (MCM) services a part of our mission and vision.	◉	○	○	○	○	0	
There are senior staff with knowledge and ability to implement and monitor HCV MCM.	○	○	○	○	◉	0	
Our agency is invested in working with all communities with risk of HCV, including people who: were born between 1945-65, inject drugs, experience homeless	○	○	○	◉	○	0	

MCM Toolkit

Download HEP's MCM Toolkit at:

hepeducation.org/mcmtoolkit



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