HCV Care Coordination Recommendations Worksheet
Bree Collaborative Hep C Workgroup
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Examples of Existing HCV Care Coordination Programs

Hepatitis Education Project (HEP)
https://cardeaservices.org/wp-content/uploads/2021/09/HEPHCVMCMToolkit-FINAL12.21.18.pdf

- Medical case management guidelines for underserved, marginalized populations that help identify people living with HCV and link them to medical care and treatment.

Hep-C Cures (SWACH, SeaMar, and CVAB)
https://southwestach.org/hep-c-cures-project-sees-success/#:~:text=The%20project%20called%20Hep%2DC,in%20a%20peer%2Dsupport%20program

- Embedded peer supports in clinics to connect with patients with new HCV diagnosis and help them follow through treatment. Initial results suggest the percentage of patients enrolled in peer-support who completed treatment was 70%, compared to less than 20% who completed treatment without peer support.

Types of Care Coordination

Provider Counseling (Recommendations from CDC, DOH, and AASLD)

- All persons with active HCV infection should be linked to a healthcare provider who is knowledgeable in and prepared to provide comprehensive management. (AASLD)
- Evaluate HCV patients for chronic liver disease, hepatitis A and B vaccination, alcohol consumption, and HIV risk assessment and testing. (CDC)
- Counsel HCV-positive persons on adherence for those receiving treatment, transmission prevention, and liver health. (DOH)
- Counsel HCV-negative persons who may be at high risk of acquiring HCV about prevention strategies, such as safer drug use practices, linkages to care, treatment and recovery services. (DOH)
- Talk to patients about the effectiveness and benefits of direct acting antivirals, the importance of avoiding alcohol, the need to follow a healthy diet, and the potential risks for HCV transmission (i.e. blood donations, needle sharing, etc.) (CDC)
- Primary care and other providers wishing to learn more about managing treatment of patients with hepatitis C can learn from the Project ECHO model of hepatitis delivery.
- Innovative models for patient that take a multidisciplinary approach will likely improve treatment access and linkage to care, including patient navigation programs, non-specialist care, and telehealth. (Zuckerman et al, 2018)

Clinical Provider Navigation Model

- Patients who screen positive for HCV should be offered patient navigation services (linkage to care services) from a clinical staff member (nurse, social worker, etc) to connect patients to treatment and help address potential barriers.
    - Embedding patient navigators into the care cascade increases the rate of linkage to care despite the prevalence of barriers (Hunt et al, Sherbuck et al, Starbird et al)
- Embedded patient navigators should provide enabling resources to HCV-positive patients to facilitate the connection to treatment. Enabling resources include:
    - Facilitating referrals: verifying insurance and need for referral, requesting referral, and confirming referral
    - Strengths-based education: education on HCV symptoms, transmission, and treatment, assessment of strengths and barriers, goals for HCV care engagement
    - Navigation: make appointments with HCV provider, reschedule as needed
    - Reminders: 1-week and 1-day appointment reminders via phone, text, or email

Peer-Support Model

- Patients who screen positive for HCV should be offered peer-support from others with lived experience undergoing HCV treatment.
    - Initial findings suggest that patients enrolled in a peer support intervention are much more likely to complete treatment than patients without a peer support intervention (Hep-C Cures program)
- Peer supporters are those with lived experience with HCV who can advocate for the patient and help increase engagement in treatment.
- HCV+ Peer educators may also expand access to diagnosis and screening services in their communities, helping reach underserved communities such as PWID.

Services Offered Outside of Traditional Clinics Models

- Invest in public/private partnerships to expand HCV treatment access, including the partnership between the Washington State Health Care Authority, Washington State Department of Health, and drug manufacturer AbbVie which includes an HCV elimination bus tour.
- Substance use disorder/opioid use disorder treatment programs and needle/syringe exchange programs should offer routine, opt-out HCV-antibody testing with reflexive or immediate confirmatory HCV-RNA testing and linkage to care for those who are infected (AASLD)
- Public health clinics, especially those providing services to patients accessing sexually transmitted infection (STI) care, serve populations at high risk of HCV. Public health clinics should offer screening and specialist linkage to care for HCV. (Falade-Nwulia et al)

- People who inject drugs (PWID) should be offered linkage to harm reduction services in addition to HCV treatment services. Active or recent drug use is **not** a contraindication to HCV treatment (AASLD)

Barriers to Care Coordination:

- Finding sustainable funding
  - Coding and reimbursement for case management in a clinical setting
  - Funding for care coordination programs in the community – human resources, supplies (testing kits, physical space), and IT needs
  - Training and supporting staff in charge of case management
- Improving services for clients
  - Improve access to low-barrier and non-stigmatizing providers
  - Increase availability of other social services (like housing or transportation),
  - Improve coverage for screening and medication (especially if medication is lost or stolen)
- Developing trust with patients/community members
- Providing low-barrier case management in community settings (like OUD treatment centers or syringe service programs)

Recommendations:

Providers:

- Attend trainings for providing buprenorphine and treating HCV
- Be open to referrals for HCV patients, either in person or through telehealth
- Treat patients with a person-centered approach/non-stigmatizing
- Develop collaborative agreements with pharmacists and HCV care coordinators.
- Review medical case management for HCV toolkit and consider providing case management services to patients.

Case Managers:

- Provide financial incentives for HIV testing and follow-up
- Work with HCV patients to find a provider, schedule appointments, and address patient's barriers to treatment, including connecting to housing and transportation need as able.
- Enroll patients in Medicaid/Apple health if needed. Work with insurers in cases where client's medication is lost or stolen
- Develop collaborative agreements with community organizations including needle exchange programs, buprenorphine clinics, and subaxone clinics to offer on-site testing for HCV.

- Consider offering on-site treatment through collaborations with pharmacists, providers, or hiring providers who can directly bill patient's insurance

Public Health

- Consider providing sustainable funding for HCV care coordination activities. Sustainable funding may come from CDC, Medicaid, certified agencies that provide case management for HIV/AIDS (title 19), or funds from the recent opioid settlement.
- Reduce barriers to funding for case management/care coordination activities, including allowing funding for transportation services
- Ensure funding for community-level work, case management training, and case management activities
- Increase access to case managers in the community, including at syringe service programs, OUD/SUD treatment centers, and expanding into eastern Washington. Consider partnering with community organizations like the Hep Education Project to provide these services.
- The Hep Education Project provides a backbone for connecting with the community and providing technical assistance for medical case management

<u>Additional Recommendations:</u>

- Consider including Hepatitis B screening and treatment with Hepatitis C programs.