Improving the HCV Care Cascade: Year 1 Results from a Dynamic, Integrated Linkage to Care Navigation Model

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BACKGROUND

• The hepatitis C virus (HCV) navigation, testing, and treatment paradigm is rapidly shifting with the emergence of dramatically improved treatment options.

• Identifying gaps along the HCV care cascade will improve identification and linkage to care, and reduce health disparities and HCV-induced morbidity and mortality. Persons who have fallen out of care may be more difficult to engage back into care.

• The HepC Linkage to Care Navigation Program at MedStar Washington Hospital Center (MWHC) is focused exclusively on identifying, linking to care, treating and managing patients with HCV.

• The objectives of this program are to:
- Identify HCV infected patients who are aware of their disease, but who have fallen out of care for greater than a year, and reengage them back into HCV care
- Develop a dynamic, multidisciplinary HCV care model, and establish best practices

METHODS

• In January 2014, the HepC Linkage to Care Navigation Program at MWHC was established, with funding from Gilead FOCUS.

• SAP®Crystal Report Software was used to search Centricity Electronic Health Records (EHR) for an initial list of HCV Ab infected persons previously engaged by ID or GI at MWHC but who had been out of care for greater than one year.

• Once identified, patients were contacted (via phone and letter) and re-engaged into ID care. Additional linkages were obtained via internal (MWHC) and external (e.g., community health clinics, shelters, long-term care facilities) and referrals.

• An integrated, involved physician-led team that included a social worker and a patient navigator was utilized from intake through the end of treatment to continually identify barriers to successful HCV management.

• Program goals were as follows: 95% of patients identified are linked with an appointment, 85% retained for 60 days, 80% at 90 days and 75% at 180 days after their first appointment . A descriptive analysis is presented.

RESULTS

• At the conclusion of year one:
- 250 eligible patients were identified, 192 (77%) were linked to care (i.e., appointment was scheduled with ID), 173 (90%) were seen at a first appointment; and 167 (97%) of those seen were HCV RNA+
- Mean age was 58.4 ± 8.7 years; 93% were black/African American, 57% were men.
- Of those seen at appointment:
  - 79% had public insurance (64% Medicaid, 36% Medicare)
  - 58% reported prior IVDU
- Regarding project goals to date:
  - 160 patients (96%) were retained in care through 60d, 147 (88%) through 90d, and 107 (64%) through 180d
- Prior to the first appointment, a social worker performed intake assessments and attempted to address major barriers, resulting in targeted interventions. These barriers were reassessed throughout time in care.

CONCLUSION

• Improving the HCV Care Cascade is necessary to identifying and engaging infected populations. This program successfully navigated, retained, and staged HCV persons previously out of care, of which 26% are possibly cirrhotic and in need of care.

• Gaps still appear in initial engagement, as well as prescriptions written and treatment initiation. Treatment delays were primarily due to insurance complications.

• Providers and systems must initiate linkage, especially for those lost secondary to prior interferon-based treatment failure which had toxic side effects, or treatment ineligibility.

• Program success was due to proactive Primary Care and Specialty providers, a determined social worker and a patient navigator, full accessibility to the team, and continuous attention to continuity of care through identifying and overcoming barriers.

• By utilizing a dynamic approach to care coordination, drop-offs can be mitigated, care integrated and treatment initiated. The ultimate goal is a flattening of the cascade after first visit.

Figure 1: HCV Care Cascade

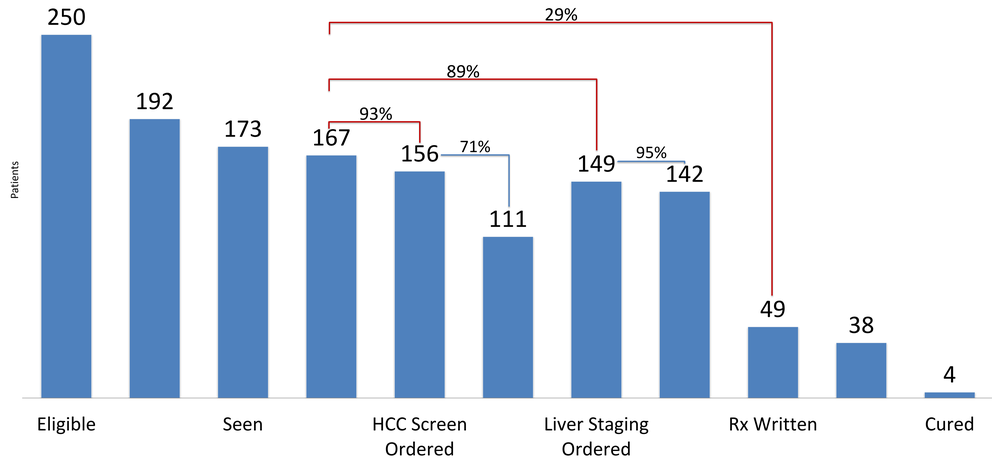

Figure 2: Linkage Origin

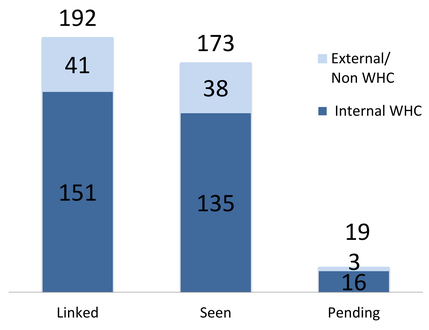

Figure 3: Fibrosis Scores at Initial Visit

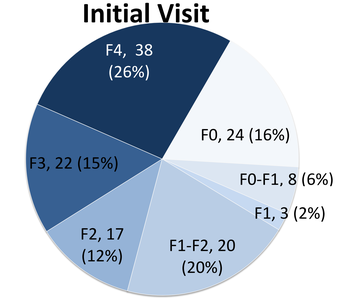

Table 1: Common Barriers to Care and HepC Team Resolutions

Physiological Need
Barrier: Patient homeless, unable to afford current living situation.
Resolution: Provided resources to housing services; made referrals and confirmed admission into transitional housing. Patient now in long-term housing.

Transportation
Barrier: Patients without reliable transportation to make appointments.
Resolution: Transportation services arranged for wheelchair-bound patients via MTM (non-emergent medical transportation provider). Assisted patients without mobility issues to obtain SmartTrip card for D.C. Metropolitan Transportation Services.

Other Barriers Encountered
- Lack of Access to Food
- Legal complications
- Inadequate health insurance
- coverage/no coverage
- Lack of education/hepatitis C awareness
- Lack of treatment options available for patients w/other chronic conditions
- Missed appointments
- Mental health issues
- Adjustment disorders/grief/loss

Belonging
Barrier: Patient without any support system, felt hopeless.
Resolution: Introduced patient to HepC team, encouraged to attend new HepC support group, implemented regular phone check-ins. Patient now vocal member of HepC support group.

Safety/Compliance
Barrier: Patient ineligible for treatment and liver transplantation due to historical alcohol abuse.
Resolution: Patient referred to APRA to complete intake for inpatient alcohol residential program. With regular patient contact, empathy, support, and encouragement, patient's insight improved resulting in self-sought alcohol abstinence. Patient now being evaluated and having HCC treated by TACE.