



SYNC  
2019

# OUTREACH AND CLINICAL MODELS DESIGNED TO IDENTIFY AND ADDRESS BARRIERS TO HEPATITIS C TREATMENT

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# CONFLICT OF INTEREST DISCLOSURE SAM FORSYTHE, BA

- No disclosures





# POPULATIONS MOST AT RISK AND THE BARRIERS WE'VE IDENTIFIED

- PWUD
- Baby Boomers
- LGBTQ identified clients
- Co-infected population
- Reentry population



# BARRIERS

## Availability of Resources

- Lack of health centers in the west and south sides of Chicago\*
- Lack of LGBTQ competent care\*
- Most providers refer out and there are lengthy wait times for HCV programs (~2 months); issue of who is allowed to treat due to state regulations

## Information and Education

- Many populations most at risk are neglected in health education opportunities (south/west sides, reentry population, etc.)
- Many who are at risk are unaware of what HCV does, why it's important to treat, and other ways it can be transmitted beyond needles.



# BARRIERS

## STIGMA

- Fear of friends and family finding out status, prohibiting conversations around transmission and entry into healthcare settings
- Judgement experienced by patients in health care settings for identity or substance use
- Beyond judgement: many providers block treatment based on substance use



## SO HOW DO WE ADDRESS THIS

What can we do to mitigate these barriers and increase access to available and compassionate care?



# SO HOW DO WE ADDRESS THIS

- Harm reduction
- Outreach
- Multidisciplinary care team model



# HARM REDUCTION

- First and foremost we move towards treatment no matter what.
- Baseline team needs: Can you take this pill at the same time daily
- Accommodating instability by attempting to preserve as much flexibility as we can.
  - Due to unstable housing, substance use, unemployment, mental health, interpersonal violence, etc. people come in and out of care.
  - Patient directed: Each care plan and timeline is individualized (ex. Patient G)
  - Creating a safety net for those who are lost to care: we follow up for a year then speak with care teams and put in chart alerts to ensure follow up when patients reengage.





# HARM REDUCTION

## The pros and cons of accommodating instability with flexibility?

### Benefits:

- We successfully treat patients within a high-risk population
- All-inclusive treatment
- Decreasing community viral load





# HARM REDUCTION

## Programmatic Stats: 2018\*

147 referrals; 5 self-cleared, 6 were negative on confirmatory

86 people began treatment

80 people were cured

23 people were in treatment at the end of the year

\*Medicaid restrictions still effective until 2019





# OUTREACH

- Meeting with participants in their own communities, agencies, and trusted spaces.
- Consulting with community or facility leadership to ask what kinds of services and education they'd like.
- Ask participants what they want out of it
- Offering people the opportunity to learn and engage where they feel comfortable while also offering one-on-one assistance
- Stressing that patients can come to us only for HCV treatment





# OUTREACH

- Including a VARIETY of spaces for outreach
  - Spanish speaking spaces, and non-English speakers in general
  - Safe spaces for those who don't have documentation(Ex. Cermak)
  - Residential programs for aging populations
  - Reentry populations
  - Substance use services and sobriety programs (Ex. Haymarket)
  - Training internal departments and team members
  - Emphasizing co-infected populations within clinics and in outreach, in all services that cater to PLWHIV





# CARE MODEL: MULTIDISCIPLINARY CARE TEAM

Team:

Thomas Ambelang- HCV Linkage to Care Coordinator, full time

Alaa Wasfi- Registered Nurse, part time

Sarah Kwasigroch- Pharmacist, part time Walgreens partner

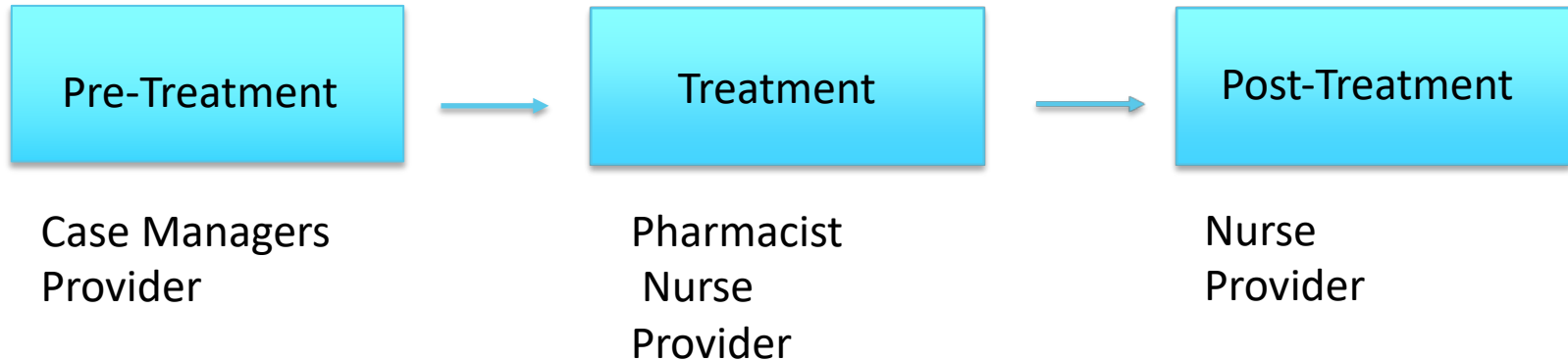
Sam Forsythe- HCV Case Manager, full time

Communication within team; Triage Meetings





# CARE MODEL: MULTIDISCIPLINARY CARE TEAM



This model allows us the capacity to address barriers: completing insurance enrollment, arranging transportation, calling in orders with patients, check-in's during treatment, internal administrative tasks.



# CARE MODEL: MULTIDISCIPLINARY CARE TEAM

- Team model prevents need for referring out
- We can intervene to manage the clinical demands that might prevent treatment (ex. Substance use, comorbidities)
- Building relationships for the purpose of engagement (ex. Patient L)
- Ensure that the language and messaging clients receive from referral to post-treatment care aligns with the harm reduction priorities of the team



# CARE MODEL: MULTIDISCIPLINARY CARE TEAM

- Providing consistent support: In our first conversation we are providing direct numbers for patients to call with every question and concern
  - Readily available, with back-up contacts
  - Complete face to face initiation visit upon starting meds
  - Pharmacy and Medical support offered at start of treatment
  - Consistency of care





# QUESTIONS ?

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