Patient Engagement Learning Series

How Do We Provide HCV Care for Individuals Experiencing Homelessness?

Tuesday, January 19, 2021 at 2:00 pm ET

NATIONAL NURSE-LED CARE CONSORTIUM

a PHMC affiliate

Disclaimer

Through the Patient Engagement Learning Series, we intend to create a space where providers, community advocates, and patient representatives can engage thoughtfully on challenging topics surrounding patient care. We commit to providing evidence-based data and research to support all content presented.

We believe that addressing this topic aligns with the aims of the Learning Series and is therefore integral to our discussion. We welcome your feedback to continue guiding our content development.

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National Nurse-Led Care Consortium

The **National Nurse-Led Care Consortium (NNCC)** is a membership organization that supports nurse-led care and nurses at the front lines of care.

NNCC provides expertise to support comprehensive, community-based primary care and public health nursing.

- Policy research and advocacy
- Program development and management
- Technical assistance and support
- Direct, nurse-led healthcare services

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Speakers

Marguerite Beiser, ANP-BC, AAHIVS
Director of HCV Services
Boston Health Care for the Homeless Program

Shukriyyah Mitchell-Hinton, BSN, RN
Nurse Supervisor
National Nurse-Led Care Consortium

Shawana Mitchell, HHS
Community Health Navigator
National Nurse-Led Care Consortium

Objectives

- Explore unique challenges to HCV treatment implementation for individuals experiencing homelessness.

- Provide practical solutions for successful engagement in HCV care for this population.

Panel Discussion

Marguerite Beiser, ANP-BC, AAHIVS
Director of HCV Services
Boston Health Care for the Homeless Program

Shukriyyah Mitchell-Hinton, BSN, RN
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Pop Up Question

What are some challenges around maintaining patient engagement in HCV care?

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How do we provide HCV care for individuals experiencing homelessness?

Marguerite Beiser, ANP-BC, AAHIVS

1/19/21

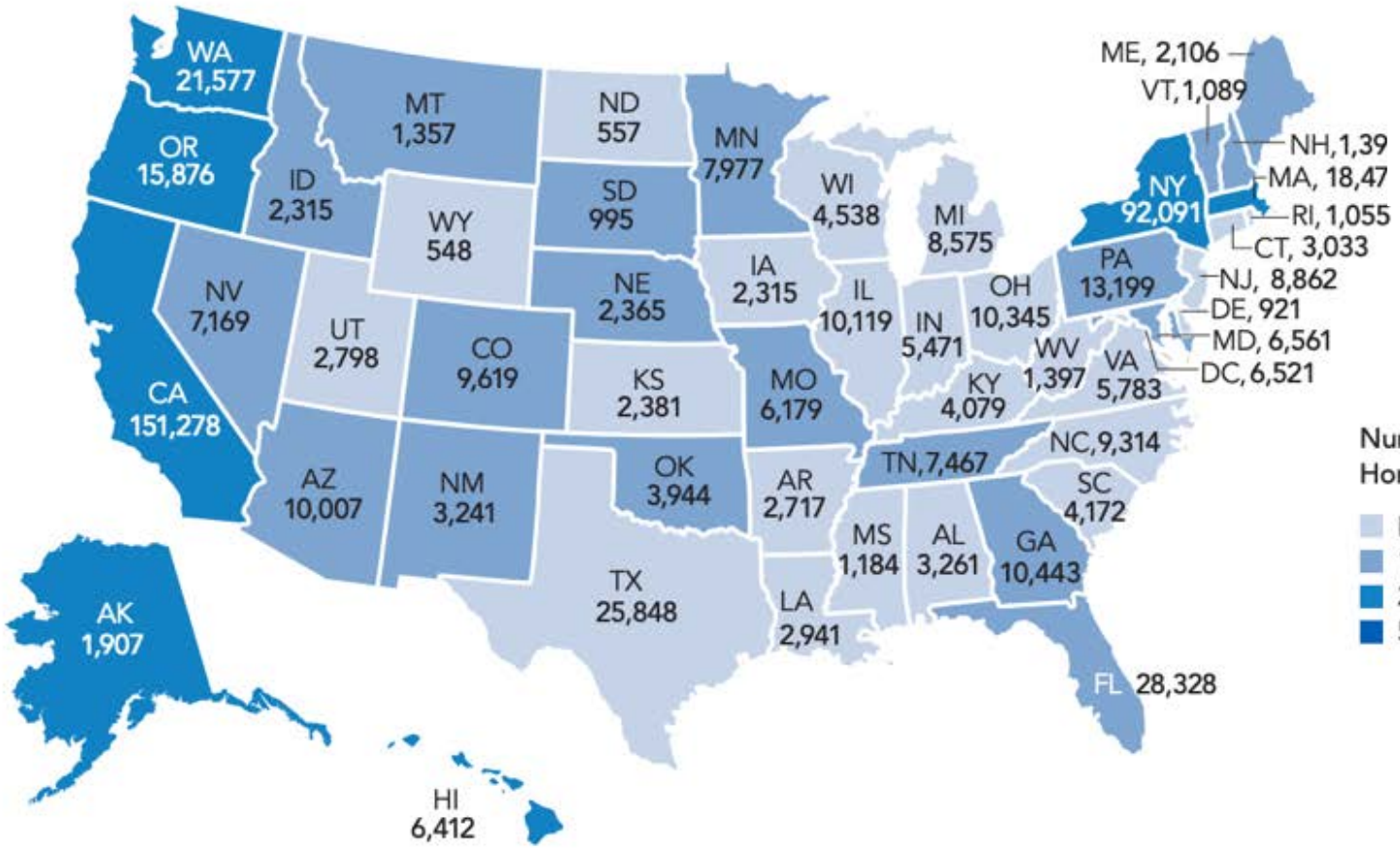
BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

- I have no disclosures
- Citations included on slides
- Thank you to my patients and colleagues at Boston Health Care for the Homeless Program!

Outline

- Homelessness in America
  - Scale of homelessness
    - National
    - Local
  - Health implications of homelessness
- Boston Health Care for the Homeless Program (BHCHP)
  - Program approach to delivering care
  - HCV treatment integration with existing services
    - Cases
- Pearls, principles and persistent challenges

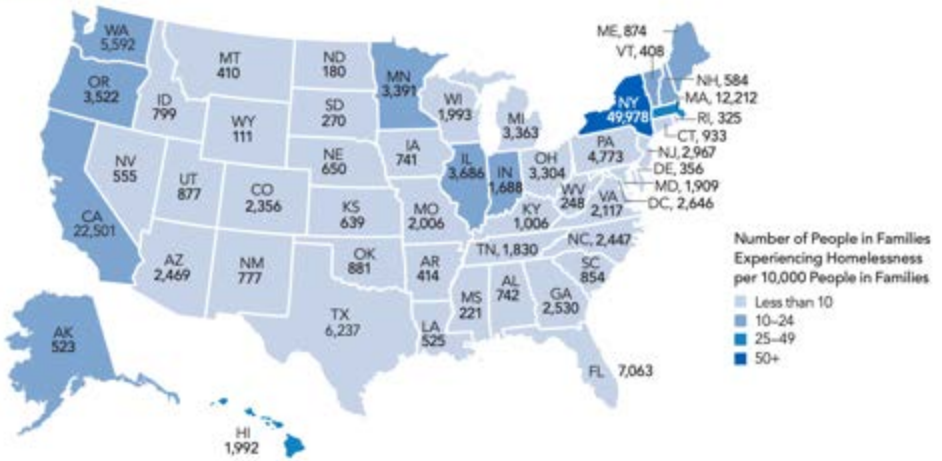
EXHIBIT 1.6: Estimates of People Experiencing Homelessness
By State, 2019



Number of People Experiencing Homelessness per 10,000 People

- Less than 10
- 10–24
- 25–49
- 50+

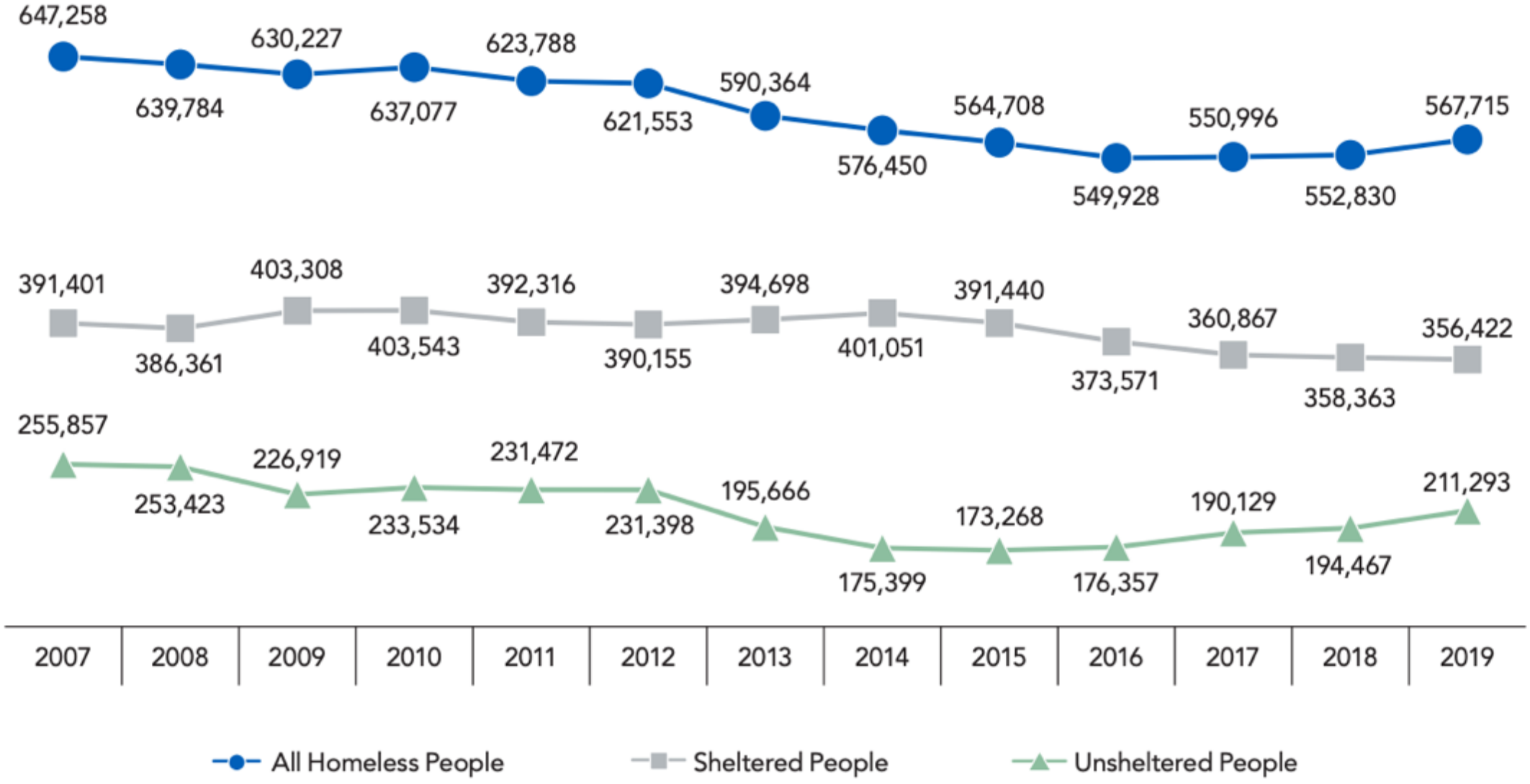
EXHIBIT 3.5: Estimates of Family Homelessness
By State, 2019



https://www.huduser.gov/portal/sites/default/files/pdf/2019-AHAR-Part-1.pdf

EXHIBIT 1.1: PIT Estimates of People Experiencing Homelessness

By Sheltered Status, 2007–2019



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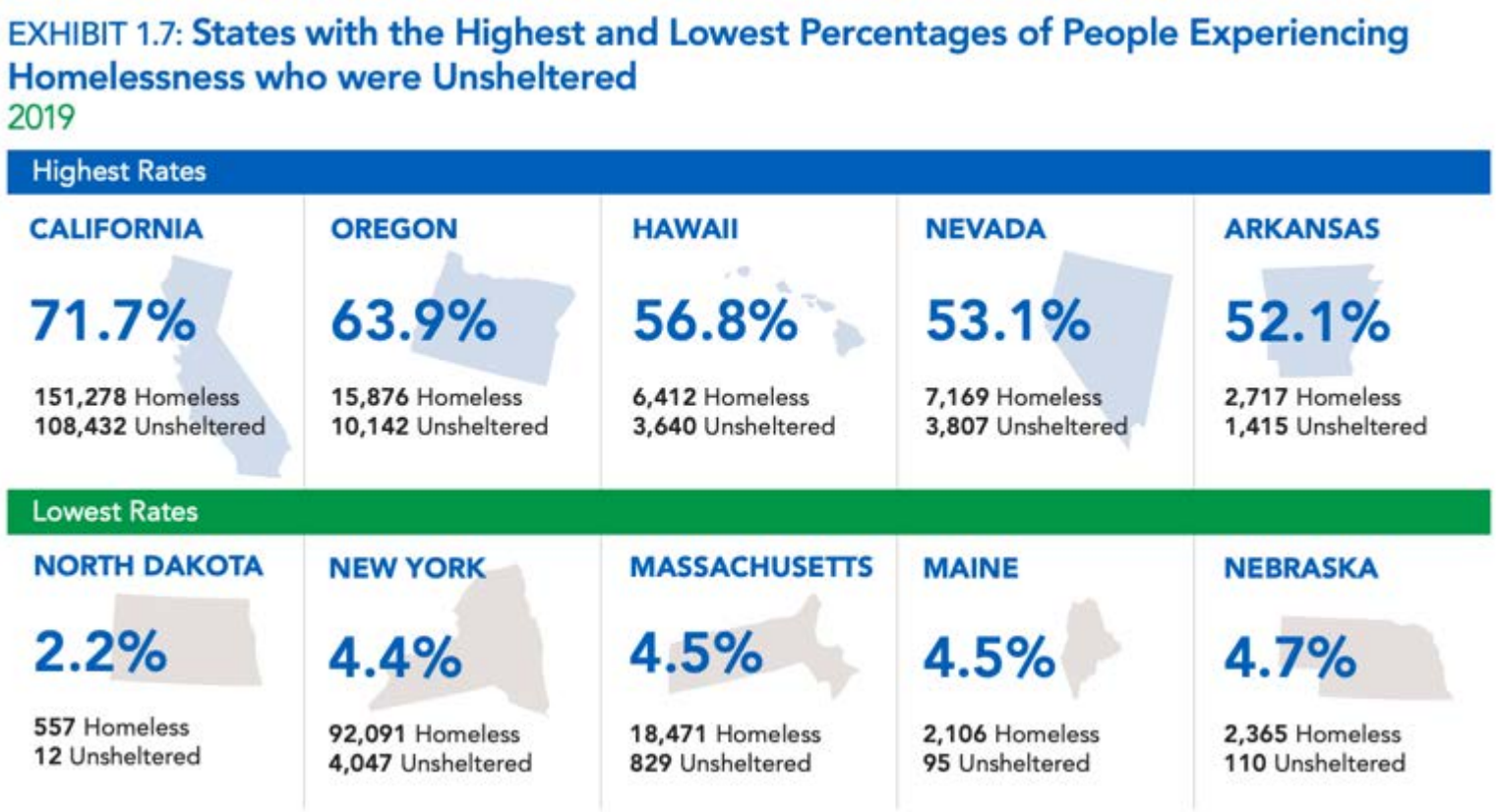
Homelessness is a heterogenous and fluid experience



- Sheltered
  - Emergency shelter
  - Family shelter
  - Hotel/motel
  - Residential treatment programs
  - Doubled up
- Unsheltered
  - Street
  - Vehicle
  - Encampment
  - Rural or urban
  - Abandoned building

https://www.huduser.gov/portal/sites/default/files/pdf/2019-AHAR-Part-1.pdf

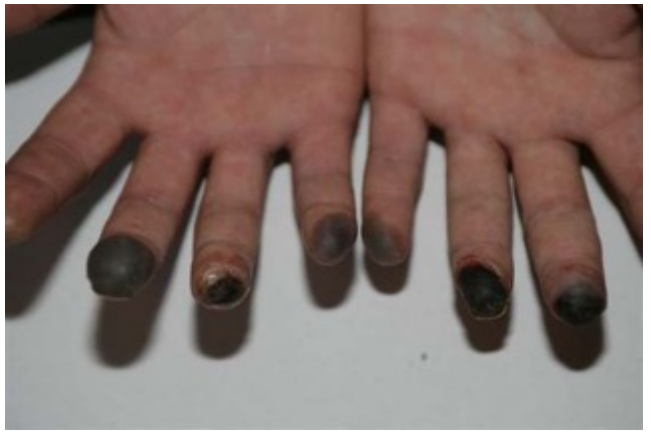
Boston homeless incidence, 2020

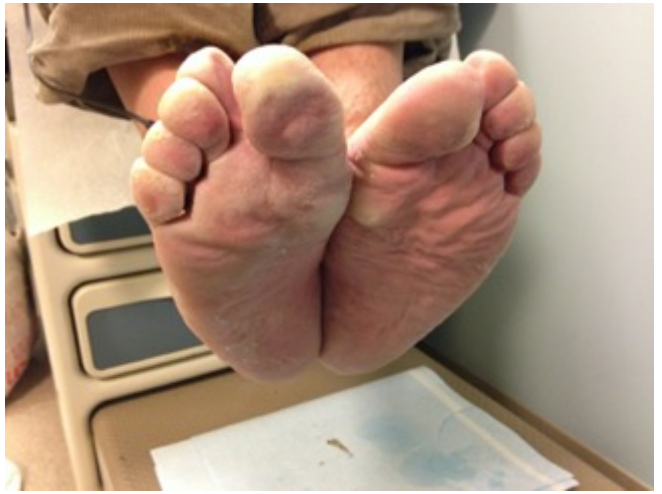
- **6,192** total homeless individuals and families
  - 2,115 individuals
    - 135 people on the streets*
  - 1,294 homeless families
    - 4,021 family members

City of Boston 40th Annual Homeless Census https://www.boston.gov/sites/default/files/file/2020/11/2020%20Census%20Memo.pdf

Health implications of homelessness

- Conditions encountered as a consequence of being homeless.
  - Infections
    - TB, respiratory infections, cellulitis
    - Violence and Injury
  - Exposure-related
    - Frostbite/heat stroke
    - Immersion foot
  - Arthropod infestations
- Conditions exacerbated by the homeless condition
  - Metabolic diseases
    - HTN
    - DM
  - Cancer
  - Behavioral Health Disorders
  - Addiction
- These can be overlapping, e.g. Diabetic foot ulcer





Stark disparities in HCV and HIV prevalence between housed and homeless

HCV	
Population studied	**Prevalence**
Household phone survey[1]	1%
Homeless at 7 HCH sites[2]	31%
Homeless @BHCHP[3]	23%

HIV	
Population studied	**Prevalence**
National estimate[4]	0.3%
Homeless meta-analysis world-wide[5]	0.3%-21%
Homeless in the US estimate[6]	3.4%
Homeless @BHCHP[7]	2.7%

1. Hofmeister MG, Rosenthal EM, Barker LK, et al. Estimating Prevalence of Hepatitis C Virus Infection in the United States, 2013-2016. *Hepatology.* 2019;69(3):1020-1031.
2. Strehlow AJ, Robertson MJ, Zerger S, et al. Hepatitis C among clients of health care for the homeless primary care clinics. *J Health Care Poor Underserved.* 2012;23(2):811-833.
3. Bharel M, Lin WC, Zhang J, O'Connell E, Taube R, Clark RE. Health care utilization patterns of homeless individuals in Boston: preparing for Medicaid expansion under the Affordable Care Act. *Am J Public Health.* 2013;103 Suppl 2:S311-317.
4. Burnett JC, Broz D, Spiller MW, Wejnert C, Paz-Bailey G. HIV Infection and HIV-Associated Behaviors Among Persons Who Inject Drugs - 20 Cities, United States, 2015. *MMWR Morb Mortal Wkly Rep.* 2018;67(1):23-28.
5. Beijer U, Wolf A, Fazel S. Prevalence of tuberculosis, hepatitis C virus, and HIV in homeless people: a systematic review and meta-analysis. *Lancet Infect Dis.* 2012;12(11):859-870.
6. HIV/AIDS and Homelessness. 2009.
7. Internal data

Boston Health Care for the Homeless Program

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

PROGRAM STATS

10,600+ unique patients in 2017

130,000 visits in 2017

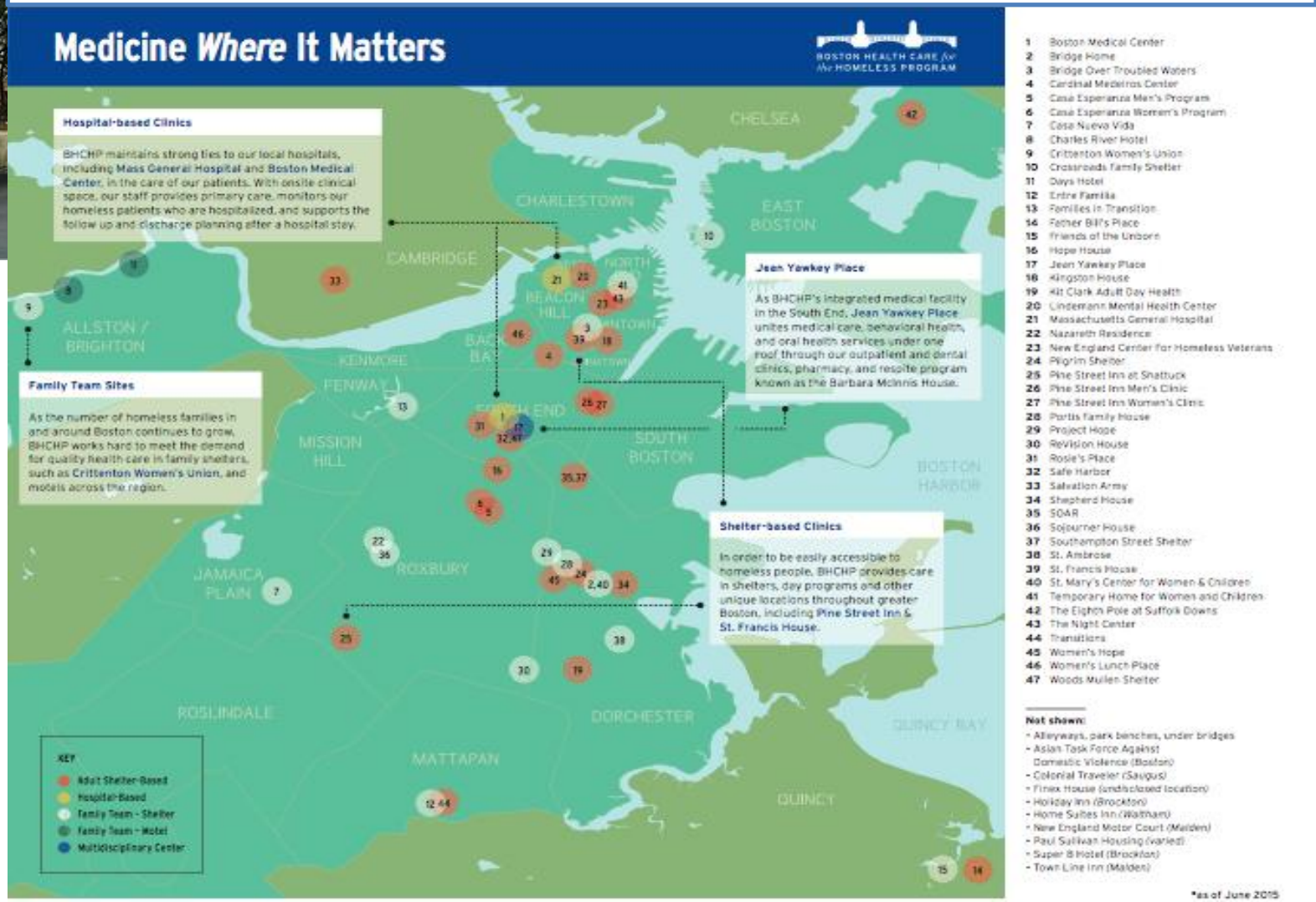
380+ employees

$55M budget, FY18

33 years in operation

40+ clinical sites

60% patients with SUD



1 Boston Medical Center
2 Bridge Home
3 Bridge Over Troubled Waters
4 Cardinal Medeiros Center
5 Casa Esperanza Men's Program
6 Casa Esperanza Women's Program
7 Casa Nuevo Vida
8 Charles River Hotel
9 Crittenton Women's Union
10 Crossroads Family Shelter
11 Days Hotel
12 Entre Familia
13 Families in Transition
14 Father Bill's Place
15 Friends of the Unborn
16 Hope House
17 Jean Yawkey Place
18 Kingston House
19 Kit Clark Adult Day Health
20 Lindemann Mental Health Center
21 Massachusetts General Hospital
22 Nazareth Residence
23 New England Center for Homeless Veterans
24 Pilgrim Shelter
25 Pine Street Inn at Shattuck
26 Pine Street Inn Men's Clinic
27 Pine Street Inn Women's Clinic
28 Portis Family House
29 Project Hope
30 ReVision House
31 Rosie's Place
32 Safe Harbor
33 Salvation Army
34 Shepherd House
35 SOAR
36 Sojourner House
37 Southampton Street Shelter
38 St. Ambrose
39 St. Francis House
40 St. Mary's Center for Women & Children
41 Temporary Home for Women and Children
42 The Eighth Pole at Suffolk Downs
43 The Night Center
44 Transitions
45 Women's Hope
46 Women's Lunch Place
47 Woods Mullen Shelter

Not shown:
- Alleyways, park benches, under bridges
- Asian Task Force Against Domestic Violence (Boston)
- Colonial Traveler (Saugus)
- Finex House (undisclosed location)
- Holiday Inn (Brockton)
- Home Suites Inn (Waltham)
- New England Motor Court (Malden)
- Paul Sullivan Housing (varied)
- Super 8 Hotel (Brockton)
- Town Line Inn (Malden)

*as of June 2015

Our Services

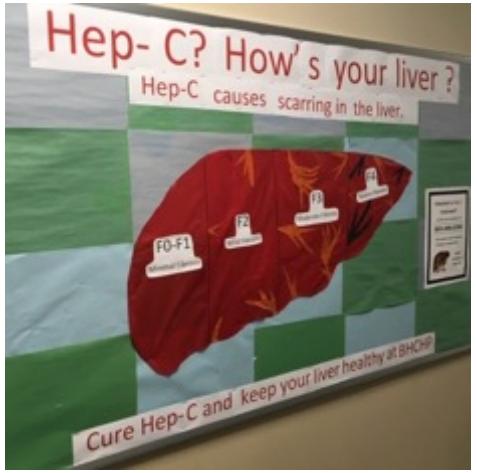
- Providing comprehensive, integrated health care services for Boston's most vulnerable individuals and families. Our services include:
  - Primary and episodic medical care
    - Main outpatient clinic, shelter-based, outreach-based
  - Dental care
  - Behavioral health services- psychiatry and counseling
  - Medical respite care- Barbara McInnis House
  - Family Team
  - Street/mobile van outreach
  - Transgender clinic
  - Office-based buprenorphine program for OUD
  - Pharmacy
  - Ryan White HIV Program- primary care, HIV, HCV and STI counseling/testing
  - HCV treatment (founded in 2014)

HCV Team

- Founded in 2014
  - Significant growth over past few years
- Comprised completely of BHCHP providers, nurse, and care coordinators
  - BHCHP PCPs who have developed HCV treatment expertise
  - PCPs already embedded in clinic, shelter, street care teams
  - We see our own patients, those referred by our colleagues/nurses/CMs, as well as outside referrals

How do we pay for it?

- Directly billable services to third party payers (Medicaid, Medicare, mostly)
- DPH and internal support for nonbillable services



- How do we provide HCV care for individuals experiencing homelessness?
  - Cases
  - Pearls and Principles

E is 59 yo Hispanic bilingual male with hx of HCV, opioid use disorder, HTN, major depression and PTSD

- Clinical situation:
  - Genotype 1a
  - HCV RNA 8,325,000
  - Tx naïve
  - Minimal fibrosis by FIB-4
  - HBSAg-, anti-HBc+, anti-HBs+
  - HIV neg
  - Medications: sertraline, prazosin, chlorthalidone, amlodipine
- Social situation:
  - Homeless, sleeping in a friend's unheated/unfinished garage
  - Working phone
  - All recent appointments kept
  - Last use of opioids a few months ago, on buprenorphine at outside facility.

Case, continued: Treatment

- E would prefer the shortest treatment duration
- Glecaprevir/Pibrentasvir x 8 weeks started 7/1/19
  - PA completed by care coordinator who arranges for med delivery to clinic
  - Pt meets with HCV RN to initiate medication and opts to keep meds in clinic with weekly visits
  - Adherence support provided by HCV RN at in-person visits
  - Week 4 HCV VL <15 not detected
  - **Pt becomes lost to follow-up in week 5**
    - Phone no longer in service
    - No address to do home visit or send letter
    - Not seen in clinic or in the area during outreach attempts

Case, continued: Returning to care

- E returns to care in December 2019
  - Relates relapse during treatment with departure from MAT clinic
  - Lost his phone
  - Didn’t come to clinic due to feeling ashamed and shift in priorities
- Labs show:
  - HCV VL 900,000
  - G1a
  - No NS5a resistance
  - Determined to have experienced **treatment failure**
  - **He didn’t feel ready to pursue retreatment at that time**

Case, continued: COVID surge

- COVID halted all HCV team activities except for pts currently on medications March-June
  - HCV team redeployed to COVID response
  - All care coordination moved to remote/phone-based
- In July-August 2020 we sought out those pts who we had been working up for treatment prior to COVID to see if they were ready to resume care

Case, continued: Retreatment

- In August E was eager to be retreated for HCV
  - Same unstable living situation
  - Focused on navigating Social Security income issues
  - Using opioids (intranasal) intermittently, not on MAT
    - Overdosed 2 weeks prior to our visit
  - Adherent to other medications and BH appointments
  - Working phone
  - Closely connected to bilingual clinic case manager, seeing her qweek
- What could we do to help support E's treatment success?

Case, continued: Retreatment

- Retreatment planning
  - Addressing current stressors:
    - Buprenorphine/naloxone initiated
      - Bridging bupe **by HCV treater** weekly while connecting to OBAT team
    - Collaborate with CM, PCP and BH provider who are regularly working with pt
      - Assist in Social Security documentation needs
    - Provide language-appropriate services

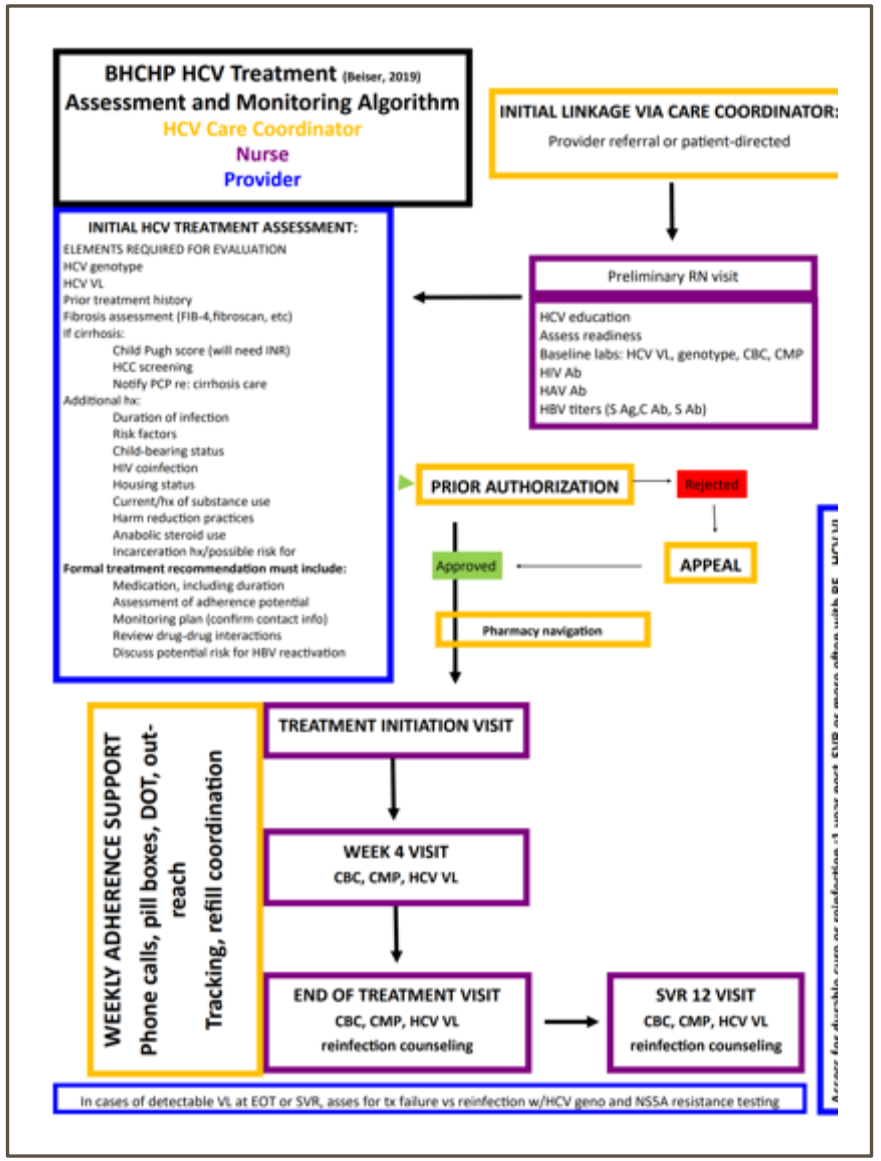
- 2 weeks of kept OBAT appts → submit PA for SOF/VEL/VOX x 12 weeks
  - Weekly pillboxes, timed with OBAT visits
  - Has kept all appointments, 4 doses missed along the way
  - Week 4 HCV VL <15 not detected
  - Has moved to Ohio to live with his sister- still in touch and in his last week of treatment.

D is a 50 yo female with hx of HIV, HCV, cirrhosis, and opioid use disorder

- I am her PCP and HCV treater- integrated HCV treatment into our care plan as soon as feasible after she entered **residential treatment**
- Around week 3 of HCV tx, she left her program and returned to the **street** and active use
  - Adjusted adherence plan from meds at program to meds at clinic with weekly disbursement. Some meds lost, repleted from clinic supply.
  - Coordination with OBAT visits/ability to accommodate walk-in visits
  - Collaborate with coworkers doing street outreach
- Lost to follow-up in week 5
- **Hospitalized** with COVID, pneumonia and osteomyelitis of toe in week 6
  - Brought meds to hospital team
- Pt transferred to **medical respite** at our site to recover from toe amputation, remaining HCV meds provided there
- HCV VL <15 NOT DETECTED

Principles for treatment evaluation

- Streamline
- Codify
- Limit unnecessary additional appointments
- Document in consistent format
- Identify clear pathway and roles through process



Pearls and principles for HCV treatment

- Everyone should be treated. Reduce barriers, don't add them

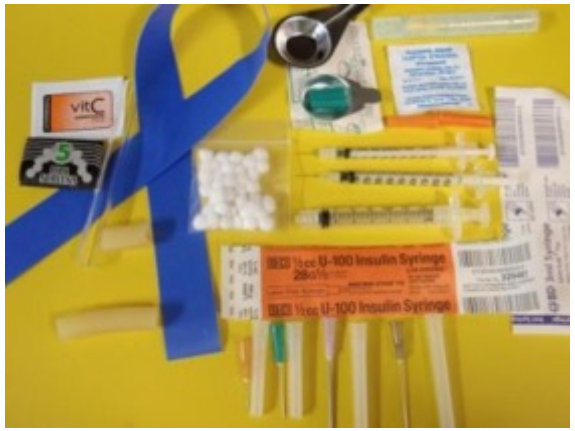
- Recognize that you have power to prioritize HCV care alongside other health issues
  - **There is no perfect situation-** kept appointments as proxy for stability
  - Be prepared/willing to address other simultaneous issues
  - Readiness can be assessed over time, but don't wait too long

- When is the wrong time for treatment?
  - Lack of contact info (and no clear work-around)
  - Lack of interest (referred by someone more invested than the pt)
  - Imminent transitions through SUDs tx continuum

- **Do not assume things are stable on treatment**
  - Weekly adherence checks allow team to respond quickly to destabilizing issues, such as:
    - Loss or theft of medication
    - Loss of insurance
    - Relapse/progression to more chaotic drug use and increased exposure risk
    - Incarceration

Pearls related to treating HCV among people currently using drugs

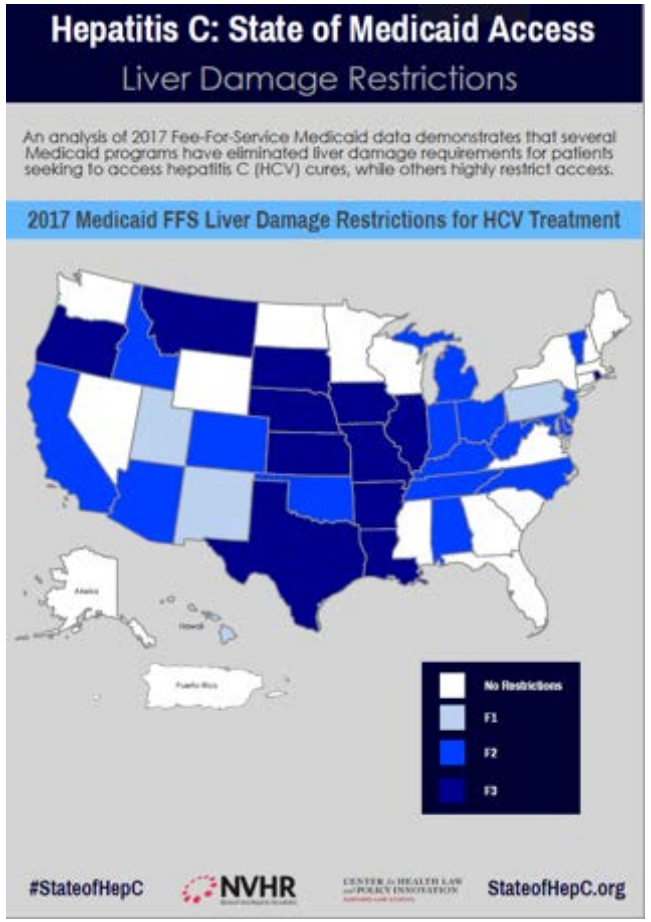
- Obtain as many points of contact as possible
  - Phone numbers, email/MyChart, case workers at programs, contacts at syringe exchange programs (SEPs)- COLLABORATE WITH EXISTING SUPPORTS
- Try to treat couples or other drug-using partners concomitantly
- Try to reinforce that the goal is to continue HCV therapy through any challenges
  - **Destigmatize**
  - Keep communication flexible and responsive to times of crisis
  - Anticipatory guidance to reduce risk of reexposure
  - ***MAT on demand by HCV treater

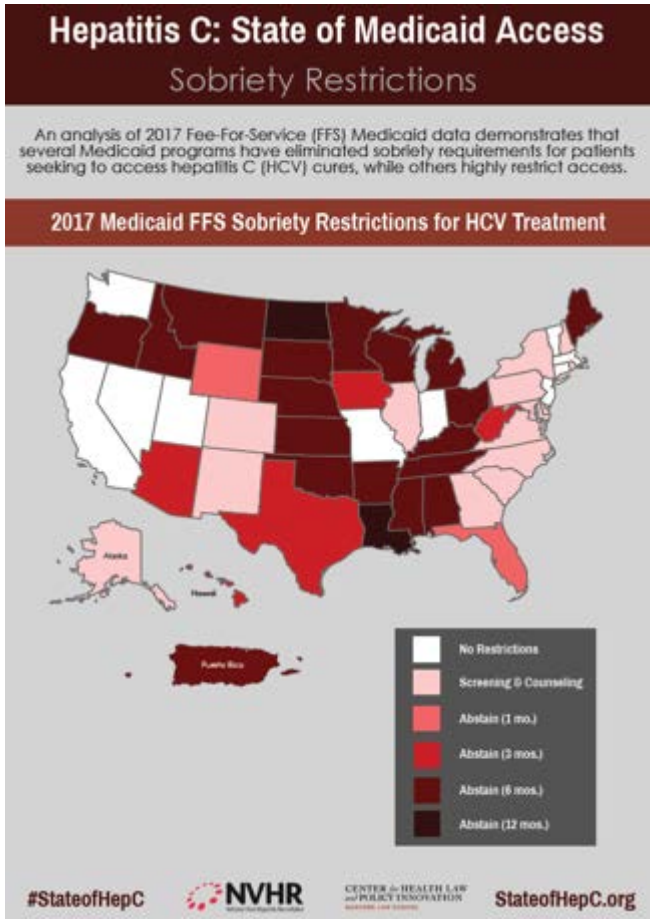


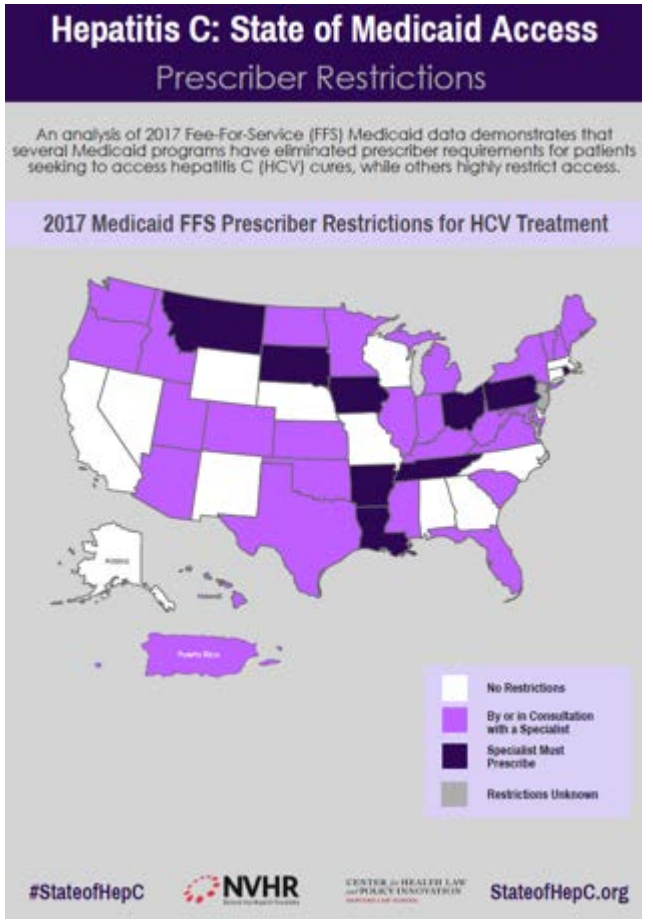
Solutions to Practical Challenges

Challenge	Solution
Readiness	Multiple visits to gauge adherence potential Anticipate RF for tx interruption Collaborate with established care teams who know pt well
Medication loss/theft prevention	DOT, weekly pill boxes, home delivery, emergency insurance override
No phone	Pre-arranged appts My Chart, if applicable Outreach to nearby shelter/program settings at reliable intervals
Lack of transportation	Bus passes, medication delivery, satellite laboratory
Competing priorities	Decrease barriers as much as possible Co-schedule with PCP or OBAT/MMT Limit unnecessary travel **Accept less than perfection**
Specialty pharmacies (copay, home delivery, time)	HCV team care coordinator navigates for pt Insurance authorized rep Mail to clinic

Ongoing barriers to HCV treatment





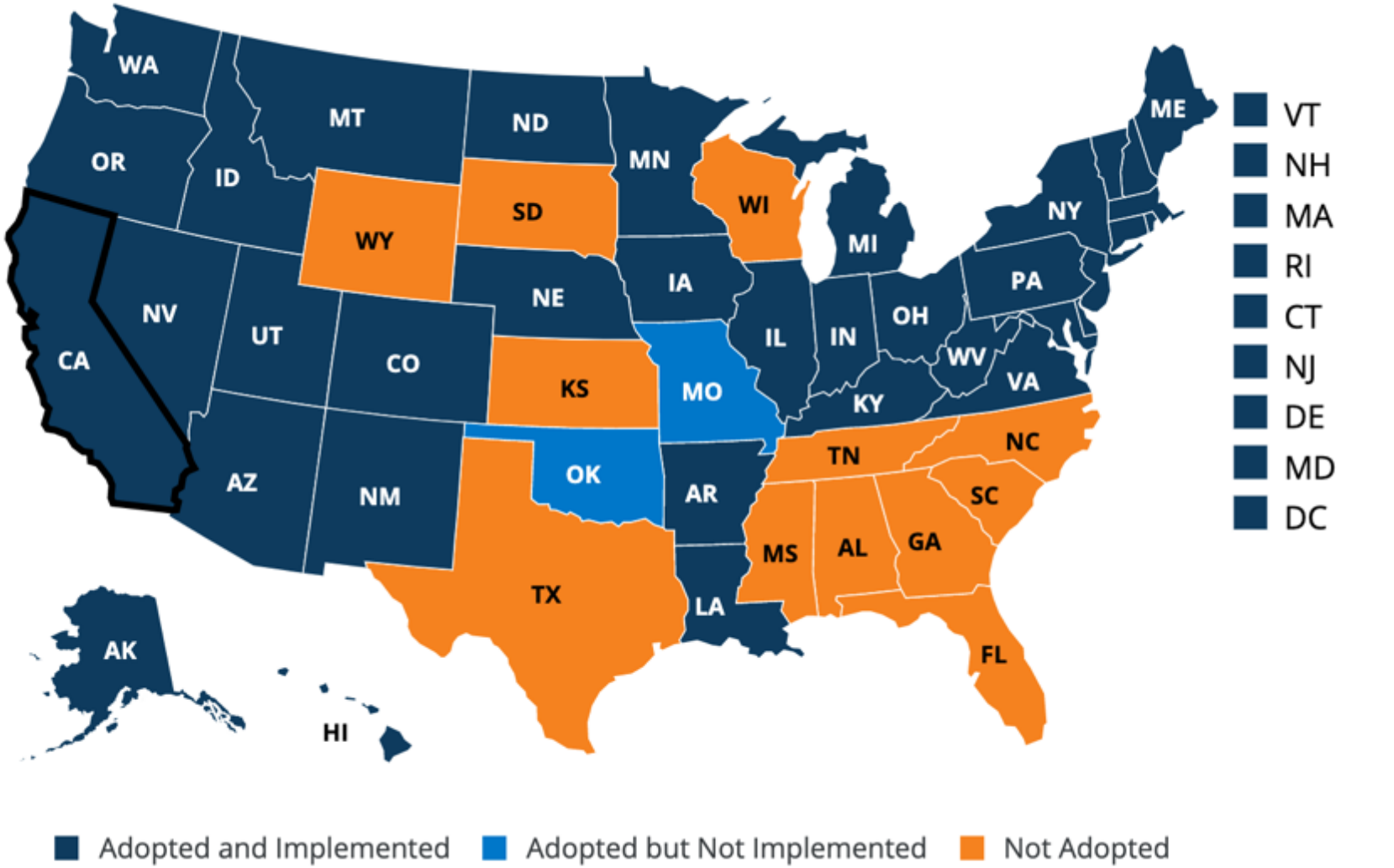


Also… stigma, competing priorities, time/administrative burden, lack of funding, etc

https://stateofhepc.org/resources/

Ongoing barriers to HCV treatment

Medicaid expansion status as of Nov 2020

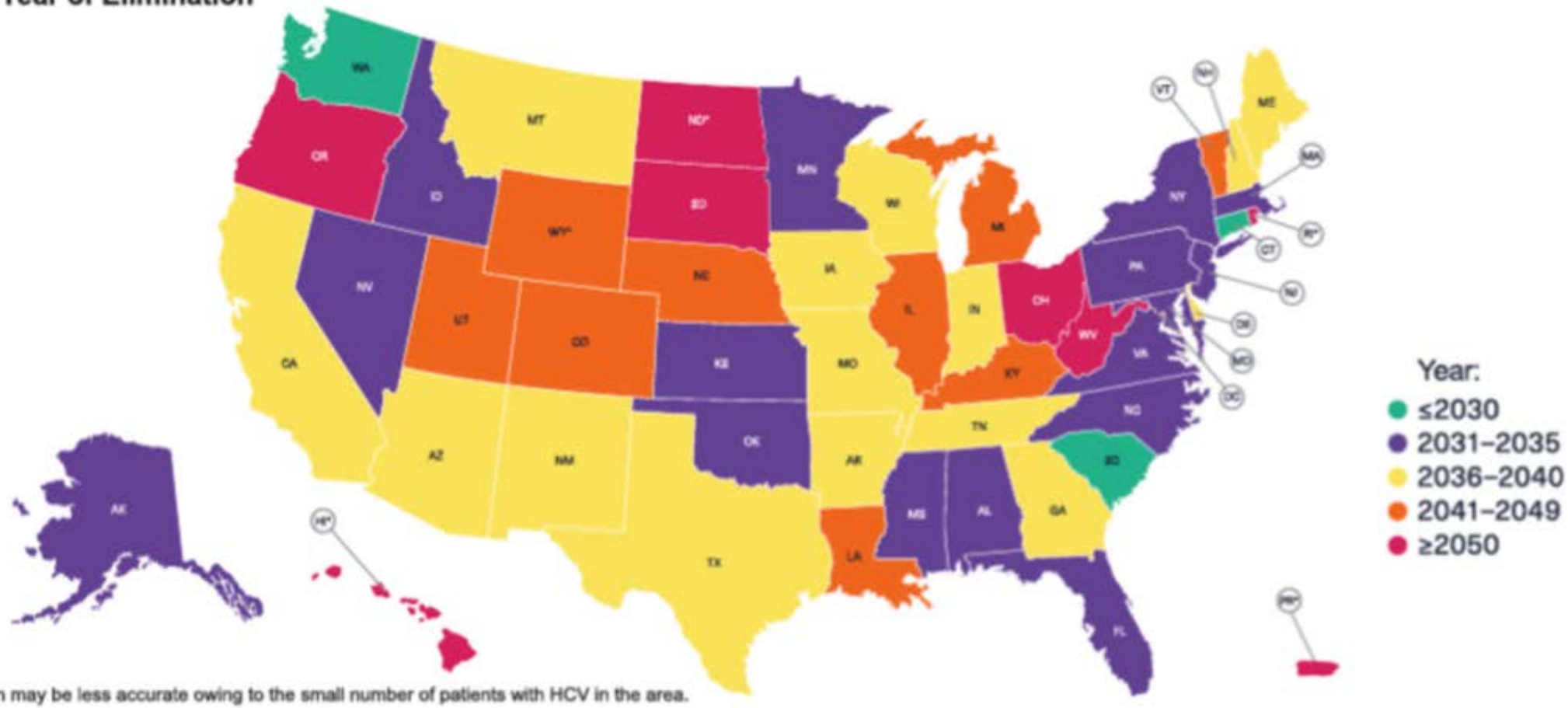


https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

ANNUAL NUMBER NEEDED TO TREAT TO MEET 2030 WHO TREATMENT TARGET

- The estimated annual number of treatments required during 2020–2030 to reach the 2030 treatment target is 173,514 in the US
- The estimated annual number of treatments ranged from 51 to 29,147 across 50 states, with Hawaii having the lowest number needed to treat (51) and California (29,147) having the highest number needed to treat (**Figure 3**)

Figure 1. Year of Elimination



*The estimation may be less accurate owing to the small number of patients with HCV in the area.

Sulkowski et al, Timing of Hepatitis C Elimination in the United States Estimating the year each state will achieve the World Health Organizations targets, EASL 2020

Resources

- NVHR/CHLPI state-based Medicaid coverage guidance https://stateofhepc.org/
- AASLD/IDSA treatment guidelines https://www.hcvguidelines.org/
- University of Washington module training on HCV and liver health https://www.hepatitisc.uw.edu/
- University of Liverpool Hep Interaction https://www.hep-druginteractions.org/
- NATAP journal and conference coverage: natap.org
- Hepatitis B Management: Guidance for the Primary Care Provider: https://www.hepatitisb.uw.edu/page/primary-care-workgroup/guidance

Thank you for your time!

Questions?

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

mbeiser@bhchp.org

Pop Up Question

What are some ways that providers can support patients to continue HCV treatment through any challenges?

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Discussion

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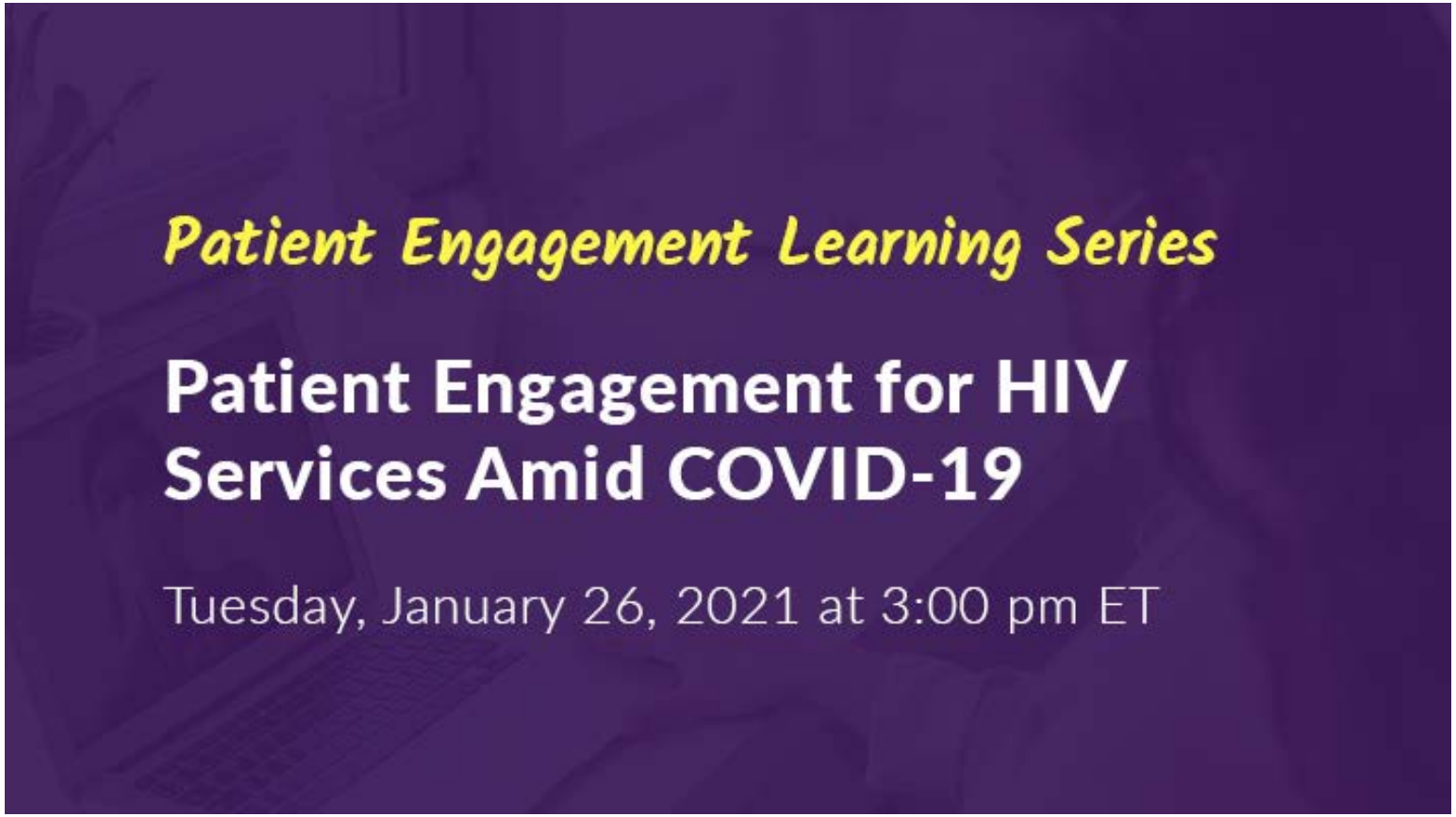
Join us next week!



Speaker: Jason E. Farley, PhD, MPH, ANP-BC, FAAN, Johns Hopkins University School of Nursing

Thank you

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