HOMELESSNESS SERVICE | BOSTON, UNITED STATES

CARE TO CURE

HCV TREATMENT FOR THE HOMELESS

The Boston Health Care for the Homeless Program's hepatitis C (HCV) treatment project provides creative, coordinated support for people experiencing homelessness. It integrates HCV care alongside other services for clients, simplifying access to treatment, and providing consistent support from HCV care coordinators.

WHY DID WE ESTABLISH THIS MODEL?

23% prevalence of HCV among our clients

Clients had increased risk of mortality from liver diseases

No local access to HCV in primary care and low engagement with specialty care

WHO ACCESSES OUR SERVICE?

25 CLIENTS PER WEEK

- People who use drugs (PWUD)
- People receiving OAT/OST*
- People experiencing homelessness
- People who are, or have been, incarcerated
- People living with HIV

*OAT/OST: Opioid agonist therapy/Opioid substitution therapy

WHAT IS THE MODEL?

At Boston Health Care for the Homeless Program (BHCHP) we have trained primary care providers, supported by a nurse and two care coordinators, to integrate HCV treatment into their existing care delivery at many of BHCHP's 40+ sites, including in shelters, drop-in centres, motels, addiction treatment programs, and a van on the street.

REFERRAL

Clients are referred by health centre colleagues, outside organisations, or self-referred.

There are expedited pathways for people coming out of jail through a correctional linkage program.

LINKAGE

A nurse or provider takes history and HCV labs on site. The provider follows up within a week to confirm the treatment plan. If the client needs fibrosis assessment beyond a FIB-4, they can easily get a FibroScan from a nearby partner gastroenterology office, which accepts walk-ins from our service.

TREATMENT

A care coordinator engages with the client to arrange treatment initiation and plans for support.

The care coordinator completes prior authorisation for medication and navigates the pharmacy process. Medications can be delivered to a home, shelter, van or the street.

SUPPORT

On-treatment support is high-touch and flexible to clients' changing needs. There are weekly phone check-ins with monthly visits, but weekly pillbox delivery or daily observed therapy is also available. We collaborate with the other teams engaging clients, including addiction or HIV treatment, street, shelter or clinic-based services.

Essential to our model

HCV Care Coordinators

We have two full-time HCV Care Coordinators. They are non-clinical staff that we have trained in case management support, and HCV care and treatment.

Our HCV Care Coordinators:

Provide high-touch, dynamic support for individuals seeking treatment, all the way from referral to cure

Navigate all insurance and pharmacy barriers to treatment

Support adherence during treatment - phone, text or in-person contact at least weekly

Collaborate with other teams engaging our clients in care, including addiction or HIV treatment, street, shelter, or clinic-based services

Provide group education to people interested in HCV treatment

Manage internal tracking documentation

"We maintain non-judgmental, low-barrier care that recognizes the competing priorities our patients face. We make it as easy as possible for them to complete treatment despite those challenges."

MAGGIE BEISER
DIRECTOR OF HCV SERVICES
BOSTON HEALTH CARE FOR THE HOMELESS PROGRAM

WHAT HCV SERVICES DO WE PROVIDE?

- HCV education and information
- HCV testing
- HCV diagnosis
- HCV treatment
- Liver disease assessment

WHAT INTERVENTIONS DO WE USE?

- **On-site testing**
- **Reflex HCV RNA testing**
- **Telehealth**
- **Clinician reminders to prompt HCV testing**
- **Pre-test counselling and education**
- **Coordinated health, substance use and hepatitis treatment services**
- **Patient navigation**

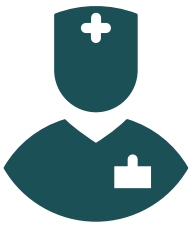
COMPLEMENTARY SERVICES WE PROVIDE

- Access to naloxone
- Access to a primary care provider
- Access to HIV testing and treatment
- Access to alcohol and other drug treatment
- Links to social support and housing

WHO DELIVERS OUR SERVICES?

PRIMARY CARE PROVIDERS

n = 10*



NURSE

n = 1

HCV CARE COORDINATORS

n = 2

*includes nurse practitioners, physicians and physician assistants

HOW IS IT FUNDED?

- MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
- BHCHP INTERNAL SUPPORT

"We looked to examples of specialty integration in HIV clinics.

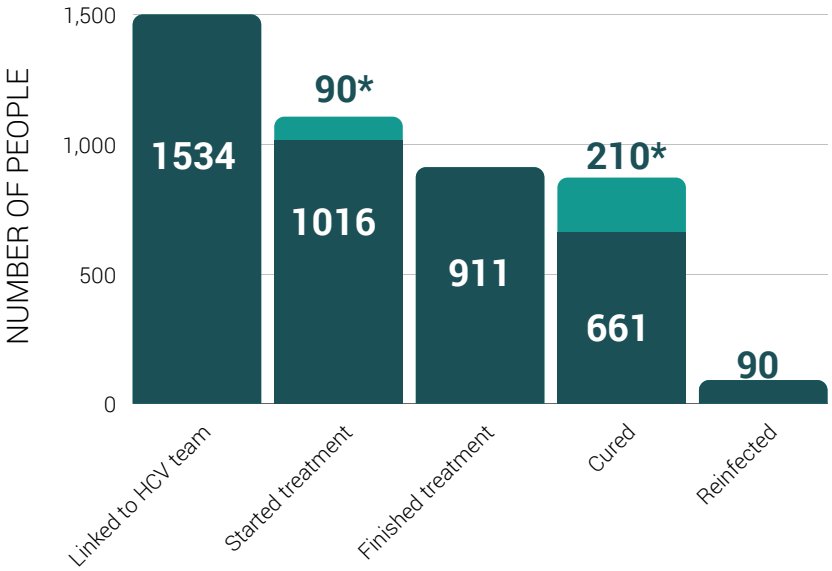
We dedicated the time for a nurse practitioner to develop a model of HCV care and to organize the program."

MAGGIE BEISER
DIRECTOR OF HCV SERVICES
BOSTON HEALTH CARE FOR THE HOMELESS PROGRAM

We provide bus and train passes and hygiene kits to incentivise completion of SVR labs.

WHAT WERE THE OUTCOMES?

January 2014 – July 2021



*Excluded or missing data. Clients with overdue or upcoming SVR dates are included here.

"We must focus on preventing reinfection by improving HCV treatment access for communities of PWUD and increasing collaboration with existing street-based harm reduction services."

MAGGIE BEISER
DIRECTOR OF HCV SERVICES
BOSTON HEALTH CARE FOR THE HOMELESS PROGRAM

WHAT WERE THE BARRIERS?

BARRIERS	SOLUTIONS
 Historically low engagement with HCV treatment through traditional specialist care, and limited examples of community-based treatment provision from which to build our own program.	Using HCV clinical guidelines and training, we designed our own program that adhered to standards of medical care but anticipated the unique support needs of our population. We modelled adherence support on proven interventions from HIV care models.
 Clients and some providers had low awareness of DAA treatment availability.	We educated providers and clients about availability of new HCV treatment through bulletin boards, health fairs, grant rounds, and email communications across BHCHP.
 Lacked expertise navigating complex insurance and pharmaceutical institutions, including prior authorisation.	Designated the care coordinator roles to develop and maintain expertise navigating prior authorisation and pharmacy systems. We standardized documentation to ensure a consistent smooth passage through insurance-related barriers.
 HCV treatment needed to happen in the context of layered physical health, psychological health, addiction and social issues.	We embed HCV treatment within sites that our clients were already receiving care for other conditions. We developed a culture of high-touch support and flexibility among the HCV team to dynamically respond to client's shifting needs and priorities.
 At first, we had limited awareness of policy activities impacting access to HCV treatment.	We participated in local and state public health department meetings to share our experiences and emphasise the needs of our population. We cultivated relationships with other HCV treaters locally, nationally and internationally, who provided us with insights into care delivery for PWUD. We developed a community network for local community providers to provide ongoing collaboration and opportunities.

LOOKING TO IMPLEMENT A SIMILAR MODEL?

OUR TOP 5 KEY CONSIDERATIONS

1

REDEFINE SUCCESS.

There is no perfect assessment to ensure treatment success. Gauge client readiness by kept appointments or engagement in other care. Less-than-perfect adherence is often successful.

2

FLEXIBLE LOGISTICS.

Frequent and consistent services allow for rapid reconfiguration of logistics when needed to keep medication in clients' hands, despite changing needs and priorities.

3

SHARE THE WEALTH.

Engage other providers in clients' treatment success and give them the tools to easily continue surveillance for HCV reinfection and liver disease.

4

RESPOND TO REINFECTION.

Reinfection signals the need to improve access to treatment for PWUD and improved access to harm reduction services and addiction treatment.

5

PARTICIPATE IN POLICY-MAKING.

Participate in systems-level advocacy to ensure that planning and policy formation considers the needs of clients on the margins. Just showing up to a meeting can make a difference.

INHSU
International Network on Health and Hepatitis in Substance Users

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

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