HOMELESSNESS SERVICE | PORTLAND, UNITED STATES

# PATIENT INCENTIVES AND NOVEL TESTING PATHWAYS FOR RAPID HEP C TREATMENT

Central City Concern has developed a unique, opt-out dried blood spot testing approach as part of their holistic health service for clients experiencing homelessness.

## WHY DID WE ESTABLISH THIS MODEL?

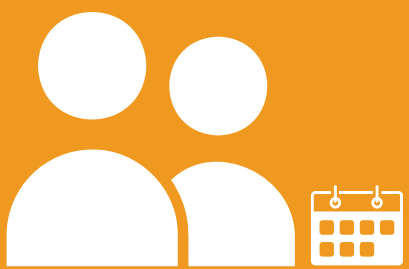
Oregon state has the 2nd highest rate of HCV in the US and the highest HCV-associated mortality

Oregon state government rationed HCV treatment due to cost

Consequently, many people with HCV were unable to access treatment

People experiencing homelessness are at higher risk of HCV, but have many competing priorities

## WHO ACCESSES OUR SERVICE?



**1,800**

**CLIENTS PER WEEK**

- People who use drugs
- People receiving OAT/OST*
- People living with HIV
- People who experience homelessness
- Transgender people at risk of HCV and HIV

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

# WHAT IS THE MODEL?

## CLIENTS ARE APPROACHED IN DIFFERENT LOCATIONS

- HOMELESS HEALTHCARE CENTRE
- MEDICALLY SUPPORTED DETOX CENTRE
- PARTNER OPIOID TREATMENT SERVICE
- STREET MEDICINE INITIATIVES

**Visit 1**

### INCENTIVISED SCREENING

All new clients are offered testing. Clients at outreach sites and Opioid Treatment Programs are given a $15 incentive when results are given.

### DRIED BLOOD SPOT TESTING

Clients are offered either DBS or our reflexive lab algorithm. DBS cards test for HCV antibody with automatic reflex to HCV RNA, if positive. HIV and HBV are also tested on the same DBS card.

### RESULTS REVIEWED

Results are reviewed by a clinician and additional testing ordered if required. Medication is ordered for insurance approval.

**Visit 2**

### TREATMENT

HCV coordinators contact clients to schedule treatment initiation which can happen either with a pharmacist or medical provider in person or via telehealth.

**Visit 3**

### SVR FOLLOW-UP

SVR* labs are ordered at the time of treatment initiation and clients receive reminders before the due date.

### RE-TREATMENT

If required, clients are offered re-treatment without judgement.

*SVR- Sustained Virological Response

# Essential to our model

## Patient incentives

*Financial incentives provided by our HCV Outreach workers have proven crucial to our model of care.*

Individuals in our program are offered financial incentives via pre-charged VISA card for:

- $15 USD for undergoing testing.
- $10 USD for each client they refer.

Dollar amounts were decided based on:

1. Informal conversations with clients
2. Program sustainability
3. Medicare rules limiting financial reimbursement

We encourage referrals to those within injecting networks to facilitate cohort treatment, possibly decreasing re-infection. Referral incentives motivate individuals who are medically disengaged.

**Pharmacists provide low barrier, judgement free treatment tailored to an individual's needs and act as a bridge to other services.**

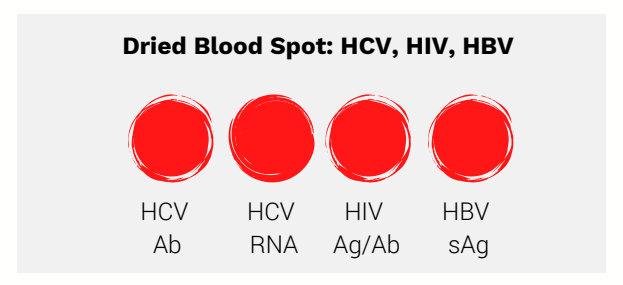
LISA NELSON, PHARMACIST

**"We engage the whole health system in HCV elimination - front desk staff, medical assistants, and outreach workers. This reduces reliance on clinicians and expands the reach of the program."**

DR ANDREW SEAMAN
CENTRAL CITY CONCERN / OREGON HEALTH AND SCIENCES UNIVERSITY

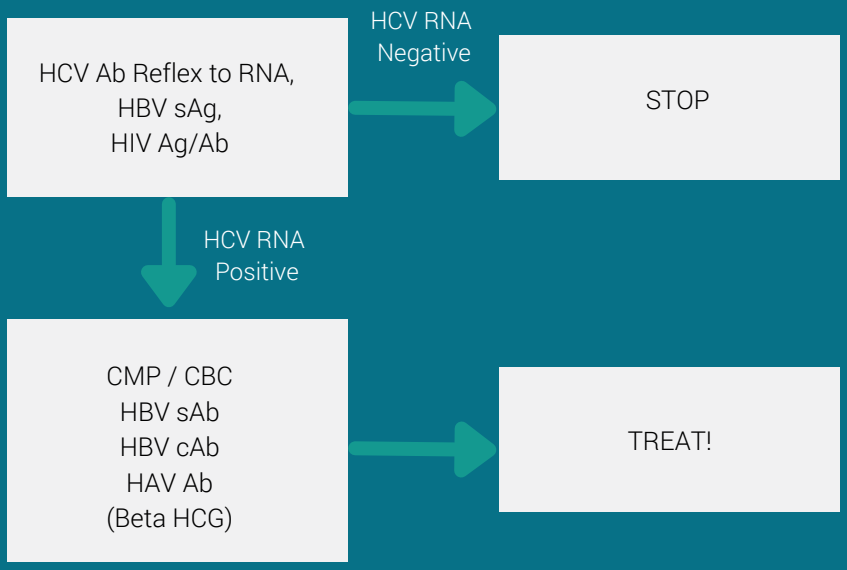
# Screening to Treatment- DBS and reflex testing

*We use DBS cards to test for HCV, HIV and HBV on the same panel.*




All clients presenting for intake to health services are offered routine opt-out HCV, HBV and HIV screening, with all pre-treatment labs reflexed through our novel single-order lab algorithm bundle. Clients are offered a choice between DBS or the phlebotomy-based reflexive lab bundle.

In the DBS algorithm, if HCV Ab is positive, then HCV RNA is reflex tested. At the same time, HBV sAg and HIV sAg are also tested on the same panel. DBS cards are sent to a centralised laboratory for processing, results are returned in 1-2 weeks. If the result is RNA positive, currently further bloods are required in order to initiate treatment. The single-order reflex laboratory bundle combines screening, confirmation, and pre-treatment laboratory evaluation from a single blood draw.




**Screening incentives are a sign of respect for the people we serve. Referral incentives allow us to reverse the poles on the HCV epidemic, treating backward through injection networks that once served as sources of transmission.**

DR ANDREW SEAMAN
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# WHAT HCV SERVICES DO WE PROVIDE?

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

# WHAT INTERVENTIONS DO WE USE?

- Opt-out screening
- On-site testing
- Dried blood spot testing
- Reflex HCV RNA testing
- Telehealth
- Clinician reminders to prompt HCV testing
- Financial incentives
- Coordinated health, substance use and hepatitis treatment services
- Patient navigation

# WHO DELIVERS OUR SERVICES?

| 15 | 7 | 2 | 4 | 7 |
|---|---|---|---|---|
| PRIMARY CARE PROVIDERS | ADDICTION MEDICINE PHYSICIANS | NURSES | PHARMACISTS | OUTREACH WORKERS |

**The core of our program is listening-to a patient's needs, stories, feedback and motivations. Forming responsive human relationships with our patients is the foundation of increasing access.**

LEANNE FALZON, HEP C COORDINATOR

# HOW IS IT FUNDED?

- PHARMACY REVENUE FROM DAA SALES (SPECIAL US SCHEME: 340B PHARMACY)
- PHARMACEUTICAL FUNDING (FOCUS SCREENING GRANT)

**We used pharmacy revenue generated from DAA sales to fund the model, which resulted in buy-in from organisational leadership.**

**This was probably the single most important factor in the program's success.**

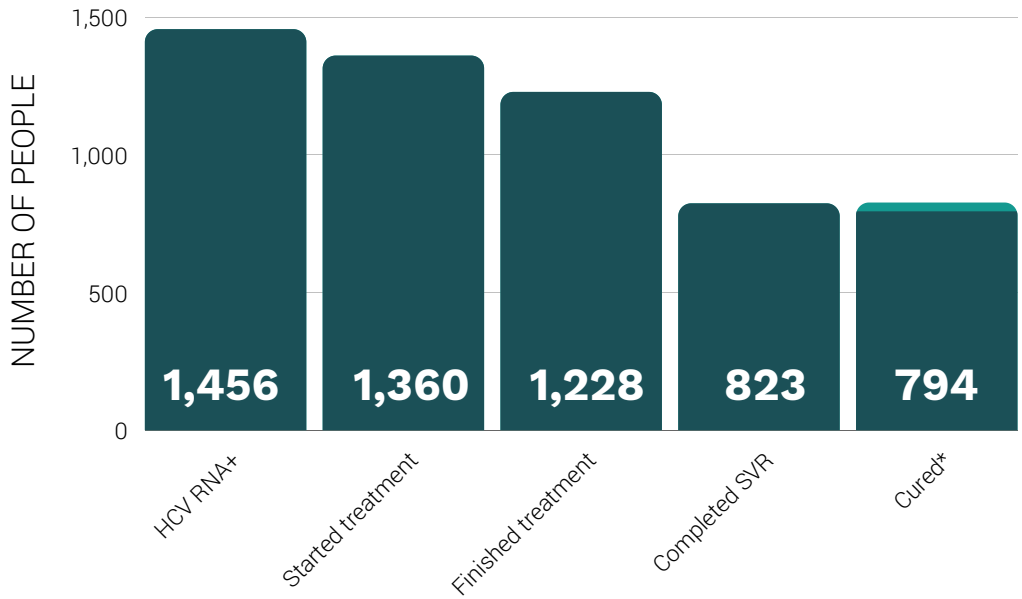
DR ANDREW SEAMAN
CENTRAL CITY CONCERN / OREGON HEALTH AND SCIENCES UNIVERSITY

# WHAT WERE THE OUTCOMES?

MAY 2017 – MAY 2020

**15,011**
PATIENTS ENGAGED IN CARE

**6,102**
PATIENTS SCREENED FOR HCV, HIV & HBV




*794 achieved SVR12 (cure)
433 awaiting SVR12 testing
32 remained viremic:

- 13 reinfected
- 19 treatment failure

# WHAT WERE THE BARRIERS?

| BARRIERS | SOLUTIONS |
| --- | --- |
|  The fragmented US healthcare system affected screening, linkage-to-care, and who we could treat. | Over 30 months of intensive advocacy we removed all fibrosis, provider, and substance use restrictions, facilitating a simplified system with limited pre-treatment work-up. |
|  Our community partners (e.g. opioid treatment programs) were slow to adopt screening interventions. | We ran HCV education sessions for community partners and have funding to provide onsite linkage-to-care support for the first year of implementation. |
|  COVID-19 presented serious challenges in safely screening and linking people to care, especially for individuals with medical co-morbidities. | We timed screening events for when clients were already on campus, changed most visits to telehealth consults, provided curbside drop or delivered medicines for high-risk clients, and screened for COVID-19 symptoms. |
|  Organisational bureaucracy, compliance/legal concerns, and systemic regulations delayed implementation on several occasions. | We learned to involve both clinical, regulatory, and information technology stakeholders early and often, and developed compliance-friendly processes to allay legal concerns. |
|  Our clients have been told they either could not or did not need to treat their HCV for years, decreasing the perceived urgency and affecting people's belief in their ability to be cured. | We advertise low-barrier initiation models and educate community health systems to use motivational interviewing and education about the real-time effects of HCV to increase treatment interest. |

# LOOKING TO IMPLEMENT A SIMILAR MODEL?

## OUR TOP 5 KEY CONSIDERATIONS

1

### SIMPLIFY.

Remove unnecessary steps in the care cascade. Use opt-out screening-to-workup lab algorithms and approve prescriptions before the patient's first visit.

2

### TASK SHIFT.

Engage and train non-clinical staff to initiate screening and referral processes, and opt-out pre-test counselling.

3

### PROVIDE INCENTIVES.

Provide financial incentives for as many steps of the care cascade as you can. Consider decentralised processes such as incentive cards at street-based walk-in screening sites to distribute incentives.

4

### TAILOR YOUR TOOLKIT.

Tailor your intervention toolkit to the needs of each client where possible. Consider offering different screening options, visit types (telemedicine/in-person), provider types (pharmacists/primary care provider), and medication dispensing frequency.

5

### COLLECT ROBUST PATIENT DATA.

Collect robust data about your clients, such as alternative contact numbers and other locations of care, so that you can re-engage them if they drop off at any point. Then treat or retreat without stigma or delay.

INHSU
International Network on Health and Hepatitis in Substance Users

CENTRAL CITY CONCERN
HOMES HEALTH JOBS

OHSU

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