Lessons Learned
From the Field

With any new model comes growing pains as well as learned best practices. Some lessons that have emerged from informal and formal evaluation of currently implemented demonstration models are:

⇒ The need for strengthened management of social and behavioral issues that the patient perceives as barriers to their care

⇒ The need to integrate the care Coordination program into the EMR. This includes creating templates to bridge communication across the interdisciplinary team.

⇒ Implementing this model in the Primary care setting may call for restructuring of clinic flow as a whole.

⇒ Stabilizing costs increases competitive edge

⇒ Leadership must be on board and supportive for successful implementation

⇒ The "one-stop-shop" model works to reduce the number of HCV related complications as well as increase screening of depression and substance use.

⇒ Implementation of the Triple Aim Approach

⇒ In assessing for cost effectiveness; one site realized they were losing revenue through mis-billing therefore a quality assurance process for billing alone, is key.

⇒ Consider the spacing, scheduling and provider capacity PRIOR to implementation. Some saw that once developed, the program did not have the capacity to treat the number of patients set forth in the deliverables.

⇒ Each Insurer is different, take time to learn how HCV treatment is covered by the companies and at what rate of reimbursement.

⇒ Identify new ways to acquire funding for current grant funded services.

What's next?

Performing an ethnographic field observation and focus group with patients engaged in this model would be of benefit.

In showing the relationship between patient navigation and desired patient outcomes (or lack thereof), organization's will be able to qualitatively support or deny the creation of a HCV Treatment Program. By drawing this connection, agencies will gain insight into its capacity to engage, retain and treat clients with HCV by further investing in its unique service model, while fostering accountability among service providers. Just the inverse, the organization could decide to explore other service model options or further explore reasons for increase treatment uptake by client population.

About the Presenter

Brooke E. Wyatt currently serves as the Project Director for Project INSPIRE, a Center for Medicaid and Medicare funded HCV care coordination and treatment demonstration project within the Mount Sinai Hospital Network in New York City. She previously served as Program Coordinator and then Director of Evaluation for Harlem United's HCV Treatment program. Brooke is a trained researcher with a comprehensive background in health disparities among minority/marginalized populations in the US. Brooke holds a BA from Columbia University in Biological Anthropology, an MPH in Epidemiology from George Washington University School of Public Health, and is currently pursuing her DrPH in Community Health Science at SUNY Downstate School of Public Health.

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Disclosure: The information presented during this presentation are my personal views and practices and do not reflect the positions of Mount Sinai or any other organization.

Developing an Integrated Hepatitis C Care and Treatment Model in a Community Based Clinical Setting

Brooke E. Wyatt, MPH **APHA Annual Meeting 2015** **Tuesday, November 3, 2015**

ABSTRACT.

Treatment readiness is a crucial component in eradicating the adverse impact of Hepatitis C Virus (HCV) on the mono-infected and co-infected (HIV/AIDS) communities and beyond. Often the steps to initiate treatment proves to be a tedious process; from readiness assessments to education and completing preliminary medical appointments and labs. Current HCV surveillance data shows an increase in both incidence and prevalence, disproportionally affecting many different sub-populations. Specifically, HCV disproportionally affects high risk African Americans with respect to race and those co-infected with HIV with respect to comorbidities. Theories show through the use of the patient navigation (PN) model in a clinical setting, both patients and providers self-efficacy are enhanced making it more likely for them to become and remain engaged through treatment completion. Because of the complexities of needs of mono-infected and HIV/HCV co-infected clients, integrated care provides maximum benefit for this population. At Harlem United this integrated care includes linkage to care, patient navigation for primary care and support services, developed curriculum based education and peer-led support groups, in addition to personalized care and treatment plans all supported by an interdisciplinary team. Since integrating the patient navigation model within the HCV program, treatment completion rates for those who test positive and are connected to care has increased from 7% (2013) to 25% (2014). To support the proposed model, a qualitative analysis should be performed to assess the model and indicators of client's willingness to progress in care.

Exploring clinics' capacity to engage, retain and treat clients/patients with HCV and inform future model modifications.

Advance Care while controlling costs

By creating an interdisciplinary HCV treatment program in community based clinical settings, we aim to:

- **Develop and implement a model to improve treatment readiness, initiation and completion for clients living with HCV**
- **Inform best practice models and evaluate effectiveness and feasibility**

This proposed interdisciplinary model will allow the medical provider to focus his/her attention on the individual, developing and maintaining rapport with the patient through a process that is extremely time consuming, even with new medications. Additionally it will create opportunities to provide higher quality of care to an increased number of patients over time. In addition to creating an interdisciplinary team, activities such as creating a comprehensive manual detailing the program processes and services will further promote adherence to protocol and foster accountability among service providers.

THE FOUNDATION

Establishing an interdisciplinary team is crucial to the success of a hepatitis treatment program. Here are some suggestions on staffing structure based on current demonstration projects and initiatives showing success.

~ ***Managing Director*** provides general oversight and drives the medical strategy including: leading the awareness and positioning of the disease in the organizations strategic plan as well as ensuring the proper training and fidelity in implementation. This should include process and outcome monitoring.

~ ***Program Coordinator*** acting as lead liaison in the clinic will provide day-to-day oversight, monitoring the flow of clients through services. Activities may include initial and readiness assessments, provide education, track steps towards treatment readiness, medication coordination and leading the prior authorization process, as well as providing education in individual or group based settings with support staff.

~ ***Medical Director and Lead Provider*** will provide medical oversight (updating treatment algorithms and delivery of care.

~ ***Registered Nurse (RN)*** to support the provider and monitor treatment complications, adherence and side effects as well as reinforce education and awareness.

~ ***Mental Health Specialist (LCSW)*** will conduct initial mental health assessments (utilizing the Prep C treatment readiness assessment), refer to treatment if necessary and post treatment follow up.

~ ***Nutritionist*** conduct initial nutrition assessments, provide education on reaching/maintaining normal body weight

~ ***Patient Navigators (PNs)*** will support the coordinator through accompaniments, education and support groups, outreach and referral services. A ***Peer*** will support the PN in all of their duties.

What is the proposed Patient Navigation model? A transient model of navigation and coordination improving quality of care and outcomes.

There are many definitions of care coordination. The Organization for Healthcare Research and Quality defines care coordination as:

> **"the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care."**

In summary, someone who works to understand the patient's fears and hopes, and who removes barriers to effective care by coordinating services, increasing a patient's chances for survival and quality of life. Often, providers have neither efficient time and in some cases expertise to meet all of their patients' clinical needs, often necessitating consultation with specialty physicians and referrals to other supportive community based services and programs. In clinics serving large patient populations with complex needs, often times even the nurse has many other responsibilities and although expected to, cannot tend to each patients personal barriers.

It is important for primary care providers (PCP) to understand the patients comorbidities outside of Hepatitis, as it could increase the complexity of care. The coordinator, serving as a lead liaison is able to update the treating physician on any changes in the patients care while ensuring the patients priorities are met. Theories show the use of the PN approach in care coordination settings promotes both linkage and retention in care. Through the use of behavioral motivational interviewing, navigators are able to foster self-efficacy, thus increasing the probability of engaging and maintaining care. Motivational Interviewing within clinical settings decreases risk factors for disease, enhancing patients' and providers' self-efficacy for behavioral change, and facilitating referral for mental health and other treatment if indicated. Literature also suggests that effect on outcomes is directly related to the amount of change talk produced during such conversations. Navigation helps individuals believe that they will be successful (effective) at making desired changes in their behavior, making it more likely that they will actually be able to do so. This type of buy-in empowers the individual which is essential to success in HCV care.
The importance of patients' participation in their own medical care and decision making is well documented, particularly for those with chronic illness. A key element in a participatory style of patient care is soliciting the patient's priorities and preferences during the medical visit which is the goal of this model.

Strategic Planning

To gain an understanding of what services are currently available, it is suggested that a needs assessment be performed of both individual and community level services, also exploring clients perceptions of those services.

Based on services available and desired future developments, program leadership should define the scope of services and deliverables. Depending on the size and extent of services offered, this may require input from varying departments/ programs. For example, are the support services available to patients open to both mono and co-infected patients? And if they differ, how so? How will referrals from the clinic to support services be handled?

By identifying more concretely what services would be available, and standardizing the messaging across the organization, focus can then shift towards integrating new services that are not yet included such as treatment readiness assessments (Prep C) and mental health care. Research should be done to understand how these added services could create new channels of revenue for the program

and clinic as a whole. Having established a work flow across the clinic and support services departments, the organization should then consider how (or if necessary at all) to standardize these services across the population it is serving.

To decide how and when the program can expand, as well as its capacity to expand, a cost analysis should be performed. This cost analysis should take into consideration the need for additional support staff, provider capacity, current revenue and deficits (if any) as well as any in kind or grant funded services and when they're slated to end. To plan for this on-going assessment of functionality and effectiveness, a strategic work plan should be developed outlining how each component of the program will be fulfilled, whose responsibility it falls under and time to completion/status updates throughout the life of the program. The clinic's Quality Assurance Manager or Evaluator should spearhead this to ensure the creation of tangible program deliverables, monitoring and evaluation, although executed by the Managing Director. Lastly, all staff should be made aware of new HCV protocols, implementation plans and details on how the program will exist within the clinic setting.

For more information on how to establish this work plan or its components, please contact the presenter.

Training Recommendations

OPERATIONAL All program team members should receive orientation to the agencies policies, procedures , and any information unique to the flow and operation of the clinic. This includes formal training on the EMR or any reporting systems relevant to HCV treatment as well as the Health Insurance Portability and Accountability Act (HIPAA). Additionally, cultural competency is a crucial component of delivering quality care and all staff should receive training as it relates to the population the program aims to serve.

SKILL BUILDING Trainings that promote skill development relative to each role should be implemented with a yearly or bi-yearly update/refresher. Specifically as it relates to patient navigation and care coordination, the following are recommended: Viral hepatitis 101; HCV Medical Care and Treatment Updates (hcvgidelines.org or aasld.org); Health Education sessions (adapted from current health education resources or utilizing the interdisciplinary team to develop their own); Motivational Interviewing (Standard full 2-day training); Psychosocial Readiness Assessment for Hep C Treatment (Visit prepc.org to sign up), Hep-SBIRT (Substance Abuse Brief Intervention & Referral to Treatment)