

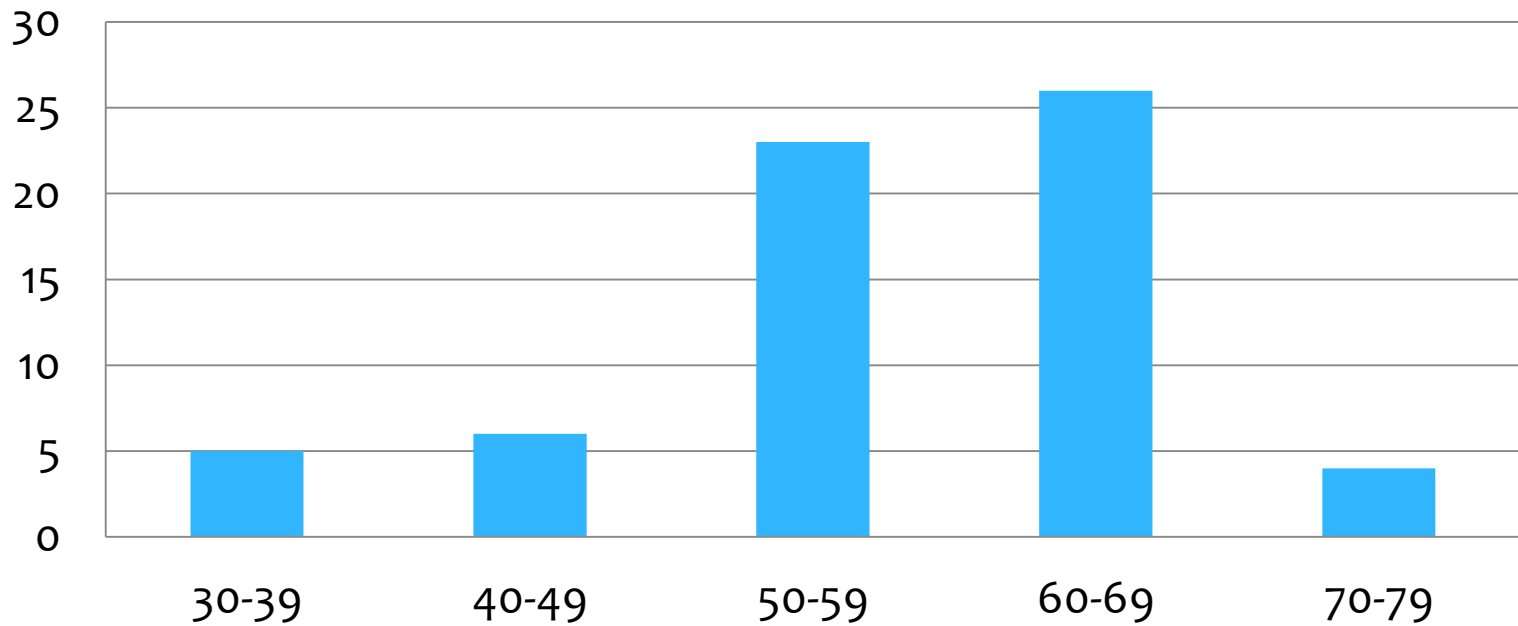
Eradicating HCV in HIV positive patients: an integrative approach

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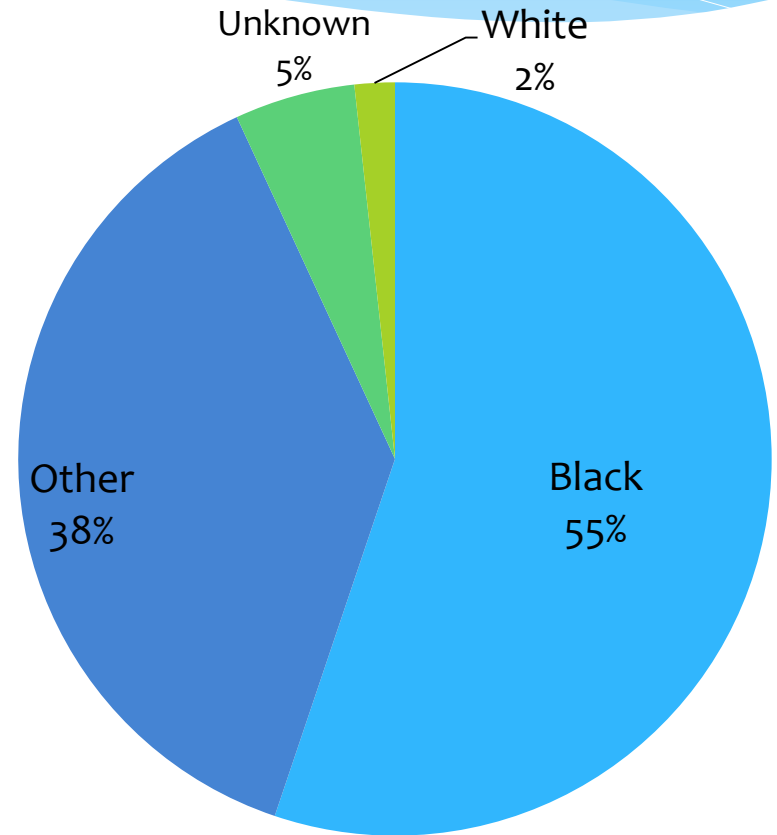
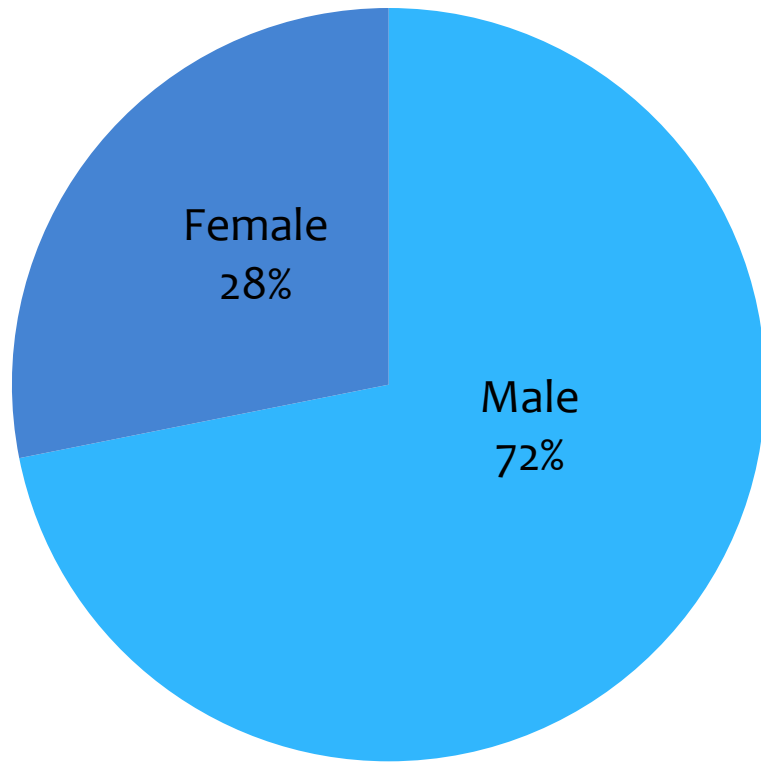
Co-Infection Patient Population Demographics

Age distribution of Patients

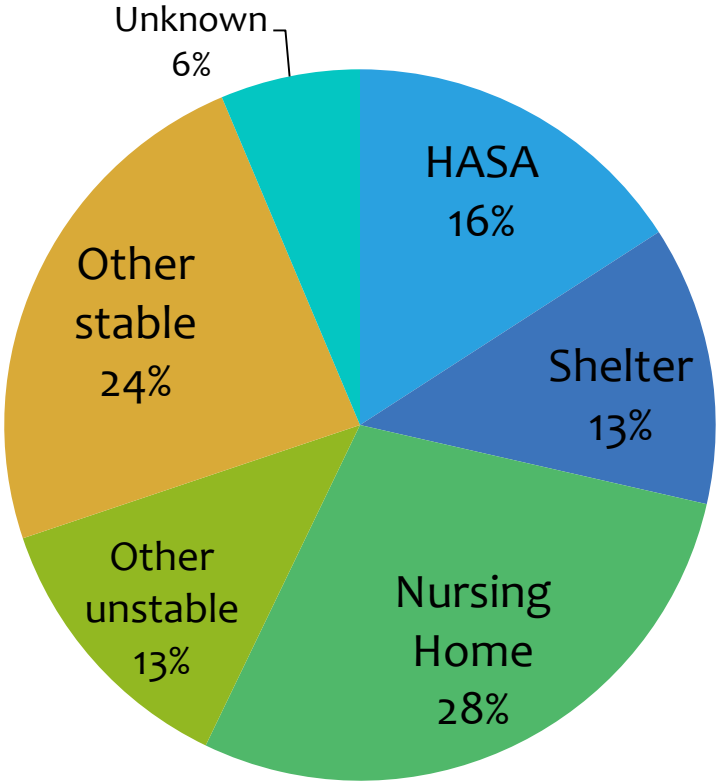
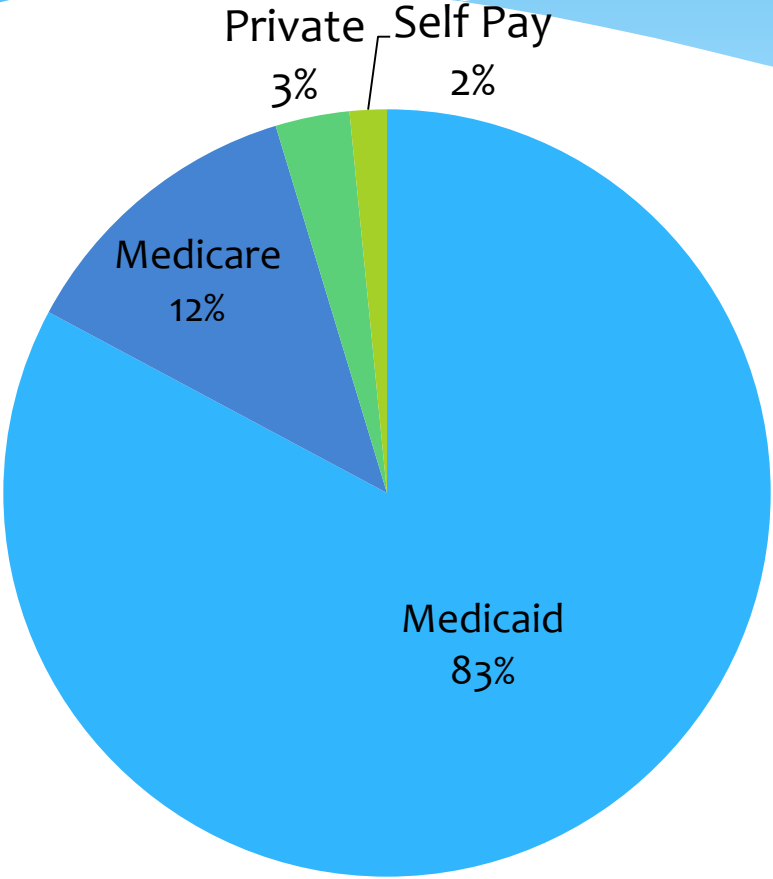
Distribution of patients based on age ranges



Gender & Race of Patient Panel

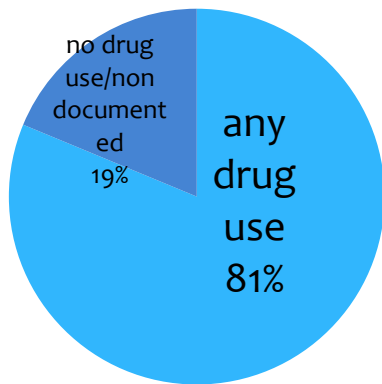


Insurance Coverage and Housing Status of Patient Panel

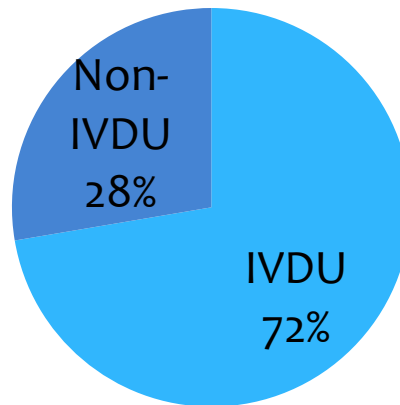


Prevalence of Substance Abuse in Patient Panel

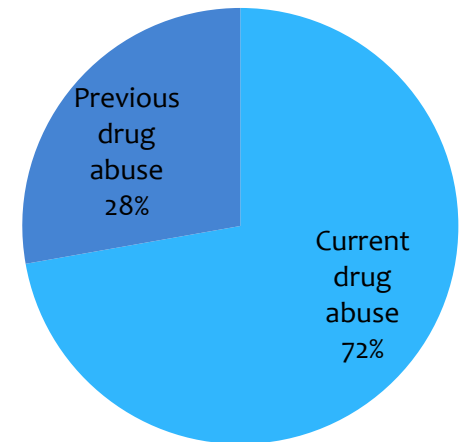
Patients with Documented Substance Abuse vs. no substance abuse/non documented



Of those with documented substance abuse, any IVDU vs. non IVDU



Of those with documented drug use, identified current substance user vs. previous substance user



Integrative Programmatic Approach



Steps in the Integrative Model

Identify and Review all patients

Reviewed lists from both internal EMR and DOH provided to compile complete co-infection panel

Chart reviewed every patient for: 1. cured/not cured/on treatment/other (deceased, moved, etc) 2. barriers to treatment, 3. Viral Load Suppression



Incorporate and/or expand existing programs

Assess all current resources and how can utilize them based on each stratification of patients

Identify areas of improvement in current programs to enhance offerings



Stratify Patients to determine approach

Unsuppressed and uncured: Check Program & VLS Action Team Model

Suppressed and uncured: Check Program & step 1 of VLS Action Team Model

On Treatment and not yet cured: Monitoring/Additional Supports

Check Program

- * City Council-funded, DOH-run, patient navigation program
- * Established at our institution in 2016
- * Patients who have not been cured of their HCV enrolled in Check program to receive care coordination, treatment readiness, patient education, etc; addressing barriers to care

VLS Action Team

- Provides therapy as determined in case management meetings
- Orchestrates any referrals identified by CHW
- Conducts home visits (if needed)

Physician

- Provides Treatment and Care
- Provides clinical advice in Case Management Meetings
- Conducts home visits (if needed)

Social Worker

Patient

CHW

- Identify barriers to care for patients
- Meets patients in clinic or inpatient or in field when identified
- Orchestrate identified action steps and care plan as determined by case management

- Outreaches to and engages patients via home visits or phone calls or letters
- Run through patient contact update protocol
- Monitors patients movement through cascades and viral load suppression

Patient Recruiter

CHW and Home Visits



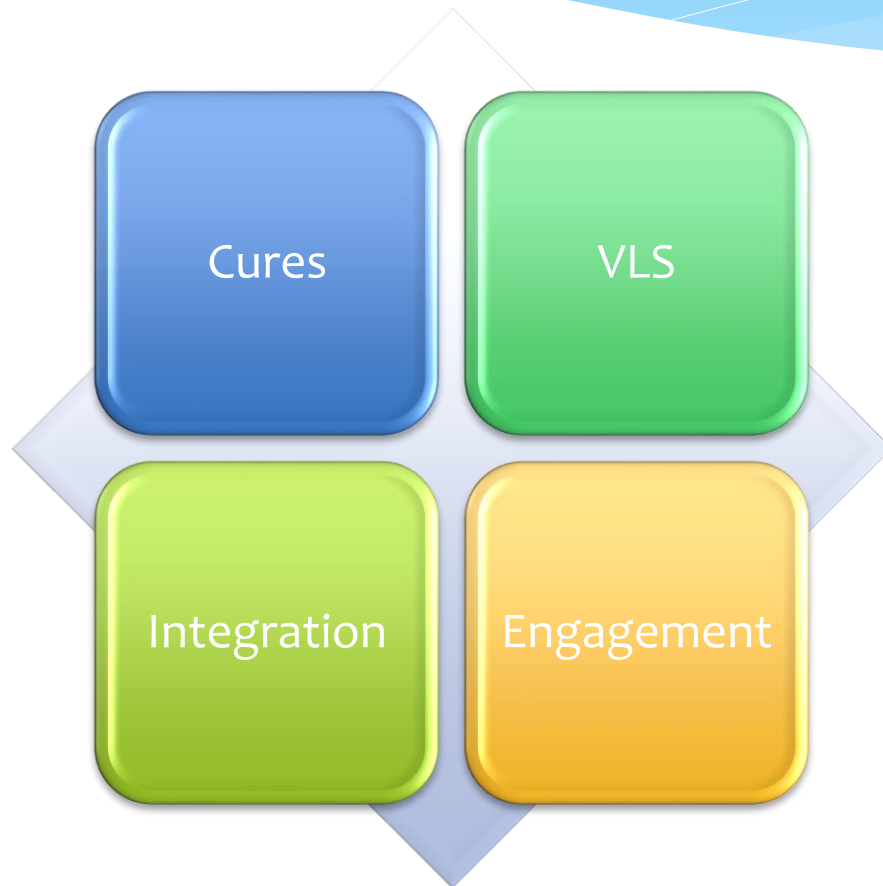
Considerations

The slide features a solid blue background. At the bottom, there are several overlapping, wavy, light blue shapes that create a sense of movement and depth, resembling stylized waves or a modern graphic design element.

Buy-In



Successes



Challenges

- * Locating patients
- * Patients shared across sites
- * Staff Turnover
- * Barriers to treatment
- * Combining different programs infrastructure to address co-infection specifically
- * Addressing areas of improvement in current projects to best support this project