

VA Portland Health Care System – Hepatitis C Treatment in Homeless Programs
An Innovative Practice in VHA Homeless Program Operations

White Paper

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INTRODUCTION

The VHA Homeless Program Office identifies and disseminates innovative practices in homeless program operations. The VA Portland Health Care System (HCS) has been recognized as a site with an innovative practice for improving access to hepatitis C treatment for homeless and formerly homeless Veterans.

PRACTICE OVERVIEW

Community-based collaborations with Hepatitis Innovation Teams and Homeless Programs are effective in screening and treating homeless and formerly homeless Veterans for hepatitis C.

Hepatitis C is a contagious, chronic liver disease caused by the hepatitis C virus (HCV) that can result in liver damage, cirrhosis, and cancer¹. Veterans enrolled in VHA health care are three times more likely to have HCV than the general U.S. population². This is largely attributable to the rate of infection of Veterans among the 1945 to 1965 birth cohort due to exposure to blood and blood products during the Vietnam Era. Contributors to the rate of infection include the standard of medical practice at the time (i.e. multidose vials and reusable medical equipment such as multidose immunization devices) and the high rate of intravenous and intranasal drug use in the subsequent years. Today, VA utilizes its National Hepatitis C Program, VISN Hepatitis C Innovation Teams (HITs), and HIT Coordinators at every VA medical center. These teams meet regularly to share best practices and utilize nationwide dashboards to share data on trends and outcomes across VHA. Through this method, HITs across VHA have systematically identified, contacted, and initiated treatment on more than 100,000 Veterans to date³.

When treating hepatitis C, treatment compliance is paramount⁴. Medications must be taken every day for up to 24 weeks without interruption or gaps. Any interruptions can cause a patient to fail therapy and not achieve sustained viral response (SVR) or cure. Additionally, if a Veteran fails treatment, he or she may develop resistance to the medication, complicating or precluding future attempts. When treatment starts, a patient must

¹ Center for Disease Control, Hepatitis C Questions and Answers for Health Professionals:

<https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm>

² Hepatitis C: Information for Veterans: <https://www.hepatitis.va.gov/pdf/Hepatitis-C-Factsheet-Veterans.pdf>

³ VA has cured 100,000 Veterans of Hepatitis C: <https://www.blogs.va.gov/VAntage/64162/va-cured-100000-veterans-hepatitis-c/>

⁴ Adherence to treatment of chronic hepatitis C: from interferon containing regimens to interferon and ribavirin free regimens: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4956799/>



follow-up with a provider at least once every four weeks, have laboratory monitoring every two to four weeks, have a method to contact a provider for any issues, and have follow-up laboratory testing three months after completion to confirm that that treatment was successful.

After years of solid progress from National HIT Initiative to Cure Hepatitis C, in November 2017, staff at the VA Portland HCS decided to go for the last mile. The number of Veterans left untreated as indicated by their tracking dashboards was significantly low. To reach the remaining Veterans, the Portland's HIT Coordinator knew they would need to use methods that they had not used before. One straightforward nationally recommended strategy was to simply review the Veterans' electronic health record (EHR) to see if they had engaged with other VA health care providers. Perhaps by identifying providers that consistently saw these Veterans, the HIT could engage them via telephone or close to their next upcoming appointments if the Veteran could not be contacted by telephone. While most of the remaining Veterans were willing to come into the hospital for outpatient care to treat their hepatitis C, Portland's HIT found some important cross cutting barriers for the Veterans who did not. Specifically, many of these remaining Veterans were also homeless. Barriers such as lack of transportation, lack of reliable communication, lack of a physical address, and others were challenges that the HIT did not encounter before or had minimal experience addressing.

The breakthrough that helped the Portland HIT start engaging with homeless Veterans came serendipitously from a Housing and Urban Development-VA Supportive Housing (HUD-VASH) program social worker within Portland's Community Reintegration Service (CRS). The social worker sent an internal instant message to one of the members of the HIT noting that, after conducting his own EHR review, records indicated that the HIT was looking for one of the formerly homeless Veterans on his caseload. Acknowledging the challenges in connecting homeless and formerly homeless Veterans to VA's mainstream outpatient services, the HUD-VASH social worker proposed that the HIT providers go out to the community and provide hepatitis C treatments directly where Veterans lived.

After working out some basic logistic details, in the winter of 2017, Portland's HIT Coordinator and a Hepatology Pharmacist drove to a HUD-VASH project-based voucher (PBV) site where 25 formerly homeless

“In a way, we were a little spoiled working in the Outpatient Clinic. But we knew that we could make this work for our Veterans. We needed to break down these silos. For the Veterans, it needed to feel seamless instead of feeling stuck either in the Hep C world or the homelessness world.

**Kari Stevens,
Hepatitis Innovation
Team Program
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Veterans lived. As this PBV location housed underserved Veterans from a low barrier framework, many of the Veterans there were highly likely to have hepatitis C. They brought equipment to draw blood for lab work and treatments such as hepatitis C medication and injectable immunizations. The HIT providers went door to door to conduct hepatitis C screens and initial tests to interested Veterans. If the initial screen indicated further assessment, the HIT providers were able to transport them in General Service Administration (GSA) vehicles back to the clinic for further care.

Recognizing the potential in collaborating with the homeless providers of Portland's CRS, the HIT providers brainstormed several improvements to make their activities more effective. They outfitted their GSA vehicle with crates of testing equipment, laptops with remote network access, and medical supplies to serve as a mobile hepatitis C clinic. This allowed them to expand the services and procedures they did in the field to include appointment scheduling, case management, checking vitals, laboratory result reviews, and medical education. They expanded their activities to a second HUD-VASH PBV site, smaller Community-Based Outpatient Clinics, the homeless program's Community Resource and Referral Center, Homeless-Patient Aligned Care Team primary care settings, and even Homeless Veteran Stand-Downs – outreach and engagement events that provided supplies and services to Veterans experiencing homelessness. To help improve visibility into Veterans who have homeless histories and who may have indications of having hepatitis C, in 2018 their HIT dashboards were updated to add homeless program encounter information based on clinical encounter stop codes and homelessness diagnoses. As many Veterans had inaccurate addresses and contact information listed in their EHR, ongoing coordination with Portland's CRS providers was critical to continue to provide effective leads to outreach and connect. To help the homeless program staff support treatment efforts, the HIT providers developed hepatitis C packets that could be used to follow up with indicated Veterans. These packets contained information about hepatitis C and treatment as well as served as a lab order that would allow Veterans to come to the clinic for rapid testing if appropriate.

Since April 2018, the Portland HIT and CRS Registered Nurse provided outreach and care to 88 indicated Veterans engaged in specialty homeless services. Additional outreach opportunities expanded to serve homeless Veteran Stand Down events with 22 Veterans served in 2018 and 16 Veterans served in 2019. Reflecting on the success, the HIT providers acknowledged two key aspects of their innovative practice. The first was focused collaboration with homeless services providers. The HIT staff were largely unaware of this other world of Veterans that needed treatment. These two worlds had not combined until this collaboration, and the HIT staff found incalculable value in the expertise of the homeless program staff in navigating and overcoming barriers that homeless Veterans face along with their willingness to collaborate.



The second was the opportunities afforded by taking their services outside of the outpatient setting and into the community. While community-based work was a fundamental component of homeless program service delivery, the cultural, logistical, and practical aspects were foreign to the HIT providers.

CONCLUSION

For HIT C Leads across VHA, their goal has consistently been to foster trusting relationships with Veterans interested in treatment to help address not only HCV, but also any other areas of need, be it homelessness, substance use disorders, or mental health issues, consistent with the VHA's principles of whole health recovery. Strong clinical work is necessary, but not sufficient. While treatment is traditionally offered to Veterans who were ready, willing, and able, extra effort by Portland's providers was critical to ensure that vulnerable populations such as Veterans experiencing homelessness were brought up to ready, willing, and able status.

We would like to thank the dedicated staff at the VA Portland HCS for sharing their practice with us. For more information, contact Kari Stevens, Hepatitis Innovation Team Program Coordinator at Kari.Stevens@va.gov; and Roberta Trewyn, HUD-VASH Registered Nurse at Roberta.Trewyn@va.gov.

