

**VIRAL HEP ECHO -
UNHOUSED HCV
TREATMENT**

DNP Amy Gordon
Community Health
Specialist Casey
Holmstrom

AGENDA

Introduction

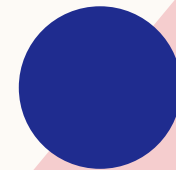
Primary goals

What is the process

Barriers to care

Strategies around Rx adherence

HCH Data



INTRODUCTION

We wanted to talk about the outreach to clinic model of Hep C care, the success and difficulties that come with the territory.

Evictions in Hennepin County

Look at eviction filings and judgments over time, by year.

[Click here to view information about this page.](#)

Hennepin County reduces disparities

The county recognizes the adverse consequences of disparities among us and supports disparity reduction among our residents. This tool is intended to support this effort.

- Year**
- 2024
 - 2023
 - 2022
 - 2021
 - 2020
 - 2019
 - 2018
 - 2017
 - 2016
 - 2015
 - 2014
 - 2013
 - 2012

Evictions

2019
Year

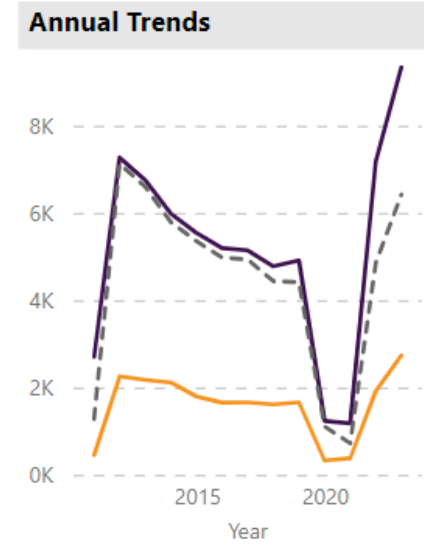
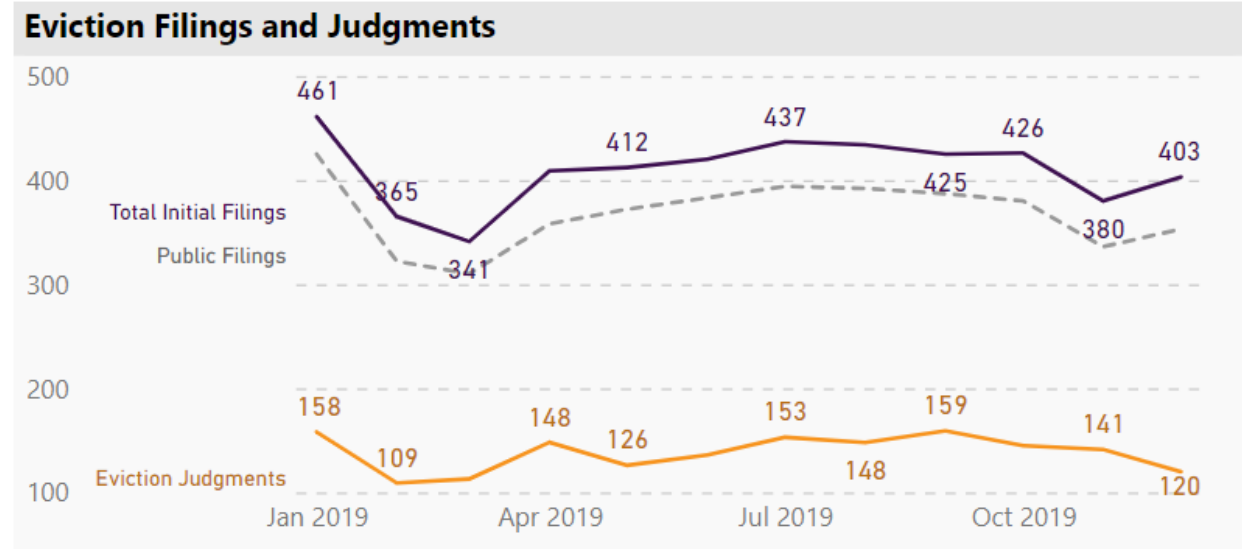
4913
Initial Eviction Filings

4412
Public Eviction Filings

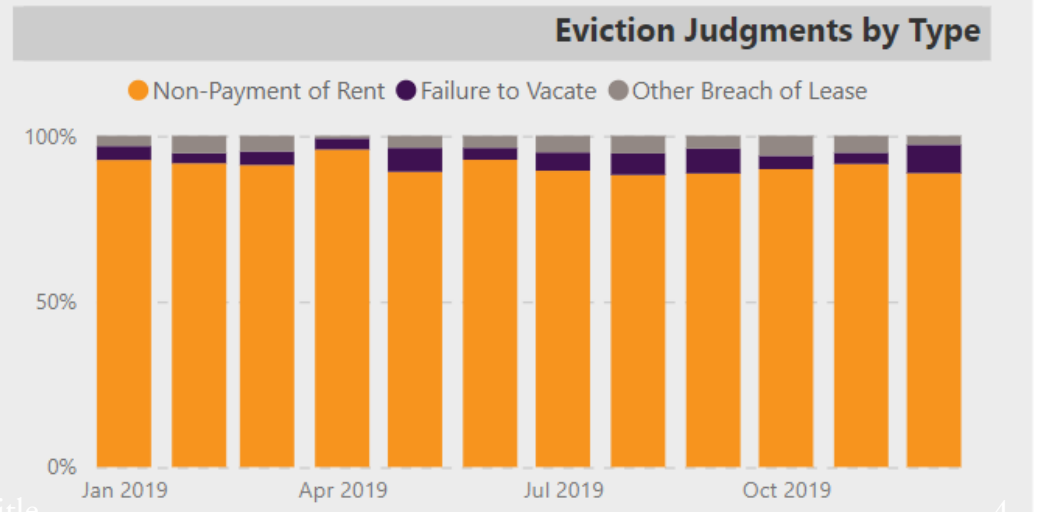
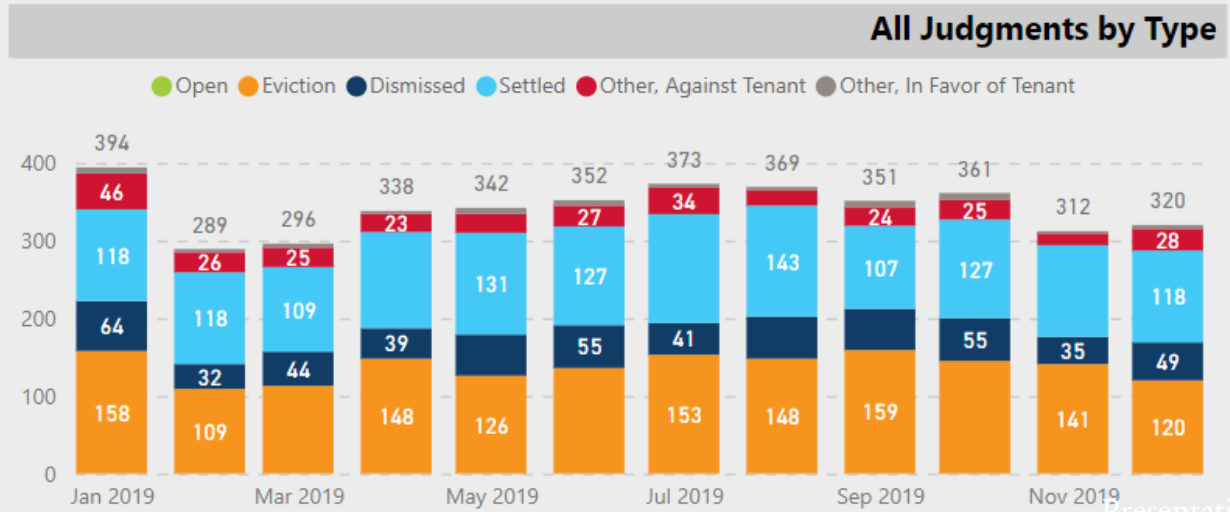
1656
Total Evictions

View:

- Monthly
- Weekly



Housing Court Judgments



Next dashboard: Eviction Rates



Evictions in Hennepin County

Look at eviction filings and judgments over time, by year.

[Click here to view information about this page.](#)

Hennepin County reduces disparities

The county recognizes the adverse consequences of disparities among us and supports disparity reduction among our residents. This tool is intended to support this effort.

- Year**
- 2024
 - 2023
 - 2022
 - 2021
 - 2020
 - 2019
 - 2018
 - 2017
 - 2016
 - 2015
 - 2014
 - 2013
 - 2012

Evictions

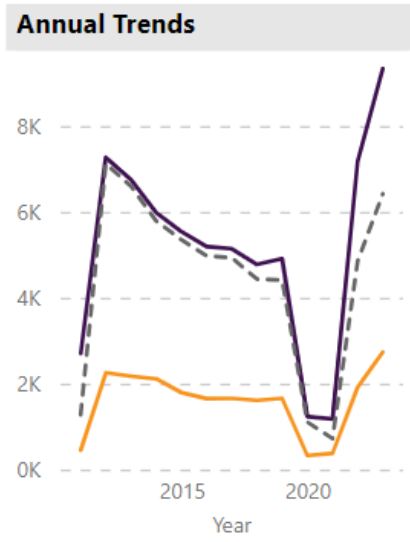
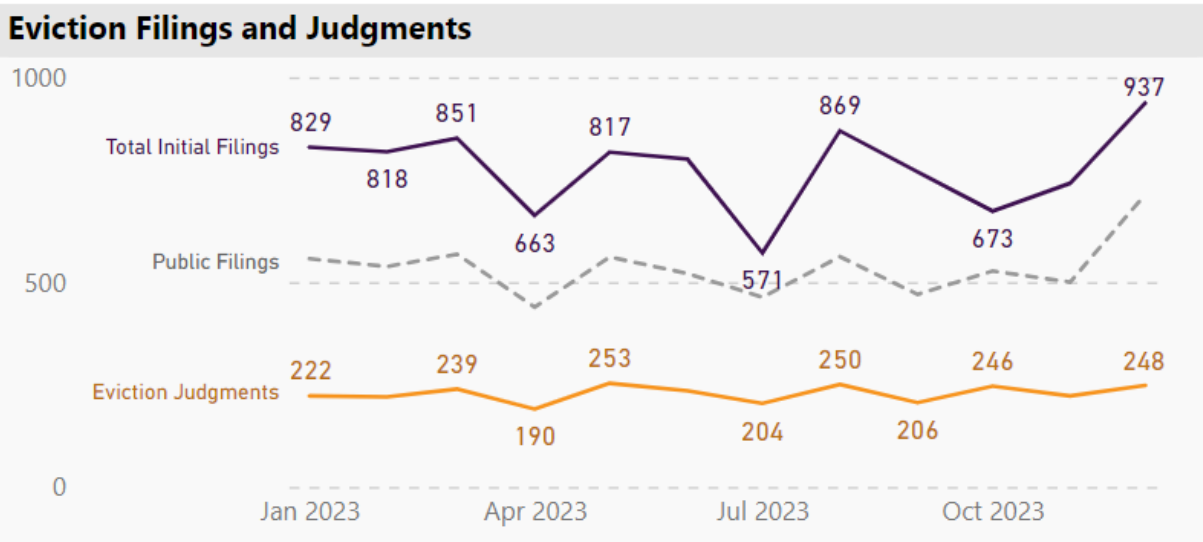
2023
Year

9338
Initial Eviction Filings

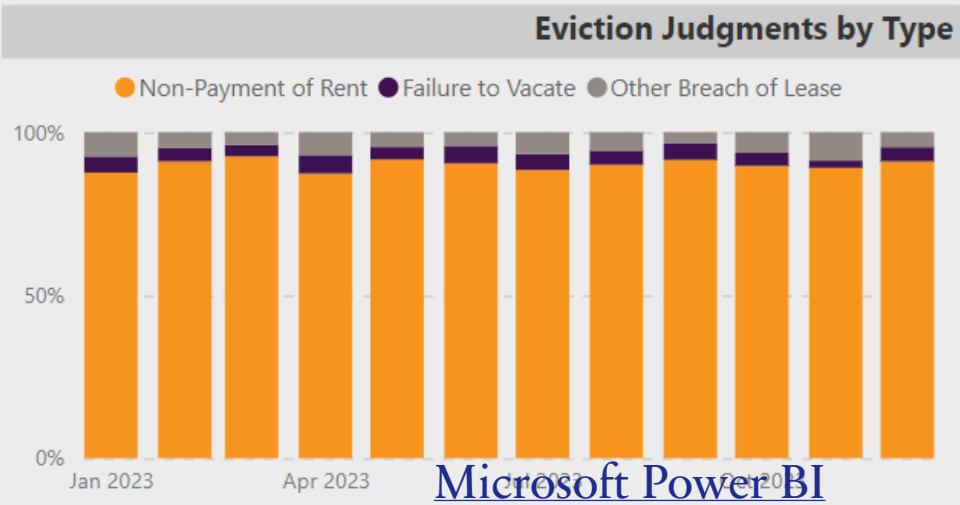
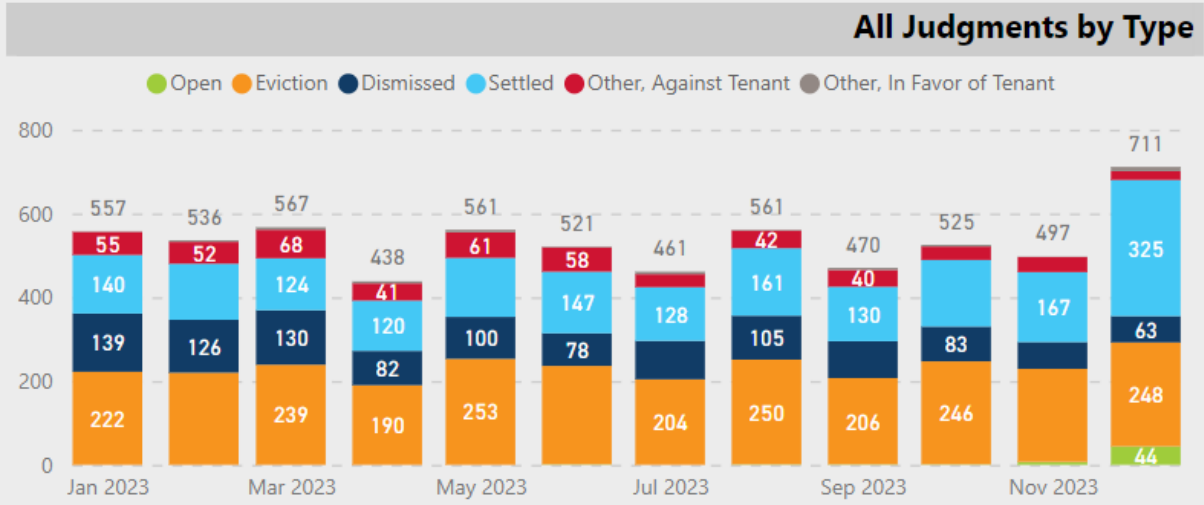
6420
Public Eviction Filings

2735
Total Evictions

View:
 Monthly
 Weekly



Housing Court Judgments



Next dashboard: Eviction Rates

Microsoft Power BI
(powerbigov.us)



Microsoft Power BI
(powerbigov.us)


Hennepin County, MN 2023 Point in Time count results

with 2022 comparisons

Every year, the US Department of Housing and Urban Development requires communities to do a census of people experiencing homelessness, in emergency shelter, transitional housing, and unsheltered locations. This year's count took place on January 25, 2023. The count enables communities to evaluate changes in the number of people experiencing homelessness in the community year on year.

3,312 people were experiencing homelessness on Jan 25, 2023

▲ 24%
from January 2022


469 people were unsheltered
▼ 3.7%

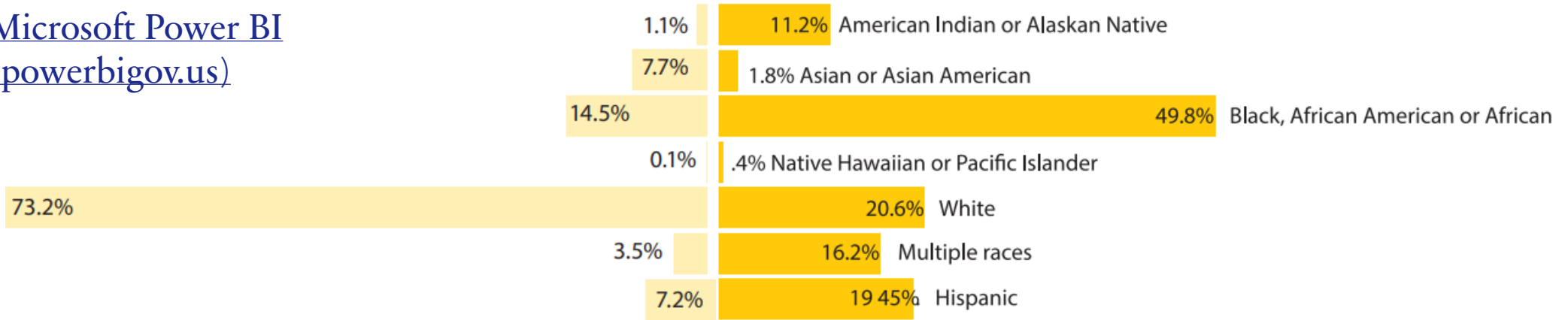

2,422 people were in emergency shelter
▲ 47.2%


421 people were in transitional housing
▼ 22.9%

Of the 3,312 people experiencing homelessness

Microsoft Power BI
(powerbigov.us)

Hennepin County population Of those experiencing homelessness



486
families
1,686 people

▲ 84.8%



1,605
single adults

▼ 6.7%



21
unaccompanied
children

▲ 16.6%



253
young adults
18 to 24

▲ 31.8%



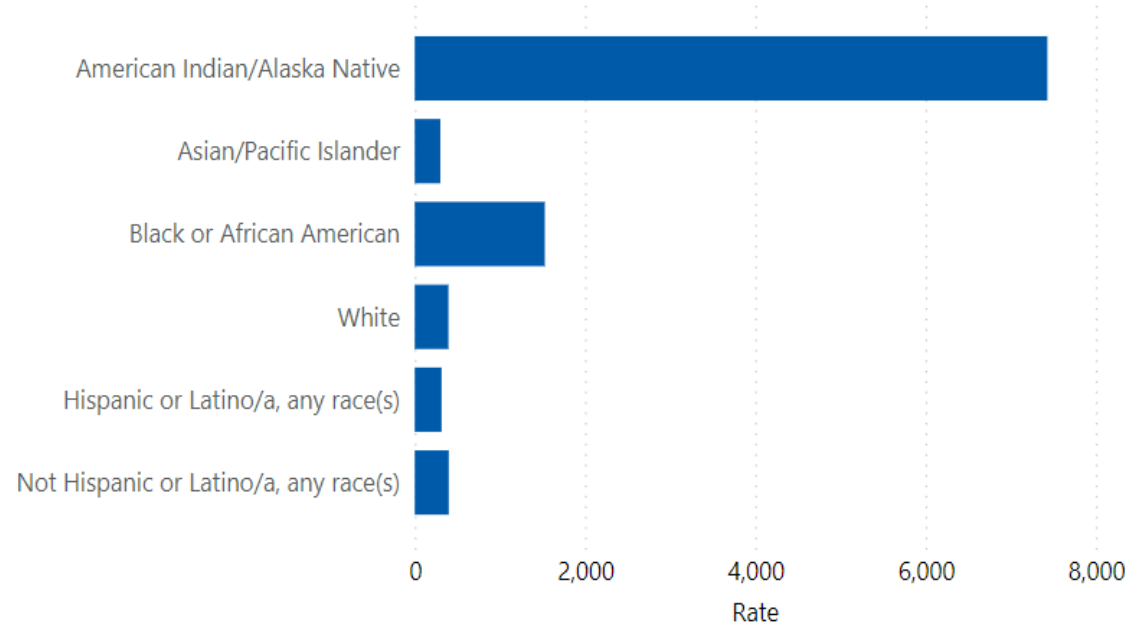


Viral Hepatitis C (HCV) Infections in Hennepin County

Year

- 2019
- 2020
- 2021
- 2022

Persons living with HCV by race/ethnicity rates per 100,000



Persons living with HCV by race/ethnicity rates per 100,000

Race/ethnicity	Rate
American Indian/Alaska Native	7,430
Asian/Pacific Islander	300
Black or African American	1,527
White	395
Hispanic or Latino/a, any race(s)	315
Not Hispanic or Latino/a, any race(s)	399

Data are updated annually and currently available through 2022.

Notes section

- Population estimates are from the 5-year American Community Survey (ACS) of the United States Census Bureau.
- Race/ethnicity groups includes persons identifying as Hispanic or Latino/a.
- Data exclude persons reported with multiple races and unknown race.

Please contact publichealthdata@hennepin.us with any questions or feedback about this report. Visit Microsoft's [Power BI For Consumers page](#) for more information on how to use Power BI.

Minnesota Department of Health data reported 5/26/2022 by K. Tibbetts

Healthcare for the Homeless patient list (n=6276): includes all unique patients with countable visits in 2020 and 2021 with eligible providers (physicians, nurse practitioners, nurses, dentists, mental health providers, case managers; excludes pharmacy, laboratory, and medical assistants)

Hepatitis C case list (n=707): confirmed, probable, and resolved cases of chronic and acute hepatitis C diagnosed between 2020-present in a Hennepin County resident and non-residents diagnosed at a Hennepin Healthcare Clinic

139
Matched

Diagnosis	Count
Hepatitis C - acute	16
Hepatitis C - chronic	123
Total	139

Case status	Count
Confirmed	102
Probable	16
Resolved	21
Total	139

County at Report	Count
Hennepin County	122
non-Hennepin County	17
Total	139

RaceEthnicity	Count
American Indian/Alaskan Native, NH	51
Asian, NH	*
Black/African American, NH	36
Hispanic	8
Multiple, NH	*
Unknown	*
White, NH	39
Total	139

IVDU	Count
YES	73

*counts have been suppressed for privacy

Case Diagnosis Date





PRIMARY GOALS

To be able to treat unhoused folks and create avenues to care that are low barrier

TREE OF LIBERATION

TREE OF STIGMA

LEAVES: ACTIONS

- Create plans together based on their goals
- Ask clarifying questions to understand the whole story & needs
- Share resources & education for their friends to have

LEAVES: ACTIONS

- Ignore the story & project your own agenda
- Require mandatory XYZ because "they won't do it otherwise"
- Only talk about the "disease" & not about what they have control over

TRUNK: BELIEFS

- "They can do _____"
- "They're telling me the truth"
- "They care about the community"

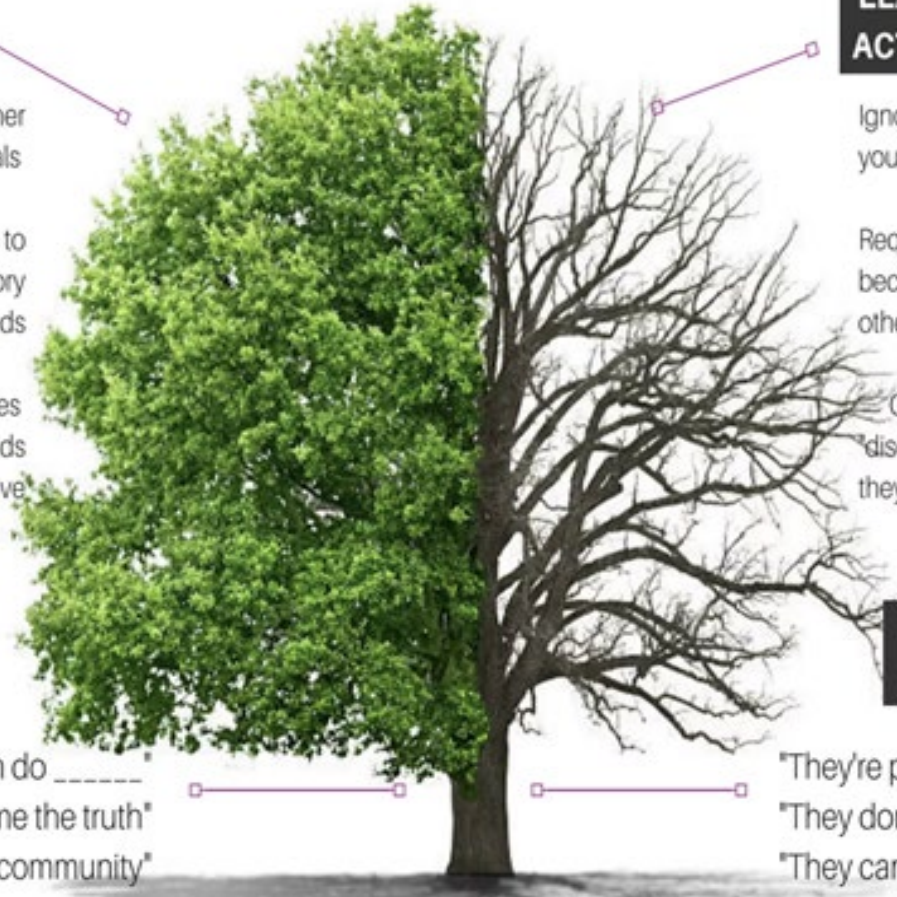
TRUNK: BELIEFS

- "They're probably lying"
- "They don't have the willpower"
- "They can't help themselves"

ROOTS: PERCEPTIONS

- Capable
- Trustworthy
- Caring

- Not trustworthy
- Lazy
- Sick



WHAT IS THE

CURRENT PROCESS

- Mostly a word of mouth service through our clinics or on the streets.
- Sometimes we hand out this flyer, so there is more information of what to expect
- Sometimes Casey will go out and get the clients, if they have a rapport built already especially with those Casey/Amy/Audrey have known a long time.
- Most of the time is it easier to let clients know where the clinic is and they can engage at their own time.
- Also, if people are already engaging with nurses in other clinics, having those nurses take lab draws previously to them coming in to speed up the process



Health Care
for the Homeless

Hep C treatment

Wednesday

8:30 a.m. to 12 p.m.

1 – 4 p.m.

Endeavors Clinic

1009 East 14th Street
(next to Elliot Park)

What to expect:

- Meet with clinic staff to set up paperwork in 1 – 2 visits
- Treatment takes 8 – 12 weeks
- Clinic visits once per week during treatment

Questions/appointments:

- Amy Gordon, *Nurse Practitioner*
612-290-6669
- Audrey Segovia, *Nurse*
612-396-2709
- Casey Holmstrom, *Community Health Specialist*
651-335-5441



10/2023

TRAJECTORY OF CONNECTION TO HEP C CARE



INITIAL ENGAGEMENT

This can look really slow and steady, not even talking about Hep C cares



CLIENT ENGAGEMENT

Client takes interest in their medical care



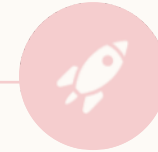
CLINIC VISIT

Set up cab ride and they make it in



TREATMENT

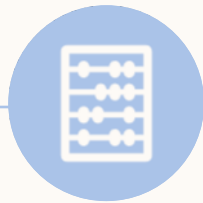
Start initially, stop randomly, re-engage in care. TREAT!



END OF TREATMENT

Helping to engage in other cares

BARRIERS TO CARE



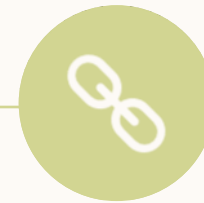
PEOPLE LIVING OUTSIDE

- Keeping medication safe
- Losing medications
- Encampment clearings
- Not a priority
- Overall moving around



SYSTEM BARRIERS

- Having the PA process
- Client's going in and out of jail/treatment/shelter



OTHER FACTORS

- Stigma
- Health Education
- Staffing

STRATEGIES TO SUPPORT MEDICATION ADHERENCE

- Address acute patient needs first (SNACKS)
- Build relationships
- Streamline efforts to connect clients with Hennepin Healthcare PharmD
- Medication storage
- Weekly clinic visits (if supportive of patient needs)
- HCH Hep C team approach (case management assistant, outreach RN, clinic RN, CMA, NP)
- Weekly outreach medication drops with syringe service exchange
- Ask about weekly compliance

THINGS TO NOTE

- Initial talking period can go slow!!!!!!!!!!!!!! Start with whatever they want to work on, and then once rapport is built engage in other cares.
- With treatment, our philosophy is if people identify they want care and we tell them what needs to get done and they say they are ready, we will move forward with treatment- regardless if we think they are ready or not.
- Once we are done with treatment, we have a model of the client who has been engaging can still access the Hep C clinic days.
- When people engage in Hep C treatment, individual is shown that they can be successful at other health related issues, more willing to engage in care at times it has been seen.

OTHER HEP C PROGRAMS



ABOUT SERVICES THE INSTITUTE CAREERS NEWS & EVENTS GET INVOLVED



ABOUT SERVICES THE

Ensuring Access

HCV treatment long proved inaccessible to those experiencing homelessness, as it was typically only available through a limited number of specialist medical providers. Our community-based HCV program changes that, establishing HCV as an area of primary care rather than specialty care. In partnership with the Massachusetts Department of Health, we invested in HCV training for clinicians and case managers to increase the spread of caregivers prepared to deliver high-quality HCV services, from screening and testing to treatment and counseling. Today, 16 (and counting) BHCHP primary care providers and two HCV care coordinators offer scheduled and walk-in HCV care across 14 locations, including shelter-based clinics and a mobile clinic van.

Quality Care

BHCHP provides patients the most up to date drug regimens to treat and cure HCV, as well as other medical services, such as HIV testing and treatment and substance use disorder treatment, to reduce their risk of complications and/or reinfection. Most uniquely, the treatment we provide isn't just pills; it's also the support of an HCV care coordinator, who offers check-ins, assistance navigating insurance and pharmaceutical systems, and linkage to other forms of medical care and social support. Partnership between patients and their care coordinator helps HCV treatment be accessible and manageable within the patients' specific personal contexts—and is why the vast majority of those enrolled in treatment walk away cured.



[Hepatitis C Care - Boston Health Care for the Homeless Program \(bhchp.org\)](https://www.bhchp.org)

HCH DATA!

In 2023:

- 21 people started and finished labs
- 14 people had SVR labs completed

THANK YOU

DNP Amy Gordon

RN Audrey Segovia

CHS Casey Holmstrom



REFERENCES

- [Microsoft Power BI \(powerbigov.us\)](https://powerbigov.us)
- [hennepin-county-2023-point-in-time-infographic.pdf](#)
- Tibbetts, K. Hennepin County Public Health, personal communication, May 26, 2022.
- [Barriers and facilitators to hepatitis C screening and treatment for people with lived experience of homelessness: A mixed-methods systematic review - PMC \(nih.gov\)](#)
- [Hepatitis C Care - Boston Health Care for the Homeless Program \(bhchp.org\)](#)
- [Microsoft Power BI \(powerbigov.us\)](#)
- [Respect to Connect: Undoing Stigma - National Harm Reduction Coalition](#)