Responsibilities and Activities for Care Navigation
HCV Outpatient Screening and Care

Overview: The care navigator promotes identification and screening of eligible individuals. S/he also ensures that positive HCV antibody tests are followed by an HCV RNA test and that patients diagnosed with chronic HCV are counseled in partnership with clinicians. The care navigator facilitates and addresses barriers to the care continuum, including laboratory testing and imaging to stage the disease, clinician-specialist case review (for uninsured patients), access to direct acting anti-viral (DAA) therapy, and treatment to cure based on negative HCV RNA test 12 weeks after completing treatment.
Expected time commitment: 10 hours per week (depending on number of patients)

Specific responsibilities related to HCV screening activities:

- Supporting clinic HCV screening:
  - Promote opt out patient education about HCV screening (flyers, posters, in-person communication)
  - Train, mentor, support other staff to assess patient eligibility and place screening orders
  - Place pending orders (for clinician approval) for eligible patients for HCV screening with reflex HCV RNA or follow-up blood draw for HCV RNA (if reflex testing is not available)
  - Monitor screening results (daily) to identify anti-HCV+ patients receive HCV RNA
  - Engage patients who are HCV RNA+ (i.e. chronically infected with HCV) in follow-up care and education
- Counseling and care navigation for chronic HCV:
  - Provide patients newly diagnosed with chronic HCV with one-on-one counseling and review the HCV educational mobile app in collaboration with the clinician
  - Arrange for follow-up laboratory testing and imaging of patients with chronic HCV
  - Assist with scheduling and reminding about clinic visits
  - Coordinate patient referral and adherence to specialist care (if insured)
  - Prepare case presentation form for primary care clinician-specialist case review during “office hours” to develop a management and treatment plan
  - Coordinate with social services to complete applications to Medicaid and pharmaceutical assistance programs (PAPs) for free DAA
- Tracking management and treatment:
  - Track management plan – including alcohol counseling, comorbidity management, medication modification (for interactions)
  - Ensure timely receipt of DAAs including initial prescription and any monthly renewals
  - Promote adherence to medication and call patients to troubleshoot adherence issues and check for side effects in collaboration with clinician or RN
  - Facilitate visits and laboratory tests per protocol from the clinician-specialist case review
  - Ensure patients receive final HCV RNA at 12 weeks post treatment completion to determine sustained virologic response (SVR12)
- Data management:
  - Track anti-HCV positive patients through REDCap including updating status of testing
  - Document clinical conditions, testing, and care of patients who have chronic HCV
  - Develop patient file for specialist review
  - Collaborate with clinical information technology (IT) team to develop performance reports for administrators and clinicians including: screening, care continuum, and cure based on SVR12