# Wake County Health & Human Services - Hepatitis C Program

Overall Goal: To make Wake County a healthier community by linking residents diagnosed with HCV to medical care and treatment for Hepatitis C while concurrently assisting clients to address other biopsychosocial barriers impacting their overall health and well-being.

#### Inputs

What We Invest

## **Measurable Outputs**

Actions We Take → People We Reach

#### **Results Based Outcomes**

What We Learned → How We Responded → Impact We Make

#### Actions

#### Organization:

 Staff (clinical social workers testers/nurses, health educators, data analyst, etc.)

#### Case Management:

- Community health education
- Client navigation and linkage to medical care and other services/resources
   Social service support
- Clinical Care/Disease Mgmt:
- Testing
- Community Outreach and Education
- Linkage to medical care - Linkage to other services/
- resources - Collaborative
- interdisciplinary community partnerships

#### Assessments:

- Client (demographics, health risks, use of services, etc.)
- Organization (current practices, work environment, infrastructure, etc.)
- Community (social service supports/resources, public health, accessability of medical care, transportation, food, etc.)

#### **Activites**

- Community testing for HCV/STIs (facilitated by testers/nurses) - Provide health education to community (facilitated by WCHS health educators)

#### WCHS - Hep C Clinical Social Workers:

- Recieve referrals to WCHS Hep C program for Wake County residents positive with Hepatitis C Engage clients through community based outreach (clinics organzations, home visits, etc.) Complete biopsychosocial assessment to determine the unique needs of each client Identify social detereminants of health and help address barriers (housing/food insecurity, lack of access to resources & support systems, substance use, employment insecurity, etc) Enroll clients in medical
- assistance programs (Medicaid, Project Access, UNC Charity Care, etc.) - Provide education on HCV and harm reduction practices (clients, community outreach and professionals) - Refer & link clients to medical
- care providers for Hep C treatment & primary care - Refer/link clients to other social services (food, transportation, mental health, etc) - Facilitate coordination of care
- between medical provider, service organizations and client
   Advocate for the needs of the clients (medically, socially, etc.)
   Engage in professional networking/collaborative efforts (participate on task forces, develop professional partnerships aimed to better serve client population,

#### **Participation**

# Clients: - Individuals 18+ - Baby Boomers - Homeless popu

- Homeless population - Individuals with mental health needs and/or chronic substance use disorder (active or in recovery)
- Individuals with comorbidities
- Individuals who are un/under-insured - Individuals who have private health insurance - Individuals who have Medicaid/Medicare

# Systemic:

- Private medical providers
   Community based medical providers
- Non Profit organizations (Project Access, etc.)
   Hospital providers and programs (UNC Charity Care, NCFIT program, etc)
- Key community change agents (task forces, etc.) - Community agencies and organizations (mental health & substance use providers, etc.)
- Wake County Social Services (Medicaid, etc.) - Local businesses

#### Short Term

# Clients: - Improved physiologic outcome (linkage to medical care, HCV cure and overall better health) - Established medical

- Improved psychosocial outcomes (linkage to mental health and/or substance services, etc.)
- Reduction of reinfection risk due to lifestyle changes
- Improved social networks and supports - Improved trust in govt. agencies, medical systems and support organization

#### Systemic:

- Íncreased client engagement in services
   Improved client access to medical care & social resources/services
   Improved community
- collaboration between agencies & organizations with an aim to provide integrated care - Increased awareness
- & acknowlegment of the impact of social determinants of health

#### Intermediate

#### - Continued focus on key community stake holders to invest/support increasing community access to HCV testing (county jail, hospitals, etc.)

- Models and procedures for more effective and efficient HCV case management/linkage to medical care
- Models for innovative implementation of technology to increase efficacy of HCV program
- Models for sustainability of HCV program and continuation of progress in the public health response to HCV (Wake County expansion request approval for HCV clinical social workers, etc.)
- Models for macro level solution focused efforts to identify and mitigate community issues (task forces, etc.)

### Long Term

- Individuals in the community cured of Hep C and linked to medical provider for primary care
- Reduction in rates of HCV infections in the community
- Reduction in number of individuals in need of long term medical care and monitoring of liver cirrhosis specifically related to chronic HCV
- Overall healthier local community
- Sustainability of HCV program and continued efficacy of public health response to HCV within the community
- Sustainability of community partnerships and professional collaboration with an integrated approach to addressing HCV
- Realized changes in cultural and institutional norms within and across communities

# Feedback Loop:

Monitoring Assumptions --- Considering External Factors --- Communicating with Partners --- Modeling Innovations --- Assessing of Sustainability --- Results-Based Outcome Evlaution

