Ontario Hepatitis C Team: The Ottawa Hospital and Regional Hepatitis Program

Programming Connection

Case Study

**Organization:** The Ottawa Hospital  
**Region:** Ontario  
**Prepared:** 2015

### Quick Facts

<table>
<thead>
<tr>
<th>Goal (immediate)</th>
<th>To increase access to hepatitis C care and treatment for priority populations; to increase knowledge and awareness to prevent the transmission of hepatitis C among priority populations; to increase collaboration, coordination and evidence-based practice across the range of stakeholders responding to hepatitis C</th>
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</thead>
<tbody>
<tr>
<td>Goal (ultimate)</td>
<td>To establish hepatitis C care and treatment services that will help curb the spread of hepatitis C by ensuring that people are diagnosed and treated</td>
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<tr>
<td>Participants</td>
<td>People living with hepatitis C</td>
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<tr>
<td>Setting</td>
<td>Hospital, community</td>
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</table>

**Required Resources**

**Community Liaison Program**

- **Full-time outreach social worker.** Builds and maintains relationships with clients and community-based service providers. Provides support and counselling to clients in the community.
- **Strong community partnerships** to improve services for hard-to-reach clients in community-based settings.

**Telemedicine**

- **Full-time outreach nurse.** Provides education to healthcare providers and support and care to clients living in rural communities.
- **Outreach social worker.** Works part-time with the Telemedicine Program to provide psychosocial support to Telemedicine Program clients over the phone or using the OTN.
- **Clinical coordinator.** Works part-time with the Telemedicine Program to provide education and support to external stakeholders on the benefits of the Telemedicine Program and to provide ongoing coordination of care for telemedicine clients.
- **Physician.** Provides care to clients, including monitoring clients on treatment, adjusting treatment if necessary and confirming treatment success once treatment is complete.
The Hepatitis Program faces a number of challenges in its work in the Community Liaison Program and the Telemedicine Program:

1. **Scheduling telemedicine appointments.** There is significant demand on the OTN for specialty medicine appointments. The Hepatitis Program has a set block of time reserved on the OTN, and it can be a challenge to schedule appointments with clients if they are not available during that time.

2. **Delays in lab results for telemedicine clients.** The Telemedicine Program is dealing with labs in rural areas that may not be familiar with tests associated with hepatitis C or that do not have access to the latest diagnostic technology. For example, Telemedicine Program clients do not have access to the Ottawa Hospital’s FibroScan, which means they must rely on FibroTests through their local labs. In addition, some hepatitis C genotypes require additional mutation testing to ensure that treatments will have the best chance of being effective. For a new telemedicine client, this challenge means that the time between their initial telemedicine appointment and their follow-up appointment can be up to four months if their lab does not complete all the appropriate tests.

3. **Marginalization and stigma.** Mainstream service providers may not have the experience necessary to work with clients in a marginalized group. The Hepatitis Program works to reduce the impact stigma has on their clients by educating external service providers about hepatitis C.

### Evaluation

#### Community Liaison Program

The Hepatitis Program collected data on the number of clients met through the Community Liaison Program between October 2013 and March 2014. These data are presented according to the type of organization that referred the clients:

- addictions programs: 39
- clinic/health centre: 27
- correctional facilities: 5
- drop-in centres: 1
- methadone maintenance clinics: 42
- shelters: 57
- transitional housing: 2

#### Telemedicine Program

The Hepatitis Program has collected the following data for the Telemedicine Program between January 2014 and October 2014:

- telemedicine sites engaged: 10
- education sessions held at rural sites: 6
- clients in care: 178
Anecdotally, improvement in healthcare providers’ awareness and understanding of hepatitis C in the Ottawa Hospital’s catchment area has been seen in the last year. Physicians and nurses are more aware of the diagnostic tests needed to confirm the presence of hepatitis C. This increase in basic knowledge has meant that an increasing number of clients who are referred to the Ottawa Hospital and Regional Hepatitis Program have a confirmed hepatitis C diagnosis, which in the past was not always the case.

The success of these educational efforts and the awareness they have raised of hepatitis C and the Ottawa Hospital and Regional Hepatitis Program are demonstrated by the fact that the number of telemedicine appointments has increased significantly since the inception of the program. In the beginning, two or three appointments were scheduled weekly. As of October 2014, 10 appointments on the OTN are scheduled each week, and there is a wait list for clients seeking care through the OTN.

What is the program?

The Ottawa Hospital and Regional Hepatitis Program is one of the 15 hepatitis C teams funded by the Ontario Ministry of Health and Long-term Care. The Hepatitis Program serves the City of Ottawa and the surrounding area.

The Hepatitis Program provides specialized care from physicians, including infectious disease specialists, a hepatologist and a psychiatrist; clinic-based and outreach nurses; a psychologist; a pharmacist; and clinic-based and outreach social workers. There is also a strong hepatitis C research program, which allows some clients to access treatments through clinical trials.

The program’s multidisciplinary team focuses on providing hepatitis treatment for clients who face barriers to care, including those co-infected with HIV and those experiencing mental illness, substance use, poverty and language barriers. The Hepatitis Program also emphasizes engaging youth, Aboriginal peoples and people who may have spent time in prison.

This case study describes two programs within the Hepatitis Program that were developed to further reduce barriers to care for clients. The Community Liaison Program, staffed by an outreach social worker, builds partnerships with community-based organizations to provide community-based hepatitis services to clients in Ottawa who may experience barriers to hospital-based care. The Telemedicine Program, staffed by a full-time outreach nurse and supported by a physician, provides access to hepatitis services to clients living outside of Ottawa.

Why Was the Program Developed?

Ottawa Hospital’s hepatitis C team is one of 15 such teams in Ontario. The teams were developed as part of a strategy to improve hepatitis C prevention, testing, treatment and support services. The primary mode of hepatitis C transmission in Canada is injection drug use. People who have used injection drugs in the past or who are currently using injection drugs may experience significant barriers to adequate and appropriate healthcare, including treatment for hepatitis C, in traditional settings.

The Ontario Ministry of Health and Long-term Care recognized this and established the Ontario Hepatitis C Nursing Program in 2007. Through this program, the Ministry of Health and Long-term Care wanted to increase access to treatment in under-serviced communities with high rates of hepatitis C.

A report on the Ontario Hepatitis C Nursing Program highlighted the need for more support for clients. The report recommended an expansion of the Ontario Hepatitis C Nursing Program to include a comprehensive approach to care. Sixteen hepatitis C teams were created to ensure a coordinated, comprehensive approach to the support and treatment of people at risk for and living with hepatitis C. As of January 2015, 15 teams are in operation.

The goal of Ontario’s hepatitis C strategy is to provide care and treatment services to help curb the spread of the virus by ensuring that people have access to prevention information and materials, are tested for hepatitis C
regularly and have access to treatment when they test positive. Its main objectives are:

- to increase access to hepatitis C care and treatment among priority populations
- to increase knowledge and awareness of hepatitis C to prevent transmission among priority populations
- to increase collaboration, coordination and evidence-based practice across the system responding to hepatitis C

Each team consists of (an) outreach worker(s), a community coordinator, nurse(s), psychosocial support workers, and peers. Teams usually also include registered social workers. In addition, they each have at least one consulting physician.

**How Does the Program Work?**

**Community Liaison Program**

The Community Liaison Program at the Ottawa Hospital and Regional Hepatitis Program was developed to reach, engage and reduce barriers to care for hard-to-reach clients living with hepatitis C. The program is coordinated by an outreach social worker who is responsible for developing and maintaining relationships with community-based agencies and clinics and for providing direct services to clients.

**The importance of developing community-based relationships**

The development of relationships with community-based agencies is an important part of the work. The Community Liaison Program has strong partnerships with a variety of community and social service agencies that serve the same population, including shelters, community health centres, methadone clinics and substance use programs. These relationships were built through networking and education to staff about the impact of hepatitis C among the population they serve. The social worker continues to nurture and maintain these relationships and build new ones as opportunities arise.

Community-based agencies are a crucial part of care for individuals with hepatitis C. These agencies provide referrals to the Hepatitis Program to ensure clients receive the care they need. They also provide a venue for the Hepatitis Program’s social worker to meet clients. Finally, community-based organizations build and maintain trusting relationships with their clients. Clients can rely on these existing relationships throughout their engagement with the Hepatitis Program as an added support.

**The role of the outreach social worker in the four stages of engagement**

The outreach social worker is available to work with any client living with hepatitis C who is considering a referral to the Hepatitis Program or who is already a client of the program. The outreach social worker provides support to clients appropriate to their level of need until they have been treated and achieved a sustained virological response. The outreach social worker has a lot of flexibility and can meet clients wherever they are comfortable in the community.

The outreach social worker connects with clients at four distinct stages of engagement in hepatitis C care. Services at each stage are tailored to the needs of clients and may include education, accompaniment to appointments, case management, counselling, referral services to other programs and resources, and advocacy on their behalf with other service providers.

At the first stage, when a client is contemplating engagement, the outreach social worker may meet with the client in a community setting to discuss the basics of hepatitis C, the Hepatitis Program and its services, and what the client might expect from care. The outreach social worker is there to counsel the client and answer any questions they may have.

At the second stage, when a client is seeking a referral, the outreach social worker may again meet with the client in a community setting and confirm they want to be referred to the Hepatitis Program. They may also review again the basics of hepatitis C and of the Hepatitis Program and its services. The outreach social worker may also facilitate the referral by setting up the first appointment and talking to the client about what they can expect from the first appointment.
The outreach social worker may provide orientation to the hospital for clients who might need it, as one way to reduce barriers for them. They will show clients where the clinic and labs are located and try to reduce any anxiety the client may feel about seeking care in this setting. During subsequent appointments, the outreach social worker can also arrange for community-based outreach workers (based in community health centres and other organizations) to accompany clients to appointments.

For clients who would prefer not to receive care at the hospital, arrangements can be made for hepatitis care to be provided by the Hepatitis Program’s outreach nurse in the community. Clients must, however, attend their first appointment at the hospital.

At the third stage, when a client is preparing for treatment, the outreach social worker may provide psychosocial support, including help with applications for financial assistance, support with food security and support finding adequate housing. The outreach social worker may also provide direct counselling to clients if needed.

At the final stage, when a client is on treatment, the outreach social worker continues to provide any psychosocial support the client needs and may provide some counselling. This may include counselling on how to remain healthy once a sustained virological response has been achieved and referrals to community-based programs that can continue working with the client, if that support is needed. Clients typically receive care at the Hepatitis Program for a year after the end of treatment, to monitor their blood work. During this time, the outreach social worker works with the client’s community-based primary care provider to transition the client back to their care.

**Telemedicine Program**

The Ottawa Hospital and Regional Hepatitis Program’s Telemedicine Program was developed to reduce barriers to specialist hepatitis care for people living in rural areas within the Champlain Local Health Integration Network. The program provides remote care and treatment to people with hepatitis C through the Ontario Telemedicine Network (OTN). Appointments are conducted remotely so that clients do not have to travel to Ottawa for care. Clients go to the OTN site nearest to their community and see their Hepatitis Program care provider in Ottawa through a video monitor.

The Hepatitis Program’s telemedicine team includes a full-time outreach nurse, an outreach social worker (who also works with the Community Liaison Program) and a physician who provides care and treatment through the Telemedicine Program once a week.

**The Ontario Telemedicine Network**

The Telemedicine Program is made possible by the OTN, a non-profit organization funded by the Government of Ontario. The service links rural primary care facilities, healthcare providers and clients with specialists in larger centres through the Internet. Clients need only travel as far as the nearest OTN site to receive specialist care. The OTN is used widely in Ontario for specialist appointments in cardiology, endocrinology and other specialty medicine.

OTN sites are housed in primary care facilities in smaller centres in rural areas. Appointments are conducted over a video monitor, allowing the client to both see and hear the care provider in Ottawa. Each OTN site has a designated OTN nurse who works with the client to make sure the technology works and faxes any necessary chart information to the Hepatitis Program during the appointment. The OTN nurse is present in the OTN office with clients during their telemedicine appointment. Service providers from the Hepatitis Program are connected to the client remotely through the Internet.

**Training for OTN and primary care providers in the Hepatitis Program’s catchment area**

The Ottawa Hospital and Regional Hepatitis Program’s Telemedicine Program became available through the OTN in 2013. During the first few months, the outreach nurse and the Hepatitis Program’s clinical coordinator met weekly with staff at the OTN sites to educate them on hepatitis C and the Hepatitis Program. This was done to prepare sites to support clients receiving hepatitis care and treatment.

Education on hepatitis C and the Hepatitis Program was also provided more broadly to care providers in the Champlain Local Health Integration Network. This was done to raise awareness of hepatitis C and to encourage providers to refer their clients with hepatitis C to the Hepatitis Program.
As the program has become established, educational sessions like these are offered as needed. For instance, OTN sites may request training for new staff or when a client is referred to an OTN site that has never had a client needing specialized hepatitis C care before.

Telemedicine appointments are the same as clinic-based appointments

Once a referral has been made, clients who do not live in the City of Ottawa are contacted by the Hepatitis Program’s outreach nurse to determine if they would prefer to seek care through telemedicine or onsite at the Ottawa Hospital. Wait times for a first appointment are significantly shorter for the Telemedicine Program and most clients choose to be seen this way. However, wait times for follow-up appointments may be longer for Telemedicine Program clients.

All appointments for clients who receive care through the Hepatitis Program’s Telemedicine Program are conducted through the OTN. The Hepatitis Program relies on the Ottawa Hospital’s general OTN booking coordinator to schedule appointments for clients at OTN sites. Telemedicine appointments are conducted remotely by the Hepatitis Program’s outreach nurse, though OTN appointments are also made with the Hepatitis Program’s physician, using the same technology. Any pre-appointment information is collected by the OTN nurse and faxed to the Hepatitis Program’s outreach nurse in Ottawa during the appointment.

When a Telemedicine Program client is ready to begin treatment, the outreach nurse travels to meet them. At this meeting the outreach nurse explains how to inject interferon (if it is part of treatment) and when and how to take their other medications. Medications may be dispensed at local pharmacies or may be delivered to a client’s home, if they are receiving medications through a pharmaceutical company’s compassionate release program.

As much as possible, Telemedicine Program clients are seen in their local health centres and hospitals if complications arise during treatment. The outreach nurse has worked with a number of local hospitals to brief them on some of the treatment side effects and has a good understanding of which community healthcare providers may be able to deal with complications during treatment. If clients cannot be seen in their community, the outreach nurse arranges for them to be seen onsite at the Ottawa Hospital.

The Hepatitis Program outreach nurse is in regular contact with Telemedicine Program clients, by phone, text or email or on the OTN. Any psychosocial support (including counselling, and help with insurance claims or claims through the Ontario Disability Support Program) is provided by the Hepatitis Program’s outreach social worker and outreach nurse.

Benefits of telemedicine

Although telemedicine can be challenging, there are obvious and important benefits for the client. Telemedicine extends the opportunity for specialized treatment and care to clients who live outside Ottawa. By bringing care to communities, rather than clients to the hospital, the Telemedicine Program reduces clients’ time away from work, school and family and enables them to avoid the costs they would incur if they had to travel to Ottawa.

Required Resources

Community Liaison Program

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- **Strong community partnerships** to improve services for hard-to-reach clients in community-based settings.

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Clinical coordinator. Works part-time with the Telemedicine Program to provide education and support to external stakeholders on the benefits of the Telemedicine Program and to provide ongoing coordination of care for telemedicine clients.

Physician. Provides care to clients, including monitoring clients on treatment, adjusting treatment if necessary and confirming treatment success once treatment is complete.

Barriers to Implementation

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**Learned and Confirmed**

Since its inception, the Ottawa Hospital and Regional Hepatitis Program has learned a number of ways to improve its outreach service delivery to clients:

- **Willingness to adapt.** Both the Community Liaison Program and the Telemedicine Program grew out of the team’s understanding that the Hepatitis Program needed to adapt to improve client care. These programs continue to evolve as the team sees new clients and collaborates with new service providers.

- **Clear communication.** Both the Community Liaison Program and the Telemedicine Program rely on strong relationships with both clients and service providers in the community. Clear, unambiguous communication with both clients and service providers about what needs to be done to ensure efficiency and optimize health outcomes is key. Ongoing discussions with clients and service providers strengthen collaboration.

**Program Materials**

- [Ottawa Hospital and Regional Hepatitis Program Information Pamphlet](http://www.catie.ca/sites/default/files/ottawa-regional-prog-info-pamphlet.pdf)
- [Ottawa Hospital and Regional Hepatitis Program Telemedicine Flyer](http://www.catie.ca/sites/default/files/ottawa-regional-telemedicine-flyer.pdf)

**Other Useful Materials**

Information found on the CATIE website

- [Information on prevention among people who use injection drugs](http://www.catie.ca/en/prevention/populations#injection)
- [Information on safer substance use and harm reduction programs](http://www.catie.ca/en/prevention/substance-use#programs)

**Resources**

**A Proposed Strategy to Address Hepatitis C in Ontario 2009-2014**
2009, Ontario Hepatitis C Task Force
Report
English, French

**Contact Information**

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