Hep C Community Navigation Model AND TOOLKIT

Improving Care for People Who Use Drugs and Other Impacted Populations

International Network on Hepatitis among Substance Users (INHSU) Model of Care Award

This project is funded by a INHSU Model of Care Award

IS YOUR MODEL OF HCV CARE THE BEST IN THE WORLD?

A global competition to find innovative models of hepatitis C care for people who use drugs

Hep C Community Navigation Model Dissemination

Implementation Support

Evaluation

Project Team

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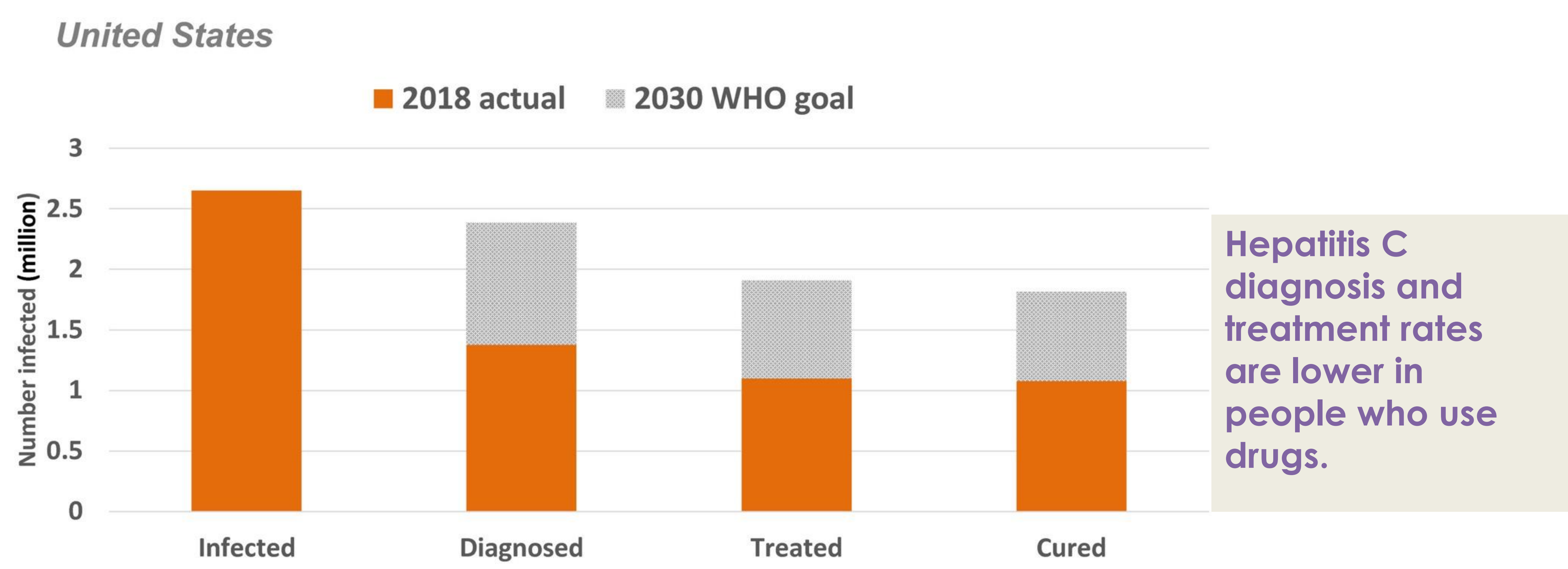
Objectives

- Describe a hepatitis C (Hep C) community navigation model developed in New York City that may be applicable to other jurisdictions
- Share Hep C navigation program training and implementation recommendations, tools and resources
- Describe limits of traditional training and the need to continuously build organizational and navigator capacity through a Community of Practice and Learning approach
- Share Health Department strategies to fund, develop and support ongoing navigation programs
- Share new NASTAD Hep C Community Navigation Toolkit and offer technical assistance to support implementation and adaption of the model

Contents

1. Hepatitis C Care Cascade in the United States
2. Health Care Navigation Model
3. Hep C Navigation Program Development
4. Training and Tools for Navigators
5. Community of Practice and Learning
6. Tele-Navigation
7. NASTAD Hep C Community Navigation Toolkit Microsite
8. Program Implementaion Technical Assistance Request Process
9. Evaluation

Hepatitis C Care Cascade in the US, 2018



Hepatitis C diagnosis and treatment rates are lower in people who use drugs.

Source: https://aasldpubs.onlinelibrary.wiley.com/doi/full/10.1002/cld.915

What are the barriers to testing and treatment?

"Routine preliminary anti-body testing but seldom immediate RNA confirmation"

provider-restrictions
homelessness
stigma
incarceration
mental-illness
confidentiality
treatment
clinic-hours
SUD
adherence
cost
labs
insurance
uninsured
housing
funding
confirmatory-testing
unstable
COVID
distrust
providers

"Lack of understanding and interest in serving PWUD"

"Provider restrictions and clinic availability "

"Cost of labs and office visits, for folks with limited insurance coverage"

Health Care Navigation

- Health navigation is an approach to **improving healthcare delivery and access** to needed care.
- People called "navigators" **work with each client to identify and reduce any barriers** they may face that make it difficult to get quality and timely care.
- **Services are tailored to each individual** and may include appointment scheduling, transportation, accompaniment, referrals, health education, and counselling.
- The overall goal is to **understand the health needs of the client and make sure they receive optimal care** regardless of their race, gender, socio-economic status and other factors that can influence access to quality care.

Health Care Navigation: A Review of Evidence:
www.thebodypro.com/article/health-navigation-a-review-of-the-evidence

Health Care Navigators Have Many Titles

- Patient Navigator
- Peer Navigator
- Care Coordinator
- Access to Care Specialist
- Case Manager
- Outreach Worker
- Patient Advocate
- Community Health Worker

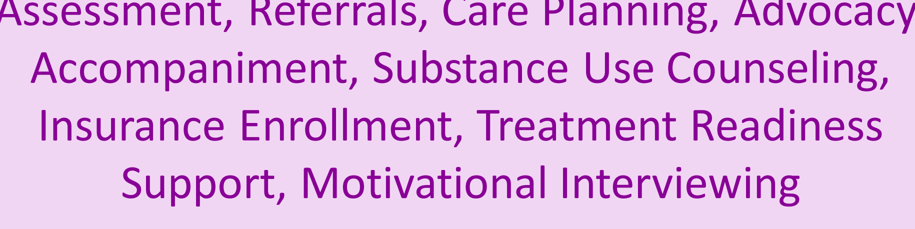
Patient Navigation Model for Hep C

Patient-centered engagement	• **Trust** enables positive behavior change • Helps identify and overcome individual barriers • Supports patient advocacy
Improved efficiency in medical care service delivery	• **Goal directed:** navigate through specific milestones • Treating provider can focus on clinical care, while Navigator coordinates referrals, appointments, and improves prior authorization: 93% covered vs. 81% without navigator (Vu, 2018)

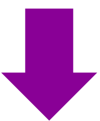
Successful navigation can reduce medical care needs and costs	• Hep C cure:
	  • Improves overall health outcomes and quality of life
	  • Reduces ongoing community transmission

Navigation Can Help Patients Get Hep C Cured

Outreach
Health Education, Linkage to Testing and Care, Telehealth Support



Treatment Adherence Support, Reinfection Prevention, Harm Reduction, Liver Care Plan



Treatment

Linkage to Care

Diagnosis

Unaware of Status

NYC Health Department Hepatitis B and C Community Navigation Program

- Piloted in 2012. Funded by NYC Council since 2014, has supported 32 organizations (hospitals, health centers, syringe exchange programs and community organizations) to employ one full time navigator staff and/or 1-2 peers
- Health Department developed program in collaboration with community organizations, and makes improvements each year
- Program goals: prevention, navigation through testing, linkage to care and treatment

2014 – 2019 Program Outcomes

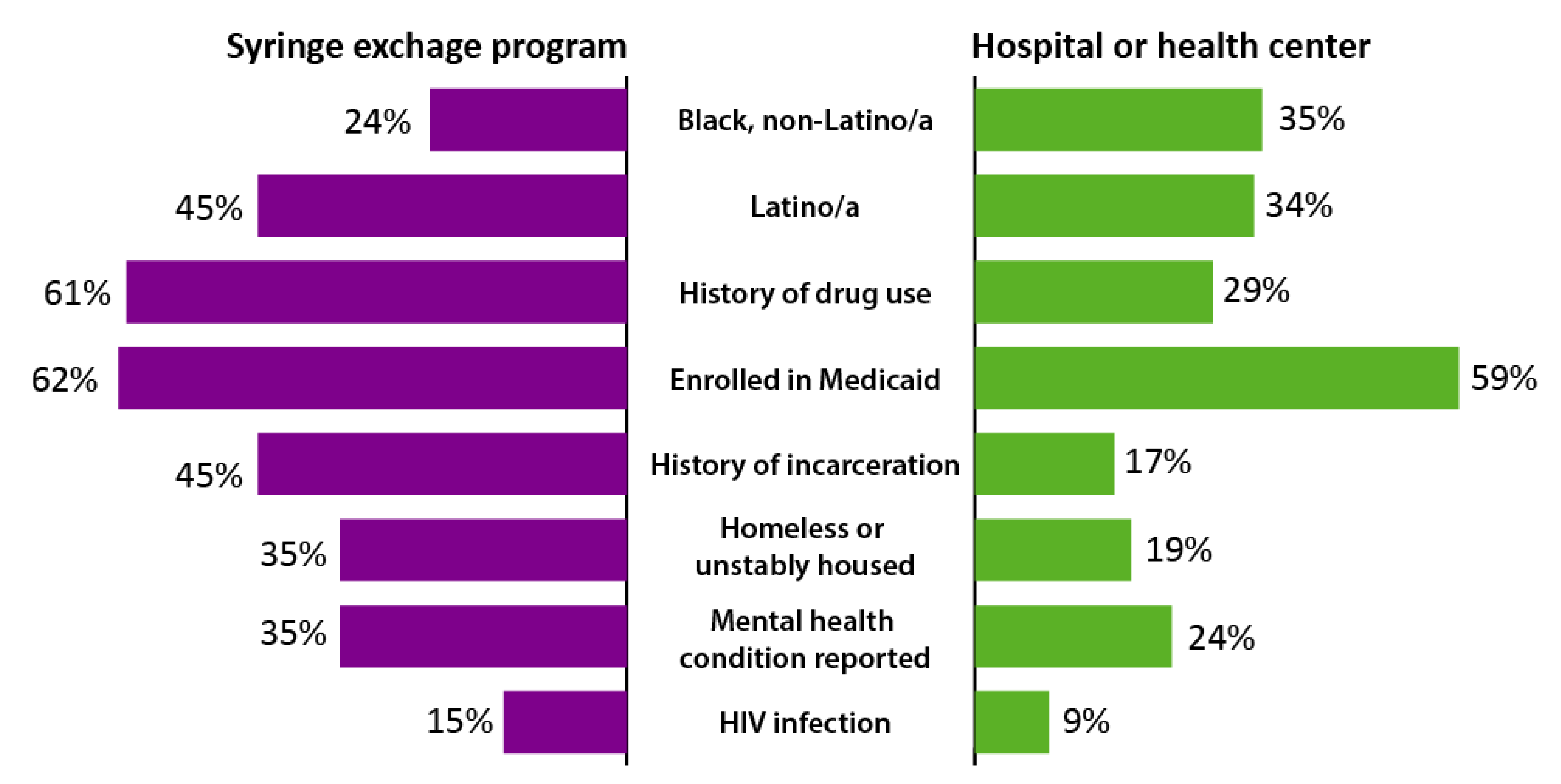
15,003 People at risk for or living with hepatitis B or C received hepatitis education and navigation

6,413 People were linked to hepatitis B or C medical care

3,187 People were treated for hepatitis B or C

Incorporated in PROJECT HERO Research Study in 8 organizations nationwide.

NYC Hep C Community Navigation Program Participant Characteristics



Hep C Navigation Workforce Development

From 2014 – 2019 the Hep C Community Navigation Progam trained and employed:

- **119 Syringe Service Program participants to become Hep C Peer Navigators**
- **53 Hep C Patient Navigators**

Navigators report they are doing this work because they **want to make a difference in people's lives**, and this role allows them to **give back to their communities**. To some peers, "this is a second chance at life."

Source: Hep C Peer Navigator Start-Up Survey 2015-2018 (N=62). NYC Hep C Peer Navigation Program. Unpublished data.

Are there Hep C Navigation Programs in your area?

If yes, please share in the chat box!

Program title and location,

and the most important support the program provides

Developing a Community Based Hep C Navigation Program

Guidance for Health Departments

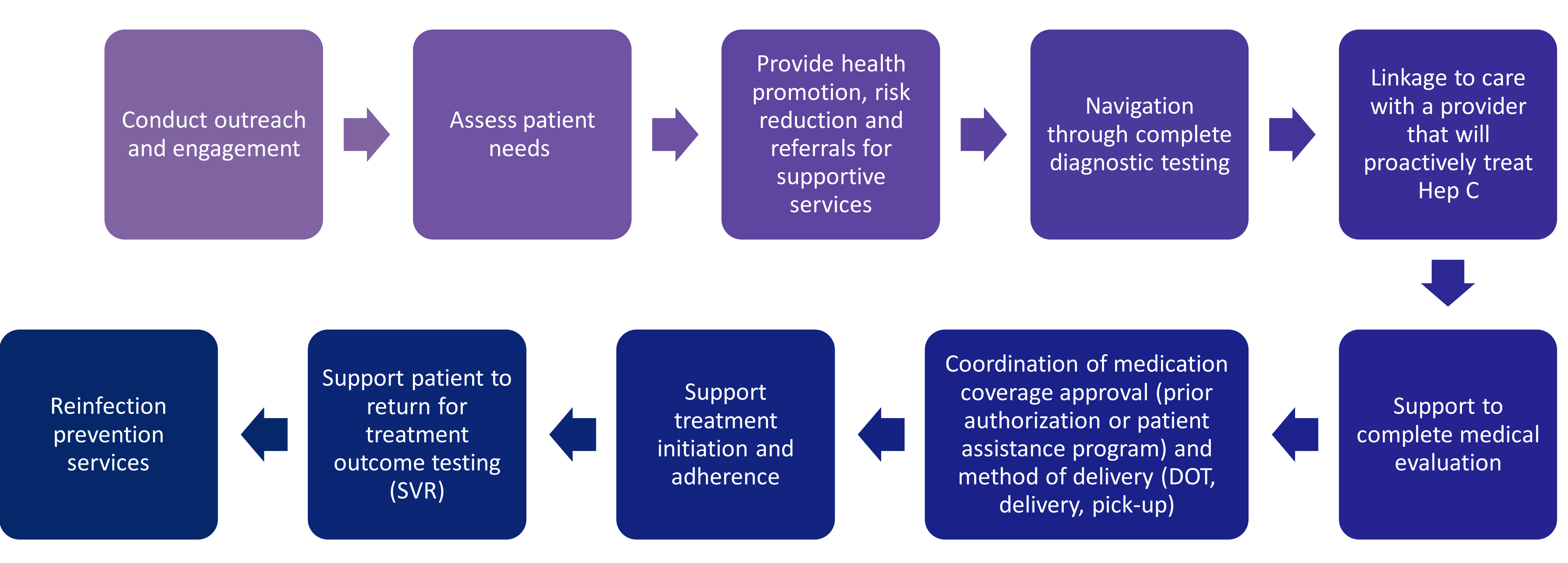
From the Patient's Point of View

Steps to Hep C Care and Cure

Hep C is a big deal. But it can be cured. You don't have to go through it alone.

Tool: Steps to Hep C Care and Cure

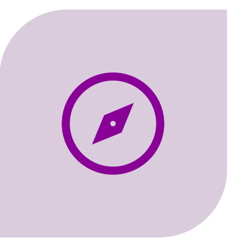
Hep C Navigation Program Milestones



Hep C Navigation Program Development Components

FUNDING

HEALTH DEPARTMENT ROLE & STAFFING



NAVIGATION GUIDANCE & TRAINING

HEALTH PROMOTION & NAVIGATION TOOLS

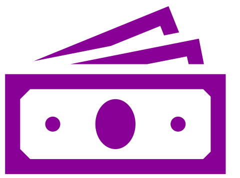
COMMUNITY OF PRACTICE AND LEARNING

PROGRAM MANAGEMENT TOOLS

DATA MANAGEMENT SYSTEMS

EVALUATION & REPORTING

Hep C Navigation Program Funding



For health departments

- Federal, State or City funding (HRSA, CDC, CMS, OMH, SAMHSA)
  - Leverage funds outside of hepatitis
- Private grants (pharma, foundation)

For community organizations

- Federal, State or City funding (City Council, NY budget for comprehensive care programs, rapid and DBS testing, HepCap (ADAP-like model for uninsured)
- Private grants
- 340B Reimbursements

Funding time period:
It can take 3-6 months to start up a new Hep C Navigation Program. Ongoing funding is ideal, one year of funding is likely minimum needed to prove effectiveness

Health Insurance Reimbursement for Navigation Services:
- Care Coordination
- Community Health Work
- Peer Navigation
- Health Homes

Hep C Navigation Program Planning for Health Departments

Data to Care

- Use surveillance and other available data to identify high burden areas, organization serving people at risk, and high risk or underserved patients.
- Support organizations to use electronic health record data to assess and monitor program level screening and treatment data.

Community Engagement

- Identify and maintain relationships with providers and organizations through ongoing community engagement, resource mapping and coalition building.

Health Equity

- Plan to work with community organizations to develop strategies to engage underserved people at risk.

Health Department Program Management Role

- Secure funding
- Develop **scopes of services**, manage contracts
- Develop program protocol, data management and reporting system, and program materials
- Develop and provide start-up and ongoing **training and technical assistance** for community navigators
- **Collect and analyze program data**, conduct quality assurance activities and create regular program reports
- **Facilitate** regular Community of Practice and Learning meetings with navigators from various programs
- Conduct regular **program evaluations** and produce **reports**

Program Manager	Data Manager	Program Assistant
• Public Health or Social Work background • Excellent organization, interpersonal skills and problem-solving skills • Health communications tools development skills • Effective meeting and training facilitation skills	• Ability to access surveillance data if available • Develop and maintain program database • Collect data from community organizations, clean, and analyze regularly • Contribute to quality improvement activities	• Public Health student intern or community coordinator • Excellent organization, interpersonal skills • Create program progress reports, assist with meeting organization, build program management skills

Health Department Program Management Tools

Program Management Protocol

CONTENTS:

Scope of Services....1
Annual Review....1
Staff involved, roles & responsibilities....1
Program start-up....2
Meetings....2
Technical Assistance....3
Site Visits....3
Data Management....3
Approving Payment....4
List of sites & funding designations....4
Start up email....5
Biscom instructions....7
Check Hep C meeting checklist....8

SCOPE OF SERVICES

See contracts: S:\BCD\COMDISshared\Hep Prevention and Control\Capacity Building\Direct Services\City Council FY2017\Check Hep C FY2017\Contracts

- Background
- Goals
- Program Requirements
- DOHMH Roles
- Staff Requirements
- Services
- Eligible clients
- Performance Measures
- Permitted Use of Funding
- Reporting Methods
- Reimbursements

ANNUAL REVIEW

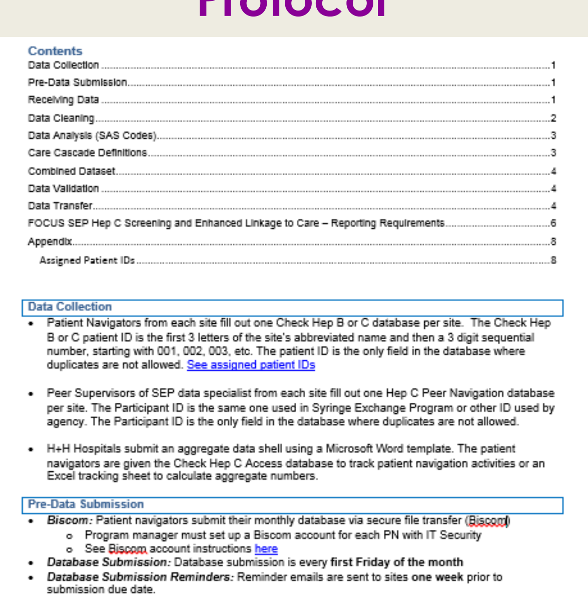
1. Annually review and update the Check Hep C program protocol and database
   a. Go to Check Hep C Model to make any revisions and save previous versions into the appropriate year folder (i.e. "2016-17")

STAFF INVOLVED, ROLES & RESPONSIBILITIES

See roles: \Capacity Building\Direct Services\City Council FY2017\General Program Management\FY17 CHC Program Management Plan_10-17-16.docx

1. Program Director
   a. Contract management (execution and scope negotiations)
2. Clinical Coordinator
   a. Data management
3. Program Manager
   a. Set up Biscom accounts for new users (Patient Navigators)
   b. Manage contact list
   c. Correspondence with sites
   d. Meeting Notes

Data Management Protocol



Contents

Data Collection....1
Pre-Data Submission....1
Receiving Data....1
Data Cleaning....2
Data Analysis (SAS Codes)....3
Care Cascade Definitions....3
Combined Dataset....4
Data Validation....4
Data Transfer....4
FOCUS SEP Hep C Screening and Enhanced Linkage to Care – Reporting Requirements....6
Appendix....8
Assigned Patient IDs....8

Data Collection

- Patient Navigators from each site fill out one Check Hep B or C database per site. The Check Hep B or C patient ID is the first 3 letters of the site's abbreviated name and then a 3 digit sequential number, starting with 001, 002, 003, etc. The patient ID is the only field in the database where duplicates are not allowed. See assigned patient IDs
- Peer Supervisors of SEP data specialist from each site fill out one Hep C Peer Navigation database per site. The Participant ID is the same one used in Syringe Exchange Program or other ID used by agency. The Participant ID is the only field in the database where duplicates are not allowed.
- H+H Hospitals submit an aggregate data shell using a Microsoft Word template. The patient navigators are given the Check Hep C Access database to track patient navigation activities or an Excel tracking sheet to calculate aggregate numbers.

Pre-Data Submission

- *Biscom:* Patient navigators submit their monthly database via secure file transfer (Biscom)
  - Program manager must set up a Biscom account for each PN with IT Security
  - See Biscom account instructions here
- ***Database Submission:*** Database submission is every **first Friday of the month**
- ***Database Submission Reminders:*** Reminder emails are sent to sites **one week** prior to submission due date.

Receiving Data

Saving Database

- Receive and download each database from Biscom. Save database in each site folder

Hep C Program Management Dashboard

Updated on: 6/6/2018

Hep C Peer Navigation (NYCC)

Project Status **On track**

ENROLLMENT (JULY 1, 2017 - JUNE 30, 2018)

Total / Goal (1500)

Site	Total
ALL SITES	1471
AFTER HOURS PROJECT	152
AIDS CENTER OF...	152
BOOM! HEALTH	135
COMMUNITY HEALTH...	99
FAMILY SERVICES...	98
HARLEM UNITED	83
HOUSING WORKS	31
LOWER EAST SIDE HARM...	62
NEW YORK HARM...	115
POSITIVE HEALTH...	100
PRAXIS HOUSING...	51
SAFE HORIZON...	30
ST. ANN'S CORNER OF...	147
VOCAL-NY	103
WASHINGTON HEIGHTS...	113

Check Hep C (NYCC)

Project Status **On track**

ENROLLMENT (JULY 1, 2017 - JUNE 30, 2018)

Total / Goal (812)

Site	Total
ALL SITES	1219
BEDFORD STUYVESANT FAMILY HEALTH CENTER	65
BOOM! HEALTH	78
BRONX LEBANON HOSPITAL	148
BROWNSVILLE MULTISERVICE FAMILY...	93
COMMUNITY HEALTHCARE NETWORK	85
H+H BELLEVUE HOSPITAL	84
H+H CONEY ISLAND HOSPITAL	316
H+H KINGS COUNTY HOSPITAL	36
HARLEM UNITED	62
MONTEFIORE COMPREHENSIVE HEALTH...	163
*FAMILY SERVICES NETWORK OF NEW YORK	41
*PRAXIS HOUSING INITIATIVES	48

Check Hep C - FOCUS Enhanced LTC (SEPs)

Project Status **On track**

ENROLLMENT (OCT 1, 2016 - MAR 31, 2018)

Total / Goal (400)

Site	Total
ALL SITES	27
AFTER HOURS PROJECT	15
COMMUNITY HEALTH ACTION OF STATEN ISLAND	8
LOWER EAST SIDE HARM REDUCTION CENTER	4

Check Hep C (Pharma)

Project Status **Complete - reporting**

ENROLLMENT (OCT 1, 2016 - DEC 31, 2017)

Total / Goal (225)

Site	Total
ALL SITES	305
CARE FOR THE HOMELESS	81
HOUSING WORKS EAST NEW YORK CLINIC	154
WYCKOFF HEIGHTS MEDICAL CENTER	70

Check Hep C (All programs)	
Total Enrolled	1551
Total Goal	1437

Program Implementation Report Template

This Program Implementation Report was developed to track organization capacity and the implementation of hepatitis navigation programs administered by NYC Health Department Viral Hepatitis Program. The checklist below provides a quick reference of key requirements for your program.

In each tab you will find categories for specific implementation actitivies or areas. **Please record your respons**

This report must be submitted quarterly. Sections must be completed by the assigned due dates, and updat please provide a "Status Update." Quarterly submission dates: 10/6/17, 1/12/18, 4/6/18, 7/6/18

Please refer to the program scope for clarification on required activities, if needed.

Sections	Due Date
Organization Profile	10/6/2017
Check Hep B Implementation	10/6/2017
Check Hep C Implementation	10/6/2017
HBV Screening Assessment (will be provided)	1/12/2018
HCV Screening Assessment	1/12/2018

Implementation Checklist	Complete
Hire Hep B patient navigator(s)	No
Hire Hep C patient navigator(s)	No
Appoint patient navigator supervisor	No
Setup for patient navigator	No
Develop a workflow for navigator to identify HBV participants who need care	No
Develop a workflow for navigator to identify HCV participants who need care	No
Hep B medical care and treatment available on-site	No
Hep C medical care and treatment available on-site	No
Identify Hep B clinical provider champion	No
Identify Hep C clinical provider champion	No
Nominate one provider for HBV treatment training	No
Nominate one provider for HCV treatment training	No

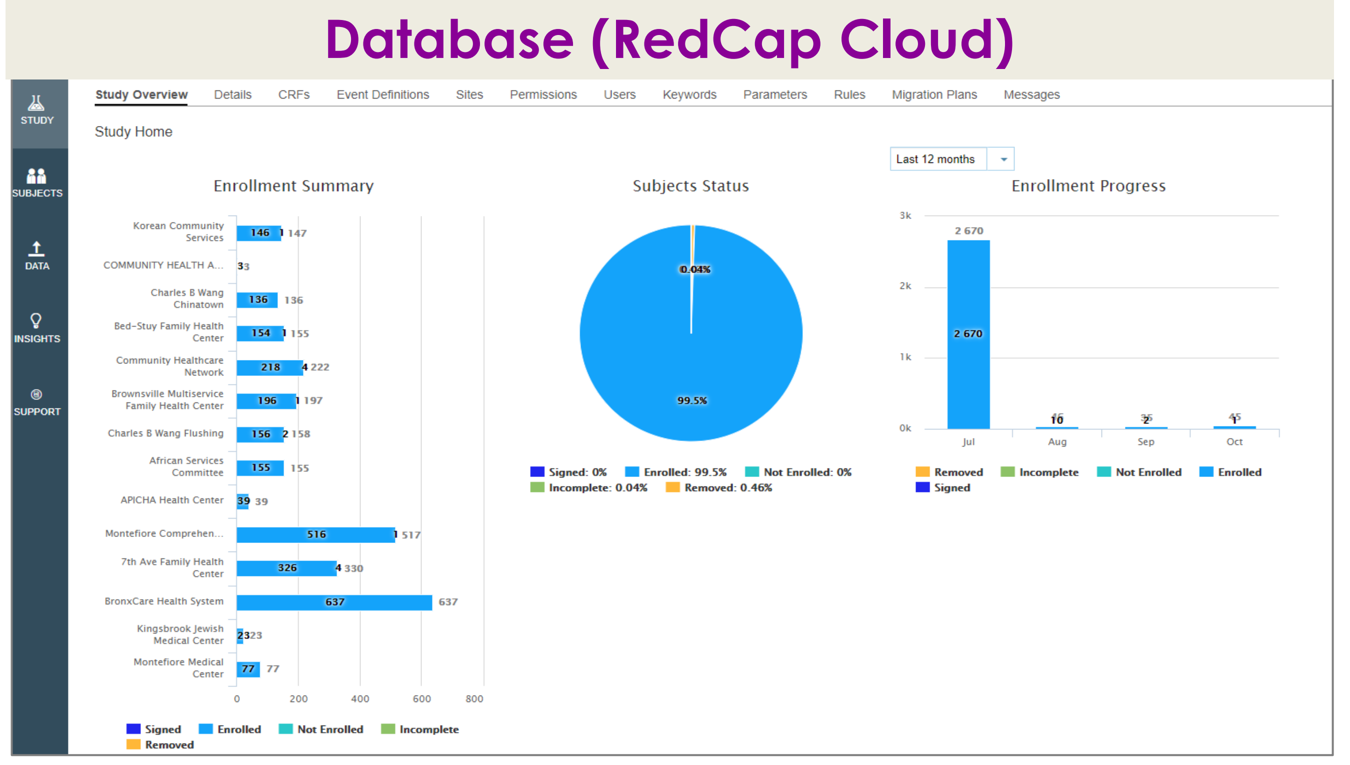
Hepatitis C (HCV) Screening Assessment: Electronic Health Record Query Tool

Health Center:	
Name:	
Address:	
Review Period:	Jan 1, 2019 - Dec 31, 2019

Item	Measure	Interpretation	Number
1	Number of unique patients with at least one visit in review period (Jan 1, 2019 - Dec 31, 2019) [I]		#
2	Of Item 1, number with at least one risk factor for hepatitis C, including birth year 1945 - 1965 [IIa], HIV positive [IIb], or other drug use/sexual risk factors [IIc], or include all unique patients if universal screening is policy*	*At-risk patients*	#
3	From Item 2, number with documentation of a hepatitis C antibody test order, test result [IIIa], or hepatitis C RNA test order or test result ever [IIIb], or hepatitis C diagnosis in problem list, ICD 10, or SNOMED codes [IIIc]		#
4	**Percent of at-risk patients with a visit at the health center during review period, ever screened for hepatitis C**	*Screening rate= Item 3 / Item 2 (turn to a percent)*	#VALUE!
5	Of Item 1, number with a positive hepatitis C RNA test result [IVa], or diagnosis of hepatitis C in problem list, ICD-10, or SNOMED codes [IVb]		#
6	Number of patients from Item 5 for whom hepatitis C medication was prescribed or who are now hepatitis C RNA negative (most recent test result) [V]		#
7	Percent of patients with hepatitis C infection who initiated treatment	*Item 6 / Item 5 (turn to a percent)*	#VALUE!

[I] CPT codes for patient encounter during the reporting period: CPT codes 99201 - 99205 (new patients), 99212 – 99215 (established patients), 99495, 99496 (transitional care management), HCPCS codes (Medicare) G0402, G0438, G0439; G0466, G0467, G0468 (FQHCs only); Inpatient CPT codes could include 99221, 99222, 99223 (initial care) and 99234, 99235, 99236 (admitted & discharged); Other billing codes may be applicable to your practice, only use those that would indicate an encounter where hepatitis C screening would be recommended and appropriate according to institutional policies and/or practices, such as Emergency Department admissions, CPT codes 99281-99285

Reporting Tools (Patient level data)



Surveillance Database Match (MAVEN)

Electronic Disease Surveillance System Terms and Conditions of Use.
If you do not agree to be bound by the terms and conditions, promptly exit this application.

The Electronic Disease Surveillance System and related services are provided subject to your compliance with the terms and conditions set forth below. Please read the following information carefully. If you do not agree to be bound by the terms and conditions, promptly exit this application.

This AGREEMENT is entered into by and between the City of New York, Department of Health and Mental Hygiene and you, the User of the Department's Electronic Disease Surveillance

This secure system provides a method for electronically entering, updating, reporting, and tracking notifiable conditions in New York City.

Login

Username: ddiazmunoz

Password: •••••••••

Application: Main

Login

Powered by Maven, a product of Conduent Public Health Solutions

Health Department Program Management Tools

CPL Meeting Planning Checklist & Curriculum

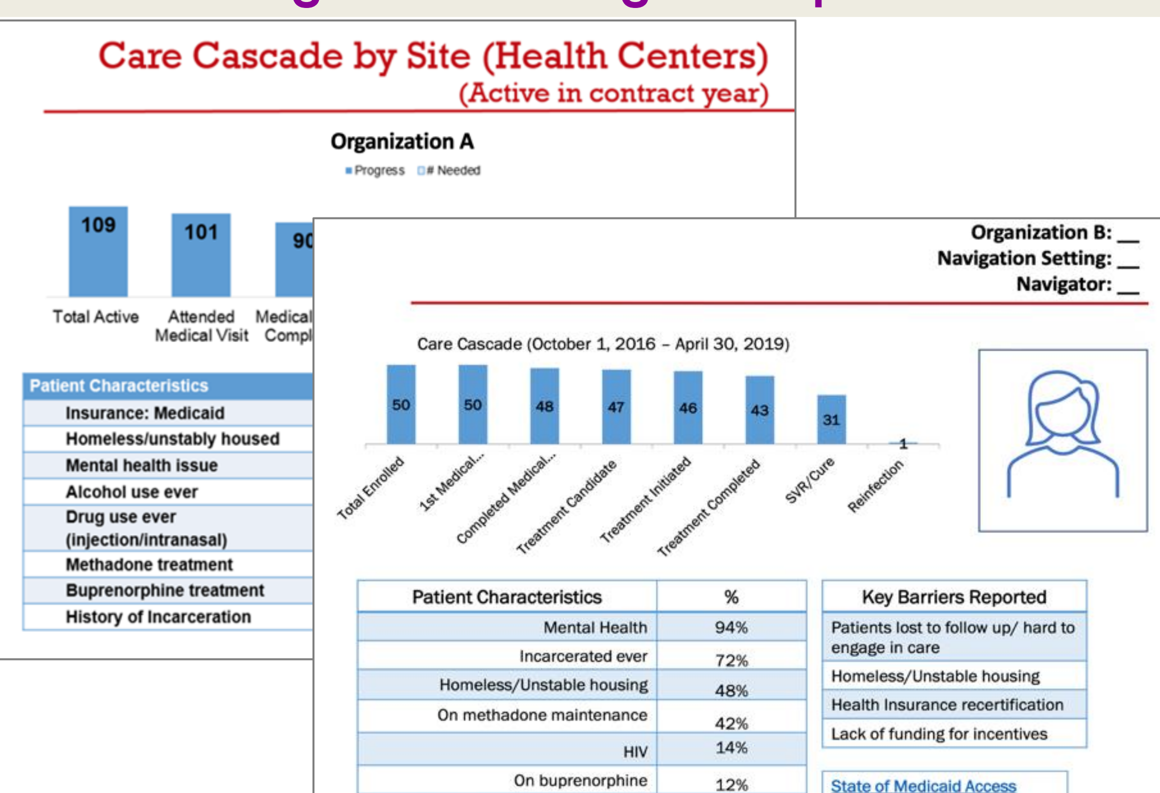
Purpose of monthly training/meetings: Showcase navigator activities and patient clinical progress. Guide navigators throughout the program activities timeline, use of materials, reporting, and getting patients through treatment. Address gaps in navigator activities, care continuum, and reporting.

General meeting outline:
1. Announcements and Program Updates
2. Data Presentation/Progress report incorporating TA topic
3. Case Discussion
4. Training Topic

Facilitator/Presentation Preparer notes:
Progress report: Showcase program-wide data relevant to program timeline (for example, first month = enrollment, assessment, referrals), and highlight sites that are doing exceptionally well, ask: what is your strategy for enrollment and completing assessments?
After PN activities/data review: (5 minutes) In pairs or trios discuss any challenges, successes, or best practices you're having in completing PN activities and services, or working with patients or providers. (10 minutes) Share and discuss as a group.
Case Discussion: Ask in advance for a volunteer or select a PN to share a case with the group at the next meeting; it can be a successful or challenging case. This allows time to research answers or find resources that can be shared at the meeting regarding the case situation.

#	TA/*Training Topic	Description	Length	Date
1	**Start-up training for Patient Navigators** ***Discharge/Transition Planning for inactive patients**	***Administer Patient Navigator Survey*** • Program Overview: Program Protocol, Health Promotion Guide, Patient Navigation Form • Share the Self-sufficiency Assessment Check List to identify inactive patients and document as discharged • Activity: In pairs (matching new with experienced navigator), go through the PN assessment using the form and Health Promotion Guide module 1-2 • Supplemental materials: patient education brochures/pocket cards, short list of resources	2 hrs	9/14/16
2	**Enrollment, Assessment & Referrals** ***Radiology services for the uninsured**	• Announcements/program updates • Progress report and discussion: Enrollment, assessment, referrals • Activity: In pairs, identify appropriate and inappropriate referrals and play out patient scenarios • Radiology services for the uninsured • Activity: Form pairs or small groups based on populations served, and discuss patient scenarios about alcohol screening, challenges and best practices.	2 hrs	10/12/16
3	***Current Hep B medical care & treatment recommendations** Guest: Amy Tang	• Announcements/program updates • Check in: PN materials usage, are they helpful, any questions? • Progress report and discussion: • Case discussion	2 hrs	11/9/16
4	**Setting up Informal MOUs**	• Announcements/program updates • Progress report and discussion: • Case discussion	2 hrs	12/14/16

Organization Progress Reports



Outcome Measures

Outcome	Indicator: Community Org Navigation Database	Indicator: Health Department Surveillance System
Linkage to care	• Date attended first medical visit	• Received a Hep C lab report, indicating a medical visit occurred
Treated	• Dates or checkboxes: Started and Completed treatment • SVR outcome (cured, not cured, unknown)	• RNA positive test reported followed by RNA negative test reported
Patient navigation effort	• Health promotion provided, Medical and supportive service referrals made, outreach attempt, care plans, treatment adherence check-in	

Example: Hep C Navigation Program Outcome Report

CHECK HEP C PATIENT NAVIGATION PROGRAM

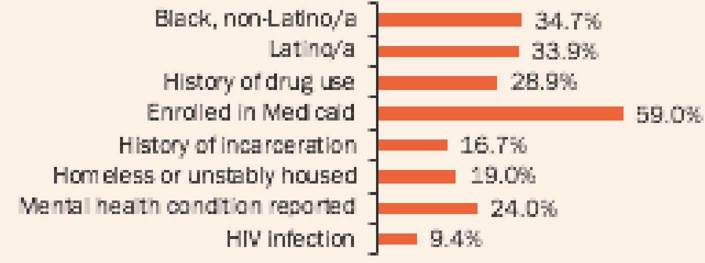
Since 2014, the Viral Hepatitis Initiative has supported health centers and hospitals to provide patient navigation to people living with chronic hepatitis C. Check Hep C patient navigators coordinate patient care to help them complete hepatitis C testing, medical evaluation and treatment. In FY19 (July 1, 2018–June 30, 2019), the Program served 1,253 people living with chronic hepatitis C.

FY15–FY19 Program Outcomes

From July 1, 2014, through June 30, 2019:

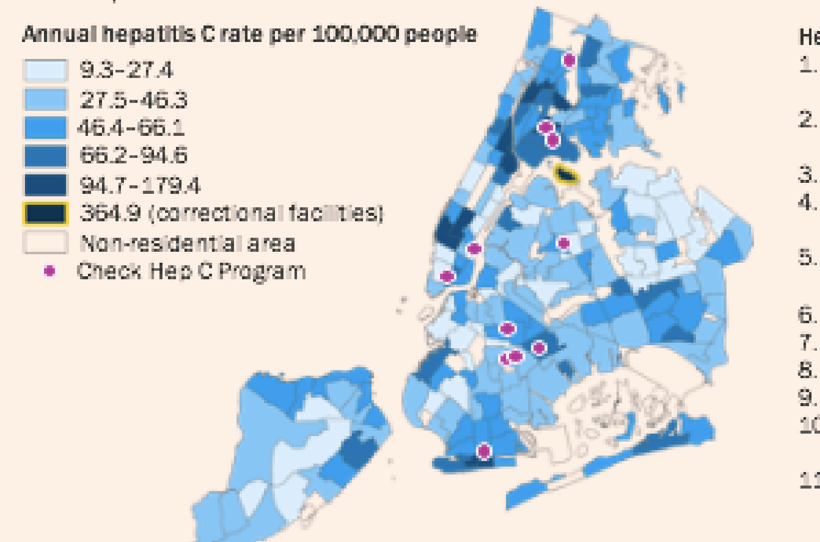
3,667 Number of enrollees **91%** Number of enrollees linked to care **59%** Number of enrollees linked to care who were treated

Patient Characteristics



Check Hep C Health Centers and Hospitals

The map below shows the rate of people newly reported with chronic hepatitis C in New York City in 2019 by neighborhood tabulation area and Check Hep C Patient Navigation Program health center and hospital locations.



Health Centers and Hospitals

1. APICHA Community Health Center
2. Bedford-Stuyvesant Family Health Center
3. BronxCare Health System
4. Brownsville Multiservice Family Health Center
5. Community Healthcare Network
6. H+H Bellevue Hospital
7. H+H Coney Island Hospital
8. H+H Elmhurst Hospital
9. H+H Kings County Hospital
10. Kingsbrook Jewish Medical Center
11. Montefiore Comprehensive Health Care Center

Determine which type of Navigators are needed to effectively engage people at risk

Peer Navigator	Patient Navigator
• Personal experience with Hep C and target patient experience (drug use, incarceration, sex work, or other) • Bilingual/Bicultural (when appropriate) • Experience in harm reduction and ability to provide services judgment-free	• College level education • Bilingual/Bicultural (when appropriate) • Experience working with target populations • Experience in harm reduction programs, safety-net clinics or hospitals

Note: Sample job descriptions provided in NASTAD toolkit page

Program Manager	Data Manager and database systems specialist (IT, EMR, etc)	Clinical Champion
• Supervises the navigator's work • Coordinates implementation of navigation program and completes program reports • Proposes and coordinates quality improvement activities	• Enter patient level data into Hep C navigation database (if peer and patient navigators don't have the capacity) • Develops EMR systems for patient navigation workflows • Develops reports of organization's screening and treatment rates	• Hep C treating provider enthusiastic about curing Hep C in the organization • Works with navigator and program manager to implement navigation program • Supports and advocates for systems changes

Community Organization Systems to Support Successful Navigation

Streamline hepatitis screening systems

- Automated system alerts (EHR/case management software)
- Standing order for laboratory tests
- Universal screening
- Hep C antibody to RNA and genotype reflex testing

Develop a patient registry and routinize patient list generation (daily, weekly, monthly)

- Use for case management to prompt screening, linkage to care, complete medical evaluation and treatment

Health Center A
Universal screening; standing order for RNA and genotype tests so Navigator can order labs on her own. In 2019, 84% of patients were screened for Hep C, medical evaluation completed by 2nd visit, and 74% RNA positive initiated treatment.

Community Organization Systems to Support Successful Navigation

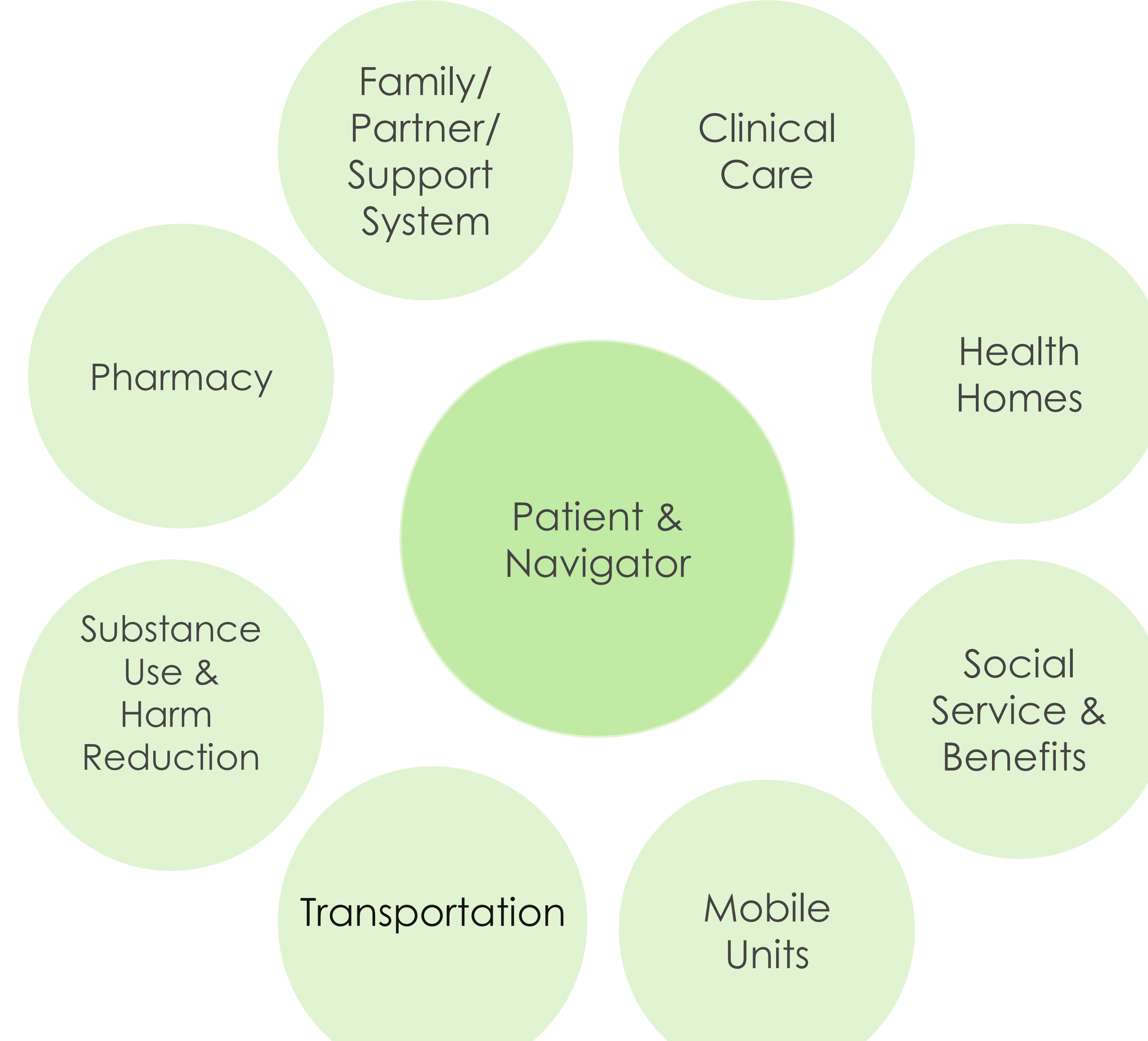
Establish Referral Agreements

- Memorandum of Understanding with clinical providers who will accept patient referrals (specify information sharing requirements)
- Formal or informal agreements with community organizations to find people at risk or living with hepatitis C

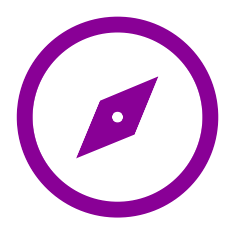
Implement medication distribution methods that meet patient need:

- Directly observed therapy
- Weekly blister packs
- Navigator pick-up
- Pharmacy home delivery
- Locker storage

Building a Care Team



Navigator Training



Essential Training

- Hepatitis A, B and C Basics
- Hep C Patient Navigation
- Harm Reduction Approach
- Motivational Interviewing
- Hep C Medical Care and Treatment
- Hep C Medication and Prior Authorization
- Trauma Informed Care
- Working with people with medical health conditions (Mental Health First Aid)

Health Promotion Modules

The Hep C Community Health Navigation Health Promotion Modules guide Navigators in: providing health promotion, assessing patient need for supportive services and referrals, developing a patient navigation care plan, completing required forms, and promoting behavior change.

HEALTH PROMOTION MODULES	WHEN TO USE
• How do I use Hep C Community Health Navigation materials? • ***Form***: Patient Navigation Form • ***Form***: Care Plan • Guide for improving readiness for change	Throughout program
I. Hep C Basics	
• What is Hepatitis C? • How do people get Hep C? • What type of Hep C do you have? • How do you know if you have liver damage? • Treatment: How is Hep C treated?	During Navigation assessment phase. Reinforce throughout pre-treatment phase as needed.
II. Getting Ready for Hep C Care	
• Mental health: Improving mental wellness • Alcohol: Does drinking alcohol damage the liver? • ***Form***: Alcohol Use Disorders Identification Test (AUDIT) • Drug use: Reducing the harm of drug use • ***Form***: Drug Abuse Screening Test (DAST) • Lifestyle changes: Protect your liver • Referrals: Getting support	During the Navigation assessment phase.
III. Getting Ready for Treatment	
• Treatment readiness: Are you ready to start treatment? • ***Form***: Treatment Planning Form	Right before starting treatment.
IV. After Treatment	
• Staying healthy and avoiding Hep C reinfection	During and after treatment.

WHAT'S IN EACH MODULE?

ASSESS NEED for health promotion. Ask questions to assess what your patient already knows or does not know. Based on their responses, tailor the talking points and action plan.

TELL PATIENTS key messages. After sharing these messages, review information, make plan, or discuss decisions.

REVIEW INFO and use the questions in this section to make sure the patient understands the information provided

MAKE A PLAN with the patient based on the information they received, and record action items on the Care Plan at the end of this guide.

DISCUSS with the patient the pros and cons of making decisions as these may require further thought.

Health Promotion Guide

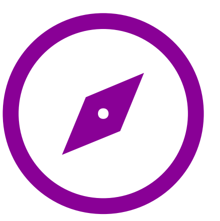
Recommended Training Depending on Role

- Hep C Rapid Testing
- Hep C Medication Coverage and Prior Authorization
- Cross-training in HIV testing, PrEP navigation, and overdose prevention

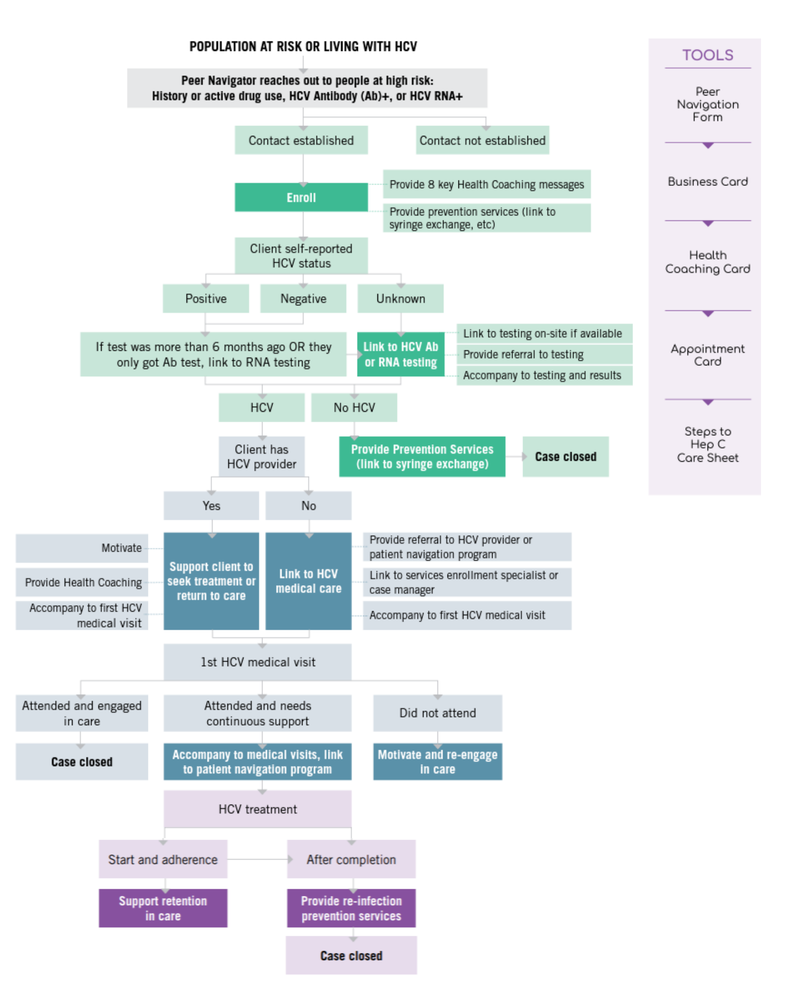
Essential and recommended trainings are available virtually through NYS AIDS Institute: www.hivtrainingny.org

Harm Reduction Coalition www.harmreduction.org/our-work/training-capacity-building/training-center

Contract or Program Specific Training

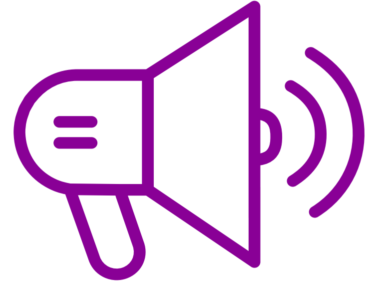


- Program or contract specific start-up training for navigators and supervisors
  - Review contract time frame, goals, deliverables
  - Review program specific protocol and workflow
- Review data management and reporting procedures
  - Offer technical assistance as needed
- Set up shadowing with an experienced Hep C Navigator working in a similar setting if possible



Hep C Peer Navigation Program – Intervention Workflow

Tools for Navigators



Tools for Navigators

Navigation Guide and Documentation Forms

Client Information

Date enrolled:	Agency Participant ID:	Initials:	Year of Birth:
Client First Name:	Client Last Name:		Date of Birth:
Address (# street, apt #, borough) Zip code		Phone 1:	Phone 2:
Race: ☐ White ☐ Asian/PI ☐ Native Hawaiian ☐ Does not identify ☐ Decline to answer ☐ Unknown	☐ Black or African American ☐ Native American /Alaskan Native ☐ Other race:________	Ethnicity: ☐ Hispanic/Latino Specify________ ☐ Non-Hispanic/Non-Latino Specify _____ ☐ Decline to Answer ☐ Unknown	Gender: ☐ F ☐ Trans M→ F ☐ M ☐ Trans F→ M ☐ Other
English: ☐ Speak ☐ Read	☐ Write ☐ None	Preferred language:	Interpretation needed: ☐ Yes ☐ No

For organization use only

Email: ______________________ **Emergency Contact Phone:** ______________

Other Contact Info:

Program Services

*Required services at time of enrollment: ☐ Health Coaching ☐ Harm Reduction

*Services: ☐ Enrolled in Hep C Peer Services ☐ Enrolled in full-time Hep C patient navigation

Hep C Testing On or After Enrollment

Hep C status at intake: ☐ Positive ☐ Negative ☐ Unknown

Antibody test date: ___/___/_____ ☐ Test declined ☐ Test not needed	Antibody test result: ☐ Positive ☐ Negative
RNA test date: ___/___/_____ ☐ Test declined ☐ Test not needed	RNA test result: ☐ Positive ☐ Negative ☐ Spontaneously cleared virus

Assessment

Treated for Hep C before program? ☐ Yes, year:___ ☐ No	If ever treated, cured? ☐ Cured ☐ Not cured
Insurance: ☐ Medicaid ☐ Medicare ☐ Private ☐ None	Name of insurance plan:
In the past year, have you had trouble paying for food, housing, medications, heating or other basic need? ☐ Yes ☐ No	
Housing: ☐ Stable housing ☐ Unstable housing ☐ Homeless	Has consistent transportation for appointments: ☐ Yes ☐ No
Injected drugs in the past year? ☐ Yes ☐ No ☐ Declined Inhaled/snorted drugs in the past year? ☐ Yes ☐ No ☐ Declined Ever injected drugs? ☐ Yes ☐ No ☐ Declined	On methadone: ☐ Yes ☐ No On buprenorphine: ☐ Yes ☐ No
Alcohol use in the past year? ☐ Yes ☐ No ☐ Declined Any mental health issues? ☐ Yes ☐ No ☐ Unknown Social support? ☐ None ☐ Family ☐ Friends ☐ Support group ☐ Program	Incarcerated in past year: ☐ Yes ☐ No ☐ Declined Incarcerated ever: ☐ Yes ☐ No ☐ Declined

Care Plan

Discuss care plan with patient. Complete the form based on agreed plan, sign and give a copy to patient.

Patient Name:________________________________ Date:____________

CARE TEAM

Name	Address	Phone Number	E-mail Address
Doctor			
Navigator			

☐ Accompaniment to medical visits ☐ Reminders for visits by: ☐ Call ☐ Text ☐ Email

CHECK HEP C PROGRAM GOALS

Goal	Date Completed
☐ Complete patient navigation assessment	
☐ Receive “Hep C basics” health promotion	
☐ Receive “Getting ready for Hep C care” health promotion	
☐ Attend 1st Hep C medical visit	
☐ Complete Hep C medical evaluation	
☐ Receive “Getting ready for treatment” health promotion	
☐ Start Hep C treatment	
☐ Complete Hep C treatment	
☐ Receive “After treatment” health promotion	

REFERRALS

Type of Service	Site Name and Address	Phone Num E-mail Add
☐ Mental health		
☐ Alcohol counseling		
☐ Substance use/harm reduction		
☐ Insurance enrollment		
☐ Benefits (Food/ financial)		
☐ Housing services		
☐ Legal services		
☐ Specialist:		
☐ Other:		

Treatment Planning Form

MY DOCTOR’S APPOINTMENTS

Complete this table with your doctor.

Visit	Date	Time	Hep C Viral Load*	Notes
1				
2				
3				
4				
5				

*The Hep C viral load is the amount of Hep C virus in your blood. If your viral load drops to “undetectable” and stays there 12-24 weeks after treatment you are cured.

Date	Ultrasound

MY NOTES

Write down the list of medications you are taking, any side effects you have, questions for your doctor, or other notes about your treatment.

Living with Hep C is not easy. But you can be treated and cured. Follow these steps:

1. Know your care team and how to contact them.
2. Take your medications the right way.
3. Go to all doctor’s appointments.

MY CARE TEAM

DOCTOR

Name:

Phone:

NAVIGATOR

Name:

Phone:

PHARMACIST

Name:

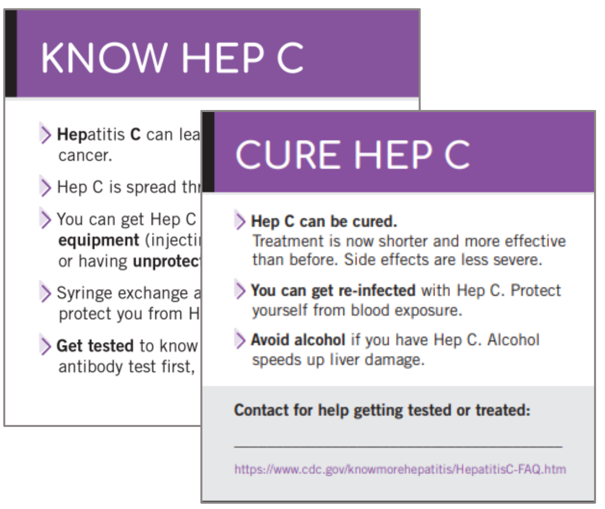
Phone:

ULTRASOUND RADIOLOGIST

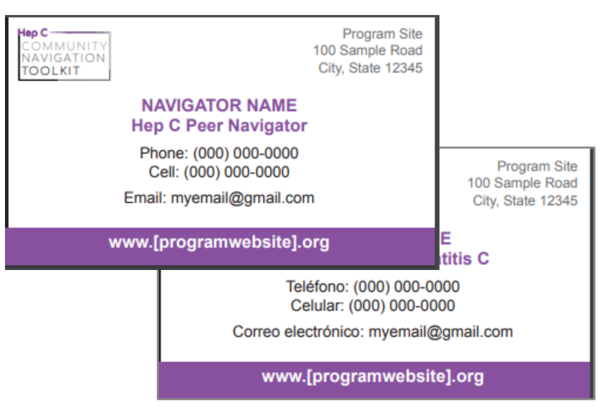
Name:

Phone:

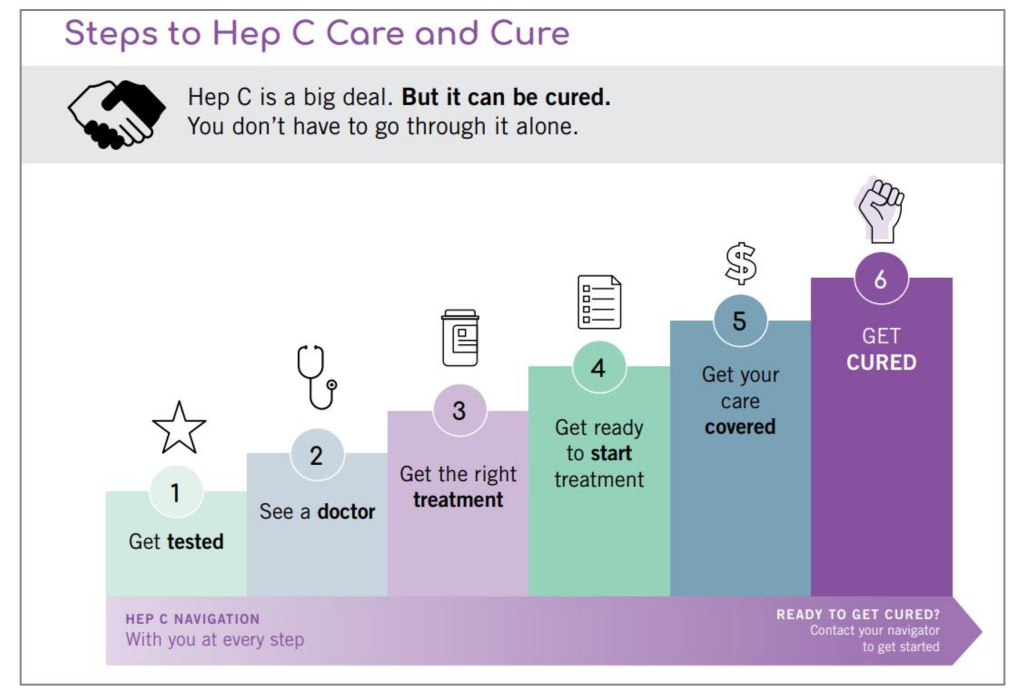
Health Promotion Tools



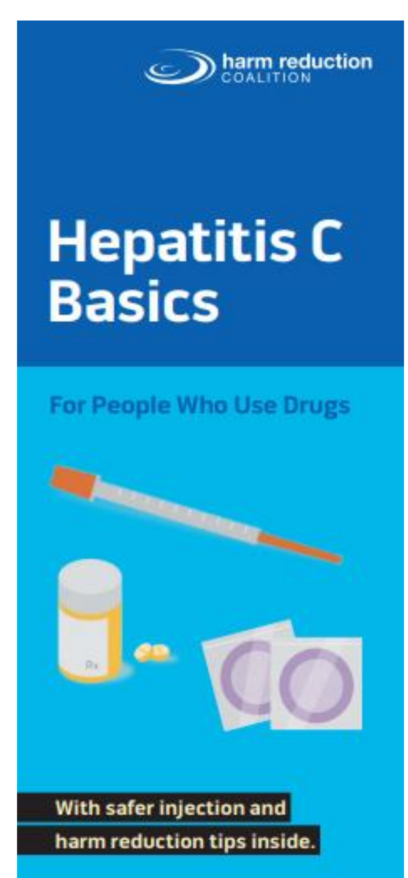
Pocket Card: "Know Hep C, Cure Hep C"



Business card template: English & Spanish



Handout: Steps to Hep C Care and Cure



KNOW HEP C

- **Hepatitis C** can lead to **liver disease** and cancer.
- Hep C is spread through **blood**.
- You can get Hep C by **sharing drug use equipment** (injecting, smoking, or snorting) or having **unprotected sex**.
- Syringe exchange and **harm reduction** can protect you from Hep C.
- **Get tested** to know if you have Hep C: antibody test first, then confirmatory test.

CURE HEP C

- **Hep C can be cured.** Treatment is now shorter and more effective than before. Side effects are less severe.
- **You can get re-infected** with Hep C. Protect yourself from blood exposure.
- **Avoid alcohol** if you have Hep C. Alcohol speeds up liver damage.

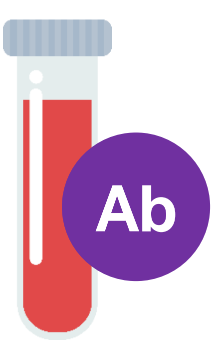
Contact for help getting tested or treated:

____

https://www.cdc.gov/knowmorehepatitis/HepatitisC-FAQ.htm

Pocket Card: "Know Hep C, Cure Hep C"

Hep C Testing: 2 Steps

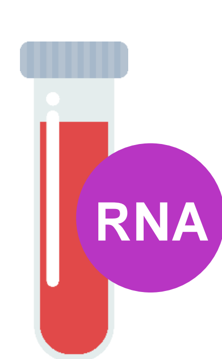


Antibody (Ab) test:

Shows if a person was ***ever*** infected

- Blood draw (results in a few days), or
- Rapid finger stick test (results in 20 min)

Source: TestHepC.com



RNA Confirmatory Test:

Shows if a person is infected ***now***

- Blood draw only. Also, called PCR Test

Treatment Then and Now

Hep C treatment before 2014

- Weekly injections and pills
- Often lasted 1 year
- Had severe side effects
- Cured half of patients

Hep C treatment now

- Pills, often just 1 a day
- Last 2-3 months
- Have mild side effects
- Cures almost all patients

What does Hep C cure mean?

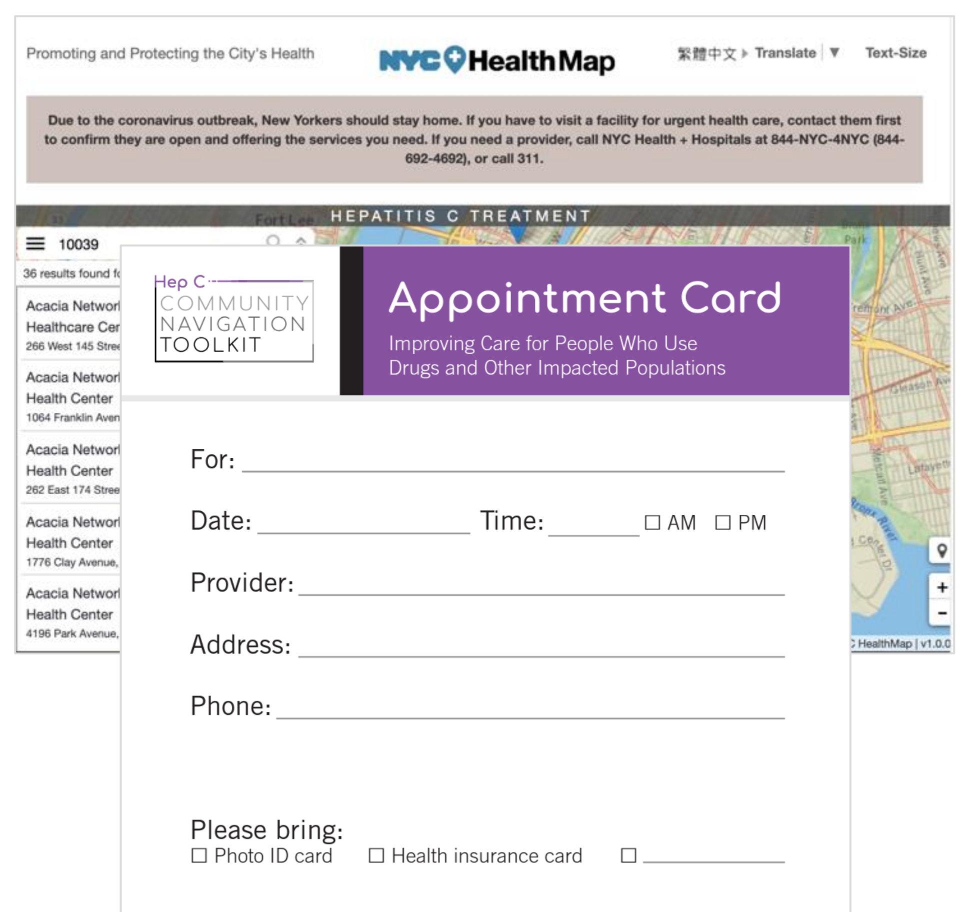
Cure means that the Hep C viral load is undetectable in the blood 12 weeks after the patient has completed treatment. Cure is known as **sustained virologic response or SVR.**

Being cured of Hep C can improve your liver health and general well-being.

Cure is not immunity. People can get Hep C again if they are exposed.

Linkage to Care Tools

- National site locators: American Liver Foundation Provider Locator or CDC
- Identify or create local site locators or referral guides (update at least annually)
- Identify resources and referrals for uninsured:
  - Benefits enrollment
  - FQHC/Public hospital
  - Grant funded programs
  - Patient Assistance Programs
- Linkage agreement



https://a816-healthpsi.nyc.gov/NYCHealthMap

Patient Advocacy Tools

Your Rights as a Patient

All patients have a right to:

- Have a family member, peer navigator, or other adult go with you to medical appointments
- Have an interpreter or translator if needed
- Receive medical care with respect, without discrimination, and in a clean and safe environment
- Receive complete information about your health and any medical conditions
- Participate in all decisions about your care and treatment
- Refuse services and know how this may affect your health

Source: PHL 2803 (1)(g) Patient's Rights,10NYCRR, 405.7,405.7(a)(1),405.7; HIPAA Privacy Rule 45 CFR 164.510(b)

Recommendations for Hepatitis C Screening and Treatment in People Who Use Drugs

Test people who use drugs (PWUD) for Hep C at least annually

TEST TYPE	TEST RESULT	
	If positive (+)	If negative (-)
Antibody Test: Use to test people who have never tested Hep C positive.	Confirm with RNA Test (Reflex RNA testing is ideal)	Retest in 12 months with antibody test
RNA Test: Use to test people who have ever tested Hep C positive.	Link to Hep C medical care	Retest in 12 months with RNA test

All PWUD with Hep C should be evaluated for treatment

- Hep C is treated with oral medications in 8–12 weeks with few side effects. See the algorithm for the management and cure of Hep C infection at www.bit.ly/simplified-hepc.
- Over 90% of PWUD with Hep C who are treated achieve a cure, less than 5% get reinfected.
- Curing Hep C prevents ongoing transmission to drug-sharing and sexual partners.
- Patient-centered care practices including Hep C patient navigation can help PWUD get care and complete treatment. To find a program, visit: ____________________

Health Insurance approves Hep C medications for PWUD

- [add a sentence about your locality's insurance requirements] ____________________
- Specialty pharmacies can support the medication prior authorization process.
- Local resource for prior authorization appeals and applications (legal aid, attorney general, state medicaid office)

Prevent Hep C and Overdose

- Link people to harm reduction and syringe service programs https://nasen.org/map/
- Link people to medication-assisted treatment, such as buprenorphine SAMHSA bupe locator
- Provide Naloxone https://nextdistro.org/naloxone and prevention tips www.bit.ly/opioid-overdose-basics

Resources

- To find Hep C patient navigation programs and programs for uninsured visit: ____________________
- Clinical Education Initiative (CEI) Hepatitis C and Drug User Health Center of Excellence: www.ceitraining.org
- American Association for the Study of Liver Disease - Identification and Management of Hepatitis C in People Who Inject Drugs: hcvguidelines.org/unique-populations/pwid
- For more information email: HepProgram @ state.gov

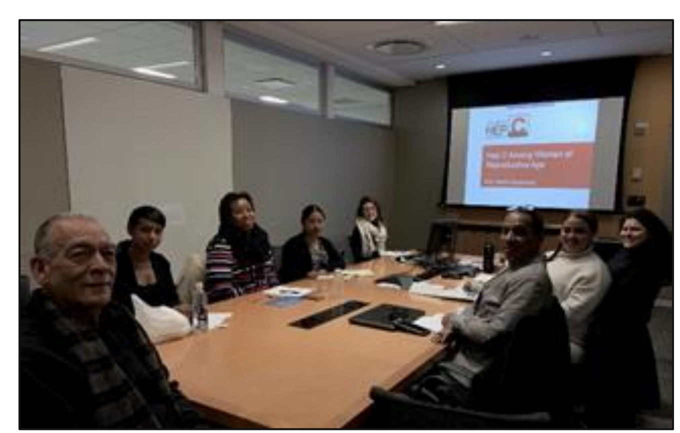
Recommendations for Hepatitis C Screening and Treatment for People Who Use Drugs

Reinfection and Overdose Prevention

- Refer to syringe service programs: www.harmreduction.org
- Refer to medication assisted treatment programs (buprenorphine, methadone): www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator
- Provide overdose and infection prevention counseling
- Provide Naloxone: https://www.naloxoneforall.org/

Community of Practice and Learning

Community of Practice and Learning



Community of Practice and Learning

- **Training is only an introduction to navigation work!**
- Organizations and navigators must implement navigation services based on local and organization policies and procedures, mission, target population, available resources and emergent patient needs
- **A Community of Practice and Learning model with regular meetings is important to build knowledge, skills and confidence on an ongoing basis** (monthly, bimonthly or quarterly)
  - Review program progress
  - Share challenges and best practices
  - Case presentation and discussion
  - Provide training on advanced topics (clinical updates, alcohol and hepatitis, self-care and burnout prevention, immigrant healthcare access)

Common Barriers and Solutions Discussed

Barrier	Solutions
Stigma	• Develop culturally competent provider referral list, tour facility • Train navigators and clinical providers in harm reduction and on treating Hep C in people who use drugs • Train navigators and staff in trauma informed care
Access to healthcare	• Assist with low cost care services or health insurance application • Manage expectations • Meet patients where they are
Language access	• Refer to providers with appropriate language capacity • Hire culturally and linguistically competent staff
Medication prior authorization	• Provide training on PA • Identify health insurance oversite, legal aid and patient advocacy organizations

Navigation Best Practices Discussed

- **Case conferencing with care team** (tester, peer, patient navigator, treating provider, social worker, pharmacist, and other related staff)
- **Effective use of incentives** (wrap-around services, transportation, metrocards, food vouchers, gift cards) for getting tested, returning for test results, first medical visit, treatment initiation, SVR testing
- **Establish rapport**
  - Build and maintain professional relationship with patients
  - Setting appropriate boundaries
- **Reduce loss to follow-up:**
  - Collect thorough **contact information** at intake: programs, hang out spots, social media, next of kin, online people finder, Medicaid visit data, justice involved history, health information exchanges
  - Coordinate with other agencies: Health homes, visiting nurse

Case Study

Tele-Navigation & Considerations

Tele-Navigation

- Telephone-based navigation shown effective in a National Cancer Institute Research-Tested Intervention Program[1] 2016
- Due to COVID-19 many Navigators shifted to deliver services by telephone

Successes

- Support contact tracing, continuation of support system during emergency
- Stay-at-home mandate resulted in some patients being easier to reach and ready for treatment
- Easy medication approval (insurance accepting labs from a year ago)
- Improved care integration: in-person and virtual (methadone and Hep C)
- One organization partnered with radiology program to conduct ultrasounds onsite

[1] Project SAFe (Screening Adherence Follow-Up Program), additional information available at: https://rtips.cancer.gov/rtips/programDetails.do?programId=307723&topicId=102264&cgId=

Tele-Navigation

Challenges

- Fewer referrals, and hesitation to visit hospitals highly impacted by COVID-19
- Navigators had to become aware of facility/grounds measures in order to manage patient expectations during bloodwork or ultrasound visits:
  - New hours, appointment required, COVID questionnaire, closure of common spaces, temperature checks and right to turn people away (politely)
- Lack of walk-in referrals for immediate care (PWUD affirming)
- Organizations that are only telecommuting lost track of homeless patients (without access to working phone) that relied on location for address or med storage
- Hep C testing rates plummeted

Tele-Navigation Considerations

- Telemedicine is becoming increasingly available for Hep C and opioid use disorder treatment. See Telehealth capacity building resources (NYS and National)
- Lack of access to technology can pose barriers: lack of smart phone/computer or consistent internet, low tech literacy. Helpful if services are available via telephone, in addition to smart phone or computer
- Unique patient privacy and confidentiality concerns when delivering services to patient at home or other setting
- Reimbursement for telehealth service can be lower than in person, or not available
- Labs and medical evaluations need to be conducted in person. Navigators can help find places to get labs, arrange transportation and help reduce wait times
- Navigator can serve as a physician extender – to assist the clinical provider to prep and follow up with patients after a visit
- COVID-19 highlighted equity problem, halt of in-person services and service adaptations can exacerbate inequities in disease screening, diagnosis and treatment[1]

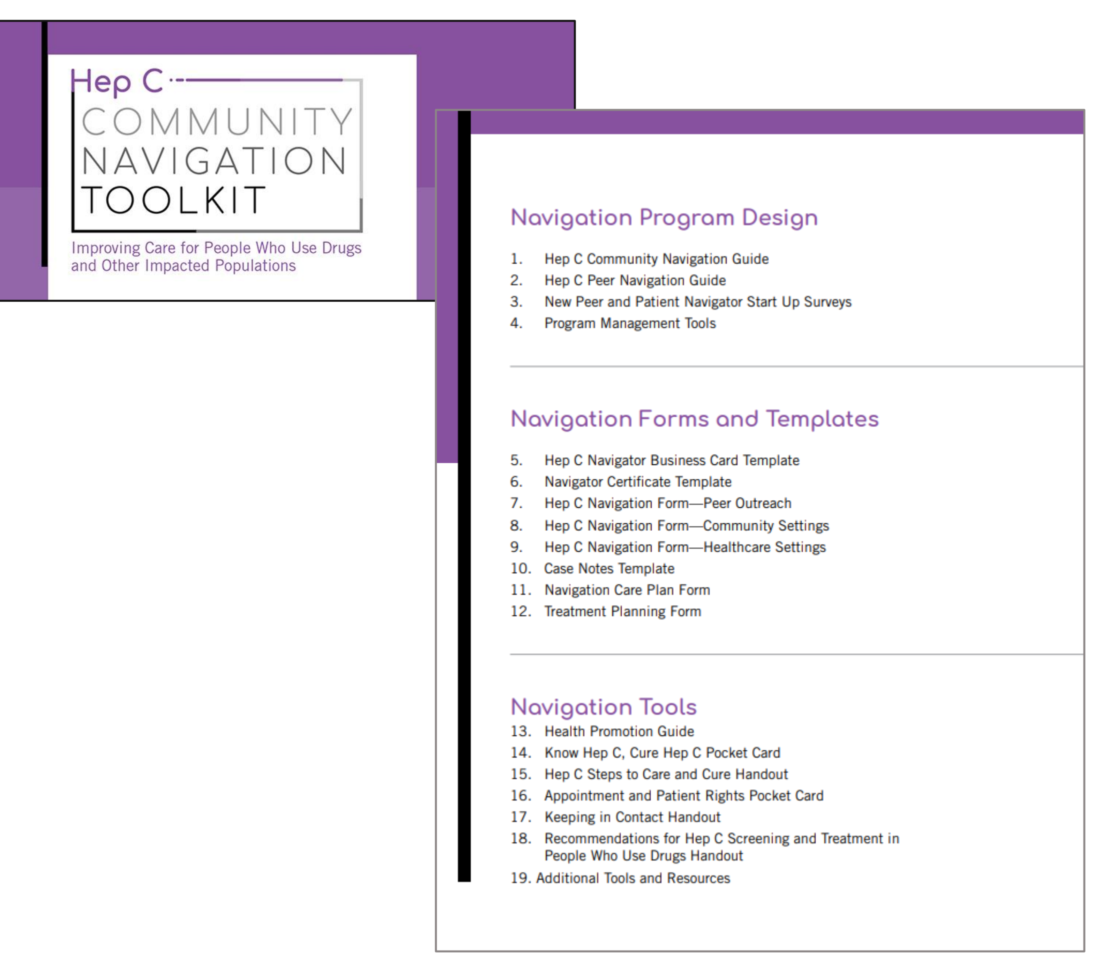
[1] Nodora JM et al. The COVID-19 Pandemic: Identifying Adaptive Solutions for Colorectal Cancer Screening in Underserved Communities, *JNCI: Journal of the National Cancer Institute*, djaa117 https://doi.org/10.1093/jnci/djaa117

Calls to Action for COVID-Adapted Services (Equity in mind)

- Invest in community health centers and syringe service programs that have historically served disenfranchised communities (funding, infrastructure, staffing and PPE)
- Support equitable and adaptable telehealth solutions now and in the future
- Invest in hepatitis testing lab processing and surveillance infrastructure at health departments
- Establish implementation recommendations for at-home or mail-based testing programs
- Identify community providers that commit to conduct medical evaluations and provide drug user health care
- Assess the hepatitis/liver cancer prevention priorities of underserved individuals (Maslow's hierarchy of needs)
- Assess regional hepatitis C screening and follow-up barriers and solutions

Adapted from Nodora JM et al. The COVID-19 Pandemic: Identifying Adaptive Solutions for Colorectal Cancer Screening in Underserved Communities, *JNCI: Journal of the National Cancer Institute*, djaa117 https://doi.org/10.1093/jnci/djaa117

NASTAD Hep C Community Navigation Toolkit



Navigation Program Design

1. Hep C Community Navigation Guide
2. Hep C Peer Navigation Guide
3. New Peer and Patient Navigator Start Up Surveys
4. Program Management Tools

Navigation Forms and Templates

5. Hep C Navigator Business Card Template
6. Navigator Certificate Template
7. Hep C Navigation Form—Peer Outreach
8. Hep C Navigation Form—Community Settings
9. Hep C Navigation Form—Healthcare Settings
10. Case Notes Template
11. Navigation Care Plan Form
12. Treatment Planning Form

Navigation Tools

13. Health Promotion Guide
14. Know Hep C, Cure Hep C Pocket Card
15. Hep C Steps to Care and Cure Handout
16. Appointment and Patient Rights Pocket Card
17. Keeping in Contact Handout
18. Recommendations for Hep C Screening and Treatment in People Who Use Drugs Handout
19. Additional Tools and Resources

Hep C COMMUNITY NAVIGATION TOOLKIT

Hep C Community Health Navigation: Program Guide

Hep C COMMUNITY NAVIGATION TOOLKIT

Hep C Health Promotion

Access toolkit here: https://www.nastad.org/hepatitis-navigation-toolkit

This presentation's recording will be archived and available soon.

HepTAC

Request Technical Assistance

HepTAC is an online technical assistance and capacity building center for health department hepatitis programs.

To request assistance, visit us at:
www.nastad.org/heptac

Hepatitis@nastad.org

Q&A

Evaluation