NYC Health Department

Hepatitis B and C
Community Navigation Program Model

NASTAD Technical Assistance Meeting
December 2019

Umaima Khatun, MPH, Check Hep B Program Manager
Nirah Johnson, LCSW, Director of Capacity Building
NYC Health Department - Viral Hepatitis Program
Hep@health.nyc.gov  www.HepFree.NYC
Hepatitis B and C in New York City

2018 Annual Report

**Hepatitis B**
- **230,000** people living with Hep B in NYC*
- **6,075** people newly reported in 2018

**Hepatitis C**
- **116,000** people living with Hep C in NYC
- **4,682** people newly reported in 2018

Many are unaware of their status and out of care

*Surveillance-Based Estimate of the Prevalence of Chronic Hepatitis B Virus Infection, New York City, 2016.*
Patient Navigation
Model to Improve Engagement in Care

Patient-centered engagement and return to care
- Trust enables positive behavior change (esp. for PWUD, HIV MSM, justice involved, immigrant)
- Promotes recommended care by helping overcome barriers
- Meets individual needs beyond preventing spread of disease

Improved efficiency in medical care service delivery
- Medical provider focuses on clinical care
- Navigator coordinates referrals, appointments, and improve prior authorization: 93% covered vs. 81% without navigator (Vu, 2018)
- Support patient advocacy

Reduced medical care needs and costs
- Care and treatment reduces risk of lifetime decompensated cirrhosis, extra hepatic manifestations and liver cancer
- Reduces secondary transmission
NYC Health Department
Hepatitis B and C Navigation Model

Data to care approach
• Use surveillance and other available data to identify priority organizations and populations (high burden areas of the city, organization, and underserved patients)
• Use surveillance data to monitor outcomes

Community Engagement approach
• Identify and maintain relationships with providers that meet patient needs
• Support community engagement and coalition building activities
• Workforce development: training, job search assistance

Continuous Quality Improvement approach
• Develop new strategies to meet emerging needs
• Reorient as needed to engage underserved people at risk
• Develop new tools, resources or approaches based on Navigator needs
NYC Health Department
Community Navigation Programs

Check Hep B Patient Navigation Program
Screening, linkage to care and clinical care coordination

Check Hep C Patient Navigation Program
Screening, linkage to care and clinical care coordination

Hep C Peer Navigation at Syringe Exchange Programs
Outreach, prevention, navigation to testing and care
NYC Participating Organizations

Community Organizations:

1. African Services Committee
2. After Hours Project
3. AIDS Center of Queens County
4. Boom! Health
5. Community Health Action of Staten Island
6. Family Services Network of NY
7. Housing Works
8. Korean Community Services
9. Lower East Side Harm Reduction Center
10. NY Harm Reduction Educators
11. Positive Health Project
12. Praxis Housing Initiatives
13. Safe Horizon Streetwork Project
14. St. Ann’s Corner of Harm Reduction
15. VOCAL-NY
16. Washington Heights CORNER Project
NYC Participating Organizations

**Hospitals:**
1. H+H Bellevue Hospital
2. H+H Coney Island Hospital
3. H+H Kings County Hospital
4. Kingsbrook Jewish Medical Center
5. Montefiore Liver Center

**Health Centers:**
1. APICHA Community Health Center
2. Bedford Stuyvesant Family Health Center
3. BronxCare Family Health Center
4. Brownsville Multiservice Family Health Center
5. Charles B Wang Community Health Center
6. Community Healthcare Network
7. Montefiore Comprehensive Health Care Center
8. 7th Ave Family Health Center at NYU Langone
Navigation Funding Sources

- Private grants

- City funds
  - New York City Council funds community organizations (Viral Hep, Harm Reduction & HIV)
  - City funds Health Department staff

- Other funding for community organizations
  - 340B
  - NYS DOH (Comprehensive Care Programs, HepCap, Testing)
  - Integration into HIV or Access to Care Programs
Program Management

Health Department Role:

- Develop scopes and manage contracts
- Develop program protocol and program materials (i.e. forms, database, patient education)
- Develop and provide start up-training, and ongoing training at monthly meetings with all navigators
- Analyze program data and create monthly program reports
- Facilitate monthly Community of Practice and Learning meetings
- Technical assistance
- Quality assurance meetings and site visits
- Monitoring of program progress (feedback, care cascades)
- Evaluation of navigation model (surveys, focus groups)
Program Management Tools

Program Management Protocol

Contents:
- Scope of Services
- Program Management Protocol
- Data Management Protocol
- CPL Meeting Planning Checklist and Curriculum

Scope of Services:
- Background
- Goals
- Program Requirements
- Objectives
- Staff, equipment
- Services
- Eligible clients
- Performance Measures
- Number of service contacts
- Reporting
- Reward

Annual Review:
1. Annually review and update the Checklist
2. Go to Check-up & Update to make appropriate changes
3. See roles and responsibilities

Staff Involved, Roles & Responsibilities:
See roles: health, case management, program management, etc.

Program Management Checklist:
1. Program Director
2. Program Coordinator
3. Program Staff
4. Program Coordinator
5. Program Manager
6. Program Coordinator
7. Program Coordinator
8. Program Coordinator
9. Program Coordinator
10. Program Coordinator

Data Collection:
- Patient Navigator: Each site visits
- B or C patient ID is the first 3 letters followed by a number, starting with 011, 022, 033, etc.
- Duplication not allowed
- See applicable sections

Pre-Data Submission:
- Essential: Patient navigator submits the following data:
- Program manager submits the following data:
- Database Submission: Database
- Database Submission Reminder
- Database Submission due date

CPL Meeting Planning Checklist and Curriculum

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

TA/Upcoming Topic:
- TA/Upcoming Topic:
  1. Discharge/Referral Planning for Admitted patients
  2. Discharge/Referral Planning for Admitted patients
  3. Discharge/Referral Planning for Admitted patients
  4. Discharge/Referral Planning for Admitted patients

Length of Discussion:
- 2 hrs / 3 hrs / 4 hrs / 5 hrs

Program Content:
- Program Overview:
- Program Protocol:
- Health Promotion Guide
- Patient Navigation form
- Sharing the Scheduling Assessment:
- Checklist to identify patient contact and document as discharged
- Activity: In pairs (matching the notes with experienced navigator), go through the form assessment using the form and Health Promotion Guide module 1-3
- Programmatic materials
- Patient navigator handouts/pocket cards, short list of resources

Enrollment, Assessment & Referrals:
- Enrollment/Assessment:
- Referral services for the Uninsured

Coding services for the Uninsured
- Coding services for the Uninsured
- Coding services for the Uninsured
- Coding services for the Uninsured
- Coding services for the Uninsured

Setting up Informal MOU:
- Setting up Informal MOU
- Setting up Informal MOU
- Setting up Informal MOU
- Setting up Informal MOU
- Setting up Informal MOU
- Setting up Informal MOU
Program Management Tools (cont.)

Hep C Program Management Dashboard

Public Health Partners Connect (Salesforce)

Maven Data Match
Tools for Program Monitoring

Program Implementation Report Template

RedCap Cloud Database

Monthly Site Reports

Brownsville Multiservice Family Health Center

Patient Characteristics

- Insurance: Medicaid 82%
- Homeless/unstably housed 8%
- Mental health issue 26%
- Alcohol use ever 28%
- Drug use ever (injection/intransanal) 66%
- Methadone treatment 52%
- Buprenorphine treatment 2%
- History of incarceration 43%

Comorbid Conditions

- HIV positive 12%
- Hep B positive 0%
- Cirrhotic 26%
- Liver cancer 2%
Patient Education Materials

HEPATITIS B
The Facts

HEPATITIS C
and Your Liver
Get Tested. Get Cured!

HEPATITIS C
Basics
For People Who Use Drugs

Hepatitis C
You are Hep C FREE!

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: JPHL, 2010, (b)(3) (a) (b) [Name be Patient’s Rights, 42 U.S.C. 300G-5(a)(3)] (b)(7)-HPAA Privacy Rule 45 CFR 164.510(b)(1)
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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.

1. Get tested
2. See a doctor
3. Get the right treatment
4. Get ready to start treatment
5. Get your care covered
6. Get cured

ALCOHOL AND HEPATITIS
If you have hepatitis, it is not safe to drink alcohol at all.

Tips for Drinking Less:
1. Avoid alcohol. Avoid keeping alcohol in your home and try to stay away from activities that involve alcohol.
2. Substitute alcoholic drinks with water or seltzer.
3. When you feel the urge, remember why you want to avoid alcohol or call a friend for support.
4. Exercise or pick up a new hobby for times when you would normally drink.

Find more info at HepatitisDrinking.nyc.gov

NYC Health
Navigator Program Staff

**Peers** (part-time or stipend):
- Personal experience with drug use and Hep C
- Experience in harm reduction and ability to provide services judgment-free
- No education requirement

**Patient Navigators** (full-time):
- Bilingual/Bicultural (when appropriate)
- Experience working with target populations, in harm reduction programs, safety-net clinics or hospitals
- AA/BA education requirement

**Program supervisor**
- Provides supervision and systems support to navigator

**Data specialist**
- IT or Data Quality Manager support

**Clinical Champion**
- Supports clinical care and provides systems support to navigator
Navigator Program Training

Program Specific start-up training
• Navigation Program protocol
• Data collection and reporting

• Clinical Provider Training
  • Hep B and/or C Clinical Training
  • Buprenorphine Waiver Training
  • Hep C Treatment in People who Use Drugs

Navigator Training
• Intro to Viral Hepatitis A, B and C or Hep C Basics
• Hep C Patient Navigation
• Hep C Point of Care Testing
• Hep C Medical Care and Treatment
• Hep C Medication Coverage and Prior Authorization
• Trauma Informed Care
• Mental Health First Aid
• Harm Reduction Approach
• Motivational Interviewing
• Overdose Prevention Training

159 Navigators trained since 2014
Community of Practice and Learning

Regular meetings for navigation staff at all programs:
- Review program outcomes and provide site specific reports
- Share best practices
- Discuss a case presentation
- Resource presentations (clinical updates, alcohol and hepatitis, self-care and burnout prevention, immigrant health)

Site visits at community navigation organizations
- Meet with interdisciplinary care team (navigator, tester, clinical provider, program manager, others)
- Data quality assurance
Navigation Steps

Outreach & Enrollment

Health Promotion

Assessment & Care Plan

Linkage to Care

Contact Screening, Hep B Vaccination

Screen

Link to Care

Medical Evaluation & Liver Cancer Screening

Treatment

Care Coordination Services

- Accompaniment and reminders
- Referrals to supportive services
- Alcohol counseling
- Case conference
- Treatment readiness and adherence support
- Medication and pharmacy coordination

Discharge/transition planning

- Hep C reinfection prevention
- Liver health education and monitoring
Overcoming Common Barriers

• **Stigma**
  - Develop culturally competent provider referral list
  - Tour facility and meet provider
  - Train clinical providers on treating Hep C in people who use drugs
  - Train navigators and staff in trauma informed care

• **Cost of care**
  - Assist with finding low cost care services or health insurance application

• **Language access**
  - Refer to providers with appropriate language capacity
  - Hire culturally and linguistically competent staff who can translate

• **Loss to follow up**
  - Take thorough contact info at intake: Social media, next of kin,
  - Use case finding software
  - Leverage other programs: Health homes, visiting nurse
Systems Level Program Supports

- **Streamline screening systems**
  - Automated alerts for screening
  - Standing orders for laboratory tests
  - Universal screening
  - Hep C antibody to RNA reflex testing

- **Routinize review of patient lists and case conferencing** to promote linkage to care and treatment
  - Develop patient registry
  - Routinize electronic health record review
  - Routinize interdisciplinary case conferences

- **Medication prior authorization**
  - Provide training and investigate local patient advocacy resources

- **Medication adherence**
  - Directly observed therapy
  - Weekly blister packs
  - Pharmacy home delivery

- **Incentives**
  - For key clinical milestones: complete testing, start of treatment
  - For wrap-around services, transportation, metrocards, food vouchers, gift cards
# Program Outcomes July 2014 – October 2019

<table>
<thead>
<tr>
<th>Service</th>
<th>Enrolled and Educated</th>
<th>Linked to Care</th>
<th>Completed Medical Evaluation</th>
<th>Started Treatment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Patients</td>
<td>1628</td>
<td>1596</td>
<td>1533</td>
<td>217</td>
</tr>
<tr>
<td>Number of Patients</td>
<td>4902</td>
<td>3680</td>
<td>2954</td>
<td>2157</td>
</tr>
<tr>
<td>Number of Patients</td>
<td>9285</td>
<td>1717</td>
<td></td>
<td>394</td>
</tr>
</tbody>
</table>

- **$63k - $109k**
  - Per org per year
- **$44k - $100k**
  - Per org per year
- **$21k - $40k**
  - Per org per year

Note: Some patients received services anonymously or in multiple locations

*20-40% of patients with chronic hepatitis B virus infection require treatment
Check Hep B: Patient Characteristics

- 88% Born outside of the United States
- 63 Countries of birth
- 30% Uninsured
- 32 Languages spoken other than English

Check Hep C: Patient Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Health centers and hospitals</th>
<th>Syringe service programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black, non-Latino/a</td>
<td>34.9%</td>
<td>25.7%</td>
</tr>
<tr>
<td>Latino/a</td>
<td>33.9%</td>
<td>44.2%</td>
</tr>
<tr>
<td>History of drug use</td>
<td>28.9%</td>
<td>60.3%</td>
</tr>
<tr>
<td>Enrolled in Medicaid</td>
<td>58.9%</td>
<td>63.8%</td>
</tr>
<tr>
<td>History of incarceration</td>
<td>16.9%</td>
<td>45.8%</td>
</tr>
<tr>
<td>Homeless or unstably housed</td>
<td>18.8%</td>
<td>37.5%</td>
</tr>
<tr>
<td>HIV infection</td>
<td>9.6%</td>
<td>14.3%</td>
</tr>
</tbody>
</table>
# Evaluating and Reporting Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Program Reports</th>
<th>Surveillance Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screened</td>
<td>Date of screening test and result</td>
<td></td>
</tr>
<tr>
<td>Linkage to Care</td>
<td>Date attended first medical visit</td>
<td>Received a Hep B or C lab report, indicating a medical visit occurred</td>
</tr>
<tr>
<td>Treated for Hep C</td>
<td>Dates started and completed treatment, SVR (chart, EMR)</td>
<td>RNA positive test reported followed by RNA negative test reported</td>
</tr>
<tr>
<td>Treated for Hep B</td>
<td>Date started treatment Hep B Viral Load suppression or ALT normalization</td>
<td>DNA lab values reported</td>
</tr>
<tr>
<td>Patient Navigation Activities</td>
<td>Documentation of supportive service referrals, outreach effort, service plans</td>
<td></td>
</tr>
</tbody>
</table>
CHECK HEP B PATIENT NAVIGATION PROGRAM

Since 2014, the Health Department has offered training and technical assistance to community organizations and health facilities that provide patient navigation to people living with chronic hepatitis B.

1,302  Number of people with hepatitis B enrolled in Check Hep B*
94%  Percentage of enrollees who completed a hepatitis B medical evaluation*
93%  Percentage of treatment candidates who started hepatitis B treatment*

*From July 1, 2014, through December 31, 2018

Check Hep B Patient Navigation Program Patient Characteristics

85%  Percentage of participants born outside of the U.S.
58  Number of countries of birth
26%  Percentage of participants who are uninsured
32  Number of languages spoken other than English

2018 Program Outcomes

In 2018, the Check Hep B Patient Navigation Program served 954 people living with chronic hepatitis B.

FIGURE 35. Rate of people newly reported with chronic hepatitis B in New York City by neighborhood tabulation area and Check Hep B Patient Navigation Program locations

Health Centers and Hospitals
1. APICHA Community Health Center
2. BronxCare Health System
3. Charles B. Wang Community Health Center
4. Health + Hospitals Bellevue Hospital
5. Health + Hospitals Elmhurst Hospital
6. Montefiore Medical Center
7. NYU Seventh Avenue Family Health Center

Community Organizations
1. African Services Committee
2. Community Health Action of Staten Island
3. Korean Community Services
Model Dissemination

The NYC Health Department has funding to disseminate the Hepatitis Community Navigation Program Model

What would be the most useful methods to share?
- Toolkit (print and/or PDF)
- Webinar (single, multiple)
- In person training or summit
- Regular community of practice and learning conference call/webinar
- Offer technical assistance (by phone or in-person)
- Peer review journal
- Other?
Contact Us!
Hep@health.nyc.gov
www.HepFree.NYC
@HepFreeNYC

More information:
Hep C Peer Navigation Program
Check Hep C
Check Hep B