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 Implementation Technical Assistance Request Process
9. Evaluation
Hepatitis C Care Cascade in the US, 2018

United States

- Infected
- Diagnosed
- Treated
- Cured

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

What are the barriers to testing and treatment?

- "Routine preliminary anti-body testing but seldom immediate RNA confirmation"
- "Provider restrictions and clinic availability" "Lack of understanding and interest in serving PWUD"
- "Cost of labs and office visits, for folks with limited insurance coverage"
- Provider restrictions
- Clinic availability
- Homelessness
- Stigma
- Incarceration
- Mental illness
- Clinics
- Hours
- Confidentiality
- Treatment
- SUD
- Adherence
- Cost
- Labs
- Insurance
- Uninsured
- Funding
- Housing
- COVID
- Unstable
- Confirmatory testing
- Distrust
- Providers
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 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

<table>
<thead>
<tr>
<th>Patient-centered engagement</th>
<th>Improved efficiency in medical care service delivery</th>
<th>Successful navigation can reduce medical care needs and costs</th>
</tr>
</thead>
</table>
| • **Trust** enables positive behavior change  
  • Helps identify and overcome individual barriers  
  • Supports patient advocacy | • **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) | • Hep C cure:  
  • Improves overall health outcomes and quality of life  
  • Reduces ongoing community transmission |
Navigation Can Help Patients Get Hep C Cured

Unaware of Status

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

Assessment, Referrals, Care Planning, Advocacy, Accompaniment, Substance Use Counseling, Insurance Enrollment, Treatment Readiness Support, Motivational Interviewing

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

Diagnosis

Linkage to Care

Treatment
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

**Syringe exchange program**
- 24%  
- 45%  
- 61%  
- 62%  
- 45%  
- 35%  
- 35%  
- 15%

**Hospital or health center**
- Black, non-Latino/a 35%  
- Latino/a 34%  
- History of drug use 29%  
- Enrolled in Medicaid 59%  
- History of incarceration 17%  
- Homeless or unstably housed 19%  
- Mental health condition reported 24%  
- HIV infection 9%
From 2014 – 2019 the Hep C Community Navigation Program 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."

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.

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

Tool: Steps to Hep C Care and Cure
Hep C Navigation Program Milestones

- Conduct outreach and engagement
- Assess patient needs
- Provide health promotion, risk reduction and referrals for supportive services
- Navigation through complete diagnostic testing
- Linkage to care with a provider that will proactively treat Hep C

- Reinfetction prevention services
- Support patient to return for treatment outcome testing (SVR)
- Support treatment initiation and adherence
- Coordination of medication coverage approval (prior authorization or patient assistance program) and method of delivery (DOT, delivery, pick-up)
- Support to complete medical evaluation
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**
# Health Department Staffing

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

Program Management Protocol

Data Management Protocol

Hep C Program Management Dashboard
Reporting Tools (Program and QI)

Program Implementation Report Template

The 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 activities or areas. Please record your responses.

This report must be submitted quarterly. Sections must be completed by the assigned due dates, and updates please provide a “status update” quantity submission dates: 1/24/2017, 11/2/2017, 4/19/18, 7/15/18.

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

Program Implementation Checklist

<table>
<thead>
<tr>
<th>Sections</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Profile</td>
<td>10/8/2017</td>
</tr>
<tr>
<td>Check Hep C implementation</td>
<td>10/9/2017</td>
</tr>
<tr>
<td>Hep C Screening Assessment (will be provided)</td>
<td>1/22/2018</td>
</tr>
<tr>
<td>Hep C Screening Assessment</td>
<td>1/22/2018</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Item</th>
<th>Measure</th>
<th>Interpretation</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Number of unique patients with at least one visit in review period [Jan 1, 2019 - Dec 31, 2019]</td>
<td>#</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Of item 1, number with at least one risk factor for hepatitis C, including birth year 1945 - 1965 [HIV positive [SI], or other drug use/sexual risk factors [SI]], or include all unique patients (universal screening)</td>
<td>At-risk patients</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>From item 2, number with documentation of a hepatitis C antibody test order, test result [HIV], or hepatitis C RNA test order or test result ever [HIV], or hepatitis C diagnosis in problem list, ICD-10, or SNOMED codes [HIV]</td>
<td>#</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Percent of at-risk patients with a visit at the health center during review period, ever screened for hepatitis C</td>
<td>Screening rate: Item 1 / Item 2 (turn to a percent)</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Of item 1, number with a positive hepatitis C RNA test result [HIV], or diagnosis of hepatitis C in problem list, ICD-10, or SNOMED codes [HIV]</td>
<td>#</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>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) [HIV]</td>
<td>#</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Percent of patients with hepatitis C infection who initiated treatment</td>
<td>Item 6 / Item 5 (turn to a percent)</td>
<td></td>
</tr>
</tbody>
</table>

Notes: CPT codes for patient encounter during the reporting period: CPT codes 99201 - 99209 (new patients), 99211 - 99223 (established patients), 99405, 99406 (transitional care management), HCPCS codes (Medicare) 13440, 13441, 13442, 00466, 00467, 00488 (HCPCS only); Hepatitis C codes could include 99211, 99270, 99272 (initial care) and 99234, 99235, 99236 (admitted & discharged). Other billing codes may be applicable to your practice, only use those that are all inclusive. Use encounter-based hepatitis C codes would be recommended and encounter codes for institutional services and lab services such as 0101201, 0102210, 0104909.
Reporting Tools (Patient level data)

Database (RedCap Cloud)

Surveillance Database Match (MAVEN)
Health Department Program Management Tools

CPL Meeting Planning Checklist & Curriculum

Purpose of monthly health meetings: Discuss program activities and patient clinical progress. Guide navigation throughout the program activities timeline, use in monitoring, reporting, and gaining feedback through treatment. Address gaps in navigator activities, care continuum, and reporting.

General meeting outline:
1. Program highlights and program updates.
2. Extra reward/亮点 Progress report incorporating CPL topics.
3. Case discussion.
4. Training topics.

Facilitator/Presenter Preparation notes:
Program report: Showcaset programmatic data relevant to program timeline. For example, first month enrollment, assessment, referrals, and highlight key takeaways from doing this case. Also include your strategy for enrollment and case following.

After-PN activities: Data review (5 minutes). In pairs or in teams discuss any challenges, successes, or best practices you're having in completing PN activities and case. Also, working with patient's programs. Discuss trends and discuss as a group.

Case Discussion: Ask for volunteers, present a PN to share to case with the group of the next meeting. It can be a successful or challenging case. This allows for more interaction and feedback that can be shared at the meeting regarding the case discussion.

<table>
<thead>
<tr>
<th>3. TC Meeting Topic</th>
<th>Description</th>
<th>Length</th>
<th>Cells</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Shares the self-referral/assessment checklist for identifying potential patients and document to discharged.</td>
<td>2 hrs</td>
<td>9/14/16</td>
</tr>
</tbody>
</table>
| 2. TCOG, Assessment & Referral | Program overview. Program profile. Patient navigation team.
| | Identifies appropriate referral sources. | 2 hrs | 10/13/14 |
| 3. Program and education for the unattached | Program overview and education.
| | Referral and education. Treatment, assessment, referral. | 2 hrs | 10/14/16 |

Organization Progress Reports

Care Cascade by Site (Health Centers)
(Active in contract year)

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>94%</td>
</tr>
<tr>
<td>Incarcerated ever</td>
<td>72%</td>
</tr>
<tr>
<td>Homeless/unstable housing</td>
<td>48%</td>
</tr>
<tr>
<td>On methadone treatment</td>
<td>42%</td>
</tr>
<tr>
<td>On buprenorphine</td>
<td>12%</td>
</tr>
<tr>
<td>Unable to read and write English</td>
<td>2%</td>
</tr>
<tr>
<td>Chronic</td>
<td>0%</td>
</tr>
</tbody>
</table>

Key Barriers Reported
- Patients lost to follow up/hard to engage in care
- Homelessness
- Health Insurance
- Lack of funding for incentives

State of Medicaid Access: Maryland: C
### Outcome Measures

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicator: Community Org Navigation Database</th>
<th>Indicator: Health Department Surveillance System</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Linkage to care</strong></td>
<td>• Date attended first medical visit</td>
<td>• Received a Hep C lab report, indicating a medical visit occurred</td>
</tr>
</tbody>
</table>
| **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
Hep C Navigation Program Staffing

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

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

Note: Sample job descriptions provided in NASTAD toolkit page
# Hep C Navigation Program Staffing

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

- Family/Partner/Support System
- Clinical Care
- Health Homes
- Social Service & Benefits
- Mobile Units
- Transportation
- Substance Use & Harm Reduction
- Pharmacy
- Patient & Navigator
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)
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
  o Review contract time frame, goals, deliverables
  o Review program specific protocol and workflow
• Review data management and reporting procedures
  o Offer technical assistance as needed
• Set up shadowing with an experienced Hep C Navigator working in a similar setting if possible
Tools for Navigators
Tools for Navigators

Navigation Guide and Documentation Forms

Client Information
- Date enrolled:
- Agency Participant ID:
- Initiates:
- Year of Birth:
- First Name:
- Last Name:
- Date of Birth:
- Address (street, apt, city):
- Zip code:
- Phone 1:
- Phone 2:
- Race:
- Mother’s Race:
- Native Hawaiian:
- Does not identify:
- Decline to answer:
- Unknown:
- Gender:
- Hispanic/Latino:
- Non Hispanic/Latino:
- Other:
- Language:
- Preferred language:
- Interpretation needed:
- Yes or No

Program Services
- Required services at time of enrollment:
- Health Coaching:
- Harm Reduction:
- Services:
  - Enrolled in HCP Peer Services
  - Enrolled in full-time HCP patient navigation

Map C Testing & After-Dismissal
- Status of HCP care:
- Positive
- Negative
- Unknown

Information and Education
- Antibody test result:
- Test declined:
- Test not needed:
- RNA test results:
- Positive
- Negative
- Spontaneously cleared virus

Assessment
- Treatment for HCP C before program:
  - Yes
  - No
- If ever treated, cured:
  - Yes
  - No
- Ever treated?
- If treated, cleared:
- If not cleared:
- Insurance status:
  - Medicaid
  - Medicare
  - Private
  - Other
- Insurance plan:
- In the past year, have you had trouble paying for food, housing, medications, or other basic needs?
- Yes
- No
- Housing status:
  - Stable housing
  - Unstable housing
  - Homeless
- Has consistent transportation for appointments:
  - Yes
  - No
- Drugs used in the past year:
  - Injected
  - Inhalants
- Ever ingested drugs:
  - Yes
  - No
- Declined:
- Alcohol use in the past year:
  - Yes
  - No
- Declined:
- Smoking cessation:
- Social support:
  - None
  - Family
  - Friends
  - Support group
  - Program

Check Hep C Program Goals
- 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 number:
- Email address:

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:
Email:

Navigation
- Accompaniment to medical visits:
- Reminders for visits by:
  - Call
  - Text
  - Email

Treatment Planning Form

NY Doctor’s Appointment
Complete this table with your doctor’s:

<table>
<thead>
<tr>
<th>Visit</th>
<th>Date</th>
<th>Time</th>
<th>Hep C Viral Load</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
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<td>4</td>
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</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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

NY Care Team
DOCTOR
Name:
Phone:

NAVIGATOR
Name:
Phone:

PHARMACIST
Name:
Phone:

ULTRASOUND RADILOGIST
Name:
Phone:

39
Health Promotion Tools

**Pocket Card:** “Know Hep C, Cure Hep C”

**Handout:** Steps to Hep C Care and Cure

**Business card template:** English & Spanish
**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
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)

**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: PHIL 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

<table>
<thead>
<tr>
<th>Test people who use drugs (PWUD) for Hep C at least annually</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TEST TYPE</strong></td>
</tr>
<tr>
<td>Antibody Test: Use to test people who have never tested Hep C positive.</td>
</tr>
<tr>
<td>RNA Test: Use to test people who have ever tested Hep C positive.</td>
</tr>
</tbody>
</table>

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 care of Hep C infection at www.blt.ly/mipI3h-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 medical office)

Prevent Hep C and Overdose:
- Link people to harm reduction and syringe service programs https://nasscn.org/map/
- Link people to medication-assisted treatment, such as buprenorphine SAMHSA tape locator

Resources:
- To find Hep C patient navigators 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: hcguidelines.org/unique-populations/pwd

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

| 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&cglId=](https://rtips.cancer.gov/rtips/programDetails.do?programId=307723&topicId=102264&cglId=)
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:
  o 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

\(^1\) 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
Access toolkit here: https://www.nastad.org/hepatitis-navigation-toolkit
This presentation's recording will be archived and available soon.
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