



# Check Hep C Program Final Report

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**Check Hep C Program Service Delivery Period:** April 1, 2014 – April 1, 2015  
*Program extended through NYC City Council funding through June 30, 2015*

## Check Hep C Program Administration

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## Check Hep C Program Overview

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Check Hep C is a NYC Department of Health & Mental Hygiene (DOHMH) program that aims to increase hepatitis C (HCV) testing, linkage to medical care, and treatment in NYC. In the first year (2012-2013), the program was funded to include HCV outreach, antibody and RNA testing, linkage to care, case management and care coordination services, and mentoring of clinical providers through telemedicine.

In the second year (April 2014-March 2015), the Check Hep C Program funded patient navigation including linkage to care and HCV clinical care coordination for HCV chronically infected individuals. Four NYC HCV health service programs were funded to employ one full time Check Hep C Patient Navigator:

- Montefiore Comprehensive Health Care Center (FQHC)
- Harlem United (Harm Reduction Program co-located with FQHC)
- BOOM!Health (Harm Reduction Program co-located with BrightPoint Health FQHC [formerly HELP/PSI] )
- AfterHours Project (Harm Reduction Program)

## Check Hep C Goals, Objectives & Activities

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### Goal

The goal of the Check Hep C program was to provide linkage to care and HCV clinical care coordination services to persons chronically infected with HCV in order to facilitate engagement in medical care and successful treatment to cure HCV infection.

### Objectives

The objectives of the Check Hep C Program were to:

1. Reach out to HCV positive patients identified in year one of the program, and provide linkage to care or return to care services.

2. Enroll at least 400 HCV positive patients into patient navigation services with the following goals:
  - a. At least 90% of patients enrolled will attend their first HCV medical appointment.
  - b. At least 80% of patients enrolled will complete a full medical evaluation, including evaluation for antiviral treatment.
  - c. Of patients clinically eligible for treatment, at least 30% will initiate HCV treatment.

### **Patient Navigation Services**

Patient Navigation services were divided into two levels depending upon where the patient received clinical care.

- **Care Coordination:** for patients receiving clinical care at the Check Hep C site.
- **Linkage to care:** and follow-up services for patients receiving clinical care at an external organization.

### **Patient Navigator Characteristics**

Four patient navigators were employed through this program, one at each site. All of the patient navigators had a Bachelors degree, one is currently in nursing school and one is currently in social work school. Only one of the patient navigators had experience in working with HCV prior to this program. Two of the patient navigators were bilingual in English and Spanish. A patient navigator supervisor was designated at each site to support the program, and participated directly in communication or meetings periodically as needed. Support from the patient navigator's supervision and organization was important to achieving the goals of the program.

### **Patient Navigation Activities**

Check Hep C Patient Navigators conducted the following activities:

- Outreach and enrollment
- Patient Navigation Assessments
- Development and continuous updates to an HCV Clinical Support Care Plan
- Linkage to medical care: First HCV medical visit within one month of enrollment
- Provision of care coordination services, including:
  - Referrals to supportive and ancillary services (case management, housing, substance abuse treatment)
  - Accompaniment (health care navigation)
  - Reminders (calls, letters, text, email, telegram)
  - Health promotion (health education and motivational interviewing)
  - Alcohol screening and counseling
  - Case conference with medical provider and with multi-disciplinary team
  - Treatment readiness and treatment adherence services
  - Medication/pharmacy coordination and support (including processing prior authorization, appeals, fair hearings and patient assistance program applications)
  - Discharge/transition planning
- Documentation, data management and reporting



- Participation in program management activities (training, program feedback, monthly meetings, and quality assurance activities such as data review and site visits).

### **DOHMH Program Management**

The DOHMH Program Management Team developed a new program protocol and data management system for Check Hep C year two. Patient navigators tracked activities on paper forms developed by DOHMH, or in their own Electronic Health Record in accordance with DOHMH provided data collection templates. Patient navigators reported data monthly in a Microsoft Access database developed by DOHMH, which was emailed to DOHMH via a secure data transfer system. Data submitted to the Check Hep C program was matched with the DOHMH Surveillance registry to validate RNA status and treatment initiation reports.

All sites were provided with program protocol training, and patient navigators participated in monthly program management meetings. Monthly meetings included a program enrollment, activity and clinical data status report, as well as program implementation challenges and successes discussion.

Trainings were provided at the start of the program and made available to patient navigators throughout the year (viral hepatitis 101, HCV point of care testing, NYS DOH HCV trainings in linkage to care HIV/HCV care, and harm reduction trainings). Trainings were also provided at several monthly patient navigators meetings, based on needs expressed by patient navigators (HCV Treatment update, Reading and interpreting HCV lab reports).

A call was conducted with Check Hep C affiliated clinical providers to learn about their experience, to support collaboration between the patient navigator and clinical providers, and to support communication between Check Hep C affiliated clinical providers.

Two Quality Assurance site visits were conducted with each Check Hep C multi-disciplinary team during the contract period. At the site visit, DOHMH randomly selected 10% of patient charts to review for completion and accuracy of transcription to the program database, and discussed program strengths, obstacles and improvement action plans. As needed, additional calls and site visits were conducted to resolve program implementation issues. One corrective action site visit was conducted during this contract period.

## Check Hep C Final Data Report

Data Reporting Period: April 1, 2014 – April 1, 2015.

### Program enrollment

As of April 1, 2015 the Check Hep C program enrolled 400 participants, meeting 100% of the program’s enrollment goal. 30% (n=121) of the participants are enrollees from year 1 of the Check Hep C program. Approximately 75% (n=301) of participants were enrolled in full care coordination services, and 21% (n=81) were enrolled in linkage to care at external healthcare organizations.

### Participant Characteristics

Check Hep C participant characteristics are consistent with those of HCV persons reported in the target neighborhoods. Twenty-nine percent (n=114) of the participants are Black non-Hispanic, 63% of participants (n=251) are Hispanic, and 8% (n=31) are White non-Hispanic. The baby boomer cohort (born between 1945 –1965) makes up the majority of the Check Hep C participants with the median age of 51. The NYC boroughs of residence are consistent with the programs’ locations, which are the boroughs with the highest burden of HCV. Fifty-two percent of participants (n=208) reside in the Bronx, 24% (n=96) live in Brooklyn, 20% (n=81) live in Manhattan, and 1% (n=5) live in Queens.

Twenty-nine percent (n=114) of Check Hep C participants report intravenous drug use (IDU) in the last year, with 48% reported as being chemically dependent at time of enrollment. The rates of IDU in the last year vary across the sites with the highest site having 57% (n=62), and the lowest site with 4% (n=4). Approximately a quarter of participants (24%, n=93) are homeless, and nearly a third (30%, n=114) are reported as having a serious mental health diagnosis.

**Table 1. Patient Demographics**

<b>Race</b>		
Black non-Hispanic	28%	(n=114)
Hispanic	63%	(n=2251)
White non-Hispanic	8%	(n=31)
<b>Age</b>		
Born 1945 –1965	61%	(n=244)
<b>Borough of Residence</b>		
Brooklyn	24%	(n=96)
Bronx	52%	(n=208)
Manhattan	20%	(n=81)
Queens	1%	(n=5)
<b>Risk</b>		
IDU	30%	(n=114)
Homeless	24%	(n=93)
Mental health diagnosis	30%	(n=114)

### Assessment and Evaluation

Across all sites, patient navigators engaged participants consistently and frequently in the program’s activities. Nearly a quarter (23%) of participants received appointment accompaniment, with many of these clients receiving accompaniment multiple times.

**Table 2. Percent of Care Coordination Enrollees Receiving Services, by Activity**

Activity	% of Total Care Coordination Enrollees (N=301)	% of CC Enrollees that have initiated Treatment (N=105)
Reminders	93%	99%
Health Promotion	97%	100%
Alcohol Counseling	96%	99%
Case Conferencing Medical Provider	64%	96%
Treatment Adherence	47%	81%
Case Conferencing Multi-Disc Team	22%	27%
Treatment Readiness	56%	81%
Medication/Pharmacy Coordination	32%	77%

The activities of the patient navigator were documented for participants enrolled in care coordination services, and the percent of participants receiving each type of service is reported on for total enrollees and for enrollees who initiated treatment during the program. Ninety-seven percent of all enrollees received health promotion, and 100% of those who initiated HCV treatment received this service (reviewing and discussing the Hep C The Facts Booklet) and motivational interviewing. All patients were screened for alcohol use, and similarly high numbers in the two groups are seen for alcohol counseling, at rates of 96% and 99%. Case conferencing with medical providers was 96% for participants who initiated treatment, highlighting the close relationship between the patient navigator and treating provider.

Treatment adherence and treatment readiness counseling was provided for 81% of participants who initiated treatment. Despite the shorter treatment durations of current HCV medications, these activities are still crucial in getting high risk participants to initiate and complete treatment successfully. The high SVR rate seen in the program (88% as of June 2015) can be in part attributable to the treatment readiness and adherence counseling provided as part of Check Hep C. Furthermore, 77% of participants required medication and pharmacy coordination services from the patient navigator, most of which time was spent on prior authorization processes.

### Treatment Initiation

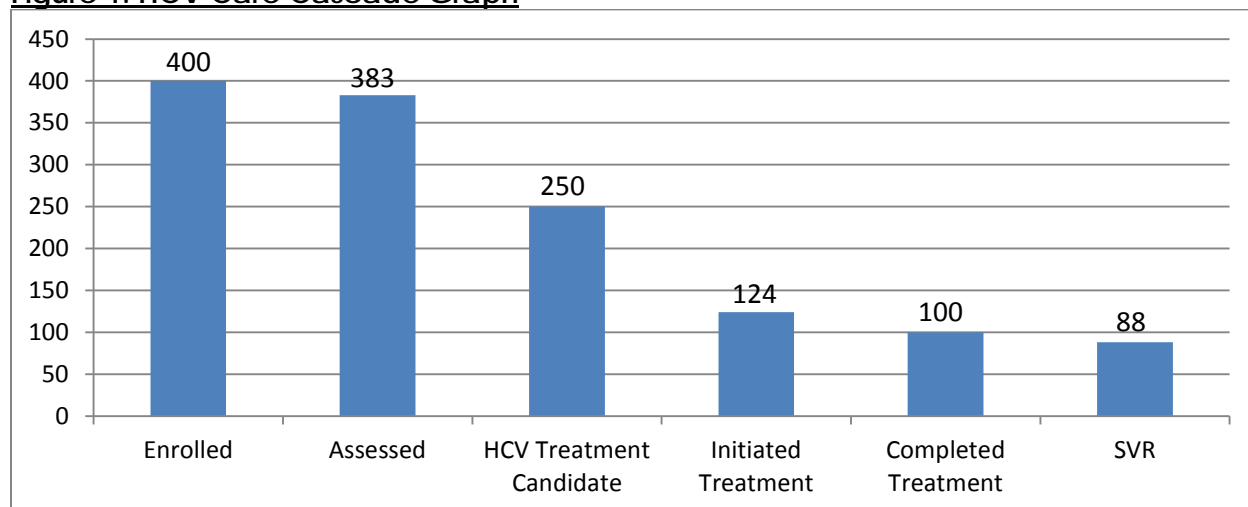
Table 3. HCV Care Cascade

	N	%
<b>Enrolled</b>	400	
<b>Assessed</b>	383	95.8%
<b>HCV Treatment Candidate</b>	250	65.3%
<b>Initiated Treatment</b>	124	49.6%
<b>Completed Treatment</b>	100	80.6%
<b>SVR</b>	88	88.0%
<b>*Percent is calculated a % of previous row</b>		

Three-hundred and eighty-three (96%) program participants were assessed by the patient navigators to determine co-morbidities, HCV risk histories, and HCV medical history. Three-hundred and twenty-seven (82%) of those assessed have received a full HCV medical evaluation. The time between completion of assessment and completion of HCV medical evaluation can vary based on the complexity of the client’s psychosocial and medical condition, health insurance status, and time required to schedule and attend medical appointments.

Two-hundred and fifty (65%) participants who completed the HCV medical evaluation were determined to be eligible treatment candidates. Primary reasons cited for treatment candidate exclusions were active alcohol or substance use, unstable housing, psychosocial issues, and frequently a combination of those challenges. Patient navigators worked to improve treatment readiness in clients with modifiable treatment candidacy status. Half (50%, n=124) of eligible treatment candidates have initiated HCV treatment and one hundred (81%) have successfully completed treatment, with an SVR rate of 88% (n=88) as of June 2015.

Figure 1: HCV Care Cascade Graph



## Check Hep C Supportive Programs

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### **CDC Grant-Funded HCV Testing**

HCV point-of-care HCV antibody testing and RNA testing was made possible at Check Hep C sites, from the start of the program through December 2014, through a 2-year CDC Grant: *Viral Hepatitis Testing and Linkage to Care for Persons Who Inject Drugs (PWID)*. Funds covered the costs of the antibody test and the RNA test only. 4,751 HCV antibody tests and 880 RNA tests were conducted under this program with 512 patients identified as HCV RNA positive. 435 (85%) of these RNA positives attended a first HCV medical appointment through Check Hep C patient navigation services.

### **NYC Council Extension of Check Hep C Program through June 30, 2015**

NYC Council allocated funding in FY2015 to Montefiore, Harlem United and BoomHealth Check Hep C programs to extend patient navigation services through June 30<sup>th</sup>, 2015. City Council also funded 2 additional clinical sites, Community Health Care Network and Bellevue Hospital Center. Afterhours was not funded for Check Hep C Patient Navigation through this extension, but was provided a small amount of funding for Peer Navigation as described below. An additional 238 patients were enrolled in Check Hep C through this extension, and the additional time allowed for previously enrolled participants to receive continued services and progress farther through the care cascade.

NYC City Council allocated a small amount of funding in FY2015 to each of the 16 Injection Drug Users Health Alliance (IDUHA) Harm Reduction Programs to provide Hep C Peer Navigation services (Including Check Hep C Sites: BOOM!Health, Afterhours and Harlem United). These programs served as a referral source for Check Hep C, and Peers supported the Check Hep C Patient Navigators in outreach, linkage to care, health promotion, accompaniment, and return to care activities. From January 2015 – June 30, 2015, 1671 participants were enrolled in the Hep C Peer Navigation Program across 14 syringe exchange program sites. Thirty-three percent of participants enrolled self-reported having HCV, 22% reported being HCV negative but at risk, while 45% did not know their status. Among the 754 participants who were unsure about their HCV status at intake, 386 (51%) received HCV Antibody testing during this program, and of those who tested positive 97 (45%) completed RNA testing. More than 272 referrals to HCV medical care were made for all HCV RNA positive participants identified through this program; and 39 were referred to the Check Hep C program. The Peer Navigation program supported the Check Hep C program in outreach, health counseling, screening, linkage to care and return to care. Supplemental peer navigation services would be a valuable addition to future Check Hep C program plans.

## **Key Check Hep C Program Findings and Developments**

### **Health Care Access for Vulnerable populations**

Patients with multiple competing psychosocial stressors and priorities such as: chemical dependence, illiteracy, unstable housing/homelessness, criminal justice involvement, and mental illness have significant barriers to HCV health care access and treatment and require more time and support than psychosocially stable patients. During this program Patient Navigators were provided with tools, resources, technical assistance



and support to help high need patients overcome barriers to health care access and treatment. Navigators discussed cases at monthly meetings and provided each other with supports and resources to increase efficacy with challenging cases. Navigators reported that development of trust and movement along the continuum of care for this population is best achieved through stable in-person patient navigation-based health promotion over an extended period of time.

### **New Materials Developed by NYC DOHMH**

'Alcohol Screening & Counseling for Hepatitis Patients' Guide for providers

'Hep C and Alcohol Action Plan' palm card for patients

New provider and patient educational materials were developed during this program based on needs expressed by patient navigators or community partners.

Persistent alcohol use in HCV patients has been reported as a barrier to HCV care and treatment in several HCV clinical programs and studies. In order to develop and standardize evidence-based practices to enact recommended alcohol screening and counseling protocols for HCV patients, a new 'Alcohol Screening & Counseling for Hepatitis Patients' Guide for providers and a 'Hep C and Alcohol Action Plan' palm card for patients was developed and provided to Check Hep C Patient Navigators and clinical providers.

Patient Navigators reported that patients continue to express fears about HCV treatment side effects due to the legacy of the interferon era, fears that new medications are experimental, and concerns about the efficacy of treatment in particular racial groups. To address this, the DOHMH developed and updated patient education materials during this program, including:

- Updated '*Hep C The Facts*' Booklet with a 'New HCV Treatments' section
- Developed HCV medication teaching pamphlets to assist with treatment readiness and adherence.
- Developed a 'New Hep C Treatments Poster'
- Updated the *NYC Liver Health Hepatitis C Mobile App* to include new treatment information

### **Clinical Provider Support**

Clinical providers affiliated with Check Hep C were provided with the following supportive resources through this program:

- Diagnosing and Managing Hepatitis C: City Health Information (CHI) 2014, Updated 2015.
- On-line and In-person CME activities were made available to clinical providers throughout the year through a monthly newsletter.
- The NYS DOH Hepatitis C Clinical Consultation Line resource was made available for expert case consultation.
- HCV medication Prior Authorization supportive tools and resources were sent as they became available.
- Weekly HCV telemedicine sessions began in Spring 2015 as part of the DOHMH 'Capacity to Cure' initiative in collaboration with the Empire Liver Foundation.

### **Prior Authorization Assistance**





Prior Authorization for HCV medications was reported to be a significant barrier to HCV treatment initiation during this program. Patient Navigators frequently provided support in obtaining prior authorization for medication, processing appeals, requesting fair hearings, and processing patient assistance program applications. In one program, prior authorization was denied for 7 patients, all requiring appeals. For 5 additional patients, the patient navigator processed applications for patient assistance programs to cover the prohibitive cost of the copay.

Patient navigators were successful in assisting patients in getting medications covered. Check Hep C Programs developed and shared strategies to streamline medication approval process, such as developing a template prior authorization justification letter (including documentation of fatigue scale, comorbid conditions, and patent risk for secondary exposure).

To support programs to advocate for HCV treatment access, and disseminate best practices to the wider NYC HCV care provider community, the NYC DOHMH held a NYC Hep C Task Force 'Hep Health Care Access Training' with a focus on medication coverage in December of 2014, and a 'HCV Medication Coverage Mini-Training' at the Harlem Hep C Task Force in May 2015. In an effort to change HCV medication access policy in NYS, NYC DOHMH wrote a letter to NYS DOH Pharmacy Program urging coverage of HCV treatment for all infected individuals, as well as highlighted this issue at the 2015 NYC Hep C Legislative Breakfast with NYC Council.

## **Conclusion**

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The Check Hep C program succeeded in enrolling 400 HCV chronically infected participants, supported treatment initiation in 124 patients, and a complete treatment course for 100 during the evaluation period for the program. The program is serving psychosocially vulnerable patients, who require supportive services in order to effectively navigate the health care system and take advantage of advances in medical care and treatment.

The program successes were achieved despite significant barriers, including: minimal HCV screening resources to assist with outreach and enrollment, minimal HCV clinical provider support, and restrictions on HCV medication prior authorization.

The Check Hep C program is an effective mechanism for linking HCV patients with significant health care access barriers to care and supporting them through treatment, and would benefit patients in additional high prevalence locations in NYC.