# CHECK HEP C PATIENT NAVIGATION PROGRAM
# FY2018 FINAL REPORT

## Background

- 116,000 people are infected with hepatitis C (Hep C) in New York City.
- Forty percent are unaware of their infection and only 14 percent cured.
- Treating and curing Hep C reduces the risk of liver disease, cancer and premature death, and prevents transmission of the virus.
- People with Hep C face strong barriers to accessing Hep C care and treatment. Barriers include drug use, homelessness, psychiatric conditions and insurance restrictions on medication coverage.
- Patient navigation can help people with Hep C overcome barriers to accessing and completing Hep C care and treatment.

## Program Description

The Check Hep C Patient Navigation Program aims to: (1) link people living with Hep C to medical care; (2) support complete medical evaluation and successful treatment; (3) prevent reinfection; and (4) help patients maintain liver health after treatment. The program is administered by the New York City Health Department.

In Fiscal Year 2018, New York City Council allocated $1,122,946 to fund at least one full-time patient navigator at 12 sites to provide linkage to care and clinical care coordination services. Sites included community organizations, health centers and hospitals.

Check Hep C services include:

- Hep C health promotion, and alcohol and drug counseling
- Referrals to supportive services, medication access support, treatment readiness and adherence support
- Linkage to Hep C medical care, accompaniment to or reminders for medical appointments, and case conferencing with medical care team

## Hep C in New York City and Check Hep C Program Sites

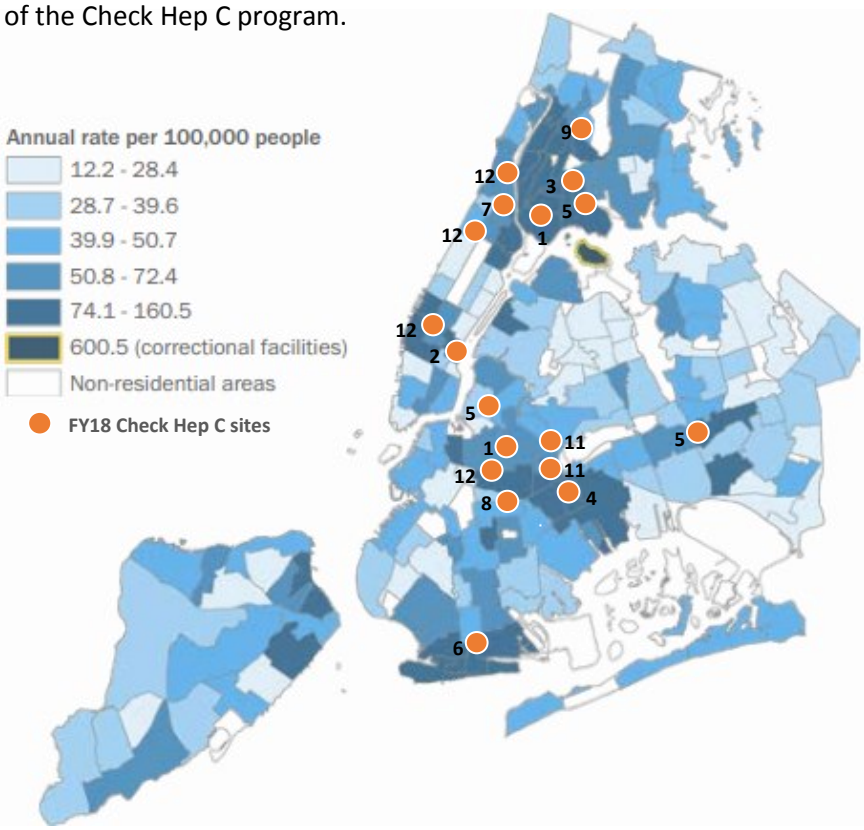
The following map shows the rate of newly reported Hep C in 2017 by neighborhood tabulation area and the locations of the Check Hep C program.

### Health Centers and Hospitals

1 **Bedford-Stuyvesant Family Health Center**
2 **Bellevue Hospital**
3 **Bronx-Lebanon Hospital Center**
4 **Brownsville Multiservice Family Health Center**
5 **Community Healthcare Network**
6 **Coney Island Hospital**
7 **Harlem United**
8 **Kings County Hospital**
9 **Montefiore Comprehensive Health Care Center**

### Community Organizations

10 **BOOM!Health**
11 **Family Services Network of New York, Inc.**
12 **Praxis Housing Initiatives, Inc.**




Health

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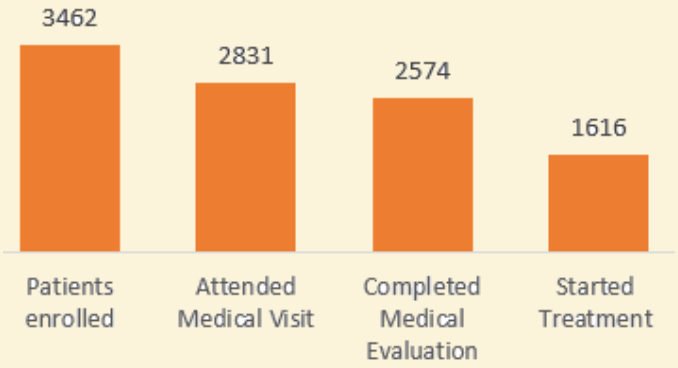
## Program Outcomes

From January 1, 2015 to June 30, 2018, Check Hep C enrolled 3,462 patient services provided for people living with Hep C. In this time, **63% of patients started treatment and were likely cured.**

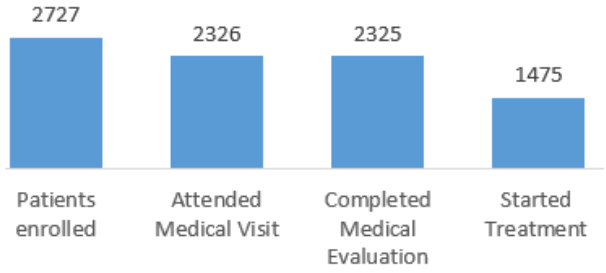



## Findings

1. In 2016 the program expanded from 5 to 12 sites in clinical and community-based settings.
2. Patient navigation at community organizations focused on testing, linkage to care, and referral to supportive services due to the **high number of patients with social and health needs**.
3. On average, clinical sites **screened 27 percent of patients at risk of Hep C.** In FY2019, the program work to improve Hep C screening rates.
4. **Intensive care coordination** and resources were needed to successfully navigate homeless people and people with mental health issues.
5. **Onsite medical care and drop-in Hep C services** support Hep C patients to complete a medical evaluation and start treatment.
6. **Motivated clinical providers or "champions" and care teams** are important to support patient navigator confidence and success.

## Health Centers and Hospitals

Nine organizations had Hep C medical care and treatment available onsite. Of the 2727 people with chronic Hep C, **85% completed a medical evaluation.**

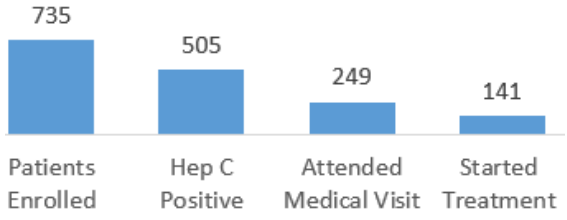



### Participants:

**40%** Black and **24%** Latinx
**69%** insured by Medicaid
**29%** reported using injection or intranasal drugs
**21%** reported mental health issue
**22%** homeless or unstably housed
**10%** HIV co-infected and **10%** cirrhotic

## Community Organizations

Three harm reduction organizations enrolled 735 people. The majority had a history of drug use or were homeless. 505 tested positive for current infection and received services to prevent transmission. 49% were linked to care at Check Hep C clinical sites and elsewhere.




### Participants:

**21%** Black and **49%** Latinx
**67%** covered by Medicaid
**70%** reported using injection or intranasal drugs
**44%** reported mental health issue
**44%** homeless or unstably housed
**16%** HIV co-infected

To learn more about the Check Hep C Patient Navigation Program, please email hep@health.nyc.gov.