CHECK HEP C PATIENT NAVIGATION PROGRAM
FY2017 FINAL REPORT

Background

- 146,500 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 2017, New York City Council allocated $962,052 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

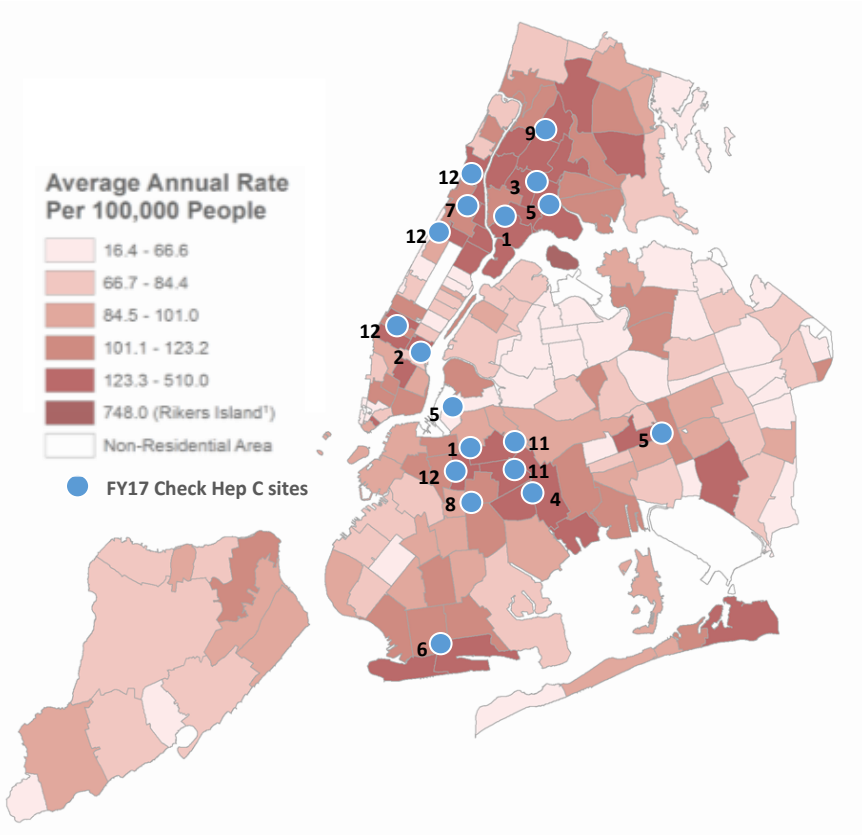
The following map shows the rate of newly reported Hep C in 2016 by ZIP code and the location of Check Hep C program sites.

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.**



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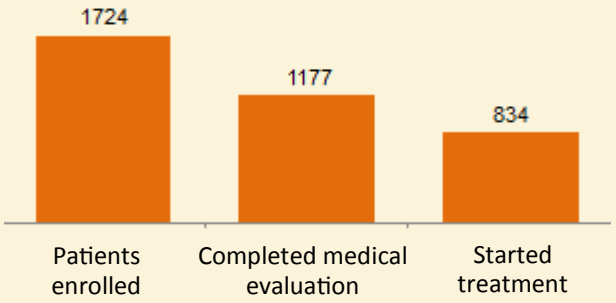
Program Outcomes

From January 1, 2015 to June 30, 2017, Check Hep C enrolled 1724 patients living with Hep C. In this time, **834 patients started treatment and were likely cured.**



Care Coordination

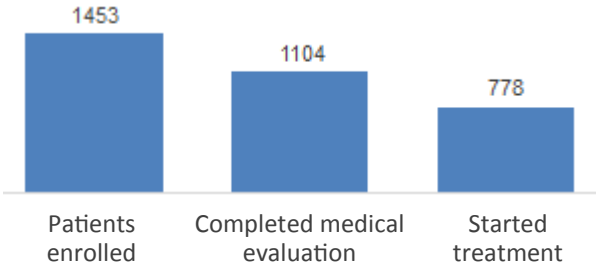
On average, each patient required the following patient navigation services: **6** appointment reminders, **5** conferences with providers, **5** medication coordination efforts, **4** treatment adherence encounters, **4** substance use coaching encounters and **1** accompaniment.

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 FY2018, the program will 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 1453 people with chronic Hep C, 778 started treatment and were likely cured.

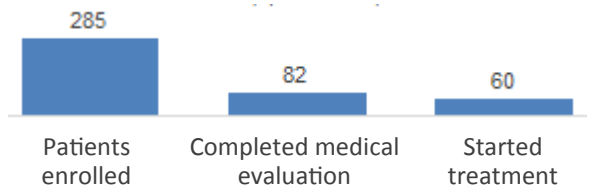


Participants:

41% Black and **35%** Latino
69% insured by Medicaid and **16%** uninsured/unknown
43% reported using injection or intranasal drugs
37% reported mental health issue
21% homeless or unstably housed
12% HIV co-infected and **13%** cirrhotic

Community Organizations

Three harm reduction organizations enrolled 285 people. The majority had a history of drug use or were homeless. All tested positive for current infection and received services to prevent transmission. 82 were linked to care at Check Hep C clinical sites and elsewhere.



Participants:

24% Black and **60%** Latino
64% covered by Medicaid and **30%** unknown
47% reported using injection or intranasal drugs
59% reported mental health issue
40% homeless or unstably housed
16% HIV co-infected and **4%** cirrhotic

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