Patient Navigation for New Moms Identified Through the Perinatal Hepatitis B Prevention Program in NYC

Viral Hepatitis Program, NYCDOHMH
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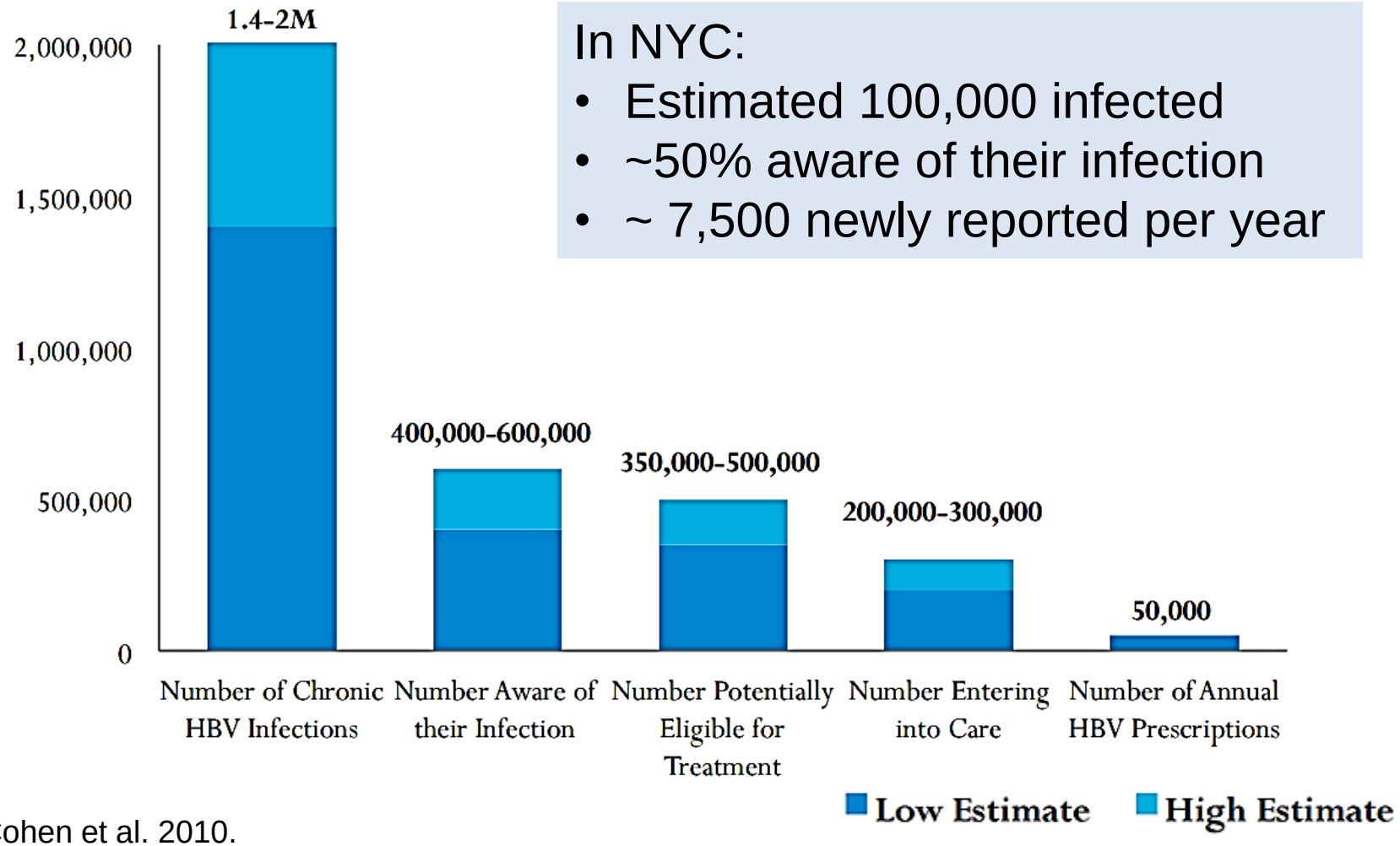
Introduction

- In February 2017, bilingual patient navigators from the NYC Health Department's Viral Hepatitis Program began enrolling women referred from the Perinatal Hepatitis B Prevention Program (PHBPP) after childbirth
- Offer patient navigation, education and support (including scheduling appointments)
- Also support to link household and family members to screening, vaccination, and hepatitis B medical care

U.S. Hepatitis B Care Continuum



In NYC:

- Estimated 100,000 infected
- ~50% aware of their infection
- ~ 7,500 newly reported per year

Source: Cohen et al. 2010.

Perinatal Hepatitis B: Problems

- A recent study found that fewer than 1 out of 5 pregnant women newly identified with hepatitis B received appropriate follow-up after delivery
- Only 1/2 to 2/3 of OB providers educated women about hepatitis B or referred them to specialty care
- Women may have high levels of viral replication/liver inflammation after pregnancy (flares)
- Undocumented women may lose health insurance soon after delivery

Sources: Chang et al. 2015, IOM Report 2010, ACOG Practice Bulletin, 2007.

Perinatal Hepatitis B Prevention Program

- 1990: NYS law mandates HBsAg* testing of all pregnant women & reporting of all positive results
- 2014: NYC Health Code amended, requires lab reporting of pregnancy status w/positive hepatitis B results
- 2015: 68% of women with hepatitis B who delivered a live birth were reported prenatally (the rest were reported postpartum)

*hepatitis B surface antigen

Profile of Women Reported to PHBPP in NYC, 2015

Group	Number	Percent of Group
Overall	1,493	N/A
Borough of Residence		
Bronx	165	11.1
Brooklyn	***679***	***45.5***
Manhattan	161	10.8
Queens	449	30.1
Staten Island	39	2.6
Region of Birth		
China	***937***	***62.8***
Africa	203	13.6
Asia (excluding China)	153	10.3
Caribbean	71	4.7
USA	47	3.2

Profile of Adult Contacts Reported to PHBPP in NYC, 2015

Group	Number	Percent of Group
Total Identified	1,927	N/A
Adults	1,016	N/A
Adults Tested	***231***	***22.7***
Immune	115	49.8
Infected	***77***	***33.3***
Susceptible	29	12.6
Inconclusive	10	4.3

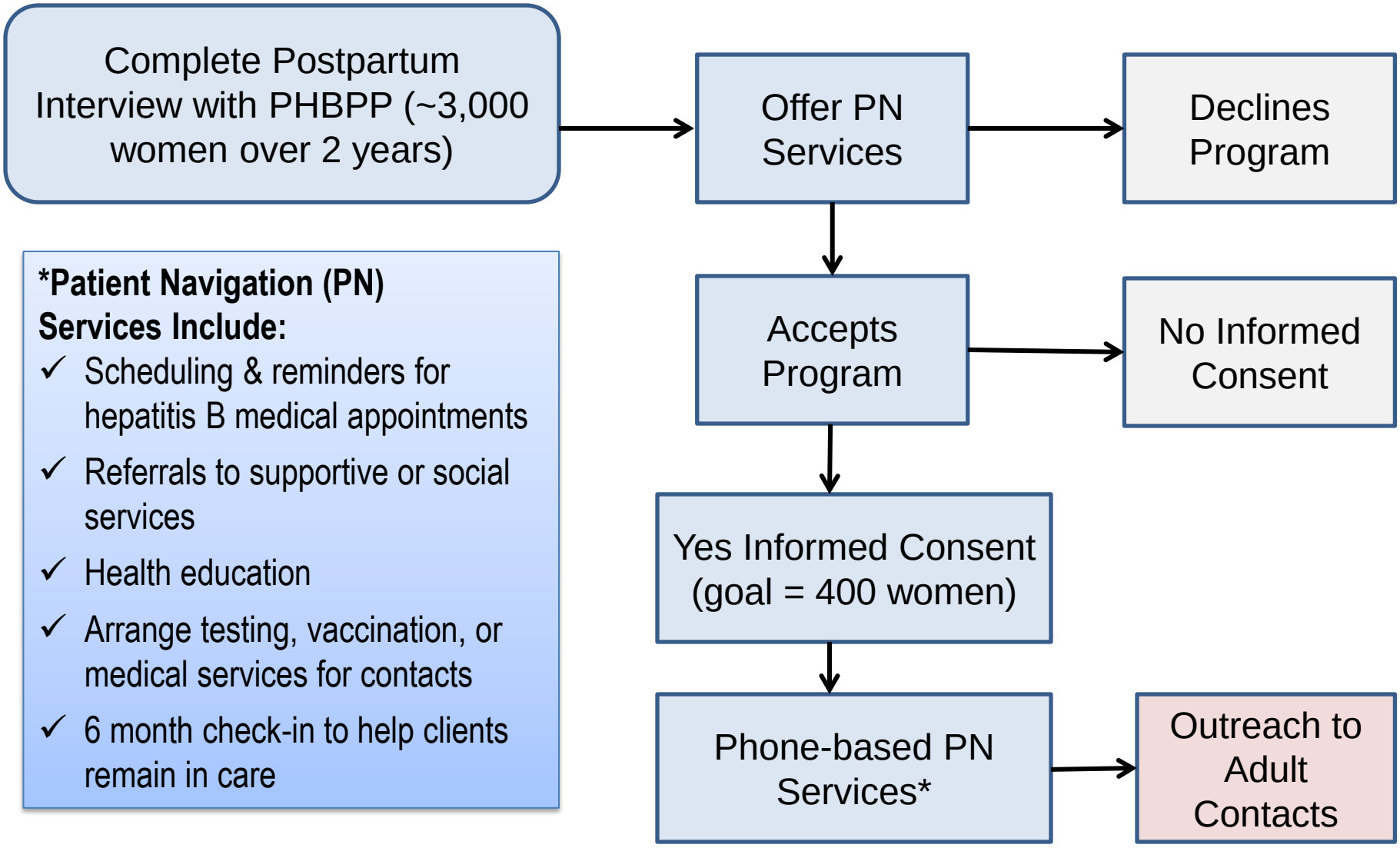
PHBPP- Activities

1) Case management for mothers to ensure infants receive recommended hepatitis B vaccine series & testing

2) Standardized health messaging for mothers

3) Letters with referral sites (Check Hep B Program sites)

Enrollment in the New Moms Patient Navigation Program



Program Goals

- Link women to hepatitis B care
- Offer assistance to overcome barriers
- Connect women to community-based organizations/services
- Support continued engagement in recommended care
- Help other close household contacts/family members get tested, vaccinated, and linked to care

Measuring Program Outcomes

- NYC Health Department surveillance data will be used to measure program outcomes:
  - Hepatitis B lab report within 6 months will be indicator of follow-up with a medical provider
  - Time to lab report (secondary measure)
- Comparison group: women followed by the perinatal hepatitis B prevention program before February 2017
- Qualitative description of barriers/facilitators to accessing care

Measurement Limitations

- No clear & consistent guidelines for postpartum follow-up of women with hepatitis B
  - AASLD currently recommends ALT every 3 months X 2 (from “technical notes” section)
  - But what about women who are newly identified with hepatitis B or out of care?
  - *Chang MS, et al., 2015:* defined as HBV DNA levels, HBe-Ag, ALT within 12 months
- Also…not all hepatitis B lab reports are tracked by NYC Health Department

Program Progress

- 18 women referred from PHBPP
  - 9 consented
  - 5 declined
  - 4 pending
- Barriers identified:
  - Lack of knowledge: don't understand test results, how to access care, or their legal rights
  - Lack of insurance: temporary Medicaid/uninsured
- So far we have been unable to reach any contacts for testing/linkage to care

We need your input!

- Given your work & knowledge, what issues/problems could you see the program encountering?
- Additional community programs/resources we should be aware of? Especially resources for the undocumented/uninsured.
- What are documented/undocumented immigrants legal rights in NYC when accessing health care?
- Other advice?

Thank You!