NYC Check Hep B Program

Final Report

Program Period: (July 1, 2014 – June 30, 2014)
Funding provided by NYC Council in FY2015

Program Administration

NYC Department of Health: Viral Hepatitis Surveillance, Prevention and Control Program

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Check Hep B Program Overview

In FY2015, New York City (NYC) Council allocated funding to four community health programs to provide hepatitis B (HBV) patient navigation, which served to establish the Check Hep B Program. The program was administered by the NYC Department of Health & Mental Hygiene (DOHMH), who contracted with the four designated community health programs to deliver services. Each program received $63,141 in funding for year one.

The Check Hep B Program funded one Patient Navigator (Navigator) at each contracted site to provide culturally and linguistically appropriate patient navigation, including linkage to care and clinical care coordination services, for NYC residents chronically infected with HBV.

Check Hep B Funded Programs

- African Services Committee (Community Based Organization)
- Bellevue Hospital (Public Hospital)
- Charles B. Wang Community Health Center (Federally Qualified Heath Center)
- Korean Community Services (Community Based Organization)

Check Hep B Goals, Objectives & Activities

Goals

The Check Hep B Program aimed to increase access to HBV medical evaluation and treatment for chronically infected persons, by providing culturally and linguistically appropriate patient navigation including linkage to care and care coordination services. In addition, DOHMH aimed to develop and pilot a standard HBV patient navigation protocol, data management system, and recommended essential HBV Patient Navigator professional qualifications.

Objectives

The objectives of the Check Hep B Program were to:

- Enroll 50 chronically infected HBV patients at each contracted site (with the exception of Bellevue which had an enrollment goal of 35)
- Link each patient to care within one month of enrollment (if not already in care)
- Ensure each patient competes a full HBV medical evaluation, including an evaluation for treatment
- Facilitate liver cancer screening according to guidelines
- For patients that treatment is recommended, assist with treatment initiation and treatment adherence

Patient Navigation Services

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

- **Care Coordination:** If the patient received care at a Check Hep B co-located clinical site
- **Linkage to care:** Follow-up services if the patient was referred to an external clinical site

In addition to patient navigation services, most of the contracted programs conducted in person and media outreach, HBV screening and HBV vaccination services using funds from other sources. These activities were critical to achieving recruitment goals.

Patient Navigator Characteristics

The Navigators employed under Check Hep B varied considerably by site. Each spoke at least two languages and was a native speaker in at least one of the languages of the target population; while at African Services Committee, the navigator spoke seven African dialects. Patient Navigators varied in educational attainment from some college to a bachelor's degree; they ranged in experience with patient navigation from less than one year to three years; and their experience with HBV ranged from less than one year to three years.

One of the navigators was a Certified Medical Interpreter at the start of the program, and two others initiated the process of being certified during the program.

Each patient navigator was supervised by an MPH, MD or BA program manager who had a range of experience with HBV from one to eight years.

Patient Navigation Activities

Check Hep Navigators conducted the following activities:

- Outreach & enrollment (in-person, media, screening)
- Conduct a Patient Navigation Assessment
- Develop and continuously update a Patient Navigation Care Plan
- Linkage to medical care: First HBV medical visit within one month of enrollment
- Provide care coordination services, including:
    - Referrals to supportive and ancillary services (case management, legal services, benefits)
    - Reminders (calls, letters, text, email)
    - Health promotion (health education & motivational interviewing)
    - Accompaniment (health care navigation)
    - Medical Interpretation (not an original required activity, see Future Program Recommendations section)
    - Alcohol screening and counseling
    - Case conference with medical provider and with multi-disciplinary team
    - Treatment readiness and treatment adherence counseling
    - Medication/pharmacy coordination (health insurance or pharmaceutical assistance program applications)
    - Discharge/transition planning
- Documentation, data management and reporting
- Participation in program management activities including: training, program feedback, monthly meetings, and quality assurance activities including data review and site visits.

DOHMH Program Management

The Check Hep B program was administered by a DOHMH team including a program manager, data manager and public health intern program assistant; all of whom provided in-kind services. The Check Hep B program protocol, forms and database were developed by DOHMH, and program training for Patient Navigators took place in November 2014. Monthly program management meetings were facilitated by DOHMH; which included a program data review, program implementation and case study discussion.

Quality Assurance

DOHMH conducted one quality assurance site visit at each contracted program site, which included a site specific meeting with the multi-disciplinary Check Hep B team, program implementation discussion, paper and electronic documentation review, and data validation review. DOHMH randomly selected 10% of patient charts to ensure that transcription from paper or electronic data collection forms to program database was accurate and complete. If documentation problems were identified, technical assistance was provided. DOHMH matched data reported by the programs to the surveillance registry at the end of the program to validate that all cases were also reported to the registry, and thus valid patients to enroll.

Check Hep B Final Data Progress Report (November 1st 2014 – June 30, 2015)

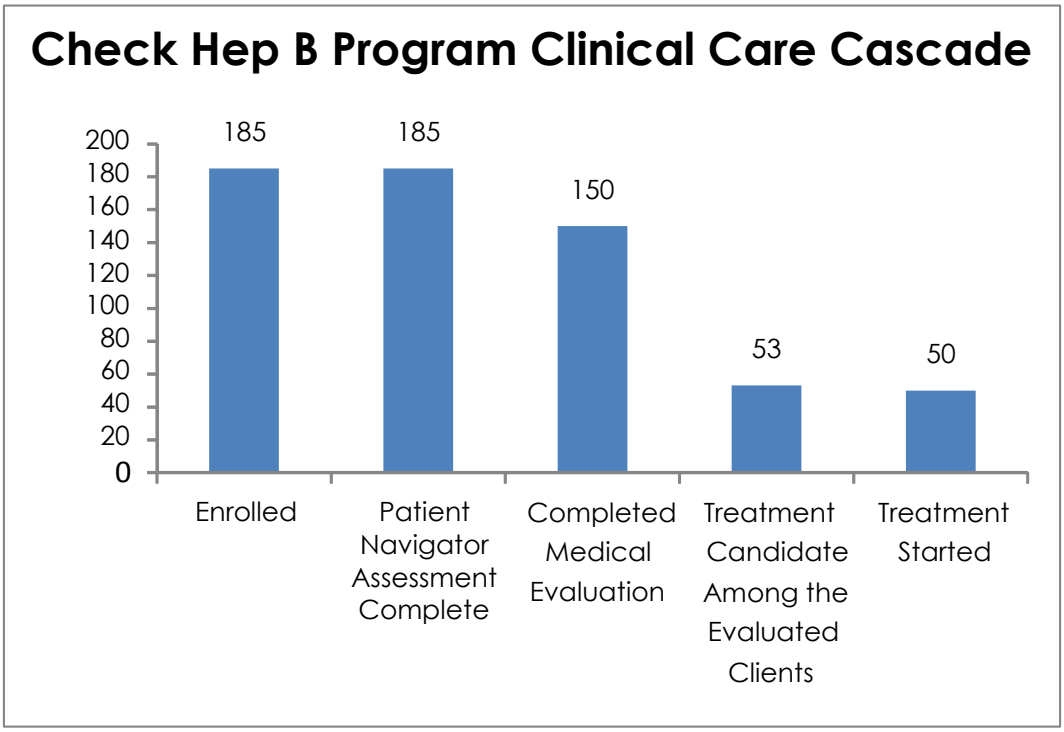
As of June 30, 2015, 185 patients were enrolled in the program and all programs reached their enrollment goal.

Patient Navigation Activities

Of the total participants enrolled, 80 (43%) received accompaniment (average of one encounter per patient), 172 (93%) received appointment reminders (average of four reminders per patient), 183 (99%) received both liver health counseling and alcohol screening and counseling. 88(48%) patients received treatment readiness counseling and 56(30%) received treatment adherence counseling.

Clinical Outcomes

Through the assistance of the Navigator, 150 patients completed an HBV medical evaluation, 53 were designated as treatment candidates, and 50 started HBV treatment. Seventy-six (41%) of patients were reported to have been screened for liver cancer under this program.



Participant Characteristics by Site

The demographics of participants who received services under Check Hep B varied dramatically by site. The wide range of country of origin and languages spoken by participants highlights the need for culturally competent Navigators to serve this population.

African Services Committee

African Services Committee enrolled 51 participants: 44 (86%) were male and the average age was 46 years, with a range of 19–65 years old. All patients were born outside of the US representing 11 African countries, speaking seven preferred languages other than English. Thirty-seven (73%) were uninsured and 25% have Medicaid. Thirty-three (65%) had an income of <$800 per month.

Country of Birth	N	%
Senegal	30	59
Guinea	4	8
Ivory Coast	3	6
Benin	2	4
Burkina Faso	2	4
Cameroun	2	4
Gambia	2	4
Mali	2	4
Mauritania	2	4
Ghaha	1	2
Nigeria	1	2

Preferred Language	N	%
Wolof	18	35
French	17	33
English	5	10
Wolof/French	3	6
Bambara/French	2	4
Mooré/French	2	4
Bambara	1	2
Dioula	1	2
Pulaar	1	2
Wolof/English	1	2

Charles B. Wang Community Health Center (CBWCHC)

At CBWCHC, all 50 patients were female and born outside of the US in either China or Taiwan, and the preferred language was Mandarin, Cantonese or Fuzhou. The average age was 30 years with a range 23-41 years old. CBWCHC enrolled only pregnant women into the program to support perinatal HBV prevention, and to promote the mother's engagement in HBV medical care after delivery. All of the women served had Medicaid, however, 28 (56%) of the patients had temporary Medicaid only due to their pregnancy, and will be uninsured after the delivery of the child. Thirteen (26%) had an income of <$800 per month.

Country of Birth	N	%
China	**48**	**96**
Taiwan	**2**	**4**

Preferred Language	N	%
Mandarin	36	72
Cantonese	10	20
Fuzhounese	4	8

Korean Community Services

At Korean Community Services, all 45 patients were born outside of the US in South Korea, China or Taiwan. Twenty-seven (60%) were male and the average age was 51 years with a range of 24-75 years old. Forty-two (93%) of patients preferred Korean as a primary language. Thirty-two (71%) were uninsured, eight (18%) had Medicaid, two (4%) had Medicare and three (7%) were privately insured. Fifteen (34%) had an income of less than $800 per month.

Country of Birth	N	%
South Korea	41	91
China	3	7
Taiwan	1	2

Preferred Language	N	%
Korean	42	93
English	3	7

Bellevue

Of the 39 patients at Bellevue, all were born out of the US representing 13 countries and preferring five languages other than English. Thirty-three (32%) were male and the average age was 41 years with a range of 25-61 years old. Twenty-eight (72%) of patients were uninsured, seven (18%) had Medicaid and one (3%) had Medicare. Sixteen (41%) had income less than $800 per month.

Country of Birth	N	%
Senegal	12	31
China	12	31
Mali	3	8
Cameroun	2	5
Guinea	2	5
Benin	1	3
Burkina Faso	1	3
Ghana	1	3
Nigeria	1	3
Philippines	1	3
Romania	1	3
Sierra Leone	1	3
Vietnam	1	3

Preferred Language	N	%
Mandarin	11	28
English	5	13
Wolof	4	10
English, French	4	10
English, French, Wolof	3	8
French	3	8
English, Wolof	2	5
French, Wolof	2	5
English, Mandarin	1	3
Mandarin/Cantonese	1	3
Romanian	1	3
French, Wolof, Foulani	1	3
Foulani	1	3

Check Hep B Program Key Findings

There were numerous findings from the first year of the Check Hep B program which can be used to improve future programs and increase health care access for HBV patients.

A Patient Navigator is often a sole source of support for HBV patients

Due to the lack of awareness and/or stigma around HBV in immigrant communities, Navigators reported that their patients often only disclosed and discussed their HBV status with the medical provider and Navigator. Many patients had no other source of practical or emotional support. Patients indicated a support group would be useful; however, no such support group exists.

Migrant workers may be able to attend medical visits only at minimal frequency

Some HBV patients under this program were migrant workers, which made follow up or complete full medical evaluation challenging in a short time frame. In some cases, the patient would send a family member to the medical visit in his or her place.

Fears of HBV medication while pregnant or breast feeding interferes with recommended treatment

Patient navigators reported that HBV positive mothers at times feared taking prescribed HBV medications during pregnancy or while breastfeeding due to concerns about adverse effect on the baby, and sometimes stopped taking medications on their own without informing the medical provider. Patient educational materials were requested by Patient Navigators to address this fear. As a result, this topic was included in an update of the DOHMH 'Hep B: The Facts' Booklet for chronically infected persons.

Uninsurable patients

The majority of patients served under this program are immigrants, and some do not have access to health insurance, unless pregnant or qualified for emergency Medicaid. Uninsured patients can pay out of pocket at the Federally Qualified Health Centers or Public Hospitals; but the cost of medical visits, labs and evaluations, and medication copays can be prohibitive. The lowest cost of care is at the public hospitals; however, not all patients in need are aware of this health care access opportunity. Greater awareness about the availably of low cost HBV care and treatment at public hospitals is needed.

Uninsured patients can get HBV medication through pharmaceutical assistance programs; however, extensive documentation is often required that could put uninsured patients at risk. Nevertheless, Check Hep B Patient Navigators assisted with patient assistance program applications to cover the cost of HBV medication.

A majority of the HBV positive pregnant women were on temporary Medicaid for pregnant women and would lose health insurance after the birth of the baby. CBWCHC made an effort through this program to connect the mother to the internal medicine department so as to ensure continuity of low cost HBV care after the birth of her child.

Under-insured patients
Patients with health insurance (specifically NYS marketplace plans) sometimes had high copays for HBV medications. In some cases under this program, patients decided to terminate their health insurance, so they could be enrolled in medication patient assistance programs to afford recommended treatments. The decision to terminate health insurance is high risk, and further investigation into alternatives is necessary.

Materials Developed During this Program

- A standardized 'Alcohol Screening and Counseling Guide' for Providers and an 'Alcohol Reduction Action Plan' Card was developed, printed and provided to patient navigators.
- The 'Hep B Vaccine: Complete the 3 Dose Series' Pocket Card (previously translated into Spanish and Chinese) was translated into French, printed and provided to African Services Committee.
- The 'NYC Liver Health' Mobile App (formerly focused on Hep C) was updated to include hepatitis B screening, care management and site locator information.
- The 'Hep B: The Facts' Booklet was updated to include information about contact notification and to address fears of pregnant women regarding safety of HBV medications.

Recommendations for Future Programs

Outreach Support
Two of the four programs had to conduct extensive outreach to identify patients to enroll. Programs conducted in-person outreach (doctors' offices, community organizations, health fairs), online outreach (emails, posting on websites), media (newspaper, newsletter, radio) and screening events using their own resources. In future programs, funding should be designated for outreach and recruitment activities.

Medical Interpretation
Though not originally a required activity under the Check Hep B Program, several of the Navigators were certified as medical interpreters. Because these individuals spoke languages that are rarely spoken by medical providers and are difficult to access via language line, medical interpretation was an important skill for Navigators in this program. In future programs, it would be ideal to employ navigators certified in medical interpretation, or allow funds to be used to pay for certification.

Patient Navigators from the Target Community
Particularly in the African outreach setting, we found that the Navigator had the greatest success enrolling patients from the same country of origin, or who spoke the same language. We presume that if there were Navigators from different regions who spoke additional languages, we would gain access to additional risk communities. We would recommend hiring a Navigator from the region of each language spoken by patients with the highest number of case reports in the DOHMH surveillance registry.

Include contact notification, screening, vaccination and follow up services
The identified patient is frequently connected to a network of other individuals at risk. In future programs it would be beneficial to support Navigators to assist with thorough contact notification, screening and vaccination.

Improved Clinical Reporting
In future programs, it would be beneficial to include improved reporting mechanisms for key clinical indicators: clinical assessment of fibrosis stage, treatment recommendation rationale, treatment delay reason and liver cancer screening frequency.

Check Hep B Program Case Studies

Case Study: African Services Committee
The patient is a 39-year-old male born in Ivory Coast but who grew up in Benin and was previously employed as Head Chef at an American Embassy. He came to the United States on a travel visa with an American woman (leaving a wife and three children) and settled temporarily in California (CA). Seeking naturalization, the couple lived together for eight months before they separated, and he was evicted from the premises. With no resources available to him including family, friends, or language, he became homeless and started consuming alcohol while living in the streets.
The patient met a stranger on the streets (an African immigrant) who paid his bus fare to NYC so he could look for friends and/or relatives. Upon arrival, due to general malaise, the patient was referred by his friends to the Group Level Intervention Program at African Services Committee (ASC). During this time, the patient was found to be HBV positive through the Testing Center at ASC. The patient received pre and post-test counseling and was referred to ancillary social programs such as food pantry and legal services. He was referred to Bellevue Hospital, and staff discouraged the patient from consuming alcohol. He was initially motivated by the timely manner by which he was referred to care and was enrolled in HHC Options (Public hospital health insurance) and attended an initial HBV medical evaluation, however, he did not return for an ultrasound or to complete a full evaluation, and he was lost to follow up.

In March 2015, the patient returned to ASC reporting that he needed to be rescheduled for an appointment at Bellevue Hospital. He reported that he had been suffering from such psychological distress that his HBV had become a low priority. The patient was enrolled in Check Hep B to monitor and ensure follow-up of future medical encounters. Through this support the patient was prescribed anti-depressants and anti-anxiety medication and significantly reduced alcohol use. He completed a medical evaluation and was not recommended treatment at this time. During this period, the patient started working for a bakery and has attended all scheduled medical appointments.

Case Study: Korean Community Services
A decade ago, Mrs. CJ immigrated to the States with her three children and later found out that she and her children were HBV carriers. None of them had been in treatment until the Patient Navigator (PN) introduced the Check Hep B Program. When PN first reached out to CJ a few months ago, she refused to be medically treated, saying that she would count on herbal medicine and nutrition therapy. Every other month, PN called her explaining the importance of the viral load and liver function tests, and also emphasized that HBV only could be treated by medication. We told her that we provide free both patient navigation services and free medical evaluation.
Recently, CJ agreed to get medical attention for herself and her children. She wanted PN to assist in changing her primary doctor to a gastroenterologist and also asked PN to help her children get treated. CJ went to her PCP to get a referral to see a hepatologist, received DNA viral load test and other liver function tests and was prescribed treatment. We will soon reach out to the other two children of CJ. to provide phone counseling. NYC Check Hep B Program opened the windows for this.

Case Study: Charles B. Wang Community Health Center
This patient initially came to CBWCHC Flushing site for OB/GYN services, with an OB Initial appointment where she was screened and self-reported positive HBV chronic infection. The patient's OB provider and nursing team referred her to follow up with Internal Medicine (IM) during pregnancy, and she came in for her first IM appointment. Patient had been aware of her status for more than 10 years before she entered the U.S. in 2014 as a visiting scholar. Patient's mother is also HBV positive, but the patient's first child is HBV negative. The patient's partner is in China. During her IM appointment, the patient declined enhanced bloodwork, stating she had previous work experience in medicine and did not think HBV follow-up during pregnancy was necessary. The IM provider notified the OB provider and patient navigator to do additional follow-up with the patient. During patient's next OB appointment, the OB provider and navigator provided more in-depth counseling regarding HBV perinatal transmission prevention. The patient ultimately decided to do enhanced HBV bloodwork in her first trimester of pregnancy. The bloodwork results indicated that the patient did not currently need antiviral treatment.

The IM provider recommended the patient to return for a second HBV evaluation closer to her third trimester of pregnancy, and notified the patient navigator of this since the patient had also declined further follow-up. The navigator saw the patient did not scheduled a second IM appointment, and so reminded the OB provider to order the second round of enhanced HBV bloodwork during one of the patient's routine OB appointments instead. The second round of bloodwork done on confirmed that antiviral treatment was not needed. The patient gave birth to a healthy baby boy.