Engaging High-Risk Persons with Hepatitis C in Care and Treatment through Community-Based Care Coordination: Check Hep C Year 2

Mary M. Ford,[1] Nirah Johnson,[1] Eric J. Rude,[1] Payal Desai,[1] Fabienne Laraque.[1]

[1]New York City Department of Health and Mental Hygiene, Bureau of Communicable Disease, New York City, NY.

BACKGROUND

- **Hepatitis C (HCV) is a blood-borne infection that is often asymptomatic and can remain undetected until symptoms from advanced liver disease occur. [1] In the United States, injection drug use (IDU) is the primary mode of transmission for HCV . [2]**
- **In recent years, major medical and public health developments have driven programs to address the HCV epidemic, including:**
  - **Increased HCV Screening**: In 2012 the Centers for Disease Control and Prevention (CDC) released recommendations for one-time HCV screening of persons born between 1945 and 1965 ("baby boomers") in light of national data showing HCV prevalence is highest in this age group, and the subsequent US Preventative Services Task Force support of this recommendation led to health insurance reimbursement of testing of this groups. [3,4]
  - **Better HCV** Treatment: Several new antiviral medications have been approved since 2013, resulting in higher rates of sustained virologic response (SVR) and fewer side effects than past treatments. There is tremendous incentive to encourage at-risk persons to get tested and undergo treatment. [5,6]
- **Studies show that only 32-38% of persons with HCV infection are linked to care and only 7-11% have been treated. [7] Historically, barriers such as access to care, poor understanding of HCV, and co-morbidities have been cited limiting progression through the care cascade [8].**
- **Patient navigation has been proven to be effective in helping HIV patients overcome these barriers, enabling them to get into care and treatment. [9] Few studies have been done on the efficacy of HCV navigation.**

PROGRAM PURPOSE

- **In 2012, the NYC Department of Health and Mental Hygiene (DOHMH) implemented Check Hep C, a community-based program that provided HCV screening, diagnosis, linkage to care and clinical capacity building through tele-medicine.**
- **Lessons learned were used to design Year 2, by focusing on supporting HCV care and treatment through intensive patient navigation and care coordination services.**

METHODS

- **Year 2 of Check Hep C aimed to enroll 400 persons between April 1st, 2014 and March 31st, 2015.**
- **Check Hep C was designed using evidence-informed interventions to develop a community-based coordinated care model for providing patient navigation services. Key project components include:**
  1) Comprehensive patient navigation assessment
  2) Health Promotion
  3) Referrals to Social Services
  4) Treatment Readiness Counseling
  5) Medication and Pharmacy Coordination
  6) Treatment Adherence Counseling
- **Patient navigation services were divided into two categories:**
  1) Linkage to Care: clinical services were based at an external site, with patient navigation assisting
  2) Care Coordination: clinical services were provided on-site at the same organization

RESULTS

Site Selection

- **The Year 2 Check Hep C program was implemented at four sites in New York City.**

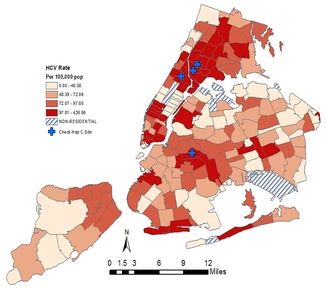


Figure 1: Check Hep C Year 2 Sites and Hepatitis C New Report Rates by Zip Code Tabulation Area in New York City 2012 – 2013.

- **Site selection was based on location in neighborhoods with high rates of newly reported HCV.**
- **Two sites were Federally Qualified Health Centers with co-located supportive and clinical services and two sites were Harm Reduction programs that linked participants to external community health centers.**

Check Hep C Participant Profile

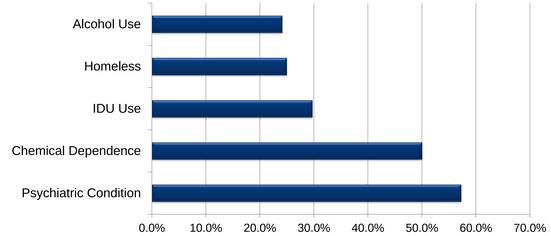
- **Between April 2014 and January 2015, 388 participants were enrolled in Check Hep C.**
- **All participants were HCV RNA positive.**
- **69 (19.4%) participants had a history of HCV treatment.**
- **Liver Disease Stage: (n=182)**
  F 0-1: 71 (39.0%)
  F 2-3: 70 (38.5%)
  F 4-Cirrhosis: 41 (22.5%)

Table 1: Check Hep C Participant Demographics

		N	%
Race			
	Hispanic	242	64.4
	Black, NH	103	27.4
	White, NH	28	7.4
	Other	3	0.8
	Total	376	100.0
Gender			
	Male	284	73.2
	Female	101	26.0
	Trans M-F	3	0.8
	Total	388	100.0
Borough			
	Bronx	218	57.5
	Manhattan	84	22.2
	Brooklyn	72	19.0
	Queens	5	1.3
	Total	379	100.0
Age			
	Born Pre-1945	16	4.1
	Born 1945 - 1965	236	60.8
	Born Post-1965	135	34.9

Participant Risk Factors

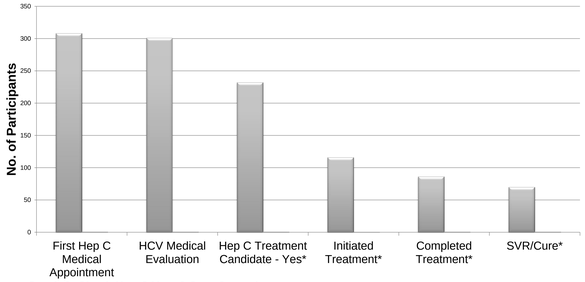
Participant characteristics including demographics and risk factors were collected and reported on using descriptive statistics.



Graph 1: Check Hep C Participant Risk Factors

Most Check Hep C participants had one or more risk factors that contributed to instability.

Check Hep C Care Cascade



Graph 2: Check Hep C Year 2 Care Cascade

- **Seventy-nine percent (n=308) of participants with HCV infection attended their first medical appointment. Of the 301 participants that completed a HCV medical evaluation, 232 (77.1%) were eligible treatment candidates.**
- **The top reasons participants were not deemed treatment candidates were (n=145):**
  - **Active drug use: 26 (17.9%)**
  - **Comorbid condition: 18 (12.4%)**
  - **Client is missing medical appointments: 12 (8.3%)**
  - **Alcohol use: 11 (7.6%)**
  - **Waiting for new medications: 11 (7.6%)**
- **As of April 30th, 2015, 116 (50.0%) of eligible treatment candidates initiated treatment and, of those, 86 (74.1%) completed treatment. Seventy (81.4%) of the 86 participants that completed treatment have achieved SVR to date.**

CONCLUSIONS

- **Check Hep C year 2 has been successful in engaging HCV-infected persons in HCV care, and a high proportion of those eligible for treatment have initiated treatment and been cured.**
- **As the program continues, many more participants are expected to undergo medical evaluation, initiate, and complete treatment.**
- **This program provides services that fill vital gaps that are currently not covered by insurance plans and are essential to getting high-risk persons into and through treatment.**
- **Therefore, the NYC DOHMH is exploring a variety of ways to expand and sustain these services.**

FUTURE RECOMMENDATIONS

- **The NYC DOHMH has received funding through City Council to continue the program through June 30st, 2015.**
- **Even with new HCV treatments, patient navigation remains integral to getting high need patients into medical care and through treatment.**
- **The demonstrated effectiveness of programs like Check Hep C can be used to support policy changes that ensure funding or insurance reimbursement is made available for HCV specific patient navigation and care coordination.**

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CONTACT INFORMATION

Mary M. Ford, MS
Bureau of Communicable Disease
NYC Department of Health and Mental Hygiene
mford4@health.nyc.gov