Check Hep C: A Demonstration Project for Providing Comprehensive Community-Based Screening, Linkage and Medical Services to New Yorkers with or at Risk for Chronic Hepatitis C Infection

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INTRODUCTION

Hepatitis C virus infection (HCV) disproportionately affects marginalized populations such as drug users, the homeless, and immigrants from high prevalence areas; many lack health insurance and social support and experience difficulties accessing HCV-related care. The New York City Department of Health and Mental Hygiene developed the Check Hep C program, a coordinated model for HCV care in high prevalence neighborhoods in NYC which contains four key components: a targeted public health awareness campaign; free anti-HCV and PCR testing and counseling; patient navigation to link chronically infected patients to care; and telemedicine consults between community physicians and academic HCV experts.

OBJECTIVES

Check Hep C seeks to test the feasibility of a coordinated care model addressing gaps in HCV care including: reactive antibody tests lacking follow-up RNA testing; difficulty of patients to navigate the health system after an HCV diagnosis; need for physicians trained in HCV medical care; and lack of adequate insurance coverage.

METHODS

Using Knowledge Translation as our theoretical framework, Check Hep C was developed to address individual and structural-level barriers to HCV screening and care. Data were collected using a common electronic medical record to ensure continuity of care from initial screening to treating clinicians; this system will also track patient clinical outcomes.

RESULTS

Table 1. Check Hep C testing and treatment sites

Federally Qualified Health Centers (FQHC)	
Community Healthcare Network (*Queens and Brooklyn*); Montefiore (*Bronx*)	
Syringe Exchange Programs (SEP)	
VOCAL (*Brooklyn*); After Hours Project (*Brooklyn*); AIDS Center of Queens County (*Queens*); New York Harm Reduction Educators (*Harlem and Bronx*)	
Both FQHCs and SEPs	
CitiWide Harm Reduction (*Bronx*); Harlem United (*Harlem*)	

Table 2. Participant demographics

Variable	N (%)
Total enrolled	2,347
Age	Ave: 44 yrs
Race/Ethnicity (non-mutually exclusive)	
Black/ African American	904 (38%)
White	717 (30%)
Hispanic	1309 (55%)
Gender (*female*)	1,013 (43%)
Currently Homeless	290 (12%)
Ever Homeless	946 (43%)
Ever Incarcerated	1,017 (46%)

Table 3. Testing and medical history

Variable	N = 2,347 (%)
Ever tested for HCV	851 (38%)
HIV-positive	142 (6%)
Ever diagnosed with STD	376 (17%)

Table 4. HCV anti-body and PCR testing results

HCV Rapid Tests (N)	Anti-HCV + (N; %)
2,255	450 (20%)
PCR Tests (N= 450)	PCR + (N= 400; %)
400 (89%)	268 (67%)

CONCLUSION

Check Hep C has successfully engaged NYC FQHCs and SEPs in expanded HCV screening, identifying significant numbers of chronically infected persons. Telemedicine driven support of primary care provides at field sites has expanded HCV treatment capability in previously underserved, high prevalence areas. The Check Hep C patient navigation model appears well accepted and holds promise as a means of engaging chronically infected, marginalized persons in HCV-clinical care.

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