

# Hep C



## COMMUNITY NAVIGATION TOOLKIT

Improving Care for People Who Use  
Drugs and Other Impacted Populations

## Introduction and Acknowledgments

This toolkit consists of program protocols, data collection tools and patient education materials used in the hepatitis C patient navigation programs developed by the NYC Health Department. The toolkit guides patient and peer navigators to: conduct targeted outreach to priority populations; provide harm reduction services, plain language health promotion, appointment accompaniments, medical interpretation, and referrals to health insurance and supportive services; and support patients throughout treatment. The tools and templates offered can be tailored to the unique health care environment in different jurisdictions.

The toolkit is the product of eight years of iterative development of the NYC Health Department's hepatitis C patient and peer navigation programs. These resources were used and refined by more than 170 patient and peer navigators at 37 organizations, serving over 15,000 people at high risk for or living with hepatitis C.

This toolkit was funded by a 2019 Models of Care Award from the International Network on Hepatitis C in Substance Users. NASTAD and the NYC Health Department thank the many patients, navigators and staff who contributed to the creation of this toolkit.

For questions about the toolkit or guidance on implementation, email [hepatitis@nastad.org](mailto:hepatitis@nastad.org). If you work in a health department, you can submit a technical assistance request to [NASTAD's Hepatitis Technical Assistance Center](#) (HepTAC).

## Navigation Program Design

1. Hep C Community Navigation Guide
  2. Hep C Peer Navigation Guide
  3. New Peer and Patient Navigator Start Up Surveys
  4. Program Management Tools
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## Navigation Forms and Templates

5. Hep C Navigator Business Card Template
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  7. Hep C Navigation Form—Peer Outreach
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## Navigation Tools

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14. Know Hep C, Cure Hep C Pocket Card
15. Hep C Steps to Care and Cure Handout
16. Appointment and Patient Rights Pocket Card
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# Hep C Community Navigation: Program Guide

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## Background

Hepatitis C (HCV) is a blood-borne viral infection that can lead to cirrhosis of the liver, liver cancer, and premature death. There are 2.4 million (2016) people in the United States (U.S.), and 71 million people globally<sup>1</sup> estimated to be living with HCV. Many are unaware of their status or are not receiving medical care. Medical treatment and a cure for HCV are available; being cured of HCV significantly improves the chances of living a longer, healthier life, and prevents ongoing transmission of the virus.

The New York City Department of Health developed the **Hep C Community Health Navigation Program** in 2012 to support community health organizations to navigate patients through complete diagnostic testing, linkage to care or return to care, treatment, and reinfection prevention after cure. Peer and Patient Navigators are at the heart of the Hep C Community Health Navigation Program. Through training and experience navigators develop expertise in the HCV landscape of prevention, care and treatment options and are able to effectively assist patients through the journey to cure.

This guide provides a framework for establishing a Hep C Navigation program at community health organizations, including: hospitals, health centers, community based organizations, substance use or harm reduction programs.

## Program Overview

### HEP C COMMUNITY HEALTH NAVIGATION PROGRAM GOALS

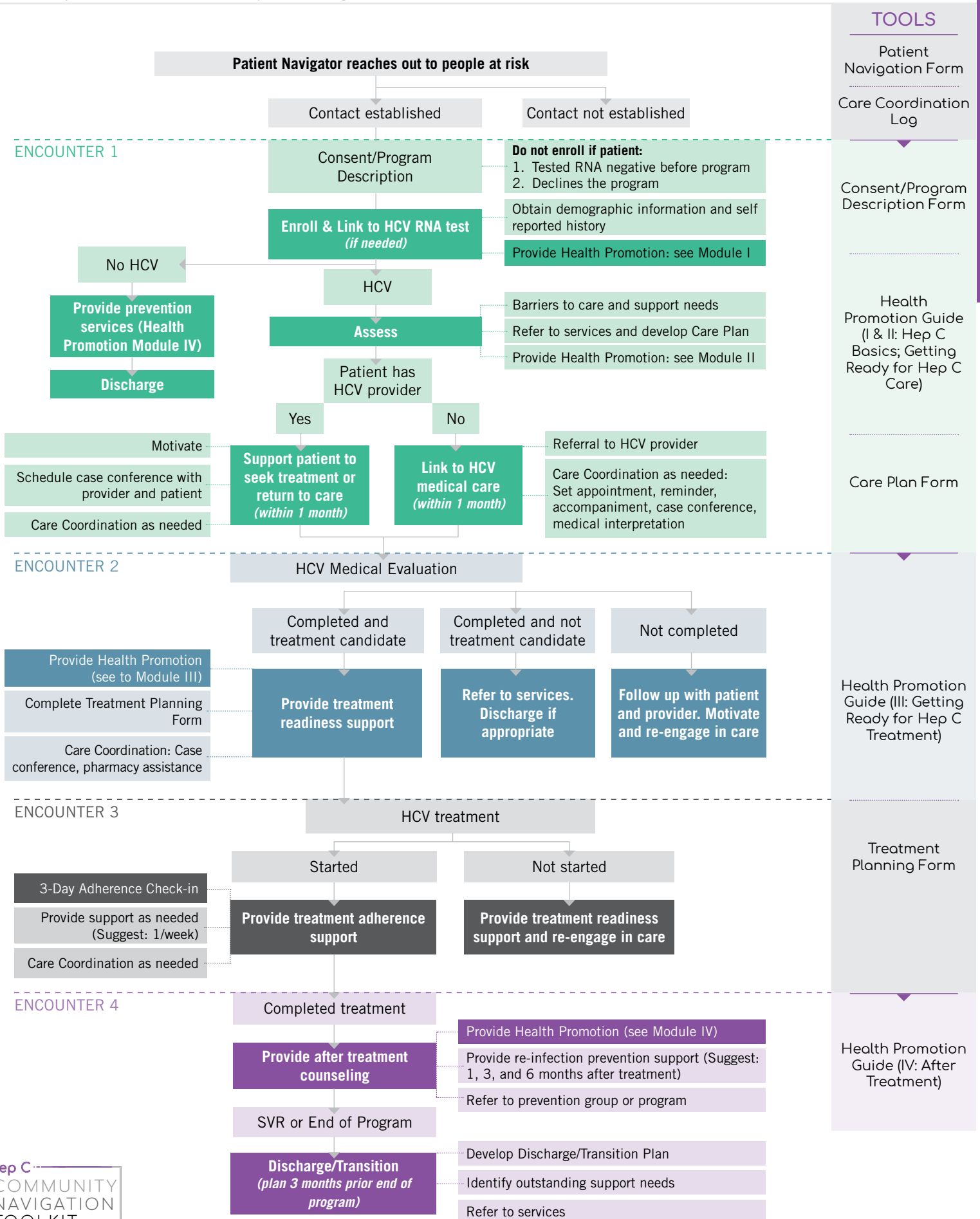
The goal of the Hep C Community Health Navigation Program is to identify people at risk for HCV, support complete diagnostic testing, and link infected patients to medical care, support a complete HCV medical evaluation and successful HCV treatment, and prevent reinfection and maintain liver health after cure.

### NAVIGATOR ACTIVITIES

Depending on their setting and role, a Navigator may conduct some or all of the following activities:

1. Outreach and enrollment
2. Prevention
3. Navigation through complete diagnostic testing
4. Patient navigation assessment
5. Development of a patient navigation care plan
6. Linkage to HCV medical care, retention in care, and return to care
7. Health promotion
8. Medical interpretation
9. Referrals and assistance in accessing supportive services
10. Accompaniment and reminders
11. Alcohol and drug use screening and counseling
12. Case conference with medical provider and multi-disciplinary team
13. Treatment readiness and adherence counseling
14. Medication/pharmacy assistance
15. Discharge/transition planning
16. Fulfilling operational and administrative program duties, including reporting program activities and progress.

# Hep C Community Navigation Guide





## Hep C Community Health Navigation Program Set Up

### INFRASTRUCTURE

The Navigator will need consistent access to the following:

1. Computer or laptop
2. Microsoft Word
3. Program Database (Access, RedCap, or other)
4. Internet
5. Email account
6. Secure data transfer system for reporting
7. Access to patient charts or electronic health record, or agreement with clinical provider to obtain clinical information necessary for reporting and to provide HCV navigation services (review Patient Navigation Form for details)
8. Secure storage file for hard copy case records
9. A desk, and access to a private space to speak with patients
10. Smart phone
11. Business cards with name, role, title, and contact information

### ORGANIZATION SUPPORT FOR HEP C NAVIGATION

The Hep C Community Health Navigation model provides guidance and a framework for conducting HCV patient navigation in a wide variety of settings. To supplement this guidance and support the Navigator in their role, the organization will need to do the following independently:

- **Appoint a supervisor** to provide at least one hour supervision per week to each Navigator. Supervision should include review of open cases, program progress, challenges, achievements and Navigator self-care management.
- **Train the Navigator** in the organization's own policies and procedures including permitted services. The Navigator can only conduct services permitted by organization policies. For example, some organizations allow for home visits, and some do not. Navigators also need safety training based on their setting.
- **Develop a referral guide for local supportive services:** Conduct ongoing assessment of patient needs and barriers to care, and develop a list of the supportive resources available to the organization in the service catchment area to meet patient needs, overcome barriers, and support successful referrals (e.g. available benefits enrollment, transportation services, food pantry, free or affordable phone plans).

## MULTIDISCIPLINARY TEAM SET-UP

The Navigator needs to work collaboratively with a multidisciplinary team to be successful. Team members may work for the same organization, or work for an outside organization.

### 1. Identify internal team members, common team members include:

- a. Tester
- b. Navigator supervisor
- c. Medical provider
- d. Mental health/behavioral health/substance use provider
- e. Case manager
- f. Other health care professionals as needed

### 2. Engaging team members in other organizations:

Develop a plan to fill gaps in the internal team through external resources.

- a. Form a memorandum of understanding (MOU) with programs providing needed services.
- b. Establish a case conference schedule and plan.
- c. Establish policies and procedures that allow for communication of patients' personal health information in cases where patients are covered by more than one program.

### 3. Establish a periodic multidisciplinary team meeting to discuss:

- a. Hep C Navigation workflow
- b. Progress in meeting program goals
- c. Details of individual cases
- d. Documentation

## Collaborative Practice: Navigator Relationship with Medical Providers

The working relationship between the Navigator and the medical provider is particularly important to establish. The Navigator's main goal is to support the clinical goals as recommended by the medical provider. The Navigator should speak with the medical provider on a regular basis about shared cases, and must be made aware of appointment dates to support attendance as well as clinical milestone attainment in order to track progress through HCV care. To establish collaborative practice relationships:

- a. Arrange a meeting or phone call with each clinical provider the Navigator will refer to or work with.
- b. Ask the provider about their HCV care and treatment approach, including their approach to treating the patients the Navigator serves. If needed, ask the provider their stance on treating people who actively use drugs, who are homeless or who have serious mental health issues.
- c. Determine how the provider and Navigator will share patient information.
- d. Establish formal agreements if needed to solidify the relationship.
- e. If there is a disruption in communication with the clinical provider, the Navigator should consult with their Supervisor and leadership to advocate for the communication needed to best serve the patient.

## TRAINING

The following trainings will prepare the navigator to provide informed and effective services.

- Program Start Up Training (provided by program administrator to cover goals, documentation requirements and logistics)
- [Hepatitis C Basics. Archived Webinar – NYS AIDS Institute](#)
- Motivational Interviewing training offered by [Harm Reduction Coalition](#) and [NYS AIDS Institute](#)
  - Online [Overview](#) and [Practice](#)
- [Talking with Clients about Hepatitis C Treatment](#) Online training offered by [Harm Reduction Coalition](#).
- [Harm Reduction Approach](#)
- [Trauma Informed Care](#). Offered by NYS AIDS Institute
- [Mental Health First Aid](#)
- Substance Abuse Brief Intervention & Referral to Treatment. Online training offered by SAMHSA: [www.integration.samhsa.gov/clinical-practice/sbirt/training-other-resources](http://www.integration.samhsa.gov/clinical-practice/sbirt/training-other-resources)
- Medical Interpretation Certification, if navigator will translate. See online trainings here: [www.certifiedmedicalinterpreters.org](http://www.certifiedmedicalinterpreters.org)

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## COMMUNITY OF PRACTICE AND LEARNING

Navigators will need ongoing training and support to fulfill their role. A regular in-person, online or conference call-based *Community of Practice* and *Learning* meeting provides an opportunity for Navigators to network with others in their role, share challenges, navigation strategies and best practices. Ideally the Community of Practice and Learning meeting covers the following topics:

- Program progress report with opportunities for the Navigator to review and check that their progress is being captured accurately
- Training based on Navigator needs
- Case presentation
- Opportunity to share Navigation challenges, successes and needs

## Documentation and Data Management

The Navigator should build the skills and competency necessary to be responsible for documentation, management, and reporting of their work.

### DATA CONFIDENTIALITY

#### *Navigator Responsibilities:*

1. Adhere to patient confidentiality in accordance with host organizations policies and all applicable laws, rules, and regulations.
2. Only send or share patient information through secure data transfer systems.
3. Never send patient information via regular email.
4. Keep confidential patient information securely.

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### DATA COLLECTION, DATA ENTRY AND REPORTING PROCESS

#### *Navigator Responsibilities:*

1. Obtain the signed patient consent or program participation agreement, if needed.
2. Document patient information and patient navigation activities on the following documents, or in the patient health record:
  - a. *Patient Navigation Form*
  - b. *Case notes template*
3. Transcribe data from the Patient Navigation Form and the Case notes template (or patient health record) into the Program Database, at least once a week is recommended.
4. Submit the Program Database monthly through secure data transfer system.

## Patient Navigation Services

The following section provides guidance for providing patient navigation services.

### 1. OUTREACH AND ENROLLMENT

The Navigator often takes part in recruiting and enrolling eligible patients. This can be done in programs inside or outside the organization. For example, HCV testing, health homes, needle exchange, drug treatment, methadone programs, homeless service organizations, dialysis, and HIV service programs.

Eligible Patients	Ineligible Patients
<ul style="list-style-type: none"> <li>• HCV Antibody positive patients of unknown HCV RNA status.</li> <li>• People at risk for HCV</li> <li>• HCV RNA positive patients. Documentation of HCV RNA status must be kept in the patient health record.</li> </ul>	To be determined based on program policies

### 2. PROVIDE PROGRAM DESCRIPTION

The patient navigator should explain the program using the Program Description or *Consent Form* as a guide, including: overall purpose of the program, services provided, and length of the program.

- If the patient agrees to participate, ask the patient to sign the *Consent Form*, if required by organization.
- If the patient declines to participate and is in need of supportive services, refer the patient to appropriate services.

### 3. ASSESSMENT

The Navigation Assessment (the first side of the Patient Navigation Form) should ideally be conducted for each patient within two weeks of enrollment in the Hep C Community Health Navigation Program. The purpose of the assessment is to learn about the patient and their readiness to engage in HCV medical care and treatment, and identify and develop plans to overcome barriers. The Assessment can be completed by patient self-report, the information does not need to be verified by documentation or the medical provider.

Use all available sources of information to complete the Assessment:

- Patient interview (self-report)
- Patient health record (if accessible)

- c. Consultation or information provided by the medical provider or multidisciplinary team
  - The Navigator should receive and review the results of patient assessments conducted by other members of the multidisciplinary team (i.e. mental health, alcohol use, drug use, health insurance, benefits, housing, transportation, and legal services).
  - The Navigator does not need to repeat the assessment, and should use the information provided to complete the Patient Navigation Assessment section, counsel patient, and coordinate supportive services as needed.

#### 4. REFERRALS

Based on the findings from the Assessment, the Navigator should identify and provide appropriate referrals to supportive services.

- a. Refer to on-site services whenever possible; otherwise, refer to off-site services.
- b. Discuss recommended referrals with the patient and document on the *Care Plan*.
- c. Help the patient set up an appointment for each referral if necessary.
- d. Determine if the patient needs a reminder or assistance in attending the referral appointment, and make a plan to ensure the patient attends the appointment.

Service Need	External Referral Locators
Mental Health	<ul style="list-style-type: none"> <li>• SAMHSA Behavioral Health Treatment Locator: <a href="http://www.findtreatment.samhsa.gov">www.findtreatment.samhsa.gov</a></li> </ul>
Alcohol Services	
Drug Use Services	
Health Insurance Enrollment	<ul style="list-style-type: none"> <li>• <a href="http://HealthCare.gov">HealthCare.gov</a></li> <li>• Some services must be identified by organization</li> </ul>
Benefits Enrollment	
Housing Services	
Transportation services	
Legal Services	
Hep C Support Group	<ul style="list-style-type: none"> <li>• American Liver Foundation <a href="http://www.liverfoundation.org/support">www.liverfoundation.org/support</a> 1-800-465-4837 (1-800-GO-LIVER)</li> </ul>

#### 5. CARE PLAN

Based on the Assessment, the Navigator will work with the patient to develop the *Care Plan*. The *Care Plan* is a tool to document mutually agreed plans and goals including: linkage to care, HCV medical care and treatment, health goals, care coordination services, and referrals.

- a. Develop and review the *Care Plan* with the patient.
- b. Both the Navigator and the patient are invited to sign the *Care Plan* as confirmation of agreement with the plan and goals.
- c. Provide the patient with a copy of the *Care Plan*.
- d. Update the content of the *Care Plan* over time as needed.

## 6. LINKAGE TO CARE OR RETENTION IN CARE

Patients should be linked to HCV medical care within one month of enrollment. Linkage to care is defined as completing an HCV medical visit.

**Linkage to Care:** For patients not receiving HCV medical care at the time of enrollment

Patients should be:

- Linked to on-site care whenever possible
- Linked to off-site care, if necessary
  - If HCV medical care will be provided off site, the Navigator should plan regular case conferences with the medical provider.
  - If the patient is linked to medical care at a program with its own HCV patient navigation or care coordination services, the Navigator should discuss this with their supervisor to avoid duplication of services.

### For uninsured patients

Free or low cost HCV medical care may be available for the uninsured at some:

- Federally qualified health centers: [www.findahealthcenter.hrsa.gov](http://www.findahealthcenter.hrsa.gov)
- Public hospitals

### Retention in Care: For patients already receiving HCV medical care at the time of enrollment

If the patient is already in HCV medical care with a provider at the time of enrollment, the Navigator should schedule a case conference with the patient and medical provider to develop the Patient Navigation *Care Plan* within a month of enrollment.

## 7. NAVIGATION ENCOUNTERS

- a. The Navigator should provide each patient with a minimum of four encounters: 1) Enrollment, Assessment and Referrals, 2) Treatment Readiness, 3) Treatment Adherence, and 4) After Treatment.
- b. Some of the services can be combined into one, or separated into multiple encounters. For example, initial services such as Enrollment, Assessment and Referrals, can occur during one encounter or three separate encounters.
- c. Encounters may occur more frequently if needed. The frequency and type of encounters needed should be decided upon based on input from the medical provider and patient during the *Care Plan* development process. Navigators have the discretion to provide services to meet the needs of patients. Weekly check-ins during treatment to support adherence are highly recommended.
- d. It is highly recommended that the Enrollment, Assessment, Referrals, Treatment Readiness and After Treatment encounters occur in-person, though they can also be provided remotely if needed. Treatment Adherence Check-in and other supplemental encounters can also occur via remote methods (e.g. phone call, text message).

### Initial Encounter

The initial encounter should take place prior to the patient beginning treatment.

- The Navigator will use the *Health Promotion Guide* modules I and II to complete the first page of the *Patient Navigation Form* (Sections: Intake, Self-Reported History, Assessment and Referrals)
- The Navigator and patient will develop the *Care Plan* together

### Treatment Readiness Encounter

In the pre-treatment encounter, the medical provider, Navigator and patient will develop a treatment plan for the patient.

Using the *Health Promotion Guide* Module III:

- The Navigator will provide treatment readiness counseling
- The Navigator and patient will discuss the frequency and method of treatment adherence support
- The Navigator and patient will complete the *Treatment Planning Form*
- The Navigator will provide or coordinate treatment adherence services for the patient as needed

### Treatment Adherence Encounter

The Navigator should contact the patient three days after the start of treatment and then weekly or as needed to address any side effects the patient may be experiencing, ask if any doses have been missed, and intervene to improve adherence (e.g. discuss side effects with the medical provider, assist the patient in setting a cell phone alarm reminder to take medications, or increase the frequency of encounters to weekly).

- **Starting treatment** (3 days after treatment start date), the Navigator must contact the patient in person or by phone.
- **During treatment**, the Navigator should contact the patient weekly throughout the course of treatment to support adherence, in person or by phone. If weekly is not appropriate, the treatment adherence encounters should occur at the frequency agreed upon and documented in the *Care Plan*.

### After Treatment Encounter

After treatment, the Navigator should use the *Health Promotion Guide* Module IV to:

- Ensure the patient is aware of future clinical monitoring requirements
- Provide reinfection prevention information, resources, referral and support engaging in referrals
- Transition patient to an appropriate supportive program, including primary care

The Navigator can support the patient after treatment is complete to follow clinical monitoring recommendations and prevent reinfection as needed.



## 8. MEDICAL CARE DOCUMENTATION

The Navigator should document the patient's progress along the continuum of HCV care on the *Patient Navigation Form* (Section: Medical Care) after each encounter with the patient.

- The medical care documentation should be provided by the medical provider or obtained from the electronic health record.
- The medical care documentation should be provided or verified by the medical provider if possible. If this is not possible, the information can be provided by the patient.

## 9. CARE COORDINATION SERVICES

As part of the *Care Plan* development process, the Navigator, patient, and medical provider determine what care coordination services will be provided, and at what frequency. These services can be documented on the *Care Plan*.

Care coordination services can include a unique combination of: accompaniment, reminders, health promotion, drug and alcohol counseling, case conference with medical provider(s), treatment readiness counseling, treatment adherence counseling, medication/pharmacy coordination, discharge/transition planning, and other meetings with the patient.

### a. Documentation of care coordination services

After an encounter with the patient, the Patient Navigator should:

- Document the encounter in the Case Notes Template.
- For reporting purposes, the Navigator should be prepared to tally the number of total encounters with the patient, as well as the number of encounters by Care Coordination type.

### b. Accompaniment

Depending on the level of support a patient needs, the Patient Navigator might accompany the patient, or arrange for accompaniment, to all or some appointments.

- **All appointments:** If the patient frequently misses appointments, has trouble understanding the medical provider or is anxious about appointments, it may be appropriate to accompany the patient to all HCV medical appointments. In this case, the Navigator should work with the multidisciplinary team to determine if there are other resources at the program that can be enlisted to meet this need, such as:
  - 1) Peer program
  - 2) Case managers
  - 3) Transportation services
- **Some appointments:** If the patient is able to attend most appointments independently but needs support at times, and/or if the Navigator needs to attend the appointment in order to fully understand the patient's care, it is appropriate to accompany the patient to some appointments.
- **No appointments:** If the patient is able to attend all appointments independently, this should be supported. The Navigator should speak with the patient and/or the medical/service providers to verify that appointments are kept and to learn the appointment outcome and next steps.

If appointments are missed, the Navigator should provide accompaniment services.

### c. Reminders

The Navigator should:

- Provide reminders for HCV related medical appointments as needed. Reminders can be provided in a wide variety of ways, including: In-person reminders, automated reminders from the clinic, telephone, email or text message.
- If appointments are missed, the Navigators should:
  - Contact the patient the same day to determine the reason for missing the appointment
  - Make a plan to ensure the next visit is kept.

### d. Health Promotion

The Navigator should use the *Health Promotion Guide* to build their capacity to educate, assess, counsel, and develop goals and plans with the patient throughout the program. This guide is not meant to be used a script; the content can be delivered in a manner that is tailored to the patient's needs. Suggested breakdown for the content delivery is as follows:

- **Module I: “Hep C Basics”**
  - Upon enrollment, reinforce as needed during navigation.
- **Module II: “Getting Ready for Hep C Care”**
  - Use to guide the navigation assessment of barrier to care, and develop a care plan to overcome barriers.
- **Module III: “Getting Ready for Treatment”**
  - Use before starting treatment to ensure the patient understand their treatment regimen and what to do if there is a treatment disruption
- **Module IV: “After Treatment”**
  - Use during or after treatment to ensure the patient understands the risk of reinfection and is engaged in appropriate harm reduction services, the ongoing health care monitoring they will need after treatment, and liver health management.

### e. Alcohol and Drug Use Screening and Counseling

Alcohol use accelerates HCV disease progression, and drug use is frequently reported as a barrier to HCV treatment. The Navigator should:

- 1) **Assess alcohol use:** Use *Health Promotion Guide* during the assessment phase to administer alcohol screening. Standardized tools such as the AUDIT or CAGE are recommended.
- 2) **Provide alcohol counseling:** If the patient drinks any alcohol at all, provide alcohol counseling as recommended in the “Alcohol Screening and Counseling for Patients with Hepatitis Guide” on an ongoing basis, as long as the patient continues to drink.
- 3) **Assess drug use:** Use *Health Promotion Guide* during the assessment phase to administer drug use screening. This includes using a tool such as the DAST-10.
- 4) **Provide referral:** If needed, provide a referral to alcohol or drug treatment and harm reduction services.

**f. Case Conference with HCV Medical Provider and Multi-disciplinary Team**

The Navigator should maintain regular communication with the HCV medical provider and multi-disciplinary team for all active cases. This communication should include:

- Reviewing all open cases with the associated medical provider and involved members of the multidisciplinary team at least once a month.
- Ideally communicating with the medical provider after each medical appointment to ensure care and treatment goals are clear to all involved. Establishing this frequency of communication can be challenging to accomplish, so if it is not possible, the Navigator should determine a feasible communication plan with the Medical Provider.
- Speaking with the medical provider at any point during the course of the program when there is a need for clarification or direction in the case, potential care and treatment disruption, or a change in the patient's condition or life circumstance (e.g. unstable housing).

**g. Treatment Readiness**

Just before the patient begins treatment, the Navigator should:

- Work through the *Health Promotion Guide* Module III: "Getting Ready for Treatment."
- Work with the medical provider and patient to develop and review the Treatment Planning Form.
- Establish a process for the patient to report any unexpected side effects to the medical provider, and document this process on the Treatment Planning Form. Side effects should be managed as soon as possible, so as to prevent a health crisis and/or treatment discontinuation.
- Document the treatment adherence plan on the Treatment Planning Form.

**h. Treatment Adherence**

The Navigator should provide treatment adherence support to ensure the patient is taking medications appropriately. This includes:

- Providing treatment adherence check-ins at a frequency decided upon by the patient, Navigator, and medical provider.
  - Daily-automated medication dose reminders (calendar alert or text) is recommended.
  - The Navigator should ideally offer weekly adherence check-ins, which could be in-person, by phone, text, email or other methods useful to the patient.
- Asking the patient if they have any side effects, and if they have missed any doses of medication.
- Report any missed doses or side effects to the medical provider, and work with the patient to develop a plan to manage side effects and improve adherence.

### i. Medication/Pharmacy Coordination

In many cases, the Navigator will need to support the patient and medical provider to order or provide medications.

- A specialty pharmacy can often support this effort. Pharmacies can help order medications and obtain prior authorizations, which can be very time consuming.
- If the patient is uninsured, or underinsured, work with a [patient assistance program](#) to obtain medications at a reduced fee, or no charge. Patient assistance programs can cover the cost of medications and/or co-pays.
- The Navigator can assist the patient and medical provider in processing: prior authorizations, appeals, request for fair hearing, grievances or complaints, and medication coverage applications.

### j. Discharge/Transition Planning

Patients who are either finished with the Hep C Community Health Navigation Program, or who are unable to participate in the program, should be discharged. Patients who need a different type of program should be transitioned to another program and discharged.

*Health Promotion Guide* Module IV: “After Treatment” should be completed prior to discharge.

1) Patients can be discharged for the following reasons:

- Completed the Program:** Confirmed as having achieved sustained virologic response (SVR), are aware of and can follow their post treatment clinical monitoring recommendations, and are engaged in appropriate harm reduction services.
- Declines Program:** Patients who no longer wish to be in the program or who are unable to participate should be discharged from the program.
- Lost to follow-up:** the time frame for designating a patient as lost to follow up must be determined by the organization, and should be consistent with other program criteria. If a patient cannot be found for more than six months, consider discharging. If needed the case can be reopened.
- Needs another type of program:** In some cases the patient is better suited in another navigation program, specialized program or higher intensity program such as a liver transplant or cancer treatment program. If the Navigator will no longer work with the patient after this referral is made, they can be discharged.
- Spontaneously clears HCV:** If a patient is no longer infected with HCV, they should be provided with reinfection prevention counseling and services, and can be discharged.
- Terminated from organization** (e.g., for inappropriate/violent behavior)

1) Discharge reason should be documented on the Patient Navigation Form.

2) Re-enrollment can be considered on a case-by-case basis.

## End of Program Transition Planning

If the program is only running for a finite period of time:

- 1) The Navigator should develop an HCV discharge or transition plan for each patient prior to the end of the program.
- 2) All members of the Hep C Community Health Navigation multidisciplinary team should be aware of the program end date, and should set up the program with this time frame in mind.
- 3) All patients should be informed of the program end date and transition plan at least a month before the end of the program.
- 4) Identify and provide referrals for patients in need of support.

## k. Patient Re-infection

There are many considerations in working with patients who may be re-infected with Hep C. This includes confirming reinfection, planning a new course of treatment and ensuring access to preventive services to avoid transmission to others or future re-infections.

- 1) **Confirming re-infection:** Patients who are treated and cured can be re-infected if they are exposed to HCV infected blood. However, some of these patients may clear the virus on their own during the acute phase. They should be tested for HCV RNA more than three weeks after the estimated time of exposure<sup>2</sup>, to know if they are chronically infected with HCV and require treatment.
- 2) **Planning a new course of treatment:** Patients should complete a new medical evaluation to know how the HCV virus has affected the liver and if there are any special considerations that can determine the type of medication (genotype, resistance, etc.). During this time, the Navigator should consult with the care team to find out how the medication will be covered, as some health insurance companies restrict multiple rounds of HCV treatment.
- 3) **Preventing transmission:**
  - a. Refer to Buprenorphine, Methadone, syringe exchange and harm reduction services.
  - b. Patients who have been cured of HCV should not reuse their own old (or share) drug use equipment and personal care items (razors, toothbrushes).
- 4) **Documenting Reinfection in the Hep C Community Health Navigation Program:**
  - a. If this is the first time the patient participates in the Hep C Community Health Navigation Program, a new record should be opened noting the patient's treatment and reinfection history.
  - b. If the patient was previously treated and cured in this program, write a note in the existing record noting re-infection. Then, create a new record to track the new treatment progress. The Navigator should review and update the assessment and care plan for the current enrollment period.

<sup>1</sup>World Health Organization. Retrieved 8/13/2018 from: <http://www.who.int/news-room/fact-sheets/detail/hepatitis-c>

<sup>2</sup>CDC: HCV infection can be detected by anti-HCV screening tests (enzyme immunoassay) 4–10 weeks after infection. Anti-HCV can be detected in >97% of people by 6 months after exposure. HCV RNA appears in blood and can be detected as early as 2–3 weeks after infection. Retrieved 8/13/2018 from <https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm#c5>



# Hep C Peer Navigation Guide

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## Program Contact:

### Program Manager Name

Title

Phone

Email

### Program Manager Name

Title

Phone

Email

## Training Contact:

### Harm Reduction Coalition

<https://harmreduction.org/our-work/training-and-capacity-building/>

## Background

Hepatitis C (HCV) is a blood-borne viral infection that can lead to cirrhosis of the liver, liver cancer, and premature death. There are 2.4 million people in the United States (U.S.), and 71 million people globally estimated to be living with HCV. Many are unaware of their status or are not receiving medical care. Medical treatment and a cure for HCV are available; being cured of HCV significantly improves the chances of living a longer, healthier life, and prevents ongoing transmission of the virus.

People with a history of drug use are at highest risk for HCV infection. Syringe service programs (SSP) serve patients at highest risk for acquiring and transmitting HCV infection. Peers working in SSPs provide service access to at risk populations, and have the experience, knowledge and skills to engage and navigate people who use drugs to prevention, testing and medical care services.

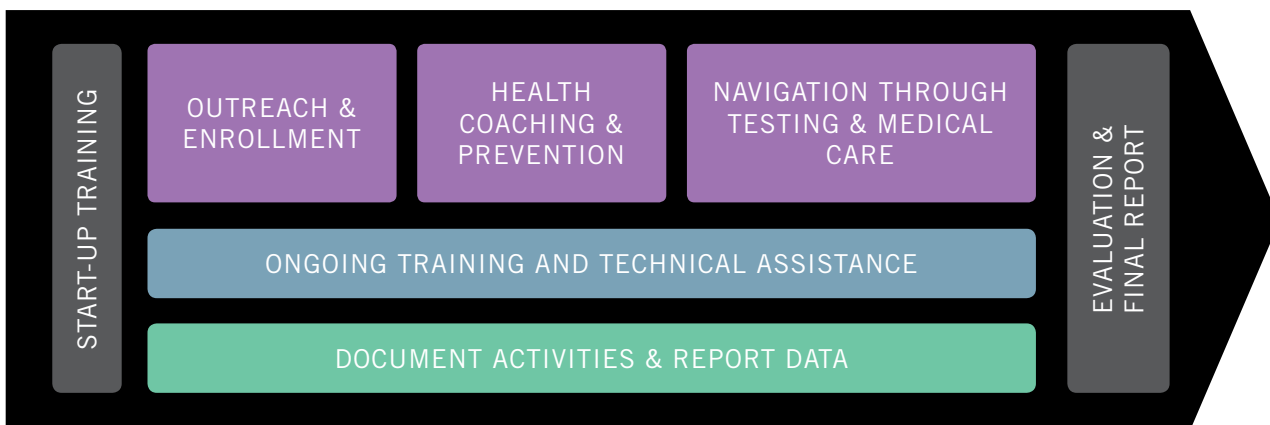
The New York City Department of Health developed the Hep C Peer Navigation Program in 2014 to support SSPs to provide Hep C outreach, prevention, and navigation support to people at risk or living with HCV to complete diagnostic testing, link to care, retain in care and access reinfection prevention services.

This guide provides a basic framework for establishing a Hep C Peer Navigation program at community-based organizations, substance use or harm reduction programs.

### PROGRAM GOAL:

Prevent new Hep C infections, and get people living with Hep C into medical care

### THE NYC HEP C PEER NAVIGATION PROGRAM IN A SNAPSHOT:





## Protocol

### STAFF AND COLLABORATION

- Agency hires at least one hepatitis C (Hep C) Peer to provide Hep C focused navigation services
- Agency appoints a Hep C Peer Navigator Supervisor with Hep C experience
  - Supervisors meet with Peer(s) weekly to review cases, work, and progress toward goals, provide support and guidance, as well as ensure that the peer has adequate emotional support
- Peer and Supervisor work together to identify and coordinate with all existing Hep C programs at their agency:
  - Other Hepatitis navigation programs
  - Hep C Testing Program
  - Other grant funded Hep C programs
  - Syringe Exchange/Harm Reduction Programs
  - Health Homes
  - Other related programs
- If Peers or Supervisors change, notify Program Manager within a week. Also, notify any problems immediately by email.

---

### LINKAGE TO CARE

- Agency establishes a Memorandum of Understanding (MOU) or linkage to care agreement with a medical provider that agrees to provide Hep C medical evaluation and treatment for participants enrolled.
- 

### PEER NAVIGATION SERVICES

- **Outreach and participant enrollment:** Peers can identify potential participants within their agency (clients known to have Hep C or who are receiving other services such as syringe exchange and Hep C support groups) or outside their agency (people reached during street outreach, community spaces, shelters or drug treatment programs).
- **Health coaching:** Peers provide key health messages to all participants, using the “Know Hep C, Cure Hep C” pocket card.
- **Prevention services:** Peers provide harm reduction messaging to all clients and connects them to syringe exchange and other services promoting safer drug use
- **Linkage to Hep C care:** Peers work with supervisor to navigate Hep C-positive patients through appropriate medical care and assist with return to care as needed.
- **Referrals and accompaniment:** Peers refer participants to supervisor or case manager for supportive services, and, if needed, accompany or escort participants to Hep C testing, test result appointments and medical appointments.

## DOCUMENTATION AND REPORTING

- Peers use the ‘Hep C Peer Navigator Activities Form’ to track activities daily. Short and long versions of the form are provided.
  - Peers submit the form to their supervisors for review after each shift.
  - The supervisor reviews, clarifies, compiles, and then inputs data from the form into the ‘Hep C Peer Navigation Database’.
  - Supervisors submit the database monthly via secure data delivery server. Never share patient information via email.
- 

## TRAINING

- New peer navigators are required to complete the following trainings:
    - 1) Start-Up Training, 2) Harm Reduction Approach, 3) Hep C Basics, 4) Hep C Treatment Update, 5) Motivational Interviewing, 6) Trauma Informed Care, 7) Mental Health First Aid
  - Peers are required to attend monthly program meetings for the full duration of the meeting.
    - Supervisors are encouraged to attend the program status report portion of the monthly meetings
- 

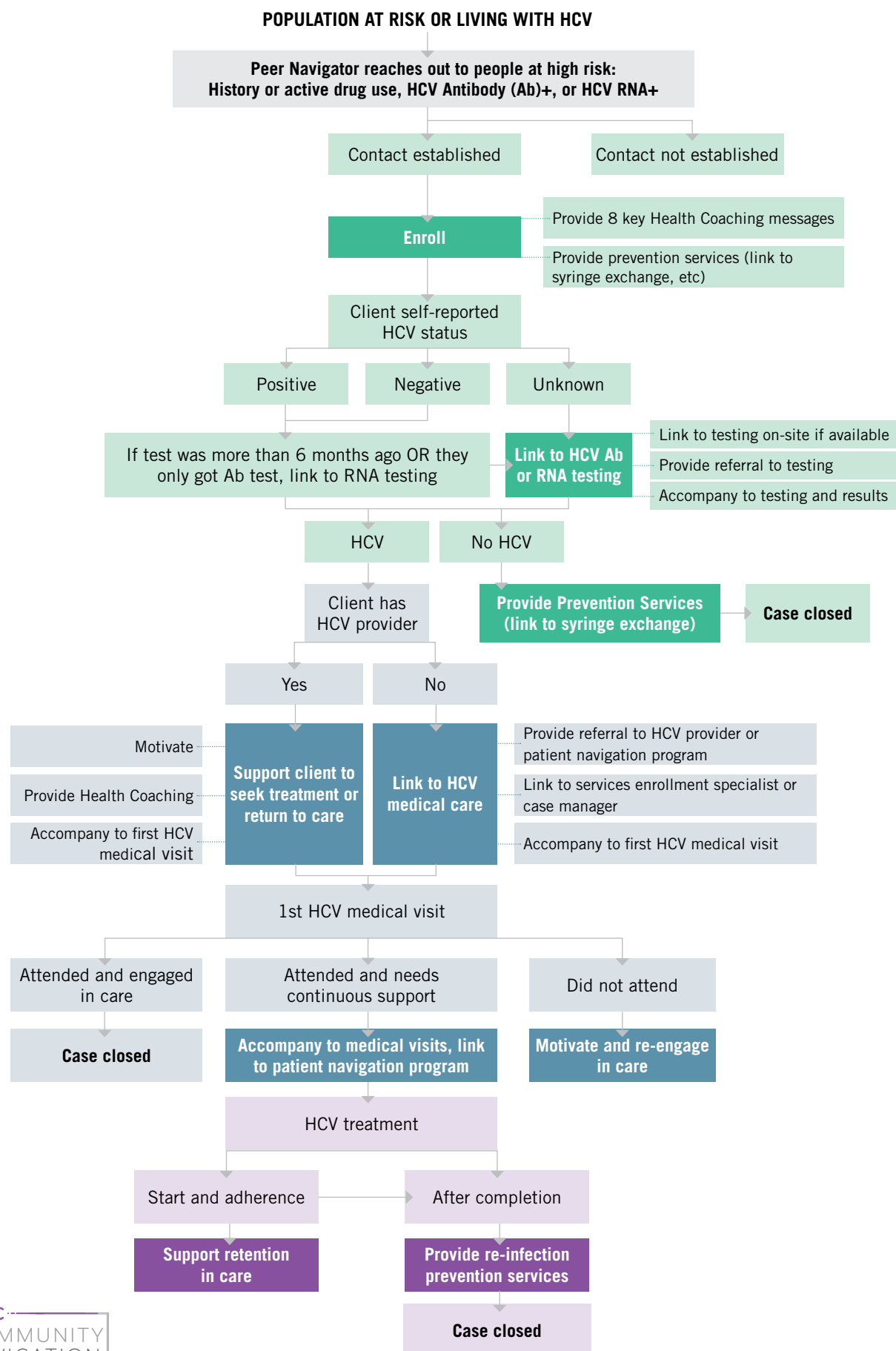
## WORKING WITH PATIENT NAVIGATORS

### *For Organizations funded for both Patient navigation and Hepatitis C Peer Navigation*

The Peer Navigator and the patient Navigator must work together to share cases:

- Patient Navigator will supervise or co-supervise the Peer.
- Patient Navigator and the Peer will meet at least once a week to discuss shared cases.
- Peer will refer all Hep C infected cases to the Patient Navigator
- Peer will work with the Patient Navigator to support linkage to care and retention in care for Hep C infected cases.
- Peer and Patient Navigator must use the same “Agency ID number” or “Organization Participant ID” for each unique individual enrolled. This number is used to identify persons in the monthly database reports.

# Hep C Peer Navigation Program – Intervention Workflow



## TOOLS

Peer  
Navigation  
Form

Business Card

Health  
Coaching Card

Appointment  
Card

Steps to  
Hep C  
Care Sheet

## Training Curriculum

### 1. Start-Up Training (Health Department and Harm Reduction Coalition)

- a. Program overview: objectives, protocol, logistics, materials and resources
- b. Peer navigator role: sharing lived experience, defining boundaries
- c. Burnout and self-care: vicarious trauma, signs of burnout, tips for self-care
- d. Social determinants of health and engaging people with Hep C: addressing stigma and healthcare barriers

Trainings are cross-listed in [NYS AIDS Institute](#) and [Harm Reduction Coalition](#)

### 2. Harm Reduction Approach

*If training dates are unavailable, complete webinar: [Harm Reduction Approach Overview](#)*

- a. Key principles of Harm Reduction
- b. Harm reduction options for substance use behaviors

### 3. Motivational Interviewing

*If training dates are unavailable, complete webinar: [MI Overview and MI Practice](#)*

- a. Principles of Motivational Interviewing
- b. Engaging clients effectively during service delivery
- c. Responding to client resistance and reluctance
- d. Stages of Change Theory

### 4. Hepatitis C Basics for Peer Workers

*If training dates are unavailable, complete webinar: [Hepatitis C Basics](#)*

- a. Basic liver functions
- b. Hepatitis C transmission and disease progression
- c. Viral hepatitis prevention and harm reduction
- d. Screening recommendations and two step testing algorithm
- e. Counseling on importance of Hep A/B vaccination, avoid alcohol and re-infection

### 5. Hepatitis C Medical Care and Treatment Update for Peer Workers

- a. Advances in Hep C treatment
- b. Basic info on health coverage options and benefits
- c. Working with care team to assist clients in accessing and completing treatment

### 6. Trauma Informed Care

### 7. Mental Health First Aid

**Recommended Trainings:**

- Syringe Access Services and Law Enforcement
- Safer Injecting and Wound Care
- Understanding & Challenging Drug-Related Stigma
- HCV Prevention With Young People Who Inject Drugs
- Talking To Clients About Hep C Treatment
- Group Facilitation Skills
- HIV And Hepatitis C Co-Infection

**HEALTH COACHING MESSAGES**

Peers provide the following health coaching messages to all participants:

1. Hepatitis C can lead to liver disease and cancer.
2. Hep C is spread through blood.
3. You can get Hep C by sharing drug use equipment (injecting, smoking, or snorting) or having unprotected sex.
4. Syringe exchange and harm reduction can protect you from Hep C.
5. Get tested to know if you have Hep C: antibody test first, then confirmatory test.
6. Hep C can be cured. Treatment is now shorter and more effective than before. Side effects are less severe.
7. You can get re-infected with Hep C. Protect yourself from blood exposure.
8. Avoid alcohol if you have Hep C. Alcohol speeds up liver damage.

**MATERIALS****Program materials:**

- Hep C Peer Navigation Activities Form
- [Know Hep C, Cure Hep C” Pocket card](#) (also in [Spanish](#))
- [Appointment Card](#) (in [Spanish](#))
- [Hep C Care Roadmap](#) (also in [Spanish](#))
- [AETC Congratulations Card](#) (English and Spanish)

**Supportive Materials:**

- [Hepatitis C Basics](#) (also in [Spanish](#)) from Harm Reduction Coalition
- [Hepatitis C and Your Liver](#) (also in [Spanish](#), [Arabic](#), [Russian](#), [Urdu](#))
- [Reduce Your Risk of Overdose, Hep C & HIV](#) (also in [Spanish](#) and [Russian](#))
- [Alcohol Screening and Counseling for Patients with Hepatitis: Guide for Health Care Providers](#)
- [Alcohol and Hepatitis Patient Palm Card](#) (also in [Spanish](#))

## Hep C Patient Navigator Survey

The purpose of the survey is to learn more about Hep C patient navigators and measure the impact of Check Hep C training and technical assistance.

We appreciate your time and honest responses in completing this survey.

Today's date: \_\_\_\_\_

**1. How many years have you been a Hep C Patient Navigator?** \_\_\_\_\_

**2. How much experience do you have working with people with Hep C? Please check one.**

- |                                     |   |
|-------------------------------------|---|
| <input type="checkbox"/> 1-3 years  | <input type="checkbox"/> More than 10 years |
| <input type="checkbox"/> 4-6 years  | <input type="checkbox"/> No experience      |
| <input type="checkbox"/> 7-10 years |   |

**3. What is the highest level of education you have completed? Please check one.**

- |   |  |
|---|--|
| <input type="checkbox"/> No schooling completed, or less than one year        | <input type="checkbox"/> Associate's degree (including occupational or academic degrees) |
| <input type="checkbox"/> Nursery, kindergarten, and elementary (grades 1 - 8) | <input type="checkbox"/> Bachelor's degree   |
| <input type="checkbox"/> High school, grades 9-12, no diploma                 | <input type="checkbox"/> Master's degree   |
| <input type="checkbox"/> High school graduate or equivalent                   | <input type="checkbox"/> Professional school degree (MD, DDC, JD, etc)                   |
| <input type="checkbox"/> Some college (1-4 years, no degree)                  | <input type="checkbox"/> Doctorate degree  |

**4. Which of the following are reasons why you are a patient navigator? Check all that apply.**

- |   |  |
|---|--|
| <input type="checkbox"/> Personal experience having Hep C | <input type="checkbox"/> Hearing about/knowning people who have been cured |
| <input type="checkbox"/> Family member with Hep C         | <input type="checkbox"/> Making a difference in people's lives             |
| <input type="checkbox"/> Close friend with Hep C          | <input type="checkbox"/> Important purpose                                 |
| <input type="checkbox"/> Financial or professional goals  |  |
| <input type="checkbox"/> Other: _____                     |  |

**5. Which of the following resources support you in your job as Hep C Patient Navigator? Check all that apply.**

- |   |
|---|
| <input type="checkbox"/> Supervisor   |
| <input type="checkbox"/> Co-workers   |
| <input type="checkbox"/> A doctor or nurse with Hep C knowledge or training                       |
| <input type="checkbox"/> External organizations (ex: Health Department, Harm Reduction Coalition) |
| <input type="checkbox"/> Online resources, please specify: _____                                  |
| <input type="checkbox"/> Other, please specify: _____   |

**6. What language(s) do you speak well enough to use at work?**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> English            | <input type="checkbox"/> Chinese - Cantonese | <input type="checkbox"/> Wolof                        |
| <input type="checkbox"/> Spanish            | <input type="checkbox"/> Russian             | <input type="checkbox"/> Other, please specify: _____ |
| <input type="checkbox"/> Chinese - Mandarin | <input type="checkbox"/> French              |   |

**7. What is your age?**

- ☐ 18-29  
☐ 30-39  
☐ 40-49  
☐ 50-59  
☐ 60 or older

**8. What is your race?**

- ☐ White  
☐ Black  
☐ Asian / Pacific Islander  
☐ Native American / American Indian  
☐ Other \_\_\_\_\_

**9. Are you Hispanic or Latino?**

- ☐ Yes  
☐ No

**10. How confident do you feel performing the following activities as part of Check Hep C? Check one box per row.**

	Not confident	Somewhat confident	Very confident
Talking to clients about their Hep C infection			
Talking to clients about mental health			
Talking to clients about alcohol and/or drug use			
Supporting clients in adhering to Hep C treatment			
Keeping in contact with clients who are hard to reach			
Helping clients access Hep C medical care			
Helping clients get Hep C medications through specialty pharmacies, patient assistance programs, prior authorization, appeals or other methods			

**11. Which of the following is not a true statement about Hep C?**

- ☐ Hep C infection can lead to liver disease and cancer.
- ☐ Syringe exchange and harm reduction can stop the spread of Hep C.
- ☐ Hep C treatment has many side effects.

**12. Which of the following is not a Hep C patient navigation service?**

- ☐ Giving appointment reminders and/or accompanying patients to appointments
- ☐ Processing applications for supportive services; for example, housing assistance
- ☐ Case conferences with the patient's care team

**13. What is the minimum number of patient encounters that should be provided to each patient prior to discharge? Please check one.**

- ☐ 2
- ☐ 4
- ☐ 6
- ☐ There is no minimum

**14. For patients that do not attend recommended medical appointments, patient navigators should:**

- ☐ Discharge the patient for non-adherence to Hep C program requirements
- ☐ Increase the intensity of services (for example, appointment reminders, health promotion)
- ☐ Continue to follow the same Care Plan that was developed during the assessment

**15. The Patient Navigation Form should be completed with information from:**

- ☐ Patients, medical providers, and patient medical records
- ☐ Patients, medical providers, patient medical records and NYC Health Department records
- ☐ Medical providers and patient medical records only

**16. Which trainings did you attend in the last year? Check all that apply.**

- ☐ Viral Hepatitis 101
- ☐ Hep C Point of Care Testing
- ☐ Hep C Patient Navigation Training
- ☐ Medical Interpretation Certification
- ☐ Motivational Interviewing

## Program Management Tools

1. Management protocol and dashboard
2. Scopes
3. Job description
4. Start-Up Training Slides
5. Community of Learning and Practice Meeting Planning
  - a. Meeting checklist
  - b. Notetaking template
  - c. Case Study Sign Up
  - d. Case Study Reminder
6. Program Implementation Report (clinical setting and CBO versions)
  - a. Quality improvement plan
  - b. Electronic health record query template
7. Patient Registry report template for CBOs
8. Care cascade definitions
9. Program database
10. Data Dictionary
11. Survey for Peer Career Pathways
12. Survey for Peer Exit Interview





Program Site  
100 Sample Road  
City, State 12345

**NAVIGATOR NAME**  
**Hep C Peer Navigator**

Phone: (000) 000-0000

Cell: (000) 000-0000

Email: myemail@gmail.com

<https://www.nastad.org/hepatitis-navigation-toolkit>



Program Site  
100 Sample Road  
City, State 12345

**NAVIGATOR NAME**  
**Navegación para Hepatitis C**

Teléfono: (000) 000-0000

Celular: (000) 000-0000

Correo electrónico: myemail@gmail.com

<https://www.nastad.org/hepatitis-navigation-toolkit>



Improving Care for People Who Use  
Drugs and Other Impacted Populations

## CERTIFICATE OF EXCELLENCE

AWARDED ON MONTH YEAR TO

# Navigator Name

### Organization Name

For outstanding performance and consistent high standards in  
hepatitis navigation, screening, and linkage to care.

---

**NAME OF PROGRAM DIRECTOR**

TITLE OF PROGRAM DIRECTOR

Organization:		Peer Navigator:		Supervisor:	
Client Information		Self-Reported History	Hep C Tests	Hep C Medical Visit	
<b>Name:</b> <b>Tel:</b> <b>Email:</b> <b>Name insurance plan:</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private <input type="checkbox"/> None <b>Participant ID#:</b> _____ <b>Date enrolled in Hep C Peer Nav:</b> ____/____/_____ <b>Required:</b> <input type="checkbox"/> Health coaching <input type="checkbox"/> Harm Reduction Services	<b>Date of Birth:</b> _____ <b>Gender:</b> <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Trans M→F <input type="checkbox"/> Trans F→M <input type="checkbox"/> Other <b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian/PI <input type="checkbox"/> Native American /Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other race: _____ <input type="checkbox"/> Does not identify <input type="checkbox"/> Decline to answer <input type="checkbox"/> Unknown <b>Ethnicity:</b> <input type="checkbox"/> Hispanic/Latino: Specify _____ <input type="checkbox"/> Non-Hispanic/Non-Latino: Specify _____ <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Unknown <b>English:</b> <input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write <input type="checkbox"/> None <b>Primary language:</b> _____ <b>Interpretation needed:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Self-reported Hep C Status:</b> +   -   ? <b>Treated Hep C before?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If treated, outcome:</b> <input type="checkbox"/> Cured <input type="checkbox"/> Not cured <b>Re-infected?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Antibody Test date:</b> ____/____/_____ <input type="checkbox"/> Declined <input type="checkbox"/> Not Needed <b>Hep C Antibody Test Result:</b> +   - <b>RNA Test date:</b> ____/____/_____ <input type="checkbox"/> Declined <input type="checkbox"/> Not Needed <b>Hep C RNA Test Result:</b> +   -	<b>Hep C medical care referral provided:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Already in Care <b>Referral Status:</b> <input type="checkbox"/> Accepted <input type="checkbox"/> Declined <b>Provider Name:</b> <b>Provider Clinic:</b> <b>Hep C medical visit attended date:</b> ____/____/_____ <b>Hep C treatment:</b> <input type="checkbox"/> Started <input type="checkbox"/> Completed <input type="checkbox"/> Discontinued <b>Hep C treatment outcome:</b> <input type="checkbox"/> Cured <input type="checkbox"/> Not Cured	
<b>Name:</b> <b>Tel:</b> <b>Email:</b> <b>Name insurance plan:</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private <input type="checkbox"/> None <b>Participant ID#:</b> _____ <b>Date enrolled in Hep C Peer Nav:</b> ____/____/_____ <b>Required:</b> <input type="checkbox"/> Health coaching <input type="checkbox"/> Harm Reduction Services	<b>Date of Birth:</b> _____ <b>Gender:</b> <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Trans M→F <input type="checkbox"/> Trans F→M <input type="checkbox"/> Other <b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian/PI <input type="checkbox"/> Native American /Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other race: _____ <input type="checkbox"/> Does not identify <input type="checkbox"/> Decline to answer <input type="checkbox"/> Unknown <b>Ethnicity:</b> <input type="checkbox"/> Hispanic/Latino: Specify _____ <input type="checkbox"/> Non-Hispanic/Non-Latino: Specify _____ <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Unknown <b>English:</b> <input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write <input type="checkbox"/> None <b>Primary language:</b> _____ <b>Interpretation needed:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Self-reported Hep C Status:</b> +   -   ? <b>Treated Hep C before?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If treated, outcome:</b> <input type="checkbox"/> Cured <input type="checkbox"/> Not cured <b>Re-infected?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Antibody Test date:</b> ____/____/_____ <input type="checkbox"/> Declined <input type="checkbox"/> Not Needed <b>Hep C Antibody Test Result:</b> +   - <b>RNA Test date:</b> ____/____/_____ <input type="checkbox"/> Declined <input type="checkbox"/> Not Needed <b>Hep C RNA Test Result:</b> +   -	<b>Hep C medical care referral provided:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Already in Care <b>Referral Status:</b> <input type="checkbox"/> Accepted <input type="checkbox"/> Declined <b>Provider Name:</b> <b>Provider Clinic:</b> <b>Hep C medical visit attended date:</b> ____/____/_____ <b>Hep C treatment:</b> <input type="checkbox"/> Started <input type="checkbox"/> Completed <input type="checkbox"/> Discontinued <b>Hep C treatment outcome:</b> <input type="checkbox"/> Cured <input type="checkbox"/> Not Cured	

# Hep C Navigation Form - Community Settings

Navigator

Supervisor

## Client Information

Date enrolled:	Agency Participant ID:	Initials:	Year of Birth:
Client First Name:		Client Last Name:	Date of Birth:
Address (# street, apt #, borough)	Zip code	Phone 1:	Phone 2:
Race: <input type="checkbox"/> White <input type="checkbox"/> Asian/PI <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Does not identify <input type="checkbox"/> Decline to answer <input type="checkbox"/> Unknown	<input type="checkbox"/> Black or African American <input type="checkbox"/> Native American /Alaskan Native <input type="checkbox"/> Other race: _____	Ethnicity: <input type="checkbox"/> Hispanic/Latino Specify _____ <input type="checkbox"/> Non-Hispanic/Non-Latino Specify _____ <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Unknown	Gender: <input type="checkbox"/> F <input type="checkbox"/> Trans M → F <input type="checkbox"/> M <input type="checkbox"/> Trans F → M <input type="checkbox"/> Other
English: <input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write <input type="checkbox"/> None		Preferred language:	Interpretation needed: <input type="checkbox"/> Yes <input type="checkbox"/> No

## For organization use only

Email: \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_

Other Contact Info:

## Program Services

**\*Required services at time of enrollment:** ☐ Health Coaching ☐ Harm Reduction

**\*Services:** ☐ Enrolled in Hep C Peer Services ☐ Enrolled in full-time Hep C patient navigation

## Hep C Testing On or After Enrollment

Hep C status at intake: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	
Antibody test date: ____/____/____ <input type="checkbox"/> Test declined <input type="checkbox"/> Test not needed	Antibody test result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
RNA test date: ____/____/____ <input type="checkbox"/> Test declined <input type="checkbox"/> Test not needed	RNA test result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Spontaneously cleared virus

## Assessment

Treated for Hep C before program? <input type="checkbox"/> Yes, year: ____ <input type="checkbox"/> No	If ever treated, cured? <input type="checkbox"/> Cured <input type="checkbox"/> Not cured
Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private <input type="checkbox"/> None	Name of insurance plan:
In the past year, have you had trouble paying for food, housing, medications, heating or other basic need? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Housing: <input type="checkbox"/> Stable housing <input type="checkbox"/> Unstable housing <input type="checkbox"/> Homeless	Has consistent transportation for appointments: <input type="checkbox"/> Yes <input type="checkbox"/> No
Injected drugs in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined Inhaled/snorted drugs in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined Ever injected drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	On methadone: <input type="checkbox"/> Yes <input type="checkbox"/> No On buprenorphine: <input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol use in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined Any mental health issues? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Social support? <input type="checkbox"/> None <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> Support group <input type="checkbox"/> Program	Incarcerated in past year: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined Incarcerated ever: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined

### Navigation to Supportive Services

<input type="checkbox"/> Alcohol Treatment <input type="checkbox"/> Benefits Enrollment <input type="checkbox"/> Hep A Vaccination <input type="checkbox"/> Hep B Care <input type="checkbox"/> Hep B Testing <input type="checkbox"/> Hep B Vaccination	<input type="checkbox"/> Hep C Genotype and Resistance Testing <input type="checkbox"/> Hep C Support Groups <input type="checkbox"/> HIV Care <input type="checkbox"/> HIV Testing <input type="checkbox"/> Holistic Services <input type="checkbox"/> Housing Services	<input type="checkbox"/> Mental Health Services <input type="checkbox"/> Primary Care <input type="checkbox"/> Substance Use Services <input type="checkbox"/> Transportation Services <input type="checkbox"/> Other:
---	---	--

☐ Health Promotion “Hep C Basics” complete  
☐ Health Promotion “Getting Ready for Hep C Care” complete  
☐ Care Plan developed and reviewed with patient

### Hep C Medical Care After Enrollment

<b>Hep C medical care referral provided:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Already in Care <b>Hep C medical visit attended date:</b> ____/____/____ <i>Date must be on or after enrollment</i>	<b>Provider name:</b> <b>Provider hospital/clinic:</b>
Co-morbid conditions: <input type="checkbox"/> HIV <input type="checkbox"/> Hep B Hep C treatment status: <input type="checkbox"/> Started <input type="checkbox"/> Completed <input type="checkbox"/> Discontinued Hep C treatment outcome: <input type="checkbox"/> Cured <input type="checkbox"/> Not Cured <input type="checkbox"/> Unknown	<b>Adherence check-in frequency during treatment:</b> <input type="checkbox"/> Weekly <input type="checkbox"/> Other:
<b>Barriers to Hep C Treatment:</b> <input type="checkbox"/> Abstinence requirement <input type="checkbox"/> Drug use <input type="checkbox"/> Recently incarcerated <input type="checkbox"/> Alcohol use <input type="checkbox"/> Homeless/Unstable housing <input type="checkbox"/> Waiting for new medications <input type="checkbox"/> Client declined treatment <input type="checkbox"/> Insurance coverage/ cost <input type="checkbox"/> Other: <input type="checkbox"/> Co-morbid conditions <input type="checkbox"/> Lost to follow up <input type="checkbox"/> Did not attend appointments <input type="checkbox"/> Psych condition	
<b>Reinfection prevention support provided after treatment:</b> <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> Referred to group that covers Hep C reinfection prevention	
<input type="checkbox"/> Health Promotion “Getting Ready for Hep C Treatment” complete <input type="checkbox"/> Treatment Planning Form reviewed with patient <input type="checkbox"/> Health Promotion “After Treatment” complete	

<b>Discharge date:</b> ____/____/____	<b>Total # encounters with client:</b>
<b>Reason:</b> <input type="checkbox"/> Completed program <input type="checkbox"/> Deceased <input type="checkbox"/> Declined program <input type="checkbox"/> Incarcerated <input type="checkbox"/> Lost to follow up <input type="checkbox"/> Moved <input type="checkbox"/> Program ended <input type="checkbox"/> Referred to another program <input type="checkbox"/> Other, explain:	

### Notes


# Hep C Navigation Form - Healthcare

Patient Navigators use this tool to document their work assisting each patient through the continuum of care. Keep in patient chart and update after each patient encounter. This form is a paper version of the Check Hep C REDCap Cloud database.

Enrollment Information			
Check Hep C enrollment date: / /		*Check Hep C patient ID:  Unique number provided for this program	Agency patient ID:
Patient last name:		Patient first name:	Date of Birth:
Address (# street, apt #, borough) Zip code		Phone 1: Phone 2:	Permission to text: <input type="checkbox"/> Yes <input type="checkbox"/> No
Race: <input type="checkbox"/> White <input type="checkbox"/> Asian/PI <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Does not identify <input type="checkbox"/> Decline to answer <input type="checkbox"/> Unknown	<input type="checkbox"/> Black or African American <input type="checkbox"/> Native American /Alaskan Native <input type="checkbox"/> Other race: _____	Ethnicity: <input type="checkbox"/> Hispanic/Latino Specify _____ <input type="checkbox"/> Non-Hispanic/Non-Latino Specify _____ <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Unknown	Gender: <input type="checkbox"/> F <input type="checkbox"/> Trans M → F <input type="checkbox"/> M <input type="checkbox"/> Trans F → M <input type="checkbox"/> Other
Country of birth:	English: <input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write <input type="checkbox"/> None	Preferred language:	Interpretation needed: <input type="checkbox"/> Yes <input type="checkbox"/> No

Assessment: Self-Reported Hep C History		Obtain the following information from the patient or patient chart.
Year of HCV diagnosis:	Ever treated for HCV? <input type="checkbox"/> Yes, year treated: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	If ever treated, was patient cured? <input type="checkbox"/> Cured <input type="checkbox"/> Not cured
<input type="checkbox"/> Health Promotion "Hep C Basics" complete		<input type="checkbox"/> Health Promotion "Overdose prevention counseling" complete

Patient Navigator Assessment Determine patient needs and develop a "Care Plan"	Referrals Made
Any mental health issues? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Mental health services</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Any alcohol use in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	<b>Alcohol treatment</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Injection drug use in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	<b>Naloxone provided date:</b> _____
Intranasal drug use in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	<b>Substance use or harm reduction services</b>
Injection drug use ever? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
On methadone maintenance: <input type="checkbox"/> Yes <input type="checkbox"/> No On buprenorphine: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> NYS Essential Plan <input type="checkbox"/> Health Exchange Plan (Metal plans) <input type="checkbox"/> Private Insurance <input type="checkbox"/> None <input type="checkbox"/> Declined to answer	<b>Insurance enrollment</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed <input type="checkbox"/> Free / Low cost care
Name of insurance plan:	
In the past year, have you had trouble paying for food, housing, medications, heating or other basic need? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Social services</b> (such as: housing, financial, food, legal, transportation)
Housing: <input type="checkbox"/> Stable housing <input type="checkbox"/> Unstable housing <input type="checkbox"/> Homeless	<input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Has consistent transportation for appointments: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Incarcerated in past year: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	
Incarcerated ever: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	
Social support? <input type="checkbox"/> None <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> Support group <input type="checkbox"/> Program	<b>Hep C support group</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
<input type="checkbox"/> Health Promotion "Getting Ready for Hep C Care" complete <input type="checkbox"/> Care Plan developed and reviewed with patient	

**Hepatitis C Medical Care***Obtain the following information from the medical provider or patient chart.*

<b>Provider name:</b>		<b>Hospital/clinic:</b>	
* <b>First HCV medical visit date after enrollment:</b> <i>[Use enrollment date, if patient had medical visit before enrollment]</i>		* <b>Most recent HCV medical visit date:</b> <i>[Enter in database before sending report]</i>	
* <b>Medical evaluation complete date:</b>	<b>Co-morbid conditions:</b> <input type="checkbox"/> None <input type="checkbox"/> HIV <input type="checkbox"/> Hep B <input type="checkbox"/> Psych <input type="checkbox"/> Other, specify:		
	<b>Stage of liver disease:</b> <input type="checkbox"/> No cirrhosis <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Not evaluated		
<b>Most recent liver cancer screening date:</b> <i>[Enter in database before sending report]</i>		<b>Outcome:</b> <input type="checkbox"/> Liver cancer <input type="checkbox"/> No liver cancer	

**Hepatitis C Treatment**

* <b>Treatment candidate:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Information not available		<b>Insurance covered medication on 1st request:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
* <b>Treatment start date:</b>	<b>If patient hadn't started treatment yet, reason why</b> <input type="checkbox"/> Alcohol use <input type="checkbox"/> Co-morbid condition <input type="checkbox"/> Did not attend appointments <input type="checkbox"/> Drug use <input type="checkbox"/> Insurance coverage/cost <input type="checkbox"/> Patient declined treatment <input type="checkbox"/> Psych condition <input type="checkbox"/> Waiting for new medications <input type="checkbox"/> Other:		
<b>Adherence Support:</b> <input type="checkbox"/> 3 day after treatment start check-in completed		<b>Adherence check-in frequency during treatment:</b> <input type="checkbox"/> Weekly <input type="checkbox"/> Other:	
* <b>Treatment complete date:</b>		* <b>Treatment outcome:</b> <input type="checkbox"/> Cured (SVR) <input type="checkbox"/> Not cured <input type="checkbox"/> Information not available	
<b>If treatment not completed, reason why:</b> <input type="checkbox"/> Insurance coverage/cost <input type="checkbox"/> Patient stopped on own <input type="checkbox"/> Side effects/adverse event <input type="checkbox"/> Other, explain:			

*Provide reinfection prevention counseling to all patients before discharge.*

<b>Reinfection Prevention</b>	<b>Support provided after treatment:</b> <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> Referred to group that covers Hep C reinfection prevention
	<input type="checkbox"/> <b>Health Promotion "After Treatment" complete</b>

*Discharge if client completed the program or ended participation. This is used to determine if client is still active in program.*

<b>Discharge</b>	* <b>Discharge date:</b>
<b>Reason:</b> <input type="checkbox"/> Completed program <input type="checkbox"/> Deceased <input type="checkbox"/> Declined program <input type="checkbox"/> Incarcerated <input type="checkbox"/> Lost to follow up <input type="checkbox"/> Moved <input type="checkbox"/> Program ended <input type="checkbox"/> Referred to another program <input type="checkbox"/> Spontaneously cleared HCV <input type="checkbox"/> Other, explain:	
<b>Case Tracking</b>	* <b>Most Recent Encounter Date:</b> <i>[Enter in database before sending report]</i>
	* <b>Total # encounters with Patient Navigator:</b>
<b>Case Notes:</b>	



## Case Notes Template

Use this form to document each encounter with the patient, as case notes. Keep this form in the patient chart.

At the time of reporting: add up the total number of encounters for each "Service Type" to date and enter into database

Patient name:	Hep C Program patient ID:	Agency patient ID:
Date of encounter:	Type of encounter: <input type="checkbox"/> Call <input type="checkbox"/> Email <input type="checkbox"/> Text <input type="checkbox"/> In-person	
Service type: <input type="checkbox"/> Accompaniment to appointments <input type="checkbox"/> Treatment Adherence Support <input type="checkbox"/> Reminder (call, letter, text, email, telegram) <input type="checkbox"/> Medication/Pharmacy Coordination <input type="checkbox"/> Alcohol/Drug Counseling <input type="checkbox"/> Other meeting with patient		
Patient stage in care plan: <input type="checkbox"/> Assessment <input type="checkbox"/> Linkage-to-care <input type="checkbox"/> Medical eval <input type="checkbox"/> Treatment prep <input type="checkbox"/> Treatment <input type="checkbox"/> Post treatment		
Notes:		
<b>If the encounter included a medical visit:</b>		
Purpose of medical visit:		On treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No <small>*Complete Treatment Planning Form before starting treatment and review at each visit while on treatment</small>
Instructions from medical provider:		
<b>Next visit planning</b>		
Date: Type: <input type="checkbox"/> Visit with medical provider <input type="checkbox"/> Visit with patient navigator	Reminder needed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Accompaniment needed: <input type="checkbox"/> Yes <input type="checkbox"/> No
Planning notes for next visit:		

## Care Plan

Discuss care plan with patient. Complete the form based on agreed plan, sign and give a copy to patient.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

### CARE TEAM

Name	Address	Phone Number	E-mail Address
Doctor			
Navigator			

☐ Accompaniment to medical visits

☐ Reminders for visits by: ☐ Call ☐ Text ☐ Email

### CHECK HEP C PROGRAM GOALS

Goal	Date Completed
<input type="checkbox"/> Complete patient navigation assessment	
<input type="checkbox"/> Receive "Hep C basics" health promotion	
<input type="checkbox"/> Receive "Getting ready for Hep C care" health promotion	
<input type="checkbox"/> Attend 1st Hep C medical visit	
<input type="checkbox"/> Complete Hep C medical evaluation	
<input type="checkbox"/> Receive "Getting ready for treatment" health promotion	
<input type="checkbox"/> Start Hep C treatment	
<input type="checkbox"/> Complete Hep C treatment	
<input type="checkbox"/> Receive "After treatment" health promotion	

### REFERRALS

Type of Service	Site Name and Address	Phone Number/ E-mail Address	Appointment Date/ Time
<input type="checkbox"/> Mental health			
<input type="checkbox"/> Alcohol counseling			
<input type="checkbox"/> Transportation services for national programs			
<input type="checkbox"/> Substance use/harm reduction			
<input type="checkbox"/> Insurance enrollment			
<input type="checkbox"/> Benefits (Food/ financial)			
<input type="checkbox"/> Housing services			
<input type="checkbox"/> Legal services			
<input type="checkbox"/> Specialist:			
<input type="checkbox"/> Other:			

## Care Plan

### HEALTH GOALS

Action	How	By when
<input type="checkbox"/> Reduce or stop drinking alcohol		
<input type="checkbox"/> Reduce or stop using drugs		
<input type="checkbox"/> Reduce or stop smoking		
<input type="checkbox"/> Work towards a healthy body weight		
<input type="checkbox"/> Review all meds and supplements with doctor		
<input type="checkbox"/> Manage other illnesses		
<input type="checkbox"/> Other:		

### NOTES

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Navigator Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## Treatment Planning Form

### MY DOCTOR'S APPOINTMENTS

Complete this table with your doctor.

Visit	Date	Time	Hep C Viral Load*	Notes
1				
2				
3				
4				
5				

\*The Hep C viral load is the amount of Hep C virus in your blood. If your viral load drops to "undetectable" and stays there 12-24 weeks after treatment you are cured.

Date	Ultrasound

### MY NOTES

Write down the list of medications you are taking, any side effects you have, questions for your doctor, or other notes about your treatment.

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Living with Hep C is not easy. But you can be treated and cured. Follow these steps:

1. Know your care team and how to contact them.
2. Take your medications the right way.
3. Go to all doctor's appointments.

### MY CARE TEAM

#### DOCTOR

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

#### NAVIGATOR

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

#### PHARMACIST

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

#### ULTRASOUND RADIOLOGIST

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

## Treatment Planning Form

### MY HEP C MEDS

Complete this table with your doctor.

Medication	When to Take	What to Avoid	Possible Side Effects
1. Name: Color:	Take ___ tablet(s) ___ time(s) a day at _____ AM/PM <input type="checkbox"/> with food		<input type="checkbox"/> Tiredness <input type="checkbox"/> Headache <input type="checkbox"/> Nausea, poor appetite <input type="checkbox"/> Diarrhea, upset stomach <input type="checkbox"/> Rash and itching <input type="checkbox"/> Coughing <input type="checkbox"/> Trouble sleeping <input type="checkbox"/> Skin reaction <input type="checkbox"/> Other:
1. Name: Color:	Take ___ tablet(s) ___ time(s) a day at _____ AM/PM <input type="checkbox"/> with food		Call your doctor right away if you notice:
1. Name:			

### TAKING MEDS DOS AND DON'TS

#### Dos

- Do **take your meds every day**. Try these tips to remember:
  - Set a clock or phone alarm
  - Use a pill box
  - Use a calendar
  - Ask a friend to remind you
  - Take your meds at the same time as another daily activity (e.g. brushing teeth, lunch/dinner)
  - Use the same pharmacy to keep track of prescriptions
- Do **talk to your doctor** about:
  - Any **side effects**
  - **Every medication** you take (prescription or OTC meds, vitamins, herbal supplements)
  - Pregnancy

#### DON'Ts

- Don't miss a dose.** Ask your doctor what to do if you miss a dose.
- Don't stop taking your meds** without talking to your doctor, even if you have side effects.
- Don't start a new medication** without talking to your doctor.
- If you get pregnant** while on medication, tell your doctor right away.

### MY STRATEGIES FOR TAKING MEDS

Complete this table with your navigator before starting treatment.

Common reasons for missing dose	Strategy to avoid missing dose
Forgetting	
Being away from home	
Being busy	
Change in daily routine	
Falling asleep	
Being high or drunk	
Feeling ill or sick	
Side effects	
Feeling depressed	
Getting refills on time	



# Hep C Health Promotion

## Health Promotion Modules

The Hep C Community Health Navigation Health Promotion Modules guide Navigators in: providing health promotion, assessing patient need for supportive services and referrals, developing a patient navigation care plan, completing required forms, and promoting behavior change.

HEALTH PROMOTION MODULES	WHEN TO USE
<ul style="list-style-type: none"> <li>How do I use Hep C Community Health Navigation materials?</li> <li><b>Form:</b> Patient Navigation Form</li> <li><b>Form:</b> Care Plan</li> <li>Guide for improving readiness for change</li> </ul>	Throughout program
<b>I. Hep C Basics</b>	
<ul style="list-style-type: none"> <li>What is Hepatitis C?</li> <li>How do people get Hep C?</li> <li>What type of Hep C do you have?</li> <li>How do you know if you have liver damage?</li> <li>Treatment: How is Hep C treated?</li> </ul>	During Navigation assessment phase. Reinforce throughout pre-treatment phase as needed.
<b>II. Getting Ready for Hep C Care</b>	
<ul style="list-style-type: none"> <li>Mental health: Improving mental wellness</li> <li>Alcohol: Does drinking alcohol damage the liver?</li> <li><b>Form:</b> Alcohol Use Disorders Identification Test (AUDIT)</li> <li>Drug use: Reducing the harm of drug use</li> <li><b>Form:</b> Drug Abuse Screening Test (DAST)</li> <li>Lifestyle changes: Protect your liver</li> <li>Referrals: Getting support</li> </ul>	During the Navigation assessment phase.
<b>III. Getting Ready for Treatment</b>	
<ul style="list-style-type: none"> <li>Treatment readiness: Are you ready to start treatment?</li> <li><b>Form:</b> Treatment Planning Form</li> </ul>	Right before starting treatment.
<b>IV. After Treatment</b>	
<ul style="list-style-type: none"> <li>Staying healthy and avoiding Hep C reinfection</li> </ul>	During and after treatment.

### WHAT'S IN EACH MODULE?

**ASSESS NEED** for health promotion. Ask questions to assess what your patient already knows or does not know. Based on their responses, tailor the talking points and action plan.

**TELL PATIENTS** key messages. After sharing these messages, review information, make plan, or discuss decisions.

**REVIEW INFO** and use the questions in this section to make sure the patient understands the information provided

**MAKE A PLAN** with the patient based on the information they received, and record action items on the Care Plan at the end of this guide.

**DISCUSS** with the patient the pros and cons of making decisions as these may require further thought.

## HEP C BASICS: KEY MESSAGES

The Navigator can deliver the following key messages to cover all basics for hepatitis C (Hep C). The content can be delivered in a manner that is tailored to the patient's needs and health literacy. The following pages provide additional guidance for assessing knowledge gaps and providing information.

### WHAT IS HEP C?

1. Hep C is a **liver infection** caused by a **virus**.
2. Hep C is spread through infected **blood**.
3. Hep C can cause **serious** health problems like **liver disease** and cancer.
4. **Get tested** to know if you have Hep C. Hep C testing is a two-step process:
  - Hep C **antibody** test
  - Hep C RNA (viral or **confirmatory**) test

Sometimes, these two tests are given together at the same time.

5. **Avoid alcohol** if you have Hep C. Alcohol can speed up liver damage.

### GET HEP C CURED

6. Hep C treatment is now usually one pill, taken daily for a few months, with few side effects.
7. Most people with Hep C can be **cured**.
8. Even if you were cured, you can get **re-infected** with Hep C.

### PREVENT HEP C

9. **Protect yourself** from blood exposure to prevent Hep C infection or reinfection.
10. If you use drugs, only use **new supplies** every time you inject, smoke or snort.
11. Always practice **safer sex**.



## WHAT IS HEPATITIS C?

### 1. ASSESS NEED

Sample question: “What would you like to know about Hep C?”

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### 2. TELL PATIENTS

1. Hepatitis C (Hep C) is caused by a virus that infects the liver.
    - Hepatitis means inflammation of the liver.
    - Your liver keeps you healthy in many ways. It removes toxins from your blood and transforms nutrients from food into energy
    - There are different causes of hepatitis. Hepatitis can be caused by excessive alcohol use, fatty liver, and viruses such as hepatitis A, B or C.
  2. Hep C virus is transmitted (passed from one person to another) through blood.
  3. Hep C can lead to serious health problems, including liver damage, liver failure, cancer, and death.
  4. Many people with Hep C do not have symptoms and do not know they are infected.
    - Symptoms of Hep C can take up to 30 years to develop.
    - When symptoms do appear, they are often a sign of advanced liver disease.
  5. Hep C can be cured.
    - If you are cured of Hep C, your liver health will likely improve.
- 

### 3. REVIEW INFO

Sample question:

- “Have you had symptoms of hepatitis?”
- “Can Hep C be cured?”
- “How would you explain Hep C to a friend or family member?”

## HOW DO PEOPLE GET HEP C?

### 1. ASSESS NEED

Sample question: “Do you know how Hep C is transmitted?”

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### 2. TELL PATIENTS

1. Hep C is transmitted (passed along from one person to another) through blood.

It only takes a tiny amount of blood to spread Hep C.

2. The most common way to transmit Hep C is through sharing drug use equipment.

- This may have happened a long time ago.
- If you use drugs, only use all new or sterile drug use equipment.
- This includes: needles, syringes, razors, cutters, ties, cookers, cups, rinse water, spoons, cotton, filters, pipes, straws, or rolled money.
- The Hep C virus is also transmitted by sharing needles or injection equipment (for blood transfusions, non-sterile injections, insulin, drug use, steroids, tattooing or acupuncture).

3. Hep C is rarely transmitted through sex.

- Risk for sexual transmission is higher when blood is present, in men who have sex with men, in people with HIV or in people with multiple sex partners.

4. Hep C can be transmitted by sharing things that touched your blood.

- This includes toothbrushes, razors, nail clippers, piercing or tattoo equipment.

5. Hep C can spread from mother to baby during pregnancy or childbirth.

If you're pregnant, tell your doctor that you have Hep C.

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### 3. MAKE A PLAN

Sample question: “What can you do to prevent passing Hep C along to others?”

## HEP C BASICS: WHAT TYPE OF HEP C DO YOU HAVE?

### 1. ASSESS NEED

Sample question: “When were you diagnosed with Hep C?”

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### 2. TELL PATIENTS

Hep C testing is usually a two-step process.

1. The first test is the Hep C antibody test.

- This test shows if you have ever had the Hep C virus.
- Even if you “cleared” or were cured of Hep C, you will always have a positive Hep C antibody test.

2. The second test is the Hep C RNA (viral load) test.

- This shows if you have the Hep C infection now.
- If this test is positive, it means you have Hep C.
- This test also shows **how much** Hep C virus is in your blood.

You need another blood test to find out what type of Hep C you have.

3. The Hep C genotype test is a third type of test that tells you what type of Hep C virus you have.

- There are at least six types (genotypes) of Hep C.
- Knowing the type you have helps your doctor decide what treatment is best for you.

Everyone with Hep C should also be tested for HIV and hepatitis B.

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### 3. REVIEW INFO

Sample question:

- “What tests have you had?”
- “What tests do you still need?”

## HEP C BASICS: HOW DO YOU KNOW IF YOU HAVE LIVER DAMAGE?

### 1. ASSESS NEED

Sample question: “Have you had symptoms of liver damage?”

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### 2. TELL PATIENTS

1. Symptoms and signs of Hep C can include: fever, fatigue, loss of appetite, nausea and vomiting, abdominal pain, dark urine, grey-colored stools, joint pain, jaundice.
  2. Most of these symptoms are due to liver inflammation or damage.
  3. Chronic Hep C can damage the liver.
    - It can cause inflammation of the liver, which can lead to scarring of the liver tissue, moderate liver damage (fibrosis), and **severe liver damage (cirrhosis)**.
    - People with cirrhosis are at high risk for liver failure, liver cancer, and even death.
    - Liver damage often happens over a period of 20 to 30 years.
  4. A medical evaluation will tell you if you have liver damage. You make take some of these tests:
    - **Fibrosis tests (e.g. Fibrosure):** Blood tests that look for liver damage.
    - **Liver ultrasound/Fibroscan:** Non-invasive imaging tests that provide a picture of the shape, size, and/or stiffness of the liver.
    - **Liver biopsy:** Removal of a small piece of liver tissue with a needle. The tissue is checked under a microscope for damage or disease. This test is rarely needed.
    - **Liver cancer screening tests:** Blood tests or ultrasound recommended for people with cirrhosis to get every six months.
- 

### 3. REVIEW INFO

Sample questions:

- “Do you have any symptoms of Hep C that concern you?”
- “Have you had evaluation to check if you have liver damage?”
- “What is your stage of liver damage?”

## HEP C BASICS: HOW IS HEP C TREATED?

### 1. ASSESS NEED

Sample questions:

- “Have you ever been treated for Hep C before?”
  - “If yes, what year? Were you cured, not cured, or infected again?”
  - “What have you heard about Hep C treatment?”
- 

### 2. TELL PATIENTS

1. Treatment is now **easier, shorter, and much more likely to cure Hep C** than in the past.

- Most people can be cured by taking antiviral medication for 12 weeks, or sometimes less.
- Treatment is now almost always pills, once a day, with few side effects.
- Sustained virologic response (SVR) is the term for cure in Hep C. SVR is achieved when no virus is found in the blood at 12 or 24 weeks after finishing treatment.

2. Your doctor will work with you to choose the best medication for you.

- This depends on what type (genotype) of Hep C you have, if you’ve ever been treated for Hep C before, and how much liver damage you have.

3. Get treated for Hep C to:

1. Remove the virus from your body
2. Slow down, stop, or reverse liver damage
3. Keep you from getting sicker
4. Keep you from needing a liver transplant
5. Keep you from developing cirrhosis or liver cancer

4. If you are cured, you will no longer be at risk of passing Hep C along to others.

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### 3. DISCUSS

Sample questions:

- “Would you like to get treated for Hep C?”
- “Why or why not?”

## GETTING READY FOR HEP C CARE: IMPROVING MENTAL WELLNESS

### 1. TELL PATIENTS

1. Living with Hep C can be stressful. It is common to experience:

- Extreme fatigue
- Sleep problems
- Aches and pains
- Stomach problems
- Fears related to health
- Social isolation
- Depression
- Anxiety

2. Any of the above issues can affect your mental health, which includes:

- Thoughts, feelings, emotions, and energy

3. People with unstable mental health often face health care barriers.

- Managing your mental health can help you get through medical care and treatment.

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### 2. ASSESS NEED AND DISCUSS

Sample questions:

- “Have you ever been diagnosed with a mental health issue?”
- “Are you taking any psychiatric medications?”
- “Do you currently see a therapist or counselor?”
- “Do you have any mental health concerns you would like help with?”

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### 3. MAKE A PLAN

If the patient expresses concerns, but is not receiving services, say:

It may be helpful to **speak with a professional** if you notice that mental health issues are getting in the way of your day-to-day activities or goals.

- This includes working, eating, sleeping, or relationships.

Record referrals on the *Care Plan*.

## GETTING READY FOR HEP C CARE: DOES DRINKING ALCOHOL DAMAGE THE LIVER?

### 1. ASSESS NEED

Use the “*Alcohol Screening and Counseling for Hepatitis Patients*” guide to assess current alcohol use and identify need for alcohol counseling. This guide includes the:

1. Alcohol Use Disorders Identification Test (AUDIT)
  2. Substance Abuse Brief Intervention and Referral for Treatment (SBIRT)
- 

### 2. TELL PATIENTS

1. Alcohol is very hard on the liver.
    - Alcohol can damage or kill liver cells.
    - Alcohol greatly increases risk for developing cirrhosis and liver cancer if you have Hep C.
  2. If you have Hep C it is safest not to drink any alcohol.
    - This includes beer, wine, whiskey, and all other liquors.
  3. People who use alcohol often face Hep C treatment barriers.
    - Cutting down or stopping drinking can help you get ready for treatment.
  4. If you cannot stop drinking completely, cutting down can help.
    - The less you drink the better.
- 

### 3. MAKE A PLAN

For patients that drink, provide alcohol counseling as indicated in “*Alcohol Screening and Counseling for Hepatitis Patients*” and develop an action plan for cutting down on alcohol.

## GETTING READY FOR HEP C CARE: REDUCING THE HARM OF DRUG USE

### 1. ASSESS NEED

Use the **Drug Abuse Screening Test (DAST)** to assess current drug use and identify the patient's need for harm reduction services or substance abuse treatment. Ask specifically about injection drug use when using the DAST.

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### 2. TELL PATIENTS

1. **Sharing drug use equipment** is the most common way that Hep C is passed from one person to another.
    - All equipment used for injecting drugs can pass along Hep C. This includes: needles, syringes, razors, cutters, ties, cookers, cups, rinse water, spoons, cotton, and filters.
    - Pipes, straws, rolled money or other snorting equipment can also pass along Hep C.
  2. People who use drugs often **face Hep C treatment barriers**.
    - Cutting down or stopping drug use can help you get ready to start treatment.
  3. Each drug has different health risks. Some drugs are very hard on the liver.
- 

### 3. DISCUSS & MAKE A PLAN

1. Use page 8 of this Health Promotion Guide ("Guide for Improving Readiness to Change") to guide a conversation that can help motivate patients to reduce or stop drug use.
2. Record goals and action items on the *Care Plan*.



## GETTING READY FOR HEP C CARE: PROTECT YOUR LIVER

### 1. ASSESS NEED

Sample question: “How do you keep your liver healthy?”

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### 2. TELL PATIENTS

1. Tell **all** of your doctors that you have Hep C.

- Your doctors can help you avoid medications that may harm your liver.

2. **Ask your doctor** before taking over-the-counter medications, natural or herbal medicines, vitamins, or supplements.

- Some over-the-counter medications such as acetaminophen (Tylenol), vitamins, supplements (such as iron), or “natural” drugs can be dangerous to your liver.
- No “natural medication” is known to work for treating Hep C.

3. Eat a healthy diet, exercise, and maintain a healthy body weight.

- Being overweight and/or eating an unhealthy diet can lead to fat build up in the liver (“fatty liver”) and can cause liver damage.
- Exercise at least two to three times a week for 30 minutes each time.
- Avoid sugary food and drinks. Eat more fruits, vegetables, and high-fiber foods.

4. Smoking tobacco can damage the liver.

5. Other health conditions can worsen liver damage.

- These conditions include HIV, Hep B, diabetes, obesity, and metabolic syndrome.
  - Some conditions, like heart disease, can make Hep C treatment more difficult.
  - It’s important to manage these conditions to improve overall health and reduce stress to the liver.
- 

### 3. MAKE A PLAN

Sample question: “Which of the tips above would help you keep your liver healthy?”

Complete the “Health Goals” section of the *Care Plan*.

## GETTING READY FOR HEP C CARE: GETTING SUPPORT

### 1. TELL PATIENTS

Sample opening statement: “Health insurance, financial issues, housing, legal issues, and relationships with family and friends can all affect your health.”

---

### 2. ASSESS NEED & DISCUSS

1. **Health insurance** can help cover your Hep C care and treatment.

- Some people without insurance may get free medications through patient assistance programs.
- Ask patients, “Do you have health insurance?”

2. If you are having trouble **making ends meet**, it can be difficult to focus on your health.

- “In the last year, have you had trouble paying for food, housing, medications, heat or other basic needs?”

3. **Not having a stable place** to live is stressful and can make it hard to keep taking your meds or take care of your health.

- “In the last year, where have you lived?”
- “Where are you living now? How long will you live there?”

4. Dealing with **legal issues** can be stressful and can take a lot of time.

- “Were you incarcerated in the last year?”
- “Were you incarcerated ever?”
- “Do you have any legal issues now?”

5. **Feeling alone** can make it hard to deal with your health.

- “Do you have family or friends you can talk to about your health?”
  - “Would you be interested in going to a Hep C support group?”
- 

### 3. MAKE A PLAN

Provide a list of suggested referrals to review with patient.

Ask if he or she accepts the referrals:

- If yes, document on *Care Plan* and review with patient.
- If no, ask patient if you can discuss again in the future.

## GETTING READY FOR TREATMENT: ARE YOU READY TO START TREATMENT?

### 1. ASSESS NEED

If possible, this discussion should take place with the patient's doctor present.

Sample question: "You are recommended to start treatment. On a scale of 1 to 10, how ready are you to start?"

---

### 2. TELL PATIENT

1. Hep C can be cured by taking antiviral medication.
    - If you are cured, you are less likely to develop liver disease and cancer, and you will be healthier overall.
  2. Take your meds at the same time every single day.
    - If you miss doses, the treatment is less likely to work and resistance to the medication can develop.
    - Planning ahead helps prepare for unexpected situations and ensure that you take your meds each day.
  3. If you have side effects, contact your doctor or navigator right away.
    - Don't stop taking your medications without talking to your doctor first.
- 

### 3. DISCUSS & MAKE A PLAN

Review and complete *Treatment Planning Form* with patient. Make sure that patients understand their prescribed regimen and plan strategies for preventing missed doses.

---

### 4. REVIEW INFO

1. Ask patient to describe their treatment regimen in full.
2. Ask patient, on a scale of 1-10, how confident he or she is to take all medications as prescribed for the duration of treatment.

## AFTER TREATMENT: STAYING HEALTHY AND AVOIDING HEP C

### 1. ASSESS NEED

Sample question: “Can you get Hep C again, after you have been cured?”

---

### 2. TELL PATIENT

1. An “undetectable” Hep C viral load means there is **no Hep C virus** found in your blood.
  - **Sustained virologic response (SVR)** is the term used for cure in Hep C. If your viral load remains undetectable 12 or 24 weeks after treatment, you are **cured**.
2. You can always get infected with Hep C again, **even if you are cured**.
  - There is no Hep C vaccine. There is no immunity to Hep C.
  - You can get re-infected from **your own old blood from before you were cured**. Throw away any razors, clippers, toothbrushes, washcloths or anything that may have your old blood on it.
  - If you use drugs, **only use new or sterile** drug use equipment. Medications such as methadone and buprenorphine can help you avoid many health risks.
  - Avoid **other people’s blood**. Do not share personal care items, such as toothbrushes, razors, needles, nail files/clippers/scissors, or washcloths.
3. Keeping seeing your doctor to keep track of your health.
4. If you have cirrhosis, you need liver cancer screening every six months.

For patients for whom Hep C treatment was not effective, reassure patient that new Hep C medications may be available in the future.

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### 3. MAKE A PLAN

1. Review the medical follow up visit plan recommended by the doctor.
  2. Review the “Getting Ready for Hep C Care: Protect Your Liver” section on page 21.
- 

### 4. REVIEW INFO

Sample question: “What will you do to stay healthy and avoid Hep C after treatment?”

# KNOW HEP C

- **Hepatitis C** can lead to **liver disease** and cancer.
- Hep C is spread through **blood**.
- You can get Hep C by **sharing drug use equipment** (injecting, smoking, or snorting) or having **unprotected sex**.
- Syringe exchange and **harm reduction** can protect you from Hep C.
- **Get tested** to know if you have Hep C: antibody test first, then confirmatory test.

# CURE HEP C

➤ **Hep C can be cured.**

Treatment is now shorter and more effective than before. Side effects are less severe.

➤ **You can get re-infected** with Hep C. Protect yourself from blood exposure.

➤ **Avoid alcohol** if you have Hep C. Alcohol speeds up liver damage.

**Contact for help getting tested or treated:**

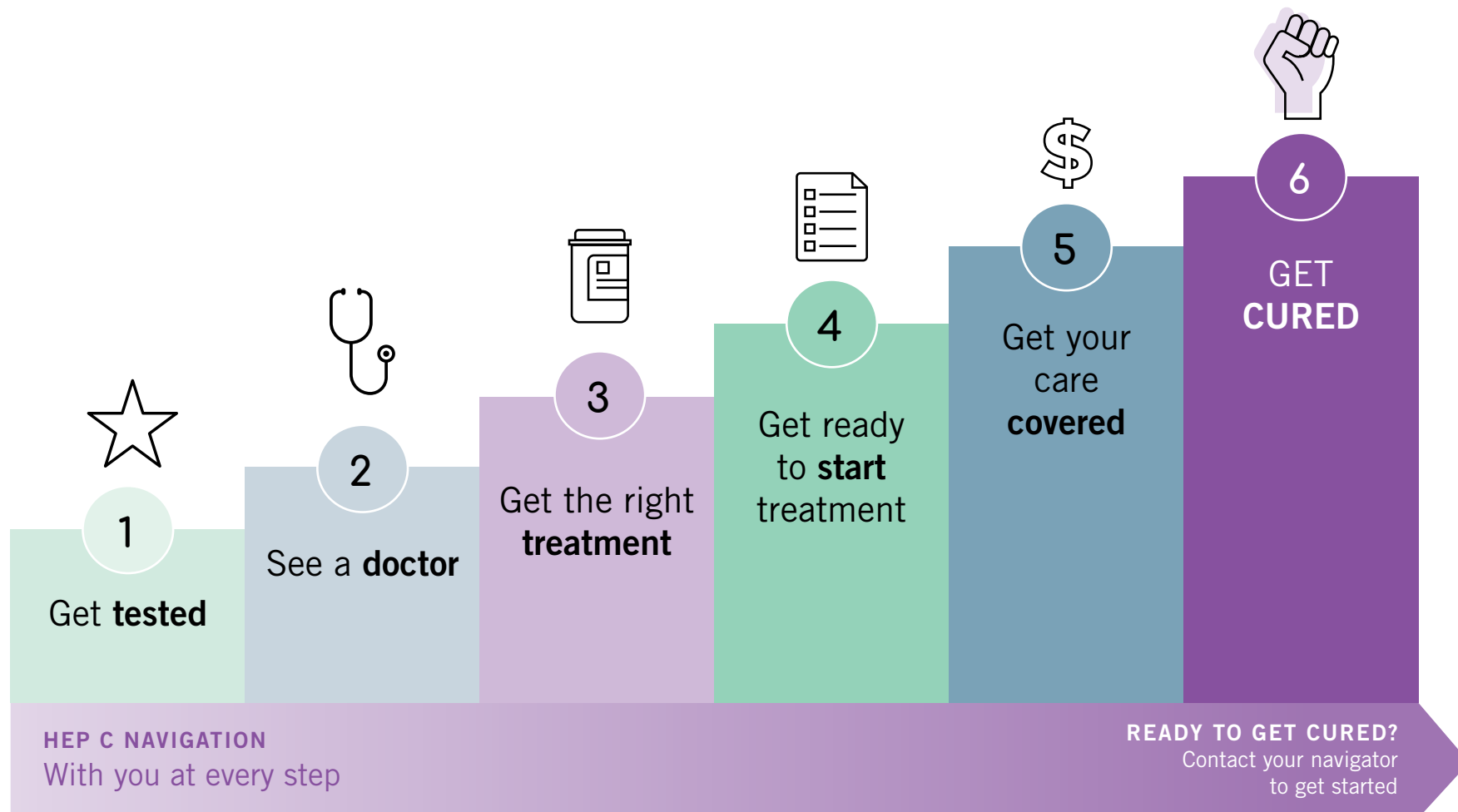
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<https://www.cdc.gov/knowmorehepatitis/HepatitisC-FAQ.htm>

# Steps to Hep C Care and Cure



Hep C is a big deal. **But it can be cured.**  
You don't have to go through it alone.



# Steps to Hep C Care and Cure



**Everyone** deserves the best care for their Hep C.  
We can help you get care and cure.

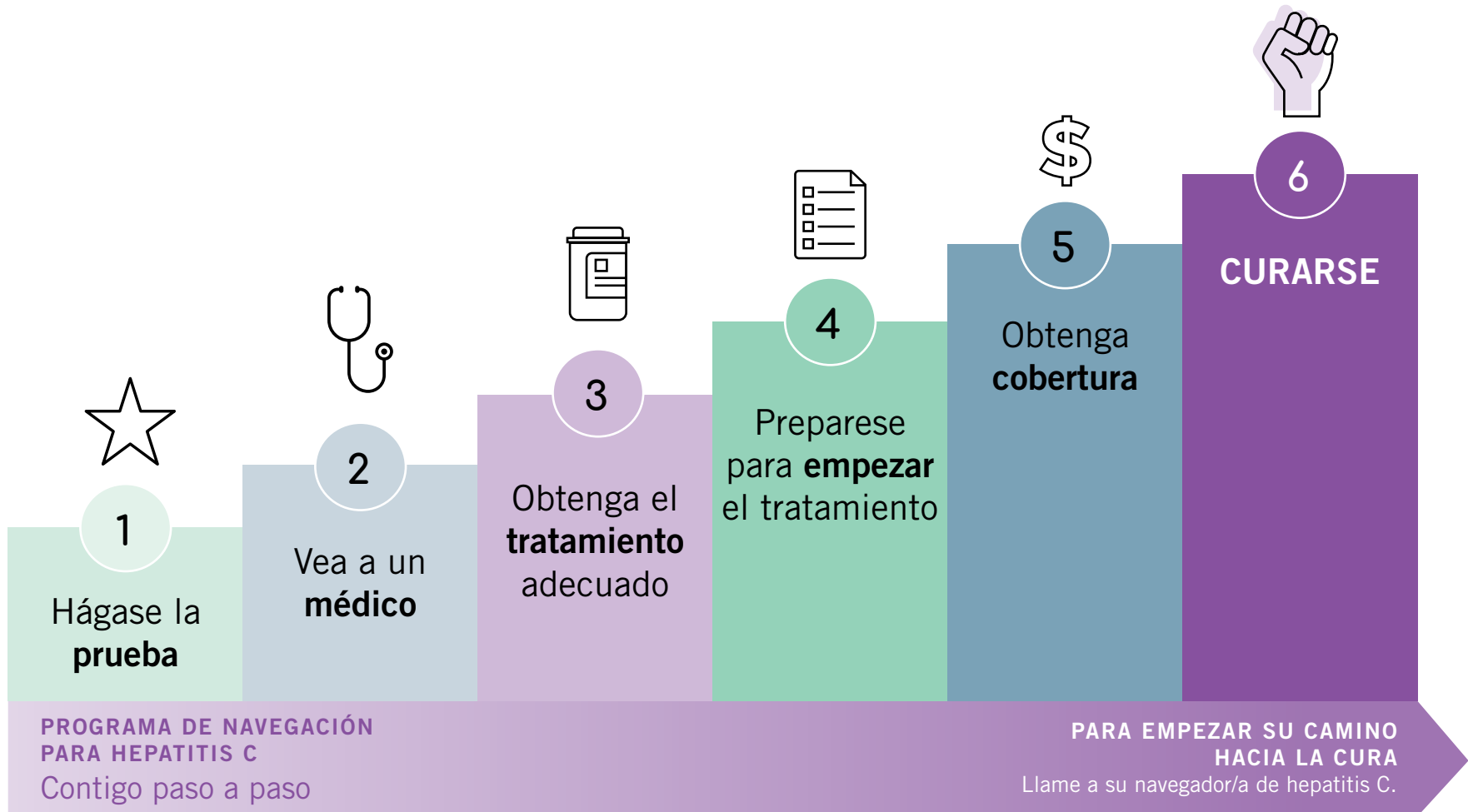




# Pasos para Cuidarse y Curarse de Hepatitis C



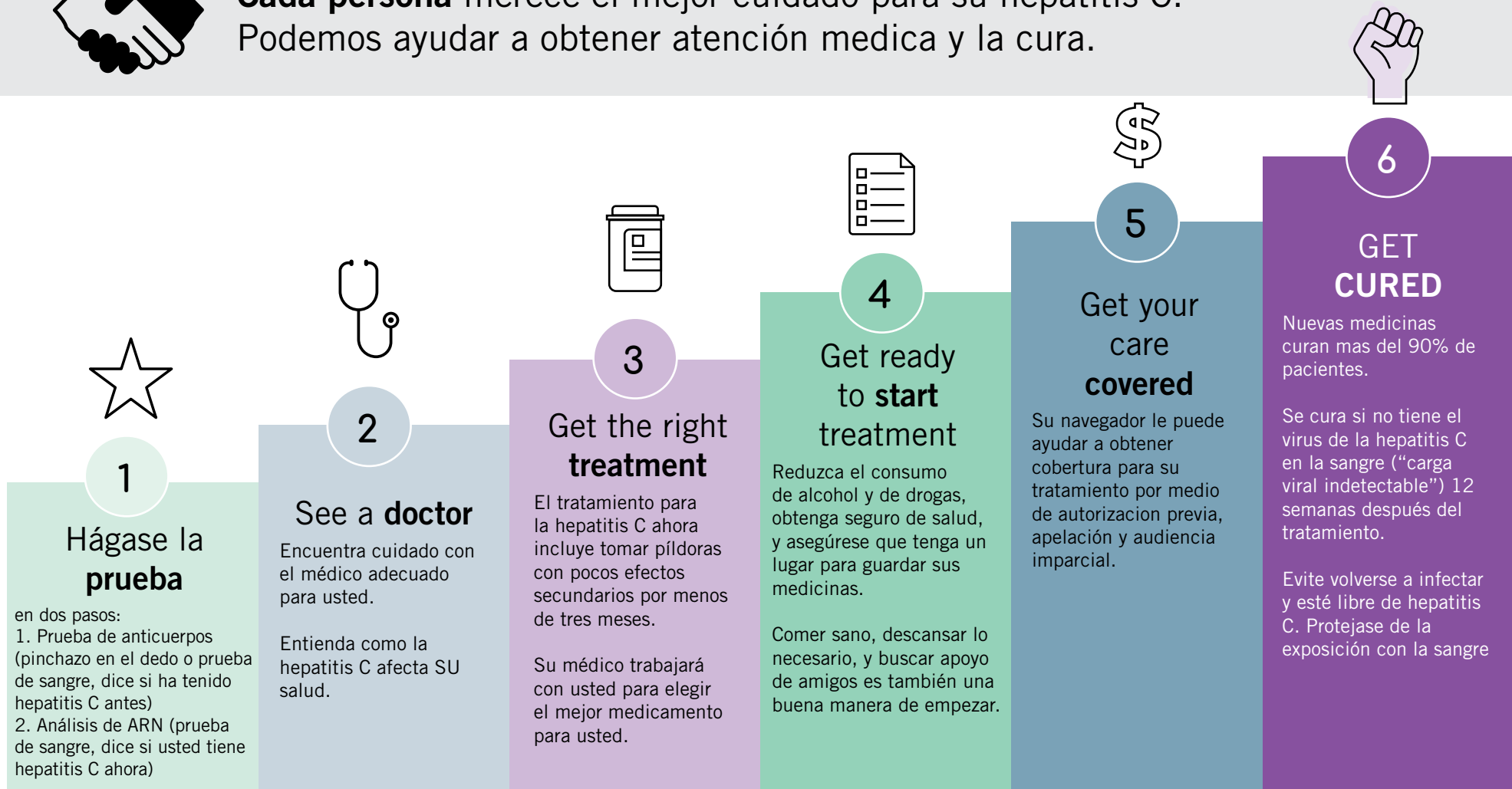
La hepatitis C es una enfermedad seria. **Pero se puede curar.**  
Podemos apoyarle y guiar en su camino.



# Pasos para Cuidarse y Curarse de Hepatitis C



**Cada persona** merece el mejor cuidado para su hepatitis C. Podemos ayudar a obtener atención médica y la cura.



**PROGRAMA DE NAVEGACIÓN PARA HEPATITIS C**  
Contigo paso a paso

**¿TODAVIA NO SABE SI EMPEZAR EL TRATAMIENTO?**  
Aprenda más acerca de la hepatitis C: Visita

# Appointment Card

Improving Care for People Who Use  
Drugs and Other Impacted Populations

For: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ ☐ AM ☐ PM

Provider: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Please bring:

☐ Photo ID card ☐ Health insurance card ☐ \_\_\_\_\_

# Your Rights as a Patient

All patients have a right to:

- Have a family member, peer navigator, or other adult go with you to medical appointments
- Have an interpreter or translator if needed
- Receive medical care with respect, without discrimination, and in a clean and safe environment
- Receive complete information about your health and any medical conditions
- Participate in all decisions about your care and treatment
- Refuse services and know how this may affect your health

# Recuerde su cita

Improving Care for People Who Use  
Drugs and Other Impacted Populations

Para: \_\_\_\_\_

Fecha: \_\_\_\_\_ Hora: \_\_\_\_\_ ☐ AM ☐ PM

Médico/Profesional: \_\_\_\_\_

Dirección: \_\_\_\_\_

Teléfono: \_\_\_\_\_

Por favor traer:

☐ Tarjeta de identificación

☐ Tarjeta de seguro de salud

☐

\_\_\_\_\_

# Sus Derechos Como Paciente

Cada paciente tiene derecho a:

- Tener un familiar, navegador, u otro adulto que le acompañe a citas médicas
- Tener un intérprete si es necesario
- Recibir atención médica con respeto, sin discriminación, y en un ambiente limpio y seguro.
- Recibir información completa acerca de su salud y de alguna condición médica.
- Participar en todas las decisiones sobre su salud y tratamientos médicos.
- Rechazar servicios y entender como esto afectaría su salud.

## Keeping in Contact to Support Hep C Treatment

*The following techniques are only to be employed if the client consents/agrees to be found.  
All client confidentiality and HIPPA guidelines, policies and procedures should be followed as usual.*

### RELATIONSHIP BUILDING

- The better relationship you have with the client, the more likely they will return & engage in care.
- Form a care team for patients likely to fall out of care, the patient may return for another appointment and if you are aware of the appointment, you can reengage.
- [Form linkage agreements](#) with organizations in the area to work together on shared cases. If the client does not return to one site, they may return to another.

### ASKING THE RIGHT QUESTIONS AT INTAKE:

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> If we needed to, are you easy to find?</li> <li><input type="checkbox"/> Do you have a phone? (If no, see below “Free Mobile Phone”)</li> <li><input type="checkbox"/> What is the best time of day to reach you by phone?</li> <li><input type="checkbox"/> Where is the best place to find you? What is the best time to find you?</li> <li><input type="checkbox"/> Besides this location, where else do you hang out?</li> <li><input type="checkbox"/> Do you access food services/shelters/methadone program/needle exchanges? If yes, which one(s):</li> <li><input type="checkbox"/> Where and when do you pick up your checks?</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Do you have a mailing address? Some clients use a friend, family member or social network address. If you get this information, you can send them a reminder letter to come to the office.</li> <li><input type="checkbox"/> Do you have a social network? For example: Do you have a close friend that serves as your go-to contact for emergency reasons? If yes, can we get his/her name and contact information?</li> <li><input type="checkbox"/> Do you have e-mail or a social media account (Facebook, Twitter, Instagram, etc)?</li> <li><input type="checkbox"/> Do you have transportation to get to appointments?</li> </ul> |
|--|--|

### GOOGLE MAPS

- Use to verify client's address.
- See the street view to get a picture of the building/neighborhood & assess safety for home visits.
- Use to find transportation or directions for client to use when returning for their appointment.

### TAKING PICTURES OF CLIENTS (follow agency guidelines to protect patient confidentiality)

- Keep photos in client's chart to remember their face or to identify a client that staff has not met.
- Keep photos of the client's insurance card or secondary insurance card

### APPOINTMENT CARD STRATEGY

Use staff business cards as appointment cards or design business cards with space on the back for follow-up appointment details.

### INCENTIVES

- Use for results & follow-up appointments (more important at these appointment then at screening).
- Low-cost & desirable items specifically targeting transient populations such as food bags, hygiene packs, metro cards, cash incentives (\$10), grocery store/pharmacy gift cards.

### CONTACTING CLIENTS

- Telephone Calls: at least 3 attempts at different times of the day.
- Site Visits: Place where client frequents often (e.g., shelter, soup kitchen, needle exchange).
- Home Visits: Ask when likely to be found at home.
- Social Media: Send a private message on Facebook, Twitter, or Instagram. Also call through Facebook.

### FREE MOBILE PHONE

- Free mobile phones can be provided for people with low income - [Safe Link](#) or [Assurance Wireless](#).
- [Google Voice](#) application provides a phone number that can be used for voice calls or text messages. Access via internet at public libraries or on smartphone application with Wi-Fi.

### WHEN CLIENT IS MIA

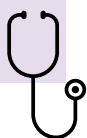
- ePACES – Verifies Medicaid eligibility claims and provides their address(es).
- Contact Court System ([Parole Officers](#)). Try the [NYS Department of Corrections Inmate Lookup](#)
- Free online people search programs: [Zabba Search](#) [Whitepages](#) [search.com](#) [Peoplesearch.com](#) [Peoplesmart.com](#) [Spokeo.com](#) [411.com](#) [fastpeoplesearch.com](#)
- [HIV Care Status Reports System](#) provides information to NYC clinicians on out-of-care patients.

[nastad.org/hepatitis-navigation-toolkit](http://nastad.org/hepatitis-navigation-toolkit)

## Recommendations for Hepatitis C Screening and Treatment in People Who Use Drugs

Test people who use drugs (PWUD) for Hep C at least annually

TEST TYPE	TEST RESULT	
	If positive (+)	If negative (-)
<b>Antibody Test:</b> Use to test people who have never tested Hep C positive.	Confirm with RNA Test (Reflex RNA testing is ideal)	Retest in 12 months with antibody test
<b>RNA Test:</b> Use to test people who have ever tested Hep C positive.	Link to Hep C medical care	Retest in 12 months with RNA test



### All PWUD with Hep C should be evaluated for treatment

- Hep C is treated with oral medications in 8–12 weeks with few side effects. See the algorithm for the management and cure of Hep C infection at [www.bit.ly/simplified-hepc](http://www.bit.ly/simplified-hepc).
- Over 90% of PWUD with Hep C who are treated achieve a cure, less than 5% get reinfected.
- Curing Hep C prevents ongoing transmission to drug-sharing and sexual partners.
- Patient-centered care practices including Hep C patient navigation can help PWUD get care and complete treatment. To find a program, visit: \_\_\_\_\_



### Health Insurance approves Hep C medications for PWUD

- [add a sentence about your locality's insurance requirements]  
\_\_\_\_\_
- Specialty pharmacies can support the medication prior authorization process.
- Local resource for prior authorization appeals and applications (legal aid, attorney general, state medicaid office)



### Prevent Hep C and Overdose

- Link people to harm reduction and syringe service programs <https://nasen.org/map/>
- Link people to medication-assisted treatment, such as buprenorphine [SAMHSA bupe locator](#)
- Provide Naloxone <https://nextdistro.org/naloxone> and prevention tips [www.bit.ly/opioid-overdose-basics](http://www.bit.ly/opioid-overdose-basics)

### Resources

- To find Hep C patient navigation programs and programs for uninsured visit: \_\_\_\_\_
- Clinical Education Initiative (CEI) Hepatitis C and Drug User Health Center of Excellence: [www.ceitraining.org](http://www.ceitraining.org)
- American Association for the Study of Liver Disease - Identification and Management of Hepatitis C in People Who Inject Drugs: [hcvguidelines.org/unique-populations/pwid](http://hcvguidelines.org/unique-populations/pwid)
- For more information email: [HepProgram @ state.gov](mailto:HepProgram@state.gov)



## Additional Tools and Resources

### Public Education Materials used in Hep B and C Navigation

1. Liver 3D Model or Picture Example
2. [Hepatitis C Basics](#) (also in [Spanish](#)) from Harm Reduction Coalition
3. [Online HCV Drug Guide – Positively Aware](#)
4. [HCV Medication Factsheets](#) from Treatment Action Group
5. [Hep C Free Postcard](#) from AETC
6. [Hep C and Women booklet](#) from NYS DOH
7. [Hepatitis C More Than Liver Disease Factsheets](#)– National Viral Hepatitis Roundtable
8. [Hep C Screening and Treatment Recommendations in People Living with HIV/AIDS](#) – AIDS Education & Training Center
9. [Hepatitis C and Your Liver Brochure](#) (also in [Spanish](#), [Arabic](#), [Russian](#), [Urdu](#)) – NYC Health Department
10. [Hepatitis C: Get Tested, Get Cured Pocket Card \(English\)](#) (also in [Spanish](#) and [Russian](#)) – NYC Health Department
11. [Reduce Your Risk of Overdose, Hep C & HIV](#) (also in [Spanish](#) and [Russian](#)) – NYC Health Department
12. [Get Hep C Checked Posters](#) (also in [Spanish](#)) – NYC Health Department
13. [Get Hep C Cured Posters](#) (also in [Spanish](#)) – NYC Health Department
14. [Alcohol Screening and Counseling for Patients with Hepatitis: Guide for Health Care Providers](#)
15. [Alcohol and Hepatitis Patient Palm Card](#) (also in [Spanish](#))
16. [Hepatitis B: The Facts Brochure](#) (also in [Español](#) | [中文](#) | [Français](#) | [한국어](#) | [Русский](#) | [বাংলা](#) | [Shqiptar](#) | [O'zbek](#)) – NYC Health Department
17. [Hepatitis B Vaccine Tracker Brochure](#) (also in [中文](#) | [Español](#) | [Français](#)) – NYC Health Department
18. [Hepatitis A and Hepatitis B Vaccination in People Who Inject Drugs](#) – CDC

### Videos:

1. General Hep Info curated playlist  
<https://www.youtube.com/playlist?list=PLLVLalLMgJ6nYu0hQsLqwUWbvfixGIT21>
2. Hep B Info curated playlist  
<https://www.youtube.com/playlist?list=PLLVLalLMgJ6mveCnkL3F9DhnmbAgjWw-e>
3. Hep C Info curated playlist  
<https://www.youtube.com/playlist?list=PLLVLalLMgJ6IJ0eR9YFeIQ-lswhad5rei>
4. Hep B Stories curated playlist  
<https://www.youtube.com/playlist?list=PLLVLalLMgJ6Ixf25d-vxKOKoknIK5Vf7R>
5. Hep C Stories curated playlist  
<https://www.youtube.com/playlist?list=PLLVLalLMgJ6miWm3iDoAzbl1YvqLwCj7I>

## Resources

1. Drug User Health Network in your region
2. Harm Reduction Coalition ([www.harmreduction.org](http://www.harmreduction.org))
3. Food Finder US ([www.foodfinder.us](http://www.foodfinder.us))
4. Hep C Testing Locations: NYC HealthMap
  - <https://a816-healthpsi.nyc.gov/NYHealthMap>
5. Low-cost care at federally qualified health centers [www.findahealthcenter.hrsa.gov](http://www.findahealthcenter.hrsa.gov)
6. Healthcare Access and Meds ([www.hepfree.nyc/health-care-access-meds](http://www.hepfree.nyc/health-care-access-meds))
7. Hep C Drug Guide (<https://www.positivelyaware.com/hcv-drugs>)
8. New York State Medicaid Hep C Medication Prior Authorization Checklist
  - [https://newyork.fhsc.com/downloads/providers/NYRx\\_PDP\\_CHC\\_checklist.pdf](https://newyork.fhsc.com/downloads/providers/NYRx_PDP_CHC_checklist.pdf)
9. SAMHSA treatment locator
  - <https://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator>
10. Integrating Peer Workers into Health Care Service Delivery for Program Directors and Supervisors
  - Webinar, 90 minutes:  
<https://www.hivtrainingny.org/User?hdnSubject=295&sortdir=ASC&endDate=1%2F1%2F9999>
11. State or Local ID card application instructions
12. National Reentry Resource Center
  - [www.nationalreentryresourcecenter.org](http://www.nationalreentryresourcecenter.org)