Center for Asian Health Equity

Asian Health Coalition
University of Chicago Medicine

HBV Testing Linkage to Care Webinar

October 30, 2018

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Clinician Advisory Board includes Cook County Health & Hospitals System (CCHHS) Ruth M. Rothstein CORE Center, Chicago Department of Public Health, University of Chicago Medicine, Sinai Health System Touhy Health Center, Heartland Health Center

Provider Partners are Touhy Health Center (Sinai Health System) and Heartland Health Center

10 Community-based Partner Organizations

Asian American Demographics in Illinois: The Diversity

Country Of Origin	Rounded Estimate
South Asian	203,000
Filipino	110,000
Chinese	95,000
Korean	64,000
Vietnamese	25,000
Japanese	17,000
Thai	6,500
Laotian	6,000
Cambodian	4,000
Other Asian	22,000
TOTAL	**552,500**

- **Chicago Metropolitan Area has the 6th Largest Asian American Population In the Nation**
- **65% of Asians in Illinois are Foreign Born**
- **80% Speak a Language Other Than English**
- **32.8% Speak English "Less Than Well" (9.6% for IL State)**
- **12% Poverty Rate for Asian Individuals Age 65 and Over (8.9% for IL State)**

Less Than 1 in 5 Uninsured Asian Americans in Illinois Receives Care at a Community Health Center

	ASIAN POPULATION			SAFETY-NET PATIENTS BY ETHNICITY		
	TOTAL ASIANS	% ASIAN UNINSURED	UNINSURED	ASIAN	TOTAL	% ASIAN
CALIFORNIA	4,900,963	*14.8%*	725,343	160,040	2,937,212	*5.4%*
NEW YORK	1,433,875	*16.4%*	235,156	63,748	1,417,414	*4.5%*
TEXAS	969,500	*21.6%*	209,412	8,002	948,685	*0.8%*
NEW JERSEY	725,077	*16.3%*	118,188	9,533	432,328	*2.2%*
HAWAII	530,937	*6.3%*	33,449	26,652	130,309	*20.5%*
ILLINOIS	590,174	*16.3%*	96,198	15,547	1,092,164	*1.4%*

The lack of culturally competent health service delivery in Illinois suggests the large majority of medically indigent are still displaced from access to care.

Community-based organizations play a critical role to mitigate the infrastructure gap through community health promotion/self-management and prevention programs.

http://bphc.hrsa.gov/datareporting/index.html

Hepatitis Education and Prevention Program (HEPP)

Established in 2005

Multilevel intervention addressing gaps in hepatitis B education, screening and vaccination

Socioecological framework

Address individual, community, organization and policy level changes (social determinants of health)

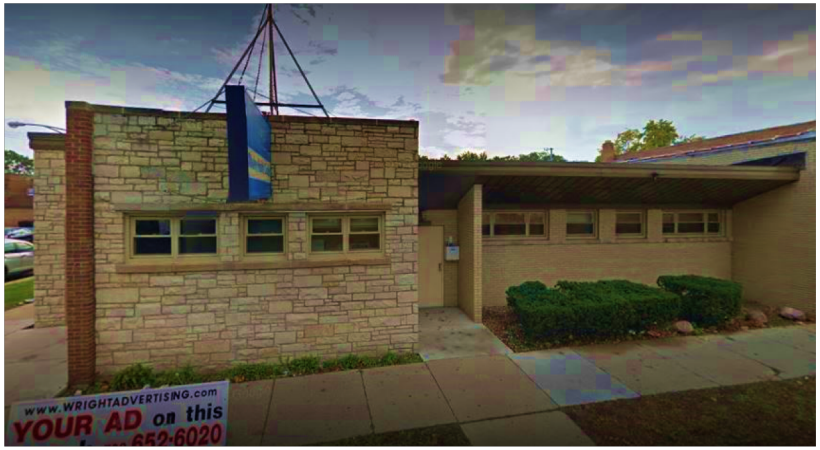
Community Health Workers

HEPP Accomplishments 2006-2011

Activity	Year						
	2006	2007	2008	2009	2010	2011*	**Total**
People Educated	3,495	4,787	7,800	6,029	8,031	2,743	**32,885**
No. Group Educations	56	49	32	47	47	33	**264**
No. Health Fair Events	0	9	8	12	15	19	**63**
No. Referred for Screening/Immunization	1,432	3,770	3,318	5,672	3,105	197	**17,494**
Brochures Distributed	2,555	1,343	3,476	6,060	2,455	1620	**17,509**
Adults Screened at AHC Organized Events	405	401	276	270	311	476	**2,139**

Despite enormous success, failure in adequate linkage to care

Our Clinic Partners



- Single hospital-affiliated refugee health center
- FQHC network with 15 community, school, and behavioral health centers
- One site has a single Hepatitis Patient Navigator (HPN) and the other has a team of three HPNs
- Both located on Chicago's northside

Our Community Partners

- Work with 10 community-based organizations that serve multiple Asian and African ethnicities
- CBOs have connection and trust with community
- Provide culturally and linguistically competent Hepatitis B education and outreach
- Link and refer community to clinics to be screened for Hep B

Community Partners

Primary Care Provider Partners

Heartland Health Centers

Touhy Health Center

HBV Treatment Specialists

- University of Chicago Medical Center
- Ruth M. Rothstein CORE Center

Community-Based Organizations

Korean American Community Services

Cambodian Association of Illinois

Chinese Mutual Aid Association

Lao American Organization of Elgin

Alliance for Filipino Immigrant Rights and Empowerment

Hanul Family Alliance

Vietnamese Association of Illinois

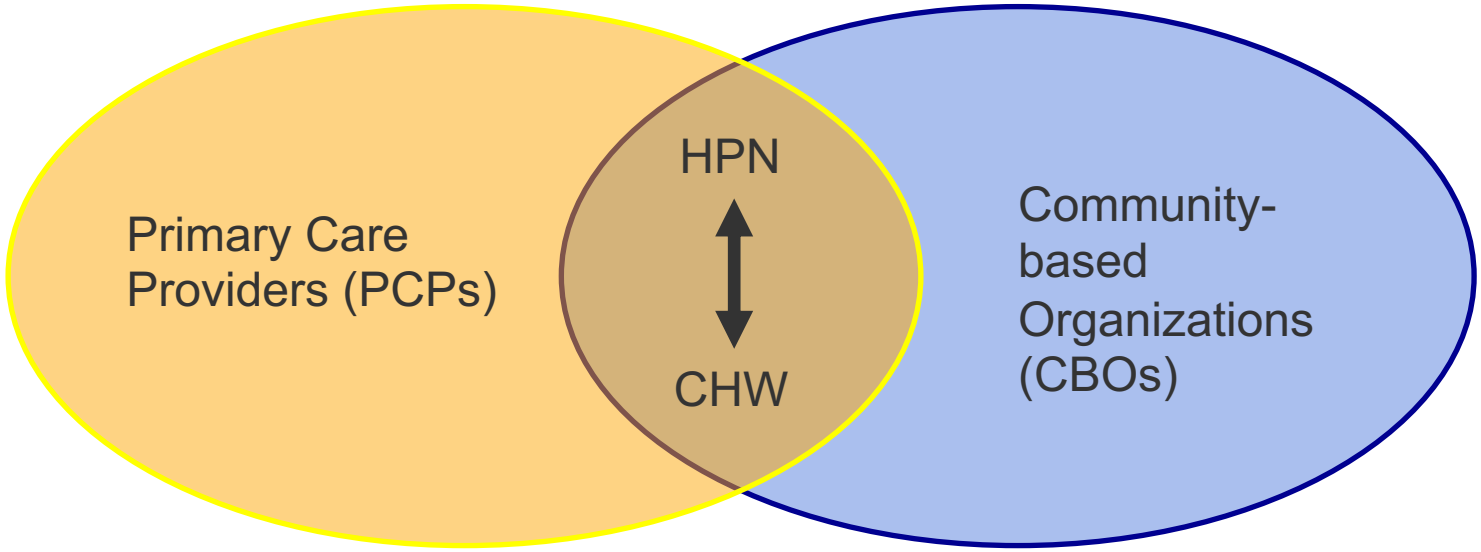
Muslim Women Resource Center

Ethiopian Community Association of Chicago

Hamdard Health

United African Organization

Hepatitis Patient Navigation-Community Health Worker Partnership



- <u>CHWs and HPNs will have joint:</u>
  - Reciprocal site and facility visits
  - Cultural competency training
  - Translation phone line training
  - HBV education and training
  - Medical Process and Linkage-to-care training

PNS-CHW Linkage

System Redesign

Hepatitis Patient Navigators (HPNs) will be assigned at each location

- Notify individuals of results
- Vaccinate susceptible patients at risk
- *Case Management for HBsAg+ patients – refer for additional lab testing, refer and schedule specialty care, assist with access and navigate barriers

Community Sites

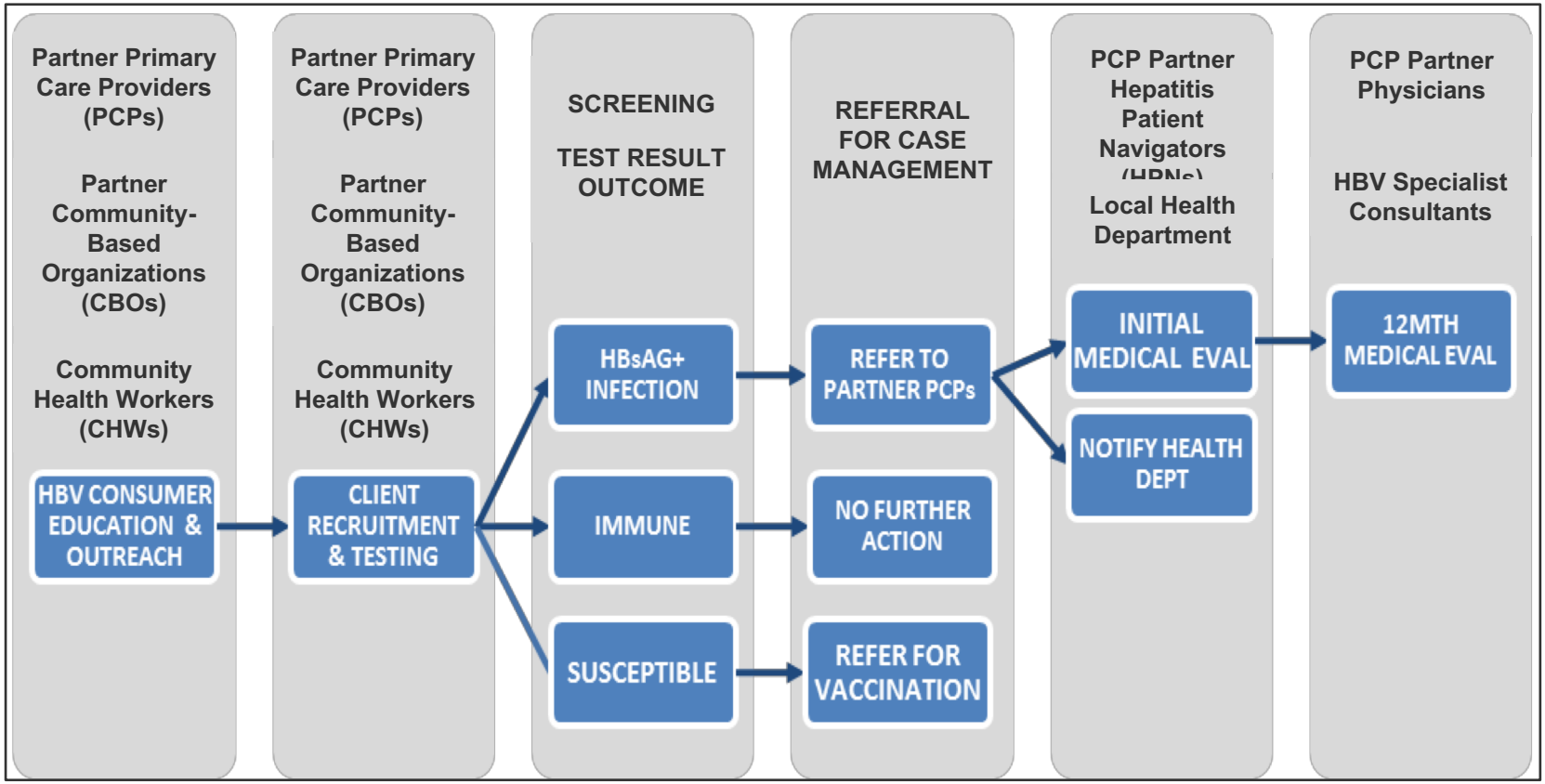
- Community-Health Workers (CHWs)
  - Provide culturally relevant education
  - Encourage screening at Health Centers or Free events
  - Notify patients of screening results
  - *Refer patients to local providers and PCP sites for vaccination and care of chronically infected

CHWs and HPNs work together to ensure patients schedule and make appointments

Patient Navigation

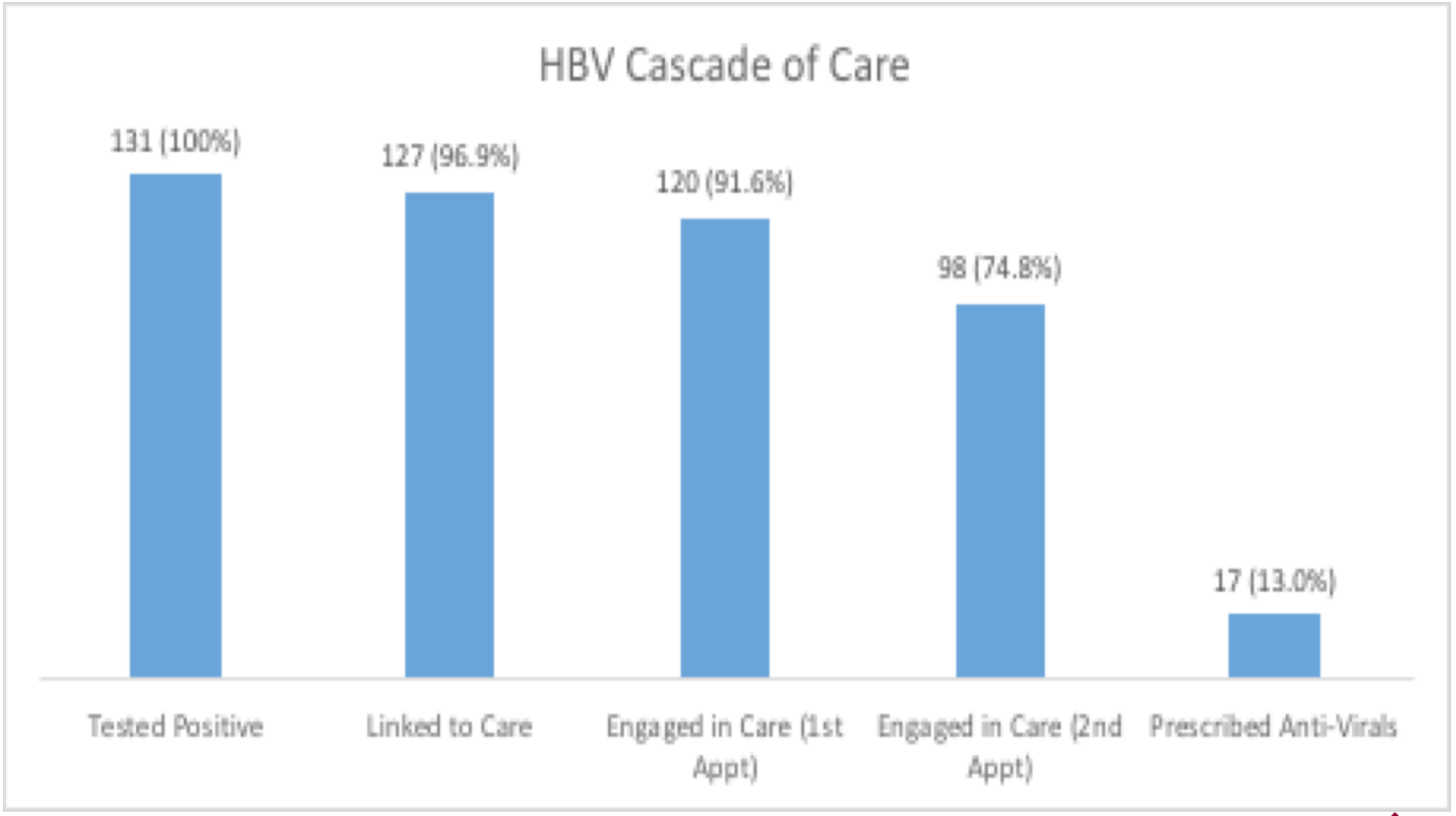
- Our Hepatitis Patient Navigators (HPNs)
  - Work with CBO's/CHWs to link community members to care
  - Identify potential high risk patients and "flag" them for HBV screening in the EMR
    - Hepatitis B surface antigen (HBsAg)
    - Hepatitis B core antibody (anti-HBc)
    - Hepatitis B surface antibody (anti-HBs)
  - Ensure anyone who tests Hepatitis B positive attend necessary follow-up medical visits, including referral to specialty care as needed
  - Work with HBV patients to help alleviate any potential challenges to health care service

Organizational Chart for Linkages to Lead Agency and Partners



Community Health Workers → Hepatitis Patient Navigators →

CHB Care Continuum



Program Successes- Provider and staff education

- Provided bi-annual HBV education to both providers and frontline staff
- Provider education was provided by medical professional and included:
  - Screening guidelines
  - Vaccination guidelines
  - Treatment guidelines
- Frontline staff education included:
  - HBV 101
  - Screening guidelines
  - Vaccination guidelines

Program Successes- Provider Recognition

- Provided a quarterly newsletter that recognized clinics and providers that screened the most individuals for HBV
  - This was determined by looking at the number of flagged patients during that given time and the number of those identified patients that were then screened
- Found that recognition helped with “pop up fatigue” and put a priority on HBV screening increasing screening rates

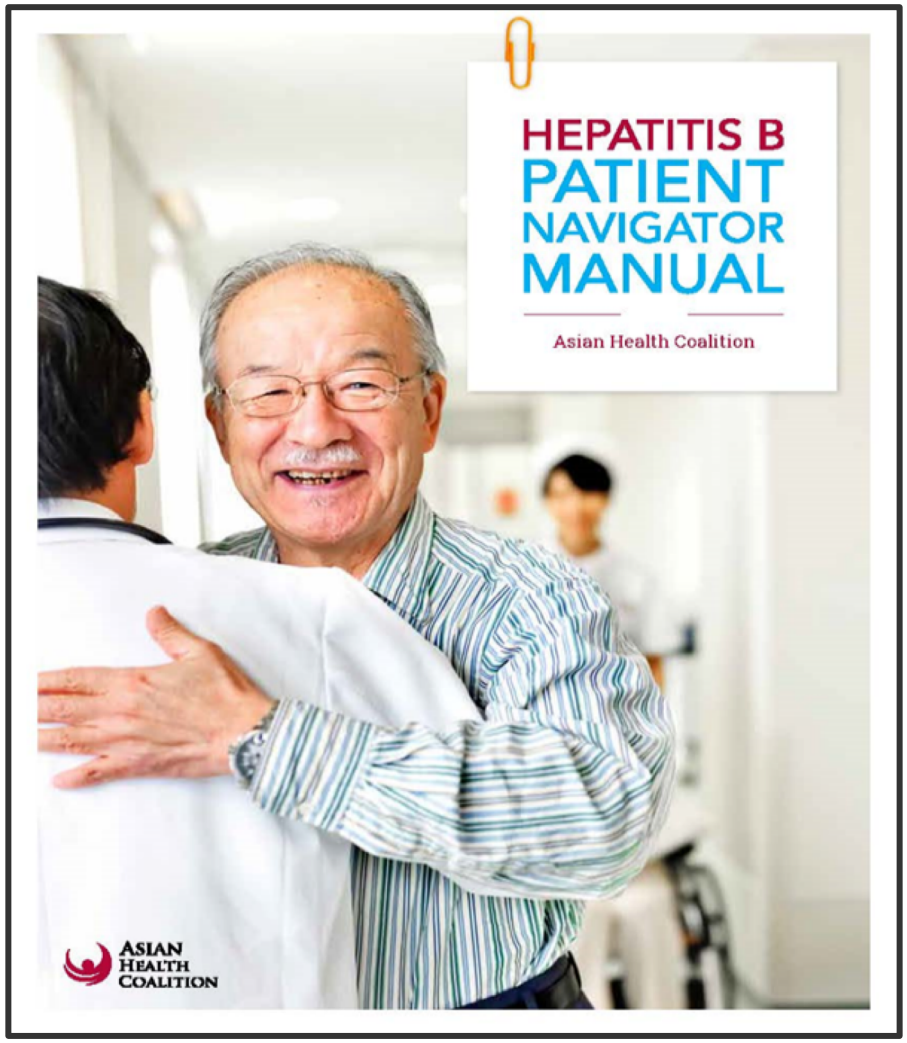
Program Successes- EMR Modifications

- Started collecting country of birth within the EMR to help identify potential individuals that need to be screened
- Enabled pop-ups that allowed for patient navigators to “flag” at-risk patients. Providers can then follow up on the flag and order the screening if needed.
- Modified EMR with “AHC HBV Panel” (HBsAg, anti-HBc, anti-HBs) to allow for easy “one-click” test ordering

What We Learned

- Every clinic is different (policy, process, provider practices)
- Provider education, progress updates, and recognition can increase HBV priority and screening
- Small changes (EMR pop-ups, easy check boxes, intake forms that collect COB) make a big difference
- Hepatitis B Patient Navigators are key to HBV+ patient linkage and engagement with care

Sharing Our Successes: HPN Manual



- A training and resource guide for HPNs
- Released in Spring 2016
- Disseminated to over 170 different partners nationwide

Conclusion

Our current data suggests a community-based Patient Navigator – Community Health Worker Partnership is successful in screening, notifying and navigating patients into medical care for chronic HBV infection

We have shown that community based screening is as effective in linking patients to care as clinic based screening using a HPN-CHW model