Project Staff

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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**

<table>
<thead>
<tr>
<th>Country Of Origin</th>
<th>Rounded Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Asian</td>
<td>203,000</td>
</tr>
<tr>
<td>Filipino</td>
<td>110,000</td>
</tr>
<tr>
<td>Chinese</td>
<td>95,000</td>
</tr>
<tr>
<td>Korean</td>
<td>64,000</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>25,000</td>
</tr>
<tr>
<td>Japanese</td>
<td>17,000</td>
</tr>
<tr>
<td>Thai</td>
<td>6,500</td>
</tr>
<tr>
<td>Laotian</td>
<td>6,000</td>
</tr>
<tr>
<td>Cambodian</td>
<td>4,000</td>
</tr>
<tr>
<td>Other Asian</td>
<td>22,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>552,500</strong></td>
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</tbody>
</table>

Chicago Metropolitan Area has the 6\textsuperscript{th} 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)
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)
# HEPP Accomplishments 2006-2011

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

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

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

HBV Treatment Specialists
• University of Chicago Medical Center
• Ruth M. Rothstein CORE Center
Hepatitis Patient Navigation-Community Health Worker Partnership

Primary Care Providers (PCPs)

HPN

CHW

Community-based Organizations (CBOs)

• CHWs and HPNs will have joint:
  • 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

- Partner Primary Care Providers (PCPs)
- Partner Community-Based Organizations (CBOs)
- Community Health Workers (CHWs)

HBV CONSUMER EDUCATION & OUTREACH

- Partner Primary Care Providers (PCPs)
- Partner Community-Based Organizations (CBOs)
- Community Health Workers (CHWs)

CLIENT RECRUITMENT & TESTING

SCREENING TEST RESULT OUTCOME

- HBsAG+ INFECTION
- IMMUNE
- SUSCEPTIBLE

REFERRAL FOR CASE MANAGEMENT

- REFER TO PARTNER PCPs
- NO FURTHER ACTION
- REFER FOR VACCINATION

PCP Partner Hepatitis Patient Navigators (HPNs)
- INITIAL MEDICAL EVAL
- NOTIFY HEALTH DEPT

Local Health Department
- 12MTH MEDICAL EVAL

Community Health Workers ➔ Hepatitis Patient Navigators ➔ PCP Partner Physicians

HBV Specialist Consultants
CHB Care Continuum

HBV Cascade of Care

- Tested Positive: 131 (100%)
- Linked to Care: 127 (96.9%)
- Engaged in Care (1st Appt): 120 (91.6%)
- Engaged in Care (2nd Appt): 98 (74.8%)
- Prescribed Anti-Virals: 17 (13.0%)
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.