

# “Innovative Strategies in Hepatitis B Prevention for Asian Americans in New York City -- A Community Health Center’s Perspectives”

Charles B. Wang Community Health Center

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# Additional Contributors

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# Disclosure

Deborah Hong, MPA

Charles B. Wang Community Health Center

- I have no financial relationships within the past 12 months relevant to my presentation
- My presentation does not include discussion of off-label or investigational use

# Charles B. Wang Community Health Center

## Mission

*To be a leader in providing quality, culturally relevant, and affordable health care and education, and advocate on behalf of the social needs of underserved Asian Americans.*

## History and Description

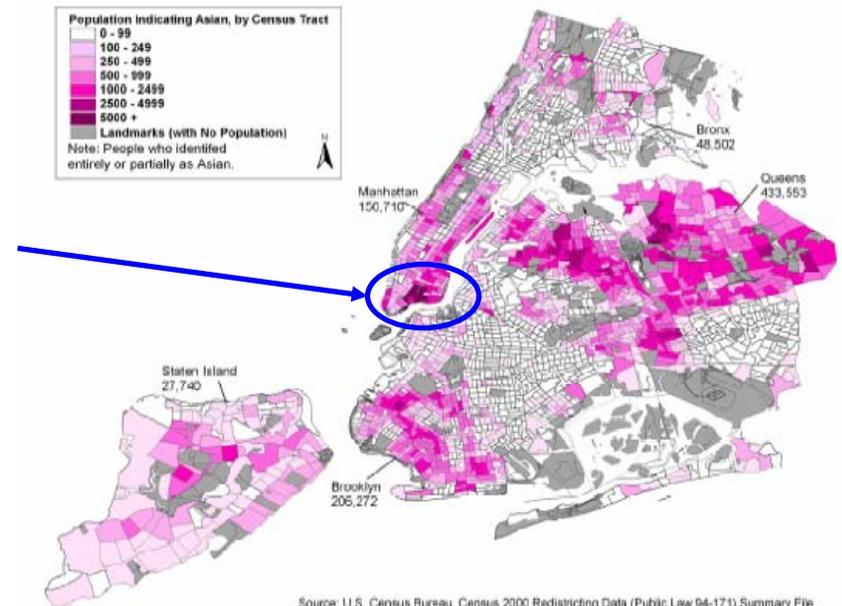
- Established in 1971
- Federally Qualified Health Center
- 2 locations in Manhattan, 1 in Flushing
- Total of ~140,000 patient visits annually
- 70% of patients insured through federal programs (Medicaid, Medicare, CHP), 28% are uninsured, 2% have private insurance
- Bilingual and bicultural services
- Comprehensive Primary and Specialty Care

# Profile of NYC's Asian American Community

According to 2000 U.S. Census --

- **787,047 Asians in New York City**
  - 54% increase since 1990
  - 78% were foreign born
  - 46% (361,531) were Chinese, 53.4% increase since 1990
- **31% of all Chinatown residents lived below the poverty line (21% NYC)**
- **31% of Asian adults in NYC do not have a high school diploma, 17% have less than a 9<sup>th</sup> grade education**
- **60% of Asian adults in NYC do not speak English “well” or “at all”**

Distribution of the Asian American Population in New York City



# Hepatitis B & the Asian American Community

- In the U.S. ~1.3 million Americans suffer from chronic hepatitis B (CHB)

50% are Asian

- Approximately 1 out of 100 Americans are chronically infected with the hepatitis B virus

1 out of 10 Asian Americans are infected

**As Asians continue to immigrate into the U.S., the high incidence and prevalence of hepatitis B will remain**

# **CBWCHC & Hepatitis B: Community-Based Screening Programs**

## **Public–Private Collaboration**



# Project: Community-Based Hepatitis B Screening Program

Year: 2000

## Goals:

1. Raise awareness of hepatitis B infection
2. Screen for patients with CHB (HBsAg +)

## Partners:

- **Oxford Health Plan**
  - Marketing and Outreach
- **CAIPA / CAMS**
  - Private physician groups
  - Patient referral base
- **CBWCHC**
  - Clinical infrastructure
  - Data management
- **Glaxo SmithKline**
  - Private sector

# Lessons Learned

- Public–Private collaboration provided efficiency and necessary resources
- How can we better ensure that carriers return for follow-up care?
- How can we provide hepatitis B vaccinations for patients at risk for infection?

# Project: Community-Based Hepatitis B Screening Program

Year: 2001

## Goals:

1. Follow-up on CHB patients identified in year 2000 screenings
2. Conduct individual screenings in provider offices to ensure better follow-up

## Partners:

- Oxford Health Plan
  - Marketing and Outreach
- CAIPA / CAMS
  - **Physicians to provide follow-up care**
- CBWCHC
  - **Screenings, health fairs**
  - **Phone survey**
- Glaxo SmithKline
  - Private sector

# Lessons Learned

- Does office screening improve follow-up?  
**13% of uninsured patients specifically indicated that lack of insurance was a barrier to seeking F/U care at MD office**
- Case management should be timely
- Only a few private MDs were involved in the screening, more manpower necessary
- **Need to vaccinate at risk patients**

# Project: Community-Based Hepatitis B Screening Program

Year: 2002 - 2003

## Goals:

1. To screen household contacts of HBsAg+ pregnant women
2. **Vaccinate all household contacts who are at risk**
3. **Refer any positive household contact for Tx**
4. Evaluate whether office screenings in year 2001 improved follow-up

## Partners:

- **NYC DOH&MH**
  - **Provide vaccines**
- CAIPA / CAMS
  - **Specialties referral base**
- CBWCHC
- Glaxo SmithKline
  - **Private sector**

# Lessons learned

- How can we maintain vaccine supply?
- How can we improve follow-up for CHB patients?  
**25% of uninsured patients indicated that lack of insurance was a barrier to seeking F/U care** – care management?
- Data management
- How can we maintain support for the project?
- Seek new partners, form new collaborations
- Need to increase marketing and outreach

# **CBWCHC & Hepatitis B: Community-Based Screening Programs**

## **Large Scale Collaboration Asian American Hepatitis B Program**

Asian American Hepatitis B Program

*Live Long. Live Healthy. B Free.*

美國亞裔乙型肝炎計劃



# Program Partners

- Funded by the New York City Council
- NYU School of Medicine
  - Center for the Study of Asian American Health
- Charles B. Wang Community Health Center
- NYC Department of Health and Mental Hygiene
- Bellevue Hospital Center
- Gouverneur Healthcare Services
- NY Downtown Hospital
- Community Healthcare Network
- American Cancer Society
  - (Chinese & Korean Units)
- Korean Community Services



# **Project: Asian American Hepatitis B Program**

**Year: 2003 - 2006**

## **Goals:**

**To provide a comprehensive HBV Program for uninsured Asian Americans in NYC**

1. Media campaign to increase HBV awareness
2. HBV community events and educational workshops
3. Large-scale no cost/low cost HBV screenings
4. No cost/low cost HBV vaccinations
5. Evaluation and treatment for those with chronic HBV

# Results

- 354 hepatitis B vaccines given
  - **93% completed dose #1**
  - **82% completed dose #2**
  - **40% have already completed the series**
- **36 CHB patients are currently being evaluated by CBWCHC physicians** (18 in Chinatown, 18 in Flushing)
- **686 persons have attended an educational workshop on hepatitis B and have received educational materials**
- Extensive media outreach via radio and newspaper to increase awareness within the community

# Lessons learned

- Case management and data management facilitate and improve follow-up
- Program targeted towards uninsured patients, making them feel more comfortable in seeking services
- Mass screenings are effective in increasing access to the community
- Large collaborations allow for more extensive outreach to the community, but more time and effort is required for community-based participation
- Education module and workshop process were developed to accommodate low literacy patients

# Overall Results of Community-Based Screening Programs

Patient Status	2000 *	2001 *	2002 – 2003	2005	Total
n (# screened)	1041	625	421	629	2716
HBsAg +/- HBsAb -	115 (11%)	102 (16%)	67 (16%)	109 (17%)	393 (14%)
HBsAg -/ HBsAb -	----	----	97 (23%)	198 (32%)	----
HBsAg -/ HBsAb +	----	----	257 (61%)	322 (51%)	----

\* Screened only for Hepatitis B carriers (HBsAg +/- HBsAb -)

# “B” Healthy Model Care Program



# Program Partners

- CBWCHC
  - Provider trainings
  - Care management
  - Education & support groups
  - Research survey
- **AAPCHO**
  - Advocacy
- **Bristol-Meyers Squibb**
  - Private sector



# **Project: “B” Healthy Model Care Program**

**Year: 2005**

## **Goals:**

1. To enhance hepatitis B treatment skills, leadership and advocacy development for the diagnosis and treatment of chronic hepatitis B through provider trainings
2. To utilize elements of the Chronic Care Model to encourage high-quality chronic hepatitis B care at CBWCHC
3. To provide community education and support for hepatitis B carriers and their families
4. To better understand knowledge, attitudes and practices of community members at high risk for hepatitis B
5. To evaluate elements of the hepatitis B primary care management model

# Chronic Care Model

- Based on the Chronic Care Model\* which identifies the following components to provide high quality care for chronically ill patients:
  - the community
  - the health system
  - self-management support
  - delivery system design
  - decision support
  - clinical information systems

*\*Wagner, EH. Chronic disease management: What will it take to improve care for chronic illness? Effective Clinical Practice. 1998; 1:2-4*

# Care Management

- Comprehensive, quality care system that engages patients by:
  - Encouraging participation in effective community programs
  - Emphasizing patients' central role in managing their own health
  - Providing navigational support and clinical care management services to ensuring access, continuity and completion of care

# Clinical Tracking: HBsAg-/ HBsAb-

- Patients requiring Hepatitis B vaccination
- Database generates:
  - Log of patients who missed vaccine #2
  - Log of patients who missed vaccine #3
  - \* *Reports are generated monthly*
  - Log of patients considered “loss to follow-up”

# Data Entry

Main Page

## Hepatitis Tracking Program

**Data Entry** New patient data entry or edit existing Hepatitis patients

Reports Generate and print reports

V 07.27.05

Window Help Type a question for help

### HepB Vaccine

#### Hepatitis B Vaccine Tracking Form

Chart #  Last Name  First Name   
Street  Sex  DOB   
City State  Zip Code  HomePhone   
Year In USA  Ethnicity

---

Department  Site   
Patient Type   
Exposure Type  Index Pt. Name   
Index Pt. Chart   
Payer Source

Screening Visit1  HBsAg Result  NYU Specimen # 981   
Visit2  Vacc #1 Date  Vac Source 1   
Visit3  Vacc #2 Date  Vac Source 2   
Visit4  Vacc #3 Date  Vac Source 3   
Visit5  Booster Date  Vac Source B

Comment

Pt. Vaccine Status

Next Appointment   
*format: 12/12/2005 12:00 pm*

Refresh Patient Info Add New Patient Update Record Delete Record

Form View NUM

# Patients Requiring Vaccination (by department)

Microsoft Access - [CHI Shot2 Report : Report]

File Window Help Type a question for help

### HepB 2nd Dose Required Report

Chart	Patient Name	Sex	DOB	Department	Patient Type	Exposure	HepB Date 1	Patient Vaccine Status	Comment
				Internal Medicine	a. Pre-exposure	3. Selfpay	7/16/2005	1 - Received 1st dose	
				Internal Medicine	a. Pre-exposure	3. Selfpay	8/1/2005	1 - Received 1st dose	
				Internal Medicine	a. Pre-exposure	3. Selfpay	8/12/2005	1 - Received 1st dose	
				Internal Medicine	a. Pre-exposure	3. Selfpay	8/9/2005	1 - Received 1st dose	
				Internal Medicine	a. Pre-exposure	3. Selfpay	8/20/2005	1 - Received 1st dose	
				Internal Medicine	a. Pre-exposure	4. Other	8/15/2005	1 - Received 1st dose	
				Internal Medicine	a. Pre-exposure	3. Selfpay	8/3/2005	1 - Received 1st dose	10/05/05 LETTER SENT
				Internal Medicine	a. Pre-exposure	4. Other	8/19/2005	1 - Received 1st dose	
				Internal Medicine	a. Pre-exposure	4. Other	8/12/2005	1 - Received 1st dose	
				Internal Medicine	a. Pre-exposure	4. Other	6/16/2005	1 - Received 1st dose	08/29/05 PTS IN CHINA & WILL BE BACK IN OCT.
				Internal Medicine	a. Pre-exposure	4. Other	8/19/2005	1 - Received 1st dose	

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Page: 1 Ready

### Hepatitis B Reports Generator

Chinatown HepB Tracking Reports

Enter Parameter Value

Department (ped, ob, int, \*)

OK Cancel

Choose one report, then run

- Patients who are required 2nd Vaccine
- Patients who are required 3rd Vaccine
- Patients who are lost Follow-up
- Patients who received any HepB Vaccine during X period
- Patients who received 1st HepB Vaccine during X period

Run

# Loss to Follow-up (by date range)

Microsoft Access - [CHI Lost Follow-up]

File Window Help

Type a question for help

### CHI Lost Follow-up

Chart	Last Name	First Name	Sex	DOB	HepB Date1	HepB Date2	HepB Date3	Pt Vac Status	Comment
					7/5/2003	6/4/2005		5 - Lost to follow up	CHANGED PCP
					4/29/2004	1/3/2005		5 - Lost to follow up	
					10/2/2004	3/26/2005		5 - Lost to follow up	PT CHANGED PCP
					11/7/2004	1/6/2005		5 - Lost to follow up	08/01/05 LETTER SENT 08/21/05 CALLED PT 08/29/05 LETTER SENT
					11/19/2004	1/2/2005		5 - Lost to follow up	
					12/6/2004	1/10/2005		5 - Lost to follow up	08/01/05 LETTER SENT 08/29/05 LETTER SENT 09/04/05 LETTER SENT
					12/10/2004	1/14/2005		5 - Lost to follow up	CHANGED PCP
					12/13/2004	1/14/2005		5 - Lost to follow up	CHANGED PCP
					12/14/2004	1/18/2005		5 - Lost to follow up	08/29/05 LETTER SENT 09/12/05 CALLED PT 9/29/05 LETTER SENT
					12/20/2004	1/21/2005		5 - Lost to follow up	6/14/05 POSTCARD SENT 08/23/05 LETTER SENT 09/04/05 LETTER SENT
					1/4/2005			5 - Lost to follow up	MOVED.
					1/14/2005	2/18/2005		5 - Lost to follow up	08/23/05 LETTER SENT 09/12/05 LETTER SENT 9/29/05 LETTER SENT
					1/17/2005			5 - Lost to follow up	03/26/05 CALLED PT 04/25/05 POSTCARD SENT 05/16/2005 POSTCARD#2 SENT

Thursday, October 20, 2005

Page 1 of 3

Page: 1 of 1

Ready

### Report Gen : Form

## Hepatitis B Reports Generator

Chinatown HepB Tracking Reports

Enter Parameter Values

First Date

OK Cancel

Choose one report, then run

- Patients who are required 2nd Vaccine
- Patients who are required 3rd Vaccine
- Patients who are lost Follow-up
- Patients who received any HepB Vaccine during X period
- Patients who received 1st HepB Vaccine during X period

Run

# Enabling Services Tracking

- MD refers patient for services
- FHW or nursing staff makes documentation
  - FHW or nursing assists patient in referrals for diagnostic x-rays or referral to specialists
  - Nursing staff assists patient in referrals to Social Work
- Forms are collected and information is entered into database
- Database is password protected

# Data Entry

Microsoft Access - [Case mgt]

File Edit View Insert Format Records Tools Window Help

CHARLES B. WANG COMMUNITY HEALTH CENTER  
Internal Medicine  
Hep B Case Management

Patient Chart #	A9977	F/U with Specialist or repeat Diagnostic Testing(s)	<input type="checkbox"/>
Service Date	9/19/2005	Need to schedule appointment for patient	<input type="checkbox"/>
Patient DOB	1/9/1976	Patient will schedule own appointment	<input checked="" type="checkbox"/>
Provider	Zhang, P	Referral Authorization	<input type="checkbox"/>
Referral to Diagnostic Testing	Abdominal U/S	Referral to Social Worker	<input type="checkbox"/>
Referral to Specialist		Pharmaceutical Compassionate Program	<input type="checkbox"/>
Others (please specify)		Medical Renewal Yearly	<input type="checkbox"/>

Record: 1 of 71

Form View

CAPS NUM

Previous Next

1st Record Last Record New Record

# Summary Report

Microsoft Access

File Edit View Tools Window Help

Type a question for help

Fit Close Setup

Double Click here to Fit Page

Case mgt\_OLD Query

B Healthy Program

General Summary

Total Number of Disease: 21

# of Patients Referred to Diagnostic Testing	38
# of Patients Referred to Specialist	11
Others	12
# of Patients F/U with Specialist of repeat Diagnostic Testing	1
Need to Schedule Appointment for Patient	12
# of Patients Will Schedule Own Appointment	38
# of Patients Require Referral Authorization	5
# of Patients Referred to Social Worker	0
# of Patients in Pharmaceutical Compassionate Program	1
# of Patients Require Yearly Medical Renewal	0

Monday, October 17, 2005

Page: 1

Enter Hep B Case Management

B Healthy Program

Enter Hep B Data

Generate Summary Report

Demography

above - High

- Intermediate

- Low

B Healthy Pr...

Ready

CAPS NUM

# B Healthy Program

## General Summary

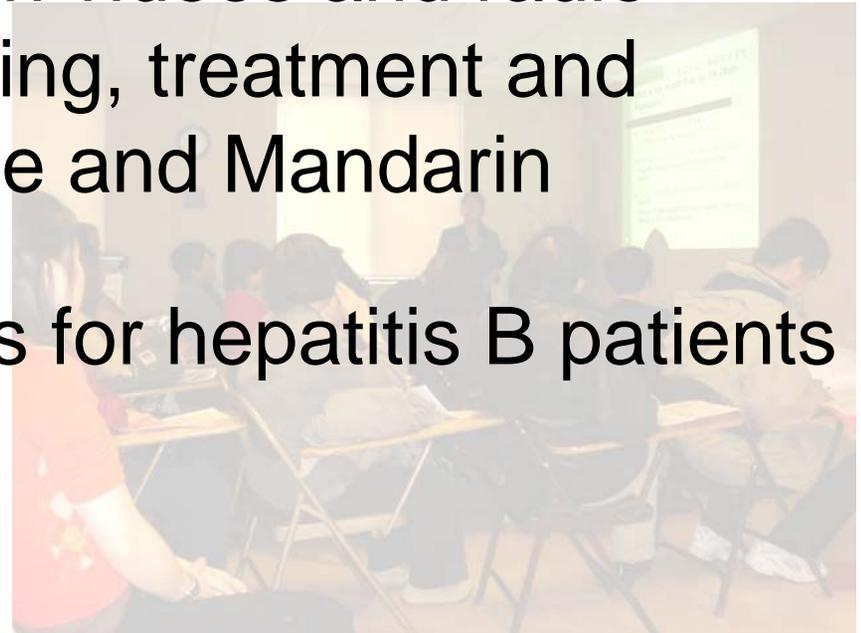
**Total Number of Patients:** 71

<b># of Patients Referred to Diagnostic Testing</b>	58
<b># of Patients Referred to Specialist</b>	11
<b>Others</b>	12
<b># of Patients F/U with Specialist of repeat Diagnostic Testing</b>	1
<b>Need to Schedule Appointment for Patient</b>	12
<b># of Patients Will Schedule Own Appointment</b>	58
<b># of Patients Require Referral Authorization</b>	5
<b># of Patients Referred to Social Worker</b>	0
<b># of Patients in Pharmaceutical Compassionate Program</b>	1
<b># of Patients Require Yearly Medical Renewal</b>	0

Monday, October 17, 2006

# Education and Support

- Provide education during screening events at CBWCHC and in the community
- Create patient education videos and radio programs about screening, treatment and adherence in Cantonese and Mandarin
- Conduct support groups for hepatitis B patients and their families



# Educating & Empowering Patients

- Importance of education
  - Many misperceptions about hepatitis B
  - Many unaware of the seriousness of a chronic infection
- Importance of empowerment
  - Self-management greatly affects disease control and outcomes
  - Empower the patient through: information, emotional support and strategies for living with chronic illness

# Perceptions of Hepatitis B in the Chinese Community\*

- Awareness of hepatitis B but many underestimate the severity
- Link between hepatitis B infection and liver cancer & liver damage is not clear
- Many myths regarding transmission
  - Spread by sharing food or chopsticks
  - Vaccine can transmit hepatitis B infection
  - Cure for hepatitis B exists

*\*Observations by CBWCHC staff from past hepatitis B programs*

# Educational Materials

- A brochure in English and Chinese was developed
- Radio and video are the most accessible media channels for our target audience:
  - Radio programs were aired in Cantonese and Mandarin
  - Two 10-minute videos were produced: patient and family member

# Support Groups

- Benefit of support groups:
  - Gain knowledge from speakers, facilitators and other patients
  - Develop and improve coping skills
  - Gain confidence and acceptance of their liver disease through the knowledge that they are not alone
- Three sessions (90 minutes each)
  - Session #1: Overview of Hepatitis B
  - Session #2: Living with Chronic Hepatitis B
  - Session #3: Family Life & Coping with Hepatitis B

# Support Group Observations

- Be culturally sensitive
- Continue to engage them and instill realistic hope
  - Support groups take time esp. with Asians unaccustomed to revealing their feelings in a group setting

# Conclusions

- Unmet need in large-scale hepatitis B screenings among the Asian community
- Role for case-management and follow up in screening programs for vaccination and evaluation for treatment
- Targeted clinical and educational interventions should be created for high risk populations
- Role of case-management and chronic disease model needs to be evaluated