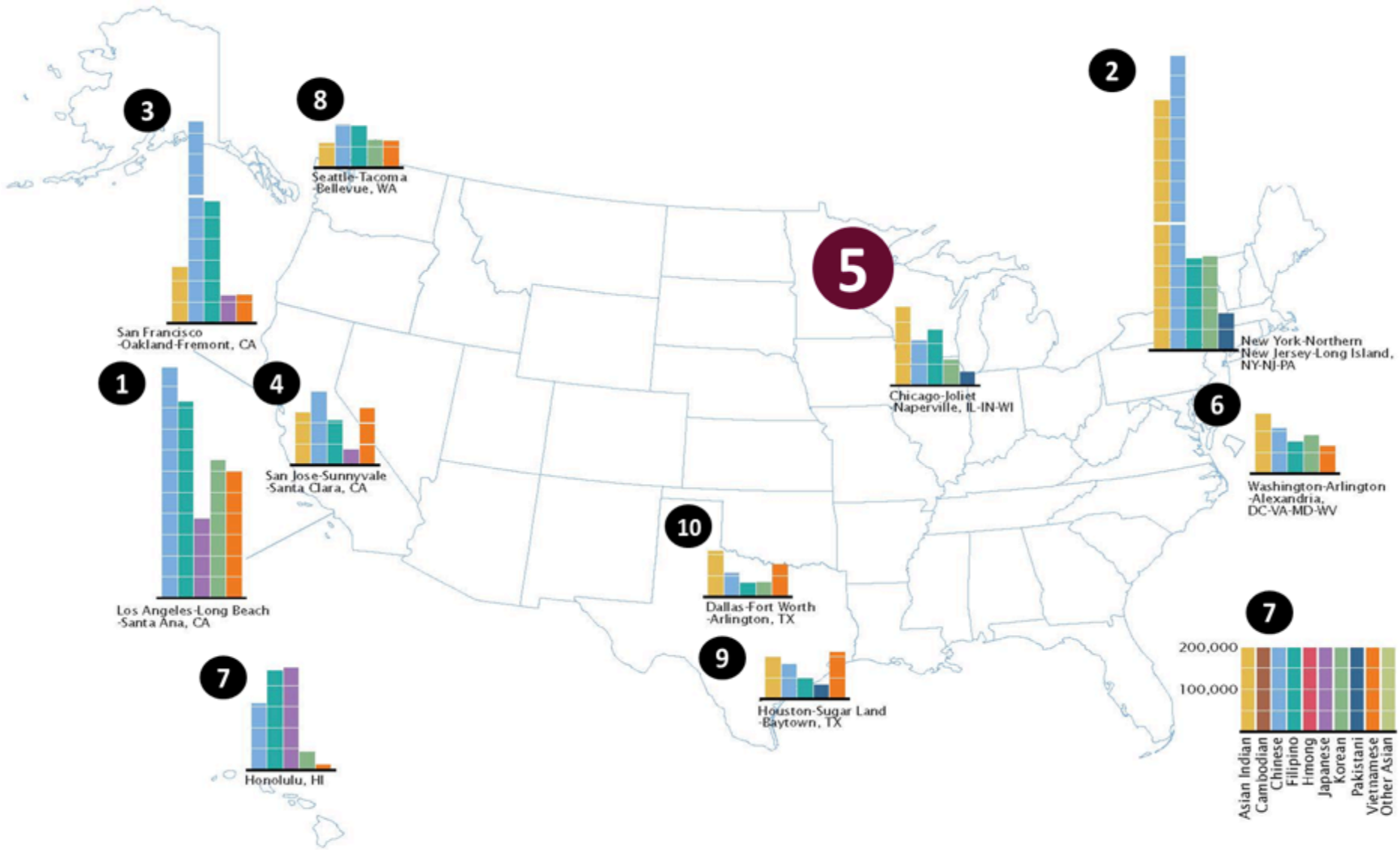
Chicago Metropolitan Area – 5th Largest Asian American Population



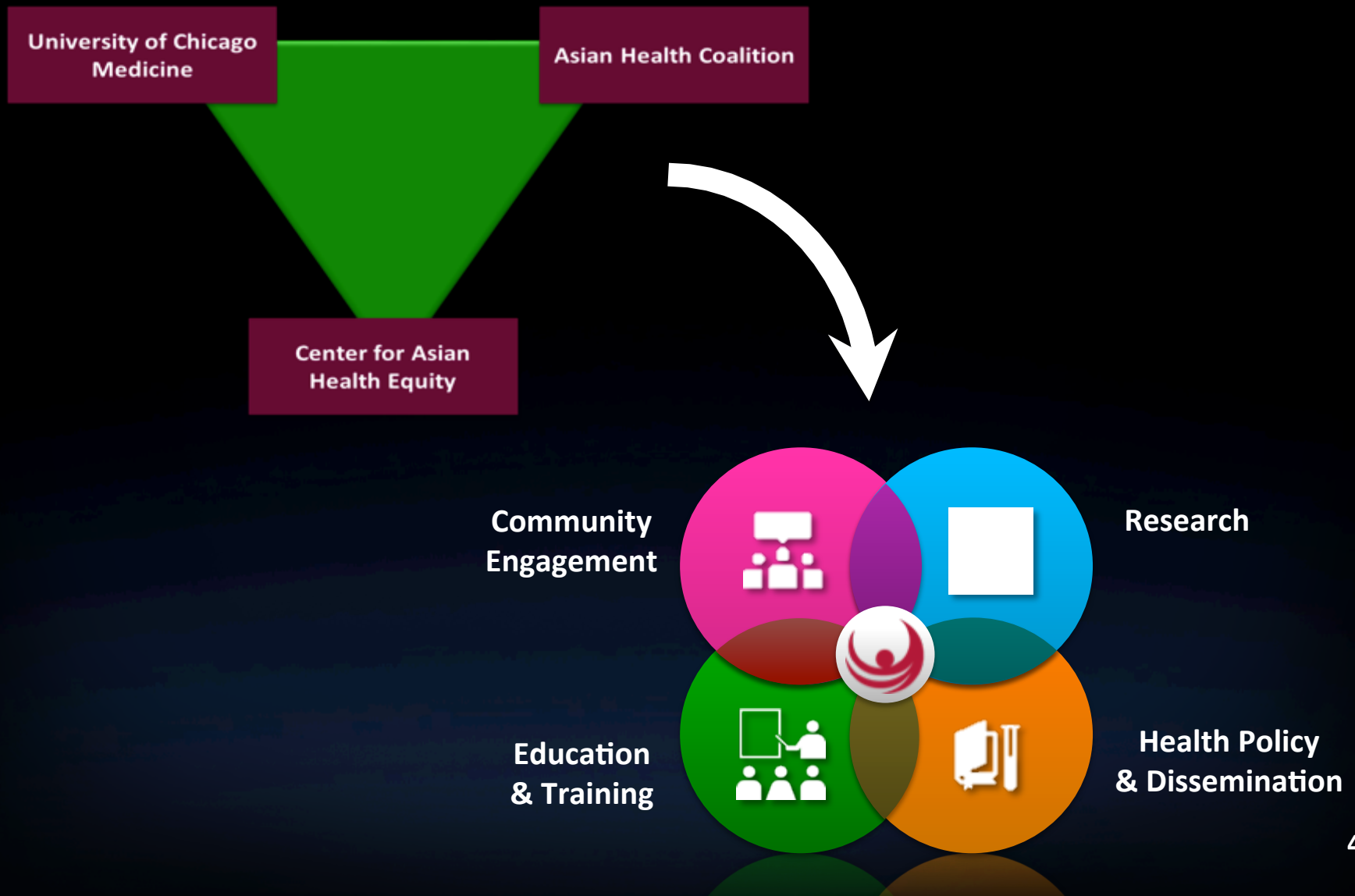
Source: U.S. Census Bureau, 2010 Census special tabulation.

Not To Be Ignored……The Growing African Immigrant Diaspora

New York-Newark-Jersey City, NY-NJ-PA Metro Area	231,384
Washington-Arlington-Alexandria, DC-VA-MD-WV Metro Area	177,351
Atlanta-Sandy Springs-Roswell, GA Metro Area	72,332
Minneapolis-St. Paul-Bloomington, MN-WI Metro Area	70,664
Los Angeles-Long Beach-Anaheim, CA Metro Area	69,797
Dallas-Fort Worth-Arlington, TX Metro Area	68,278
Boston-Cambridge-Newton, MA-NH Metro Area	66,162
Houston-The Woodlands-Sugar Land, TX Metro Area	61,184
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD Metro Area	50,724
Chicago-Naperville-Elgin, IL-IN-WI Metro Area	46,147
Seattle-Tacoma-Bellevue, WA Metro Area	43,988
Baltimore-Columbia-Towson, MD Metro Area	33,737
Columbus, OH Metro Area	31,959

SOURCE: SELECTED CHARACTERISTICS OF THE FOREIGN-BORN POPULATION BY REGION OF BIRTH: AFRICA, AMERICAN COMMUNITY SURVEY 5-YEAR 2010-2014

Asian Health Coalition/Center for Asian Health Equity

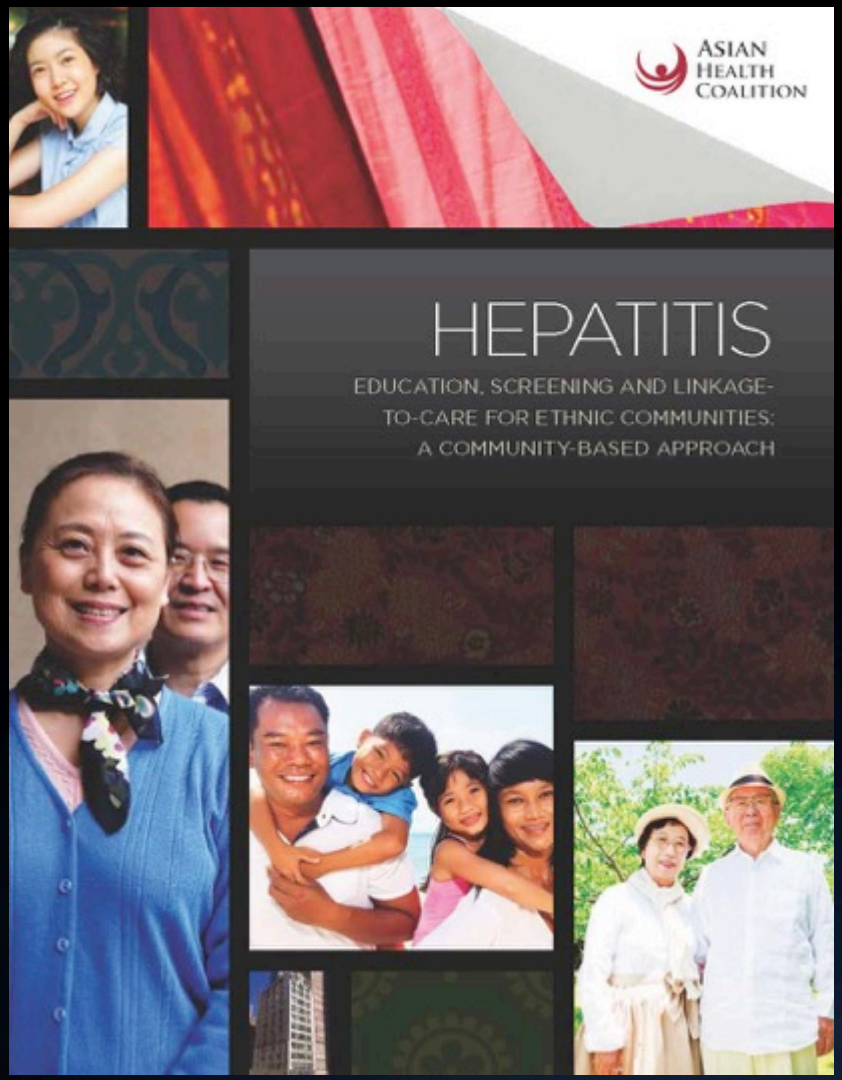


Program Partners

Principle Investigators:	**Edwin Chandrasekar, Asian Health Coalition** **Karen Kim MD MS, University of Chicago**
Project Staff:	**Angela Forfia MA, Alia Ryan MPH, Sharon Song PhD** **Asian Health Coalition**
Patient Navigators:	**Arely Garsca, Heartland Health Centers** **Ruth Lopez, Heartland Health Centers** **Guadalupe Naranjo, Heartland Health Centers** **Manar Alsakini, Touhy Health Clinic, Sinai Health Systems**
Medical Advisory Board:	**Department of Infectious Diseases,** **Chicago Department of Public Health** **CORE Center, Cook County Health and Hospitals** **Stroger Hospital, Cook County Health and Hospitals** **Heartland Health Centers** **Sinai Health Systems**

Support for the creation of the hepatitis navigator guide was provided through a cooperative grant 5U51PS004616 from the Centers for Disease Control & Prevention

Hepatitis Education & Prevention Program



- **The Hepatitis Education & Prevention Program (HEPP) describes the effectiveness of hepatitis B education, outreach and pathways to screening through the formation of strategic partnerships with community and faith-based organizations; use of bilingual community health workers, and medical providers.**

- **Community-based hepatitis B screening programs are generally effective in identifying and screening patients at risk of HBV.**

- **Few programs are able to track effectiveness of linkage-to-care of those chronically infected clients.**

Gaps in Continuum of Care for Hepatitis B Patients

Patient Process	Education and Counseling	Health Screening	Diagnostic Process	Treatment and Management	Maintenance
Service Roles	Community Health Worker	Missing --------- Patient Navigation			
Activities	Provide Health Education Provide Health Screening Referrals Provide Prevention Counseling	Link to Healthcare System Assistance with Insurance Coverage Link to Financial and Transportation Assistance	Link to Diagnostic Tests and Follow Up Link to Medical Home	Identify and Reduce Barriers to Care Tailor Care to Patient Needs	Link to Healthcare System Assistance with Insurance Coverage
Training	AHC Community Health Worker Training Program	Missing --------- Patient Navigator Training			

Target Populations

Foreign-born Individuals from Asia and Africa at high risk for suboptimal health care outcomes:

- **Newly tested and diagnosed for chronic hepatitis B**
- **Previously tested and diagnosed for chronic hepatitis B and lost to care/never in care**

Asians and Africans Born Outside the United States are at High Risk for Hepatitis B

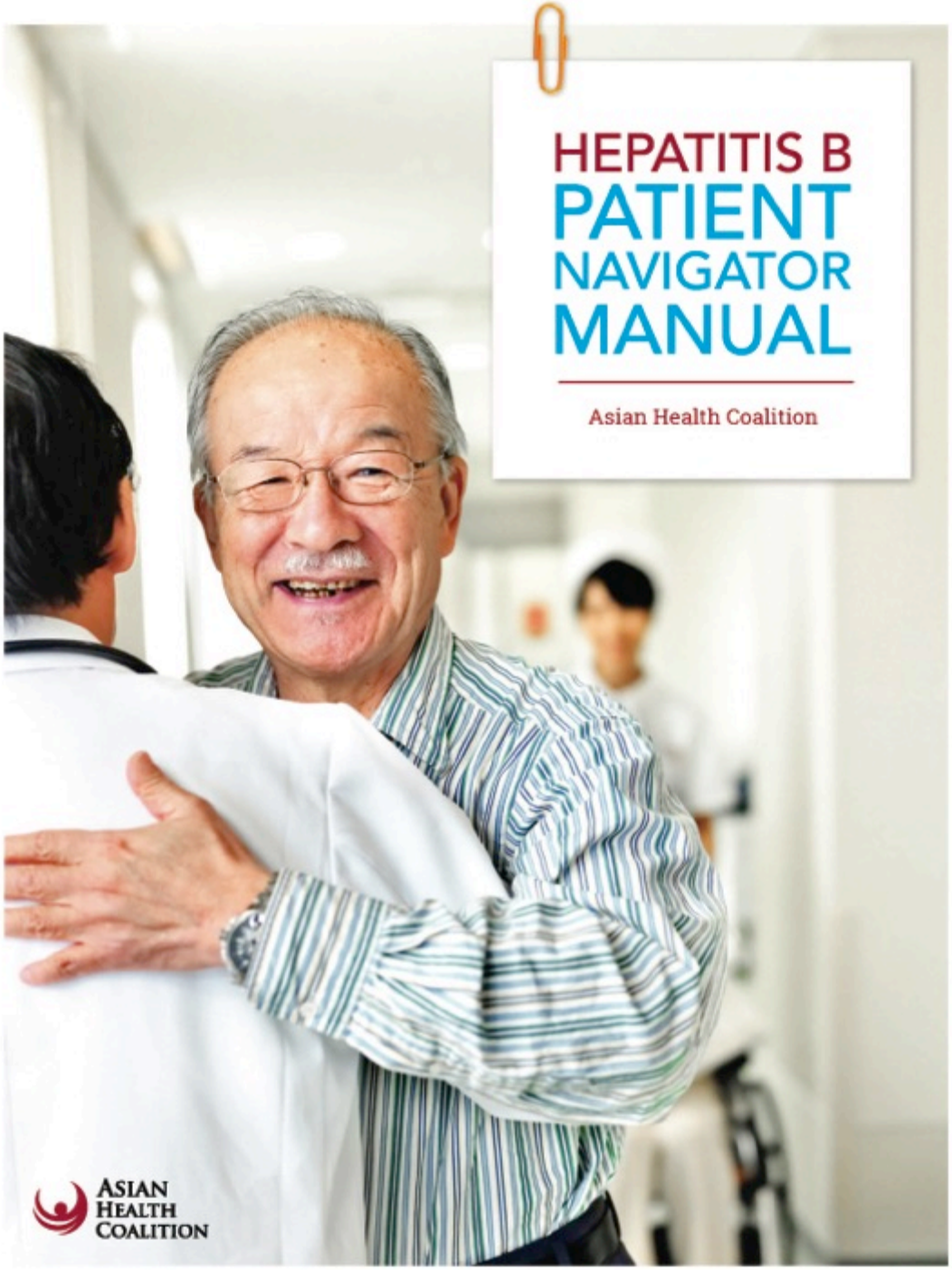
Waasia na Wafrika Waliozaliwa Nje ya Marekani wako kwenye Hatari Kubwa ya Homa ya Manjano B

Hepatitis Linkage-to-Care Components

- Patient navigation has been traditionally used in the cancer continuum of care, and applied to diabetes, palliative care and HIV/AIDS.

- The Patient Navigator model can also be adapted to serve the needs of individuals with chronic hepatitis B.

- We created the training guide for organizations interested in training new lay individuals to serve as hepatitis patient navigators in both clinical and non-clinical settings.



Preliminary Evaluation* (Oct 2014 to Dec 2015)

* Project is scheduled to continue though Sept 2016

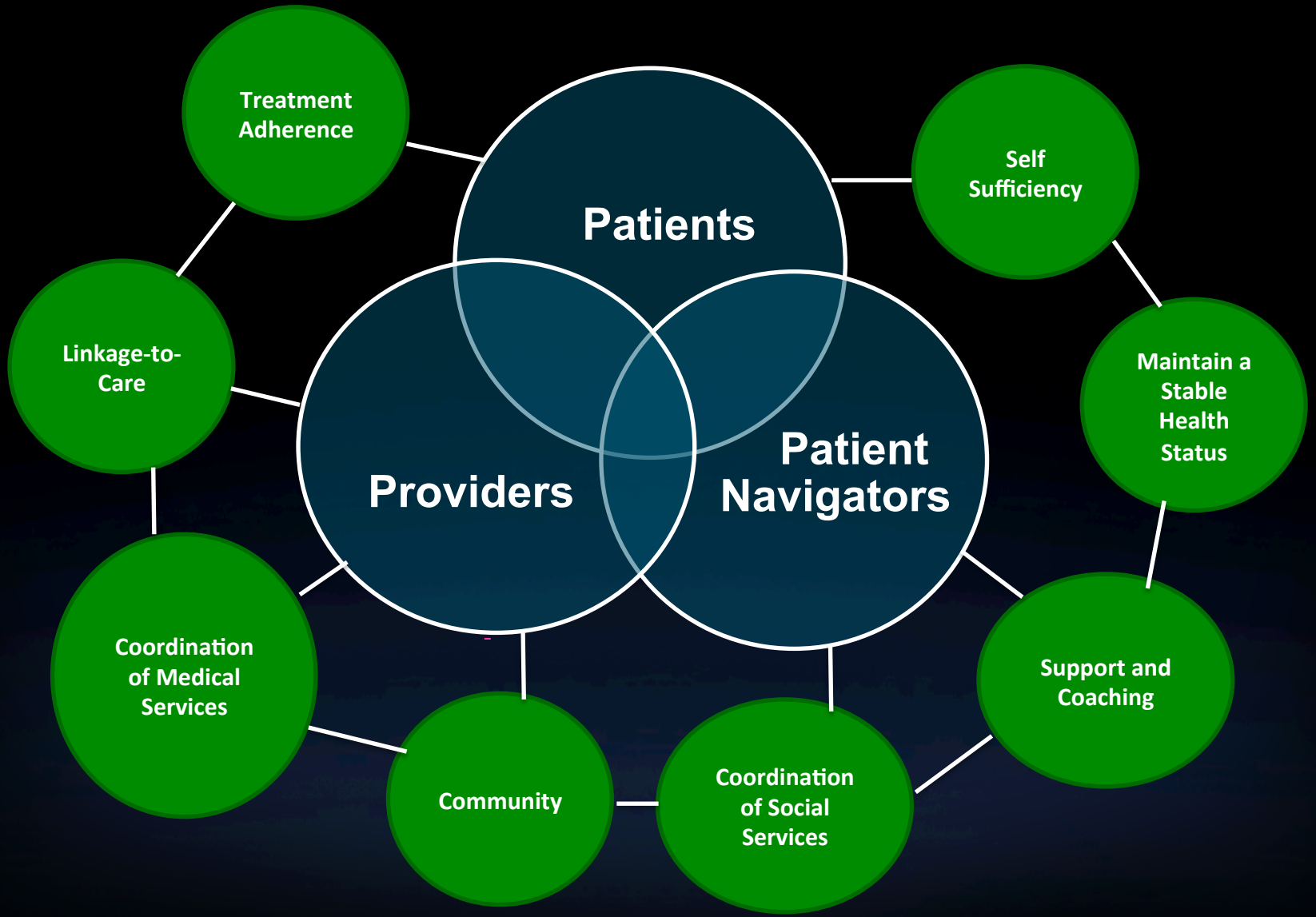
Role of the Hepatitis Patient Navigator

- **The Hepatitis Patient Navigator (HPN) is a person who guides patients through and around barriers in our complex health care system to help ensure timely diagnosis and treatment for chronic hepatitis B.**

- **Barriers to quality care fall into a number of categories:**
  - **Financial and economic**
  - **Language and cultural**
  - **Communication**
  - **Health care system**
  - **Transportation**
  - **Bias based on culture/race/age**
  - **Stigma**

Patient Navigators Serve as Key Players in the Hepatitis Continuum of Care to Bridge the Gap between the Clinic and Community

Patient Navigators as Integrated Care Specialists with Community-Clinic Linkages



Lessons Learned: Provide Adequate Training and Technical Assistance

Initial trainings

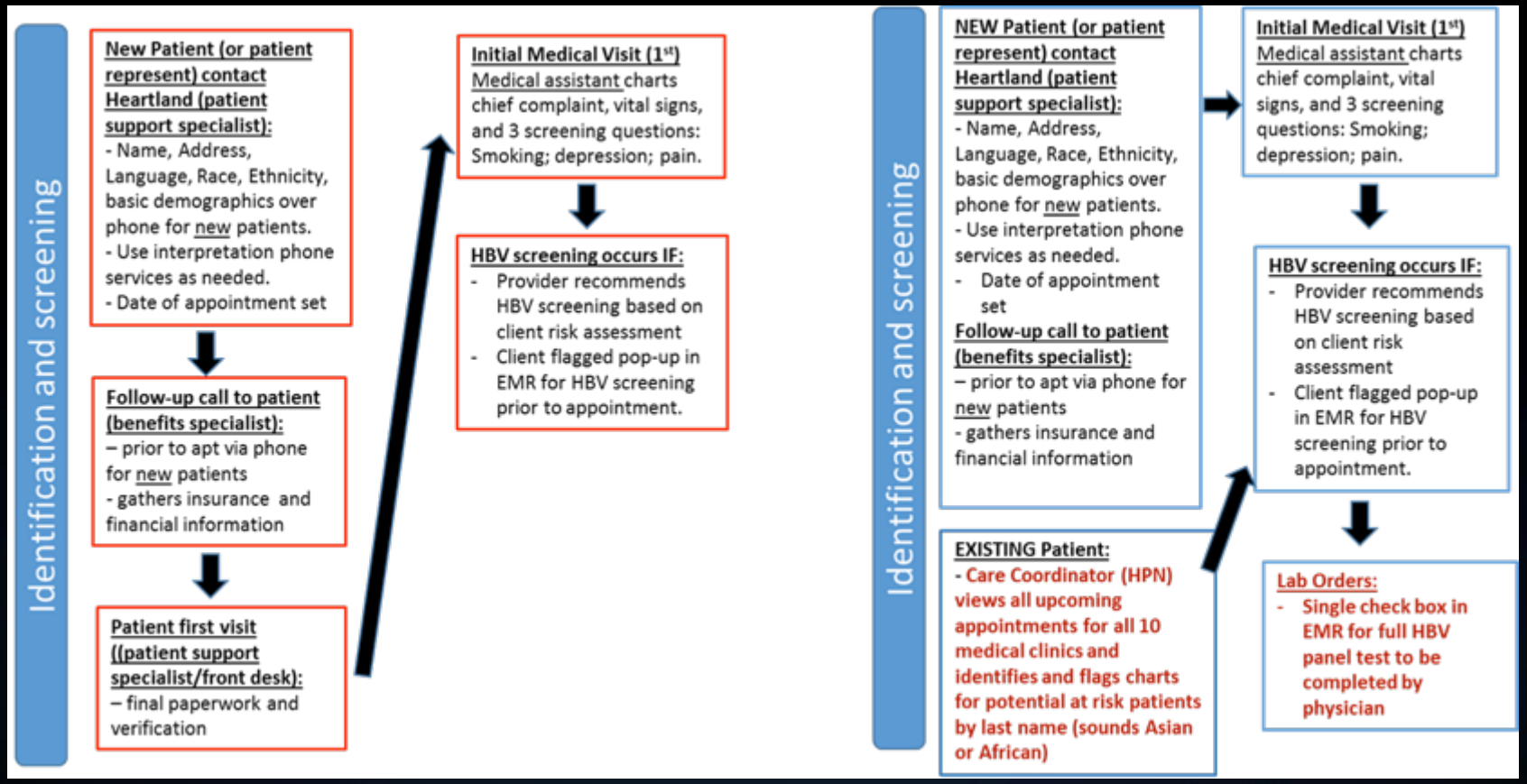
- 2 full day community health worker training workshops
- 2 full day patient navigator training workshops
- 1 half-day bi-directional joint training for community health workers and patient navigators

Ongoing support

- Refresher HPN trainings
- Minimum bimonthly site visits

Lessons Learned: Conduct Organization Scan of Clinic Sites Prior to Implementation

1. **Document the current clinic screening, referral and linkage-to-care protocols and processes to help identify gaps/ opportunities for improvement.**



Pre-Navigator Implementation

Post-Navigator Implementation

Lessons Learned: Getting Physician Provider Buy-In is Imperative

1. Clinical Grand Rounds and Presentations with Community Physicians at Monthly Meetings
2. Separate Presentations to Anchor Staff i.e. Nurses, Medical Assistants, Front Desk Staff
3. Medical Advisory Board Meetings

THANK YOU