Check Hep B Patient Navigation Program – Intervention Workflow Population with positive HBV Tools Surface Antigen result Patient Navigation Form Patient Navigator reaches out to subset of population Contact established Contact not established Consent/Program **Encounter 1** Care Coordination Log Description Obtain demographic information and self reported history Barriers to care and support needs Do not enroll if patient: Enroll & Refer to services and develop Care Plan 1. Is in HBV care Assess coordination Facilitate contact screening and (within 2 weeks) 2. Declines the program vaccination as needed. Enroll HBV+ contacts into Check Hep B. Consent/Program Patient has Provide Health Promotion **Description Form HBV** provider (see Modules I & II) Yes No Motivate Referral to HBV provider Link to HBV Support Health Promotion Guide Schedule case patient to seek medical Care Coordination as needed: (I & II: Hep B Basics; Getting conference with treatment or care Set appointment, reminder, Ready for Hep B Care) provider and patient (within 1 return to care accompaniment, case conference, Care Coordination as (within 1 month) month) medical interpretation needed **Encounter 2 HBV Medical Evaluation** Provide Health Completed and Care Plan Form Completed and not Not completed Promotion treatment candidate treatment candidate (see Module III) Follow up with **Complete Treatment** patient and Planning Form provider. Provide treatment Care Coordination: readiness support Motivate and re-Case conference, engage in care pharmacy assistance Health Promotion Guide (III: Getting Ready for **Encounter 3 HBV** treatment Treatment) 3-Day Adherence Check-in Not started Started Provide ongoing monitoring support as needed (Suggest: 1/week or 1/month) Provide treatment Referral to a specialty readiness support Provide treatment Treatment Planning Form pharmacy for long term and re-engage in care adherence support treatment adherence support **Encounter 4** Health Promotion Guide Educate patients: Provide Health (IV: Staying Healthy with Promotion (see Clinical monitoring requirements, liver health, and secondary Hep B) Module IV) HEP B

Discharge/Transition (plan 3 months prior

end of program)

Develop Discharge/Transition Plan

Identify outstanding support needs

Refer to services