

# Check Hep B Patient Navigation Program

**Program Training  
for Patient  
Navigators**



Hi there! I'm your Check Hep B Patient Navigation Program trainer.

In this training, we're going to explain what the Check Hep B program is, describe your role as a Check Hep B patient navigator, and explore the various forms and tools to help you in your work.

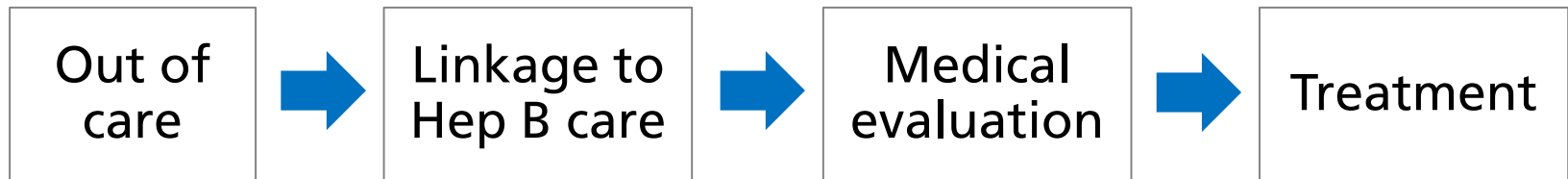
# Check Hep B Patient Navigation Program

**Program Background:  
Why Is Patient  
Navigation Needed in  
the Care and Treatment  
of Hepatitis B?**

# Barriers to Hep B Testing and Care

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## STEPS TO HEP B TESTING AND CARE



## BARRIERS TO GETTING TESTED AND TREATED FOR HEP B

Lack of health insurance

Hep B is a lesser priority (other health issues, unemployment, immigration status, caring for family members)

Language barriers

Fear to learn Hep B status

Shame and stigma

Health care system hard to navigate

Skip or miss appointments

Cost of treatment

Stress

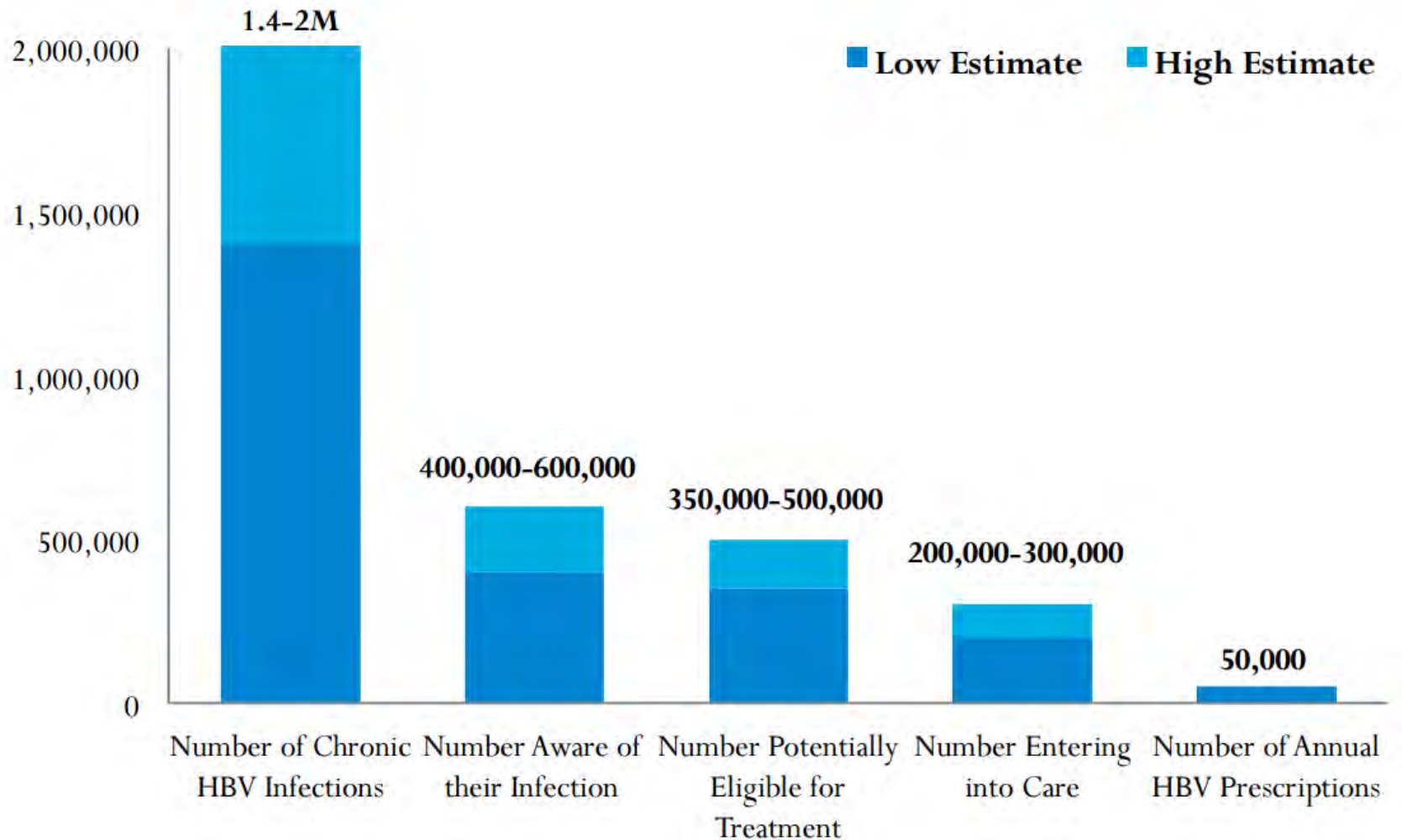
Depression

Feel powerless to control illness (fatalism)

Transportation issues

Having no symptoms or "feeling fine"

# Hepatitis B in the U.S.: Critical Gaps



Source: Cohen et al. 2010.

# Check Hep B Patient Navigation Program

**What is the  
Check Hep B  
Patient Navigation  
Program?**

# What is Check Hep B?

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The **Check Hep B Patient Navigation Program**...

helps people infected with Hep B **access Hep B medical care and treatment**...

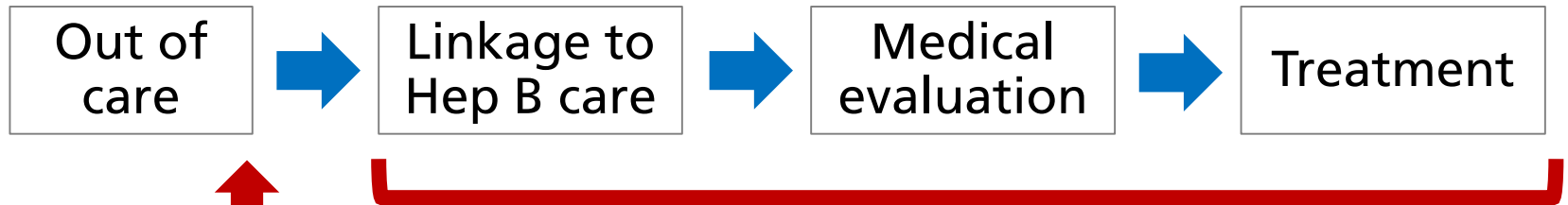
by funding **Hep B patient navigation services** at community-based organizations and health care facilities

**To date, we have helped  
over 300 people complete  
Hep B medical evaluation!**



# How Does Check Hep B Work?

## Stages of Hep B care



**Outreach & Enrollment**

**Assessment & Care Plan**

**Linkage to Care**

**Health Promotion**

**Contact Screening, Vaccination and Linkage to Care**

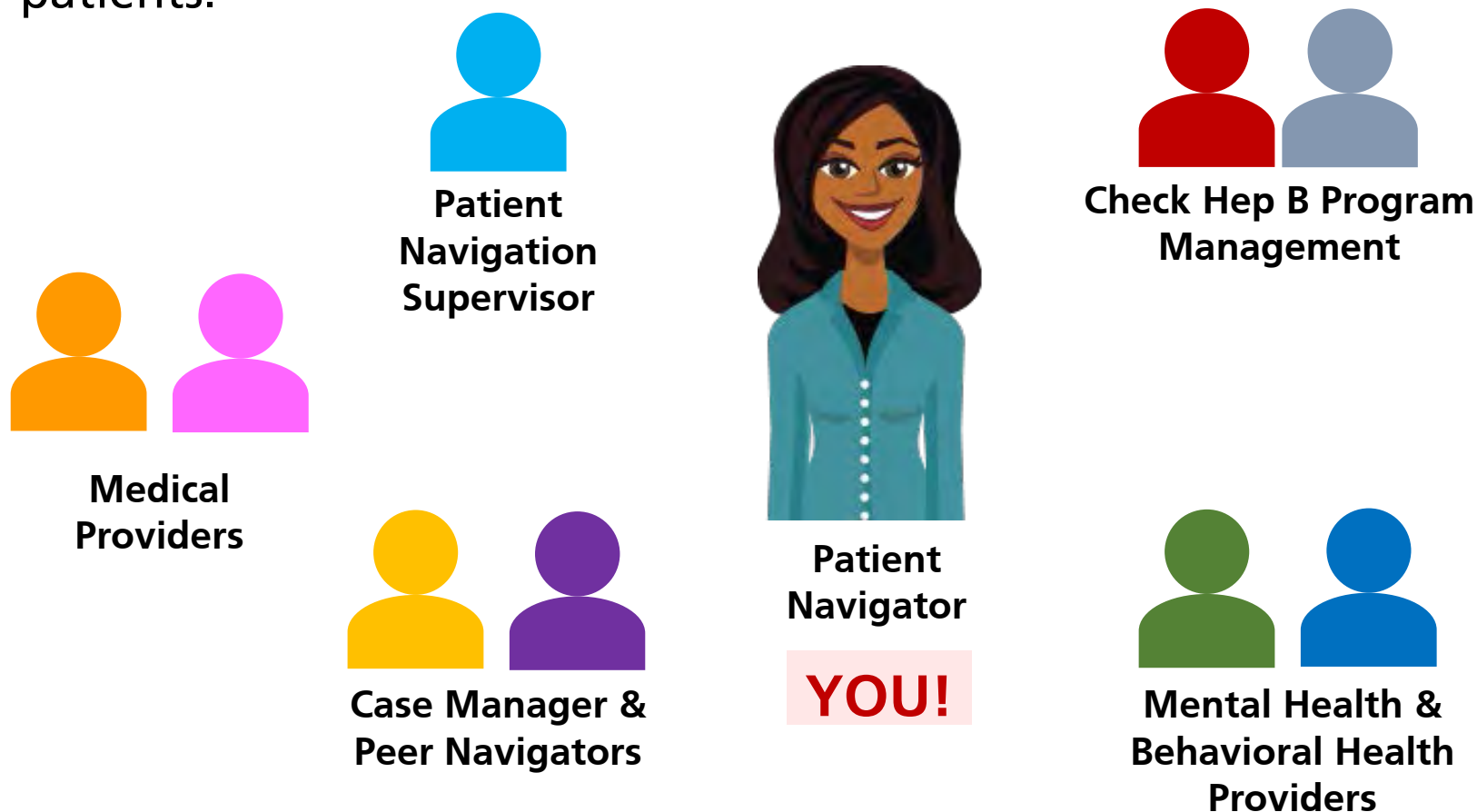
### **Care Coordination Services**

- Accompaniment and reminders
- Referrals to supportive services
- Alcohol counseling
- Case conference
- Treatment readiness and adherence support
- Medication and pharmacy coordination
- Discharge/transition planning

**Check Hep B Patient Navigation Services**

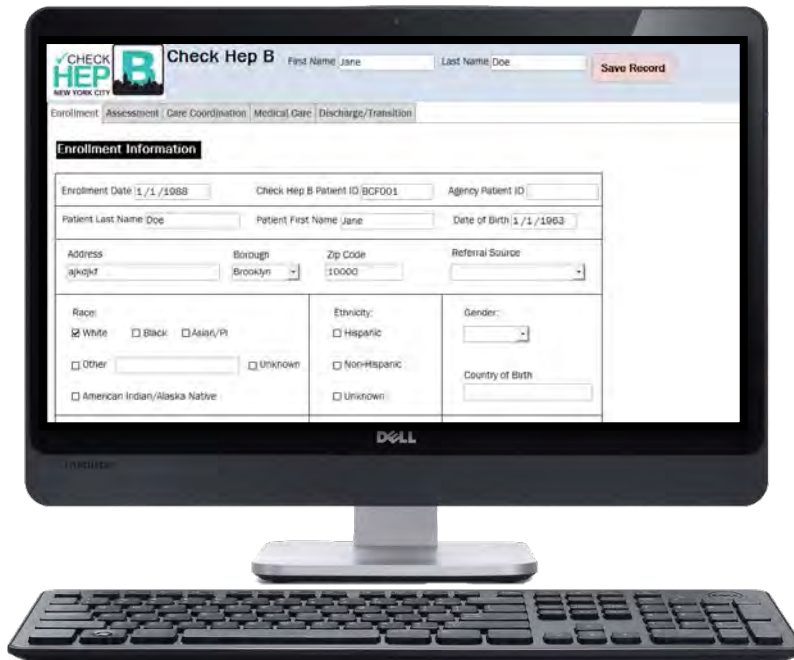
# Who Is Part of Check Hep B?

Patient navigators (PNs) are the heart of Check Hep B. But PNs are **not alone** in supporting Hep B patients through care! The multidisciplinary care team should work together to support patients.



# Documenting Patient Navigation Services

- PNs are required to enter and submit Check Hep B patient data and PN services monthly in the Patient Navigation Database.
- PNs can use the *Patient Navigation Form* as a guide to document patient data and PN services during individual encounters, but must submit monthly data via the database.



Patient Navigation Database

A detailed "Patient Navigation Form" document. It includes sections for Enrollment Information, Assessment: Self-Reported Hep B History, Patient Navigator Assessment, and Referrals Made. The form contains numerous checkboxes and text fields for documenting patient data and services. At the bottom, it includes a "Patient Navigation Service Level" section with options for Low Intensity and High Intensity, and a footer indicating it is the "Check Hep B Program | Patient Navigation Form | 2016".

Patient Navigation Form

# Documenting Patient Navigation Services

**CHECK HEP B**  
with your care

**Patient Navigation Form**

(This form is a tool for the Patient Navigator to document their work assessing each patient through the continuum of care. Keep this form in the patient chart and update after each patient encounter. This form is a paper version of the Check Hep B database.)

Enrollment Information		
Enrollment Date:	Check Hep B Patient ID: (Unique number provided for this project)	Agency Patient ID:
Patient Last Name:	Patient First Name:	Date of Birth:
Address (# Street, Apt #, Borough):		Zip Code:
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian/PI <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> American Indian/Alaska Native	Ethnicity: <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown Country of Birth:	Referral Source: <input type="checkbox"/> Internal <input type="checkbox"/> External Gender: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Trans M → F <input type="checkbox"/> Trans F → M
English: <input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write <input type="checkbox"/> None	Preferred Language:	Interpretation needed: <input type="checkbox"/> No <input type="checkbox"/> Yes
<small>For patient navigator use only, do not enter in database</small>		
Phone: Home: _____ Cell: _____ Email: _____	Permission to text: <input type="checkbox"/> Yes <input type="checkbox"/> No HBV provider name: _____ Best time to call: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening Contact info: _____	

Use "Health Promotion Module 1: Hep B Basics" to complete this section.

Assessment: Self-Reported Hep B History		
Year of HBV diagnosis:	Ever treated for HBV? <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes, years treated: _____	If YES, currently taking HBV meds? <input type="checkbox"/> No <input type="checkbox"/> Yes HBV medication: <input type="checkbox"/> Health Promotion Guide Module 1 complete

Use "Health Promotion Module 2: Getting Ready for Hep B Care" to complete this section, and develop a "Care Plan" with patient.

Patient Navigator Assessment		Referrals Made
How many children? _____ Pregnant: <input type="checkbox"/> No <input type="checkbox"/> Yes		Pediatric Care: <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Any household, family or partners in need of notification? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined If YES: how many contacts: _____		Prenatal Care: <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Any mental health issues? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No		HBV Test/Vaccine for Contacts: <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Any alcohol use in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer		Mental Health Services <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Injection drug use in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer		Alcohol treatment <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Intranasal drug use in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer		Substance Abuse or Harm Reduction Services <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Injection drug use ever? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer		Insurance Enrollment <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed <input type="checkbox"/> Referred to free/low cost care
On methadone maintenance: <input type="checkbox"/> Yes <input type="checkbox"/> No On buprenorphine: <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of insurance plan:	
Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> None		
Temporary insurance for pregnant women? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Income (per month): <input type="checkbox"/> \$800 or less <input type="checkbox"/> \$801-\$1,200 <input type="checkbox"/> \$1,201-\$1,500 <input type="checkbox"/> \$1,501-\$2,500 <input type="checkbox"/> \$2,501+ <input type="checkbox"/> Declined to answer		Social Services (such as: housing, financial, food, legal, transportation) <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Housing: <input type="checkbox"/> Stable housing <input type="checkbox"/> Unstable housing <input type="checkbox"/> Homeless		
Has consistent transportation for appointments: <input type="checkbox"/> Yes <input type="checkbox"/> No		Social Support <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Social Support <input type="checkbox"/> None <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> Support Group <input type="checkbox"/> Program		
<input type="checkbox"/> Health Promotion Guide Module 2 complete <input type="checkbox"/> Care Plan developed and reviewed with patient		
Patient Navigation Service Level: <input type="checkbox"/> Low Intensity <input type="checkbox"/> High Intensity		

Check Hep B Program | Patient Navigation Form | 2016

The *Patient Navigation Form* documents patient's:

- Demographic/contact information
- Hep B medical history
- Need for referrals
- Care coordination services
- Hep B medical care progress
- Discharge/transition plan

The form is an exact replica of the *Patient Navigation Database*.

All sections must be completed for all patients in the *Database*!

# Check Hep B Patient Navigation Services

1

Outreach & Enrollment

2

Assessment & Care Plan

3

Linkage to Hep B Care

4

Care Coordination

Detailed guidelines for each PN service are in the **Check Hep B Program Protocol**!



Outreach &  
Enrollment

Assessment &  
Care Plan

Linkage to  
Hep B Care

Care  
Coordination



# Patient Navigation Service 1: **Outreach & Enrollment**

# Recruiting Patients Through In/Outreach

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PNs are responsible for recruiting and enrolling eligible patients. Patients can be enrolled from within or outside of the organization.

## **Eligible Patients**

- HBV surface antigen-positive
- Resident of service coverage area of program

## **Ineligible Patients**

- HBV surface antigen negative
- Do not reside in service coverage area of program
- Enrolled in another HBV or HIV care coordination program (to avoid duplication of services)

# Obtaining Patient Consent

Use the *Consent Form* to explain the purpose, services and length of the Check Hep B Program.

Read through the consent form, inviting questions and providing answers:

- If the patient **agrees** to participate, ask for their signature.
- If the patient **declines**, refer to appropriate services if needed.

**Check Hep B Program: Patient Consent**

This document describes the Check Hep B patient navigation program. Please read this document to understand the program and your role before you agree to participate in the program. If you have any questions, contact \_\_\_\_\_.

You should \_\_\_\_\_.

**What is the purpose of the program?**  
The Check Hep B Program is a patient navigation program for people with hepatitis B. The program provides support services to help you understand the program and your role. The program also provides support services to help you understand the program and your role.

**What is expected of you?**  
Program participants are expected to:  
1. Attend all scheduled appointments.  
2. Attend all scheduled appointments.  
3. Work with the program staff to understand the program and your role.  
4. If you read the whole document, you will understand the program and your role.

**How will the program help you?**  
• All staff in the program are trained to provide support services to help you understand the program and your role.  
• Information and type of support services will be provided to you.  
• The New York City Department of Health and Mental Hygiene has a program and report card for the program.  
• Any report card for the program can be found on the program website.

**Check Hep B Program: Patient Consent**

**What if I do not want to participate, or if I want to stop after I enroll?**  
Participation in this program is voluntary. You may end your participation at any time. If you wish to end your participation, please inform your Patient Navigator, Check Hep B program staff or your doctor can also end your participation in the program at any time. They can end your enrollment for medical, program-related or administrative reasons. Ending your participation does not affect your eligibility for non-Check Hep B medical or social services.

**Statement of Agreement**

I, (print patient name) \_\_\_\_\_, understand the information provided above and agree to enroll in the Check Hep B Program at (print agency name) \_\_\_\_\_.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date (mm/dd/yyyy)

Check Hep B Program Staff administering consent:

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Initials

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date (mm/dd/yyyy)

NYC Department of Health—Check Hep B Program Patient Consent—FY2016 2

# Documentation During Enrollment

Upon enrollment, complete all fields in the **ENROLLMENT INFORMATION** section in the *Patient Navigation Form*.

Patient contact information is for patient navigator use only and not reported to Check Hep B program management.

**CHECK HEP B**  
NEW YORK CITY

**Patient Navigation Form**

This form is a tool for the Patient Navigator to document their work assisting each patient through the continuum of care. Keep this form in the patient chart and update after each patient encounter. This form is a paper version of the Check Hep B database.

**Enrollment Information**

<b>Enrollment Date:</b>	<b>Check Hep B Patient ID:</b> <small>[Unique number provided for this project]</small>	<b>Agency Patient ID:</b>
<b>Patient Last Name:</b>	<b>Patient First Name:</b>	<b>Date of Birth:</b> / /
<b>Address (# Street, Apt #, Borough):</b>	<b>Zip Code:</b>	<b>Referral Source:</b> <input type="checkbox"/> Internal <input type="checkbox"/> External
<b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian/PI <input type="checkbox"/> Other: <input type="checkbox"/> Unknown <input type="checkbox"/> American Indian/Alaska Native	<b>Ethnicity:</b> <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown	<b>Gender:</b> <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Trans M → F <input type="checkbox"/> Trans F → M
<b>English:</b> <input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write <input type="checkbox"/> None	<b>Country of Birth:</b>	<b>Interpretation needed:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Preferred Language:</b>		
<small>For patient navigator use only, do not enter in database</small>		
<b>Phone: Home:</b> <b>Cell:</b> <b>Email:</b>		
<b>Permission to text:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Best time to call:</b> <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	
<b>HBV provider name:</b>	<b>Contact info:</b>	

Use "Health Promotion Module 1: Hep B Basics" to complete this section.

**Assessment: Self-Reported Hep B History**

<b>Year of HBV diagnosis:</b>	<b>Ever treated for HBV?</b> <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes, years treated:	<b>If YES, currently taking HBV meds?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>HBV medication:</b> <input type="checkbox"/> Health Promotion Guide Module 1 complete
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Use "Health Promotion Module 2: Getting Ready for Hep B Care" to complete this section, and develop a "Care Plan" with patient.

**Patient Navigator Assessment**

<b>How many children?</b> <b>Pregnant:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	<b>Referrals Made</b>
<b>Any household, family or partners in need of notification?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <b>If YES: how many contacts:</b>	<b>Pediatric Care:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed <b>Prenatal Care:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
<b>Any mental health issues?</b> <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	<b>HBV Test/Vaccine for Contacts:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
<b>Any alcohol use in the past year?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	<b>Mental Health Services</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
<b>Injection drug use in the past year?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	<b>Alcohol treatment</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
<b>Intranasal drug use in the past year?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	<b>Substance Abuse or Harm Reduction Services</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
<b>Injection drug use ever?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	<b>Insurance Enrollment</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed <input type="checkbox"/> Referred to free/low cost care
<b>On methadone maintenance:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>On buprenorphine:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Insurance</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> None
<b>Temporary insurance for pregnant women?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Name of insurance plan:</b>
<b>Income (per month):</b> <input type="checkbox"/> \$800 or less <input type="checkbox"/> \$801-\$1,200 <input type="checkbox"/> \$1,201-\$1,500 <input type="checkbox"/> \$1,501-\$2,500 <input type="checkbox"/> \$2,501+ <input type="checkbox"/> Declined to answer	<b>Social Services</b> (such as: housing, financial, food, legal, transportation) <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
<b>Housing:</b> <input type="checkbox"/> Stable housing <input type="checkbox"/> Unstable Housing <input type="checkbox"/> Homeless	<b>Social Support</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
<b>Has consistent transportation for appointments:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Social Support</b> <input type="checkbox"/> None <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> Support Group <input type="checkbox"/> Program	
<input type="checkbox"/> Health Promotion Guide Module 2 complete <input type="checkbox"/> Care Plan developed and reviewed with patient	
<b>Patient Navigation Service Level:</b> <input type="checkbox"/> Low Intensity <input type="checkbox"/> High Intensity	

Check Hep B Program | Patient Navigation Form | 2016

Outreach &  
Enrollment

Assessment &  
Care Plan

Linkage to  
Hep B Care

Care  
Coordination



## Patient Navigation Service 2: **Assessment & Care Plan**

# Patient Navigator Assessment

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- The *Patient Navigator Assessment* identifies areas where patients could benefit from additional support that patient navigators can provide or refer patients to, such as presence of mental health issue or health insurance status.
- Addressing these issues can better prepare patients for a more successful medical evaluation and treatment outcome.
- The assessment can be completed through patient and provider interview, by reviewing the patient's health record and/or by consulting with their care team.
- PNs should focus on helping the patient complete Hep B medical evaluation, begin and adhere to treatment if recommended, and will not have time to meet all of the patients' related needs. The PN should refer for supportive services where possible rather than attempting to provide time-consuming supportive services themselves.

# Documentation During Assessment

**CHECK HEP B**  
NEW YORK CITY

**Patient Navigation Form**

This form is a tool for the Patient Navigator to document their work assisting each patient through the continuum of care. Keep this form in the patient chart and update after each patient encounter. This form is a paper version of the Check Hep B database.

**Enrollment Information**

Enrollment Date:	Check Hep B Patient ID: [Unique number provided for this project]	Agency Patient ID:
Patient Last Name:	Patient First Name:	Date of Birth: / /
Address (# Street, Apt #, Borough):		Referral Source: <input type="checkbox"/> Internal <input type="checkbox"/> External
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian/PI <input type="checkbox"/> Other: <input type="checkbox"/> Unknown <input type="checkbox"/> American Indian/Alaska Native	Ethnicity: <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown Country of Birth:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Trans M → F <input type="checkbox"/> Trans F → M
English: <input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write <input type="checkbox"/> None	Preferred Language:	Interpretation needed: <input type="checkbox"/> No <input type="checkbox"/> Yes
<small>For patient navigator use only, do not enter in database</small>		
Phone: Home: _____ Cell: _____	Email: _____	
Permission to text: <input type="checkbox"/> Yes <input type="checkbox"/> No	Best time to call: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	
HBV provider name:	Contact info:	

**Assessment: Self-Reported Hep B History**

Year of HBV diagnosis:	Ever treated for HBV? <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes, years treated:	If YES, currently taking HBV meds? <input type="checkbox"/> No <input type="checkbox"/> Yes HBV medication:
<input type="checkbox"/> Health Promotion Guide Module 1 complete		

Use "Health Promotion Module 2: Getting Ready for Hep B Care" to complete this section, and develop a "Care Plan" with patient.

**Patient Navigator Assessment**

How many children? _____ Pregnant: <input type="checkbox"/> No <input type="checkbox"/> Yes	<b>Referrals Made</b>
Any household, family or partners in need of notification? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined If YES: how many contacts: _____	Pediatric Care: <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed Prenatal Care: <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Any mental health issues? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	HBV Test/Vaccine for Contacts: <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Any alcohol use in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Mental Health Services <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Injection drug use in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Alcohol treatment <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Intranasal drug use in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Substance Abuse or Harm Reduction Services <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Injection drug use ever? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Insurance Enrollment <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed <input type="checkbox"/> Referred to free/low cost care
On methadone maintenance: <input type="checkbox"/> Yes <input type="checkbox"/> No On buprenorphine: <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Services (such as: housing, financial, food, legal, transportation) <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> None	Social Support: <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Name of insurance plan:	
Temporary insurance for pregnant women? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Income (per month): <input type="checkbox"/> \$800 or less <input type="checkbox"/> \$801-\$1,200 <input type="checkbox"/> \$1201-\$1,500 <input type="checkbox"/> \$1501-\$2,500 <input type="checkbox"/> \$2501+ <input type="checkbox"/> Declined to answer	
Housing: <input type="checkbox"/> Stable housing <input type="checkbox"/> Unstable Housing <input type="checkbox"/> Homeless	
Has consistent transportation for appointments: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Social Support: <input type="checkbox"/> None <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> Support Group <input type="checkbox"/> Program	
<input type="checkbox"/> Health Promotion Guide Module 2 complete <input type="checkbox"/> Care Plan developed and reviewed with patient	
Patient Navigation Service Level: <input type="checkbox"/> Low Intensity <input type="checkbox"/> High Intensity	

Check Hep B Program | Patient Navigation Form | 2016

Within 2 weeks of enrollment, complete all fields in the **SELF-REPORTED HEP B MEDICAL HISTORY** and **PATIENT NAVIGATOR ASSESSMENT** of the *Patient Navigation Form*.

# Referrals to Supportive Services

Based on the *Patient Navigator Assessment*:

1. **Identify need** for supportive services that cannot be met by PNs or agency (e.g. mental health, alcohol counseling or harm reduction, health insurance enrollment, or social support services)
2. **Discuss** recommended referral with patient
3. If patient accepts referral, **document** on the *Care Plan*
4. **Help patient** make appointments, if needed
5. **Make a plan** to ensure that the patient attends the appointment (e.g. determine need for reminder or assistance)

**Check Hep B Care Plan**

Navigator Instructions: Patients start with a patient navigator. Complete the form based on agreed-upon goals. Sign and give a copy to the doctor.

Patient Name: \_\_\_\_\_ Title: \_\_\_\_\_

**Care Team**

Name	Address	Phone Number	E-mail Address
Doctor			
Navigator			

☐ Accompanyment to medical visits ☐ Reminders for visit day ☐ Call ☐ Text ☐ Email

**Check Hep B Program Goals**

Goal	Date Completed
<input type="checkbox"/> Complete patient navigation assessment	
<input type="checkbox"/> Receive "Hep B basics" health information	
<input type="checkbox"/> Receive "Getting ready for Hep B care" health promotion	
<input type="checkbox"/> At least 1 full Hep B medical visit	
<input type="checkbox"/> Complete Hep B medical evaluation	
<input type="checkbox"/> Receive "Getting ready for treatment" health promotion (if applicable)	
<input type="checkbox"/> Start Hep B treatment (if applicable)	
<input type="checkbox"/> Receive "Staying healthy with Hep B" health promotion	
<input type="checkbox"/> Consult services (notification if applicable)	


**Referrals**

Type of Service	Site Name and Address	Phone Number/ E-mail Address	Appointment Date/Time
<input type="checkbox"/> Mental health			
<input type="checkbox"/> Alcohol counseling			
<input type="checkbox"/> Substance use/abuse counselor			
<input type="checkbox"/> Insurance enrollment			
<input type="checkbox"/> Social (Food/Financial)			
<input type="checkbox"/> Housing services			
<input type="checkbox"/> Legal services			
<input type="checkbox"/> Spiritual			
<input type="checkbox"/> Other			

NHC Department of Health - Check Hep B Program Care Plan - Patient

# Patient Navigation Care Plan

The *Care Plan* is a tool for PNs and patients to use to discuss, agree upon, and monitor the patient's care plan. This includes agreement on the care coordination services needed; for example, type or frequency of accompaniment and/or type of reminders needed.



Navigator instructions: Discuss care plan with patient. Complete the form based on agreed plan, sign and give a copy to patient.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Care Team**

Name	Address	Phone Number	E-mail Address
<b>Doctor</b>			
<b>Navigator</b>			

☐ Accompaniment to medical visits ☐ Reminders for visits by: ☐ Call ☐ Text ☐ Email

**Check Hep B Program Goals**

Goal	Date Completed
<input type="checkbox"/> Complete patient navigation assessment	
<input type="checkbox"/> Receive "Hep B basics" health promotion	
<input type="checkbox"/> Receive "Getting ready for Hep B care" health promotion	
<input type="checkbox"/> Attend 1st Hep B medical visit	
<input type="checkbox"/> Complete Hep B medical evaluation	
<input type="checkbox"/> Receive "Getting ready for treatment" health promotion (if applicable)	
<input type="checkbox"/> Start Hep B treatment (if applicable)	
<input type="checkbox"/> Receive "Staying healthy with Hep B" health promotion	
<input type="checkbox"/> Conduct contact notification (if applicable)	

**Referrals**

Type of Service	Site Name and Address	Phone Number/ E-mail Address	Appointment Date/Time
<input type="checkbox"/> Mental health			
<input type="checkbox"/> Alcohol counseling			
<input type="checkbox"/> Substance use treatment			

## To develop a *Care Plan*:

1. Review the *Care Plan* with the patient and discuss and decide on a plan and goals.
2. Sign the plan as confirmation of this agreement.
3. Provide the patient with a copy.
4. Update the *Care Plan* over time as needed.

Outreach &  
Enrollment

Assessment &  
Care Plan

Linkage to  
Hep B Care

Care  
Coordination



## Patient Navigation Service 3: **Linkage to Hep B Care**

# Linking Patients to Hep B Medical Care

---

## 1. For patients not in Hep B care:

Link patients to care **within one month** of enrollment:

- On-site, whenever possible
- Off-site, if necessary

Plan case conferences with both on- and off-site providers.

Uninsured patients can receive low-cost Hep B care at some public hospitals, or community health centers.

## 2. For patients in Hep B care:

Schedule a case conference to discuss collaboration and the *Care Plan* **within one month** of enrollment.



Read more about linking patients to Hep B medical care in the **Check Hep B Program Protocol!**

# Documenting Hep B Medical Care

Page 2



## Patient Navigation Form

Use the "Care Coordination Log" to document each care coordination service encounter.

Care Coordination Service	First Service Date	Most Recent Date	Total # of Days
Accompaniment			
Reminders			
Alcohol/Drug counseling			
Case conference			
Treatment adherence support			
Medication/pharmacy coordination			
Other meeting with patient			

Enter in database only  
[Enter most recent date of service  
and total number of each service to  
date in database before sending  
report.]

Obtain the following information from the medical provider.

Hepatitis B Medical Care		
Provider name:		Hospital/clinic:
First HBV medical visit date after enrollment:	Most recent HBV medical visit date: [Enter in database before sending report]	Total # medical visits to date: [Enter in database before sending report]
Medical evaluation completion date:	If evaluation not completed, reason why: <input type="checkbox"/> Did not attend appointments <input type="checkbox"/> Declined tests <input type="checkbox"/> Cost <input type="checkbox"/> Other:	
Stage of Liver Disease: <input type="checkbox"/> No Cirrhosis <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Not evaluated		
Co-morbid conditions: <input type="checkbox"/> None <input type="checkbox"/> HIV <input type="checkbox"/> Hep C <input type="checkbox"/> Psych <input type="checkbox"/> Other:		
Most recent liver cancer screening date: [Enter in database before sending report]		Outcome: <input type="checkbox"/> Cancer <input type="checkbox"/> No cancer

Use "Health Promotion Module 3: Getting Ready for Hep B Treatment" to complete this section, and develop the "Treatment Planning Form" with the medical provider and patient.

Hepatitis B Treatment	
Treatment candidate: <input type="checkbox"/> Yes <input type="checkbox"/> No	Rationale for Treatment: <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Liver cancer <input type="checkbox"/> Abnormal labs <input type="checkbox"/> Other:
Treatment start date:	If treatment delay, why: <input type="checkbox"/> Did not attend appointments <input type="checkbox"/> Lost to follow up <input type="checkbox"/> Other: <input type="checkbox"/> Could not afford treatment <input type="checkbox"/> Patient declined treatment, explain:
Adherence Support	<input type="checkbox"/> 3 day after treatment start check-in completed Adherence check-in frequency during treatment: <input type="checkbox"/> Weekly <input type="checkbox"/> Other:
Treatment discontinuation date:	If treatment discontinued, reason why: <input type="checkbox"/> Side effects/adverse event <input type="checkbox"/> No viral response <input type="checkbox"/> Patient stopped on own <input type="checkbox"/> Insurance coverage/cost <input type="checkbox"/> Other, explain:
Treatment outcome:	HBV DNA (viral) suppression <input type="checkbox"/> Yes <input type="checkbox"/> No Normalization of ALT <input type="checkbox"/> Yes <input type="checkbox"/> No

☐ Health Promotion Guide Module 3 complete  
☐ Treatment Planning Form reviewed with patient

Complete "Health Promotion Module 4: Staying Healthy with Hep B" after the medical evaluation is complete.

Patient:
<input type="checkbox"/> Attended first routine HBV monitoring visit independently <input type="checkbox"/> Is adherent to medications (if applicable)
<input type="checkbox"/> Health Promotion Guide Module 4 complete

Discharge	Date:	Total # encounters with Patient Navigator:
Reason: <input type="checkbox"/> Declined Program <input type="checkbox"/> Program ended <input type="checkbox"/> Completed Program <input type="checkbox"/> Spontaneously cleared HBV <input type="checkbox"/> Referred to another program <input type="checkbox"/> Lost to follow up <input type="checkbox"/> Deceased <input type="checkbox"/> Incarcerated <input type="checkbox"/> Moved <input type="checkbox"/> Other:		
Case Notes:		

Information about hepatitis B medical evaluation and treatment must be provided by the patient's medical provider and/or obtained from the medical record. This section cannot be completed using patient report alone.

Outreach &  
Enrollment

Assessment &  
Care Plan

Linkage to  
Hep B Care

Care  
Coordination



## Patient Navigation Service 4: **Care Coordination**

# Care Coordination Services

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REMINDERS &  
ACCOMPANIMENT



CASE  
CONFERENCE



MEDICAL  
INTERPRETATION



ALCOHOL/Dr  
ug  
COUNSELING



MEDICATION &  
PHARMACY  
COORDINATION



TREATMENT READINESS  
& ADHERENCE SUPPORT



DISCHARGE/  
TRANSITION  
PLANNING

# Care Coordination Services

---

## ACCOMPANIMENT

Depends on: (1) level of support patient needs to fully engage in care and (2) ability of PN to monitor and support patient's care:



- **All appointments:** Find other resources to support accompaniment, e.g. case managers, transportation services
- **Some appointments:** If patients only need support at some appointments
- **No appointments:** PN should speak to patient and provider to verify appointments are kept, learn appointment outcome and next steps.

Discuss options with the patient, come to an agreement and document your accompaniment plans on the *Care Plan*.

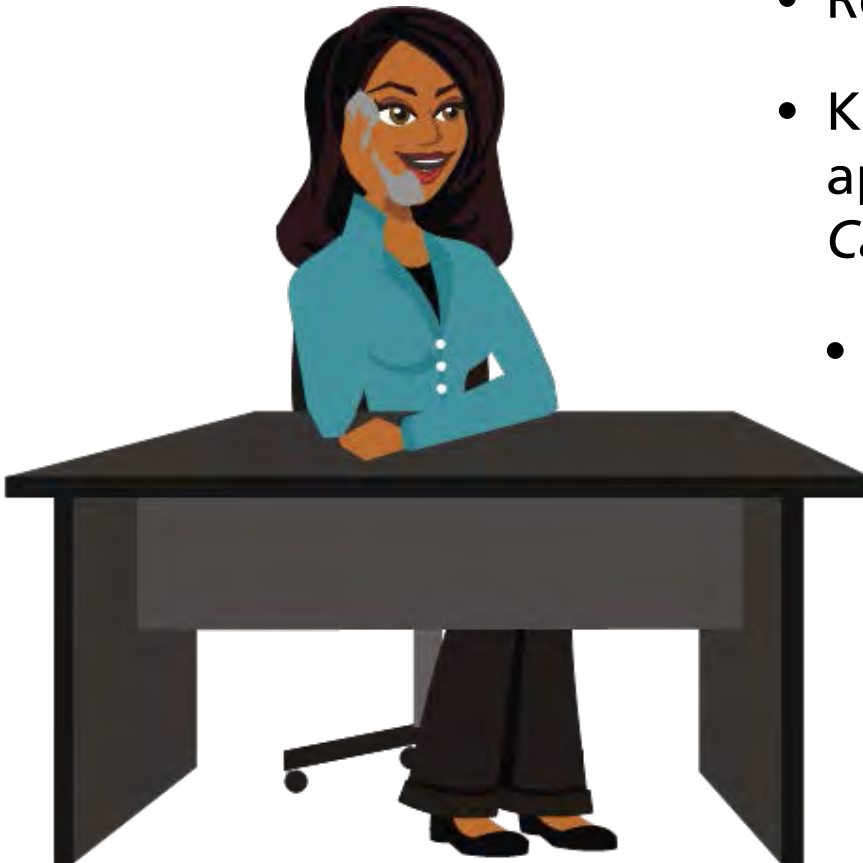
# Care Coordination Services

---

## APPOINTMENT REMINDERS



- Remind by phone/text/email.
- Keep a record and verify that appointments were kept using the *Care Coordination Log*.
- If appointments are missed:
  - Contact patient the same day to determine reason
  - Make a plan to ensure the next visit is kept
  - Consider accompaniment for future visits



# Care Coordination Services

---



## CASE CONFERENCE WITH HEP B MEDICAL PROVIDER & CARE TEAM

Review active cases with provider and multidisciplinary care team at least once a month

PNs should talk to the provider:

1. After **each** appointment to confirm care and treatment goals
2. When there is a: need for clarification on care and treatment goals, or change in patient's circumstances (e.g. housing)
3. When there is a potential disruption to medical care and treatment



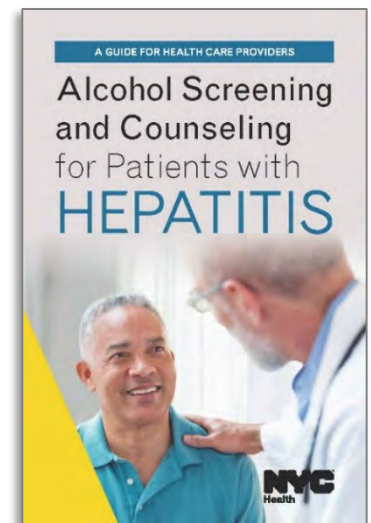
# Care Coordination Services



## ALCOHOL/DRUG COUNSELING & REFERRAL TO TREATMENT

After assessing alcohol/drug use during the assessment:

- Tell all patients that “it is safest not to drink any alcohol if you have hepatitis.” This counts as an “alcohol counseling” care coordination service that all patients should receive by the end of the program.
- If patient drinks any alcohol, **provide alcohol counseling** at each encounter.
- If warranted, **refer to alcohol and/or drug treatment**.



# Care Coordination Services

---



## TREATMENT ADHERENCE SUPPORT

**Before** the patient starts treatment:

1. Make sure patients understand their treatment regimen
2. Discuss ways to ensure treatment adherence
3. Agree on a check-in schedule during treatment

**During** treatment:

1. Check in with patients according to agreed-upon schedule
2. Ask patients if they have missed any doses
3. Ensure patients report side effects to their medical provider right away

# Care Coordination Services

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## MEDICATION/PHARMACY COORDINATION

In many cases, PNs will need to support the care team to order medications:

1. **Use a local specialty pharmacy**, which can help order medications and support treatment adherence.
2. For un/underinsured patients, **enroll in a patient assistance program** for low/no-cost meds.

# Care Coordination Services

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## DISCHARGE & TRANSITION PLANNING

- Develop discharge/transition plan **3 months before** program end.
- Patients can be discharged earlier if:
  - Patient no longer wants to participate
  - Is Lost to follow up
  - Needs another service, e.g. residential drug treatment program, liver transplant program
  - Spontaneously clears Hep B virus
  - Moves out of service area
  - Terminated from organization
- Discharge according to organizational policy and document discharge reasons

# Contact Notification & Related Services

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## CONTACT NOTIFICATION, VACCINATION AND LINKAGE TO CARE SERVICES

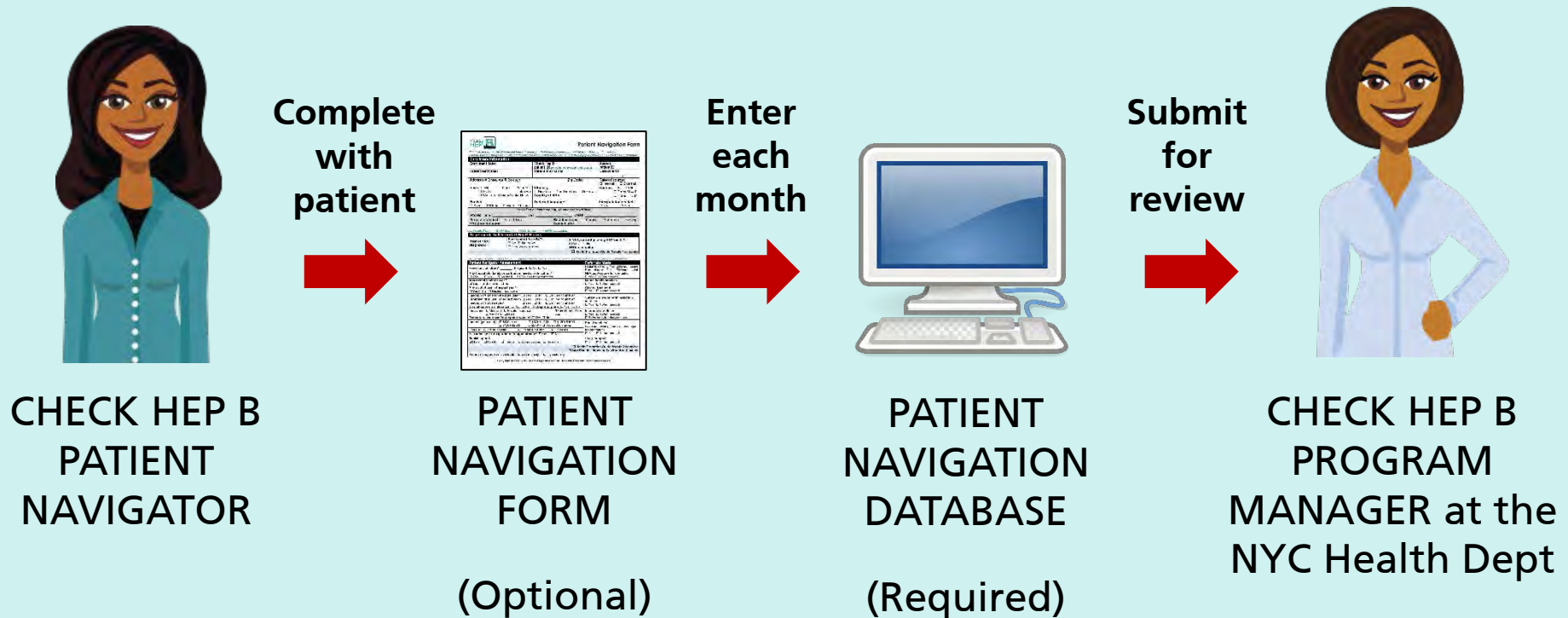
PNs should ensure that patient contacts – including children, sexual partners, family members, other household contacts – are screened and vaccinated for Hep B and linkage to Hep B care if needed.

- **For children:** PNs should schedule Hep B screening/vaccination appointments for children of patients.
- **For adults:** PNs should help patients form a plan to notify contacts of the need for Hep B screening and the availability of vaccination and care.
- **For Hep B-positive contacts:** PNs should reach out to infected contacts not currently in care to enroll in Check Hep B.

# Check Hep B Patient Navigation Program

**Reporting:  
Check Hep B  
Patient Navigation  
Form & Database**

# Reporting Patient Navigation Services



The patient navigation form and database serve two purposes:

1. Help PNs track patient progress and deliver patient navigation services.
2. Help the NYC Health Department learn how the program is going at each site and figure out how to better support each site.

# Review: Patient Navigation Form – Page 1

**CHECK HEP B**

**Patient Navigation Form**

*This form is a tool for the Patient Navigator to document their work assisting each patient through the continuum of care. Keep this form in the patient chart and update after each patient encounter. This form is a paper version of the Check Hep B database.*

**Enrollment Information**

Enrollment date:	Check Hep B patient ID: [Unique number provided for this project]	Agency patient ID:
Patient last name:	Patient first name:	Date of birth: / /
Address (# Street, Apt #, Borough):	Zip Code:	Referral source: <input type="checkbox"/> Internal <input type="checkbox"/> External
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian/PI <input type="checkbox"/> Other: <input type="checkbox"/> Unknown <input type="checkbox"/> American Indian/Alaska Native	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown Country of birth:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Trans M → F <input type="checkbox"/> Trans F → M
English: <input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write <input type="checkbox"/> None	Preferred language:	Interpretation needed: <input type="checkbox"/> No <input type="checkbox"/> Yes

*For patient navigator use only, do not enter in database*

Phone: Home: Cell: Email:

Permission to text: ☐ Yes ☐ No Best time to call: ☐ Morning ☐ Afternoon ☐ Evening

HBV provider name: Contact info:

*Use Health Promotion Guide Module 1: "Hep B Basics" to complete this section.*

**Assessment: Self-Reported Hep B History**

Year of HBV diagnosis:	Ever treated for HBV? <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes, years treated:	If YES, currently taking HBV meds? <input type="checkbox"/> Yes <input type="checkbox"/> No HBV medication: <input type="checkbox"/> Health Promotion Guide Module 1 complete
------------------------	---	--

*Use Health Promotion Guide Module 2: "Getting Ready for Hep B Care" to complete this section and develop a Care Plan with patient.*

**Patient Navigator Assessment**

How many children? _____ Pregnant: <input type="checkbox"/> No <input type="checkbox"/> Yes	<b>Referrals Made</b>
Any household, family or partners in need of notification? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined If YES: how many contacts: _____	Pediatric care: <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed Prenatal care: <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed HBV test/vaccine for contacts: <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Any mental health issues? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	Mental health services <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Any alcohol use in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Alcohol treatment <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Injection drug use in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer Intranasal drug use in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer Injection drug use ever? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer On methadone maintenance: <input type="checkbox"/> Yes <input type="checkbox"/> No On buprenorphine: <input type="checkbox"/> Yes <input type="checkbox"/> No	Substance use or harm reduction services <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> None	Name of insurance plan:
Temporary insurance for pregnant women? <input type="checkbox"/> Yes <input type="checkbox"/> No	Insurance enrollment <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed <input type="checkbox"/> Referred to free/low cost care
Income (per month): <input type="checkbox"/> \$800 or less <input type="checkbox"/> \$801-\$1,200 <input type="checkbox"/> \$1201-\$1500 <input type="checkbox"/> \$1501-\$2500 <input type="checkbox"/> \$2501+ <input type="checkbox"/> Declined to answer	Social services (such as: housing, financial, food, legal, transportation) <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Housing: <input type="checkbox"/> Stable housing <input type="checkbox"/> Unstable housing <input type="checkbox"/> Homeless	
Has consistent transportation for appointments: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Social support <input type="checkbox"/> None <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> Support group <input type="checkbox"/> Program	Social support <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed

☐ Health Promotion Guide Module 2 complete  
☐ Care Plan developed and reviewed with patient

Patient navigation service level: ☐ Low intensity ☐ High intensity

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Upon enrollment, complete  
**ENROLLMENT INFORMATION**

1. Within 2 weeks of enrollment, complete **SELF-REPORTED HEP B HISTORY & PATIENT NAVIGATOR ASSESSMENT**.
2. Track referrals on *Care Plan*.

# Review: Patient Navigation Form – Page 2

**CHECK HEP B**

**Patient Navigation Form**

Use the "Care Coordination Log" to document each care coordination service encounter.

Care Coordination Service	First Service Date	Most Recent Date	Total # to Date
Accompaniment			
Reminders			
Alcohol/Drug counseling			
Case conference			
Treatment adherence support			
Medication/pharmacy coordination			
Other meeting with patient			

Enter in database only  
(Enter most recent date of service and total number of each service to date in database before sending report.)

Obtain the following information from the medical provider.

Hepatitis B Medical Care		Hospital/clinic:
Provider name:		
First HBV medical visit date after enrollment:	Most recent HBV medical visit date: [Enter in database before sending report]	Total # medical visits to date: [Enter in database before sending report]
Medical evaluation completion date:	If evaluation not completed, reason why: <input type="checkbox"/> Did not attend appointments <input type="checkbox"/> Declined tests <input type="checkbox"/> Cost <input type="checkbox"/> Other:	
Stage of Liver Disease: <input type="checkbox"/> No Cirrhosis <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Not evaluated		
Co-morbid conditions: <input type="checkbox"/> None <input type="checkbox"/> HIV <input type="checkbox"/> Hep C <input type="checkbox"/> Psych <input type="checkbox"/> Other:		
Most recent liver cancer screening date: [Enter in database before sending report]		Outcome: <input type="checkbox"/> Cancer <input type="checkbox"/> No cancer

For patients who are treatment candidates: use the Health Promotion Guide Module 3: "Getting Ready for Hep B Treatment" to complete this section, and develop the "Treatment Planning Form" with the medical provider and patient.

Hepatitis B Treatment	
Treatment candidate: <input type="checkbox"/> Yes <input type="checkbox"/> No	Rationale for treatment: <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Liver cancer <input type="checkbox"/> Abnormal labs <input type="checkbox"/> Other:
Treatment start date:	If treatment delay, why: <input type="checkbox"/> Did not attend appointments <input type="checkbox"/> Lost to follow up <input type="checkbox"/> Other: <input type="checkbox"/> Could not afford treatment <input type="checkbox"/> Patient declined treatment, explain:
Adherence support	<input type="checkbox"/> 3 day after treatment start check-in completed <input type="checkbox"/> Adherence check-in frequency during treatment: <input type="checkbox"/> Weekly <input type="checkbox"/> Other:
Treatment discontinuation date:	If treatment discontinued, reason why: <input type="checkbox"/> Side effects/adverse event <input type="checkbox"/> No viral response <input type="checkbox"/> Patient stopped on own <input type="checkbox"/> Insurance coverage/cost <input type="checkbox"/> Other, explain:
Treatment outcome:	HBV DNA (viral) suppression <input type="checkbox"/> Yes <input type="checkbox"/> No Normalization of ALT <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Health Promotion Guide Module 3 complete <input type="checkbox"/> Treatment Planning Form reviewed with patient	

For patients who are treated, complete the Health Promotion Guide Module 4: "Staying Healthy with Hep B" after treatment has started.  
For patients who do not start treatment, complete this module any time after medical evaluation is completed.

Patient:	
<input type="checkbox"/> Attended first routine HBV monitoring visit independently <input type="checkbox"/> Is adherent to medications (if applicable)	
<input type="checkbox"/> Health Promotion Guide Module 4 complete	

Discharge	Date:	Total # encounters with Patient Navigator:
Reason: <input type="checkbox"/> Declined program <input type="checkbox"/> Program ended <input type="checkbox"/> Completed program <input type="checkbox"/> Spontaneously cleared HBV <input type="checkbox"/> Referred to another program <input type="checkbox"/> Lost to follow up <input type="checkbox"/> Deceased <input type="checkbox"/> Incarcerated <input type="checkbox"/> Moved <input type="checkbox"/> Other:		
Case Notes:		

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After delivering care coordination services, enter the first service date in **CARE COORDINATION SERVICE**

During/after accompaniments and case conferences, complete **HEPATITIS B MEDICAL CARE** and **HEPATITIS B TREATMENT** sections (verify with medical provider) and track in *Care Plan*.

Document **DISCHARGE/ TRANSITION** plan, inform patient 1 month prior to program end date.

# Care Coordination Log



## Patient Navigation Form

### Care Coordination Log

Use this form to document each encounter with the patient, as case notes. Keep this form in the patient chart.

At the time of reporting: add up the total number of encounters for each "Service Type" to date and enter into database

<b>Patient name:</b>	<b>Check Hep B patient ID:</b>	<b>Agency patient ID:</b>	
<b>Date of encounter:</b>	<input type="checkbox"/> Called <input type="checkbox"/> Emailed <input type="checkbox"/> Texted <input type="checkbox"/> In-person		
<b>Type of encounter:</b> <input type="checkbox"/> Accompaniment <input type="checkbox"/> Reminder <input type="checkbox"/> Alcohol/Drug counseling <input type="checkbox"/> Treatment adherence support <input type="checkbox"/> Medication/pharmacy coordination <input type="checkbox"/> Other meeting with patient			
<b>Patient stage in care plan:</b> <input type="checkbox"/> Assessment <input type="checkbox"/> Linkage-to-care <input type="checkbox"/> Medical evaluation <input type="checkbox"/> Treatment prep <input type="checkbox"/> Treatment			
<b>Notes:</b>			
<b>If the encounter included a medical visit:</b>			
<b>Purpose of medical visit:</b>		<b>On treatment:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <small>*Complete Treatment Planning Form before starting treatment and review at each visit while on treatment</small>	
<b>Instructions from medical provider:</b>			
<b>Next visit planning</b>			
<b>Date:</b>	<b>Type:</b> <input type="checkbox"/> Visit with medical provider <input type="checkbox"/> Visit with patient navigator	<b>Reminder needed:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Accompaniment needed:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Planning notes for next visit:</b>			

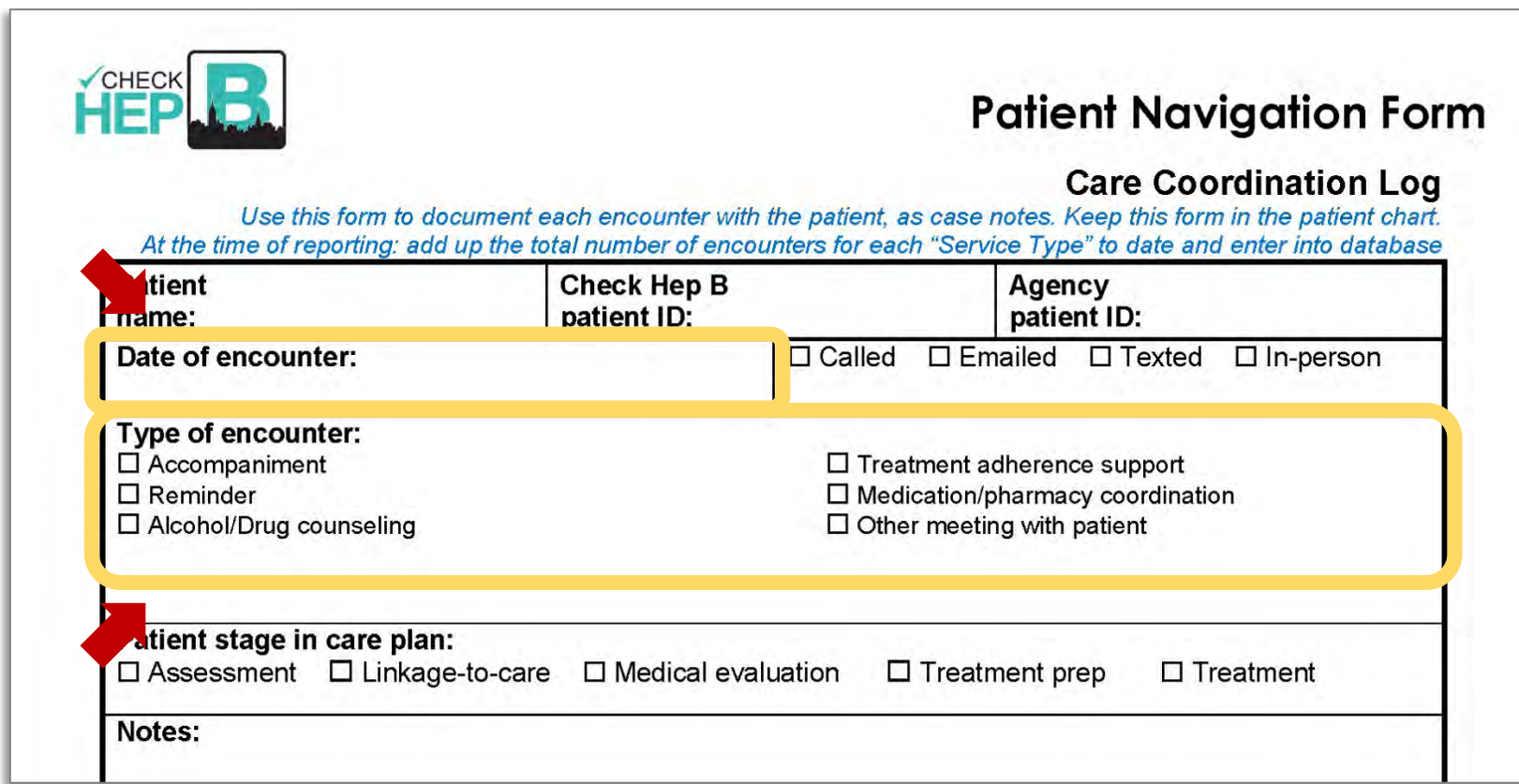
Use this page as case notes to document each encounter with patients.

- For monthly reporting, count the number of encounters for each service category, and enter the total number to date in the database at the time of reporting
- This form is for your records and can be substituted with progress notes or EHR pages used at your organization

# Documenting Care Coordination Services

## After every encounter:

Document the date and type of encounter in *Care Coordination Log*



The form is titled "Patient Navigation Form" and "Care Coordination Log". It includes a logo for "CHECK HEP B" with a checkmark and a stylized 'B'. Instructions state: "Use this form to document each encounter with the patient, as case notes. Keep this form in the patient chart. At the time of reporting: add up the total number of encounters for each 'Service Type' to date and enter into database". The form is divided into several sections. The first section contains fields for "Patient name:", "Check Hep B patient ID:", and "Agency patient ID:". Below these are checkboxes for "Called", "Emailed", "Texted", and "In-person". The second section, highlighted with a yellow border, is titled "Type of encounter:" and contains checkboxes for "Accompaniment", "Reminder", "Alcohol/Drug counseling", "Treatment adherence support", "Medication/pharmacy coordination", and "Other meeting with patient". The third section, also highlighted with a yellow border, is titled "Patient stage in care plan:" and contains checkboxes for "Assessment", "Linkage-to-care", "Medical evaluation", "Treatment prep", and "Treatment". The final section is labeled "Notes:".

**CHECK HEP B**

**Patient Navigation Form**

**Care Coordination Log**

Use this form to document each encounter with the patient, as case notes. Keep this form in the patient chart.  
At the time of reporting: add up the total number of encounters for each "Service Type" to date and enter into database

<b>Patient name:</b>	<b>Check Hep B patient ID:</b>	<b>Agency patient ID:</b>
<b>Date of encounter:</b>	<input type="checkbox"/> Called <input type="checkbox"/> Emailed <input type="checkbox"/> Texted <input type="checkbox"/> In-person	
<b>Type of encounter:</b> <input type="checkbox"/> Accompaniment <input type="checkbox"/> Treatment adherence support <input type="checkbox"/> Reminder <input type="checkbox"/> Medication/pharmacy coordination <input type="checkbox"/> Alcohol/Drug counseling <input type="checkbox"/> Other meeting with patient		
<b>Patient stage in care plan:</b> <input type="checkbox"/> Assessment <input type="checkbox"/> Linkage-to-care <input type="checkbox"/> Medical evaluation <input type="checkbox"/> Treatment prep <input type="checkbox"/> Treatment		
<b>Notes:</b>		

# Documenting Care Coordination Services

## After every encounter:

Enter the first date each service was delivered in the *Patient Navigation Form*



## Patient Navigation Form

Use the "Care Coordination Log" to document each care coordination service encounter.

Care Coordination Service	First Service Date	Most Recent Date	Total # to Date
Accompaniment			
Reminders			
Alcohol/Drug counseling			
Case conference			
Treatment adherence support			
Medication/pharmacy coordination			
Other meeting with patient			

Enter in database only  
[Enter most recent date of service and total number of each service to date in database before sending report.]

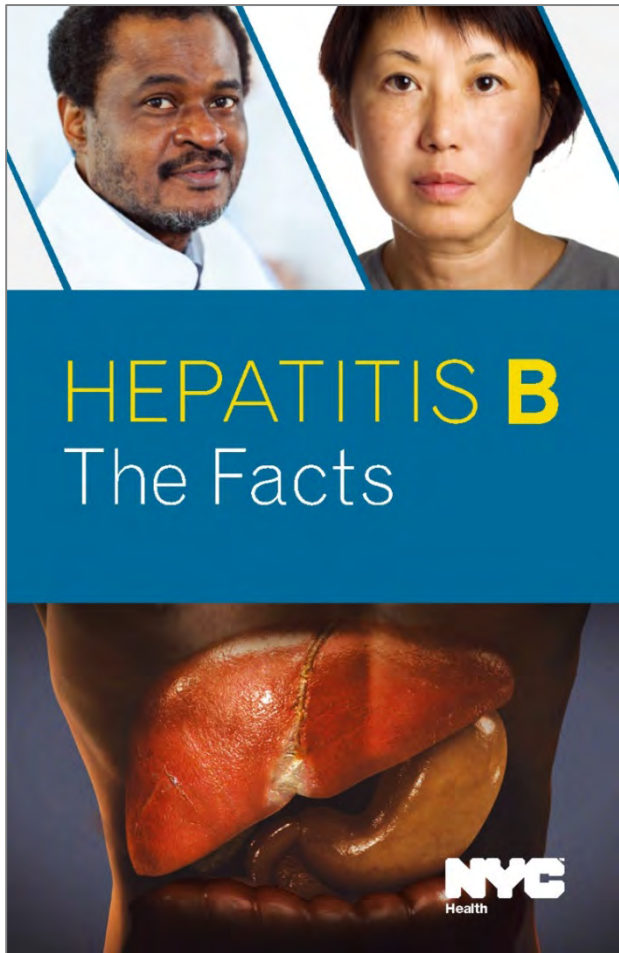
Obtain the following information from the medical provider.

Hepatitis B Medical Care			
Provider name:		Hospital/clinic:	
First HBV medical visit date after enrollment:	Most recent HBV medical visit date: [Enter in database before sending report]	Total # medical visits to date: [Enter in database before sending report]	
Medical evaluation completion date:	If evaluation not completed, reason why: <input type="checkbox"/> Did not attend appointments <input type="checkbox"/> Declined tests <input type="checkbox"/> Cost <input type="checkbox"/> Other:		
Stage of Liver Disease: <input type="checkbox"/> No Cirrhosis <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Not evaluated			

# Check Hep B Patient Navigation Program

**Health Promotion &  
Referral to  
Supportive Services**

# “Hepatitis B: The Facts” for Health Promotion



All patients should receive a copy of “Hepatitis B: The Facts.”

- **“Hepatitis B: The Facts”** is a 13-page patient education booklet on Hep B:
  - Risks and symptoms
  - Tests, care and treatment
  - Prevention
- Written in plain language to help patients understand complex health info
- Available in [English](#), [Spanish](#), [Chinese](#), [French](#), [Korean](#), and [Russian](#)
- To order free copies, contact [hep@health.nyc.gov](mailto:hep@health.nyc.gov).

# “Hepatitis B: Are You At Risk?” for Health Promotion



- “Hepatitis B: Are You At Risk” is a 1-page patient education material on Hep B risk, transmission, symptoms, and testing recommendations.
- Available in [English](#), [Burmese](#), [Simplified Chinese](#), [Traditional Chinese](#), [Hmong](#), [Khmer](#), [Korean](#), [Lao](#) and [Vietnamese](#)
- Similar fact sheets are available for:
  - People from Africa (in [English](#) and [French](#))
  - Native Hawaiians and Pacific Islanders (in [English](#))

# “When Someone Close to You Has Hepatitis B”



- “When Someone Close to You Has Hepatitis B” is a 1-page patient education material that promotes Hep B testing and vaccination for contacts of people with Hep B.
- Available in [English](#), [Burmese](#), [Simplified Chinese](#), [Traditional Chinese](#), [Hmong](#), [Khmer](#), [Korean](#), [Lao](#) and [Vietnamese](#)
- Similar fact sheets are available for:
  - People from Africa (in [English](#) and [French](#))
  - Native Hawaiians and Pacific Islanders (in [English](#))

# Visuals for Hep B Health Promotion

Visuals can help make complex information easier to understand.

## Risks of Chronic Hep B

About one in four people with chronic Hep B develop serious liver damage, including scarring and fibrosis (moderate liver damage) and cirrhosis (severe liver damage).

Liver damage often happens slowly, over 20 to 30 years.



Healthy Liver      Fibrosis      Cirrhosis      Liver Cancer

People with chronic Hep B are at risk for liver cancer at any stage of the disease, and should be screened for liver cancer every six months.

## Hep B and Liver Health Tests

Your doctor may perform some of these tests to confirm that you have Hep B or to find out how Hep B is affecting your health:

### Blood Tests

- **Hep B Surface Antigen (HBsAg) Test:** Shows if you are infected with Hep B.
- **Hep B Surface Antibody (anti-HBs) Test:** Shows if you are immune to Hep B.
- **Hep B DNA Tests:** Shows the amount of Hep B virus in your blood.
- **Liver Function Tests (LFTs):** Measure how well the liver is working. High levels may mean you have liver inflammation or damage.

Page 2



Healthy Liver

Fibrosis

Cirrhosis

Liver Cancer

The ["Hepatitis B: – Get Tested" video](#) also shows liver health complications!



# Check Hep B Patient Navigation Program



**Health Promotion Guide**  
For Check Hep B Patient Navigators

**Using the *Health  
Promotion Guide*  
to Deliver Hep B  
Health Promotion**

# Health Promotion

---

## HEALTH PROMOTION

Use the *Health Promotion Guide* to:

1. **Educate** patient on Hep B, liver health, and treatment readiness
2. **Assess and track** patient's needs for supportive services and medical care
3. **Counsel** on substance use and treatment readiness
4. **Develop** a care plan and treatment plan



# Health Promotion Guide: Overview

---

The *Check Hep B Health Promotion Guide* was created to guide Hep C health promotion when delivering key educational messages in “Hepatitis B: The Facts.”

There are 4 required modules:

1. **Hep B Basics**
2. **Getting Ready for Hep B Care**
3. **Getting Ready for Treatment**
4. **After Treatment**



**Health Promotion Guide**  
For Check Hep B Patient Navigators

# Health Promotion Guide: Overview

Each page of the *Health Promotion Guide* offers guiding questions and key messages to deliver to Check Hep B patients.

**HEP B BASICS:  
WHAT IS HEPATITIS B?**

**1. ASSESS NEED**

Ask patient:

- "What would you like to know about Hep B?"

**2. TELL PATIENTS**

1. Hepatitis B (Hep B) is caused by a **virus** that infects the liver.
  - Hepatitis means inflammation of the liver.
  - Your liver keeps you healthy in many ways. It removes toxins from your blood and transforms nutrients from food into energy.
  - There are different types of hepatitis. Hepatitis can be caused by excessive alcohol use, fatty liver, and viruses such as hepatitis A, B or C.
2. Hep B virus is transmitted (passed from one person to another) through **infected blood and sexual fluids, or from mother to child during birth.**
3. Hep B can lead to **serious health problems, including liver damage, liver failure, cancer and death.**
4. Many people with Hep B do **not** have symptoms and do not know they are infected.
  - Symptoms of Hep B can take up to 30 years to develop.
  - When symptoms do appear, they are often a sign of advanced liver disease.
5. Hep B can be **treated.**
  - Hep B cannot be cured, but treatment can slow or stop the virus from damaging the liver.

**3. REVIEW INFO**

Ask patient:

- "When do Hep B symptoms usually show?"
- "How would you explain Hep B to a friend or family member?"

**For More Info**  
Review "Hepatitis B: The Facts" and "Hepatitis B: Get Tested." video at <http://hepfree.nyc.gov/free-hep-b-educational-resources/#video>

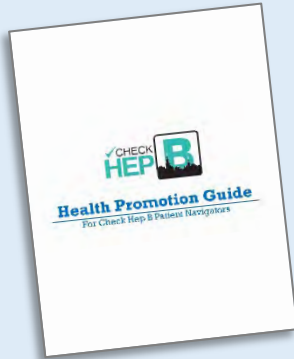
NYC Department of Health – Check Hep B Health Promotion Guide – FY2016 4

The 1<sup>st</sup> section offers questions to help assess patient's need for education or support.

The 2<sup>nd</sup> section offers key messages that PNs should share with all patients.

The 3<sup>rd</sup> section gives guidance for reviewing the information taught and/or creating an action plan, e.g. *Care Plan*.

# Health Promotion Guide: Module 1

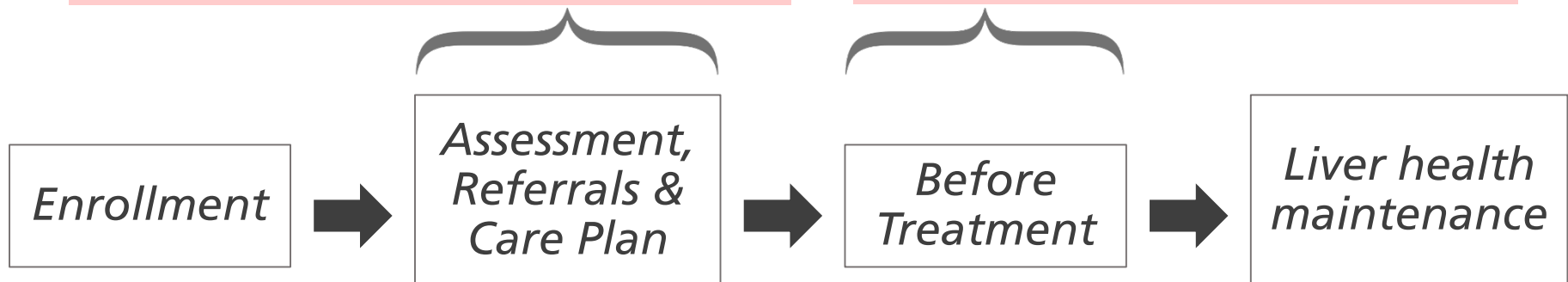


## Module 1: Hep B Basics

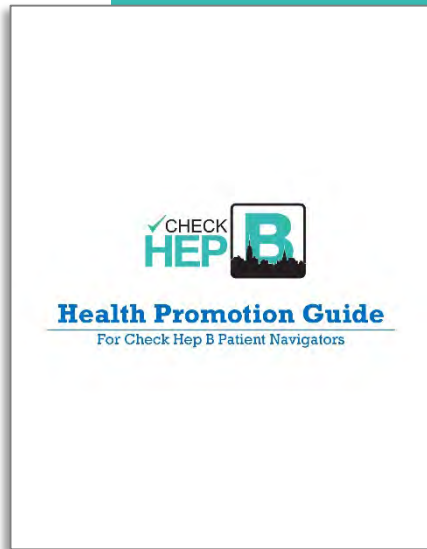
Covers: Hep B transmission, testing, care and treatment, and effects on liver health

Use Module 1 to deliver key messages on Hep B basics and medical care.

Reinforce Module 1 key messages before treatment as needed.



# Check Hep B Patient Navigation Program



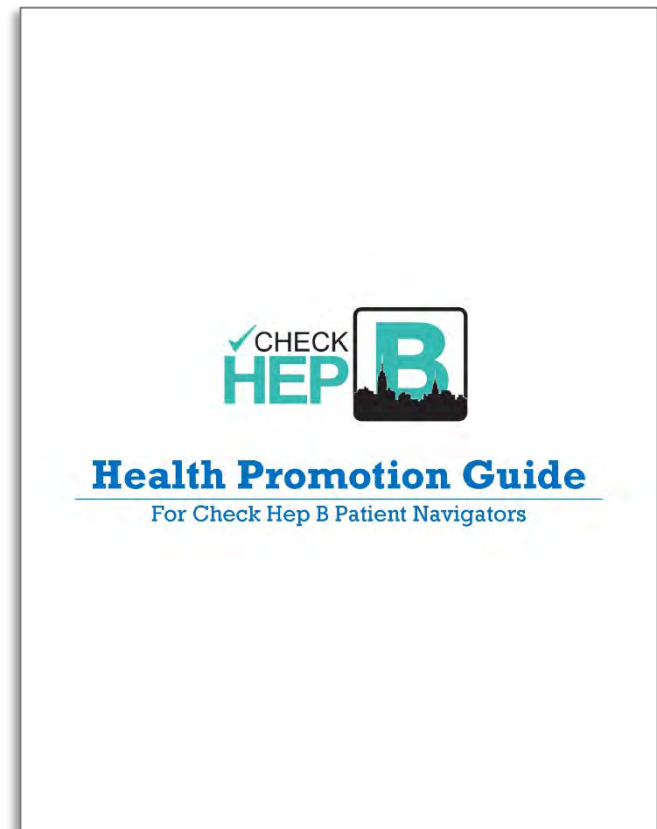
**Using the *Health Promotion Guide*  
to Assess, Refer,  
and Develop  
Action Plans**

# Health Promotion Guide: Overview

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In addition to guiding health promotion, the *Check Hep B Health Promotion Guide* was created to help PNs:

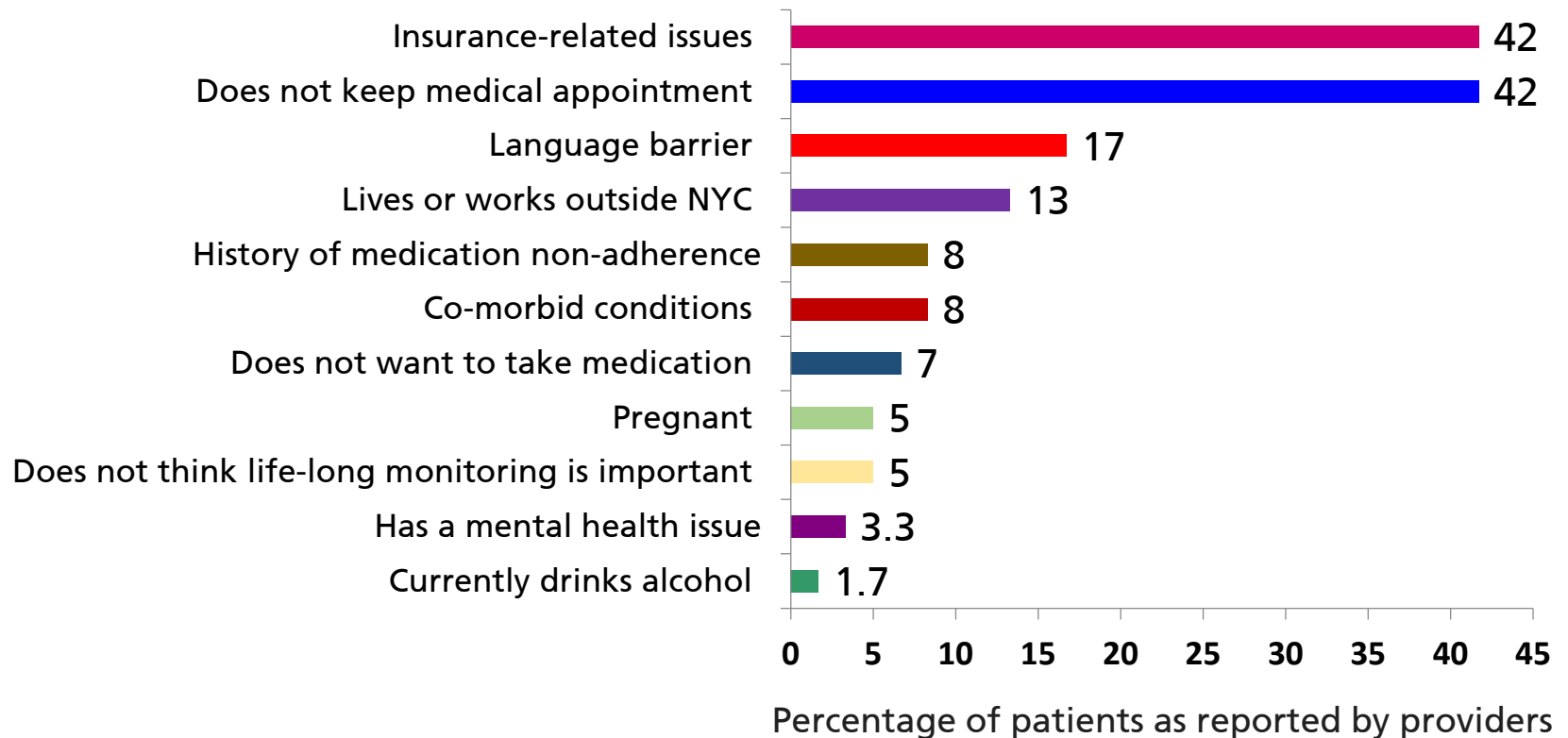
1. **Assess patients' needs** and **encourage referrals** to supportive services
2. **Develop an action plan** with patients to promote advancement through Hep B care continuum
3. **Complete required forms** (*Patient Navigation Form, Care Plan, and Treatment Planning Form*)
4. **Promote behavior change** to promote treatment readiness (e.g. substance use reduction)



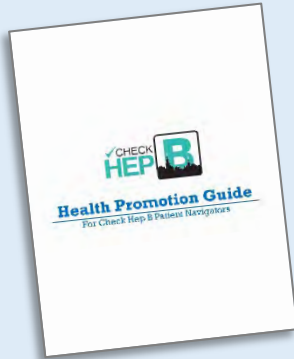
# Health Promotion Guide: Background

The *Guide* was also created to help PNs address common barriers to Hep B care.

## REASONS FOR NOT INITIATING HEP B TREATMENT: RESULTS OF 2015 SURVEY OF 60 HEP B-POSITIVE NYC PROVIDERS



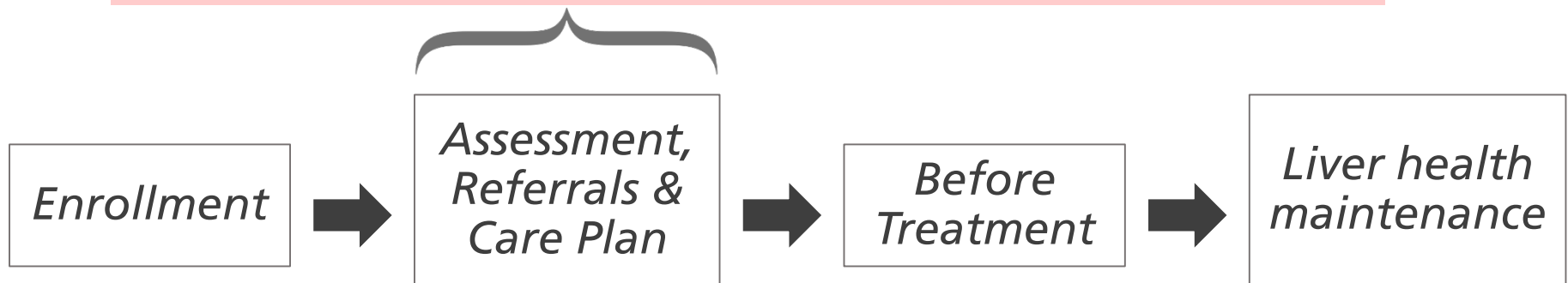
# Health Promotion Guide: Module 2



## Module 2: Getting Ready for Hep B Care

Covers: mental health, alcohol and drug use, lifestyle behaviors to improve liver health, and supportive services to promote readiness for Hep B care

Use Module 2 to help assess patient's need for supportive services (to improve readiness for Hep B care) and encourage referrals.



# Completing the Patient Navigator Assessment: Frequently Asked Questions

Refer to Module 2 of the *Health Promotion Guide* for questions you can ask to assess need for mental health services.

Income can be pulled from patient charts (e.g. social worker assessments) or estimated (refer to the Bureau of Labor Statistics May 2015 Wage Estimates: [http://www.bls.gov/oes/current/oes\\_nat.htm](http://www.bls.gov/oes/current/oes_nat.htm))

Use Health Promotion Guide Module 2: "Getting Ready for Hep B Care" to complete this section and develop a Care Plan with patient

## Patient Navigator Assessment

How many children? \_\_\_\_\_ Pregnant: ☐ No ☐ Yes

Any household, family or partners in need of notification?

☐ Yes ☐ No ☐ Declined If YES: how many contacts: \_\_\_\_\_

Any mental health issues?

☐ Yes ☐ Unknown ☐ No

Any alcohol use in the past year?

☐ Yes ☐ No ☐ Declined to answer

Injection drug use in the past year? ☐ Yes ☐ No ☐ Declined to answer

Intranasal drug use in the past year? ☐ Yes ☐ No ☐ Declined to answer

Injection drug use ever? ☐ Yes ☐ No ☐ Declined to answer

On methadone maintenance: ☐ Yes ☐ No On buprenorphine: ☐ Yes ☐ No

Insurance: ☐ Medicaid ☐ Private Insurance

☐ Medicare ☐ None

Name of insurance plan:

Temporary insurance for pregnant women? ☐ Yes ☐ No

Income (per month): ☐ \$800 or less ☐ \$801-\$1,200 ☐ \$1,201-\$1,500

☐ \$1,501-\$2,500 ☐ \$2,501+ ☐ Declined to answer

Housing: ☐ Stable housing ☐ Unstable housing ☐ Homeless

Has consistent transportation for appointments: ☐ Yes ☐ No

Social support

☐ None ☐ Family ☐ Friends ☐ Support group ☐ Program

Patient navigation service level: ☐ Low intensity ☐ High intensity

# Documenting Referrals on the PN Form

Use the *Patient Navigator Assessment* of the PN form to document the referrals for supportive services you make.

Use Health Promotion Guide Module 2: "Getting Ready for Hep B Care" to complete this section and develop a Care Plan with patient

Patient Navigator Assessment		Referrals Made
How many children? _____ Pregnant: <input type="checkbox"/> No <input type="checkbox"/> Yes		Pediatric care: <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Any household, family or partners in need of notification? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined If YES: how many contacts: _____		Prenatal care: <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Any mental health issues? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No		HBV test/vaccine for contacts: <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Any alcohol use in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer		Mental health services <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Injection drug use in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer		Alcohol treatment <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Intranasal drug use in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer		Substance use or harm reduction services <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Injection drug use ever? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer		Insurance enrollment <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed <input type="checkbox"/> Referred to free/low cost care
On methadone maintenance: <input type="checkbox"/> Yes <input type="checkbox"/> No On buprenorphine: <input type="checkbox"/> Yes <input type="checkbox"/> No		Social services (such as: housing, financial, food, legal, transportation) <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> None	Name of insurance plan: _____	Social support <input type="checkbox"/> Yes <input type="checkbox"/> No/not needed
Temporary insurance for pregnant women? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Income (per month): <input type="checkbox"/> \$800 or less <input type="checkbox"/> \$801-\$1,200 <input type="checkbox"/> \$1201-\$1500 <input type="checkbox"/> \$1501-\$2500 <input type="checkbox"/> \$2501+ <input type="checkbox"/> Declined to answer		
Housing: <input type="checkbox"/> Stable housing <input type="checkbox"/> Unstable housing <input type="checkbox"/> Homeless		
Has consistent transportation for appointments: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Social support <input type="checkbox"/> None <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> Support group <input type="checkbox"/> Program		
Patient navigation service level: <input type="checkbox"/> Low intensity <input type="checkbox"/> High intensity		

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- Check "No/not needed" if the patient does not need the referral.

- Check "Yes" if the patient needs the referral, even if the referral is not accepted.


- At future visits or calls, encourage the referral. Patients may become more open to the referral over time.
- Referrals can be for both internal and external services.

# Assessing Needs and Providing Referrals Using the Health Promotion Guide

## Step 3: Make a Plan

- Ask patient if they are willing to consider the referrals.
- Share recommended referrals and ask patient if they accept referrals:
  - If **yes**, document on *Care Plan* and review with patient.
  - If **no**, ask patient if you can discuss again in the future.

Even if the patient does not accept a referral, PNs should continue to work toward the primary goal of getting patients through medical evaluation and treatment.

**Care Plan**

Navigator instructions: Discuss care plan with patient. Complete the form based on agreed plan, sign and give a copy to patient.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Care Team**

Name	Address	Phone Number	E-mail Address
Doctor			
Navigator			

☐ Accompaniment to medical visits ☐ Reminders for visits by: ☐ Call ☐ Text ☐ Email

**Check Hep B Program Goals**

Goal	Date Completed
<input type="checkbox"/> Complete patient navigation assessment	
<input type="checkbox"/> Receive "Hep B basics" health promotion	
<input type="checkbox"/> Receive "Getting ready for Hep B care" health promotion	
<input type="checkbox"/> Attend 1st Hep B medical visit	
<input type="checkbox"/> Complete Hep B medical evaluation	
<input type="checkbox"/> Receive "Getting ready for treatment" health promotion (if applicable)	
<input type="checkbox"/> Start Hep B treatment (if applicable)	
<input type="checkbox"/> Receive "Staying healthy with Hep B" health promotion	
<input type="checkbox"/> Conduct contact notification (if applicable)	

**Referrals**

Type of Service	Site Name and Address	Phone Number/ E-mail Address	Appointment Date/Time
<input type="checkbox"/> Mental health			
<input type="checkbox"/> Alcohol counseling			
<input type="checkbox"/> Substance use/harm reduction			
<input type="checkbox"/> Insurance enrollment			
<input type="checkbox"/> Benefits (Food/financial)			
<input type="checkbox"/> Housing services			
<input type="checkbox"/> Legal services			
<input type="checkbox"/> Specialist: _____			
<input type="checkbox"/> Other: _____			

# Patient Navigation Form vs. Care Plan

## PATIENT NAVIGATION FORM

**CHECK HEP B** **Patient Navigation Form**

This form is a tool for the Patient Navigator to document their work assisting each patient through the continuum of care. Keep this form in the patient chart and update after each patient encounter. This form is a paper version of the Check Hep B database.

**Enrollment Information**

Enrollment date: \_\_\_\_\_

Patient last name: \_\_\_\_\_ Patient first name: \_\_\_\_\_

Address (# Street, Apt #, Borough): \_\_\_\_\_ Zip Code: \_\_\_\_\_

Race: ☐ White ☐ Black ☐ Asian/PI ☐ Other: \_\_\_\_\_ Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

American Indian/Alaska Native Country of birth: \_\_\_\_\_

English: ☐ Speak ☐ Read ☐ Write ☐ None Preferred language: \_\_\_\_\_ Interpretation needed: ☐ No ☐ Yes

Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Permission to text: ☐ Yes ☐ No Best time to call: ☐ Morning ☐ Afternoon ☐ Evening

HBV provider name: \_\_\_\_\_ Contact info: \_\_\_\_\_

For patient navigator use only, do not enter in database

**Assessment Self-Reported History**

Year of HBV diagnosis: \_\_\_\_\_ Ever treated for HBV? ☐ No ☐ Unknown ☐ Yes, years treated: \_\_\_\_\_

If YES, currently taking HBV meds? ☐ Yes ☐ No HBV medication: \_\_\_\_\_

☐ Health Promotion Guide Module 1 complete

Use Health Promotion Guide Module 2: "Getting ready for Hep B Care" to complete this section and develop a Care Plan with patient.

**Patient Navigator Assessment**

How many children? \_\_\_\_\_ Pregnant: ☐ No ☐ Yes

Any household, family or partners in need of notification? ☐ Yes ☐ No ☐ Declined If YES: how many contacts: \_\_\_\_\_

Any mental health issues? ☐ Yes ☐ Unknown ☐ No

Any alcohol use in the past year? ☐ Yes ☐ No ☐ Declined to answer

Injection drug use in the past year? ☐ Yes ☐ No ☐ Declined to answer

Intranasal drug use in the past year? ☐ Yes ☐ No ☐ Declined to answer

Injection drug use ever? ☐ Yes ☐ No ☐ Declined to answer

On methadone maintenance: ☐ Yes ☐ No On buprenorphine: ☐ Yes ☐ No

Insurance: ☐ Medicaid ☐ Private insurance Name of insurance plan: \_\_\_\_\_

Temporary insurance for pregnant women? ☐ Yes ☐ No

Income (per month): ☐ \$800 or less ☐ \$801-\$1,200 ☐ \$1,201-\$1,500 ☐ \$1,501-\$2,500 ☐ \$2,501+ ☐ Declined to answer

Housing: ☐ Stable housing ☐ Unstable housing ☐ Homeless

Has consistent transportation for appointments: ☐ Yes ☐ No

Social support ☐ Yes ☐ No ☐ Family ☐ Friends ☐ Support group ☐ Program

☐ Health Promotion Guide Module 2 complete ☐ Care Plan developed and reviewed with patient

Patient navigation service level: ☐ Low intensity ☐ High intensity

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The PN form documents  
PNs' work, assessment  
and/or recommendations.

## CARE PLAN

**CHECK HEP B** **Care Plan**

Navigator instructions: Discuss care plan with patient. Complete the form based on agreed plan, sign and give a copy to patient.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Care Team**

Name	Address	Phone Number	E-mail Address
Doctor			
Navigator			

☐ Accompaniment to medical visits ☐ Reminders for visits by: ☐ Call ☐ Text ☐ Email

**Check Hep B Program Goals**

Goal	Date Completed
<input type="checkbox"/> Complete patient navigation assessment	
<input type="checkbox"/> Receive "Hep B basics" health promotion	
<input type="checkbox"/> Receive "Getting ready for Hep B care" health promotion	
<input type="checkbox"/> Attend 1st Hep B medical visit	
<input type="checkbox"/> Complete Hep B medical evaluation	
<input type="checkbox"/> Receive "Getting ready for treatment" health promotion (if applicable)	
<input type="checkbox"/> Start Hep B treatment (if applicable)	
<input type="checkbox"/> Receive "Staying healthy with Hep B" health promotion	
<input type="checkbox"/> Conduct contact notification (if applicable)	

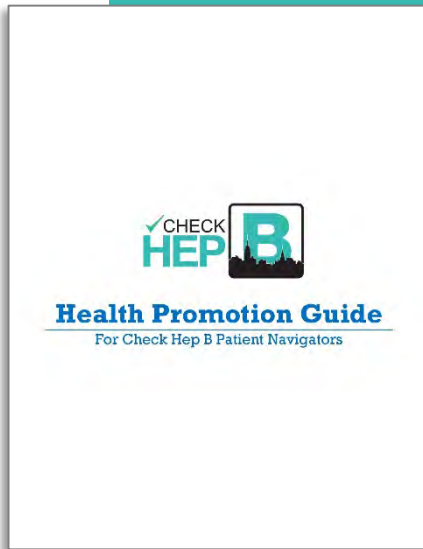
**Referrals**

Type of Service	Site Name and Address	Phone Number/ E-mail Address	Appointment Date/Time
<input type="checkbox"/> Mental health			
<input type="checkbox"/> Alcohol counseling			
<input type="checkbox"/> Substance use/harm reduction			
<input type="checkbox"/> Insurance enrollment			
<input type="checkbox"/> Benefits (Food/financial)			
<input type="checkbox"/> Housing services			
<input type="checkbox"/> Legal services			
<input type="checkbox"/> Specialist: _____			
<input type="checkbox"/> Other: _____			

NYC Department of Health - Check Hep B Program Care Plan - FY2016

The Care Plan documents  
the mutually agreed plan  
with patients.

# Check Hep B Patient Navigation Program



Using the *Health  
Promotion Guide*  
to Screen Alcohol  
Use

# Using Health Promotion Guide, p11 to Screen Alcohol Use and Refer to Treatment

Module 2 of the *Health Promotion Guide* refers PNs to the *Alcohol Screening and Counseling for Patients with Hepatitis C*. Use this to screen patients' alcohol use....

## GETTING READY FOR HEPA DOES DRINKING ALCOHOL DAMAGE THE LIVER?

### 1. ASSESS NEED



Use the 'Alcohol Screening and Counseling for Patients with Hepatitis C' guide to assess current alcohol use and need for alcohol counseling. This guide includes:

1. Alcohol Use Disorders Identification Test (AUDIT)
2. Substance Abuse Brief Intervention and Referral for Treatment (SBIRT)

### 2. TELL PATIENTS

1. Alcohol is **very hard** on the liver.
  - Alcohol can damage or kill liver cells.
  - Alcohol greatly increases risk for developing cirrhosis and liver cancer if you have Hep C.
2. If you have Hep C it is safest **not to drink any alcohol**.
  - This includes beer, wine, whiskey, and all other liquors.
3. People who use alcohol often **face Hep C treatment barriers**.
  - Cutting down or stopping drinking can help you get ready for treatment.
4. If you cannot stop drinking completely, **cutting down can help**.
  - The less you drink the better.

### 3. MAKE A PLAN



For patients that drink, provide alcohol counseling as indicated in 'Alcohol Screening and Counseling for Hepatitis Patients' and develop an action plan for cutting down on alcohol.

NYC Department of Health – Check Hep C Health Promotion Guide - FY2016

....and follow the "Alcohol Counseling" guidance, which walks PNs through methods to promote alcohol use reduction.

## A GUIDE FOR HEALTH PROMOTION

## Alcohol Screening and Counseling for Patients with Hepatitis C



### Alcohol Screening

At initial and annual visits, screen all patients with hepatitis for alcohol use with the **Alcohol Use Disorders Identification Test – Consumption (AUDIT-C)**.

1) How often do you have a drink containing alcohol?

Response	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
SCORE	0	1	2	3	4

2) How many standard drinks containing alcohol do you have on a day when you drink?

Response	1 or 2 drinks	3 or 4 drinks	5 or 6 drinks	7, 8 or 9 drinks	10 or more drinks
SCORE	0	1	2	3	4

3) How often do you have six or more drinks on one occasion?

Response	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
SCORE	0	1	2	3	4

### Alcohol Counseling

1) Review screening results.

- "You answered some questions about alcohol use. Can we discuss the results?"

2) Explore the patient's reasons for drinking and any barriers to reduction.

- "Help me understand, through your eyes, the pros and cons of drinking alcohol."

3) Ask for permission to provide counseling messages.

- "Drinking alcohol when you have hepatitis increases your risk for developing cirrhosis, liver disease and liver cancer."

4) Help the patient develop an action plan.

- "What are steps that will work for you to reduce your alcohol use?"
- "What support do you have to help you make the change?"
- "Those are great ideas! Let's write down your action plan."

5) Provide resources.

- "I have resources that people sometimes find helpful. Would you like to hear about them?"
- Visit [www.niaaa.nih.gov](http://www.niaaa.nih.gov) to find tips about cutting down to share with patients.
- Review some of the tips for cutting down listed in the "Alcohol and Hepatitis" patient card.
- Refer patients to the NYC Liver Health app.

### CREATE AN ACTION PLAN

What? \_\_\_\_\_

When? \_\_\_\_\_

Where? \_\_\_\_\_

How? \_\_\_\_\_

By? \_\_\_\_\_

NYC Department of Health, 100 York Street, 10th Floor, New York, NY 10038

Call 311 to order free "Alcohol and Hepatitis" patient cards, which help your patients make a plan to reduce drinking.

# Screening for Alcohol Use

## Alcohol Screening

At initial and annual visits, screen all patients with hepatitis for alcohol use with the **Alcohol Use Disorders Identification Test – Consumption (AUDIT-C)**.

1) How often do you have a drink containing alcohol?

Response	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
SCORE	0	1	2	3	4

2) How many standard drinks containing alcohol do you have on a day when you drink?

Response	1 or 2 drinks	3 or 4 drinks	5 or 6 drinks	7, 8 or 9 drinks	10 or more drinks
SCORE	0	1	2	3	4

3) How often do you have six or more drinks on one occasion?

Response	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
SCORE	0	1	2	3	4

After completing the screening, add the scores for questions 1 through 3.

SCORE RANGE	NEXT STEPS
Women: 1-2, Men: 1-3	Provide alcohol counseling messages.
Women: 3 or more Men: 4 or more	Provide alcohol counseling messages. Complete full AUDIT screening and provide brief intervention according to Screening, Brief Intervention and Referral to Treatment (SBIRT) protocol.

Adapted from the Brief Negotiated Interview, Boston University School of Public Health, The BNI-ART Institute, [www.bu.edu/bniart](http://www.bu.edu/bniart)

1. Administer the short Alcohol Use Disorders Identification Test (AUDIT-C), consisting of 3 questions:

“How often do you have a drink containing alcohol?”

“How many standard drinks containing alcohol do you have on a day when you drink?”

“How often do you have six or more drinks on one occasion?”





# Screening for Alcohol Use

If short, if the AUDIT-C score is:

- 3 or more for women
- 4 or more for men:

Administer the full 10-question AUDIT screen

(The AUDIT form is provided in the *Health Promotion Guide*.)

AUDIT						
<p>PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.</p> <p>For each question in the chart below, place an X in one box that best describes your answer.</p>						
<p>NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:</p>						
<p>  12 oz. of beer (about 5% alcohol) =   8-9 oz. of malt liquor (about 7% alcohol) =   5 oz. of wine (about 12% alcohol) =   1.5 oz. of hard liquor (about 40% alcohol) </p>						
Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
<b>Total</b>						
<p><small>Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink serving sizes in the United States (14g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at <a href="http://www.who.org">www.who.org</a></small></p>						
<p>Excerpted from NIH Publication No. 07-3769 National Institute on Alcohol and Alcoholism <a href="http://www.niaaa.nih.gov/guide">www.niaaa.nih.gov/guide</a></p>						

# Screening for Alcohol Use

**AUDIT**

PATIENT: Because alcohol use can affect your health and can interact with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each size contains the same amount of pure alcohol (see counts as a single drink):

12 oz. of beer (about 5% alcohol) = 8-9 oz. of malt liquor (about 7% alcohol) = 5 oz. of wine (about 12% alcohol) = 1.5 oz. of hard liquor (about 20% alcohol)

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	4
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	1
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	3
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	1
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	2
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	1
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	2
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	3
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	4
<b>Total</b>						<b>21</b>

Note: The questionnaire (AUDIT) instrument was permission from the World Health Organization. Symbols, drink serving sizes in the United States (12 oz. beer, 8-9 oz. malt liquor, 5 oz. wine, 1.5 oz. hard liquor) are provided for information only. A free AUDIT manual is available at [www.who.int/substance\\_abuse/publications/publications.htm](http://www.who.int/substance_abuse/publications/publications.htm).

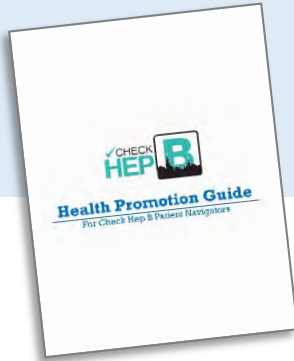
Excerpted from "NIAA Publication No. 07-2709" National Institute on Alcohol and Alcoholism [www.niaa.nih.gov/publications](http://www.niaa.nih.gov/publications)

AUDIT Score	Intervention
0 – 7	• Alcohol education
8 – 15	• Simple advice
16 – 19	• Simple advice • Brief counseling • Continued monitoring
20 – 40	• Referral to specialist for evaluation and treatment



Refer to Check Hep B Program Protocol for online site locators of alcohol services

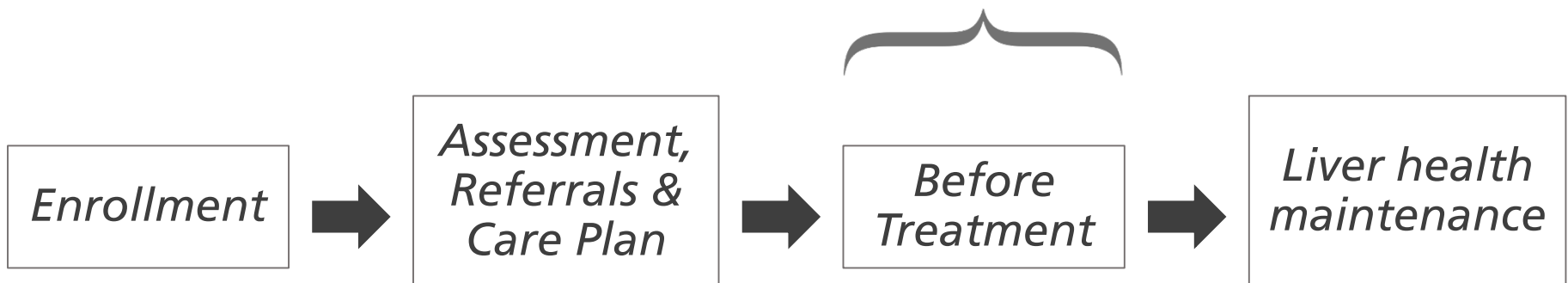
# Health Promotion Guide – Module 3



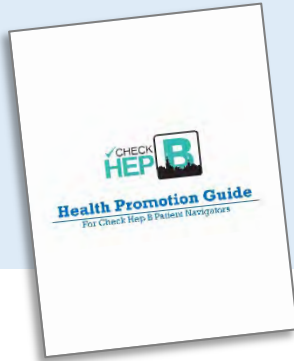
## Module 3: Getting Ready for Treatment

Covers: Hep B treatment planning

Use Module 3 to develop a treatment plan and anticipate adherence issues.



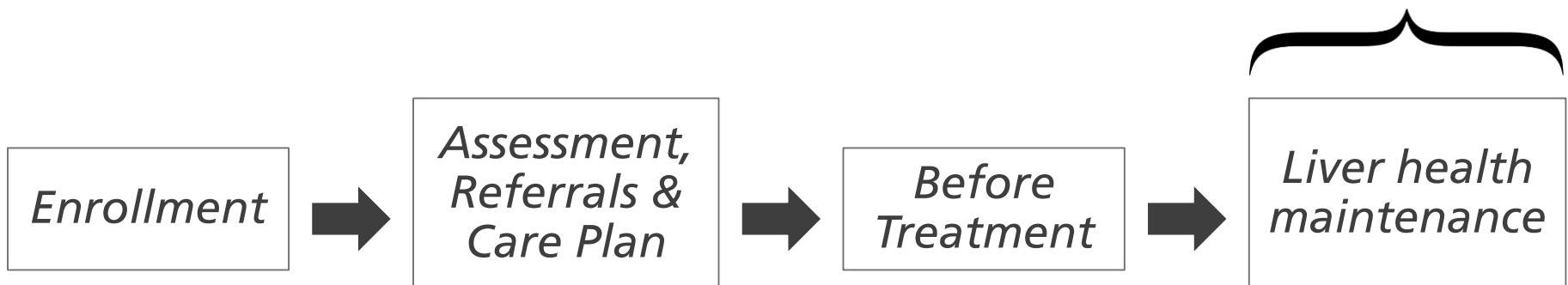
# Health Promotion Guide – Module 4



## Module 4: Staying Healthy with Hep B

Covers: Liver health maintenance and preventing Hep B transmission

Use Module 4 to promote lifestyle changes to protect liver health and preventing Hep B transmission.



# Check Hep B Patient Navigation Program

**Supporting Behavior  
Change to Promote  
Liver Health**

# When to Promote Behavior Change

Outreach & Enrollment

Assessment & Care Plan

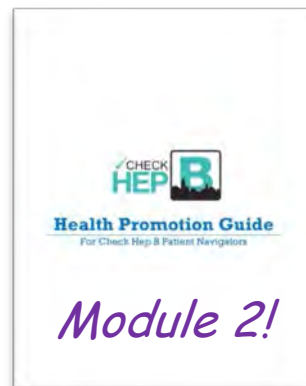
Linkage to Hep B Care

Care Coordination

Promoting behavior change can happen at any stages of PN service.

But it should mostly take place when using module 2 of the *Health Promotion Guide* to complete the *PN Assessment* during the **Assessment & Care Plan** stage.

Remember to record any behavior change goals and relevant referrals in the *Care Plan*.

This is a screenshot of a form titled 'Check Hep B Program Patient Navigation Form'. It contains several sections for data entry. A purple rectangular box highlights the 'Patient History' and 'Assessment' sections. The text 'the PN Assessment!' is written in a large, purple, cursive font across the middle of the form.This is a screenshot of a form titled 'CHECK HEP B Care Plan'. It contains several sections for data entry. The text 'on Page 2!' is written in a large, purple, cursive font at the bottom right of the form.

# Supporting Behavior Change for Liver Health

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PNs are responsible for supporting behavior change in their patients to promote liver health, in particular:

- **Reducing alcohol use to reduce liver damage**
- **Reducing harm from substance use**
- **Getting ready for Hep B care and treatment**
- **Getting to a healthy weight for liver health**



Behavior change can be difficult for both patients and providers promoting change. This section presents one evidence-based method recommended for PNs.

# Steps to Improving Readiness to Change

## (using “Brief Negotiated Interview” techniques)

---

The Brief Negotiated Interview is a method for increasing patient's intrinsic motivation to make behavior changes by:

- Speaking to patients with respect and without judgment
- Asking open-ended questions and listening reflectively
- Exploring and resolving ambivalence (mixed or contradictory feelings about the behavior)
  - **Not** telling patients what to do or arguing



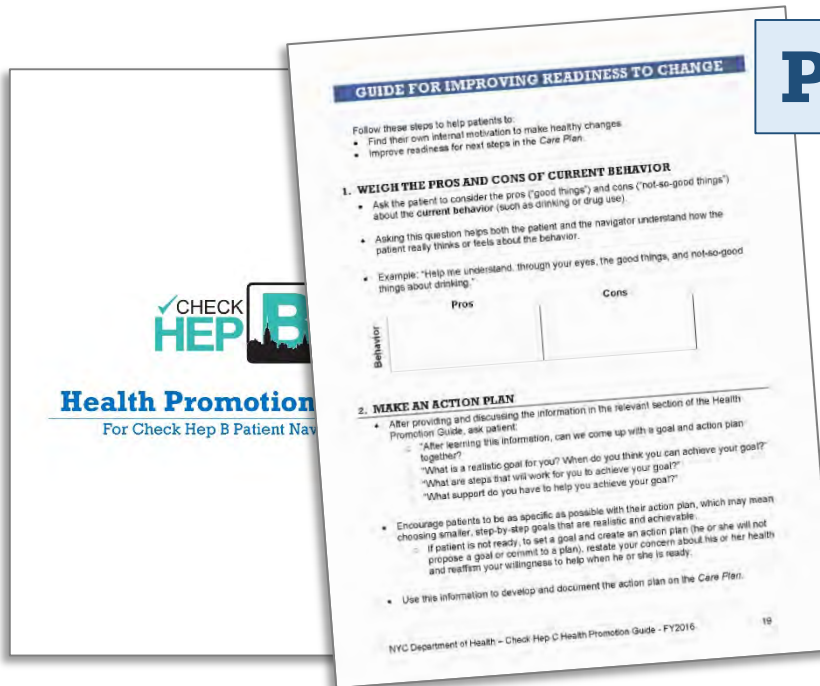
*Brief Negotiated Interview:*



- *Open-ended questions*
- *Affirmations*
- *Reflective listening*
- *Summarizing*



# Using the Health Promotion Guide to Improve Readiness to Change



## Page 8

Use the Page 8 ("Guide to Improving Readiness to Change") to guide use of Brief Negotiated Interview techniques in promoting readiness to change.

Enrollment



Assessment,  
Referrals &  
Care Plan

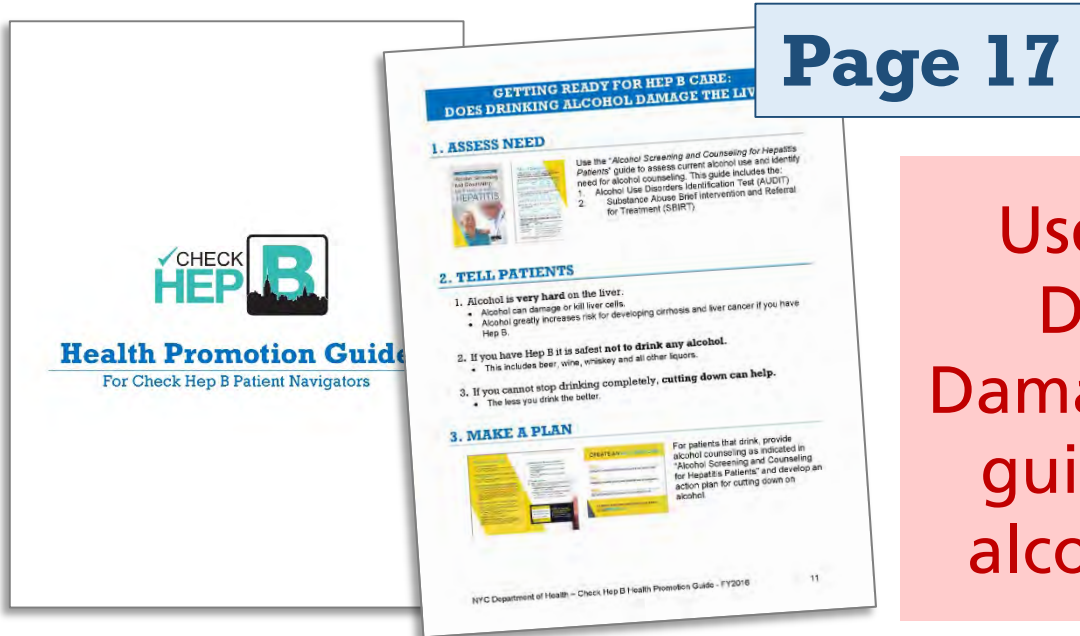


Before  
Treatment



After  
Treatment

# Using the Health Promotion Guide to Improve Readiness to Change



Use page 17 ("Does Drinking Alcohol Damage the Liver") as a guide for promoting alcohol use reduction

Enrollment



Assessment,  
Referrals &  
Care Plan

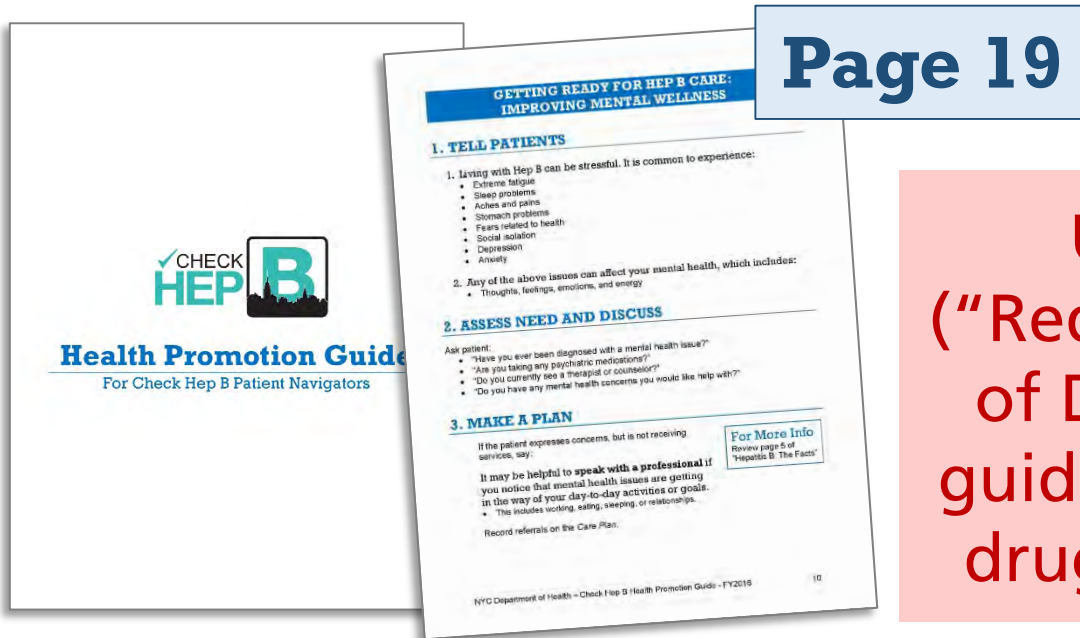


Before  
Treatment



After  
Treatment

# Using the Health Promotion Guide to Improve Readiness to Change



Use page 19  
("Reducing the Harm  
of Drug Use") as a  
guide for promoting  
drug use reduction

Enrollment



Assessment,  
Referrals &  
Care Plan



Before  
Treatment



After  
Treatment

# Using Health Promotion Guide, p12 to Assess Drug Use

Page 19 ("Reducing the Harm of Drug Use") refers PN's to the Drug Abuse Screening Test (DAST).

Use this to screen patients' drug use....

## GETTING READY FOR REDUCING THE HARM OF DRUG USE

### 1. ASSESS NEED

Use the Drug Abuse Screening Test (DAST) to assess current drug use and identify the patient's need for harm reduction services or substance abuse treatment. Ask specifically about injection drug use when using the DAST.

### 2. TELL PATIENTS

- Sharing drug use equipment is the most common way that HIV and hepatitis C are passed from one person to another.
  - All equipment used for injecting drugs can pass along Hep C. This includes: needles, syringes, razors, cutters, ties, cookers, and filters.
  - Pipes, straws, rolled money or other snorting equipment can also pass along Hep C.
- People who use drugs often face Hep C.
  - Cutting down or stopping drug use can help reduce the risk of getting Hep C.
- Each drug has different health risks. Some drugs are very hard on the liver.

### 3. DISCUSS & MAKE A PLAN

- Use page 19 ("Guide for Improving Readiness to Change") to guide a conversation that can help motivate patients to reduce or stop drug use.
- Record goals and action items on the Care Plan.

#### For More Info

- Review:
- "Hepatitis C: The Facts" booklet (p7)
  - "Take Care, Take Charge: Safety Tips for People Who Use or Inject Drugs" booklet

....and follow the guidance to use Brief Negotiated Interview methods to promote drug use harm reduction.

## Drug Abuse Screening Test, DAST-10

Tailored for viral hepatitis patients

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Tell patient: "The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the past 12 months. The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcoholic beverages. Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right."

### Screening Questions

In the past 12 months...	Yes	No
1. Have you used drugs other than those required for medical reasons?	1	0
2. Do you use more than one drug at a time?	1	0
3. Are you unable to stop using drugs when you want to?	1	0
4. Have you ever had blackouts or flashbacks as a result of drug use?	1	0
5. Do you ever feel bad or guilty about your drug use?	1	0
6. Does your spouse (or parents) ever complain about your involvement with drugs?	1	0
7. Have you neglected your family because of your use of drugs?	1	0
8. Have you engaged in illegal activities in order to obtain drugs?	1	0
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	1	0
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	1	0
Calculate total score		

### Viral Hepatitis-Related Screening Questions

- What drug(s) did you use?
- How often did you use the drug(s)?
- Are any drug(s) you used injectable?

### Interpretation of Score

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Adapted from Drug Abuse Screening Test (DAST-10). (©1982 by the Addiction Research Foundation.)

# Check Hep B Patient Navigation Program

**Treatment Readiness  
and Adherence and  
Planning for Transition  
or Discharge**

# Treatment Readiness & Adherence Support

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## **BEFORE TREATMENT, PNs should:**

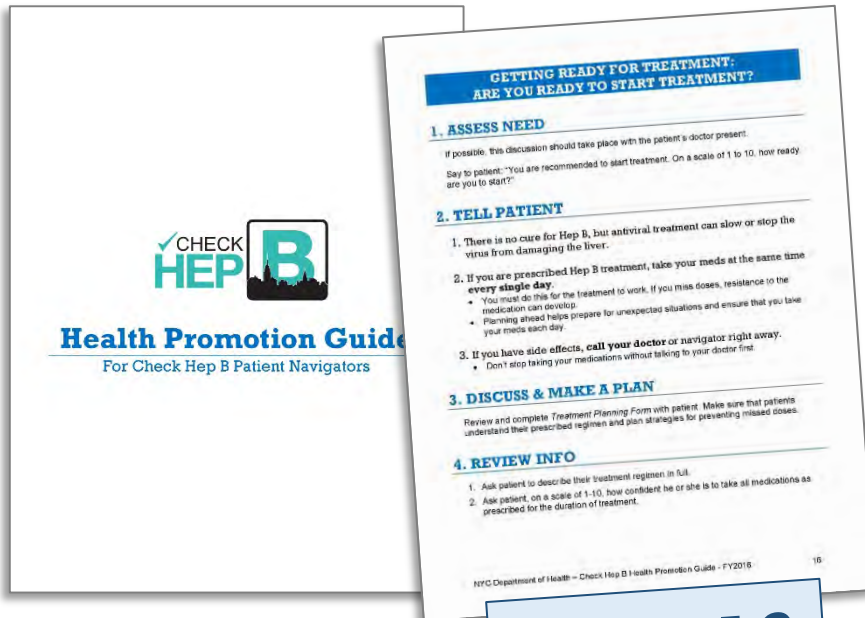
1. Make sure patients understand their treatment regimen
2. Discuss ways to ensure treatment adherence
3. Agree on a check-in schedule during treatment



## **DURING TREATMENT, PNs should:**

1. Check in with patients according to agreed-upon schedule
2. Ensure patients report side effects to their medical provider right away

# Using the Health Promotion Guide to Help Patients Prepare for Treatment



**Page 16**

After the medications have been prescribed and before treatment has started, work through the *Health Promotion Guide* Module 3: "Getting Ready for Treatment."

Enrollment



Assessment,  
Referrals &  
Care Plan



Before  
Treatment



After  
Treatment



# Making a Treatment Plan

**CHECK HEP B**

## Treatment Planning Form

Living with Hep B is not easy. But medical care can help you stay healthy. Follow these steps:

1. Know your care team and how to contact them.
2. If you are prescribed medications, take your medications the right way.
3. Go to all doctor's appointments.

### MY CARE TEAM

**DOCTOR**  
Name: \_\_\_\_\_  
Phone: \_\_\_\_\_

**NAVIGATOR**  
Name: \_\_\_\_\_  
Phone: \_\_\_\_\_

**PHARMACIST**  
Name: \_\_\_\_\_  
Phone: \_\_\_\_\_

**ULTRASOUND RADIOLOGIST**  
Name: \_\_\_\_\_  
Phone: \_\_\_\_\_

Use the *Treatment Planning Form* to:

**1. Record** important information and track progress

**2. Educate** patients about their treatment regimen  
(in presence of medical provider, when possible)

**3. Promote** treatment readiness and adherence before and during treatment

# Making a Treatment Plan

## Inner Pages

### Treatment Planning Form

#### MY HEP B MEDS

Complete this table with your doctor.

Medication	When to Take	What to Avoid
1. Name:	Take ___ tablet(s) ___ time(s) a day	
Color:	at ___ AM/PM <input type="checkbox"/> with food	
2. Name:	Take ___ tablet(s) ___ time(s) a day	
Color:	at ___ AM/PM <input type="checkbox"/> with food	
3. Name:		

### 3 MY HEP B MEDS

Complete this table with the patient and doctor to ensure that the patient understands their treatment regimen and knows what to do when experiencing side effects.

#### TAKING MEDS DOs AND DON'Ts

##### DOs

1. Do take your meds every day.

Try these tips to remember:

- Set a clock or phone alarm
- Use a pill box
- Use a calendar
- Ask a friend to remind you
- Take your meds at the same time as another daily activity (e.g. brushing teeth, lunch/dinner)

○ Use the same pharmacy to keep track of your prescriptions

○ Tell your doctor about all other medications (prescription or OTC meds, vitamins, herbal supplements)

2. Do talk to your doctor about:

- Any side effects

##### DON'Ts

1. Don't miss a dose. Ask your doctor what to do if you miss a dose.

2. Don't stop taking your meds without talking to your doctor, even if you have side effects.

3. Don't start a new medication without talking to your doctor.

○ If you are pregnant or planning to get pregnant, tell your doctor right away.

#### MY STRATEGIES FOR TAKING MEDS

Complete this table with your navigator before starting treatment.

Common reasons for missing dose	Strategy to avoid missing dose
Forgetting	
Being away from home	
Being busy	
Change in daily routine	

### 2 MY STRATEGIES FOR TAKING MEDS

Use this section to discuss and develop individualized strategies to ensure adherence by anticipating potential adherence issues.

### 1 TAKING MEDS DOs & DON'Ts

Use this section to educate patients on how to take Hep B medications and prevent non-adherence.

# Making a Treatment Plan

## Back Page

### Treatment Planning Form

#### MY DOCTOR'S APPOINTMENTS

Complete this table with your doctor.

Visit	Date	Hep B Viral Load* (IU/mL)	ALT** (U/L)	Notes (e.g. other liver health indicators like HBeAg)
1				
2				
3				
4				
5				

\*The **Hep B viral load** is the amount of Hep B virus in your blood.

\*\*The **ALT** test measures the amount of stress in your liver.

Date	Ultrasound

#### MY NOTES

Write down the list of medications you are taking, any side effects you have, questions for your doctor, or other notes about your treatment.

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## 1 MY DOCTOR'S APPOINTMENTS

Keep track of appointments and important clinical indicators to track patient's treatment progress.

## 2 MY NOTES

Encourage patients to use this section to note side effects and questions to discuss with their medical provider at the next visit.

# Scheduling Treatment Check-Ins

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Prior to starting treatment, the PN should plan a schedule for regular check-ins to promote adherence:

## Required Treatment Check-In Schedule:

- **3 DAYS** after treatment start date
- 
- Optional: Additional check-ins based on patient need (example once a month)
  - Check-ins can be in-person, by phone, text or other methods.

# Promoting Self-Sufficiency

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The goal of Check Hep B is to get patient through full HBV medical evaluation, and either start and adhere to treatment if recommended or remain in HBV care to monitor and maintain liver health over time.

Check Hep B patients can be discharged once they have achieved self-sufficiency:

- Are adherent to medications, if applicable
- Are compliant with medical monitoring as recommended by medical provider

# Discharge & Transition Planning

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- PN should develop discharge or transition plan for each patient **3 months before** program end date.
- Patients should be informed of their transition plan **1 month before** program end date.
- All members of the Check Hep B care team – including patient – should know when the program ends and plan care accordingly.
- Identify need for continual support for:
  - Hep B medical evaluation or treatment
  - Supportive services needed to ensure access to Hep B care
- Provide referrals
  - The NYC Health Dept can help identify referral sites if needed.