



HEPATITIS

EDUCATION, SCREENING AND LINKAGE-
TO-CARE FOR ETHNIC COMMUNITIES:
A COMMUNITY-BASED APPROACH



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FOREWORD

With over 50 distinct ethnic subgroups embodying different linguistic and cultural characteristics, the Asian American and Pacific Islander (AAPI) population in the U.S. is markedly diverse. However, despite these differences, the limited available health data are often aggregated into a single broad classification, which masks the diversity of health outcomes, disease burdens, and health disparities within and across the AAPI population. Therefore, commonly collected aggregated data are not always useful for guiding community-specific health care programs.

The Asian Health Coalition (AHC) was founded in 1996 to improve the health and well-being of Asian American and Pacific Islanders (AAPIs) in the Midwest region of the United States through advocacy, technical assistance, capacity-building, and community-based research. The agency's goal is to address pan-Asian health disparities and institutionalize systemic change to improve community health. AHC identified an alarming disparity with the high prevalence of chronic Hepatitis B in our community and the devastating consequence of liver cancer occurring in 25% of those chronically infected. One in 10 to 12 Asian Americans is infected with chronic Hepatitis B, and of the newly diagnosed cases of liver cancer in the United States, 50% occur in Asian Americans. To address this major health concern, in 1997 we initiated the Hepatitis Education and Prevention Program (HEPP), targeting immigrant and refugee populations at high risk for Hepatitis B and liver cancer.

The key to the success and uniqueness of HEPP is the close partnership that the Asian Health Coalition has developed with community-based organizations and health care providers. This distinguishes HEPP from other community-based programs by providing guideline-based, evidence-based education with linkage to care opportunities. Many other community programs fail to utilize a strong collaboration with a physician provider and therefore, misinformation can be communicated.

In this manual, we will describe our partnership strategy, Community Health Worker model, and the various components of the HEPP program. It is our desire that this manual serve as a guide for other organizations to replicate our approach, in part or in whole, to address chronic Hepatitis B infection in their community. Community-based health centers, public health entities, social service agencies, and other organizations can review their available resources and determine if HEPP's partnership strategy and/or its Community Health Worker model would be the most appropriate for addressing Hepatitis B infection in their targeted populations.

The Asian Health Coalition is proud to share the meaningful observations and results that have been learned from the HEPP program, and we hope that this will serve as a CALL TO ACTION to our readers to address the needs in your community, and the strengths of collective partnerships that will serve as invaluable catalysts for change in reducing Hepatitis B disparities in all immigrant and refugee communities.”





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We acknowledge the valuable contributions made by individuals from our partnering organizations, project coordinators, staff and community health workers to HEPP over the past 15 years including the following:

- | | | | |
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HEPATITIS EDUCATION & PREVENTION PROGRAM COMMUNITY MANUAL

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SECTION 1

INTRODUCTION

In 1991, recognizing the difficulty of vaccinating high-risk adults and the substantial burden of Hepatitis B-related disease acquired from infections in childhood, a comprehensive national strategy was developed to eliminate Hepatitis B transmission in the United States. The strategy focused on universal childhood vaccination, prevention of perinatal Hepatitis B transmission, vaccination of adolescents and adults in high-risk groups, and catch-up vaccinations for susceptible children in high-risk populations. In 1995, routine vaccination was recommended for all adolescents who had not been vaccinated previously. This “catch up” program resulted in the development of the Asian Health Coalition’s Hepatitis Education & Prevention Program (HEPP) in 1997.

Originally, the goal of HEPP was to reduce the incidence of Hepatitis B by promoting the vaccine for children up to age 18 using a school-based intervention. The Hepatitis B immunization compliance rate in Chicago’s public schools was as low as 20-40%. Between 1997 to 2001, vaccination levels rose to 90% or greater in most Chicago schools with the implementation of a new Illinois state Hepatitis B vaccination policy, along with HEPP’s intervention to target at-risk Asian children and youth.

During this period, national studies along with data collected by the Asian Health Coalition showed a wide variation in health barriers and disease susceptibility between the Asian subgroups. This important finding was the impetus to design a more rigorous approach to understanding barriers, risk factors and disease burden in disaggregated AAPI communities. With robust community partners, we redesigned HEPP as a rigorous evidence-based community participatory model. From 2008 to 2011, HEPP provided culturally and linguistically competent Hepatitis B education to more than 32,000 AAPI community members, and screened 2,500 people for the virus, with 1,490 linked to follow-up care, either to receive the three series vaccination series or medical services for chronic HBV infection.





WHAT IS HEPP'S COMMUNITY PARTNERSHIP STRATEGY?

Paramount to AHC's successful Hepatitis B outreach is our close collaboration with community-based organizations (CBOs) and health care providers. CBOs provide a myriad of social services and other outreach to populations at risk for chronic Hepatitis B. Community Health Workers (CHWs), employed by these agencies, are the vital culturally competent link between these at-risk populations and the health care services they need. Other services provided by the agency, such as employment counseling, ESL classes, citizenship courses, and cultural programming, enhance and support the outreach efforts of the CHW. The educational outreach and screenings are conducted at the community agencies, which are trusted by the target population and easily accessible to them. Health care providers provide the medical follow-up for those found to be either chronically infected with Hepatitis B or susceptible to the virus and in need of immunization. By working closely with the community-based organizations to provide culturally sensitive and linguistically tailored outreach and screenings, and health care providers to assure appropriate medical follow-up to the screenings, the Asian Health Coalition has created an easily replicable model for addressing chronic conditions in vulnerable populations.

Over the last 15 years, AHC has established, maintained, and strengthened partnerships with over 25 ethnic-specific, community-based organizations in the metropolitan Chicago area, including the Cambodian, Chinese, Korean, Vietnamese, Lao, Japanese, Indian, Filipino, and Pakistani communities. Through these collaborations, AHC administers health programs and initiatives in the areas of viral Hepatitis, HIV/AIDS, diabetes, obesity, mental health, substance abuse, and other health issues. AHC has found that building the capacity of our partner organizations and helping to build the infrastructure to address identified health issues contributes to sustainable and long-term solutions.

WHY THE AHC CHOSE THE COMMUNITY HEALTH WORKER MODEL

In designing the Hepatitis Education and Prevention Program (HEPP) targeting Asian-Americans in the greater Chicago area, the Asian Health Coalition chose the Community Health Worker (CHW) model for its intervention strategy. Noting the great diversity in language, culture, education, socioeconomic status, and level of acculturation among area Asian American immigrants and refugees, AHC determined that partnerships with community-based organizations (CBOs) and the training of CBO staff members as Community Health Workers would be the most effective strategy.

As described in Section 2, chronic Hepatitis B is a serious health concern affecting Asian-Americans that demands a response that takes into consideration the cultural nuances, beliefs, language, and acculturation levels of the target population. In certain Asian countries, such as China, Hepatitis B is so stigmatized that a person found to be chronically infected cannot find employment. Other populations are unaware of or misinformed about Hepatitis B, its mode of transmission and health risk, or how to protect oneself and one's family from the virus. Stigma, ignorance, and misinformation can best be addressed by a bilingual, bicultural, and trusted Community Health Worker.

On an individual level, the Community Health Worker is able to connect with members of the often disenfranchised immigrant and refugee population. They speak the language and understand the cultural nuances underlying a health issue. With proper training and support, CHWs can not only effectively teach about Hepatitis B, but also influence attitudes and motivate community members to be screened for the virus.

On a neighborhood level, the Community Health Worker is connected with local institutions, including faith-based organizations, ethnic media, schools, and small business owners. The CHW is part of a social network that expands the program's outreach and can also enhance the CHW's status. CHWs may be interviewed by the local ethnic media or asked to present at a local school function. Often they are publicly recognized and endorsed by community and faith leaders for their expertise and ability to help individuals in need.

WHO ARE COMMUNITY HEALTH WORKERS?

Community Health Workers (or CHWs) are lay persons who have received training in either a specific health issue or general health outreach in order to function as educators and liaisons between members of their communities and the health services they need. Stemming from the *promotores de salud* model that began in Latin America in the 1970s, CHWs traditionally work with low-income communities who are often medically underserved because of linguistic, economic, or cultural barriers. CHWs themselves are members of these hard-to-reach communities, and their success in health outreach can be credited to their understanding of the cultural nuances and language of the target population, and the trust that the community places in them. The concept of the Community Health Worker will be explained in greater detail in Section Three: What is the Community Health Worker Model?

WHAT IS THE GOAL OF THE HEPATITIS EDUCATION AND PREVENTION PROGRAM (HEPP)?

The goal of HEPP is to create a sustainable, culturally competent, and replicable model of community partnerships to address the prevalence of Hepatitis B in underserved AAPI populations. Specific program goals reflect the important role of the Community Health Worker within these community partnerships:

Goal #1: Build the infrastructure and capacity of AAPI communities for the implementation of hepatitis education and prevention methods,

Goal # 2: Provide targeted outreach and health education through Community Health Workers to AAPI communities regarding viral hepatitis,

Goal #3: Increase hepatitis screening rates for at-risk Asian populations through culturally sensitive recruitment by Community Health Workers, and

Goal #4: Provide appropriate linkage to care for AAPIs through Community Health Workers for either the hepatitis vaccine or medical follow-up for chronic hepatitis infections.

WHAT ARE THE KEY COMPONENTS OF HEPP?

The program is composed of four key areas:

- (i) **Community capacity building:** Building the capacity of community-based partners involves more than just the selection and training of the Community Health Workers (CHWs). It also involves working with the agency administration to implement all aspects of the program, provide guidance in assessing the community needs and recognizing community assets, and assist in effective program outreach.
- (ii) **Hepatitis B education and outreach:** Hepatitis B virus (HBV) education and outreach involves raising awareness within the community of the risk of chronic Hepatitis B through culturally and linguistically competent education, done by the Community Health Worker either through one-on-one interaction or in group settings. The education can be done within the social service agency, or in other settings such as faith-based organizations and community centers.
- (iii) **Screening:** Screenings are large-scale events organized and carried out with the assistance of a health care organization or medical professional, and always accompanied by an educational presentation on Hepatitis B.
- (iv) **Linkage to care:** Successful implementation of HEPP involves the identification of and linkage to affordable health care for those members of the population in need of immunization or follow-up medical care. HEPP's community partnerships with health care providers allows for reliable and sustainable linkage to care, and the Community Health Worker is key to the effectiveness of this linkage to care, often serving as a patient navigator and interpreter.

SECTION 2

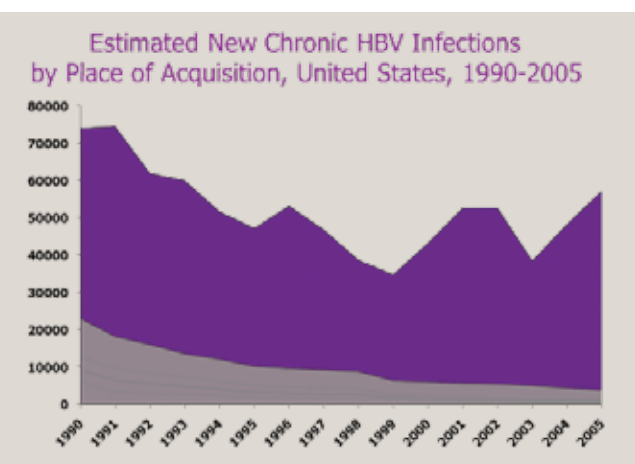
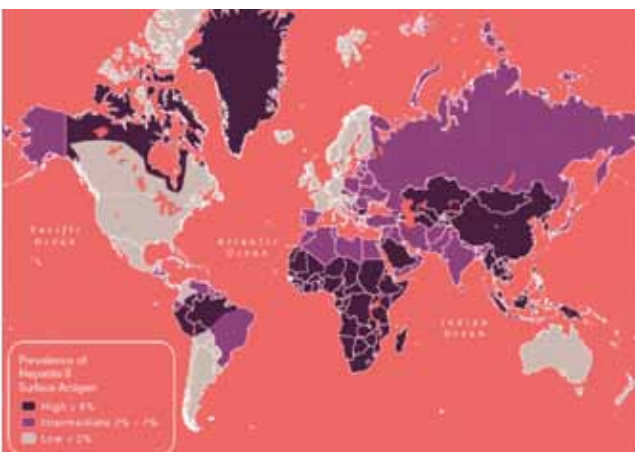
HEPATITIS B DISPARITY IN ASIAN AMERICANS & PACIFIC ISLANDERS (AAPIS)

Approximately one third of the world's total population of 2 billion has been infected with Hepatitis B virus (HBV). While most individuals develop natural immunity after an acute infection with Hepatitis B, in regions with high levels of perinatal transmission, the baby's immature immune system can result in chronic infection. Of the approximately 350 million people with chronic or lifelong HBV infection, about 78% or nearly 275 million of these chronically infected individuals reside in Asia or the Pacific Islands. Without appropriate monitoring or treatment, 1 in 4 of those chronically infected will die from liver cancer or liver failure.

WHY IS HEPATITIS B A CONCERN FOR AAPIS AND THE U.S. HEALTHCARE SYSTEM?

In the United States, AAPIS are the fastest growing ethnic minority population. Between 1996 and 2006 the AAPI population increased by 63%, accounting for approximately 5% (14 million) of the US population.

According to Census 2010, there were 590,174 AAPIS living in Illinois which represents the 6th largest concentration of Asian Americans in the nation. Nearly 80% reside in a 4 county area comprising Cook (which includes the City of Chicago), DuPage, Kane and Lake. Nearly two-thirds are foreign-born and many immigrate from countries with high Hepatitis B burden resulting in highest prevalence of Hepatitis B among Asian Americans compared to any other U.S. population group. Most Asian and Pacific Islanders are infected with the Hepatitis B virus as infants or young children, frequently from an infected mother who unknowingly passes the virus to their newborn baby at birth (vertical transmission). Since 65% of all Asian Americans are foreign born, the global burden of this disease from Asia is carried directly into Asian American communities. Recently, the Institute of Medicine and Department of Health and Human Services reported on the global burden of Hepatitis B with implications for the US. Chronic Hepatitis B (CHB) among foreign born citizens and residents was described as a ticking time bomb with CHB a major HBV challenge and source of disparity in the US. Ninety percent of new CHB cases are 'imported' with 49,000 new CHB from foreign born immigrants (2003-2007) compared to 3,000-5,000 US born. Currently, of the 1.7 million in the US with CHB, 375,000-975,000 are foreign born, with numbers that are increasing (and severely under-reported). Importantly, the disproportionate burden of Hepatitis B among Asian Americans is tremendous. Most disturbing is that 66% of this population is unaware that they have chronic Hepatitis B and therefore remain



an active reservoir; without HBV screening and treatment, they are at risk of passing the infection onto others as well as developing liver cancer. It makes sense therefore that 60-80% of liver cancer in AAPIs is secondary to infections with HBV. AAPIs have nearly three times the mortality rates than Whites due to liver cancer. There is, therefore, a pressing need to study the AAPI population in regards to Hepatitis B and effective community-based responses. The burden of HBV in the AAPI population continues to be an enormous public health risk, and both health care providers and AAPI communities need to be informed about HBV and liver cancer. HEPP strives to respond to this need.

IS THERE A SOLUTION TO THE PROBLEM OF CHRONIC HEPATITIS B INFECTION IN THE AAPI AND OTHER VULNERABLE COMMUNITIES?

Several approaches exist to eradicate, prevent, and risk stratify individuals at risk for Hepatitis B.

Hepatitis B vaccine: The Hepatitis B vaccine became available in 1986 and was included as part of routine childhood immunization in 1991. The routine use of this vaccine has resulted in a significant decrease in acute Hepatitis B among all populations in the US. This primary prevention of Hepatitis B, in theory, should sufficiently reduce the chronic disease burden of HBV in the US. However, as discussed above, this reduction has not been seen in Asian Americans, primarily because of their immigration history and HBV transmission pattern. Therefore, the administration of Hepatitis B vaccine in Asian Americans must be combined with Hepatitis B screening, as outlined in the 2008 updated CDC Hepatitis B screening guidelines.

Hepatitis B screening: The CDC recommends testing for HbsAg (Hepatitis B surface antigen virus) for the following population groups:

- Persons born in geographic regions with HBsAg prevalence of $\geq 2\%$
- US born persons not vaccinated as infants whose parents were born in geographic regions with HBsAg prevalence of $\geq 8\%$ including Asia and Africa
- Injection-drug users
- Men who have sex with men
- Persons with elevated ALT/AST (liver enzyme levels) of unknown etiology
- Persons with selected medical conditions who require immunosuppressive therapy
- Pregnant women
- Infants born to HBsAg-positive mothers
- Household contacts and sex partners of HBV-infected persons
- Persons who are the source of blood or body fluid exposures that might warrant postexposure prophylaxis (e.g., needlestick injury to a health care worker)
- Persons infected with HIV

Disease treatment and monitoring: For those individuals found to be chronically infected with Hepatitis B, medical follow-up with careful monitoring and counseling is required. Early detection and treatment can help people live longer and prevent the spread of the virus to others. The HBV is extremely contagious, **100 times more contagious than the HIV virus**, and able to survive one week at room temperature outside of the human body. For that reason, close family members of a person found to be chronically infected with HBV need to be counseled, tested for the virus, and appropriately protected against infection.



LIVED EXPERIENCE: DR. KIM'S STORY

As president of the Board of Directors of the Asian Health Coalition and an Associate Professor of Medicine at the University of Chicago, Dr. Karen Kim is dedicated to improving the health and well-being of Asian immigrants. Karen's commitment to Asian-Americans, but in particular women and girls, stems from her own life story as family member watching a loved one trying to understand and navigate a foreign (US) healthcare system in an effort to combat complications from Hepatitis B. Despite medical education and advanced training, Karen was unaware about the disparities of Hepatitis B among Asian Americans, until she learned first hand through the death of her mother. The loss of her mother to liver cancer caused by chronic Hepatitis B, endemic in Asian Americans and frequently transmitted mother to child, cemented Karen's zeal to empower immigrants and refugees to take charge of their health. She developed the HEPP program in collaboration with the AHC to provide language and cultural tailored programs for Hepatitis B and for the past 15 years, Karen has been a leading proponent of the use of Community Health Workers to teach other immigrants, either one-on-one or in small groups, to be concerned about their own health. In many ways, Karen's work involves a cultural shift in Asian-American's attitudes towards health with prevention and awareness being key component for improving lives of individuals and their families. Karen also has been a leader in medical professional education and policies regarding Hepatitis B and liver cancer disparities among Asian Americans. Because of Karen's vision and commitment, more immigrants are being screened for Hepatitis B, and she has worked with the medical provider community to ensure access to care for vaccinations and treatment for the chronically infected.

SECTION 3

THE COMMUNITY HEALTH WORKER MODEL



WHO ARE COMMUNITY HEALTH WORKERS?

Community Health Workers (CHWs) are lay persons who have received training in either a specific health issue or general health outreach in order to function as educators and liaisons between members of their communities and the health services they need. Although CHW programs have been associated primarily with health service delivery in developing nations, CHWs in this country have been instrumental in successful outreach to hard-to-reach and vulnerable populations in health areas as diverse as asthma education, AIDS prevention and linkage to care, and diabetes self-management.

WHAT IS THE DIFFERENCE BETWEEN COMMUNITY HEALTH WORKERS AND OTHER LAY HEALTH POSITIONS?

There are similar lay positions within the US health care system such as peer counselors, patient navigators, health advocates, and health educators. Many of these positions are sponsored by a community health center or hospital to help patients better understand and manage their health condition or to guide them through the health care delivery process. Community Health Workers, however, are members of the targeted community and hired to work in their own community, whereas the other lay positions are often people hired by a health care provider to work within a health care institution with community clients. CHWs work in the community, in homes, faith-based organization or social centers, and often with people who are disenfranchised from the formal health care system. They are able to engage the hard-to-reach members of the community.

WHAT ARE THE QUALITIES OF A GOOD COMMUNITY HEALTH WORKER?

Effective Community Health Workers speak the same language, come from the same ethnic background, and share the same socioeconomic status and life experiences with the community members they serve. Often they live in the same community where they serve, and connect with the target population as both neighbors and clients. Other desirable qualities include motivation for service, creativity, commitment, and open-mindedness to new ideas and ways of looking at health and disease.

“My happiness comes from taking care of people. That’s my Buddhist upbringing.”—Community Health Worker from Lao community.

“I like to (tap into) our cultural traditions to promote good public health measures. For example, during the cold and flu season, I encourage my community members to bow to each other rather than shake hands.”

—Community Health Worker from the Lao community.

In the implementation of HEPP, the gender of the Community Health Worker did not affect his or her acceptance by the community. (However, in other health outreach areas, such as breast cancer screening or HPV promotion, the gender of the CHW may play an important role.) Both men and women served as Community Health Workers with equal community acceptance in HEPP.

“I took personal care of a family member who was very ill. My community knew that, and I think it helped me to be accepted when I began working as a Community Health Worker.”—CHW from the Korean community.

Whereas gender did not matter in HEPP implementation, often the age of the Community Health Worker did. The health promoter to the Lao community was an older man who acknowledged that his age does provide him with a certain authority. The Cambodian community’s health promoter, however, stated that she carried little authority when she first started working as a CHW as a young woman, but eventually earned the respect of her community as she grew older and more experienced in community education and outreach.

Educational level attained did not seem to be a factor in the CHW’s effectiveness but may initially affect in a positive way the community’s acceptance of the CHW. A health promoter to the Chinese immigrant community felt that people did listen to her despite her youth because it was commonly known she was a nurse in China. A CHW in his mid-20s serving Korean-American immigrants admitted he was able to overcome his “youth” because of having attended graduate school. However, the CHW also credited his culturally appropriate efforts to honor and respect elders and his history of community service to his eventual acceptance by the community.

Other CHWs had high school degrees from their countries of origin and no higher education, yet were very effective Community Health Workers. In AHC’s HEPP program, there was no minimum age or educational level required to be trained as a CHW.

“My own health and habits are watched by the community. When I had my heart surgery, the fact that I don’t smoke and drink helped in my quick recovery. Many community members commented on how quickly I was back on my feet.”

—Community Health Worker from the Lao community.

RECRUITMENT AND SELECTION OF THE HEPP COMMUNITY HEALTH WORKER

In AHC’s partnership approach, the CHWs were employees of the collaborating community-based organizations (CBOs). Some the CHWs had been functioning in this role for a number of years within their agency and received additional training



LESSON LEARNED:

Although program planners may think that the concept of a Community Health Worker (CHW) would be familiar to immigrant and refugee populations based on the popularity of CHWs in many developing countries, that is not necessarily true. Immigrants from certain countries may come from an experience of doctors and nurses being available in even the most rural of health centers. In fact, the “Barefoot Doctors” program developed during the Cultural Revolution in China in the 1960s and effectively a pre-cursor of the Community Health Worker in other parts of the world, was phased out in 1981 in favor of the medical professional model for all health centers. The concept of a Community Health Worker may have to be explained to both partners and target populations who are used to the medical model of health outreach.



Women at the Lao Temple in Kane County

LESSONS LEARNED:

Key considerations in CHW recruitment include whether the position is full-time, part-time, or volunteer. Some CBOs may not be able to hire a CHW in either a part-time or full-time capacity, and may wish to recruit volunteers for this role. The decision whether or not the CHW should be salaried or a volunteer position is up to the sponsoring CBO in light of available resources and anticipated work load. If the decision is made to make the CHW position volunteer, it is important to support the volunteer and acknowledge his or her contribution for the good of the community. The CHW is a position of respect and trust, not easily gained with high position turnover, so every effort must be made to promote stability in the role.

LESSONS LEARNED:

- 1) The Community Health Worker should be visible and play a predominant role in all three areas involved in program implementation (outreach and education, screening, and linkage to care). As a trusted and recognized community member, the presence of the CHW promotes a sense of continuity and confidence among the targeted population in the multi-step program.
- 2) There are situations in which the CHW is not the appropriate person to take a lead role in a HEPP event. It has been AHC's experience that certain venues, such as a Hepatitis B education and screening event in which blood samples are drawn, lend to a presentation by a medical professional rather than a CHW. The presence and authority of the "white coat" is more appropriate during these education and screening events. (See Section 8 Program Implementation: Screening, Vaccination, Treatment and Care.)
- 3) Gaining the confidence of the target community: The "raison d'être" for many CHWs in their initial community involvement is often their ability to interpret for monolingual clients in need of health care. Although their training as CHWs is beyond the role of an interpreter, helping community members in this manner is not time wasted. The act of helping people in need generates trust and good will, and the wait time before consultations and procedures allows for targeted one-on-one education and counseling. In addition, accompanying a community member provides experience and insight into the health care system that can be of value in later community education and consultation

on HBV as part of the HEPP program. Other CHWs were already working in another capacity in their agency and were selected by that agency to be trained as a CHW in the HEPP program. Others still were hired specifically for the HEPP program to be trained as CHWs. In all cases, the CHW for HEPP was not a full-time position, although some CHWs may be full time with their salary supplemented with other programs.

Because AHC is a capacity-building organization, AHC did not directly hire the CHWs. Rather, AHC worked with the partnering agencies to recruit and select the CHWs by creating a job description for the CBOs' use and providing guidance for the selection process. The CHW job description is included in Appendix 3a. Partnering CBOs were encouraged to select potential CHWs who matched the desirable qualities outlined in the job description, in particular candidates who were comfortable with public speaking and indicated a commitment to community service.

ROLE OF THE COMMUNITY HEALTH WORKER IN THE IMPLEMENTATION OF HEPP

Community Health Workers are not trained health professionals. They are the culturally and linguistically competent bridge, or link, between health care services and the community. Because CHWs are immersed in the culture of those they serve, they are able to understand how a person's living environment and community influence their health behaviors and impact their access to and use of health resources. This insight into the targeted population and their position of trust within the community was fundamental to the successful implementation of HEPP.

Once trained, the CHW's role was indispensable in Hepatitis B education and outreach, recruitment for screening, and follow-up. The CHW provided the community education and outreach on Hepatitis B, either through one-on-one consultations or group settings. Following up on the education and outreach, the CHW encouraged community members to be screened, promoted the screening event, and during the event assisted the health professionals with interpretation and the participants with completing the necessary forms.

After the screening event, the CHWs helped community members who sought their assistance in receiving the three-series HBV vaccination or medical follow-up for chronic HBV infection. It is important to point out that the individual screening results are protected under HIPPA, and the CHW did not know the results of a particular client's screening unless that client informed the CHW, usually in the capacity of seeking linkage to care.

More detail on the training of the CHWs and their roles and responsibilities in the program areas of education and outreach, screening, vaccination, and linkage to care is provided in Chapters 6 and 7 of this manual.

CASE STUDY

VAN DUONG

COMMUNITY HEALTH WORKER

VIETNAMESE ASSOCIATION OF ILLINOIS

A Community Health Worker since 1994, Van Duong was born in Vietnam and, after multiple failed attempts, managed to escape to the United States with her husband in 1980. The two joined others in an arduous trek across the jungles and landmine-strewn fields through Vietnam and Cambodia before being admitted to a refugee camp in Thailand. After a brief internment in the camp, Van and her husband were transferred to a UN refugee camp in Indonesia before eventually being resettled in Chicago.

Van's first child was born in 1981, shortly after arriving in Chicago. Her husband died tragically in 1982, when Van was pregnant with her second child. Faced with raising two children alone in a city where she did not speak the language and had no marketable skills, Van was determined to provide for her daughters the opportunities and future for which she and her husband had risked so much. She was able to secure government assistance for herself and her children, developed a network of support for the care of her daughters, and enrolled in the local community college. Over the next ten years, working her way through ESL classes to an associate's degree awarded from the community college, Van eventually earned a bachelor's degree in computer sciences from DePaul University in Chicago. After graduation, she was employed as a computer specialist until the company went bankrupt two years later. In 1994, she found a job as a case manager at the Vietnamese Association of Illinois (VAI,) a social service agency in Chicago that provided outreach to Vietnamese refugees.

Through a series of similarly-targeted outreach programs, Van's role at the VAI evolved into that of a Community Health Worker who enjoyed the trust and respect of the people she served. Her personal story as a young widowed refugee and mother of two small children who worked hard to learn English and graduate from college earned her a position of respect within the community. In addition, stemming from her job as a case manager in the large social service agency where she worked before she joined the VAI, Van had earned a reputation as being helpful and committed to the needs of her community. She also lived and shopped in the Uptown neighborhood where she worked, and attended the local Buddhist temple. Van was known and trusted not only in her own neighborhood, but her reputation extended to other Chicago neighborhoods and nearby suburbs where Vietnamese refugees lived. Van's many community contacts made it possible for her to target participants for health outreach programs, and the trust and respect she had earned made an effective health educator and promoter. When the Asian Health Coalition approached the Vietnamese Association of Illinois to partner in the HEPP program, Van was the logical staff member to be trained as a Community Health Worker for Hepatitis education and outreach.



SUPPORTING THE CHW TO CARRY OUT HEPP

In order to carry out his or her HEPP program responsibilities, the Community Health Worker required financial and administrative support, initial and on-going training, Hepatitis B educational resources, and technical assistance. The CHW also benefited from the support of the community, especially the key opinion leaders who could strongly influence the outcome of a particular intervention.

In HEPP, the CHWs were employees of the partnering community-based organizations (CBOs) with financial support coming from a grant obtained by the Asian Health Coalition. The partner CBO supported the work of the CHW through employment (part-time or full-time), in-kind support of space and equipment necessary to conduct the individual and community outreach, and other administrative needs.

As the lead agency, the Asian Health Coalition provided the initial half-day workshop training on Hepatitis B and the culturally and linguistically appropriate health education tools necessary for community outreach and education. In addition, AHC supported the work of the CHW through bimonthly meetings for program updates, discussion of issues and concerns, and on-going training in Hepatitis B community outreach. The HEPP Program Manager also made a yearly site visit to each agency, and was available by email and phone. The monthly reports that were submitted by each CHW to the Program Manager included a section for noting any concerns or problems that need to be addressed. The Program Manager also researched and made available culturally and linguistically appropriate Hep B health education materials such as bilingual pamphlets, videos, and other useful tools for use by the Community Health Worker. (More information about the on-going support of the CHW is included in Section 6, *Training of the Community Health Worker*.)

The support of community leaders was both cultivated and earned through regular interactions on the part of both the CHW and the CBO administration. Of particular benefit was the support and endorsement of faith leaders, who often counseled their congregations to take advantage of the health promotion efforts (including HBV education and outreach) of the CHW.

MENTORING, SKILL-BUILDING, AND CARING FOR A COMMUNITY HEALTH WORKER

Beyond training and the acquisition of knowledge, CHWs were mentored regarding their roles and responsibilities, and skill-building exercises took place during the regularly scheduled meetings. More experienced CHWs were role models for less experienced CHWs. In addition, story-telling and exchanges of experiences during the regular CHW meetings helped the new CHW learn tips on community outreach and program implementation. Finally, CHWs were helped through personal support and guidance in regards to care of him or herself, setting boundaries, and compassion fatigue.



One of the greatest strengths of the Community Health Worker model was that the CHW lived in the community where he or she served. It was also one of the greatest drawbacks of the model. CHWs ran a risk of “never being off duty.” On weekends and evenings, they encountered clients in neighborhood stores and on the street, and were sometimes unwillingly pressed into providing some kind of counseling or linkage to care outside of their work hours. In addition, the identification of the CHW as a “go-to” person for people in need could lead to frustration as they tackled issues beyond their capacity. Compassion fatigue was a concern as community members burden them with so many problems. At times, CHWs were at risk of overstepping boundaries, either in an effort to be of assistance or simply because the need was so great and they felt compelled to do more. As seen in the example below, these risks and concerns arose during the implementation of the HEPP program, and were addressed as part of the on-going training of the CHW.

SUPERVISION OF THE CHW

As employees of the partnering CBOs, the day-to-day supervision of the CHWs was conducted by their agency supervisors. The CHWs were expected to submit monthly reports to the AHC Program Manager who reviewed how the program was being implemented at the community level. Programmatic concerns were brought to AHC program staff either directly or during the regularly scheduled bimonthly meetings. On the part of the AHC staff, any concerns regarding the CHW or the implementation of the program were addressed directly to the CHW, and if necessary, to the CHW’s agency supervisor.



LESSONS LEARNED

CHWS AND FAITH-BASED INSTITUTIONS

Outreach through the faith-based organizations is key to successful implementation of HEPP. For Lao and Cambodian refugees and immigrants, the local Buddhist temple is the spiritual, cultural, and social center of the community. The monks are highly respected and trusted leaders. Both the Laotian and Cambodian CHWs benefit greatly from the support of the monks who both refer community members to them for linkage to health care and encourage the community to participate in the health events being promoted by the CHW.



LESSON LEARNED

CARE FOR THE CHWS

During one of the bimonthly meetings, a CHW described a problem with one of her clients who was found to be HBV positive, uninsured, and struggling with family issues. During the ensuing conversation, it was evident that the CHW was overwhelmed with the client’s problems and physically and emotionally drained. The Program Manager privately addressed the CHW’s concerns after the meeting and worked with the CHW to link the client to services. The experience led to a subsequent in-service for the CHWs on self-care, compassion fatigue, and setting boundaries.

This incident reminded AHC of the need to keep in regular contact with the CHWs and be helpful with obstacles they may face. The Program Manager worked with the CHW to problem-solve the issues facing this client, and the CHW was very appreciative of the Program Manager’s support.

SAMPLE JOB DESCRIPTION FOR COMMUNITY HEALTH WORKER

DESCRIPTION OF PROGRAM AND POSITION

The **(name of community-based organization)** is partnering with the Asian Health Coalition (AHC) to implement Hepatitis Education and Prevention Program (HEPP), a hepatitis education, screening, and immunization initiative targeting Asian communities in suburban Cook County. The goal is to reduce the incidence of acute hepatitis B infection through education and immunization, and to detect chronic infection through screening and reduce mortality from liver disease.

(Name of community-based organization) is seeking a dedicated person to be trained as a Community Health Worker to carry out the day-to-day activities of the program. The candidate will be expected to provide one-on-one and group education to community members on hepatitis, assist with the implementation of community hepatitis screening events, and provide follow-up linkage to care for clients as needed.

KEY RESPONSIBILITIES

- Must be bilingual in **(target language)** and English
- Serve as the main liaison between the **(name of community-based organization)** and the AHC HEPP program manager
- Attend 2 half day trainings on hepatitis provided by AHC and become familiar with a Hepatitis Resource Guide
- In a 12 month period, educate at least 350 community members in hepatitis, in group settings or one-on-one basis utilizing the Hepatitis Resource Guide
- Refer community members to local screening events
- Assist at screening events as interpreter or in other capacity
- When needed, assist community members with follow-up care by making appointments with provider and assuring available interpretation.
- Fill out monthly reports and submit them to AHC
- Attend bi-monthly HEPP partners' meetings to review program progress

QUALIFICATIONS:

Ideally, the CHW will be an active member of the **(target)** community and well-acquainted with the **(target)** community's culture and local resources. Candidate should have an interest in public health, community service, or social work. She/He will have demonstrated organizations skills and good bilingual verbal and written communication skills.





SECTION 4

SETTING UP A COMMUNITY ADVISORY BOARD

PURPOSE OF THE COMMUNITY ADVISORY BOARD (CAB)

At the Asian Health Coalition, a Community Advisory Board (CAB) was formed to provide oversight for the HEPP program. The CAB was made up of a group of individuals who served in a good faith role to guide the design and implementation of the program. These individuals served in a voluntary capacity and had no legal authority over the program or the organization. One of the benefits of such a board was that the CAB provided the agency with an opportunity to engage in an open discussion with individuals who had the expertise and were vested to address the problems of Hepatitis B in the community. The CAB served as an important partner in facilitating the agency's capacity to promote and increase education, screening, and treatment for Asian communities throughout the Chicago metropolitan area.

COMMUNITY ADVISORY BOARD ROLES AND RESPONSIBILITIES

- Advise and guide the direction of the HEPP Program
- Provide critical feedback on the program's efforts and continuing progress
- Specifically tailor the program to the target community needs
- Provide guidance to modify the program as needed
- Help in providing needed resources and linkages
- Respect the collaborative process and the CAB as a forum to discuss issues
- Be willing to listen to differing views
- Promote bi-directional learning
- Review models for dissemination
- Seek additional funding opportunities

HOW WERE CAB MEMBERS SELECTED?

AHC sought a diverse representation on our Community Advisory Board, to be composed of health professionals and members from the community who worked in communities with high rates of Hepatitis B. Members were selected based on their experience with Hepatitis B prevention and treatment, history of working in the Asian American community, and personal commitment to the eradication of the disease. CAB members included local area physicians in private practice, nurses, pharmaceutical representatives, public health department coordinators, local community leaders, and academic researchers.



The selection process for the CAB members in the HEPP program involved the following steps:

- 1) AHC sought candidates for the Community Advisory Board through informal communications with its community partners, local health department, and physician contacts.
- 2) The candidates were reviewed based on the above criteria, and selected nominees were contacted by AHC staff members either via phone calls or in-person interviews.
- 3) During the interviews, the candidates were provided with an introduction to the agency, a description of the HEPP program, and an explanation of the role and expected responsibilities of the CAB member in the program.
- 4) The candidates who expressed interest were invited to join the HEPP Community Advisory Board

HOW DID THE CAB OPERATE?

The CAB's model of operation was flexible and accommodated the competing demands on members. As the board was being assembled, members were individually consulted as to availability and preferred method of involvement outside formal meetings. The CAB met 2 times a year, usually in the late afternoon to accommodate the members' work schedules. The meetings usually lasted about 90 minutes, with the agenda distributed before the meetings and meeting minutes and action plans distributed shortly after the meetings. The AHC Board President and Executive Director joined the HEPP program staff at the meetings in presenting to the CAB members program updates, including progress made and obstacles encountered, and upcoming activities. Board members assisted in the review of educational materials used, linkage-to-care with physician providers and speaking at Hepatitis events organized by the agency. In addition, board members were also consulted outside of the formal meetings on the average about once a year for assistance in program implementation, such as presenting on Hepatitis B at a community event.

DETERMINING THE RIGHT SIZE FOR THE CAB

From AHC's viewpoint, the CAB size affected how efficiently and effectively members shared and fulfilled their responsibilities. Larger boards did not always mean better boards as members may defer to someone else to take on responsibility and feel less ownership or accountability for the work. With many people at the table, it could be difficult for everyone to engage in the meetings. A few members could dominate the discussion, while quiet members faded into the background.



“Each CAB member has their own special reason for volunteering their time and efforts. As a Korean-American liver transplant surgeon, I see many patients who have become afflicted with liver cancer as a result of viral Hepatitis. In fact nearly 80% of all liver cancer cases are due to viral Hepatitis. I am passionate about serving on this community-based program because I believe strongly in the need for increased education and prevention in Asian American communities when it comes to closing the gap on health inequities in Hepatitis.”

Joseph Ahn, MD
Medical Director
Liver Transplantation
Loyola University Medical Center

With smaller boards like the HEPP program (which has 12 members), the agency found that members experienced a greater feeling of unity, common purpose, and ownership. Each CAB member was given the opportunity to be active and engaged during the meetings and this made for a more rewarding experience. The CAB members also became better acquainted with each other, which made their work together more meaningful. The AHC also found the logistics with a small board was more flexible in terms of scheduling meetings and setting agendas. With fewer people's schedules to accommodate, the HEPP board was able to meet more frequently both in-person and by phone to take care of matters as they arose.

KEY FACTORS IN THE SUCCESS OF THE AHC'S CAB

The positive interaction between the CAB with the Board President, Executive Director, and staff proved to be an effective way of maintaining good communication channels and gave the community members a sound understanding of the program operations and agency's direction for the HEPP program. The CAB's diversity in terms of professions and ethnicity represented, and its effective communication with the HEPP program staff contributed its success. Diversity broadens the board's perspective on hepatitis as a public health issue, and brings an element of creativity and responsiveness

For example, one CAB member alerted the agency to potential private funding opportunities for hepatitis screening when government-level funding was reduced due to budget cuts. In addition the CAB encouraged the agency to raise health issues of concern to the community, including those outside the current priorities of AHC. One of the health areas that was incorporated into the HEPP program was more comprehensive education on Hepatitis C as it is closely related to Hepatitis B through co-infections.



LESSON LEARNED

Unlike a traditional board of directors, the Community Advisory Board members had a non-voting role and serve as a sounding board for generation of ideas, problem solving, networking, dissemination, recruitment and funding.



LESSON LEARNED

- 1) Having an ongoing list of potential CAB members is helpful just in case someone has to leave or drop out from the board. Do not be discouraged if an individual declines to serve on the CAB as rejection is not uncommon due to individual constraints.
- 2) A diverse board makes for a more responsive and effective board. Diversity broadens the board's perspective on the public health issue that we are trying to resolve.
- 3) At times, email or telephone contact may be substituted for attendance at working group meetings, and is equally valued.



SECTION 5

PLANNING THE HEPATITIS EDUCATION AND PREVENTION PROGRAM

GOAL OF PROGRAM PLANNING

After creating the Community Advisory Board to oversee and guide the program, the next step for the Asian Health Coalition was program planning. Especially when applied to a chronic health issue such as HBV in the Asian-American community with cultural, behavioral, structural, and financial barriers, it is important to take an ecological approach to program planning. Such an approach would identify not only the needs of the community, but also the resources, both human and institutional, that could be tapped in program implementation. The goal of HEPP program planning stage, therefore, was to gain a better understanding of the community's needs. Specifically, the spectrum of barriers to Hepatitis B prevention and care and the resources available to address those barriers. This knowledge would then be used to set priorities and plan the program, including what should be integrated into the training of the Community Health Workers, what health care agencies should be involved, and what other community resources are available.

The need for a Hepatitis B intervention program had been identified on a large scale, using aggregated data for Asian American populations. However, community-level, disaggregated data needed for program planning and implementation was not available. To meet this need, AHC followed a three-step process of a Community Needs Assessment, followed by data analysis, and then strategic planning.

CONDUCTING COMMUNITY NEEDS ASSESSMENT

AHC conducted a four-pronged Community Needs Assessment (CNA): 1) community scan; 2) organizational capacity assessment; 3) provider resource inventory; and 4) individual client surveys. Each partner agency's community was assessed according to where the target population primarily lived and culturally and linguistically competent health care resources available. In addition, the partner agency itself was assessed in terms of its capacity to implement the HEPP. Individual members of the target population were surveyed to determine basic demographic information, general knowledge of HBV, and any cultural, financial, or linguistic barriers to health care. Attention was also paid to any current efforts to address HBV in the community and the long-term sustainability of the project by AHC's community partners. The Community Needs Assessment was conducted during the first year of the HEPP program in collaboration with our community partners. The process was overseen by AHC's HEPP coordinator with guidance from the Program Manager and Community Advisory Board. The tools that AHC used to conduct the Community Needs Assessment are included in the appendix. More information on Community Needs Assessments and how to conduct them is available on the Internet. One such resource is the Community Tool Box at <http://ctb.ku.edu>.



LESSON LEARNED:

Having decided to use GIS to conduct the community scan, AHC discovered that learning GIS software required using significant staff time and resources, and GIS consultation fees were expensive. AHC was fortunate to find a GIS expert who volunteered his time to conduct the scan, but this is not a replicable or sustainable solution to the cost of GIS. It is possible to partner with a local institution or arrange an internship for a student with GIS capacity, or to invest staff time and resources into learning GIS technology. There are a number of companies that provide on-line webinar GIS.

In conducting the Community Scan using GIS technology, AHC also learned that the information that was being sought was also available from existent population data sources such as health department statistics, census tract data, and other on-line resources. It was not worth the time and resources to use GIS when the information we needed was already available on-line.



LESSON LEARNED:

It is notoriously difficult to get participants to return surveys, and that was certainly the experience of AHC in conducting organizational capacity assessments. Friendly reminders and target deadlines can help move the partners to completion of the assessments. It is also important to make certain that the surveys are succinct and targeted to the needs of the program. On-line survey tools may be easier alternatives.

1. COMMUNITY SCAN

A community scan is a valuable CNA tool to gain greater understanding of the target population's demographic data, including languages spoken at home, poverty level, health insurance coverage, and age distribution, and available resources such as health centers, civic organizations, media outlets, faith-based organizations, and other local assets. The scan is conducted seeking information relevant to the overall goal of the program and tapping into existent data such as census information, public health data, information from non-profit and service organizations, and other published resources. Most of this data can be found on-line.

In order to achieve a greater understanding of the target community's needs and assets using available published data, AHC's community scan used Geographic Information System (GIS) technology, which provided a visualization of the partners' target populations and their health care needs and resources. The result was a map of the greater Chicagoland area that indicated the density of the Asian American population by zip code, the location of our partnering CBOs, the address of the local public health departments, and the location of physicians in the targeted areas who provide care for people with chronic HBV. The information gained was used in planning HEPP implementation in the different communities. It was particularly valuable to learn the availability of physicians who could provide linguistically competent care for Asian Americans with chronic HBV, their contact information, and payment options. In addition to shedding light on the overall health care landscape for AAPIs with chronic Hepatitis B, the information was helpful in the development of the physician directory.

2. ORGANIZATIONAL CAPACITY ASSESSMENT

The strength of HEPP reflected the capacity of its partnering community-based organizations to implement and sustain the program. In selecting partnering CBOs, it was imperative to assess their overall capacity to implement the program; identify their resources, programs, and services that could support the HEPP program; and note any gaps in knowledge or skill that could affect program implementation. In selecting its HEPP partners, AHC completed an initial assessment of each organization's capacity, based on the strength of its leadership, existing programs and outreach, strategic plan, financial stability, and support staff. Having selected its partners for HEPP, AHC conducted a more in-depth assessment of each organization, incorporating questions that would provide valuable insight into the design of the program for its eventual implementation in partnership with the CBO.

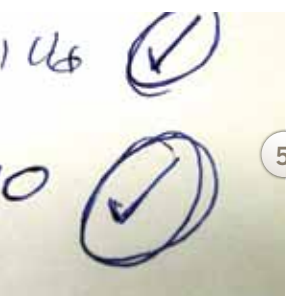
AHC assessed the organizational capacity of its partners through a paper-and-pencil survey. The intent of the survey was to: 1) assess the health needs among the AAPI communities from the community organization's perspective and; 2) to assist in guiding the infrastructure of the HEPP expansion and dissemination to Asian communities. The survey included organizational information, target population demographics, perceived barriers to health care, and the organization's capacity to provide Hepatitis B education for the community. A copy of the Organizational Capacity Survey is included in Appendix 5a.

CASE STUDY

KOREAN AMERICAN COMMUNITY SERVICES

Korean American Community Services (KACS) is a large agency that provides a variety of social, educational, and employment services to area immigrants, primarily Korean and Hispanic. The agency also runs a small-scale health center that provides primary health care and screening services at low cost. The health center did not provide HBV education, screening, vaccination, or linkage to care prior to the agency's partnership with AHC. Through its involvement in the HEPP program, however, KACS was able to leverage the training of its staff member as a Community Health Worker, access to HBV educational tools, and HBV campaign in local Korean media to obtain its own hepatitis screening and vaccination resources through complementary funding. The experience of KACS is an example of an organization not only assessed to have the capacity to implement HEPP, but also having the infrastructure to build on the program and enhance existing services.





3. PROVIDER RESOURCE DIRECTORY

Key to addressing the problem of chronic Hepatitis B in the Asian American community is the identification of culturally and linguistically competent local health resources that can provide services along the continuum of HBV care (screening-vaccination-treatment). Coupled with organizational capacity-building, identification of such resources was essential to HEPP's long-term goal of program sustainability at the community level. It was also imperative that community members identified as being susceptible to HBV or chronically infected with HBV be linked to culturally and linguistically competent services. Researching appropriate and accessible HBV health care resources also helped to identify gaps in the provision of needed services that needed to be addressed.

HEPP's *Physician Resource Directory* was both a printed booklet and an on-line resource. It was created based on a Provider Resource Inventory conducted in the first year of the HEPP program by the program coordinator. Its purpose was to determine the availability and accessibility of HBV services for community members in their geographical area. The inventory noted provider name, contact information, services provided, types of payments accepted, languages spoken by the provider, staff or through translation services, website when appropriate, and whether new patients were being accepted. The inventory was then used to create a Hepatitis B Physician directory (see Appendix 5b for the template used in creating the inventory.) for the partners' use in connecting community members to HBV screening, vaccination, and treatment. A copy of the Provider Resource Directory is available on the Asian Health Coalition website (www.asianhealth.org).

Conducting the Physician Resource Inventory was labor-intensive and completed primarily by AHC interns with oversight by the program coordinator.

Here are suggested steps to developing a Physician Resource Directory:

1. Use a search engine such as Google, WebMD Physician Directory, Doctorfinder (from the AMA), to search the targeted geographic areas for the locations of physicians and health care professionals who provide HBV health services.
2. Record the information gathered on a spreadsheet that includes physician name, affiliated hospital or health center, location (or locations) of office, and contact information.
3. If necessary, reduce the provider list to a more manageable number by focusing only on those providers most likely to provide accessible and culturally and linguistically competent healthcare. At AHC, only physicians with Asian last names were selected.
4. Verify the information gained from the Internet research by calling each of the providers listed in the inventory. On-line resources are not always maintained with up-to-date information. A sample provider call script is included in Appendix 5c.
5. Once confirmed, the provider information can be inserted into an appropriate template using word processing or desktop publishing software for later printing or on-line accessibility.

AHC printed 500 copies of the *Physician Resource Directory* which included, in addition to the names and above listed information for each provider, an overview of the Hepatitis virus, national and local organizations involved in Hepatitis, and multi-lingual Hepatitis education resources available on the Internet. The directory was also made available on AHC's website. In addition, an on-line template was made available for health care providers to complete who want to be included in AHC's next Hepatitis B Physician Directory. The directory was published in English.

Partnering agencies and Community Health Workers found the Physician Resource Directory useful when linking their insured clients found to be carriers of HBV with bicultural, bilingual health care providers. The diversity of ethnicity, languages spoken, and geographic locations reflected in the Directory helped to make it a particularly valuable resource. Uninsured clients found to be carriers of HBV were linked to health care through the county health department.

4. INDIVIDUAL CLIENT SURVEYS

As the fourth step in the Community Needs Assessment, Individual Client Surveys (ICS) were created, distributed, and analyzed in the first year of HEPP. The purpose of the ICS was to: (1) define the demographic and socioeconomic profile of the target population; (2) determine the knowledge, attitudes, and behaviors regarding HBV of the target population; and (3) assess any barriers to the continuum of HBV experienced by HEPP’s target population. Insight gained through the ICS would be incorporated into the HEPP implementation plan, especially in the training of the Community Health Workers and the development of the education and outreach strategies.

AHC created a 50-question survey and then pilot tested it among partner agency staff for clarity of questions and ease of completion. Feedback was incorporated into the final version which was then translated into the five target languages (Chinese, Korean, Khmer, Vietnamese, and Lao). Because of the diversity of languages in which the survey was administered, it was necessary to create a survey template utilizing a Likert scale that could be easily scored. (See Appendix 5d for the English version of the ICS.) Answers to open-ended questions were translated by the bilingual CHW.

The surveys were administered by partner agency staff at their CBO, health fairs, and other community sites such as churches, temples, and mosques. Each partnering CBO was asked to distribute 25 surveys, which were then returned to the program coordinator. Completed surveys were tabulated by the HEPP program staff. During the process of tabulation, staff used 10 questions to quantify overall knowledge of HBV on a ten point scale (1-Low knowledge, 10-High knowledge). AHC staff examined which individual characteristics (education, ethnicity, years residence in the US, age, and insurance status) were associated with high and low knowledge of HBV.

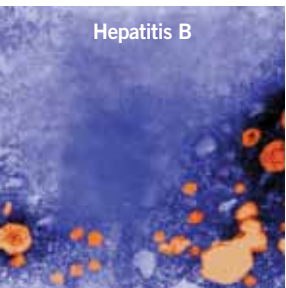
DATA ANALYSIS

Data gathered through four methods from the Community Needs Assessment (CNA) was analyzed, summarized, and presented to the Community Advisory Board for eventual incorporation into the community-level planning and implementation of HEPP. Key findings through the CNA that provided guidance in the HEPP program design include:

Barriers to Follow Up	Percent
Don't Have Insurance	55 %
Don't Have a Doctor I understand	27 %
Don't Believe There is a Cure	27 %
Cannot Afford Healthcare	18 %
Don't Understand What to Do	13 %
Don't Feel This is Important	13 %
Other	13 %
Don't Have Transportation	9 %
Don't Have Time	9 %
Don't Know Where to Go	5 %

- 1. Community Scan:** With the guidance of the Community Advisory Board, AHC staff incorporated key findings from the Community Scan into the final plans for HEPP’s implementation by the partnering agencies. Examples of findings that were useful in HEPP program planning included the need for tailored programs to meet the specific needs of each Asian subgroup (disaggregated Asian subgroup approach to HEPP planning and implementation), the tremendous need for education and awareness about Hepatitis B and its impact in the community, the lack of bilingual resources, the challenges of navigating the healthcare system and perhaps, most importantly, the strengths, resilience, and commitment of the communities to improve their health.
- 2. Organizational Capacity Assessment:** The survey results indicated a number of insights regarding the CBOs’ perspective of the health needs of their community and suggestions for program implementation. While a variety of outlets can be utilized for relaying important health information, monthly meetings with CBO leaders, health fairs, and community centers were seen as the most convenient locations for community education in addition to churches and temples. One CBO indicated that the doctor’s office was convenient for obtaining health information. The CBOs listed the strongest barriers to health care access among their communities were the cost of prescription drugs and cultural and linguistic barriers. All of the CBOs viewed the CHW model as an effective strategy towards educating their communities on Hepatitis B.

3. **Provider Resource Inventory:** The physician directory included a list of nearly 70 physicians in the Chicago metropolitan area who treated liver health and Hepatitis. Providers were also asked if they spoke any other language besides English and/or had translation services readily available. In addition, information was also included on whether or not the providers accepted low-income patients and what type of follow-up care was available (i.e. vaccination, chronic HBV treatment, counseling, etc). The directory entry form has also been made available on the AHC website for any physicians interested in registering their information on the AHC website.
4. **Individual Client Survey:** The Individual Client Survey (ICS) goal was to determine the knowledge and behaviors regarding Hepatitis B of the Laotian, Chinese, Cambodian, and Korean populations. In addition to knowledge and behaviors surrounding Hepatitis B, the survey also collected information on demographics, barriers to care and knowledge of Hepatitis C and HIV. The 50 question survey was administered by staff at the 5 CBOs to any community who sought services (e.g., health, employment, ESL, etc). Key results of the Individual Client Surveys are listed below.



Characteristics of ICS Sample

Approximately, 34% of the survey participants were less than 46 years old; 36.3% had a high school of less than high school education, and 35.7% had an average income of \$25,000 or less. Sixty-one percent of the participants were women, 29.4% had been living in the US for less than 10 years, and 43.7% had no insurance. Demographics by CBO group are available in Appendix 5e.

Hepatitis B, Hepatitis C, HIV Screening

Only 30.3% of participants reported that they had ever been screened for HBV. Self-report of receiving HBV screening was highest for participants that receive services at Korean American Community Services - KACS (42.1%) and lowest for individuals who received services at Lao American Organization-Elgin - LAOE (18.2%). In addition to asking about past HBV screening participation, the ICS asked participants if they had ever been diagnosed with HBV; 10.8% responded yes. Participants at both Korean CBO had the highest rates of Hepatitis B (KACS: 15.9% and Hanul Family Alliance -HFA:12.9%).

Hepatitis C and HIV are two viruses that can co-occur with Hepatitis B. ICS participants were asked if they had ever heard of Hepatitis C or HIV and had ever been tested for either virus. Approximately 39% of participants had heard of Hepatitis C and 59.2% had heard of HIV. With respect to testing, only 7.6% and 14.8% of ICS participants had ever been screened for Hepatitis C or HIV respectively.

HEPATITIS B AWARENESS AND KNOWLEDGE

Ten Questions on the ICS survey which asked about the presence of Hepatitis B symptoms and how HBV is transmitted were summed together to create a composite Hepatitis B knowledge score (0-10). Results showed the average survey participant's knowledge of Hepatitis B was 4.9 (sd=2.64). Characteristics that were associated with more knowledge of Hepatitis B were higher education and having insurance. Results also showed individuals of Chinese and Korean ancestry had more knowledge of Hepatitis B than individuals of Cambodian ancestry. These results were incorporated into an action plan for creating a target group for outreach strategies and education educational message.

ASIAN HEALTH COALITION HEPATITIS EDUCATION AND PREVENTION PROGRAM

SUBURBAN ORGANIZATIONAL ASSESSMENT SURVEY (OAS)

NAME:
ORGANIZATION:
EMAIL:
PHONE:
ORGANIZATION WEBSITE (IF APPLICABLE):

1) Which of the following programs and services does your agency currently provide?
Please check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Legal Aid | <input type="checkbox"/> Youth Services |
| <input type="checkbox"/> Literacy/ESL | <input type="checkbox"/> Employment Services |
| <input type="checkbox"/> Senior Services | <input type="checkbox"/> Immigration & Citizenship |
| <input type="checkbox"/> Healthcare or Health Education Services | <input type="checkbox"/> Physical Activity (i.e. dance or sports) |
| <input type="checkbox"/> Other, please specify | |

2) Which health topics does your agency currently focus on? Check all that apply.
Please list any others that the list does not include.

- | | |
|--|---|
| <input type="checkbox"/> Alcohol and other Substance Abuse | <input type="checkbox"/> Breast Cancer Screening |
| <input type="checkbox"/> Dental Care | <input type="checkbox"/> Cervical Cancer Screening |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Heart Disease/Hypertension |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Hepatitis Education |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Nutrition and Diet |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Smoking Cessation | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Women's Health | <input type="checkbox"/> Other, please specify |

3) Number of clients served annually (non-duplicated, meaning unique clients per year)

4) Specify the towns where clients served by your organization reside.

5) What language populations or ethnic communities are served by your organization? Check all that apply.

- | | | | | |
|----------------------------------|--|------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Bengali | <input type="checkbox"/> Cantonese | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Chinese Simplified | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> English | <input type="checkbox"/> Gujarathi | <input type="checkbox"/> Hindi | <input type="checkbox"/> Hmong | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> Korean | <input type="checkbox"/> Lao | <input type="checkbox"/> Mon-Khmer | <input type="checkbox"/> Spanish | <input type="checkbox"/> Tagalog |
| <input type="checkbox"/> Thai | | | | |
| <input type="checkbox"/> Urdu | <input type="checkbox"/> Other, please specify | | | |

6) What is the education level of the majority of your population?

- | | | |
|--|---|--|
| <input type="checkbox"/> Below 5 th Grade | <input type="checkbox"/> Some High School | <input type="checkbox"/> Completed High School |
| <input type="checkbox"/> Bachelor's Degree | <input type="checkbox"/> Graduate Degree | <input type="checkbox"/> Other, please specify |

7) What type of insurance do the majority of your clients have?

- Private Insurance Medicare Medicaid KidCare
 FamilyCare Sliding Scale for uninsured client None
 Other, please specify

1) As it pertains in your ethnic community, what barriers to health care access do community members experience? Check any that apply and rank them from 1 (least barrier) to 5 (most barrier).

Cost of Prescription Drugs

1 (least) 2 3 4 5 (most)

Cultural Barriers

1 (least) 2 3 4 5 (most)

Transportation Barriers

1 (least) 2 3 4 5 (most)

Language Barriers

1 (least) 2 3 4 5 (most)

Lack of Health Insurance

1 (least) 2 3 4 5 (most)

Not a priority in my community

1 (least) 2 3 4 5 (most)

Lack of Evening/Weekend Hours for Appointments

1 (least) 2 3 4 5 (most)

Lack of Documentation

1 (least) 2 3 4 5 (most)

Lack of Knowledge about Healthcare Services

1 (least) 2 3 4 5 (most)

Not Eligible for Public Benefits because of Immigration Status

1 (least) 2 3 4 5 (most)

Other, please specify

1 (least) 2 3 4 5 (most)

12) Do you currently have a program that addresses Hepatitis B Health Education?

- Yes No

13) If yes, does your organization provide written information (pamphlets, posters, magazines) on Hepatitis B?

- Yes No

14) If yes, does your organization provide translated written information (pamphlets, posters, magazines) on Hepatitis B?

- Yes No

15) Do you currently talk to your clients about Hepatitis B?

Yes No

15a) If yes, do you initiate the conversation, or only if the client brings the topic up?

Yes No

15b) If no, what are the perceived barriers for this conversation with community clients?

16) Have you (or anyone else in your organization) ever received any training or education regarding Hepatitis B?

Yes No

16a) If you or anyone else in your organization has received Hepatitis B training, was the training or education done within the last 2 years?

Yes No

17) If you, or anyone else, have not received any training or education regarding Hepatitis B, please mark the reasons that apply:

- | | |
|---|---|
| <input type="checkbox"/> Training has not been offered | <input type="checkbox"/> Lack of funding |
| <input type="checkbox"/> Not perceived as priority by the CBO | <input type="checkbox"/> Not part of the organization mission |
| <input type="checkbox"/> Hepatitis is not a priority or issue in my community | <input type="checkbox"/> Not interested |
| <input type="checkbox"/> Additional Comment | |

18) Do you feel that Hepatitis B is a problem among members in your community?

Yes No

Additional Comment

18a) If yes, you do feel that Hepatitis B is a problem among members in your community, how severe is the problem?

1 (not very severe) 2 3 4 5 (very severe)

19) I know enough about Hepatitis B to help others learn about the disease.

Yes No

20) I know where to help my clients get low cost screening, immunization, and treatment for Hepatitis B.

Yes No

21) If your organization does not currently provide any Hepatitis B health education programs, do you think it is important that your organization develops a Hepatitis B health education program?

Yes No

22) I or others in my organization feel comfortable about educating and talking about Hepatitis B with clients at my organization.

Yes No

23) In your opinion, what are the best ways for your community members to get health information? Check all that apply. Rate the convenience as well.

Monthly house meetings with leaders

1 (not very convenient) 2 3 4 5 (very convenient)

Health fairs

1 (not very convenient) 2 3 4 5 (very convenient)

Community centers

1 (not very convenient) 2 3 4 5 (very convenient)

Church

1 (not very convenient) 2 3 4 5 (very convenient)

Temple

1 (not very convenient) 2 3 4 5 (very convenient)

Doctor's office

1 (not very convenient) 2 3 4 5 (very convenient)

Other, please specify

1 (not very convenient) 2 3 4 5 (very convenient)

24) In your opinion, would the lay health advisor or lay health education model work for providing education on Hepatitis B in your communities?

Yes No

25) If no, please describe why the lay health advisor or lay health education model would not work for providing education on Hepatitis B in your communities. List some strategies for education that would work in your communities.

ASIAN HEALTH COALITION HEPATITIS EDUCATION AND PREVENTION PROGRAM

INDIVIDUAL CLIENT SURVEY

Instructions: Thank you for taking this survey. This survey will help AHCI determine the level of the Asian American population in the areas of Cook, DuPage and Kane Counties that understand or know about the issue of hepatitis B. Also important is the need to measure the need for sustainable education and prevention programs at the local community-based organizations. Please fill out the form as it pertains to you. This survey maintains individual client confidentiality. Please answer every question to the best of your knowledge. After you are finished with the survey please give it back to the community health worker.

THIS SECTION WILL TEST YOUR GENERAL KNOWLEDGE OF HEPATITIS B:

IDK= I don't know

1) Do you know what Hepatitis B is?

Yes

No

IDK

If yes, briefly describe your source:

Friend

Family Member

Doctor

Other

Community Health Worker

Please answer either true, false, or IDK (for I don't know) to the following questions:

2) When infected with Hepatitis B there are always signs and symptoms. True False IDK

3) Hepatitis B can be passed through genes (hereditary). True False IDK

4) Hepatitis B can be passed through a blood transfusion. True False IDK

5) Hepatitis B is passed from mother to child during birth (vertical transmission). True False IDK

6) Hepatitis B is transmitted by inhaling the air of an infected person. True False IDK

7) Hepatitis B is transmitted from sexual relationships. True False IDK

8) Hepatitis B is transmitted from sharing food or spoons and bowls. True False IDK

9) Hepatitis B is transmitted from razor (shaver) or toothbrush. True False IDK

10) The Hepatitis B Virus can cause liver cancer. True False IDK

11) Does the Hepatitis B vaccine treat Hepatitis B Infection? True False IDK

12) Do you feel that you are at risk for Hepatitis B? True False IDK

Additional comment:

If yes, **why** do you feel that you are at risk? _____

13) If someone asked you about Hepatitis B, would you be comfortable giving them advice? Yes No

If no, please explain:

THESE NEXT FEW QUESTIONS ADDRESS SCREENING, PREVENTION, AND TREATMENT OF HEPATITIS B

14) When do you seek medical care?

Please specify:

15) Have you been diagnosed with Hepatitis B? Yes No IDK

If yes, **where** and **when** were you diagnosed?

16) If you were diagnosed with Hepatitis B, have you been treated? Yes No IDK

If yes, how were you treated? _____

17) Has anyone asked you to be screened, ex: you primary care physician, community organization, church, temple, etc.?

Yes No

If yes, **when**: _____ and **where**: _____

18) If you wanted to get screened for Hepatitis B, would you know where to go? Yes No

If yes, **where**:

19) Have you ever participated in Hepatitis B Screening? Yes No IDK

If yes, please specify **where** and **when** you had the screening done. _____

20) Do you know where to get screened for Hepatitis B if you cannot afford screening? Yes No

If yes, please specify **where**:

21) Has anyone suggested that you get immunized? Yes No

If yes, **where** and **when** did someone suggest you get immunized? _____

22) If you wanted to get immunized for Hepatitis B, would you know where to go? Yes No

If yes, please specify **where**:

23) Do you know where to get low-cost vaccinations? Yes No

If yes, please specify **where**:

24) Have you received any vaccinations for Hepatitis B? Yes No IDK

If yes, shot 1 **date**: _____ **where**: _____

shot 2 **date**: _____ **where**: _____

shot 3 **date**: _____ **where**: _____

25) Have you received any treatment for Hepatitis B? Yes No IDK

If yes, where: _____ when: _____

26) If you wanted to receive treatment for Hepatitis B, would you know where to go? Yes No

If yes, please specify where?

27) Do you know where to get low-cost treatment? Yes No

If yes, please specify where? _____

28) If pregnant, did you have prenatal screening for Hepatitis B? Yes No

29) Which language do you prefer to have the health information written in? _____

30) If you wanted to know more about Hepatitis B in your language, would you know where to get it?

Yes No

If yes, please specify where? _____

31) Where do you get your health information from? (Check all that apply)

Monthly house meeting with leaders Health fairs Community Center Church/Temple

Doctor's office Other, please specify: _____

32) What barriers, if any, do you have to accessing Hepatitis B screening, vaccine, or treatment in your community?

Financial difficulty Lack of translations services/language barrier No services available

Don't know where to go Feel fine Lack of transportation/unable to get to the provider

Not a problem Other: _____

33) How confident are you filling out medical forms by yourself?

Not at all confident A little bit confident Somewhat confident Quite confident Extremely confident

34) Have you heard of Hepatitis C? Yes No

35) Have you ever been screened for Hepatitis C? Yes No

36) Have you heard of HIV? Yes No

37) Have you been screened or tested for HIV? Yes No

LASTLY, WE WILL ASK SOME BASIC DEMOGRAPHIC QUESTIONS:

38) What is your gender? Female Male

39) What is your age?

10-17 18-25 26-35 36-45 46-55 56-65 66 and above

40) What year did you arrive in the U.S.? _____

41) What is your ethnicity? Please check all that apply or specify if ethnicity is not listed.

- Bangladeshi Cambodian Chinese Ethiopian Filipino Guamanian Gujarathi
 Hindi Hmong Japanese Korean Lao Mon-Khmer Thai
 Urdu Vietnamese Other, please specify _____

42) What language do you speak at home? _____

43) Are you currently employed?

- No Full-time Part-time Other, please specify _____

44) What is your average income for your household?

- Below \$25,000 \$26,000-\$40,000 \$41,000-\$70,000 \$71,000-\$90,000 \$91,000-\$100,000
 Above \$100,000

45) What is your highest level of formal education?

- Primary school High School Some college College Graduate degree No school
 Other, please specify _____

46) Do you have health insurance? Yes No

If **yes**, please indicate which type:

- Private Medicare Medicaid (Public Aid) Family Care KidCare None Refugee status
 Other, please specify _____

47) What is your zip code? _____

48) Do you speak English during your visits to the doctor? Yes No

Thank you for your participation in this survey. Your input is very valuable!
Do not forget to hand this survey back to the surveyor.

ASIAN HEALTH COALITION HEPATITIS EDUCATION AND PREVENTION PROGRAM

**TABLE X.1
INDIVIDUAL
CLIENT
SURVEY
PARTICIPANTS'
DEMOGRAPHIC
CHARACTERISTICS
BY COMMUNITY
BASE
ORGANIZATION.**

Characteristics	Total (N=446) %	CAI (n=89) %	HFA (n=132) %	KACS (n=126) %	LAOE (n=22) %	XILIN (n=77) %
Ethnicity						
Cambodian	19.7	98.9	-	-	-	-
Chinese	16.8	-	-	-	-	97.4
Korean	54.5	-	92.4	96.0	-	-
Lao	4.0	-	-	-	81.8	-
Other	4.9	1.1	7.6	4.0	18.2	2.6
Education						
Less than HS	10.1	34.8	4.5	.8	27.3	1.3
High School	26.2	41.6	31.1	19.8	27.3	10.4
Some College	13.5	11.2	9.1	15.9	22.7	16.9
College or More	43.9	12.4	41.7	57.9	9.1	71.4
Other or Missing	6.3	0	13.6	5.6	13.6	0
Age						
10-17	1.1	1.1	2.3	0	0	1.3
18-25	3.8	6.7	7.6	.8	0	0
26-35	8.3	9.0	5.3	14.3	9.1	2.6
36-45	19.1	24.7	11.4	33.3	4.5	6.5
46-55	20.4	19.1	25.0	29.4	9.1	2.6
56-65	17.9	13.5	29.5	11.9	31.8	9.1
66 and above	23.8	20.2	10.6	7.1	27.3	76.6
Missing	5.6	5.6	8.3	3.2	18.2	1.3
Gender						
Female	61.0	58.4	65.9	70.6	22.7	50.6
Male	33.0	38.2	25.8	23.8	63.6	45.5
Missing	6.1	3.4	8.3	5.6	13.6	3.9
Years Living in the US						
<=5 yrs	14.3	5.6	8.3	21.4	9.1	24.7
6-10 yrs	15.0	3.4	18.2	18.3	0	22.1
11-15 yrs	11.9	1.1	14.4	15.1	0	18.2
16-25 yrs	20.4	21.3	22.7	20.6	4.5	19.5
26+ yrs	28.5	59.6	20.5	19.8	63.6	10.4
Missing	9.9	9.0	15.9	4.8	22.7	5.2
Current Employment						
None	39.2	40.4	20.5	40.5	27.3	71.4
Full-time	35.2	32.6	50.8	38.1	36.4	6.5
part-time	13.5	13.5	14.4	14.3	4.5	13.0
Self-Employed/Retired/Other	4.7	.0	5.3	3.2	18.2	7.8
Missing	7.4	13.5	9.1	4.0	13.6	1.3
Average Income						
<=25k	35.7	29.2	44.7	27.8	50.0	36.4
26k-40k	25.1	57.3	15.9	29.4	9.1	1.3
41k-70k	11.0	7.9	8.3	17.5	18.2	6.5
>=70k	5.8	2.2	7.6	6.3	0	7.8
Missing	22.4	3.4	23.5	19.0	22.7	48.1
Insurance Type						
No Insurance	43.7	15.7	52.3	52.4	27.3	51.9
Private	20.4	29.2	18.2	23.0	13.6	11.7
Medicare	7.4	5.6	7.6	5.6	22.7	7.8
Medicaid	7.0	14.6	2.3	3.2	9.1	11.7
Other	9.6	11.2	12.1	9.5	13.6	2.6
Insurance type Unknown	7.0	20.2	0	1.6	0	14.3
Missing	4.9	3.4	7.6	4.8	13.6	0

Individual Client Survey Participants' HBV, HCV, and HIV Screening Participation.

	Total (N=446) %	CAI (n=89) %	HFA (n=132) %	KACS (n=126) %	LAOE (n=22) %	XILIN (n=77) %
Know What HBV Is						
No/Don't Know	41.7	46.1	47.7	35.7	63.6	29.9
Yes	56.1	52.8	49.2	61.1	36.4	68.8
Missing	2.2	1.1	3	3.2	0	1.3
Ever Tested for HBV						
No/Don't Know	63.4	69.7	75	48.4	68.2	61
Yes	30.3	29.2	19.7	42.1	18.2	33.8
Missing	6.1	1.1	5.3	9.5	13.6	5.2
Ever Diagnosed with HBV						
No	74.9	66.3	78	75.4	54.5	84.4
Don't Know	12.6	24.7	9.1	7.1	22.7	10.4
Yes	10.8	9.0	12.9	15.9	4.5	2.6
Missing	1.8	0	0	1.6	18.2	2.6
Heard of HCV						
No/Don't Know	57.4	52.8	62.1	59.5	40.9	55.8
Yes	39.2	46.1	37.1	35.7	36.4	41.6
Missing	3.4	1.1	.8	4.8	22.7	2.6
Ever Tested for HCV						
No	89.2	92.1	94.7	94.7	63.6	83.1
Yes	7.6	6.7	4.5	4.5	9.1	14.3
Missing	3.1	1.1	.8	.8	27.3	2.6
Heard of HIV						
No	36.5	24.7	56.8	48.4	9.1	3.9
Yes	59.2	71.9	40.2	48.4	68.2	92.2
Missing	4.3	3.4	3.0	3.2	22.7	3.9
Ever Tested for HIV						
No	81.2	85.4	91.7	80.2	68.2	63.6
Yes	14.8	12.4	6.1	15.1	9.1	33.8
Missing	4	2.2	2.3	4.8	22.7	2.6

SECTION 6

TRAINING THE COMMUNITY HEALTH WORKER



TRAINING GOALS

Community Health Workers (CHWs) are the key to the successful implementation of AHC's Hepatitis Education and Prevention Program (HEPP), and their training needed to be comprehensive, effective, and reflect the multi-faceted role the CHWs play in the program. To this end, the goals of the CHW training were to provide a grounding in the various aspects of Hepatitis B as a disease and persistent health disparity disproportionately affecting AAPIs, as well as develop the CHWs' skills in community outreach, teaching techniques, client support and advocacy, and program logistics.

LEARNING OBJECTIVES

Training for the CHWs emphasized a curriculum that was client-centered and culturally competent. AHC identified the following learning objectives for CHWs completing the HEPP training workshops:

- 1. Core competencies in Hepatitis Knowledge:**
 - a. Have a basic understanding of the liver and its function in the human body
 - b. Understand that hepatitis is caused by a virus that can damage the liver
 - c. Know that there are different kinds of hepatitis, including Hepatitis A (HAV), Hepatitis B (HBV), and Hepatitis C (HCV)
 - d. Be able to name some of the common symptoms of acute hepatitis, and know that chronic hepatitis often has no symptoms
 - e. Understand the significance of chronic Hepatitis B in the AAPI community
 - f. Understand how HAV, HBV, and HCV are transmitted
 - g. Understand the difference between "immune," "carrier," and "susceptible" in regards to HBV screening
 - h. Understand basic Hepatitis prevention measures, including immunization against HAV and HBV
- 2. Core competencies in Community Outreach and Education**
 - a. Recognize opportunities and venues for one-on-one and group education sessions
 - b. Understand basic principles of adult, non-formal education as it relates to health promotion and behavior change
 - c. Demonstrate an understanding of various pedagogical techniques (multimedia/Powerpoint presentation, demonstration, short lecture, story-telling, etc)
 - d. Understand the social, cultural, and economic barriers to HBV screening and linkage to care
- 3. Role of the Community Health Worker in Hepatitis Education and Prevention (HEPP)**
 - a. Basic skills in listening and communicating with clients
 - b. Understanding of program logistics in regards to screening events, how clients' results are handled, client confidentiality, and HIPPA regulations.
 - c. Knowledge of local resources regarding HBV follow-up and linkage to care for those needing the three-series vaccination or long-term medical care
 - d. CHW program responsibilities, including documentation and monthly reports

LESSONS LEARNED:

NO TWO CHWs ARE ALIKE

1. CHWs from partnering agencies represent a variety of ages and educational backgrounds. Some of the CHWs are health professionals in their countries of origin and have a greater understanding of the disease than others. The CHWs also vary in terms of their ages and community experiences. It is important to value all the CHWs equally in terms of their unique roles in their specific communities, and encourage sharing of experiences and expertise.
2. CHWs learn best when the course is interactive, allows time for the sharing of stories and experiences, and incorporates skill-building exercises. Role playing provides the CHW with the opportunity to practice motivational interviewing skills.
3. Often, CHWs approach a training with a lifetime of experiences and beliefs related to Hepatitis B. These personal and cultural views should be addressed respectfully during the workshop. In this manner, stigma and other obstacles to addressing HBV education and outreach are recognized and discussed.

PLANNING THE TRAINING

AHC took a three-pronged approach to training: 1) increase the CHWs' *knowledge* regarding the Hepatitis B virus, including its prevalence in the AAPI community, transmission, effect on the body, signs and symptoms, treatment, and prevention; 2) build the CHWs' *skill* level to conduct effective community outreach, carry out effective one-on-one and group education sessions, and link clients to needed health services; and 3) provide and train the CHWs on the *tools* needed to conduct outreach and education.



AHC began with an evidence-based curriculum on Hepatitis B that had been developed by a physician at the University of Chicago. Insights gained during the Community Needs Assessment (CNA - see Section Five) were incorporated into the curriculum, which consisted of a multimedia (Powerpoint) presentation and additional notes. Examples of added material based on CNA findings were the role of stigma against Hepatitis B as an obstacle to community outreach, and the barriers to health care access experienced by the HEPP partners' client population. The Individual Client Surveys (ICS) provided particularly valuable information about the target population's knowledge, attitudes, and behavior regarding HBV.

The enhanced curriculum was then reviewed by the AHC staff for its cultural competency and health literacy level suitable for community outreach, paying particular attention to the target communities' attitudes and beliefs regarding Hepatitis B. Appropriate modifications were made. Emphasis was placed on simple illustrations and minimal text. To accompany the curriculum, AHC developed a toolkit ("HEPP Hepatitis Resource Guide") for the CHWs' use with additional background material on HBV, local resources for HBV prevention and treatment, and language and literacy-level appropriate brochures that could be duplicated and distributed within the community. Sample pages of the hepatitis knowledge assessment tests are included in Appendix 6b and 6c. Samples of the brochures included in the Resource Guide are in Appendix 7c and 7d. The complete documents are available on Asian Health Coalition's website: www.asianhealth.org.

IMPLEMENTING THE TRAINING

The training of the CHWs in Hepatitis Education and Prevention took place over two half-day workshops held at AHC's offices. In addition to the CHWs, the partnering agencies' management staff was encouraged to attend in order to increase their understanding of the program and its implementation. The first workshop covered the core competencies in hepatitis knowledge (see above), and the second workshop focused on core competencies in community outreach and education and the role of the CHW in hepatitis awareness campaigns. A variety of pedagogical techniques were used, not only for their proven effectiveness but also to model teaching styles that could be replicated by the CHWs. Emphasis was placed on teaching techniques such as story-telling and the effective use of the HEPP multi-media educational tool/Powerpoint.

The second workshop provided an opportunity for the CHWs and the partnering agencies' staff to critique the community education Powerpoint for its cultural and linguistic competency and to brainstorm with AHC program staff opportunities for HEPP community outreach. Modifications based on that feedback were made to the community education Powerpoint, and an electronic version of the educational tool was provided to each of the partnering agencies. Community outreach strategies and partner expectations were also reviewed during the second workshop.

CHW ONGOING TRAINING, EVALUATION, AND SUPERVISION

AHC HEPP program staff and the partner agency CHWs met bi-monthly as a group to assure effective CHW training and support. The meetings fulfilled multiple purposes:

- Brief evaluation of CHWs' core competencies in Hepatitis B knowledge, outreach and education skills, and knowledge of linkage to care logistics
- Ongoing training and education to respond to identified gaps in knowledge
- Monitor program progress
- Address implementation obstacles
- Listen to community feedback
- Present new areas of research

Examples of on-going education regarding Hepatitis B included its co-morbidity with HIV, and clarification on the differences between Hepatitis A, B, and C. Supplementary training was provided on these topics as well as appropriate educational tools for the CHWs' use in community outreach. An important skill that was identified as key for the CHWs to encourage community members to be screened for HBV and for follow-up linkage to care was Motivational Interviewing (MI). AHC staff arranged for the CHWs to attend a full-day MI workshop provided by professional psychologists. Local resources for Motivational Interviewing training can be found by doing an Internet search.

In addition to ongoing training through regularly scheduled program meetings, the CHWs were encouraged to attend outside Hepatitis B educational events, either sponsored by a private organization (pharmaceutical company) or a public agency (health department). AHC program staff facilitated the CHWs' participation in these additional Hepatitis education and awareness events whenever possible.

The CHWs' grasp of core competencies was evaluated during these bimonthly meetings through both short pencil-and-paper quizzes and fun, interactive games such as Jeopardy. Gaps in knowledge and understanding identified through these brief evaluations were then addressed either during that meeting or in subsequent sessions.

EVALUATION OF CHW TRAINING

The training of the CHW in identified core competencies was evaluated by:

- 1) changes in knowledge as measured on pre-and post- workshop questionnaires;
- 2) practice presentations on core HBV messages;
- 3) training satisfaction surveys added to the post-workshop forms; and
- 4) one-on-one and informal conversations with the CHWs during program meetings or site visits.

Changes in knowledge of hepatitis and other core competencies were noted, and gaps in understanding of important concepts were identified to be addressed in a subsequent training. The practice presentations in a supportive environment provided opportunities for the CHWs to learn from each other and gain confidence in their presentation skills, and also allowed AHC to identify areas for further training and education. Monitoring CHW satisfaction with the training provided was important to assure CHW overall satisfaction with the program and enhance their comfort level in community outreach and education.

CASE STUDY

SOMLITH VISAYSOUK

LAO AMERICAN ORGANIZATION OF ELGIN

Somlith Visaysouk has been the Community Health Worker (CHW) for the Laotian refugee community since 2004, first with the Chicago-based Lao American Community Services, and later with the Lao-American Organization of Elgin, based in the rural Kane County region of Illinois. Somlith was born in Laos, but fled that country in 1979 and arrived in Chicago as a refugee in 1981. His ability to speak English landed him a position as bilingual teacher's aide during the cultural orientation classes given to fellow refugees prior to their resettlement in the United States and at the public high school. He continued to help his community through a series of jobs as an employment counselor at the local YMCA, and as a case manager at a local refugee mental health program and later at a social service agency. When he began his position as a CHW, he had a long history of helping his community and was trusted by his fellow refugees as a person concerned for the welfare of others. Out of both esteem and affection, he is often addressed as "Luong" ("uncle" in Laotian) by the Lao community.

Since his arrival in the United States, Somlith has lived primarily in the Elgin area part of the Fox River Valley region, which represents the largest Lao community in the Midwest and enjoys the respect of leaders both within the Lao community and the local government. He has earned the admiration of the monks at the local Buddhist temple, who advise fellow Laotians to seek his assistance in matters concerning health and social service needs. The monks also consistently support Somlith's health and outreach activities at the temple for the benefit of the Laotian community. Somlith describes the local Buddhist temples as spiritual as well as community centers, and does his most effective community health education and outreach in connection with temple activities. The support from the monks is key to his success as a Community Health Worker, but his success is also earned through his dedication to the needs of the refugees.

Somlith frequently accompanies clients to Cook County Hospital, the safety net health care agency for the uninsured. In order to be seen that day, patients often begin lining up at 6AM. Somlith drives his clients to Cook County and spends hours with them, serving as interpreter and health advocate. Sometimes his clients give Somlith cash to cover the cost of the gas expended, but Somlith feels rewarded when he is able to help his fellow refugees receive the medical care they need. His clients are grateful for his assistance, and often later invite him to family parties. Because it is difficult for the Lao community to get accurate health information that is culturally and linguistically competent, he sees his role as a CHW trained in HBV education and outreach as paramount to a successful public health intervention such as the HEPP program. Somlith is trusted by the community not only for the health information he provides, but also to maintain patient confidentiality for those clients found to be chronic carriers of the Hepatitis B virus. He feels that this trust makes him an effective Community Health Worker.

ASIAN HEALTH COALITION HEPATITIS EDUCATION AND PREVENTION PROGRAM

ABCS OF HEPATITIS: STAFF CAPACITY BUILDING

Circle the correct answer.

1. The liver is an important organ in your body that:

- A. Cleans blood
- B. Stores energy
- C. Makes proteins, vitamins and hormones
- D. All of the above

2. Hepatitis is a disease caused by a virus that can damage the liver

- A. True
- B. False

3. There are several kinds of Hepatitis, the most important ones are:

- A. A, B, C
- B. A, D, E
- C. B, C, E

4. The short-term (acute) symptoms of hepatitis include jaundice, dark urine, nausea and vomiting among others

- A. True
- B. False

5. A person can be chronically infected with hepatitis without any symptoms

- A. True
- B. False

6. Hepatitis A is not transmitted through the following

- A. Contaminated food and water
- B. Contaminated human waste
- C. Contaminated blood

7. Hepatitis B and C are caused by

- A. Animal bites
- B. Infected blood and sexual fluids
- C. Sneezing and coughing

8. Although Hepatitis A can make a person very sick, the person can almost always get better

- A. True
- B. False

9. Hepatitis B and C are more serious infections than Hepatitis A that can lead to chronic liver disease

- A. True
- B. False

10. Most of the Asian Americans with chronic Hepatitis B became infected with the virus at birth.

- A. True
- B. False

11. Asians have the highest rates of Hepatitis, but most don't even know if they are infected.

- A. True
- B. False

12. A simple blood test can check to see if a person is a "carrier" "susceptible" or "immune" to Hepatitis. (Write the correct word next to their meanings below)

- A. A person was exposed, but fought it off _____
- B. A person has been infected and needs treatment _____
- C. A person has never been infected, but should get vaccinated _____

13. You can prevent infection and become immune to Hepatitis with a vaccine.

Vaccines are available for:

- A. Hepatitis A and B
- B. Hepatitis B and C
- C. Hepatitis A, B and C

14. Children born in the US receive their first vaccination against Hepatitis B the first day of life.

The vaccination series includes two additional shots over a six month period.

- A. True
- B. False

15. Hepatitis screening results can be shared with the client and their close family members only.

- A. True
- B. False

16. People infected with Hepatitis can lose their jobs if they reveal they have the disease.

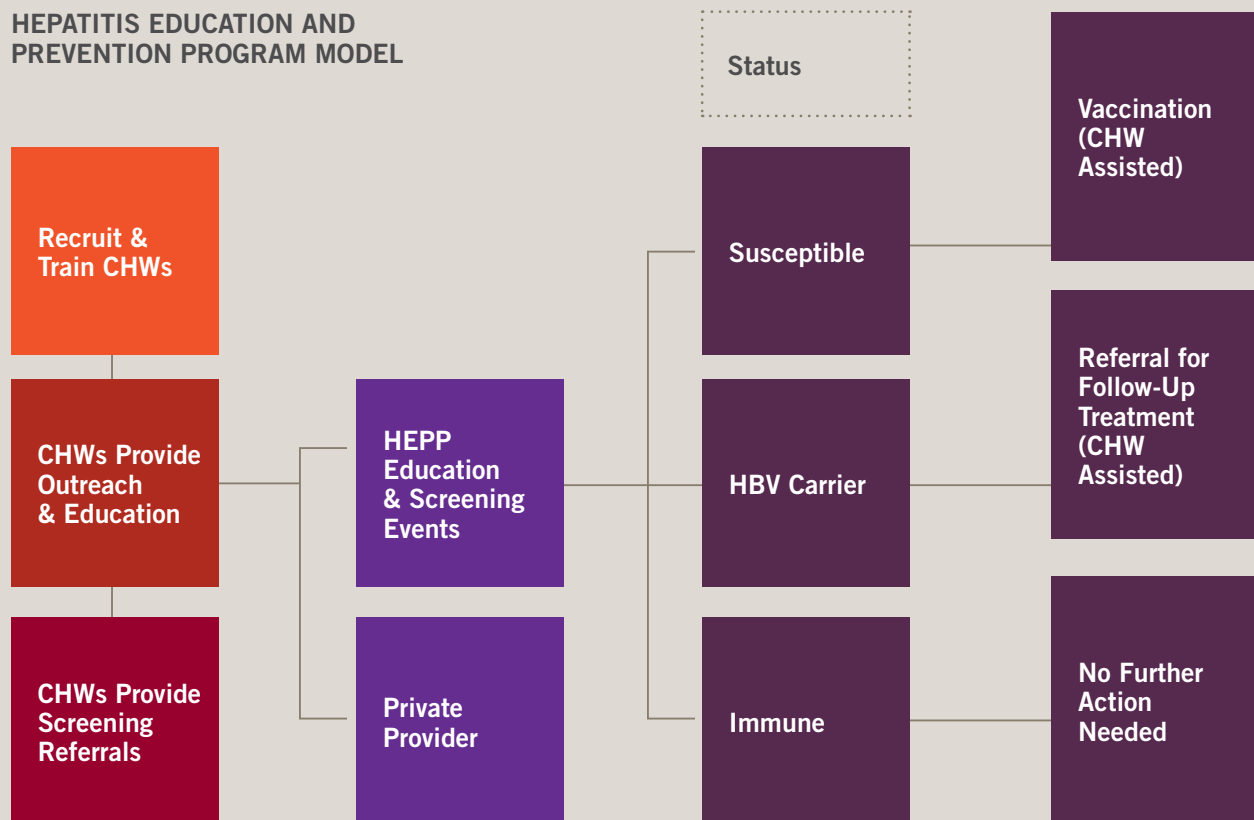
- A. True
- B. False

SECTION 7

PROGRAM IMPLEMENTATION: COMMUNITY EDUCATION AND OUTREACH

Many AAPI communities lack knowledge and awareness of Hepatitis B. This knowledge gap can have several consequences. Misinformation, missed opportunities for prevention and treatment, unknowingly passing infection to family members or friends a just a few of these consequences (Institute of Medicine, 2010). Through community outreach and education, community health workers (CHWs) can relay information to their community members that is both culturally and linguistically appropriate for community members' circumstances. HEPP is unique because it targets a limited-English speaking, Asian American population in a geographic area that has not previously experienced a Hepatitis B outreach education and prevention program.

HEPATITIS EDUCATION AND PREVENTION PROGRAM MODEL





LESSON LEARNED:

The Community Needs Assessment provided unique cultural insights that were incorporated into the educational and outreach materials and approaches. Examples of such insight include stressing the fact that the hepatitis vaccine does not give you the disease and that people can be infected with Hepatitis B or C for years without symptoms. In specific Asian countries, stigma associated with chronic hepatitis is so prevalent that people are concerned about their status being revealed. The CHWs were trained in the confidentiality rules incorporated in HIPPA and both the health professionals and CHWs emphasized in their educational outreach that people infected with HBV or HCV have all their legal rights protected.

METHODS OF EDUCATION AND OUTREACH

CHWs conduct outreach and education on Hepatitis to their community members through a variety of methods. Outreach is conducted by displaying posters and distributing culturally appropriate brochures to community members at health fairs, flu shot vaccination events, senior service agencies, temples, and churches.

Hepatitis education is provided by CHWs to community members through one-on-one consultations (e.g., in-person, telephone) or in group settings (e.g., before a screening event). Tools that are used in hepatitis education include the HEPP community education tool “The ABCs of Hepatitis,” multi-lingual hepatitis brochures, and an illustrated storybook about Hepatitis B and an immigrant family. (More extensive description of these tools are provided below, and sample pages are included in Appendix 7a, 7c, 7d, and 7e.)

The one-on-one HBV education can occur spontaneously when a community member seeks assistance from the CHW for a social service or information about another health condition. It is not unusual for the CHW to also conduct individual consultations outside of the social service agency setting, often when meeting a community member at a neighborhood store or family event. For example, AHC’s CHW who works with HEPP’s Korean CBO partner, Korean American Community Services (KACS), integrate one-on-one Hepatitis education into the KACS’s breast cancer screening program, delivering education to women while they wait to receive their mammography. CHWs conduct group presentations either within the partnering CBO (ESL or citizenship class, for example) or in a community setting, such as a faith-based organization, a local health fair, or HEPP screening event. CHWs also use their social networks to provide Hepatitis education in non-traditional locations. For example, the Cambodian CHW has provided education to parents at a child’s birthday party while the children were playing.

Group education also takes place before a hepatitis screening event. AHC follows the policy that clients should be provided with education on hepatitis prior to being screened for HBV or HCV. Without the educational session, screened individuals may not fully understand their test results and its implications. Because of the nature of the event (screening for the existence of a virus with serious health consequences), AHC recommends that a health professional, such as a volunteer physician or nurse, provide the hepatitis education. If necessary, the CHW provides interpretation for the community members. Having a health professional provide the community education at a screening allows the event participants the opportunity to have their hepatitis questions and concerns addressed directly.

KEY CONCEPTS FOR PLANNING COMMUNITY EDUCATION AND OUTREACH:

- a. Community education tool should be evidence-based and culturally and linguistically competent
- b. CHW should be trained for one-on-one and group education
- c. Community education should include various pedagogical models, including story-telling
- d. CHW knowledge assessments are key for monitoring core competencies
- e. Database of knowledge assessment results based on pre-and post tests completed at group or individual education events is valuable to evaluate effectiveness of education tool and intervention
- f. Education should include linkage to care resources in the community
- g. Models of care

EDUCATION AND OUTREACH MATERIALS

Materials used in hepatitis education and outreach were created by HEPP staff and based on four sources of information:

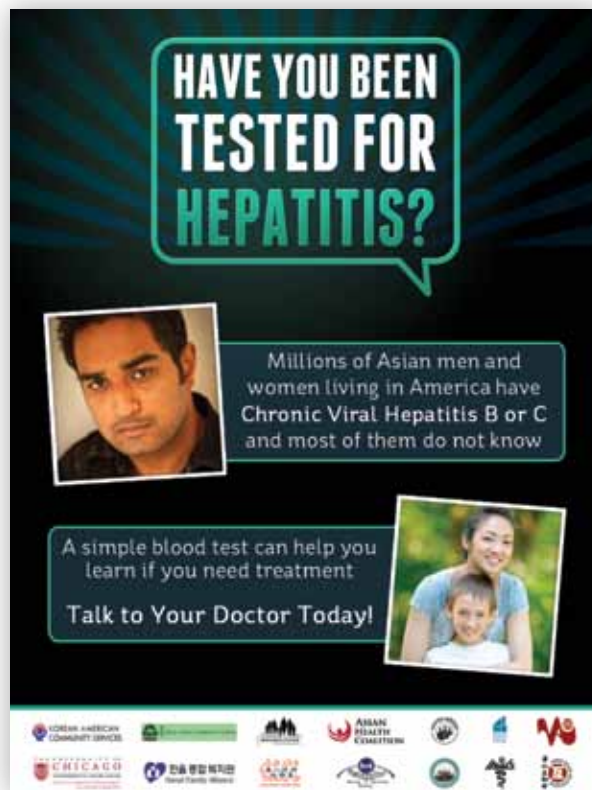
- 1) evidence-based curriculum also used in the training of the CHWs;
- 2) insights gained during the Community Needs Assessment;
- 3) guidelines developed by a physician consultant; and
- 4) published research.

Key concepts and insights gleaned through these four sources were used to develop three educational tools, each one in a unique format for targeted use. The educational tools developed through HEPP for community education and outreach are:

- a) a multi-media presentation (Powerpoint) for large-group presentations;
- b) informational brochure for one-on-one education; and
- c) low-literacy storybook for community members to share with family and friends.

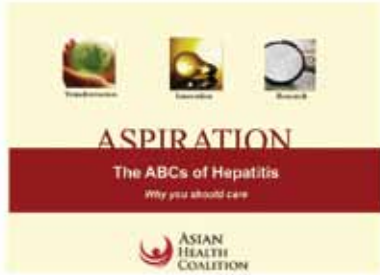
These tools are described in greater detail below. In all three formats used, care was taken to assure cultural and linguistic competency, with the text developed for a 6th grade reading level and integrating Asian images, proverbs, and values. The material was reviewed by CBO

partner staff for their feedback, and then translated into the targeted languages. In addition, hepatitis educational resources available from reputable sources on the Internet were reviewed for cultural and linguistic competency. More information on Internet resources is detailed below.



Multi-media presentation (Powerpoint): *The ABCs of Hepatitis: Getting the facts and taking action!*

AHC created the multi-media tool *The ABCs of Hepatitis* to provide basic information on hepatitis that can be presented to a large group on a screen (Powerpoint) or printed as individual full page slides, placed in clear page protectors, inserted into a binder, and used as a flipchart. The tool includes information on Hepatitis A, B, and C in order to clarify the difference between the three viruses, review their various modes of transmission, and emphasize the importance of vaccination for Hepatitis A and B, and screening for Hepatitis B and C. Special emphasis is placed on Hepatitis B and the Asian-American community, noting its prevalence, primary mode of transmission (mother-child in the AAPI population), and addressing myths and stigma surrounding hepatitis. The multi-media presentation is included in Appendix 7a.



To evaluate the effectiveness of the multi-media (Powerpoint) tool, the HEPP staff created a simple, eight question pre-and post-test knowledge assessment tool that reflects the key messages in the education tool. Because so many of the target population have low-literacy skills, the evaluation was created with colorful illustrations and written at the 3rd grade reading level. The knowledge assessment tool is included in Appendix 7b.

Brochure: *The ABC's of Hepatitis*

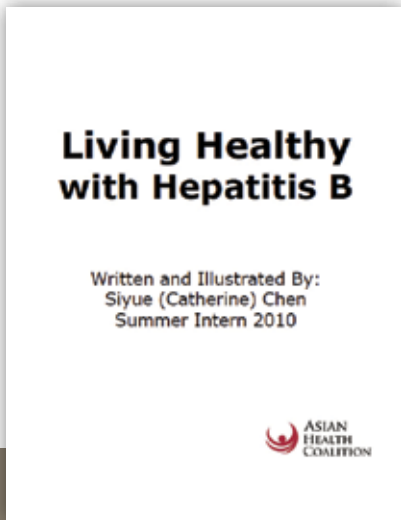
This educational brochure was created to complement the community multi-media presentation and incorporates key messages and similar graphics. The brochure reviews Hepatitis A, B, and C, with special emphasis on prevention and the importance of screening.

Brochure: *What You Need To Know about The "Silent Killer" Hepatitis B Virus*

This educational brochure focuses on Hepatitis B only, and targets the Asian-American population. It provides specific information on Hepatitis B, its prevention and transmission, how it affects the body, and the importance of being screened. This brochure is available in English, Chinese, Korean, Khmer, and Laotian and is sensitive to individuals who are limited-English proficient.

Living Healthy with Hepatitis B Storybook

Our Living Healthy with Hepatitis B Storybook was written and illustrated by one of our undergraduate interns. It tells the story of an immigrant Asian family who confronts Hepatitis B. In a simple narrative, the reader learns of how members of the same family are found to have different HBV status. The grandmother and mother are discovered to be carriers of HBV and enter into medical care; the father and daughter are found to be susceptible and are vaccinated; and the newborn receives the HBV vaccine in the first day of life. The storybook is culturally competent, emphasizing family unity, and is designed to be taken home and shared with family and friends. It is sensitive to individuals who have limited-English proficiency and/or low health literacy, and are available in English, Chinese, Korean, Lao, and Khmer on the Asian Health Coalition's website (www.asianhealth.org)



OTHER RESOURCES FOR OUTREACH AND EDUCATION MATERIALS

There is a wealth of Hepatitis B and C outreach and education materials in a variety of languages and formats available on Internet and through selected pharmaceutical companies. Care should be taken to download resources only from reliable sources. Established, national organizations committed to fighting liver disease or promoting health education are good resources. Examples of such organization are:

- NPIN: Center for Disease Control's National Prevention Information Network <http://www.cdcnpin.org/scripts/hepatitis/index.asp>
- Hepatitis B Foundation: <http://www.hepb.org>
- Asian Liver Center: <http://liver.stanford.edu/>
- American Liver Foundation: <http://www.liverfoundation.org/>

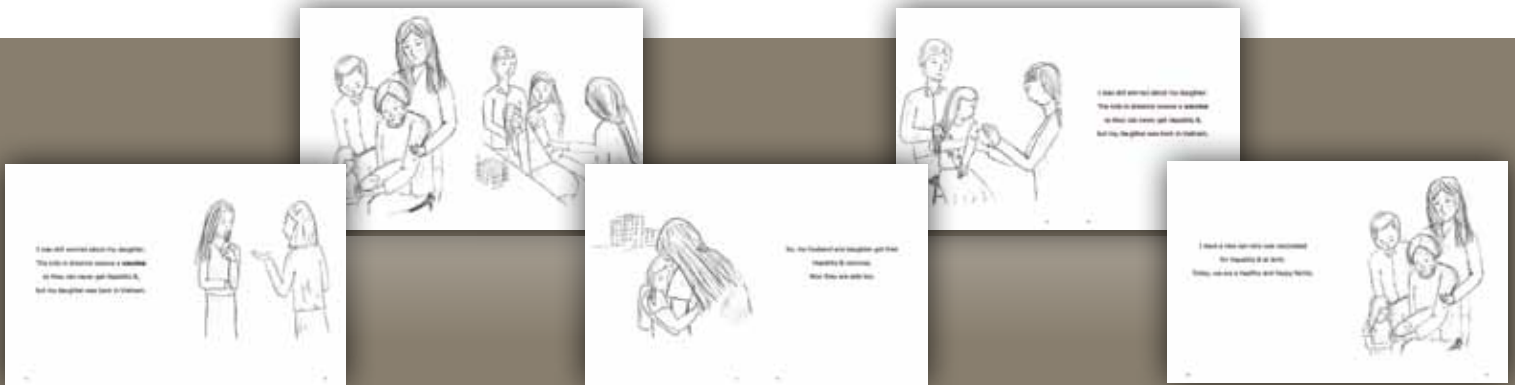
Pharmaceutical agencies that provide hepatitis educational materials include Gilead for Hepatitis B information (<http://www.gilead.com>) and Vertex for Hepatitis C information (<http://www.vrtx.com/patientresources.html>)

- **Brochures and Pamphlets:** The AHC website (www.Asianhealth.org) provides some information materials in English and some Asian languages, as well as links to reliable Internet websites. This is not an exhaustive list and organizations are always creating or updating materials so it is recommended to perform a search every 6 to 12 months to check for updates.
- **Videos:** Videos are available in various languages on different reliable websites for either downloading or purchasing. One such website is the Hepatitis B Foundation which has an 8-minute video on Chronic Hepatitis B in English, Mandarin, Cantonese, Vietnamese, and Korean. A \$10 donation payable to the "Hepatitis B Foundation" is requested. The link is: http://www.hepb.org/resources/hepatitis_b_videos.htm. Other links to videos are listed on the AHC website.
- **Posters:** Posters may be available from various organizations or pharmaceutical agencies, especially during National Hepatitis Awareness month (May).



LESSONS LEARNED

1. We found that sometimes you have to just create your own education materials if you can't find anything that is culturally appropriate or in the language of your targeted community. This especially was the case for our Lao and Cambodian populations that we serve.
2. In some situations, the CHW is able to translate the educational material for you. Even when professionally translated, it is recommended to have the CHW review the material or pilot test it with a few community members to assure accurate translation of content.
3. Hepatitis B educational posters are a great way to get people's attention. They can be displayed in places visited often by at-risk community members and inside the partner organization. Educational videos are an excellent teaching tool for use by CHWs when conducting education with community members who have low literacy in their primary language. AHC's Cambodian CHW often uses videos in English but then translates the video while performing education



SECTION 8

PROGRAM IMPLEMENTATION: SCREENING, VACCINATION, AND TREATMENT



As explained in the previous chapter, the Community Health Worker (CHW) plays an integral role in providing health education and outreach on Hepatitis B to the local members, either through one-on-one consultations or group settings. Following up on the education and outreach, the CHW encourages and recruits members from the community to be screened for the hepatitis virus. During the screening event, the CHW coordinates the flow of attendees, interprets for the health professional providing the Hepatitis B education, and assists participants with paperwork. Most importantly, the CHW is the trusted presence in the screening setting and the identified “go-to” person for assistance.



Screening events are held in a variety of community venues, including partner social service agency locations, schools and faith-based organizations. They are often held on weekends, at times convenient for the target population, and are usually large-scale events with typically between 40 to 100 screening participants. The screening events are held either in conjunction with another function like a health fair or can be dedicated just to Hepatitis B education and screening. Prior to the screening event, the CHW helps with publicizing the event through flyers, brochures, local media, and word-of-mouth (See Appendix 8a). Often CHWs will personally call their clients and encourage them to attend the screening. AHC’s HEPP program covers 12 different Asian-American CBOs located throughout the Chicago metropolitan area including suburban county locations. Community members participating in the screening sessions are not provided with monetary incentives for participation, but they are made aware that after receiving blood screening they would be informed of the results of their infection status, and those found unimmunized would have an opportunity for receiving vaccination. There is generally no eligibility restriction for education and screening. However, the only selection criterion for vaccination for those found unprotected is that the subject be at least 18 years old to receive vaccination. (The age limit is so defined because many youngsters aged <18 may have received the vaccination in school.) Individuals had their blood drawn at either the screening event location. Blood specimen is obtained from each individual, and the specimen is sent to a local lab for analysis.



GOALS OF A HEPATITIS B SCREENING EVENT:

There are three goals to a Hepatitis B screening event:

1. Increase community awareness of Chronic Hepatitis B, risk for the AAPI population, and HBV prevention (education)
2. Increase community members’ awareness of their own HBV status (screening)
3. Arrange for appropriate follow-up action based on screening results (linkage to care)

The appropriate follow-up action based on screening results are as follows:

- Individuals identified with Chronic Hepatitis B (infected) should be referred for medical follow-up and close contacts should be screened for the virus
- Individuals identified as at risk for Hepatitis B (susceptible) should be immunized
- Individuals identified as not at risk for Hepatitis B (immune) need no follow-up.

PLANNING A HEPATITIS B SCREENING EVENT:

- 1. Publicity:** As stated above, publicity for a HBV screening event is usually organized by the CHW in conjunction with his or her community-based organization. Bilingual flyers are posted in the partnering agency, ethnic newspapers, community centers, and faith-based organizations. Much of the publicity is conducted by word-of-mouth, with the CHW inviting agency clients and community members.
- 2. Cost consideration:** The cost of conducting a screening event can range from \$800 to \$2,000 depending on the size of the event and number of participants. The largest portion of expenses will be for the lab screening tests which start at around \$900 for 30 participants. Estimated expenditures are as follows:

Stipends to volunteers/nurses/
translators for travel and time
\$25-\$40/hour

Honorarium (if education is provided
by health professional)
\$100-\$200

Lab screening costs (non-profits
may qualify for discounted rates)
\$30-\$40 per screen

Miscellaneous (refreshments, snacks)
\$50-\$150



3. Staffing:

- a. Event coordination: Volunteers, including the CHW, are key to coordinating the flow of participants from arrival through the educational session, completion of paperwork, and blood draw. Bilingual volunteers are often needed to assist with interpretation.
- b. Community education: A volunteer health professional or the trained CHW gives the educational presentation before the screening, using the HEPP Community Education Powerpoint.
- c. Paperwork: Bilingual staff or volunteers are needed to assist the participants in the completion of the Participant Information Form and Screening Consent Form. (Descriptions of the forms are provided below.) In addition, the volunteer should fill in the lab requisition form based on the information provided by the participant.
- d. Blood draw: A health professional, usually a nurse or medical assistant is needed for the blood draw. As a general rule of thumb, one nurse or medical assistant is needed for each 25 anticipated screenings.



LESSON LEARNED:

CAPACITY BUILDING AND THE PIPELINE

In order to implement our screening program, we partnered with numerous organizations and individuals including the local CBOs, nursing associations and medical schools. While HEPP was designed to improve the lives of the community, the opportunity for our volunteer base to learn, participate and engage with these often hard-to reach-communities was very powerful. Medical students around Chicago have volunteered for HEPP screening events and have found the events to be educational, empowering and a front line experience of the disparities of Hepatitis B among Asian Americans. This important opportunity will allow these future healthcare leaders to revisit their commitment to Asian health, advocacy and the global-local perspective.

4. **Forms:** Three forms are completed before the participants' blood is drawn. The paperwork includes:
 - a. Participant Information form: This form has been translated into targeted languages and reviews the participant's demographic information as well as risk factors. A sample of the Participant Information Form is included in Appendix 8b.
 - b. Screening Consent form: This form is in compliance with HIPPA rules and indicates the participant's permission to have his or blood drawn, release of liability, and understanding that the results of the screening will be kept confidential. It has been found, however, that was necessary to add an additional sentence to the consent form in the event that the AHC could not adequately convey the results of the screening due to language barriers or other circumstances. In such an event, it is necessary to inform the Community Health Worker from the sponsoring agency of the participant's status in order to ensure that the participant is relayed the results of the screening in a culturally and linguistically competent manner. A copy of the Screening Consent form is included in Appendix 8c.
 - c. Laboratory Requisition Form: The testing laboratory will provide this form and instructions for its completion.
5. **Laboratory support:**

The HEPP Program Manager is responsible for making arrangements with a laboratory to have the specimens analyzed. The Asian Health Coalition has worked with a number of laboratories with facilities in the local area and will contact the lab a week before a screening event. The lab is responsible for collecting the specimens at the designated event location and will then provide an analysis of each individual result sent directly to the HEPP Program Manager via confidential fax. In general, results are made available within 1 to 2 days following the screening event.

CHECKLIST FOR A SCREENING EVENT

Pre-Planning

- Publicity/media
- Cost considerations

Implementation of Screening Event

- Staffing
 - staff or volunteers to coordinate participant flow
 - staff or volunteers to provide community education
 - staff or volunteers to complete paperwork
 - phlebotomists for blood draw
 - health professional oversight (MD or RN)
- Blood processing
 - lab identification and arrangement for specimen pickup
 - forms

Post-screening protocol

- Reporting mechanism
- Bilingual results form
- Linkage to care
- Database of results



CASE STUDY

SAROEUN SOEUN

COMMUNITY HEALTH EDUCATOR

CAMBODIAN ASSOCIATION OF ILLINOIS

Over the years that Saroeun Soeun has served her fellow Cambodian refugees as a Community Health Worker, she has touched many lives. At the Cambodian Association of Illinois (CAI), where Saroeun is employed, she provides health education, outreach, interpretation, and linkage to care to the target population of nearly 4,000 Cambodian refugees in the Chicagoland area. Fear and ignorance in the face of disease are common in the community Saroeun serves. Their experience as refugees from the Khmer Rouge and Pol Pot regime, coupled with their cultural and linguistic isolation, makes her community particularly vulnerable. Saroeun arrived in Chicago as a refugee at the age of 17, after escaping from Cambodia and spending years in a UN refugee camp in Thailand. She was able to complete her high school education in Chicago, and undertook two years of “general studies” at a local community college while working part-time as a receptionist at CAI. Eventually, she left her studies when a full time position opened up at CAI as a family health outreach worker, a position that eventually developed into her role as a health educator.

Saroeun was selected to be trained in AHC’s Hepatitis Education and Prevention Program nearly a decade ago and as a bilingual educator, Saroeun is an important link to health education and services for her community. She describes herself as “a connector between people and providers,” helping people who do not have health insurance access health care, often through a local community health center where other services as well can be provided. Saroeun also serves as an interpreter, accompanying her clients to their doctor and hospital visits or making herself available for phone interpretation. She says she feels very good when she can help her community members with the health information they need or making important linkages to care.

The local Buddhist temple is the center of the Cambodian community, and an important venue for Saroeun’s work as a community health educator. The monks view her as a valuable resource, referring community members to her when they lose their health insurance, need social services, or could benefit from her health education training. At the temple, Saroeun can make announcements about upcoming hepatitis education and screening events, and pass out Khmer-language brochures on hepatitis. Because their community is relatively small and does not have its own media outlets, word of mouth is the principal way of getting messages out among Cambodian refugees. Married with four children, including a young set of twins, Saroeun is actively involved in her community’s social and cultural events, as well as religious activities at the temple. Taking advantages of these opportunities, Saroeun frequently conducts hepatitis education and outreach at community social events such as birthday parties and cultural festivities.

In her years of working as CHW in hepatitis education and outreach, Saroeun has developed a number of strategies to encourage her community to be screened for the virus. She has learned that her community members often don’t feel the need to be screened themselves, either because they do not focus on their own health or because they don’t “feel sick.” Saroeun encourages her clients to be screened “for their family and the future of their children.” Because of her community’s respect for health professionals, she recruits doctors or nurses to provide a talk on hepatitis or other health conditions to different age groups. Saroeun works hard to explain the concept of prevention to a community used to only seeking health care in an emergency. When asked what is her most effective strategy in hepatitis education and outreach, Saroeun simply states “one-on-one conversations, and don’t force anyone.” Saroeun’s reputation as a “helper,” her commitment to her community, and her understanding of the cultural nuances of health education and promotion within the Cambodian refugee population makes her a very effective Community Health Worker.



FOLLOW-UP AFTER A HEP B SCREENING

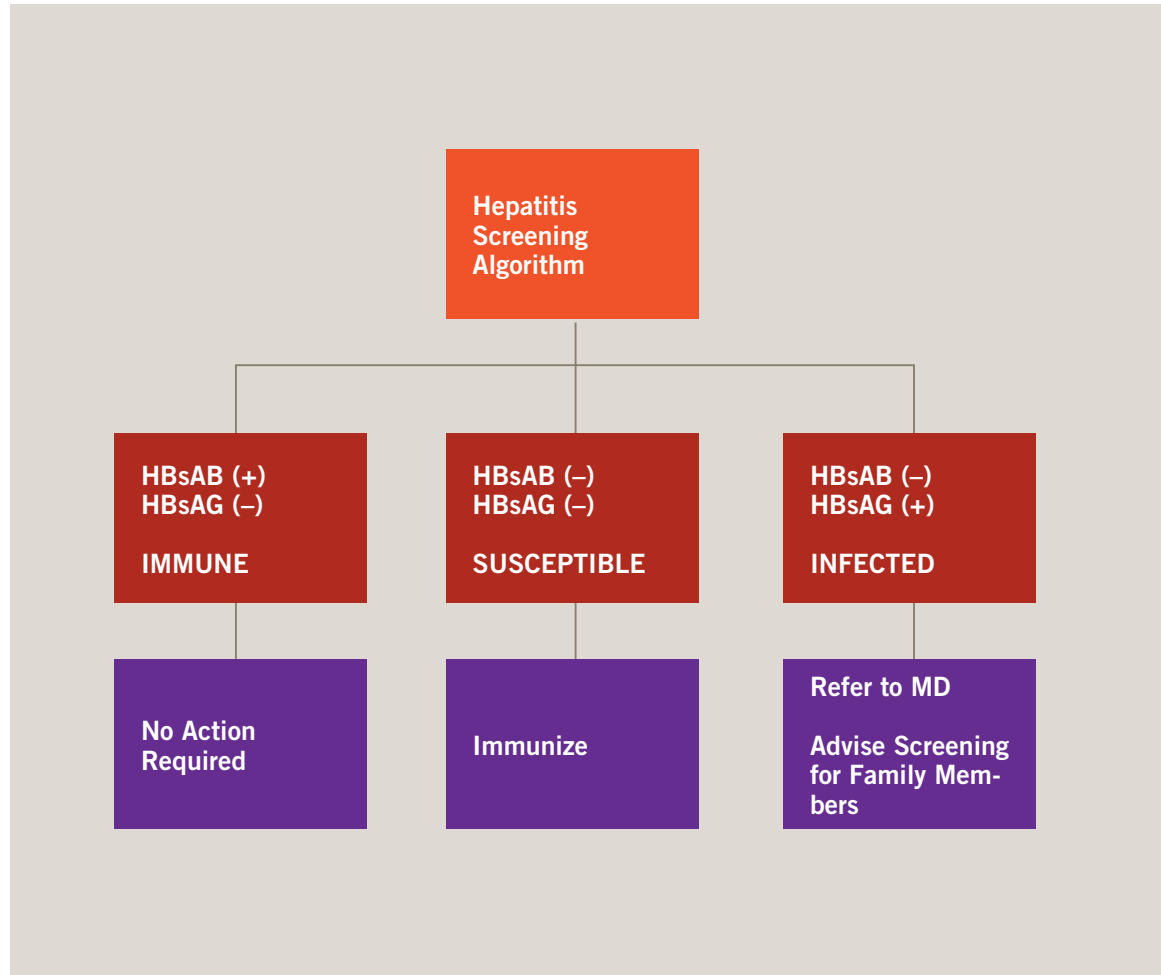
LESSONS LEARNED:

FINDING THE FUNDING

1. AHC has funded community hepatitis screenings through public and private sources. As public health funding has decreased, especially for hepatitis screening and prevention, AHC has sought financial support from private sources. These private sources include foundations and pharmaceutical companies.
2. Funding for the three series Hepatitis B vaccinations continues to be a significant barrier for follow-up linkage to care for those found to be susceptible to the virus, without health insurance, and unable to cover the cost. It is necessary to constantly seek resources either through local health departments or private foundations to cover the cost of the vaccines
3. There are unique challenges in Illinois for vaccination. Obtaining the hepatitis vaccine has become increasingly difficult as the Centers for Disease Control (CDC) has significantly reduced funding for adult hepatitis vaccines, and this has impacted the agency's ability to procure vaccines at no cost to uninsured individuals through the Chicago Department of Public Health. Each vaccine dose is approximately \$50 to \$60 without administration cost which can amount to anywhere from \$150 to \$200 for the entire 3-series dosage. This is cost-prohibitive to many low-income immigrants and refugees. AHC has worked to find alternative ways to link such individuals to local Federally Qualified Health Centers (FQHCs) in the area where they have been able to obtain the vaccine series at a nominal cost.

1. Interpreting the results:

Screening requires a blood draw with measurement of both Hepatitis B surface antigen (marker which indicates chronic infection when positive) and Hepatitis B surface antibody (marker which indicates immunity when positive). Note that individuals who were immunized in the past might not have measurable levels of HBV surface antibody but still are immune. It will be necessary to discuss their status with a physician.



2. Communicating the Test Results:

The Asian Health Coalition has developed a lab result notification system that respects HIPPA guidelines but takes into consideration the limited English and literacy skills of the target communities. Lab results are sent to AHC's HEPP Program Manager who makes an aggregate record of the findings and a copy of each individual lab result. The Manager then mails a copy of the results to the participant along with a brochure on Hepatitis B and a results notification letter (see Appendix 8d) with an explanation of Hepatitis screening results. Both the brochure and the Notification Letter are English and the participant's native language.

The test results and notification letter fall into 3 categories:

- 1) **Immune:** An individual found to be immune to HBV requires no further follow-up
- 2) **Susceptible:** An individual who does not have immunity or has not been vaccinated is susceptible for exposure to Hepatitis B. It is recommended that the client receive the three-series vaccine dose.
- 3) **Infected:** For those clients who are discovered to be chronically infected with HBV, medical follow-up is imperative. The reporting form states that if the client needs assistance with either attaining the vaccination or receiving medical follow-up, he or she is to contact the CHW whose name and phone number is written on the form. With guidance from the HEPP program manager, the CHW assists the client in making an appointment with a local health provider for further treatment and care.

The notification letter instructs the participant to either do nothing (in the event of immunity) or to seek follow-up care (in the event of a positive result for Hepatitis B or the need for HBV vaccination). If the participant does not have a primary care provider or would like assistance in accessing follow-up care, he or she is instructed to contact their CHW. The name and phone number of the CHW is listed on the Notification letter. The CHW does not receive a copy of the lab results of his or her clients, and will only know a client's hepatitis status if the client chooses to inform them.

3. **Following-up based on screenings results:** Individuals who fall into the "Susceptible or "Infected" categories are referred to a network of health providers depending on insurance status. The Asian Health Coalition has created a Hepatitis Provider Directory (See Chapter 5 for how this directory was developed) with local area health provider resources. Individuals with insurance can generally choose a provider of their choice. It should be noted that the about half of the participants that have historically come to AHC-led screening events tend to be economically disenfranchised with lack of health insurance.

These individuals without insurance are generally linked to Cook County's Stroger Hospital. As a "safety net" institution, Stroger Hospital provides a wide range of acute and inpatient services, mainly to underserved and uninsured populations in Cook County. The CHWs will assist in navigating patients by facilitating appointment scheduling, providing them with transportation directions, and accompanying patients with limited English proficiency during their visits, and arranging follow up care. The HEPP Program Manager is available to advise the CHW as he or she helps the individual navigate through the health care system.



ASIAN HEALTH COALITION HEPATITIS EDUCATION AND PREVENTION PROGRAM

PARTICIPANT INFORMATION FORM

To Be Completed By Partner Agency:

Today's Date:	Partner Agency:	Screening Location:
---------------	-----------------	---------------------

To Be Completed By Participant:

Last Name:	First Name:	Middle Initial:	Date of Birth: MM/DD/YYYY _/_/____	
Home Phone Number (with area code):		Cell Phone:	IL County:	
Street Address:	Apt #:	City:	State:	Zip Code:
E-mail:	Preferred Primary Contact (check one): <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> E-mail			

Note: The above information will remain confidential.

1. Age:	2. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	3. Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Member of unmarried couple		
4. Is English your primary language: <input type="checkbox"/> Yes <input type="checkbox"/> No If No, specify other language: _____				
5. Race/Ethnicity: <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Native American/Alaska Native <input type="checkbox"/> Hispanic <input type="checkbox"/> Other (please specify): _____				
6. In what country were you born?	7. Year of Arrival in the United States:	8. Mother's Country of Birth:	9. Father's Country of Birth:	
10. Do you currently have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		11. Do you have a regular doctor or health care provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		

12. How many years of school did you attend?
 0-8 years 9-11 years 12 years More than 12 years

13. Why are you here for testing?
 My doctor recommended I come in for testing
 My insurance won't cover testing and I want to be tested
 I think I might be infected with hepatitis B or C
 A family member or personal contact is infected with hepatitis B or C
 I saw/heard an ad for it
 My family member recommended I come in
 I was here or at an event and someone recruited me
 Other (please specify): _____

14. Are you currently pregnant or suspect that you are pregnant?..... Yes No

RISK FACTOR INFORMATION

1. How many people are currently living with you? _____

2. Do any of people currently living with you have:

Hepatitis B.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Hepatitis C.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know

3. Have you ever had your blood tested for hepatitis B or C?.....

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
--

If yes, what was the outcome of the test?

Hepatitis B.....	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Don't Know
Hepatitis C.....	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Don't Know

4. Has a doctor ever told you that you were positive for:

Hepatitis B.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Hepatitis C.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know

5. Have you ever received vaccinations or shots to protect you from hepatitis B?.....

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
--

6. If you test positive for hepatitis B or C, do you intend to seek treatment with the next 6 months?
 - Yes
 - I'd like to, but I cannot pay for treatment if I'm positive
 - No, I don't want to be treated right now for non-financial reasons

7. Do you have any of these Hepatitis B or C Risk Factors?
 - a. A family member with hepatitis or other liver disease?.....

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
--

If yes, what is the relationship?

<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Cousin
<input type="checkbox"/> Sibling	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle	<input type="checkbox"/> Other	

 - b. Are you a health care worker?.....

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
--

 - c. Have you ever had a blood transfusion?.....

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
--

 - d. Have you ever had dialysis?.....

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
--

 - e. Have you ever had a tattoo or body piercing?.....

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
--

 - f. Have you ever had acupuncture?.....

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
--

 - g. Have you ever used intravenous street drugs?.....

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
--

 - h. Have you had multiple sexual partners at anytime in your life?....

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
--

ASIAN HEALTH COALITION HEPATITIS EDUCATION AND PREVENTION PROGRAM

CONSENT FOR SCREENING (1.17.11)

Hepatitis B and C are liver diseases that are widespread among Asians, Pacific Islanders and Africans. Infection with the hepatitis B or C virus can lead to liver damage or liver failure. Both these viruses can spread from person to person by contact with infected blood and body fluids. The only way to know if a person is infected is to be tested. Today you will be tested for hepatitis B and/or hepatitis C. The results from these tests will be mailed to the name and address on this form.

I understand that by signing this consent, completing the survey questionnaire, and having my blood drawn and tested I have agreed to participate in this program. I understand that the results of my screening will be kept confidential; however, I agree that my test results may be used for statistical reporting and research purposes.

In the event that the Asian Health Coalition cannot adequately convey the results of this screening due to language barriers or other circumstances, I understand that [insert community health worker] from [organization name] may gain access to my results in order to inform me and to ensure that I receive access to care in a timely manner.

CONSENT

I consent to having a sample of my blood drawn and tested for hepatitis B and hepatitis C and agree to release the Asian Health Coalition, all testing personnel, physicians, all sponsors and testing agencies from any liability arising from or connected with this hepatitis B/C screening and the use of derived data.

I have read this consent form, understand and voluntarily agree to participate in this testing program.

Name: _____

Telephone _____

Address: _____

Signature: _____ Date: _____

CASE STUDY

NAM KYU KIM, MSW

HANUL FAMILY ALLIANCE

Nam represents a new dimension of Community Health Workers serving Asian immigrant populations. He is young, well-educated, and proficient in outreach through social media. Born in Korea, he attended college in the United States from 2005-2007 as an exchange student. He returned to the US in 2009 to enter graduate school at Case Western University in Cleveland, completing his studies there in 2011 with a Master's in Social Work. It was during his graduate work at Case Western that Nam decided to work to improve the welfare of Korean immigrants in the United States. He moved to Chicago and found employment at Hanul Family Alliance (HFA), a large social service agency in Chicago that targets Korean-American immigrants. HFA's mission is "to empower individuals and families in need to enhance their quality of life by providing assistance in all areas." HFA provides services across the life spectrum, including Senior Welfare, Family Support, Legal and Immigration Assistance, Community Health, and Culture and Education. Nam was hired as the Community Health Program Coordinator, which encompassed his role as a Community Health Worker.

Nam became interested in the interface between health and the community while serving as the primary caretaker of his grandfather who had been stricken with Alzheimer's Disease. Nam cared for his grandfather in their home in Korea until his death. His mother is a breast cancer survivor, and Nam saw firsthand how two devastating diseases can overwhelm a family. For a while Nam considered studying to be a doctor, but decided that he wanted to work more closely with people and how they deal with disease at home and at the society level. In a culture that holds physicians and scientists in high esteem, his family at first did not support his decision to study social work over medicine. However, noting how happy and fulfilled Nam feels in his role, they are now pleased with his decision.

As a Community Health Worker, Nam coordinates a number of health programs in addition to HEPP. He sees a significant amount of cross-over of health needs among the different programs, and "enjoys trying to make

the connections." He educates clients from his diabetes and chronic disease self-management groups about hepatitis, and encourages them to attend screening events. Recognizing that a significant portion of the Korean immigrants receiving services at his agency are adults and seniors, Nam has made a particular effort to reach out to youth. He distributes HBV information at college fairs, and makes updated HBV educational material available on Hanul's website and Facebook page.

Nam is skilled in the use of social media, and uses it to conduct hepatitis and other health education outreach to Korean-American youth as well as engage them in community service. He writes in both Korean and English on the Facebook page, recognizing that many Korean-American youth can speak but not read or write Korean. Below is a message posted by Nam in March 2012 on Hanul's Facebook page.

Hi Eric, Big THANKS for posting the healthfair flyer on your facebook!! We will send updated flyer to you soon. Thanks again for showing your volunteerism in the last Hepatitis B screening event.

Nam feels his youth makes him an excellent Community Health Worker, and contributes to his being open to new ideas and perspectives. Because he was raised in Korea but educated in this country, he feels he can connect with first generation Koreans (immigrants), 1.5 generation (born in Korea but raised in the United States), and second generation Koreans (children of immigrants). He understands the various perspectives of each generation, and tries to incorporate these perspectives in his outreach strategy. He also feels his youth makes him open to new ideas and new ways of doing things, so important in dealing with social and community issues.

Although Nam considers his youth an asset in his work as a CHW, he recognizes that in a culture where respect comes with increasing age, his youth can be a problem. Older clients tell him "he hasn't experienced what they have experienced." Nam employs three strategies to gain the respect of the older community members. First, he educates himself as much as can on a health issue. He attends

workshops and seminars, and researches information on the Internet. Second, he behaves professionally. He makes certain that he is always prepared for any workshops or activities he is leading. Finally, he is patient and respectful of his clients. He listens carefully, and responds to his clients with respect, reflective of the Korean culture.

Nam is passionate about two aspects of his work: helping people understand their disease and make healthy lifestyle changes, and creating connections to benefit his community. He loves seeing how people change when they receive the information and support they need. His one-on-one

interactions with his clients as well as his group sessions are chances to "apply all the theory I studied in school, helping people where they live." As his own cohort group would say, he is the "ultimate networker." Nam recruits local Korean pharmacists to assist with flu immunizations and conduct health education presentations at his agency. He connects his clients with local Korean physicians, and connects the Korean physicians to HFA to support the work of the agency.

Having already earned a master's degree, Nam does not have immediate plans to return to school. He is interested, however, in the certification of CHWs and formal recognition of their role. As a bilingual, bicultural CHW who can effectively reach out to immigrants of all ages, he is key to the elimination of disparities in Hepatitis B outcomes in the Korean American community.



SECTION 9

MONITORING & EVALUATING THE HEPP PROGRAM

Throughout the implementation of HEPP, the Asian Health Coalition maintained a concurrent evaluation protocol to measure the program's progress toward the stated goal of creating a sustainable, culturally competent, and replicable model of community partnerships to address the prevalence of Hepatitis B in underserved AAPI populations. In this section, the strategy of evaluating program implementation and impact is discussed. Evaluation of the Community Health Worker training, on-going education, and support is discussed in Section 6 and is not included in this section.

The evaluation strategy incorporated both process and outcome measures, utilizing quantitative as well as qualitative techniques. Feedback and “lessons learned” during process evaluation provide valuable insight to improve the ongoing implementation of the program. Outcome evaluation included quantitative measures to assess whether the program achieved its stated goals and the efficacy of the HEPP model. Qualitative process and outcome evaluation techniques provided “implementation tips” for organizations interested in replicating the HEPP model.

HEPP EVALUATION STRATEGY: PROCESS

The process of HEPP's implementation was evaluated using three sources of data:

- 1) monthly activity reports submitted by the CHWs using a template created by AHC;
- 2) bimonthly partner meetings; and
- 3) site visits to the partnering agencies.

1) Monthly report form: The monthly report form required each CHW to record HEPP-related activities, noting details such as date, time, number of participants, and location. Specific activities included: a) hepatitis educational activities attended by the CHW (either AHC-sponsored or by an outside agency) ; b) hepatitis group education sessions presented by CHW; c) individuals counseled and educated on hepatitis; d) hepatitis flyers or brochures distributed; e) community events and health fairs during which Hepatitis B awareness activities took place (presentations, one-on-one education, or distribution of brochures); and f) screened clients referred for follow-up medical care. In addition, the report template included a narrative section for partnering CBO staff members to list HEPP-related challenges and successes, and to note any requests for technical or other assistance from AHC. The monthly reports were reviewed by the project coordinator to make certain that the community partners are making progress toward the program goals, to monitor the partners' fidelity to the program, and to take action to address challenges or act upon requests for assistance. A sample of the monthly report form is included in Appendix 9a.

Examples of successes and challenges noted by a CHW on the monthly report: “It (is) very hard for me to do education during the day because they are working. Most I do education over the phone after (they are home) from work.”—Cambodian CHW

“Some of the clients that I give out the brochure in our language, they don’t read our language. I just educate them and let them take the brochure for their family or relative (in an effort to) reach out to them (as well).”—Cambodian CHW, October 2011

“Through individual education, most clients realize how important Hepatitis B is. Many of them did not know whether or not they were immunized. Thus the clients want to have Hepatitis B screening.”—Korean CHW, October 2011

2) Bi-monthly partner meetings: The bi-monthly partner meetings provided an opportunity for a qualitative evaluation of the program’s implementation in the community. Using a structured group interview format, the Program Coordinator probed the partners’ strategies for outreach and education, the agencies’ commitment to the program, and the CHWs’ capacity and interest to provide hepatitis education. Some of the indicators that the Program Coordinator monitored can include:

- a. Partner agencies’ strategies for outreach and education:
 - Does the agency look to implement HEPP-related activities in conjunction with other agency programs?
 - Does the agency initiate HEPP education activities outside of its agency (i.e., at local faith-based centers, schools, or community events)?
- b. Partner agencies’ commitment to the program
 - Do other partner agency staff members know about the HEPP program and seek to complement their specific program goals with HEPP?
 - Does the agency management support the CHW?
- c. CHWs’ capacity and interest to provide hepatitis education
 - Does the CHW take advantage of a client visit to provide one-on-one HEPP education?
 - Does the CHW give group presentations, or arrange for someone else to give the presentation? (Does the CHW need more training on group presentations?)

Other questions can be directed to the CHW:

- In doing outreach and education about Hepatitis B to your community, what works well?
- What doesn’t work and we should change?
- How can AHC be of greater assistance in your role as a CHW in Hepatitis B outreach?

LESSONS LEARNED:

1. It has been AHC’s experience that the community partners embraced the HEPP program and looked to incorporate hepatitis education, outreach, and screening into as many of their programs as possible. The agencies were aware of the health risk that Chronic HBV presents, and were interested in providing the opportunity to be educated and screened to all their clients, including home care workers, ESL students, and those seeking social services.
2. The majority of our partners also conducted outreach activities in the community, especially in faith-based organizations such as churches, mosques, and temples. These faith centers are often the principal gathering places for immigrant and refugee communities.
3. The Community Health Workers gain confidence with time. They will begin conducting primarily one-on-one education, and eventually will feel comfortable enough with the material to present to a larger group. Practice teaching a short HBV lesson during the bimonthly partners’ meetings will help the CHWs gain confidence.

PARTICIPATION IN HEPP EDUCATION, SCREENING, & VACCINATION ACTIVITIES

People Educated	32,885
Number of Group Educations	264
Number of Health Fair Events	63
Number Referred for Screening/ Immunization	17,494
Brochures Distributed	17,509
Adults Screened	2,139
Adults Screened at HEPP Events	1,430
Adults Vaccinated	1,205

Some of the qualitative evaluation key findings during the bi-monthly partner meetings:

- a. Outreach and education strategies: A number of the partner agencies also employed Home Health Care Workers (HHCWs), low-skilled workers who assisted elderly and disabled people in their homes. By nature of their work, these HHCWs run a risk of either contracting or passing the hepatitis virus. A number of these partners took advantage of HEPP screening events to make certain that their HHCWs were screened for the Hepatitis B virus

3) Site visits to partner agencies: Site visits to the partnering agencies provided insight into the CBOs' commitment and capacity to implement HEPP. AHC staff participated in HEPP education and screening events to both provide support for the partners and note gaps in implementation capacity. AHC has also made annual site visits to the partnering agencies to discuss program implementation successes and challenges. These site visits served to renew relationships with agency staff.

HEPP EVALUATION STRATEGY: OUTCOME

Outcome evaluation strategies included both quantitative and qualitative measures reflecting the four program components:

- 1) community capacity-building;
- 2) Hepatitis B education and outreach;
- 3) screening for Hepatitis B among the targeted population; and
- 4) linking clients to appropriate follow-up care, either for the 3-series Hepatitis B vaccination or medical care for chronic Hepatitis B.

1. Community capacity building: Both quantitative and qualitative measures were used to evaluate the capacity of the partners to implement the program and sustain it as a response to the Hepatitis B disparity in their community. Quantitative measures reflected the numbers resulting from program outreach and education, screening, and vaccination or linkage to care for those requiring follow-up. Table 1 summarizes AHC's hepatitis education and prevention program activities between 2006-2010. Note that some of the partners conducted screenings or vaccination activities on their own, leveraging their HEPP training and educational resources to seeking outside funding.

Qualitative measures provided other insight into the effectiveness of the model, and included questions such as how committed the partner CBOs were to sustaining the program and whether they were looking for potential funding and other resources for program implementation at the completion of the project.

2. Hepatitis B education and outreach: Outcome evaluation of the education provided during the outreach activities was monitored by a low-literacy pre- and post-presentation survey that was translated into the target languages. (See Appendix 7b for a sample knowledge assessment survey). The survey was distributed before and following a group presentation, and both sets of surveys were returned to the program coordinator who maintained a data base of the results. By measuring the change in HBV knowledge, AHC was able to determine if the outreach educational strategy (presentation using low-literacy educational tool) was effective.

3. Hepatitis B screening: Screening outcome results were recorded using anonymous labeling in order to monitor if the rate of Hepatitis B positive results reflected the rates published in the literature for that particular ethnic group. Also, results were reviewed in the aggregate according to participants' place of birth. Table 2 shows the results of this aggregated data.

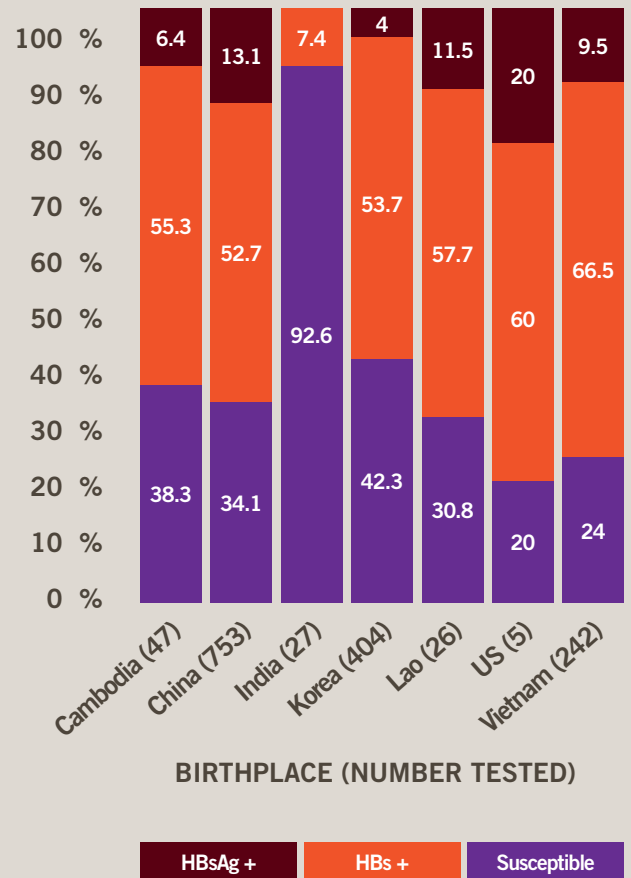
4. Linkage to care: Because the results of the HBV screening (in a bilingual document) were sent directly to the client to preserve patient confidentiality, it was difficult to monitor every client found to need follow-up care. Clients found to be susceptible and in need of the Hepatitis B vaccination series, or chronic Hepatitis B carriers in need of follow-up medical care were encouraged to contact their own health care providers. Those clients without a health care provider were instructed to contact the CHW who can link them to care. Together with the Program Coordinator, the CHW facilitated the linkage to care, whether it was the three-series vaccine or a medical appointment. The Program Coordinator monitored the number of these linkages to care as part of outcome evaluation.

HEPP Model as an innovative approach: AHC's model as an innovative approach to addressing Hepatitis B disparity in the Asian American community was evaluated qualitatively looking at the following indicators.

- Has AHC been successful in attaining additional funds to sustain and disseminate HEPP?
- Are partner agencies whose capacity has been built implementing aspects of the HEPP program on their own?
- Are other CBOs that serve Asian Americans seeking information about HEPP? Are HEPP program leaders and medical advisors asked to present on the program at conferences or to other interested parties? Are they asked to join local efforts to eradicate the effects of chronic Hepatitis B?
- Are the results of HEPP leading to any policy or system change to address Hepatitis B disparities affecting Asian-Americans?

Qualitative findings: Over the past several years, AHC has been the recipient of numerous grants to sustain HEPP, and has built the capacity of several CBOs have successfully obtained Hepatitis B funding. As stated earlier, one of our partners (Korean American Community Services) has leveraged its experience through HEPP to seek funding and implement their own Hepatitis B screening and immunization events. AHC has presented this model at several national conferences including the American Gastroenterological Association, AHRQ, American Public Health Association, and numerous medical school grand rounds. HEPP has given AHC staff a platform to engage with US senators, congressmen and local politicians in order to discuss disparities and potential solutions to help eradicate Hepatitis B. HEPP program leaders have been selected to serve on numerous local and national committees focused on disparities, hepatitis, Asian health issues, and cancer. Recently, AHC was awarded the CDC Public Health Conference Grant to host a Midwest viral Hepatitis symposium.

HBV SCREENING RESULTS BY PLACE OF BIRTH—CHICAGO



ASIAN HEALTH COALITION SUBURBAN HEPATITIS B EDUCATION AND PREVENTION PROGRAM

MONTHLY REPORTING FORM

Please email or fax this form the first week of each month to:
 Mona Artani, Project Coordinator, Asian Health Coalition of Illinois,
 312-372-7070 ext 224 (tel) 312- 372-7171 (fax) Artani@asianhealth.org (email)

AGENCY NAME:

MONTH:

DATE OF SUBMISSION:

Activity	Date	Location (Site Name, Address)	Topics (Training Education or Presentation)	Number and Type of Participants			
				Children	Adults	Professionals	Totals
Training/ Education Workshops Attended							
Workshops related to the Project Conducted							
Written Info/ Flyers/Brochures Distributed							
Individual Teaching in Person or by Phone							
Health Fairs/ Screening Immunization Events							
# Patient Referrals							
Other Items/Extra							

Narrative

Any Challenges
or Barriers this Month?

Any Particular Successes/
or Failures?

SECTION 10

DIVERSITY IN ACTION – AN ASIAN COMMUNITY RESPONSE TO HEPATITIS B

It is our hope that this manual will provide the impetus to replicate and disseminate HEPP in your community. As discussed in chapter 1-9, there are numerous factors to consider for hepatitis outreach, many of which will need to be tailored based upon your community needs and resources. Each phase builds upon infrastructure development and partnered support to create a robust and sustainable program for Hepatitis B education and prevention. List below are a summary of these stages and key considerations that may facilitate successful replication of HEPP in your community.

A. PHASE 1: CAPACITY BUILDING

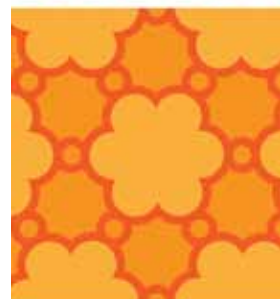
The first goal of HEPP is building community capacity. While it is easy to provide education, the ability of the community to use this knowledge requires an assessment of community readiness. There are three objectives that are required for this stage:

- Create and educate the advisory board (see chapter 4)
- Conduct comprehensive needs assessments to determine the resource landscape (see chapter 5). Included in the needs assessment are: patient survey, provider resource assessment, organizational capacity, and community context.
- Environmental scan (see chapter 5) to determine ethnic enclaves, health resources, and socioeconomic distribution of communities.

B. PHASE 2: PROGRAM IMPLEMENTATION

The second goal of HEPP is to implement the community health worker model. As discussed, the community health worker model is an essential component of the HEPP program. There are three objectives for implementation of this model:

1. Identification of community partners with culturally competent community health workers
2. Provide culturally tailored training and evaluation
3. Develop goals and objectives which are outlined below:
 - increase community awareness through education;
 - establish a physician linkage program for future referrals and screening inquiries;
 - increase the number of AAPI individuals identified for HBV immunization and diagnosed with chronic Hepatitis B infection by conducting community screenings;



It is our hope that this manual will provide the impetus to replicate and disseminate HEPP in your community. As discussed in chapter 1-9, there are numerous factors to consider for hepatitis outreach, many of which will need to be tailored based upon your community needs and resources. Each phase builds upon infrastructure development and partnered support to create a robust and sustainable program for Hepatitis B education and prevention. List below are a summary of these stages and key considerations that may facilitate successful replication of HEPP in your community.

C. PHASE 3: DIFFUSION, SUSTAINABILITY & INSTITUTIONALIZATION

The last goal of the HEPP diffusion plan will be to demonstrate its effectiveness through widespread adoption in underserved and racial/ethnic minority communities. There are three main objectives for this phase.

1. To evaluate the effectiveness and feasibility of diffusing the HEPP's CHW model
2. To document the challenges and successes of the HEPP diffusion process, and disseminate the findings to facilitate program replication.
3. To increase the sustainability and institutionalization of HEPP in the community.

Finally, it is important to keep in mind that there are several key considerations that must be factored into the process of HEPP replications. These key considerations will better prepare your organization for the successful replication of the HEPP program.

- Location: urban vs rural-the location will determine infrastructure and resource needs
- Population-homogenous vs heterogeneous-the population will determine the need for cultural adaptation and modification for addressing broad communities
- Resources-language and culture specific, funding for program implementation, manpower-available resources will be an essential component to program implementation and sustainability. This key consideration should be addressed prior to the initiation of any phase of HEPP.
- Partnerships-community partners, public health departments and physician base-partnerships will provide sustainability and create a culture of shared importance and engagement.
- Linkage to care-This is a key element for HEPP. It ensures that patients will be referred to treatment in a timely manner. This component distinguished HEPP from many community based programs which may not have a mechanism for linkage beyond screening.
- Policy/advocacy-identification of champions-this key consideration will provide a mechanism for broader impact and policy changes to support community needs
- Impact-describe the disparity-documentation of program impact will help with future funding and dissemination of your program

The HEPP program was designed to address the needs of the AAPI communities residing in the Chicago metropolitan area. Through a collaborative and iterative process, we were able to create a program that we firmly believe can be implemented in other communities and locations. HEPP has created a sustainable public-private partnership and most importantly, has provided the broader AAPI community with knowledge and power to combat and prevent this potentially fatal disease. Our linkage to care component is integral to our program and forms the basis for reduction in disease burden and mortality in those with chronic hepatitis B. We are committed to supporting organizations and communities interested in HEPP replication. We look forward to working together to eradicate this preventable disease.



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