

Questions and Answers from CoE Webinar: Hepatitis B in Refugees

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Best Practice Alert in Electronic Health Record

Could you please discuss the process behind the BPA development within the EHR?

The development of the Global Health Wizard Hepatitis B best practice alert (BPA) began in 2012. The development was an iterative process between the primary investigator, Dr. Patricia Walker, and the HealthPartners Institute EPIC build team. This BPA was possible due to the collection of granular demographic variables within the HealthPartners system. As part of a system-wide initiative to identify and address disparities beginning in 2002, rooming duties included asking each patient's race/ethnicity and preferred language in which the patient preferred to interact with the health care delivery system, and for which they requested an interpreter. In 2005, country of birth was added to these tasks in part because of patients' preference to identify themselves by country of birth rather than as Hispanic or Latino. To collect country of birth data, the rooming nurse asks the patient the country in which they were born and gives them the option of choosing not to answer. At the time of the initial study, language interpreter request data existed for 73% of and country of origin data existed for 99% of the HealthPartners Clinic population in the 9 clinics, and 80% and 99%, respectively, among those patients triggering the alert. The BPA was originally designed to be triggered by country of birth, and if missing then by language. The EPIC programming team created the logic for identifying hepatitis B screening using laboratory values and the project team created the language used in the BPA. This project was supported in part by the Program for Health Disparities Research at the University of Minnesota, the Medtronic Foundation, and the Minnesota Center of Excellence in Refugee Health supported by the Centers for Disease Control and Prevention (CDC) (NU50CK000459).

I currently work as a family physician at an academic medical center, I would love to adopt something like this at our outpatient sites. We have Epic, anyone I could talk to about how to go about this?

The team has received approval and is in the process of posting the BPA in the EPIC library. Please see [Epic Community Library \(https://comlib.epic.com/\)](https://comlib.epic.com/) for updates on this; search for "Hepatitis B Wizard".

In preparation, health systems can ensure that "country of origin" or "birth country" is collected as a variable in their EPR, as this is necessary for using the template.

Did you get funding to begin the registry or what kind of resources are required/needed?

The funding for this project was supported in part by the Program for Health Disparities Research at the University of Minnesota, the Medtronic Foundation, and the Minnesota Center of Excellence in Refugee Health supported by the Centers for Disease Control and Prevention (CDC) (NU50CK000459).

Additional resources include provider-champions, a dedication to working with non-U.S. born patients and limited English proficiency populations to discuss screening and disease management, referral networks for appropriate treatment, and a motivated project team.

Quality Improvement Data Analysis

Can you share again what your data was when you mentioned only 21% were up to date in the BPA analysis?

As part of the CDC Center of Excellence in Refugee Health, we took part in a collaborative quality improvement project to evaluate long-term management of refugees who had positive hepatitis B screening during the refugee domestic medical exam (DME). During follow-up, we found 137 refugee patients who underwent DME during March 2008–March 2017, had a positive hepatitis B surface antigen during the DME, and had been seen at a HealthPartners clinic within the 3 years prior to March 2017. Of those 137 patients, 21% were receiving optimal care, defined as having had an ALT and hepatitis B viral load in the previous 6 months, liver imaging for hepatocellular carcinoma screening in the previous 6 months, a visit with the patient's primary care provider in the previous 12 months, and had at least one appointment with a gastroenterologist at any point in time.

I would be curious to know how "tight" your rules were (i.e., if someone did labs after 8 months vs. 6 months did they get flagged as "not meeting criteria").

For the quality improvement project, the criteria for receiving optimal care were followed exactly as described above. For the registry, we are still following these ideal criteria, but are evaluating the registry differently, so will provide a range of acceptable time criteria for meeting the specific care measures (e.g., we may allow between 6 to 9 months for routine labs or look at whether all recommended screening at been performed within the previous 18 months). We are still deciding on this approach for the registry evaluation.

Hepatitis B Testing and Treatment

In the studies mentioned, how often did HBV-exposed infants undergo recommended testing (HBsAb and HBsAg) at 9 to 12 months of age? I'm wondering how to improve our testing rates.

Due to differences in resources and systems, testing rates may vary broadly between and within states. Some recommendations include identifying if there is a state public health worker assigned to the task of assuring timely hepatitis B vaccination completion and testing for immunity and infection. If this is not currently in place, it may be useful to explore with the

state if such a person could be assigned. Standard letters to providers can be developed with wording including the need to test other immigrant children in the family (if they were born overseas). Similarly, you could consider developing partnerships between the newborn nurseries and outpatient medical teams to develop standard "warm handoffs" of these infants to outpatient teams and then having a registry within your HR and an assigned person to track this list.

What is the mainstay treatment for hepatitis B and is it affordable?

This webinar was geared toward primary care providers. The focus was on appropriate screening for foreign-born populations, reviewing the various stages of hepatitis B infection to provide more information about diagnosis, and monitoring for chronic inactive Hepatitis B infection. Not all patients with chronic hepatitis B need treatment. Whether or not patient starts treatment, it is very important to have regular visits with a liver specialist or a health care provider who is knowledgeable about hepatitis B. For more information on treatment, consider visiting [CDC: Hepatitis B \(https://www.cdc.gov/hepatitis/hbv/index.htm\)](https://www.cdc.gov/hepatitis/hbv/index.htm) or [Hepatitis B Foundation \(https://www.hepb.org/\)](https://www.hepb.org/).

Who usually is assigned the "Patient Navigator" clinical role? Are the responsibilities usually given to the clinical refugee coordinator? What funding covers these positions?

Not all clinics have "patient navigator" roles, and those that do have a broad range of approaches and funding sources. Community health workers (CHW) are sometimes an option. Calls from a bilingual, bicultural professional to remind patients of follow-up appointments and to troubleshoot in partnership with the patient can be effective. Some clinical sites have an assigned team that is responsible to run the list of hepatitis B patients, monthly, to see who is behind on care. This could include a clinician lead, RN and medical assistant. If studies are due (e.g., LFTs e AG and e Ab), the team can send a request to the PCP and then outreach the patient to get them in. Social work may also be used in this case to address other barriers to care, like transportation. Patient navigators are wonderful additions to teams but funding to cover their time is not paid by Medicaid, sadly. Some teams has grant-funded navigators who help with these efforts.

What guidelines do you use for referral (at what level of LFT elevation or viral load)?

We typically have patients seen by a gastroenterologist or hepatologist once after a diagnosis of hepatitis B is made to help with creation of a routine monitoring care plan. Each patient needs to be evaluated on a case-by-case basis to determine whether they have cirrhosis, if there is liver inflammation based on ALT results, and the hepatitis B viral load. These clinical characteristics are taken into account when deciding how to manage a patient and whether or not treatment is indicated.

Does Medicaid pay for the treatment of HBV?

Yes.

Resources

What is the role of CareRef?

CareRef (<https://careref.web.health.state.mn.us/>) is a clinical decision making tool for newly arriving refugees. It directly links to the CDC Domestic Refugee Screening Guidelines and is updated as soon as the CDC site is updated. It is designed to be used during a clinical encounter to help make clinical decisions on what testing is needed for a new refugee arrival.

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