

HepTalk: Patients As Co-Authors of Their Hepatitis Prevention Plans



On-Site Training Manual 2006

**HepTalk is a project of the Migrant Clinicians Network, in cooperation with
Community Health Education Concepts, funded by the Centers for Disease
Control and Prevention**

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How to use this manual

- Pink pages indicate the two main sections and green pages are brief outlines of modules within the sections.
- Blue pages are more detailed outlines of each section. They are numbered separately and can be removed by the trainer and used during the workshop to guide and prompt the trainer.
- The white pages are detailed descriptions, intended to be read and studied beforehand by trainer. They can also be used at the training, according to the trainers' preferences. Some trainers may prefer to have just an outline in front of them during the training; others prefer more detail.

Workshop Section

The image shows a page from a manual with several annotations in red and blue boxes. The page content includes:

- Text: "Prompt on last question for location and "methodology" (i.e., read it with, give to take home, etc.) Presenter asks each pair/group to say why this might be effective or not, and whether it could be used or appropriate for their clinic. **Talk about them in your groups.** Report to large group and discuss."
- Text: "Include simple signs about hepatitis testing and immunization, good brochures, good posters, including materials in Spanish. On each piece, indicate where the material was placed: include lab area and waiting room signage, posters in bathroom, brochures in exam room, etc. Also low literacy materials, Spanish language, and pictorial.)"
- Text: "Refer to **handout with ideas for best uses of materials** and briefly review it—link to discussion of brochures. (Pick your messages carefully—a few important messages + methods info includes STI risk, avoid clutter, placement of materials, low literacy, pictorial, simple signs, etc.)"
- Section header: "Slide 30 Charting and forms" with a small image placeholder.
- Text: "4. Trio exercise on charting and forms: maximizing risk assessment and education quality and efficiency
Intro: **When effective risk assessment questions are on the forms, they get asked. When these questions are sensitive, having them on the forms makes asking them less awkward: we ask everyone these questions. Similarly, a place to document risk reduction plan and education give can help remind clinicians and clinical staff to do these things.**"
- Section header: "Slide 31 Charting Exercise" with a small image placeholder.
- Section header: "Hints for Client Health and History Forms"
- Bullet points: "•You do not need a separate hepatitis risk list—these risk factors overlap with many other communicable diseases!"
•if you are mentioning other diseases, do mention hepatitis (for example, if you list HIV or other STIs, list hepatitis B as well).
• Nurse or medical assistant can look over history/risk assessment to see if client has completed or has questions, and flag concerns for clinician to save clinician time."
- Text: "The risk factors for Hepatitis A, B, and C diseases are common to many other diseases transmitted via sexual contact, drug and needle use, inadequate hygiene and water safety. Communicable diseases not addressed in this handout include airborne diseases such as tuberculosis, influenza, etc."
- Text: "Refer to **Charting Forms Handout**. You can use this handout, which includes sample questions in key areas for hepatitis risk to compare to your forms. These questions illustrate clear simple language and direct questions that get quickly to the risk issues."

Annotations:

- Red box: "Instructions to the trainer are in normal font." (points to the first paragraph)
- Red box: "Text intended to be spoken aloud (or verbatim) by the trainer to the participants is **bold**. No other text in the manual appears in bold." (points to the bolded text in the intro)
- Red box: "References to peripheral materials appear in green." (points to the green text "handout with ideas for best uses of materials")
- Red box: "All ppt slides are shown in small clips." (points to the slide placeholder)
- Red box: "Text from slides is in text boxes. If the slide is a place holder or introductory slide, no text is included in the manual." (points to the slide placeholder)
- Blue box: "Trainer tips are in blue call-out boxes. Tips include suggestions of processes that worked well during actual training sessions." (points to the blue call-out box containing hints)

HepTalk SPI Training Schedule

Objectives: At the end of this training, participants will be able to:

1. Incorporate hepatitis risk assessment into the visit, in addition to addressing the primary reason for visit.
2. Gather enough information to get an adequate portrait of the patient’s risk for hepatitis through combination of history taking, risk assessment and awareness of cues.
3. Address barriers to adequate risk assessment presented by mobile and non-English speaking clients.
4. Provide information and education as necessary, plan for follow-up if not enough time.

Time: 1 hour; 1 hour CME or CNE for clinicians who see SPI in scheduled role visit.

Audience: Clinic staff, including clinicians, clinical staff who see patients, reception and education staff, and administrators.

Design:

Time	Steps
Prior to visit	1. Set up Visit: SPI scheduled in 1-3 patient slots: to see each clinician/provider
Varies 10-15 min	2. Reception – New Client Paperwork
Varies 0-20 min	3. Pre-exam work-up (vitals, interview, etc)
Varies 15-25 min	4. Exam with clinician
Varies 0-20 min	5. Post exam education, labs, etc.
15-20 min	6. SPI feedback to clinician as well as MA/nurse/other clinical staff who saw SPI
15-20 min to review feedback	7. Written individual feedback to clinician as well as MA/nurse/other clinical staff who saw SPI

Materials Needed

Feedback Forms (enough copies of each for each staff person)
<ul style="list-style-type: none">• checklist• rubric• verbal feedback form
Laminated cards to hand to provider for the following:
<ul style="list-style-type: none">• genital/pelvic exam• breast exam• blood draw, other lab tests or medication

Procedure for SPI Visits

Appointments and/or walk-in times, appropriate chart forms, the number of SPI visits to be performed, the number and positions of staff to be included will be arranged in advance by the HepTalk team and the clinic contact person.

HepTalk team member and SPI will arrive before clinic opens, if walk-in clinic. If the SPI has appointments, the team will arrive half an hour before first appointment. SPI will sit in waiting room and review role or read. Team member will talk to staff to make sure the appointments are set up and ready to go, review morning and afternoon with office manager, answer questions, make all contact with staff, including briefing the staff on how to treat the SPI (see Instructions to Staff, next page).

SPI will remain in waiting room until name is called, with limited or no contact with staff other than in the course of the visit. He/she will proceed through visit as if it were a normal visit. If there is time in waiting room or exam room, it's recommended that the SPI fill out the checklist and make notes right away. **Neither of these forms will be given directly to the staff person.** They are for the use of the SPI only, to help him or her remember details of the visit, to cue him/her as to what to look and listen for, and what to say during feedback. (This is a part of "standardizing" the training—using the same criteria/looking for the same things from everyone)

Following the visit, SPI will take 10-15 minutes in private to go over notes and finish filling out checklists and verbal feedback forms for each staff person. The checklist form has a cut-off point for MAs, LPNs, or other staff who are not expected, according to their clinic protocol, to do risk assessments.

The SPI will give verbal feedback to each staff person in the order of the visit. At the end of the feedback session, the SPI will also give rubric form and instructions for filling it out, **to those earning CME or CNE credits only.** (See SPI manual for details of all of the above.) SPIs should encourage staff to turn in the rubric by the end of the day, though mailing address is provided.

After the rubrics are returned to the HepTalk team, a written feedback letter/report will be sent to the **individual**, along with the rubric. The letter will clearly state that the rubric and the feedback will not be shared with anyone at their clinic or agency and will be destroyed at the end of the project.

Meanwhile, HT team member will assist when necessary, prepare for the afternoon session (make room arrangements, get coffee, get chart forms, set up PowerPoint, etc.), and set up a tentative final visit date with the office manager.

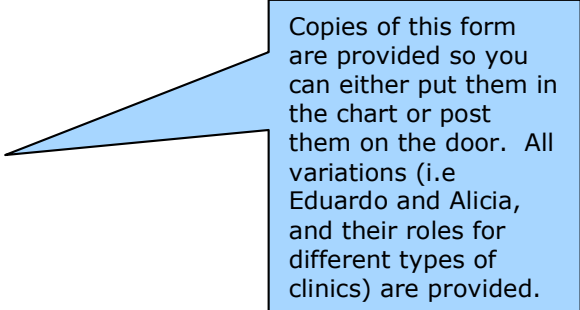
INSTRUCTIONS TO STAFF AND PROVIDERS

Good Morning.

When you enter the exam room this morning you will find patient Alicia Contreras. This is the first time you have seen Alicia. Alicia needs to get another Depo shot.

Alicia is a standardized patient instructor, not a real patient. However, she has a complete history, medical history and personality. You should treat the SPI exactly as you would a real patient. The SPI will stay “in role” at all times. If it is necessary to step out of the role, the SPI will hand you a card with instructions on it.

Remember that all you need to do is conduct the visit exactly as you would with a real patient, unless the SPI instructs you to do otherwise. At the end of the visit, the SPI will speak to you briefly, as an instructor, not as a patient, and offer you some feedback on your encounter.



Copies of this form are provided so you can either put them in the chart or post them on the door. All variations (i.e. Eduardo and Alicia, and their roles for different types of clinics) are provided.

Trainer Tip: This section is all “tips” for the Standardized Patient Instructor that will be helpful to review before each on-site clinic day. (More in SPI Manual.)

Feedback Cheat Sheet

Re-read each morning before work with clinics. Let the following principles guide your feedback interactions:

- The Standardized Patient Instructor (SPI) and clinician should work as "allies" with common goals. Feedback presents information, not judgment.
- Offer feedback only within the feedback session -- it should not come 'out of the blue'. Be sure to define the start and end of the feedback session.
- Feedback should be based only on facts and first-hand data. Use specific examples of behavior to illustrate your comments. Avoid using opinions or judgmental statements.
- Feedback should be regulated in quantity. Pick no more than four and no fewer than two areas to cover with the clinician.
- Feedback should be limited to behaviors that are remediable.
- Feedback should be phrased in descriptive, non-evaluative language.
- Feedback should deal with specific performances, not generalizations.
- Feedback may offer 'subjective' opinions, which should be clearly labeled as such.
- Feedback should deal with decisions and actions, rather than assumed intentions and interpretations.

(Adapted from Feedback in Clinical Medical Education, Jack Ende, MD. JAMA, August 12, 1983 - Vol. 250, No. 6. Further adapted for HepTalk from: *University of Washington Health Sciences Clinical and Laboratory Services*. <http://depts.washington.edu/hsasf/clinical/sp.html>)

HepTalk Feedback: Models for SPIS to use in feedback session with clinic staff

“The feedback follows a [learner-centered] model since we are promoting a patient-centered model and feel a sincere obligation to model our behaviors accordingly. So, SPIS are asked to begin the discussion with an open-ended question such as, " What did you think about [the encounter] today?" They are then asked to use **the skills of reflective listening (repeating, paraphrasing, and summarizing)**. Additionally, they are expected to "reframe" the [clinic staff] concerns into the language of the [HepTalk model] and provide feedback accordingly. In other words, SPIS are expected to discuss the [clinic staff] concerns in the language of the [feedback tools.] We emphasize the concept of the teachable moment and learner readiness, and focus the feedback to the [staff’s] concerns rather than to all the items on the checklist. We also employ a coaching framework **building on strengths and identifying areas for growth.**” Marilyn Guenther, University of Michigan

1. Opening statement models

These models invite the staff person to participate in the discussion.

- *Thank you for participating and sharing your time with us.*
- *How did that feel for you? What did you think about the encounter today?*

2. Observation statement models

These models are useful because they link a response to an action

- *I felt _____ when you said/did _____.*
- *I felt _____ because you said/did _____.*

Examples

- *I felt comfortable when you checked in with empathetic statements like _____.*
- *Your body language helped me to feel comfortable—[because] you leaned forward, and you made direct eye contact with me, and you shook my hand when you came in.*
- *I felt like you were interested in me because you asked me questions about _____.*
- *I felt uncomfortable when you started right in to the visit without saying anything to introduce yourself or to explain what you would be doing.*
- *I felt that you were really interested in me and got quickly to my concerns when you asked me what I thought had caused the symptoms.*

3. Praise models: asking about specific risk factors and reinforcing education

It’s important to let the provider/staff person know what they are doing well and why that particular step is important.

I noticed that you asked not just about drug use, but specifically about

- injection drugs. This is good because it is specifically injection drugs that are risk factors for hepatitis (and HIV). This is good because you can quickly determine hepatitis risk by asking specifically about injection drugs. You may want to have another discussion about other drugs, but if your purpose is to determine risk, this is the most efficient question.
- other types of injections (vitamins, etc), which is really good, because we don't know how big a risk factor that is for the migrant population. What we do know is that these practices are more common in Mexico and Central America.

I noticed that you asked

- about condom use. This is important because condom use reduces the risk both of acquiring or transmitting more than one STI, including hepatitis, and it is a good reminder for the patient.
- whether I had had a hepatitis B vaccination. This is a good question because it is efficient at eliminating risk for Hep B. If the patient has been vaccinated, he or she is not at risk.
- if I had access to clean washing and drinking water. This is a good question because it helps determine risk for Hep A.
- how many sexual partners I had had in the last 6 months. This is a good question because it is very efficient: any number more than one is an indication of risk and an indication to vaccinate as well.
- about gender of partners. This is important because same sex partners can be a reality for patients that they are hesitant to share unless asked. Asking the question gives them permission to speak about it. For example, we know Eduardo has had sex with other men, but he is very unlikely to bring it up on his own.
- whether my partner had any other partners. This is important because it can be a concern for patients that they are hesitant to share unless asked.

I noticed that you probed when I

- was vague about an answer. This is good because vagueness is almost always a clue to uncertainty on the part of the patient. The uncertainty may be about how his/her answer is accepted, whether or not it is the "right" one, or about its truthfulness/accuracy.
- hesitated after the question about _____. This is good because hesitation is almost always a clue to uncertainty on the part of the patient. The uncertainty may be about how his/her answer might be accepted, whether or not it is the "right" one, or about its truthfulness/accuracy.

I noticed that you explained what hepatitis was and how it was transmitted. This is good because many patients may not have very much accurate information about this disease. It has not reached the level of awareness in the general population as HIV/AIDS.

4. "Teaching" observations (performance keys)

Explaining the important of the steps you are suggesting is key to the staff person's acceptance of your feedback. Keep your feedback objective by using the language of the checklist, using examples, and being explicit about behaviors that you noticed. When offering negative observations (I noticed that you didn't____), it is a good idea to follow it up with positive actions—identifying areas for growth.

Sometimes organizing the visit helps the patient who may be unfamiliar with the system to understand what you are doing. If the patient understands where you are going and why you are asking questions, it can reduce confusion, which takes time.

Agenda-setting helps to organize the visit. You may be very familiar with the routine of a visit, but your patient may not. It helps to explain. A useful pattern is “First I’m going to do X. I’m going to do X because _____. Next I’m going to do Y,” and so on. An example would be, “first I’m going to ask you some questions about your medical history. I need to know these things so I can take care of you properly. Then we’ll talk about your back. Is that okay with you?”

I noticed that when you did the sexual history taking, you didn’t

include a question about number of partners. A good question to ask is “how many sexual partners (relationships?) have you had in the last six months?” If the answer is more than (one?) then you have determined there is a risk for hepatitis B or other STIs.

probe for more information when I said I only used condoms sometimes. This is a good opportunity to introduce or reinforce the reasons why condom use is necessary.

mention hepatitis. A good place to do that would be when you ask about HIV and other STIs.

“You’re right, it is hard to address all the prevention concerns you could, especially with a patient who is in for back pain or a routine birth control check, or has an acute illness. What I know about the role of Eduardo/Alicia is that he/she is also at risk for sexually transmitted infections, but he is not going to bring that up if you don’t ask.”

Like many young men, Eduardo is not going to access the healthcare system unless/until he has some problem that prevents him from working, so any other health concern is not going to be addressed if some one doesn’t ask him about it. The fact that his ability to prevent STIs by being reminded about risk reduction strategies like condom use, or the fact that he may already have something that he could be passing along to others, will also not be addressed unless you bring it up.

Like many women from Mexico and Central America, Alicia is more used to the idea of receiving injections in non-medical contexts, and she has participated in one or two “Depo parties,” gatherings where women get together to give each other Depo injections. She is also concerned that her partner may have had sex with other partners during the time that he was away doing jobs in other states. She’s worried that she may be exposed to STIs, but it is very difficult for her to say this about her partner. In all likelihood, this will not be addressed unless you bring it up.

You’re right—all we can do is try.

Even though behavior change doesn’t happen quickly, it helps to plant the seed.

I felt that you were really interested in me and got quickly to my concerns when you asked me what I thought had caused the symptoms.

It’s a great idea to ask what the patient’s concerns are. Asking a patient about his or her concerns early in the visit will help to avoid the extension of the visit, the “doorknob” question. You might say this by asking the patient:

- why do you think this happened?

- what do you think this is?
- was there something going on when these symptoms started?

Though questions about other partners or gender of partners may always be uncomfortable for the patient, they need not be seen as judgmental, if you ask the questions routinely, and explain why you are asking them. A good parallel to remember is that we are used to doing many physical procedures that are uncomfortable for the patient (like mammograms or pelvic or rectal exams), yet we don't NOT do them because they are uncomfortable. Indeed, patients accept them because they understand why they are necessary.

Normalizing lines can really help to alleviate patient discomfort. When at all possible, switch the focus of questions from a moral or judgmental framework to a medical/objective framework. Some examples are:

- I ask all my patient the same set of questions.
- These are important questions for all men in your age range.
- I'm concerned about your health not only today, but also down the road, in five years. That's why I'm asking these questions now.

5. Interpretation tips

It is important to let the provider know that there are a number of things in his/her control, even when working with an unfamiliar translator. He or she can use the following concrete suggestions to help communication happen effectively. These suggestions come from Communicating Effectively through an Interpreter, The Cross Cultural Health Care Program 270 S. Hanford Street, Suite 100, Seattle WA, 98134.

In order to facilitate communication when using an interpreter, you can:

- Maintain control of the interview—do a pre-session with the interpreter and client. This is very important because it allows you to take all of the following steps as well. You may not know the interpreter, in which case it's important to make your expectations clear ahead of time. Or, you may be very familiar with the interpreter, but remember that the patient is unfamiliar with the person as well as the clinic system, so it's important that you set the rules and help the patient understand them before you begin.
- Seat interpreter unobtrusively. This is important because it helps you to remember to speak directly to the patient
- Speak to the patient, not to the interpreter. This is important because it helps to make the patient feel like you are interested in him/her and want to communicate directly. The patient is not the third party, the interpreter is.
- Assume/insist that EVERYTHING is interpreted. This is important because the patient will trust that you are communicating to him/her, not to the interpreter. He/she will not have to wonder and worry about what is being said.

- Remember lack of equivalence between languages—it may take longer to say what you said. This is important because it will help you to remember to give the interpreter plenty of time.
- Speak at a moderate pace, in short sentences, one question at a time. This is important because it will help the interpreter to remember and interpret everything you say.
- Avoid slang and difficult medical terminology. This is important because both your patient and your interpreter may have difficulty either understanding or interpreting these phrases.
- Check for understanding. This is important because it's very easy to miss something in interpreted conversation. You can check visually, but you can also use some of the same phrases mentioned above. "Did you understand me?" "Is that okay with you."

HepTalk Group Training Schedule

Description: This training briefly orients staff to issues specific to the health of mobile populations, including barriers to health care experienced by migrant workers, recent immigrants, and other mobile underserved persons. A second module takes clinic staff through an overview of hepatitis A, B and C, including risk factors, transmission modes, symptoms, basic disease characteristics, and prevention strategies for each. The final module leads clinic staff through a process of examining the clinic environment—patient flow, charts and forms, education materials, and more—for opportunities to seamlessly incorporate risk assessment, education and hepatitis risk reduction planning into the patient visit. Staff will review important communication techniques for addressing potentially sensitive issues, and practice good risk assessment strategies.

Objectives: At the end of this training, participants will be able to:

1. Identify strategies for overcoming common barriers to preventive health care experienced by migrants and mobile underserved individuals.
2. Differentiate the primary risk factors and protective behaviors for hepatitis A, B, and C.
3. Demonstrate effective risk assessment techniques.

Time: 4 hours

Audience: Clinic staff, including clinicians, clinical staff, reception and education staff, and administrators. Most effective if attended by staff representing a broad range of positions.

Design:

Time	Module
15 min	Intro
30 min	1. Migration Health
35 min	2. Hepatitis Overview
10 min	Break
2 hours, 15 min	3. Effective & Efficient Risk Assessment and Follow-up Within Our Clinic System
15 min	Wrap Up: Emerging Issues and Take-Aways

Participant and Clinic Packet

PARTICIPANT PACKET (1 for each participant)	
Participant Packet Resources	Participant Packet Handouts
HepQuick (laminated) Patient Education Resources list MCN Spanish Glossary HepTalk hepatitis month posters (3) Hepatitis A and B world prevalence maps	Feedback Form (colored paper) PowerPoint Slides (note form) printout Quick Hepatitis Facts Hepatitis ABC Handout Venn Diagram- Viral Hepatitis Risks Blueprint for Creating More Hepatitis Risk Assessment and Education Opportunities in Your Clinic Best Uses of Patient Education Materials Hepatitis Charting handout Opening + Follow-up lines laminated card
CLINIC PACKET (1 per clinic)	
Clinic Packet Resources	
Speedy Spanish OASIS video dvd Patient Education Resources cd MCN Hepatitis Position Paper HepQuick (not laminated) Sample State Protocols: SC hep C protocol, NM hepatitis immunization and testing protocol Patient Education Resources List MCN Spanish Glossary HepTalk hepatitis month posters (3) (laminated) Hepatitis A and B world prevalence maps All of Participant Packet Handouts (above- green) National Standards for Practice for Interpreters in Health Care MSM: Clinician's Guide to Incorporating Sexual Risk Assessment in Routine Visits (GLMA) IAC clinician resources: "Do You Vaccinate Adults?" "If you have chronic hepatitis B virus (HBV) infection..." Hepatitis B Facts: Testing and Vaccination" IAC screening tools: "Should You Be Vaccinated Against Hepatitis A/B?" Should You Be Tested For Hepatitis C?" "Brief Sex History Questionnaire" MMWR Recommended Adult Immunization Schedule AMA: "Improving Immunization: Addressing Racial and Ethnic Populations, A Primer for Physicians" CDC brochures, posters Pepin comic books (hepatitis A and B) and dvds	

Materials Needed

Materials Needed

Participant Packets (see above) for each participant

Sign-in sheet

Name tags

Markers (enough for one for each participant)

Flip chart stand

Flip chart pads

Tape

Laptop w/PowerPoint presentation loaded, or PowerPoint on memory stick or CD

Projector

Green, red, and yellow dot stickers

Scripts for interpretation role plays (3 copies, large font)

Answer cards for hep quiz

O.A.S.I.S. dvd

Examples of effective patient education materials and signage

This clinic's medical history and risk assessment forms: enough copies for each group of three

Two different scripts for risk assessment role-plays, half with patient cues, half without; enough copies for each group of three.

Titles for 3 flip chart sheets: A, B, and C Protective Behaviors We'd Like to See

Migration health module: 6-10 possibilities for reducing barriers, printed on colored card stock and laminated. Include several unlaminated blank sheets for adding new ideas

Hep module: Questions for hep quiz, printed on white card stock and laminated; answers printed on index cards and laminated.

Clinic Profile

Set Up

- Set up computer, LCD projector, and test to make sure PowerPoint and Oasis DVD are working.
- Tape colored "Possibilities Exercise" sheets and white "Hepatitis Basics" Quiz answers around the room on the walls. Include several blank colored sheets.
- Can use blue or yellow dots as tape when it's time for Hepatitis Quiz questions
- Put tape on three "Behaviors We'd Like to See" sheets to have ready for posting on wall
- Make nametags and sign-in sheet available in a prominent place.

HepTalk Training

Introduction

Description: This introduction will give participating staff a chance to introduce themselves and their clinic/agency to HepTalk training team, and will give HepTalk team members a chance to introduce MCN, the HepTalk project, and themselves to the staff

Time: 15 minutes

Trainer Tip: have participants fill out name tags and put them on as they gather.

Design:

Time	Activity	Materials needed
5-10 mins	Introductions A. Staff to HepTalk Team B. HepTalk team members to Staff	Name tags
3 min	Talk about your clinic	Flip chart and markers
2 min	Describe purpose of HepTalk Project and of afternoon training	Laptop, projector, PowerPoint presentation: 7 slides Participant packets Feedback Form Sign-up sheet

Trainer Tip: One of the primary objectives of the introduction portion, from the trainer’s perspective, is that each person vocalize so they are “warmed up” to participate in future activities. So be sure everyone talks here.

HepTalk Training Detail

Introduction

Slide One Intro slide HepTalk



Put up at the beginning, while people are getting settled. Pass out **participant packets** and ask participants to take a moment to fill out the first side of the **feedback form** (on colored paper).

Slide Two Introduction



If there are many people and this exercise will take a long time, you can limit to just names.

1. Introductions:

HepTalk team members introduce themselves.

Ask each person to introduce the person next to him/her: **Tell us your name, position here at the clinic, and describe something you have seen that person do to make a patient feel comfortable.**

2. Talk about your clinic:

Trainer asks clinic staff to refresh his/her memory of what their clinic is like. **Please help us remember some of the specifics of your situation here. I'm going to read a list of statements that may or may not be true of your clinic. Stand up if you feel the statement is true. Stay seated if you think it is false.**

Most of us in the room were here when the HepTalk team visited last year
We have enough space.
We have enough staff.
Most of us have lived in _____ for more than 5 years.
Most staff here has worked with migrants for 3 or more years.
We have easy access to hospital care and specialized treatment referrals for our clients.
We see mostly migrants/immigrants.

Trainer Tip: If you would rather not have people stand/sit, you can go around the room and call on each staff person to agree or disagree. This gives everyone a chance to talk. Standing/sitting is a more active wake-up version. You can then invite other staff to participate and discuss answers, but keep an eye on the time.

We see a few migrants/immigrants.
 We see more and more migrants/immigrants.
 Our clinic has plenty of money.
 We have enough bilingual staff.
 Most of our patients speak English.
 X (illness or health care problem) is our biggest patient concern/illness.
 We've seen some of the same patients for many years.
 On the whole, we drink lots of coffee.
 We've had some of the same staff for many years.
 [Add one or two more characteristics of this clinic if needed]

3. PowerPoint Slides: Describe HepTalk and goal of training

Slide Three: Description of HepTalk



HepTalk is a five-year research project funded by the CDC. HepTalk is working with 27 clinics across the US to develop a model for more comprehensive integration of hepatitis prevention into primary care and public health clinics through site-based training.

Slide Four HepTalk Concepts



Patients will engage in discussions of emotionally charged issues surrounding Hepatitis A, B, and/or C risk and prevention if the clinic environment includes:

- Access to appropriate information on Hepatitis
- Occasion to discuss sensitive personal health topics
- Clinicians able to encourage and participate in these discussions

Slide Five Three Phases.



1. Assessment Phase: Baseline Site Visit (One day on-site visit by two people; 27 clinics in 5 regions)
 - 27 clinics observed
 - 172 staff interviewed
 - 63 patients shadowed
 - 52 patients exit-interviewed
 - 234 knowledge surveys returned
- ♣ 2. Resources and Training Phase (♣ This is where we are now)
 - Onsite training at 10 clinics
 - Distance Learning training at 17 sites
3. Findings Phase: Follow-up Visit (One day on-site visit 27 clinics) and reporting

Slide Six HepTalk Materials and Resources.



Some HepTalk materials and resources

These are some of the resources we've been providing as the project continues. You can access them at the Migrant Clinicians website on the Hepatitis page. You'll find resources both for patients and clinic staff.

Look at your **participant packet**. On the right are handouts; materials we will refer to throughout the afternoon, and on the left are resource materials that we will not be looking at until the end of the session.

Slide Seven: Agenda for the day:



HepTalk Training Agenda Total: 4 hours
Intro – 15 min
Module I – 30 min Migration Health
Module II – 35 min Hepatitis Basics
Break- 10 min
Module III – 2 hours, 15 min
Effective & Efficient Risk Assessment and Follow-up Within Our Clinic System
Wrap-Up – 15 min Take-Aways

Our goal for training this afternoon is to work with your clinic as you have described it today, and to help find ways to integrate hepatitis risk assessment and prevention into your clinic system.

HepTalk Training Module 1

Introduction to Migration Health

Description: This module briefly orients staff to issues specific to the health of mobile populations, including barriers to health care experienced by migrant workers, recent immigrants, and other mobile underserved persons.

Objectives: At the end of this module, participants will be able to:

1. Identify characteristics of adult migrants that make them vulnerable to poor health.
2. Describe clinic-based strategies to overcome barriers to preventive health care for migrants and the mobile underserved.
3. Demonstrate effective interpretation techniques.

Time: 30 minutes

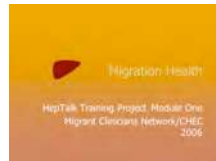
Design:

Time	Activity	Materials needed
5 min	1. Talk: Migrant Health Basics	<ul style="list-style-type: none"> • Laptop, projector, PowerPoint presentation: 11 slides
15 min	2. Activity: Possibilities Exercise	<ul style="list-style-type: none"> • Colored sheets titled with possible activities and several blank sheets, taped to the walls • Tape • Green, red and yellow dot stickers (removable)
10 min 3 min.	2. Activity: Interpretation Role Plays and Discussion	<ul style="list-style-type: none"> • Interpretation role play scripts

HepTalk Training Detail

Migration Health

Slide 8 Intro slide Migration Health



Put slide up to cue new module

1. PowerPoint Slides: A changing definition

Slide 9 Migrants: A Changing Definition



In the past, most migrants were:

- Farmworkers from Mexico and Central America.
- Doing physically demanding work.
- Culturally different from the standing population.
- Usually living below the poverty level & limited in formal education.
- Functioning with the intention of returning.

Slide 10 In the present



In the present, many migrants are:

- NOT farmworkers.
- From more and different parts of Mexico and Central America.
- Members of indigenous groups whose first language isn't Spanish.
- Intending to return, but crossing borders is much more difficult than in the past.
- Facing greater levels of suspicion and prejudice post 9/11.

Slide 11 They are still...



Migrants are still:

- Doing physically demanding work.
- Culturally different from the standing population.
- Usually living below the poverty level & limited in formal education.

Slide 12: In addition to agriculture: Portraits of Migrants



In addition to agriculture: janitorial, construction, factory/warehouse work, meat/poultry industries, hotel work, and restaurant work.

If there is time, you can initiate discussion by asking what barriers they have encountered in their clinic, or what they think might be barriers to good health care for migrant clients, before you present the slide.

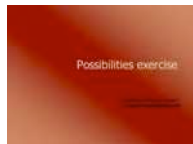
Slide 13: Mobility, Barriers to Good Health Care and Hepatitis Risk



Mobility, Barriers to Good Health Care, and Hepatitis Risk
Factors that affect the health of the mobile population in general may also increase their risk for hepatitis.
Fewer opportunities to receive care
Fewer opportunities to establish relationships with caregivers
Lack of continuity of care
Temporary living conditions may be sub-standard
Low incomes
Language barriers

2. Possibilities Exercise: Alleviating Barriers to Good Health Care for Migrants and Recent Immigrants into Clinic Systems and Practices
“No Way; Maybe; or Absolutely”

Slide 14 Intro slide: Possibilities exercise



Exercise Premise: There are differences between our migrant clients and our other clients and we may need to adjust some of our clinic strategies to provide successful health care to both populations.

We have put up sheets around the room that have possible activities to alleviate some of the barriers to good health care for migrants and recent immigrants. For example, here is one: having all bilingual staff would really help solve most of the problems that arise because of language barriers.

Slide 15 Traffic light



Red = No Way
Yellow = Maybe
Green = Absolutely (or if you already do this)

Each of you has a sheet of dot-stickers. You'll need the red, green and yellow ones for this exercise. Think of your clinic (or if you work with several clinics, think of one that you work with). Please walk around the room and put a sticker up on each sheet. Rate each activity by whether you think that your clinic could do it:

There are also some blank sheets if anyone would like to add other potential activities.

We will have about 5 minutes to walk around and put up stickers.

Posted activities:

- Having all bilingual staff
- Offering clinic hours at times accessible to migrant clients
- Having a written protocol for how to use a translator.
- Having a written protocol for who to go to if you need a translator
- Having access to and training in using phone line translation
- Securing extra funds hire a translator.
- Offering on-site Spanish language classes
- Having all signs in clinic translated into other languages.
- Scheduling Spanish-speaking clients into specific hours when translators are available
- Networking with other clinics to provide continuity of care
- Having Spanish medical dictionaries available in exam rooms
- Getting patient materials in multiple languages.
- Getting training for how to use a translator
- Having at least one bilingual staff person.
- Offering education about hygiene and sanitation
- Blank page for other solutions
- Blank page for other solutions

Trainer Tip: You may want to select 6-10 items from this list ahead of time. Prepare your sheets ahead of time. In the discussion following, you could bring up solutions that haven't been mentioned.

Discussion: Let's look at which ones have mostly green, which are yellow, and which have the most red. Are there any ways that you have thought about today, or thought about in a new way today to help migrants/recent immigrants have better access to clinic system?

2. Interpretation Role Plays and Discussion:

Slide 16 Intro slide: Interpretation Role Play



Role Play Premise: Of the many problems that can occur when interpreters are used, two things that can be done in any situation that will help the patient feel as though the communication is more meaningful and valuable are if the provider or staff person makes eye contact and speaks directly to the patient instead of to the interpreter.

Introduce two role plays: **For our next activity, we're going to do two role plays, one right after the other, and so for the first part of this activity, all we want you to do is watch both of them, and take some mental notes about what you observed. Specifically, we'd like you to note the differences between the two role-plays.**

Introduce patient: **First let me introduce you to [the Standardized Patient Instructor] Some of you might have met him/her before, this morning in the clinic, in his/her and so you'll know a little bit more about him/her than the others, and all of you will learn more about him/her later. S/he will be our patient in this role-play.**

Choose volunteer: **Now, we need a volunteer to be our provider, and I will be the interpreter. Do we have any volunteers? Don't worry; all you have to do is read off a script.**

Hand out **interpretation role-play scripts** (for yourself, SPI, volunteer).

Do first and second role-plays one after the other. In the first one, situate group in a triangle. In second one, "provider" will situate patient and interpreter side by side with the provider facing the patient.

Role-play of poor interpretation situation (SPI, provider, and interpreter)

Male SPI (Role Play 1)

Provider [looking at interpreter]: Ask him if he has pain in his back?

Interpreter: [looks at patient] ¿Tiene dolor en su espalda?

Male SPI: [Nods]

Interpreter [looking back at provider]: He says yes.

Provider [looking at interpreter]: Does he have pain anywhere else? In his leg?

Interpreter [looks at patient]: ¿Tiene dolor in sus piernas?

Male SPI: [Shakes his head] No, en mi espalda. [Puts his hand on his back.]

Interpreter: [looking at provider] No just in his back.

Provider: [writing in chart] Ask him if he feels it, if it hurts when he stands up.

[HepTalk \(Community Health Education Concepts/Migrant Clinicians Network\) 2006.](#)

Male SPI: [Stands up]

Interpreter: No, no- quiere saber si tiene dolor cuando esta de pie. (No, no, she wants to know if it hurts when you stand up)

Male SPI: [sheepishly] Oh, si, si. [Sits back down]

Provider: OKAY. [looks at interpreter] When does it hurt him more, morning or night?

Interpreter [looking at Male SPI] Duele en la mañana o en la noche (Does it hurt in the morning or at night?)

Male SPI: Si, si en la mañana and en la noche. Por la mañana me duele bastante, pero después cuando me levanto y camino un poco se me pasa, luego por la noche me comienza a doler otra vez. A mi me parece que solo me duele cuando estoy sin hacer nada y se me quita cuando se me calientan los huesos.

(Yes in the morning it hurts a lot, but then when I get up and walk a bit it goes away, then at night it starts to hurt again. It seems to me that it only hurts when I don't do anything and it goes away when I walk around and my bones warm up.)

Interpreter: [Interrupting] He says both.

FEMALE SPI (Role Play 1)

Provider [looking at interpreter]: Ask her if she has pain in her belly.

Interpreter: [looks at patient] ¿Tiene dolor en su estomago?

Female SPI: [Nods her head]

Interpreter [looking back at provider]: She says yes.

Provider [looking at interpreter]: Does she have pain anywhere else? In her back?

Interpreter [looks at patient]: ¿Tiene dolor in su espalda?

Female SPI: [Shakes his head] No, en mi estomago. [Puts her hand on her stomach.]

Interpreter: [looking at provider] No just in her belly mostly.

Provider: [writing in chart] Ask her if she feels worse when she stands up and walks around.

Female SPI: [Stands up]

Interpreter: No- no quiere saber si es peor cuando esta caminando. (No, no, she wants to know if it's worse when you're walking around)

Female SPI: [sheepishly] Oh, si, si. [Sits back down]

Provider: OKAY. [looks at interpreter] When does it hurt her more, morning or night?

Interpreter [looking at Female SPI] Duele en la mañana o en la noche? (Does it hurt in the morning or at night?)

Female SPI: Si, si. Por la mañana me duele mucho hasta que me levanto y como algo para desayunar pero a veces si como demasiado me duele mas y ya no se que hacer porque tengo que comer por los dos pero me siento muy mal y no se que es mejor para el niño y tengo miedo hacerle daño si como demasiado, no se doctor, no se. (Yes, yes. In the morning it hurts a lot until I get up and I eat something for breakfast, but sometimes, if I eat too much it hurts more and I don't know what else to do, because I have to eat for the both of us, but I feel very bad and I don't know what is best for the baby and I am afraid of hurting it if I eat too much, I don't know doctor, I just don't know what to do.)

Interpreter: She says yes, in the morning when she eats breakfast, she doesn't know what to do.

Role-play of good interpretation. (Same group as above):

MALE SPI (Role Play 2)

Provider [enters room] Hi, so _____ you're translating for me today? Would you sit here next to the patient? And if you can, please translate everything the patient says, exactly as he says it? Thank you.

Provider [looking at Male SPI]: So, you have some pain in your back?

Interpreter [looking at Male SPI]: Entonces, esta sintiendo un poco de dolor en su espalda?

Male SPI [Nods.]: Si, si. [Puts his hand on his back. Looks at provider]

Provider [looking at Male SPI]: Does it hurt anywhere else? For example, do your legs hurt too?

Interpreter [Looking at Male SPI]: Le duele en algun otro sitio? Por ejemplo tienen dolor in sus piernas?

Male SPI [Looking at provider]: No, mas que nada en la espalda pero se me baja por la sentadera.

Interpreter [Looking at provider]: Mostly in my back but it does go down my leg.

Provider [Looking at Male SPI]: Does it hurt when you stand up?

Male SPI: [Stands up]

Interpreter: No, no—quiere sabe si tiene dolor cuando esta de pie.

Male SPI [sheepishly]: Oh, si, si. [Sits back down]

Provider: So, does it hurt when you stand up?

Interpreter: Asi es que le duele cuando se pone de pie?

Male SPI: Si, si.

Provider: Okay, [Looks at Male SPI] when does it hurt worse, morning or night?

Interpreter: [looking at Male SPI] ¿Cuando le duele mas por la mañana or la noche?

Male SPI: Si, si en la mañana and en la noche. Por la mañana me duele bastante, pero después cuando me levanto y camino un poco se me pasa, luego por la noche me comienza a doler otra vez. A mi me parece que solo me duele cuando estoy sin hacer nada y se me quita cuando se me calientan los huesos

Interpreter: Yes in the morning it hurts a lot, but then when I get up and walk a bit it goes away, then at night it starts to hurt again. It seems to me that it only hurts when I don't do anything and it goes away when I walk around and my bones warm up.

FEMALE SPI (Role Play 2)

Provider [enters room]: Hi, so, _____ you're translating for me today? Would you sit here next to the patient? And if you can, please translate everything the patient says, exactly as she says it? Thank you.

Provider [looking at Female SPI]: So, you have some pain in your stomach?

Interpreter [looks at patient]: ¿Entonces esta sintiendo dolor en su estomago?

Female SPI [Nods]: Si, si. [Puts her hand on her stomach. Looks at provider]

Interpreter [looking back at provider]: Yes.

Provider [looking at Female SPI]: Does it hurt you anywhere else? Does your back hurt too?

Interpreter [looks at patient]: Le duele en algun otro sitio? ¿Tienen dolor in su espalda tambien?

Female SPI: [Shakes his head] No en mi estomago. [Puts her hand on her stomach]

Interpreter: [looking at provider] No just in my stomach.

Provider: [looking at Female SPI] Does it hurt when you are resting or just when you stand up and move around, when you are busy working?

Female SPI: [Stands up]

Interpreter: No, no- quiere saber si tiene dolor cuando esta descansando o nomas cuando esta de pie y caminando, cuando esta trabajando.

Female SPI: [sheepishly] Oh, si, si. Me duele mas si yo no estoy descansando----- [Sits back down]

Interpreter: Yes it hurts more if I am not resting

Provider: Okay. [looks at Female SPI], (Is it worse in the morning or at night?)

Interpreter: [looking at Female SPI] ¿El dolor esta peor en la mañana or en la noche? (Does it hurt in the morning or at night?)

Female SPI: Si, si. Por la mañana me duele mucho hasta que me levanto y como algo para desayunar pero a veces si como demasiado me duele mas y ya no se que hacer porque tengo que comer por los dos pero me siento muy mal y no se que es mejor para el niño y tengo miedo hacerle daño si como demasiado, no se doctor, no se

Interpreter: Yes, yes. In the morning it hurts a lot until I get up and I eat something for breakfast, but sometimes, if I eat too much it hurts more and I don't know what else to do, because I have to eat for the both of us, but I feel very bad and I don't know what is best for the baby and I am afraid of hurting it if I eat too much, I don't know doctor, I just don't know what to do.

Discussion: What did you notice? How did these differ? Which scenario do you think was most useful? What else can you suggest that might help improve the situation for the three participants? What can you do in your clinic?

Slide 17 Eye contact slide



Eye Contact: Elementary but Essential

“ [The] doctor who makes eye contact and tilts his head while the patient explains complaints of concern; that physician appears empathetic.... Our own studies have shown that patients who are satisfied with their physicians perceive their visits were two minutes longer than they actually were and these patients are better at following the physician's instructions. We also found that patients who felt their physician was not empathetic, perceived their visit to be two minutes shorter than it actually was.”

To review: of the many problems that can occur when interpreters are used, two things that can be done in any situation that will help the patient feel as though the communication is more meaningful and valuable are 1) if the provider or staff person makes eye contact with the patient and 2) speaks directly to the patient instead of to the interpreter. Here is one quick reminder of how valuable eye contact can be.

REFER to **SPEEDY SPANISH** in clinic packet, and specifically mention “**National Standards of Practice for Interpreters in Health Care**” in **Clinic Packet**.

HepTalk Training Module 2

Hepatitis Overview

Description: This module takes clinic staff through an overview of hepatitis A, B and C, including risk factors, transmission modes, symptoms, basic disease characteristics, and prevention strategies for each.

Objectives: At the end of this module, participants will be able to:

1. Describe the most common transmission modes for hepatitis A, B and C, respectively.
2. List at least two of the most common risk factors for hepatitis A, B and C, respectively.
3. Identify which of the three common hepatitis viruses can cause chronic illness.
4. Identify ways to prevent contracting hepatitis or lessen its severity.

Time: 35 minutes

Design:

Time	Activity	Materials needed
15 min	1. Hep Basics Quiz	<ul style="list-style-type: none">• Laptop, projector, PowerPoint presentation: 6 slides• Hepatitis quiz answer cards, removable dot stickers, questions posted on wall.
10 min	2. Oasis Video Clip(s)	<ul style="list-style-type: none">• Oasis DVD
10 min	3. Hepatitis risk assessment basics: Group list making.	<ul style="list-style-type: none">• Three flip chart sheets labeled with A, B, C Protective Behaviors• Markers

HepTalk Training Detail

Hepatitis Overview

1. Introduction

Slide 18 Intro slide: Hepatitis Overview



Slides 19 Hot topic



Hepatitis--hot topic? We keep hearing about hep--what are we supposed to be doing about it?

- Hepatitis A outbreaks
- Hepatitis C co-infection with HIV
- Hepatitis A and B immunization info
-

Hepatitis seems to be newsworthy lately: there have been recent outbreaks of hepatitis A; there is a lot of new health literature on co-infection of hepatitis C with HIV; and there continue to be updated recommendations for A and B immunizations. Clinicians have been asking MCN for guidance in incorporating hepatitis into their already-full agendas with patients.

Slide 20 Hep A and Immigrant populations



When we are talking about hepatitis and immigrant populations, one thing to remember is that hepatitis A and B might be much more prevalent in the countries from which the migrants come.

In the case of hepatitis A, it is endemic in Mexico, and Central America, and many other parts of the world. This can affect your practices for immunization and testing of immigrant and migrant clients. Please see the [MCN position paper](#) (in your Clinic Packet) for specifics on this. In reality, no one knows a lot about risk related to country of origin for migrant workers in the U.S. But we do know that we might want to have a higher index of suspicion for some communicable diseases among immigrant groups. Also, migrants move all around the US

HepTalk (Community Health Education Concepts/Migrant Clinicians Network) 2006.

hepatitis A immunization recommendations vary by state incidence. Therefore, we recommend vaccinating young children of all mobile families. In contrast, most Latin American immigrant adults and adolescents have already develop immunity to hepatitis A and need not be immunized, even if they plan to travel to high incidence countries.

Slide 21 Hep B geography



In the case of hepatitis B, if you have clients from Asia, you already know that you need to have a higher index of suspicion for chronic hepatitis B. In the case of migrants, there is some evidence that hepatitis B prevalence is also very high in parts of Central America and the Caribbean, and these clients should also be considered for hepatitis B testing. (ALL pregnant women should be tested, of course.)

2. Hep Basics Quiz

Pass out **answers to questions**. Ask participants to put the answer on the wall that matches it. Use yellow or blue dot stickers as tape to stick the answer to the appropriate question, or put tape on back ahead of time.

Have participants each read their answers and questions (modify to fit room size, number of people, and ability to read cards: have each person read only one, or the one nearest to them, or read the answer yourself.)

Quiz Q/A:

- | | |
|--|---|
| What is the most common blood-borne illness in the world? | Hepatitis C |
| Are there more than three types of hepatitis? | Yes. However, A, B, and C are the most common. |
| True or false: people with hepatitis usually turn yellow. | False. Hepatitis is usually asymptomatic, however, jaundice can be a symptom. |
| True or false: hepatitis A is common in Mexico. Caribbean. | True. It is also endemic in other parts of Central and South America and the Caribbean. |
| Is hepatitis B more common in other parts of America? | Higher rates appear in Honduras, El Salvador, Guatemala, Haiti, Dominican Republic, and some South American countries. |
| What is the primary mode of transmission of Hepatitis A? | Fecal-oral route (food, hygiene) |
| What is the primary mode of transmission of Hepatitis B? | In the U.S., it is primarily a sexually transmitted disease. In some other parts of the world it is commonly transmitted from mother to child at birth. |
| What is the primary mode of transmission of Hepatitis C? | Intravenous (IV) drug use. Also blood transfusions before 1987. |
| Can you be vaccinated against hepatitis? | For A and B, yes! No for hepatitis C. |
| Should some one who used injection drugs long ago be tested for hepatitis C? | Yes. Anyone who has tried them even <i>once</i> (and for B as well). |
| Can acute hepatitis become chronic? | A cannot. Yes for B and C. |
| Should all prenatal clients be tested for Hepatitis B? | Yes. Every woman for <i>each</i> pregnancy. |

[HepTalk \(Community Health Education Concepts/Migrant Clinicians Network\) 2006.](#)

Refer to quick facts handout (quiz key).

3. OASIS (The Organization to Achieve Solutions in Substance Abuse) Video clip- hepatitis C overview and treatment

Introduce video. **One of the other CDC hepatitis prevention grantees in our group has developed some excellent patient education videos about hepatitis C. We thought they were so good that many clinicians would find them helpful as well. Though they are targeted specifically towards a drug-using population, which you may not have, they are also targeted towards a multi-ethnic medically uninsured or underinsured community, and they deal with complex hepatitis issues very clearly. We also think they deal with drug transmission in a way that could be very helpful for staff who are unfamiliar with drug use, paraphernalia, etc.**

I'd like to show you one of their short videos. The first one is an overview of Hepatitis C.

Show "Hepatitis C: The Basics."

Trainer Tip: Familiarize yourself with the video equipment as well as the OASIS dvd. Skip intro and conclusion sections as appropriate because time is limited

The other three short videos from O.A.S.I.S. are also very good, and we have included them in your training packets.

4. Hepatitis risk assessment basics: what you need to know about risk from your patient and what you'd like your patient to know about protective behaviors

Slide 22 Hepatitis A B and C



Okay let's quickly review some of the risk factors we mentioned in our Hepatitis Basics quiz; you have the basics in this handout:

Refer to **Handout Hepatitis A, B, C**

The risk factors for A, B, and C vary and overlap. Let's look in a little more detail in this diagram, and try to simplify it a little bit. In terms of efficiency for a risk assessment protocol, it can be helpful to sort out the most common factors among the three, and to have a good grasp of the important differences.

Slide 23 Venn diagram PowerPoint



Viral Hepatitis Risks

Hepatitis A

Living in or traveling to areas of the US with increased rates of hepatitis A

Hepatitis B

Having a diagnosis of an STD
Having sexual contact with an infected person

Hepatitis C

Received clotting factors before 1987
Received blood and or/solid organs before 1992
Having undiagnosed liver problems
Having sex with an infected, steady partner

Hep A and B

Men having sex with men
Traveling to or from countries with high rates of hepatitis A or B

Hep B and C

Having multiple sex partners
Being on hemodialysis
Working in healthcare and public safety
Being born to infected mothers

Hep C and A

Using non-injecting drugs

Hep A B and C

Using IV drugs
Having household contact with an infected person

Go through Venn slide animation and refer to **Venn diagram handout** in packet.

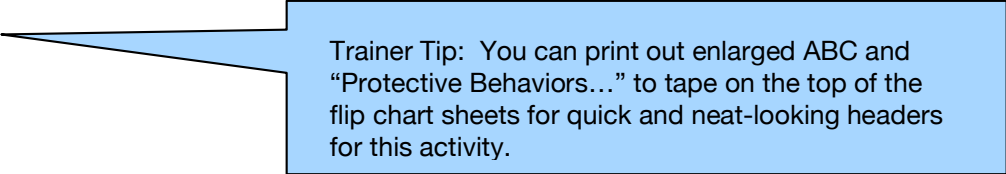
Brainstorm protective behaviors we want to encourage for A, B, and C. Write ideas on paper on wall headed with A, B and C and “Protective behaviors we’d like to see.” As you do this, discuss. Look at what is on lists, what is not, etc.

A
Wash hands
Wash food
Get vaccinated
Use condoms
Don't share household items

B
Use condoms
Get vaccinated
Don't share household items
Communicate with partners

C
Don't share drug paraphernalia, especially needles
Get treatment for drug addiction
Use condoms
Don't share household items

[HepTalk \(Community Health Education Concepts/Migrant Clinicians Network\) 2006.](#)

A light blue callout box with a black border and a pointer on the left side. The text inside is centered and reads: "Trainer Tip: You can print out enlarged ABC and 'Protective Behaviors...' to tape on the top of the flip chart sheets for quick and neat-looking headers for this activity."

Trainer Tip: You can print out enlarged ABC and “Protective Behaviors...” to tape on the top of the flip chart sheets for quick and neat-looking headers for this activity.

5. Reiterate, Review and Look Ahead

As we move on to the next section, we want to keep in mind that we hope this training will not add time to your clinic procedure, but help streamline it.

In other words, given these facts about hepatitis, the risk factors and the protective behaviors we’d like to see, we want to think about what are the **most important pieces** of information we want get from as well as to share with the patient. We want to think about **how** we ask the questions that best get this information, and what the patient needs to know, so we can determine risk and make a plan for the client. This is what we’ll be working on in the next module.

The other thing we want to keep in mind, in terms of integrating or streamlining this process is this: **Because hepatitis A, B and C cover many of the risk factors for many communicable diseases, this information should be useful for a risk profile for more than just hepatitis. (Examples: HIV/Other STD’s)**

Refer to resources in participant packets—**HepQuick**. We developed this reference for use in exam rooms. It has the condensed CDC risk, immunization and screening info for all three common forms of viral hepatitis on one page. Also, there you will see the **MCN position paper** on hepatitis and mobile populations, with specific issues and recommendations specific to migrants and recent immigrants.

HepTalk Training Module 3

Effective & Efficient Risk Assessment and Follow-up Within Our Clinic System

Description: This module leads clinic staff through a process of examining the clinic environment--patient flow, charts and forms, education materials, and more—for opportunities to seamlessly incorporate risk assessment, education and hepatitis risk reduction planning into the patient visit. Staff will review important communication techniques for addressing potentially sensitive issues, and practice good risk assessment strategies. Staff will identify ways to link risk assessment to targeted patient education.

Objectives: At the end of this module, participants will be able to:

1. Identify at least three strategies within the clinic system to enhance hepatitis risk assessment.
2. Demonstrate effective risk assessment techniques.
3. Develop at least two educational responses to a client with risk factors for hepatitis.

Time: 2 hours, 15 min

Design:

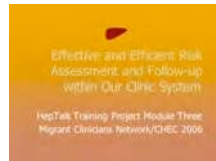
Time	Activity	Materials needed
3 min	1. Walk in Patient's footsteps: Part I of Visualization, Flow Map	<ul style="list-style-type: none"> • Flip chart, markers • 17 PowerPoint slides
15 min	2. Whole group discussion of opportunities to do risk assessment:	<ul style="list-style-type: none"> • Flip chart, markers
10 min	3. Patient educational materials review	<ul style="list-style-type: none"> • Examples of effective patient educational materials and signage, enough for one/group of three
15 min	4. Charting and Forms exercise: efficient and effective risk assessment.	<ul style="list-style-type: none"> • This clinic's forms; copies for everyone
3 min	5. Part II of Visualization	
10 min	6. Who needs risk assessment?	

45 min	7. Three Practical Tactics 7a and b. 2 Role-plays: Recognizing Patient-initiated opportunities for risk assessment AND Creating staff-initiated opportunities to do risk assessment (using opening lines). 7c. Clearing the path ahead: Agenda-setting	<ul style="list-style-type: none"> • Cues/No Cues role play texts; some of each, enough for one/group of three
15 min	8. Linking assessment to education: What does the patient need to know?	
4 min	9. Part III of Visualization	

HepTalk Training Detail

Efficient and Effective Risk Assessment and Follow-up Within Our Clinic System

Slide 24 Intro slide: Effective and Efficient Risk Assessment



The second part of our training today is on effective and efficient risk assessment and follow-up within your clinic system. We've shared some information, now we want to get to the meat of the training, some practical work. During this part of the training, we won't have formal breaks, just get up and stretch or use the rest room as you need to. Feel free to stand or move around.

Slide 25 Visualization



1. Walk in the patient's footsteps: how does the visit look from the patient's perspective?

Visualization: **Close your eyes and imagine yourself walking in through the clinic doors. Imagine the first things you notice and see. Think about who you first talk with. Imagine that you are a new patient. Visualize which forms you will be given, and imagine yourself filling out the questions that are asked on those forms. Imagine where you will sit to do this. Imagine that some questions are hard for you to answer and how long it might take. After you turn in your forms, imagine how long you will wait. Think about who calls you from the waiting area and where you go next. How does this first interaction set the tone for the rest of the visit?**

Statement on Public Health Perspective --**Open your eyes. This imagination exercise is not about quality customer service, in the traditional sense. Think about what you imagined from a public health perspective: our concern in this session is on communicable disease. We want to ensure that some one who is at risk for a communicable disease is tested, immunized, or treated, so that these diseases are not spread. We will come back to this imagined visit a little later.**

[HepTalk \(Community Health Education Concepts/Migrant Clinicians Network\) 2006.](#)

Slide 26 Intro slide: opportunities to do risk assessment



2. Whole group discussion of opportunities to do risk assessment

Let's look at what risk assessment happens at each stage of the visit, and what education at each stage.

Define Risk Assessment: **Before we do this, let's define risk assessment and education for our purposes. We are looking at hepatitis and communicable disease in this project, but we are interested in how your clinic does risk assessment overall. We are looking at questions that are asked about risks such as a family history of certain diseases, about behaviors that put you at risk--from smoking to lack of exercise to multiple sex partners and drug use. It has been our experience all over the country that risk assessment is an area of difficulty at most primary care settings.**

Slide 27 Clinic Blueprint



What does the flow look like in your clinic? What happens first? What next? On a large piece of paper, diagram (tree diagram) clinic flow with staff: reception, waiting room, etc. (trainer as scribe.) List client stops with staff from front door to exit: reception, waiting room, etc.
Who does risk assessments? Where/When do you do risk assessments? Check each stop where there is an assessment done.

Discuss: **Where in this flow is the risk assessment built-in, or routine? (Because if it is not "ROUTINE" it will often be neglected in a busy office day)** (Use one color marker for where it is done routinely.) Discuss: **Where could risk assessment be done--or facilitate?** (Use a different color marker for where it could be done.) Goal is to increase two kinds of opportunities: recognizing client-initiated in-the-moment opportunities during a client visit, and creating or increasing the number of routine opportunities via chart forms and clinic protocol.

One of the things we've heard at other clinics is that staff does not always know what happens in stages of the visit in which they don't participate. Do you have any suggestions about how to address that? (If not mentioned, say that one thing we find helps when looking at risk assessment and education opportunities throughout the patient visit is a regular staff development practice of observing each other. Sometimes medical assistants do not actually know what education the physician does, or the nurse practitioner doesn't know what the nurse covers. A regular observation rotation schedule--once a month, each person observes another, for instance--can help streamline history taking, risk assessment, and

education. Staff can also use this opportunity to give constructive feedback on patient communication skills such as eye contact, not using jargon, etc.)

Refer to Blueprint Handout on how clinics fit in risk assessment. **This diagram shows some of the ways and places that clinics have facilitated risk assessments.**

Slide 28 Intro slide: Patient education materials



3. Reviewing Patient Educational Materials: Signage, posters, brochures, etc.

Intro: **We do not believe that brochures are the be all and end all of patient education. What we hope clinics use educational materials for is to prompt clients to ask questions. For instance, if you are worried about needle use and you don't know how clinic staff will treat you if you ask, a poster on the wall might give you an indication that those questions are OK here. A brochure on sexually transmitted diseases might help you in the same way, or might answer questions you are still afraid to ask. At best, a simple sign, brochure, or poster might prompt you to consider behavior change: get immunized, use condoms, wash your hands, etc. Many clinics also use brochures as follow up on education given, as a reminder for patients to re-read later, at home.**

Example: **One example we have had from the project already was when we one of the clinics put up a poster about hepatitis that we had provided them. The medical director told us a story about a client who asked to be tested for hepatitis C. The doctor said that he did not think the client would have asked had he not seen the poster, and since the client had no apparent risk factors, he would not have been screened or questioned about hepatitis by the staff had he not asked. The client is now aware of his positive Hep C status, and that clinic has the capacity for treatment and treatment support.**

How do you use patient education materials well here? (If possible, presenter has example/s from this clinic as well.) **How can you use them to facilitate risk assessment?**

Here are some examples of education materials we saw being used in clinics. Please work in groups of two or three (depending on group size, trainer should divide people). **Please take one and pass it along.**

Slide 39 Patient Education Materials



What do you like about it?
What don't you like about it?
How would you use it in your clinic?

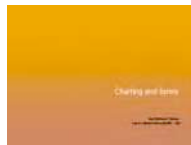
[HepTalk \(Community Health Education Concepts/Migrant Clinicians Network\) 2006.](#)

Prompt on last question for location and “methodology” (i.e., read it with, give to take home, etc.) Presenter asks each pair/group to say why this might be effective or not, and whether it could be used or appropriate for their clinic. **Talk about them in your groups.** Report to large group and discuss.

Include simple signs about hepatitis testing and immunization, good brochures, good posters, including materials in Spanish. On each piece, indicate where the material was placed: include lab area and waiting room signage, posters in bathroom, brochures in exam room, etc. Also low literacy materials, Spanish language, and pictorial.)

Refer to **handout with ideas for best uses of materials** and briefly review it—link to discussion of brochures. (Pick your messages carefully—a few important messages + methods info includes STI risk, avoid clutter, placement of materials, low literacy, pictorial, simple signs, etc.)

Slide 30 Charting and forms



4. Trio exercise on charting and forms: maximizing risk assessment and education quality and efficiency

Intro: **When effective risk assessment questions are on the forms, they get asked. When these questions are sensitive, having them on the forms makes asking them less awkward: we ask everyone these questions. Similarly, a place to document risk reduction plan and education give can help remind clinicians and clinical staff to do these things.**

Slide 31 Charting Exercise



Hints for Client Health and History Forms

- You do not need a separate hepatitis risk list--these risk factors overlap with many other communicable diseases!*
- If you are mentioning other diseases, do mention hepatitis (for example, if you list HIV or other STIs, list hepatitis B as well).
- Nurse or medical assistant can look over history/risk assessment to see if client has completed or has questions, and flag concerns for clinician to save clinician time.

*The risk factors for Hepatitis A, B, and C diseases are common to many other diseases transmitted via sexual contact, drug and needle use, inadequate hygiene and water safety. Communicable diseases not addressed in this handout include airborne diseases such as tuberculosis, influenza, etc.

Refer to **Charting Forms Handout**. You can use this handout, which includes sample questions in key areas for hepatitis risk to compare to your forms. These questions illustrate clear simple language and direct questions that get quickly to the risk issues.

Slide 32 Charting Exercise



Four main areas for Hepatitis Risk

- hygiene
- drug/alcohol/needle use
- sexual risk
- medical history

Presenter breaks group into trios. Each group gets a copy of their clinic's forms. **Look at your clinic forms, as well as the handout on charting. You can write right on the forms, feel free to mark them. Note which of the suggested risk assessment questions are on your forms, which are not, and what additional risk questions you ask, and how your risk assessment questions are worded**

Each group reports back: things they noticed, things that could be added. Discuss the implications for electronic medical records, if appropriate. (Clinic has some say in what forms they choose, can add questions, etc.) **What questions are NOT necessary?** Discuss: **We want to consider the minimum number of questions you need to ask and the best wording to get a complete risk portrait. Consider your clinic's priorities, time considerations, and effectiveness of the questions. We know that you have real limits and there is a tension you have to maintain, a balance between providing the ideal best care and time realities.**

One example we have seen is that many clinics include, "Are you married?" on their sexual risk histories. How could that question be more efficient? Discuss briefly that the risk factors we want to know about are number of partners, whether partner has partners, and, possibly, condom use. So that asking, "Are you married really doesn't get that info and might not be an efficient use of time or chart space.

Slide 33 Visualization I

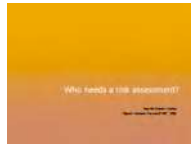


5. Visit From the Patient's Eyes, part II

Visualization: **Close your eyes and imagine yourself as a patient again, in the exam room. Imagine how long in the exam room for the clinician. Notice what is in the room and how it strikes you. Imagine what you discuss when the provider arrive. Visualize whether or not your discussion feels comfortable and whether or not it is rushed, too long, or just right. Imagine that your primary concern is one that makes you uncomfortable. Does the clinician ask questions that lead you to discuss the problem, or do you bring it up?**

Open your eyes. From a public health perspective, we want to make sure that some one who is sick or infected gets treatment to stay as well as possible. We want to make sure that some one who is not infected, but just worried, has the chance to put those fears to rest, or that someone who may be infected without knowing it is given the opportunity to find out. Furthermore, we want to think not only about the client's health status today, but also five years from now. What features of our client's life today may affect his health in five years? Let's talk more about the risk assessment process, and we'll go back to our imaginary visit again after that.

Slide 34 Intro slide: Who needs a risk assessment?



- Who needs risk assessment? Why do risk assessment?

You may want to ask the SPI to read his/her profile here.

Slide 35: or 36 Profile of E or A



Profile of "Eduardo"

- "Eduardo" has been in the US for a little over a year.
- From Mexico
- Single, 33 years old
- Worked in crops for 10 months, moved three times
- Has recently switched to construction.
- Lives in an apartment with 5 or 6 other men
- Speaks Spanish and some limited English
- Is visiting the clinic because he has back pain



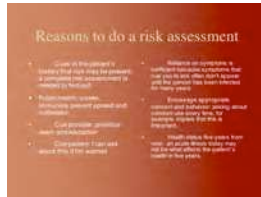
Profile of "Alicia"

- Alicia has been in the US for about a year.
- From Mexico
- Single, 25, but came to the US with her boyfriend.
- Has been working in a poultry plant for most of the time.
- Her boyfriend has continued to move for work, but comes back occasionally. He's recently come back after three months away.
- Lives in an apartment with two other women, and one of the woman's boyfriend.
- Speaks Spanish and some limited English
- Is visiting the clinic to get a DepoProvera shot

This is what you know so far about Eduardo/Alicia, from his/her chart and from a brief opening conversation. HT team member reads profile (choose one or the other) while it is up on the PowerPoint.

Pose question: **Should you ask some one who is not presenting with symptoms or concerns about a sexually transmitted disease or concerns about their sexual history and risk profile? Let's think about Eduardo/Alicia. What should be included in a risk assessment for Eduardo/Alicia?** If they do not bring it up in discussion, ask them what they think the chances are of Eduardo returning to the clinic? Follow up w/idea that this may be their only chance to do a risk assessment.

Slide 37 Why do risk assessment?



- Cues in the patient's history that risk may be present: you need to do a complete risk assessment to find out.
- Public health: screen, immunize, prevent spread and outbreaks.
- Cue provider: prioritize exam and education
- Cue patient: I can ask about this if I'm worried
- Reliance on symptoms is inefficient because symptoms that cue you to ask often don't appear until the person has been infected for many years
- Encourage appropriate concern and behavior: asking about condom use every time, for example, implies that this is important.
- Health status five years from now: an acute illness the patient is here for today may not be what affects his health in five years.

Slide 38 Why you might not do an assessment



- risk assessment questions may make the patient uncomfortable,
- there may not be a "natural" opening in the dialogue, it feels awkward
- it may seem difficult to fit everything in.

Slide 39 Eduardo cont. or 40 Alicia cont.



Profile of Eduardo (continued)

- Will seek out sex workers when he can afford it
- Does not use condoms
- Has had several sexual encounters with men who shared his apartment
- Does not consider himself gay.
- Has never used IV drugs himself
- Moderate alcohol use
- Has recently smoked pot once or twice
- Thinks of himself as basically healthy
- A little bit worried about STIs and HIV/AIDS



Profile of Alicia (continued)

- She had several partners when she lived in Mexico but has been in a relationship with her current partner for about three years.
- She and her partner do not use condoms
- She has never used IV drugs
- She drinks only occasionally
- She thinks of herself as basically healthy.
- She is a little bit worried about STIs and HIV

Here is some more information. This is info that neither patient is likely to volunteer. What risk questions would you have needed to get this info? If you saw Alicia or Eduardo this morning, were you able to access this info?

So the questions for the next section are: How are you going to fit in this risk assessment? How are you going to find a little lever to pry open some space in the interview to ask risk questions, and more importantly, how are you going to do it in a way that allows both you and the patient to feel comfortable? We're going to look at three related ways to help make doing a risk assessment easier for both you and the patient.

Slide 41 Intro slide: Three practical tactics



7. Three Practical Tactics: Facilitating Risk Assessment

Premise: Though there may be general agreement that risk assessments should be done, it can be difficult or uncomfortable for a variety of reasons: risk assessment questions may make the patient uncomfortable, there may not be a “natural” opening in the dialogue, it may seem difficult to fit everything in. Recognizing patient openings, using standard, normalizing opening lines, and setting agendas with the patient can help.

We're going to suggest three tactics for conducting an effective risk assessment. Recognizing patient openings, using standard, normalizing opening lines, and setting agendas with the patient can help overcome the reasons for not doing a risk assessment.

Slide 42 Intro slide



7a. 2 Role-plays: Recognizing Patient-initiated opportunities for risk assessment AND creating staff-initiated opportunities to do risk assessment (using opening lines).

Divide group into trios. Hand out one script per group. Make sure roughly half of the trios have Role Play NO 1 (CUES) and half of the trios have Role Play NO 2 (NO CUES). Say that the scripts begin from the same moment in a provider/patient interview. Then there are some slight differences, but the tasks for each group are the same:

FOR PRIMARY CARE/PRENATAL CLINICS

Role Play 1 (CUES) ALICIA:

Provider: Other than your concerns about morning sickness, do you have any other worries or concerns?

Patient: Well, I'm kinda worried. I used to think I was pretty healthy, but especially since I came here, in the last few months or so, I seem to be getting sick a lot, just infections and colds and things like that. I never used to get sick before.

Provider: Uh huh.

Patient: I don't know, just little infections and things.

Role Play 1 (CUES) EDUARDO:

Provider: Other than concerns about your back, do you have any other worries or concerns?

Patient: Well, I'm kinda worried. I used to think I was pretty healthy, but especially since I came here, in the last few months or so, I seem to be getting sick a lot, just infections and colds and things like that. I never used to get sick before.

Provider: Uh huh.

Patient: I don't know, just little infections and things.

Role Play 2 (NO CUES) ALICIA:

Provider: Other than your concerns about morning sickness, do you have any other worries or concerns?

Patient: No I'm pretty good. Think I'm pretty healthy.

Provider: No other concerns or worries?

Patient: No, I feel good.

Role Play 2 (NO CUES) EDUARDO:

Provider: Other than your concerns about your back, do you have any other worries or concerns?

Patient: No, I'm pretty good. Think I'm pretty healthy.

Provider: No other concerns or worries?

Patient: No, I feel good.

FOR STI CLINICS

Role Play 1 (CUES) ALICIA:

Provider: Other than the discharge, are there any other things you're concerned about?

Patient: I don't know. Not really. Kind of embarrassing. Just the same kind of stuff, you know. You know, infections and things. My guy, he's not always—you know.

Provider: Uh huh.

Patient: I don't know, just little infections and things.

Role Play 1 (CUES) EDUARDO:

Provider: Other than the discharge, are there any other things you're concerned about?

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Patient: I don't know. Not really. Kind of embarrassing. Just the same kind of stuff, you know. You know, infections and things

Provider: Uh huh.

Patient: I don't know, just little infections and things.

Role Play 2 (NO CUES) ALICIA:

Provider: Other than the discharge, do you have any other worries or concerns?

Patient: No I'm pretty good. Think I'm pretty healthy.

Provider: No other concerns or worries?

Patient: No, I feel good.

Role Play 2 (NO CUES) EDUARDO:

Provider: Other than the discharge, do you have any other worries or concerns?

Patient: No, I'm pretty good. Think I'm pretty healthy.

Provider: No other concerns or worries?

Patient: No, I feel good.

1. **Decide if there is a patient-initiated opportunity to “squeeze” in a risk assessment.** [For STI clinics, say “a more in-depth risk assessment”—presumably they already do a risk assessment. You'll need to shift the focus away from opening lines a bit, and more towards follow-up and agenda-setting. How do you draw a patient out who is not offering information, how do you set the context for risk assessment, and how do you follow the lead of a patient who is indicating some concern?] In other words, if the patient is expressing some cue that would be a natural opening into the risk assessment questions, find it and figure out how you might respond to the cue. (What cue do we MOST OFTEN rely on to clue us in to a problem? SYMPTOMS. We'll get back to this in a minute.) [For STI clinics, say first decide if the patient is expressing concerns that you need to follow up on. Find it and figure out how you might respond to that cue.]
2. **If there is, advance the dialogue by using that opening. Write on your paper how the next few lines of dialogue might go.**
3. **If there is not, try to come up with some opening lines that would introduce the risk assessment questions in a way that would be comfortable for you and for the patient.** [For STI clinics, say, if the patient is being reticent and seems reluctant to give information, figure out some lines that allow you to put the patient at ease, and set a context that “normalizes” this process of asking questions.] Please feel free to write on the script. Your group needs to come up with a way to start into a risk assessment. In other words, what could you say next? Figure out some new dialogue that helps to advance this conversation towards risk assessment.
4. **Practice your role-play, once you have decided on the new dialogue: have one person be the patient, one person be the provider and the third person can be the note-taker.**

Trainer can facilitate groups individually; allow about 10 minutes.

Ask for volunteers for two groups to perform role-play—one with cues and one without. Discuss briefly.

7b. Moving from cues OR opening lines to risk assessment

In same groups of three, continue with the same role-play. Each pair should now move from the opening lines or cue to the risk assessment. Use the risk assessment tools created by the groups previously.

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Have one pair from each group perform the whole role-play.

Depending on time, have each person write down an opening line to use—if not providers, but other staff, ways that they can, in their capacity, facilitate risk assessment. Read aloud or share.

Slide 43 Opening Lines



Facilitating Risk Assessment: Opening Lines

- We ask all our patients the same questions. We ask these questions so we can understand your health better. All of your answers are confidential.
- I'm asking you these questions because I'm concerned about your health, not just today, but in the future.
- These questions can be a little bit uncomfortable, but they are important because they help me to understand your health better. Your answers will not be shared with anyone else.
- These can be uncomfortable topics, but my concern is for your health, and I'd like to help you protect yourself from some of the dangerous diseases out there.

Slide 44 Follow-up Lines



Facilitating Risk Assessment: Follow-up Lines

- What do you think is causing this?
- What kinds of things are you worried about?
- It sounds like you're concerned about something. Anything you say here is confidential.
- My concern is for your health and to help you stay healthy.
- What was going on when this started?

Hand out the opening lines cue cards, Go briefly over slides if not already suggested. **Having some good lines to rely on can really help alleviate patient nervousness about difficult topics that they will encounter if you do a risk assessment. It can really be useful to get used to saying these lines—memorize them if you have to, or practice them until they come comfortably and naturally to you—the more used you are to the idea of saying these things, the more often you'll use them.**

Slide 45 Intro slide: Agenda-setting



7c. Clearing the path ahead: Agenda-setting

Now to our third practical tactic. One of the things we've noticed that can really help smooth out difficult communication is agenda setting. We've noted that practitioners often use a skill very similar to agenda setting very well when it comes to physical exams. We've observed some stellar pap exams for first time patients: (First I'm going to touch you and my hand is going to be a little cold. I'm going to do this because I need to insert the speculum. Then I'm going to insert the speculum and you'll hear a little clicking noise because that's how this

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thing works. etc.) The provider is clearing the path, letting the patient know what's going to happen next. You can do the same thing in the history-taking part of an exam. Think of your whole visit, especially with a migrant patient, who is unfamiliar with the health care system in the US, as a first-time pap exam, and you have to talk your patient through the visit, just like you talk her through a pap exam, especially when she's never had one before.

For example: **Slide 46 (ANIMATED) "I'm kinda worried"**



Well, I'm kinda worried. I used to think I was pretty healthy, but since I came here I seem to be getting sick a lot, infections and things...
Uh oh. I need to figure out this back pain, but it sounds like there's something else going on.
Hmm, sounds like you're kind of worried about something.
Well, I just seem to be getting sick a lot. I've always got some kind of infection.
Should I tell him? It seems like he's really listening.
Since I've been here, I've had a lot of relationships with different people and I think I might be getting something from them.
Now I have to start planning
Phew, I did it, I actually said it!
Uh huh. Uh huh. Okay. Here's what we're going to do. First I'm going to ask you a few more questions to see if we can't figure out more about what's going on, and then we'll come back to your back pain. Is that okay with you?

Go through animations and discuss how agenda setting has helped the provider get back to the main issue of back pain. What other benefits can you see? What other tactics has the provider used?

Slides 47 Where is this conversation going



So, in a conversation, just like a physical exam, you can use "sign-post" language, language that provides rationales for what you are doing. It helps the patient to understand what direction you are going, and where the visit is headed.

Slide 48 Signposts



First I'm going to...
I'm going to do this because...
Then I'm going to...
I'm going to do this because...
Is that okay with you?

Slide 49: (ANIMATED) Do you use condoms?"



Do you use condoms?
Not very often really.
Yes, well sometimes.
Okay, well let's check your blood pressure.
I guess that means it's okay that I don't wear condoms all the time.

Discuss how this is an agenda-setting issue. (The provider knows where she is going, and is pursuing a goal, but has not let the patient know what that is.) . Talk about some agenda-setting statements that would help to smooth the path: and facilitate here.

For example, what if the provider had said, at the beginning: “Okay, first I’m going to ask you some questions about your sexual history. I’m asking because they will help me to understand if you are at risk for any sexually transmitted diseases. I’m going to ask you all the questions at once. Then I’d like to discuss your answers with you. Is that okay with you? What this “signpost language,” or these transitional statements do is help you get past awkward or difficult moments in the conversation.

7d. Role Play using all three practical tactics:

Okay, now let’s try to put together all three of our practical tactics, recognizing patient-initiated opportunities for risk assessment AND Creating staff-initiated opportunities to do risk assessment (using opening lines), and setting agendas, in one role play.

Slide 50 Intro slide: Combining three practical tactics



Call up two people to role-play an encounter with a client. One person plays the staff person and one plays the patient. The staff person gets to choose one person to be his/her angel.

Slide 51, 52, and 53



Recognizing Patient-Initiated Opportunities

- Has your patient expressed any cues or hints of underlying concerns?
- Is your patient hesitating, using vague statements or fractured language?
- Are there follow-up questions you can ask when you hear a cue or a hint, like hesitation, from your patient?
- Can you help your patient clarify vague or fractured language?



Creating Staff-Initiated Opportunities

- Are there routine questions in the chart form?
- Is there anything on the medical history form that may alert you to risk?
- Can you use a standard opening line?



Clearing the path ahead: agenda setting

- Where is the conversation going?
- Can you help your patient understand the direction of your thoughts by using phrases like, "First I'm going to... And then..."?

Tell the players: Play an encounter with the client and include a risk assessment using all three practical tactics. To the patient: be a little bit hesitant to give information. To the clinician: if you get stuck, you can ask the angel for some help in using the skills that we talked about today.

Debrief questions: How did that feel for you as the staff person? As a patient, how did that feel? To the group: what did you notice? Did she use any opening lines? Did she initiate the conversation about risk? How did she use agenda setting? How did the patient react?

Who else wants to do it?

Slide 54: Intro slide: Linking assessment to education



8. Linking assessment to education: What does the patient need to know?

Premise: Asking the risk assessment is an important first step—it allows you to determine the patient's risk. But the patient may need an explanation of the questions so that he or she can also understand his/her risks.

Ask for a volunteer staff person to participate in a role-play. Tell all the others that they are to pretend that they are the patient too, though only one person will actually be there. Staff person can answer in any way.

Have you eaten cheese more than three times in the past week?

Did you use a fork to eat your cheese?

How often do you eat cheese without a fork?

Have you ever eaten cheese and bread together? How many times?

Good, okay well, now I'm going to check your blood pressure.

Ask the audience:

- What is the staff person concerned about? Why is she asking these questions?**
- What should the patient continue to do or not do?**
- What is the patient at risk for, if anything? Is it serious?**

Our experience has been that you may need to state clearly that this is an imaginary disease--

In fact this is the deadly cheese disease. It causes a serious infection in two circumstances: if you eat it with your hands, or if you eat it with bread. You can actually eat as much cheese as you want as long as you eat it with a fork and not with bread.

As a group, make a list of basic information that the patient needs to reduce Hep risk. Can't assume that patients know this information. Hepatitis is not yet in the public's awareness, the way HIV is. [Refer to SC Hep form in resources.](#) The list should include the following:

- Hep is infectious. It can be transmitted to you, or by you, if you have the infection
- It is transmitted through blood and body fluids, can be sexually transmitted
- Using condoms can prevent sexual transmission
- Using clean needles can prevent transmission
- Washing hands regularly can prevent transmission
- Hepatitis is pretty common
- Hep can be serious, even life-threatening
- You can have it without having any symptoms

Slide 55 Visualization III



9. Visit From the Patient's Eyes, part III

Visualization: ***Close your eyes and imagine yourself at the end of your clinic visit. When the exam is over, do you talk more with the clinician? Do they give you any paperwork or instructions? Do you talk with anyone else? What other stops do you make? When you walk out the door, how do you feel?***

Open your eyes. I hope that we've helped take not only Eduardo/Alicia, through a visit in which we assessed their communicable disease risks, helped ensure that they will not infect others if they do have hepatitis, and addressed any concerns or fears they had about hepatitis or other communicable diseases; but that your imaginary tour through your clinic has been helpful as well.

HepTalk Training

Wrap-Up

Description: This conclusion to the HepTalk training will give participants a chance to give some feedback on the training, as well as verbalize actions they intend to take as a result of the training. Trainers will review resources available for participants.

Time: 15 minutes

Design:

Time	Activity	Materials needed
10 min.	1. Resources	Resources to share
5 min	2. Wrap-up	

HepTalk Training Detail

Wrap-Up

1. Resources and questions.

Patient education resources to share: CDC, others.

MCN hepatitis website, other web resources.

Share other resources: best things we've found: [2 posters](#), [SC Hep C protocol](#), [NM hep immunization and testing protocol](#), others.

2.

To wrap up, I'd like each person to share one thing that you think you'll do differently in your work as a result of today's training.

Please fill out the back of your [Feedback form](#).

Thank you for your time and thoughtful consideration.

HepTalk Training Overview

Introduction

Time	Activity	Materials needed
5-10 mins	<p><u>Slide 1 on at the beginning, while people are getting settled</u></p> <p><u>Slide 2 (placeholder) Introduction</u></p> <p>1. Introductions</p> <p>A. HepTalk team members to Staff</p> <ul style="list-style-type: none"> HepTalk team members introduce themselves. <p>B. Staff to HepTalk Team</p> <ul style="list-style-type: none"> Ask each person to introduce the person next to him/her: Tell us their name, position here at the clinic, and describe something you have seen that person do to make a patient feel comfortable. 	Name tags
3 min	<p>2. Talk about your clinic</p> <ul style="list-style-type: none"> Help us remember some of the specifics of your situation here. Read list of statement, tell them: Stand up if you feel it is true. Sit if you think it is false. <p>Most of us in the room were here when the HepTalk team visited last year We have enough space. We have enough staff. Most of us have lived in _____ for more than 5 years. Most staff here have worked with migrants for 3 or more years. We have easy access to hospital care and specialized treatment referrals for our clients. We see mostly migrants/immigrants. We see a few migrants/immigrants. We see more and more migrants/immigrants. Our clinic has plenty of money. We have enough bilingual staff. Most of our patients speak English. X (illness or health care problem) is our biggest patient concern/illness. We've seen some of the same patients for many years. On the whole, we drink lots of coffee. We've had some of the same staff for many years. [Add one or two more characteristics of this clinic if needed]</p>	Flip chart and markers
2 min	<p>3. Describe purpose: of HepTalk Project and of afternoon training</p> <ul style="list-style-type: none"> Powerpoint Slides: Describe HepTalk and goal of training <p><u>Slide 3 Description of HepTalk</u></p>	Laptop, projector, powerpoint presentation

<p>Slide 4 HepTalk Concepts</p> <p>Slide 5 Baseline visits/</p> <p>Slide 6 Position Paper, Sharing materials, best practices and information, listserv.</p> <ul style="list-style-type: none">• Pass out participant packet. Explain: On the right are handouts, on the left are resource materials which we will review at the end of the session.• List serv form.• Feedback Form <p>Slide 7 Agenda for the day: Our goal - to help find ways to integrate hepatitis risk assessment and prevention into your clinic system.</p>	<p>5 slides</p> <p>Participant packets</p> <p>Listserv signup sheet</p> <p>Feedback Form</p>
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HepTalk Training Overview

Migration Health Basics

Time	Activity	Mat. needed
5 min	<p>1. Talk: Migrant Health Basics</p> <p>1. Powerpoint Slides Migration Health Basics</p> <p>Slide 8 Intro slide</p> <p>Slide 9 Migrants: A Changing Definition</p> <p>Slide 10: In addition to agriculture: Portraits of Migrants</p> <p>Slide 11, 12, and 13 Mobility, Barriers to Good Health Care and Hepatitis Risk</p> <p>Slide 14 Activity Intro slide</p>	<ul style="list-style-type: none"> Laptop, projector, powerpoint presentation 11 slides
15 min	<p>2. Activity: Possibilities Exercise</p> <ul style="list-style-type: none"> Explain: Sheets have possible activities to alleviate barriers to good health care for migrants and recent immigrants. Review each activity and clarify if necessary. Explain: Rate each activity by whether you think that your clinic could do it: Slide 15 traffic light <ul style="list-style-type: none"> Red = No Way Yellow = Maybe Green = Absolutely (or if you already do this) Blank sheets: If you think of another activity, write that down to be rated. Discussion: Look at which ones have mostly green, which are yellow, and which have the most red. Put in spectrum if useful. Say: Are there any ways that you have thought about today, or thought about in a new way today to help migrants/recent immigrants have better access to clinic system? 	<ul style="list-style-type: none"> Sheets titled with possible activities <ul style="list-style-type: none"> Tape Green, red and yellow dot stickers
10 min	<p>3. Activity: Translation Role Plays and Discussion</p> <ul style="list-style-type: none"> Slide 16 (placeholder) role play Explain: we're going to do two role plays, one right after the other. For the first part of this activity, all we want you to do is watch and take some mental notes about what you observed. Note any differences you think there are between the two roleplays. Introduce SPI as patient and ask for volunteer "provider;" you will be translator, hand out scripts for volunteer, SPIr and yourself. Role Play: poor translation situation Role Play: good translation situation Discussion – what did you notice? How did these differ? Which scenario do you think was most useful? What can you do in your clinic? Slide 17 Eye contact slide: two simple things will help your patient feel listened to. 	<ul style="list-style-type: none"> Scripts

HepTalk Training Overview

Hepatitis Overview

Time	Activity	Materials needed
15 min	<p>Slide 18 Intro slide</p> <ul style="list-style-type: none"> Slides 19 (Hot topic) 20 (Hep and Immigrant populations) and 21 (Hep B geography) Slide 22 (placeholder A B and C) <p>1. Hep Basics Quiz</p> <p>Pass out answers to questions—Ask them to put the answer on the question posted on the wall that matches it.</p> <p>Refer to quick facts handout (quiz key).</p>	<p>Laptop, projector, powerpoint presentation: 6 slides Hepatitis quiz answer cards, Hep Quiz questions on wall.</p>
10 min	<p>2. Oasis Video Clip</p> <ul style="list-style-type: none"> Introduce video. One of the other CDC hepatitis prevention grantees in our group has developed some excellent patient education videos about hepatitis C. We thought they were so good that many clinicians would find them helpful as well. OASIS is a clinic in Oakland, CA that provides Hepatitis C treatment. They primarily serve multi-ethnic drug and alcohol users, and these videos are from that perspective. <p>The other three short videos from O.A.S.I.S. are also very good, and we have included them in your clinic packet.</p>	<ul style="list-style-type: none"> TV, DVD player, Oasis DVD

<p>15 min</p>	<p>3. Hepatitis risk assessment basics: Group list-making. (large group) Listing and discussion: Protective behaviors you'd like to see</p> <p>Okay let's quickly review some of the risk factors we're worried about in our Hepatitis Basics quiz, You have the basics in this handout:</p> <p>Refer to Handout hepatitis A, B, C</p> <p>Let's look in a little more detail in this diagram:</p> <ul style="list-style-type: none"> • Venn diagram powerpoint slides 23 • Go through Venn slide animation and Refer to Venn diagram handout. in packet. • Brainstorming Exercise: On wall, 3 big sheets of paper with A, B and C and "Protective behaviors we'd like to see" • Brainstorm behaviors we want to encourage for each one. <p>Have them get up and write at least one protective behavior they would like to see. (Can also do as group with trainer as scribe.)</p> <ul style="list-style-type: none"> • Discuss. Look at what is on lists, what is not, etc. <p><u>We think effective risk assessment will not add time to your clinic procedures, but help streamline them. So our goal is to focus on the most important pieces of information we need to help determine risk and make a plan to incorporate the best questions into your existing clinic procedure.</u></p> <p><u>Hepatitis A, B and C - many of the same risk factors for other communicable diseases, this information should be useful for a risk profile for more than just hepatitis.</u></p> <p>Refer to resources in participant packets—HepQuick - for use in exam rooms.</p> <p>MCN position paper on hepatitis and mobile populations, with specific issues and recommendations specific to migrants and recent immigrants.</p>	<ul style="list-style-type: none"> • Three flip chart sheets- hep A, B, C basics • Blank sheets topped Protective Behaviors for ABC sheet (2 sheets for each) • Markers-enough for each participant
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HepTalk Training Overview

Effective and Efficient Risk Assessment and Follow-up

Time	Activity	Materials needed
3 min	<p>Slide 24 Intro slide</p> <p>1. Walk in Patient’s footsteps: Part I of Visualization, Flow Map</p> <p>Intro module (‘meat’ of the afternoon: take breaks on your own)</p> <p>Slide 25 Walk in the patient’s footsteps</p> <ul style="list-style-type: none"> • Guided visualization—your clinic through a patient’s eyes. (large group) (first part of visit) <i>Close your eyes and imagine yourself walking in through the clinic doors. Imagine the first things you notice and see. Think about who you first talk with. Imagine that you are a new patient. Visualize which forms you will be given, and imagine yourself filling out the questions that are asked on those forms. Imagine where you will sit to do this. Imagine that some questions are hard for you to answer and how long it might take. After you turn in your forms, imagine how long you will wait. Think about who calls you from the waiting area and where you go next. How does this first interaction set the tone for the rest of the visit?</i> • Statement on Public Health Perspective - Open your eyes. This imagination exercise is not about quality customer service, in the traditional sense. Think about what you imagined from a public health perspective: our concern in this session is on communicable disease. We want to ensure that some one who is at risk for a communicable disease is tested, immunized, or treated, so that these diseases are not spread. We will come back to this imagined visit a little later. 	<ul style="list-style-type: none"> • Flip chart, markers • 2 Ppt
15 min	<p>Slide 26 Intro slide</p> <p>2. Whole group discussion of opportunities to do risk assessment:</p> <ul style="list-style-type: none"> • Define Risk Assessment for this: We are looking at hepatitis and communicable disease in this project, <u>but we are interested in how your clinic does risk assessment overall: questions that are asked about risks such as a family history of certain diseases, about behaviors that put you at risk for poor health--from smoking to lack of exercise to multiple sex partners and drug use.</u> • Slide 27 Blueprint Slide • Slide 28 Who does what where? • (Large group) trainer as scribe: List client stops with staff from front door to exit: reception, waiting room, etc. 	<ul style="list-style-type: none"> • Flip chart, markers • Blueprint handout • 3 ppts

	<p>⚠ Then ask: where do you do risk assessments/who does risk assessments? (Check each stop where there is an assessment done or use different colored markers for where it is done and where it could be done.)</p> <p>Discuss: <u>Where in this flow is the risk assessment and education built-in, or routine?</u> Where is risk assessment and education an in-the-moment opportunity? Again Mark with different colored asterisks</p> <p>Note if they don't know what each other does. Do you have any suggestions about how to address that? Suggest observations.</p> <ul style="list-style-type: none"> • Refer to Blueprint Handout on how clinics fit in risk assessment. <p>This diagram shows some ways clinics have fit in risk assessment during the clients' visits.</p>	
10 min	<p>Slide 29 Intro slide</p> <p>3. Patient educational materials review:</p> <p>We hope brochures will</p> <ul style="list-style-type: none"> • prompt questions, • begin or reinforce behavior change, • provide more detailed information later • facilitate risk assessment <p>Example: Hep C – no risk factors, saw a sign, asked for testing and was positive.</p> <p>How do you use patient education materials well here?</p> <p>In pairs or small group takes a sample piece, identifies an effective use of that piece and if/where in their clinic it could be used. (pairs or groups)</p> <p>Slide 30 What do you like about it, what don't you like about it? How could you use it in your clinic?</p> <p>(Prompt on last question for location and "methodology" (ie, read it with, give to take home, etc.)</p> <p>Refer to Handout: best uses of patient education materials (large group)</p>	<ul style="list-style-type: none"> • Examples of effective patient educational materials and signage. • 2 ppt
15 min	<p>Slide 31 Intro slide</p> <p>4. Charting and Forms exercise: efficient and effective risk assessment.</p> <p>Intro: Risk Assessment Form</p> <ul style="list-style-type: none"> • When risk assessment questions are on the forms, they get asked. • Makes sensitive topics less awkward: we ask everyone these questions. • A place to document risk reduction plan and education reminds staff to do it. <p>Slide 32 Charting Exercise</p> <p>Refer to Chart Forms: Some basic recommendations Handout Compare to your forms.</p> <p>Slide 33 Headings</p> <p>These sample risk assessment questions also illustrates clear simple language and asking direct questions that get quickly</p>	<ul style="list-style-type: none"> • Hepatitis Charting Hints handout • This clinic's forms 3 ppt

	<p>to the risk issues.</p> <ul style="list-style-type: none"> • Small groups: Give each trio a copy of this clinic’s forms, plus some good examples from other clinics. Discuss in small groups what you like about your forms. What’s different? • Large group: Each group reports back. Discussion as time and interest allow. 	
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<p>3 min</p>	<p>Slide 34 Intro slide</p> <p>5. Part II of Visualization</p> <ul style="list-style-type: none"> • Guided visualization—your clinic through a patient’s eyes. (large group) (exam room part of visit) <i>Close your eyes and imagine yourself as a patient again, in the exam room. Imagine how long in the exam room for the clinician Notice what is in the room and how it strikes you. Imagine what you discuss when the provider arrive. Visualize whether or not your discussion feels comfortable and whether or not it is rushed, too long, or just right. Imagine that your primary concern is one that makes you uncomfortable. Does the clinician ask questions that lead you to discuss the problem, or do you bring it up?</i> <p>Open your eyes. From a public health perspective, we want to make sure that some one who is sick or infected gets treatment to stay as well as possible. We want to make sure that some one who is not infected, but just worried, has the chance to put those fears to rest, or that someone who may be infected without knowing it is given the opportunity to find out. Furthermore, we want to think not only about the client’s health status today, but also five years from now. What features of our client’s life today may affect his health in five years? Let’s talk more about the risk assessment process, and we’ll go back to our imaginary visit again after that.</p>	<p>1 ppt</p>
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<p>10 min</p>	<p>Slide 35 Intro slide 6. Who needs risk assessment?</p> <ul style="list-style-type: none"> Presenters read profile of SPI patient Eduardo or Alicia Slide 36: Profile of Eduardo or Slide 37 Alicia <u>Read first part of profile</u> while it is up on the powerpoint. Should you ask some one who is <u>not</u> presenting with symptoms or concerns about a sexually transmitted disease or concerns about their sexual history and risk profile? Would you for Alicia/Eduardo? Will you see him/her again? Discussion of why and who. (possible answers below): <ul style="list-style-type: none"> a. Public health: screen, immunize, prevent spread and outbreaks. Cue provider: prioritize exam and education; b. Cue patient: I can ask about this if I'm worried; c. Reliance on symptoms is inefficient because symptoms that may cue you to ask often don't appear until the person has been infected for many years d. Encourage appropriate concern and behavior: asking about condom use every time, partner's partners, etc. implies that this is important.) <p>Discussion of why you might <u>not</u> do an assessment:</p> <ul style="list-style-type: none"> risk assessment questions may make the patient uncomfortable, there may not be a "natural" opening in the dialogue, it feels awkward it may seem difficult to fit everything in. <p>Slide 38 Ed cont. or 39 Alicia cont.</p> <p>Here is some more information. This is info that neither patient is likely to volunteer. What risk questions would you have needed to get this info? If you saw A or E this morning, were you able to access this info?</p>	<p>5 Ppt slides</p>
<p>60 min</p>	<p>Slide 40 Intro slide</p> <p>7. Three Practical Tactics</p> <ul style="list-style-type: none"> We're going to suggest three tactics for conducting an effective risk assessment. Recognizing patient openings, using standard, normalizing opening lines, and setting agendas with the patient can help overcome the reasons for not doing a risk assessment. <p>7a. Slide 41 Intro slide 2 Role plays: Recognizing Patient-initiated opportunities for risk assessment AND Creating staff-initiated opportunities to do risk assessment (using opening lines).</p> <ul style="list-style-type: none"> Hand out scripts to groups of three. Say that the scripts begin from the same moment in a provider/patient interview. Then there are some slight differences, but the tasks for each group are the same: 	<p>7 Ppt slide</p> <p>2 sets of Written scripts one with cues, one without.</p>

- **Decide if there is a patient-initiated opportunity to “squeeze” in a risk assessment. In other words, if the patient is expressing some cue that would be a natural opening into the risk assessment questions, find it and figure out how you might respond to the cue.**
- **If there is, advance the dialogue by using that opening. If there is not, try to come up with some opening lines that would introduce the risk assessment questions in a way that would be comfortable for you and for the patient.**
- **Please feel free to write on the script. Your group needs to come up with a way to start into a risk assessment. In other words, what could you say next? Figure out some new dialogue that helps to advance this conversation towards risk assessment. Practice your role play, once you have decided on the new dialogue: have one person be the patient, one person be the provider and the third person can be the note-taker.**
- Trainer can facilitate groups individually; allow about 10 minutes.
- Ask for volunteers for two groups to perform role play—one with cues and one without.
- Discuss their decisions, ideas etc.
- Hand out the opening lines cue cards

7b. Moving from cues OR opening lines to risk assessment

- In same groups of three, continue with the same role play. Each pair should now move from the opening lines or cue to the risk assessment. Use the risk assessment tools created by the groups previously.
- Have one pair from each group perform the whole role play.
- Depending on time, have each person write down an opening line to use—if not providers, but other staff, ways that they can, in their capacity, facilitate risk assessment. Read aloud or share.

• Slide 42 Opening Lines

Slide 43 Follow-up Lines

Slide 44 intro slide

7c. Clearing the path ahead: Agenda-setting

- Slide 45 “I’m kinda worried” Note: This slide is animated
- Go thorough animations and discuss how agenda setting can help you get back to the main issue of back pain
- Slides 46 Where is this conversation going
- and 47 Sequence of First I’m going to, I’m going to do this because, etc.
- Slide 48 How would you solve this agenda-setting problem?

15 min	<p>Slide 49 intro slide</p> <p>8. Linking assessment to education: What does the patient need to know?</p> <ul style="list-style-type: none"> • Do a role play where the provider is asking the pt a set of risk assessment questions for an invented disease, ends the risk assessment and moves on to the next topic. • Ask the audience: <ul style="list-style-type: none"> ▪ What is the doctor concerned about? Why is she asking these questions? ▪ What should the patient continue to do or not do? ▪ What is the patient at risk for? Is it serious? ▪ • As a group, make a list of basic information that the patient needs to reduce Hep risk • 	<p>1 ppt slide</p> <p>Role play text</p> <p>Flip chart</p>
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4 min	<p>Slide 50</p> <p>9. Part III of Visualization</p> <p>Guided visualization—your clinic through a patient’s eyes. (large group) (final part of visit) Imagine that you are finished with your visit. You’re walking out of the exam room. You may have lots of different feelings: imagine what these might be. Maybe you have one final stop at the check-out desk, to pay a fee or to make another appointment. Notice if your worries and concerns addressed Maybe there are some questions you wish you’d asked Visualize the person you’d feel comfortable calling on to answer them. Maybe there is something you notice on the way out the door, or maybe you are just anxious to move on. Imagine what you are carrying with you. What will you remember?</p>	<p>1 ppt slide</p>
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HepTalk Training Overview

Wrap-up

10 min.	1. Resources <ul style="list-style-type: none">• Patient education resources to share: CDC, others.• MCN hepatitis website, other web resources.▪ Share other resources: best things we've found: 2 posters, SC Hep C protocol, NM hep immunization and testing protocol, others.	
5 min	2 Wrap-up <ul style="list-style-type: none">▪ To wrap up, I'd like each person to share one thing that you think you'll do differently in your work (or "that you will take away from the training today") as a result of today's training.▪ Please fill out the back of your Feedback form.• Thank you for your time and thoughtful consideration	<ul style="list-style-type: none">• Resources to share