

PROGRAM COMPONENTS

THE MOVERS, SHAKERS & DOERS: GETTING BUY-IN

Our STD program wants to offer hepatitis B vaccine. Whom do we need to convince that this is a worthwhile activity?

OUR PATIENTS ARE AT RISK. HOW DO WE GET THIS UP AND RUNNING?

While every public health agency, STD clinic or community clinic is different, there are usually some common organizational features. For example, most health delivery systems have medical and administrative directors. Your particular organization may have an elected board of supervisors or an appointed health officer. Your community may have a very active healthcare coalition comprised of political leaders, healthcare professionals, and consumers.



Whatever the situation, you will need to be familiar with the rules and regulations of your particular organization (or find someone who knows the ropes and is willing to guide you) to assure that you get required approvals and keep everyone appropriately informed. While this may sound removed from the actual task of administering a dose of hepatitis B vaccine, it is absolutely necessary if you hope to add this service and make it part of the standard of care in your organization.

Possible Key Players

- Medical Director
- Administrative Director
- Health Officer
- Board of Supervisors
- Community Healthcare Coalition

WHO SHOULD TAKE THE LEAD?



This will vary from site to site. It may be a collaborative effort between the Chief of the STD Program and the Chief of Immunizations, or it may be a community coalition that initiates the idea of delivering vaccine in the STD clinic and the pursuit of funding for that activity. But there needs to be one individual identified as the lead person to coordinate efforts and keep track of all activities.

Individuals up and down the chain of command need to be kept informed of plans to initiate a new service in the clinic. Whether that requires a face-to-face meeting or merely a memo describing the planned activity will depend on the local organizational and procedural policies. If your activity will involve any collaborations with outside agencies, you need to include representatives from those agencies at every stage and keep lines of communication open.

There are many resources available to assist in all stages of the planning and implementation process. One of the first agencies to approach is the CDC's Division of Viral Hepatitis, Division of STD Prevention, or National Immunization Program. They can provide valuable technical consultation and put you in contact with sites that have successfully implemented hepatitis B vaccination in their STD Clinic or other clinical site. Additionally, your State Department of Health is an essential resource with which you

want to forge a strong alliance. Also, check out the Immunization Action Coalition's new website **to find a list of programs that are up and running.**

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: www.hepprograms.org :
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Possible Leaders:

- STD Chief
- Immunization Chief
- Community Leader
- Medical Director

WHO WILL PAY FOR THIS ACTIVITY?

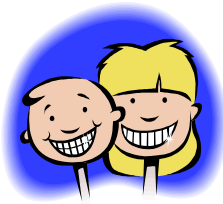
It is unfortunate that the issue of funding raises its ugly head so early in the implementation plan. But anyone with experience in public health knows that until this question can be answered, an organization cannot move forward in pursuing the initiation of vaccine delivery in the STD clinic. Also, the answer to this question may determine who the organization's collaborators will be and how much input they will want into the actual implementation.



The following information addresses only the actual cost of vaccine. It is assumed that you will be using your existing staff. If you plan to hire staff specifically for the delivery and tracking of hepatitis B immunization, additional funding and "approvals" within your organization (including such detail as where the staff will sit and who pays for their paper clips) will be necessary. We have found that existing staff can integrate this service into the clinic routine shortly after gaining familiarity with the procedures.

It's time for a quick course called "Publicly Funded Immunizations 101." There are several public sector sources of funding for vaccines, federal and state, as well as local (city or county).

THE VACCINES FOR CHILDREN (VFC) PROGRAM



The VFC program provides funding for hepatitis B vaccines and other vaccines to a wide range of providers for eligible children/adolescents who are 18 years of age or younger and:

- Medicaid eligible (Medi-Cal and Child Health and Disability Prevention Program (CHDP) eligible in California); or
- Uninsured (do not have health insurance); or
- Are American Indian or Alaska Native

VFC-provided vaccine can also be administered at nonprofit community health centers to children who have health insurance which does not cover vaccines. To become a VFC provider, contact your local immunization program.

AT A MINIMUM:

Under VFC, every STD clinic can offer hepatitis B vaccine to all clients under 19 years of age

<http://www.cdc.gov/nip/vfc.htm>

FEDERAL 317 GRANT FUNDS

This is the traditional federal funding for public health vaccines, other than VFC; some states may also allocate certain general funds for vaccine purchase. Public health department clinics use this source of funding to vaccinate children who do not qualify for VFC vaccine. In general, these public sector funds are not used for purchase and support of adult vaccination in settings such as an STD Clinic. Childhood immunizations are clearly the priority for these funds.

If you do receive HBV vaccine through VFC or 317, you will need to comply with the accounting and administration rules and regulations of those funds. One important rule is that you cannot charge for the actual dose of vaccine in your clinic, although it is permissible to charge a dose administration fee.

It is worthwhile to contact the state or local health department Immunization Program to pursue the allocation of 317 vaccine funds for adult hepatitis B vaccine. Some limited funds may be designated for a pilot or demonstration project. Even if they are not, it is important to keep in contact with the Immunization Program which can provide excellent technical/legal information and guidance in starting up a new program.



Local public sector agencies, such as a county or city health department may be eligible to obtain vaccines at a reduced cost by accessing the existing federal purchase contract. This is the best vaccine purchase price.

OTHER POTENTIAL FUNDING SOURCES

Local civic organizations or **foundations** may want to support HBV immunizations. Knowing they will receive reports with clearly understood

Possible (Local) Funding Sources:

- Civic Organization
- Foundation
- City or County Government
- HIV Prevention Programs

accomplishments, such as number of doses dispensed and number of individuals who completed the vaccine series, may make such a proposal attractive to them. National foundations may also be approached, but you will be competing with significantly higher numbers of proposals. Also, a local funding source allows an inside track and ample opportunities to foster an ongoing relationship.

Your local government entity, whether county or city, may view the cost of hepatitis B vaccine as a necessary expense of running a STD service. If the medical experts and providers in your community view this as a “standard of practice” for high-risk populations, it may be included in the general budget just as is the cost of treating syphilis and gonorrhea.

There may be bulk purchase options available as a governmental agency. If you join or form a coalition of agencies in your state or region, your agency may be eligible for purchase under the federal contract pricing. A portion of the cost of vaccine purchase could be offset by charging a nominal per dose fee within your clinic — a charge of five dollars per dose may not be out of line for most patients, and would certainly help defray costs.

Top Level Buy-in



Vaccine Supply Secured

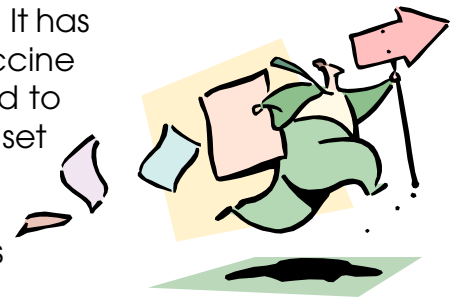


Creative approaches to supporting adult vaccines are needed. Ultimately, if enough demand is put on federal, state and local funding sources there may be a shift in policy toward public sector support of adult hepatitis B immunization for high-risk individuals. However, this is a long-term goal and until it is achieved, every conceivable funding strategy should be explored.

WHAT'S NEXT?

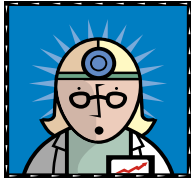
So far, so good. All the Movers and Shakers in the organizational chain think hepatitis B vaccine should be offered in the STD Clinic. Vaccine has been secured for twelve months. It has even been approved that a five dollar vaccine charge (which can be waived) will be added to the fee ordinance and any revenue will be set aside for future vaccine purchase.

While it may seem that most of the challenges have been met, some of the biggest hurdles are just to be overcome, by the Doers!



WHO ARE THE DOERS?

Every site will have its own list but most include:



Clinical Staff

- Doctors
- Nurse Practitioners
- Nurses
- Counselors

Management

- Program Manager
- STD Clinic Manager
- Immunization Manager

Clerical Staff

- Receptionist
- Back Office Support
- Data Entry



Other Departments

- Supply Center
- Immunization Program
- Health Education
- Information Technology



The support and cooperation of these staff members (and maybe some that will be unique to your facility) is necessary to institute hepatitis B vaccination in an existing clinic.

Of course, how these individuals are initially informed of the impending activity will differ by location. Certainly, by the time upper level approval has been gained and a supply of vaccine secured, many of the Doers will have heard about the plan — news travels fast and not always accurately in any large organization.

ONE MORE ACTIVITY

Ideally, mid-level managers and supervisors will have been kept informed of the plan to offer vaccination and will be able to answer the questions and concerns that their staff members raise. A combination of meetings and follow-up written communications is usually an effective way to assure that everyone gets the same information. The follow-up written communication (memos, posters, etc.) is essential to guarantee that everyone is on the same course — it will also be useful documentation in the development of policies and procedures.



Unfortunately, in today's workplace reality of staff reductions and expanding job duties, new activities are often seen as a burden rather than a new opportunity. The frontline clinic staff, both medical and clerical, will be most heavily impacted by this activity and will need to receive a lot of positive reinforcement that this is a worthwhile and important service. As soon as possible, representatives from each group (management, clinical, nursing, clerical etc.) should become involved in working meetings to discuss issues such as:

- ◆ Will all patients be offered vaccine, or only a select group?
- ◆ Will vaccine be offered every day or only during designated times?
- ◆ What paperwork is necessary for this activity? (The answer may depend on who supplies the vaccine, but at least the clinic will need to get some type of informed consent signature).
- ◆ Who is responsible for tracking vaccine usage?
- ◆ How will tracking be done?
- ◆ Can patients just come in for vaccine or does it need to accompany a STD related examination?

The more the staff believes that their input is valued, the easier it will be to implement the program. While not every decision can or should be open to discussion, clinic staff members are very knowledgeable about the problems and barriers that will need to be addressed. Achieving their buy-in (which often begins with the support of one or two key staffers) is essential to successful implementation.



All of these factors lead to the next major topic: identifying and meeting training needs.

THE 4 W'S OF TRAINING: WHO, WHAT, WHY, AND WHEN

*All staff – clinicians, nurses, and clerical need training!
And don't forget the patients!
Where do we begin? Who should conduct the trainings?*

WHO SHOULD BE TRAINED?

As mentioned in the previous section, key staff should have been kept informed of the intent to offer hepatitis B vaccine in the clinic throughout the initial planning and approval stages. By the time the clinic is ready to focus on training needs, all staff should have attended meetings where information about the importance and relevance of hepatitis B has been presented.

At least two months prior to start-up, communications should be sent to all staff informing them of the implementation date and providing a schedule of training sessions. If the training sessions involve staff from other programs (such as Immunizations, HIV or an outside agency), more lead time may be needed to coordinate everything. Supervisors will need to be involved in determining which staff members attend various training sessions.



If your clinic staff have not administered immunizations for many years, or ever, you may want to include a practicum during which staff members give immunizations under observation to become “certified.” It is suggested that the vaccine series be offered to any staff not already immunized (especially the clinic office support staff). This is a way to reinforce staff buy-in, as well as providing them with a tangible personal benefit. It also educates the staff about the vaccination procedures and process; they can now speak to clients with firsthand experience. It provides ready subjects for your physicians and nurses to practice their technique. And, perhaps most importantly, it protects staff who may be engaging in high-risk behaviors but are reluctant to self-identify.

Examples of staff that need to be trained:

- Administrative
- Clinicians (includes part-time physicians)
- Nurses
- Counselors (e.g., HIV)
- Communicable Disease Investigators
- Clerical
- Case Managers
- Outreach Workers



WHAT SHOULD THE TRAINING CONSIST OF?

Materials from training courses offered in San Diego are included in **Section VI, Attachments: Training Materials**. Additionally, sample training materials from CDC can be found on their website.

www.cdc.gov/hepatitis

Not all staff members will need every training component. However, some staff members do need every component, and to have it reviewed many times!

At a minimum, all staff should receive a "Hepatitis A-E 101" training, which covers the basics of symptoms, transmission, risk activities, and disease consequences.

The following are the broad areas which should be covered:

- Hepatitis A, B, C, D & E
- Serology and testing for hepatitis B
- Vaccine issues
- Communicating with patients
- Clinic policies related to HBV vaccination
- Procedures / Forms

WHY IS TRAINING SO IMPORTANT?

The front line staff is instrumental in the success of any vaccination program, and therefore it is critical to ensure that they are properly trained on the subject of hepatitis B.



Many people find it difficult to keep straight the differences between hepatitis A, B, C, D, and E. Providing staff members with a base knowledge of hepatitis will more effectively enable them to answer patient questions on hepatitis. Countless times, patients have stated that they already had hepatitis B but when questioned how they got it the reply is, "I got it from eating bad food". Clearly the patient is confusing hepatitis A with B and the staff needs to be aware of this and be able to communicate to the patient the differences in transmission and possible outcomes.

Providing training on the serology and diagnosis of viral hepatitis is essential for all clinical staff. Clear understanding of the differences among hepatitis A, B and C is imperative. For HBV, it is even more important that medical staff be fluent with explaining acute versus chronic infection to their patients. Administrative and clerical staff do not need to be trained as thoroughly on these issues since a policy should be in place ensuring that patients with these questions will be referred to a medical professional.

Hepatitis is confusing!

Staff members must be able to explain to patients the differences between hepatitis A, B, C, D & E

FORMS, FORMS, FORMS...



The paperwork associated with any new activity always seems to be one of the greatest burdens, but whether a clinic receives federally funded vaccine or buys it directly, accounting for every dose will be required by whomever pays the bills. Informed consents, notations in medical records about administration of vaccine, reasons for a patient declining the vaccine, and appointment reminder slips for the next dose are just a few of the paper trail details involved in delivering one dose of vaccine. Multiply this by 50 or more

patient visits per day and it becomes clear that procedural guidelines, and training about following the guidelines, must be in place prior to commencement of the program.

See Section IV-A, pp. 53 for more detail on forms development. Sample forms from the San Diego Project are also located in **Section VI-Attachments:Forms**.

Paper, paper & more paper

- Informed consent
- Vaccine Information Statement (VIS)
- Notations in medical chart
- Reasons for vaccine decline
- Appointment reminder card
- Immunization record



WHEN SHOULD THE TRAINING TAKE PLACE?

Training schedules will be different for various levels of staff and also depend on the type of training required. The bulk of training should occur in the month just prior to initiation of vaccine delivery. If hands-on training (such as vaccine administration) is involved, this will necessitate longer lead-time.

It is suggested that a training schedule be made available to staff (and supervisors) as early as possible, since lead-time is crucial to pulling staff away from essential duties. Invariably, trainings should be repeated to ensure that all staff members are given an opportunity to attend.

Within the first month of vaccine delivery, discussions on these issues should be held at regular staff meetings, thereby determining if any additional training sessions are needed. Again, this will vary at each site and is dependent on factors such as staff turnover, changes in policies and procedures, and other clinical priorities.

A final word on training...

It never stops!

REFRESHER CLASSES

Day-to-day procedures, seemingly well entrenched in the minds and hearts of all staff, fall by the wayside. It is human nature that familiar activities are often performed on “automatic pilot”. Small slips in procedure one day are carried forward to the next day; new staff is trained in less than perfect fashion; and information is miscommunicated, misunderstood and perpetuated.

Regular refresher courses should be planned for all staff members (at least annually). Staff should be given a role in planning and leading the trainings, and the sessions should be challenging and fun. As hepatitis B vaccination is something positive and proactive that the staff is doing for the patients, so should the training sessions be for the staff.



TRAINING RESOURCES

There are a variety of resources available from health departments, universities and community based professionals. Trainings on hepatitis A-E should be available from the following divisions of local health departments:

- Communicable Disease
- Epidemiology
- Health Education
- Public Health Lab
- Immunizations

In the community, trainers can also be found at:

- American Liver Foundation
- Local hospitals and universities
- Vaccine manufacturers

Training Needs

- Annual Trainings
- Involve Staff
- Challenging
- Fun

PATIENT EDUCATION

WHAT THEY NEED TO KNOW:

- ◆ What is hepatitis B
- ◆ Why they need the vaccine
- ◆ The vaccine is safe
- ◆ Cost of vaccine



TYPES OF EDUCATIONAL MATERIALS



- ◆ Brochures
- ◆ Fact Sheets
- ◆ Vaccine Information Statement (VIS)
- ◆ Videos
- ◆ Posters
- ◆ Information Counseling

BROCHURES & FACT SHEETS:

There are several free resources for good patient education

- ◆ CDC
 - Can be downloaded from website, or
 - Ordered in quantity

- ◆ Vaccine Manufacturers
 - Call a local vaccine representative to obtain all the needed materials



- ◆ Immunization Action Coalition
 - All materials can be downloaded from their website, modified, and copied in quantity as long as the organization is acknowledged
 - Many materials are in Spanish & other languages
 - Materials for high-risk populations
 - Sexually active adults
 - MSM
 - Asian/Pacific Islander communities

www.immunize.org

CREATE YOUR OWN

If you are developing your own materials it is a good idea to test the information in a focus group setting. Obtaining feed back from the targeted population is the best way to ensure that the appropriate information is being communicated.

The reading level of your clients and language needs are important considerations when developing educational materials. Health educators are trained to understand these issues and are a great resource.

VACCINE INFORMATION STATEMENT (VIS)

All patients must read a VIS statement when receiving federally purchased vaccine. The statements are mainly designed for childhood vaccination; nevertheless, they provide all pertinent information on the vaccine, including possible side effects.



VIS statements are available through local immunization programs, the CDC, or from the Immunization Action Coalition website. The hepatitis B statement is available in Spanish and many other languages.



VIDEOS

Hepatitis B and C prevention videos that target adults are limited. The majority of available videos are directed towards adolescents and children. The videos are short (<10 min.), upbeat, and catchy. There is a charge (approximately \$30) for each video .

- ◆ **“The Silent Killer”** (9 min.) Hepatitis prevention for adults.
Hepatitis Foundation International www.hepfi.org
- ◆ **“Get The Facts, Then Get The Vax!”** For Teens (6 min.) Immunization Action Coalition www.immunize.org
- ◆ **“Respect Yourself - Protect Yourself: Teens talk to teens about liver wellness, substance abuse & hepatitis prevention”** (9 min.)
Hepatitis Foundation International www.hepfi.org

POSTERS

Vaccine manufacturers have hepatitis B posters, or you can make your own. (**See sample, Section VI-Attachments, Patient Education Materials**) Posters work well in waiting rooms where patients may not read literature that has been handed to them.

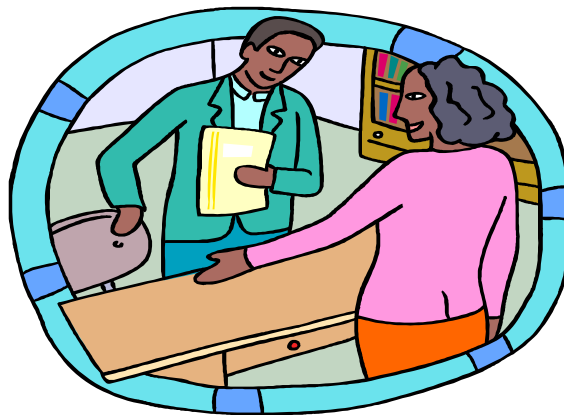
INFORMATION COUNSELING

The best type of patient education is one-on-one counseling. Patients respond better to having a service recommended by a health care professional, rather than merely reading about something they “should do.” Employing an information counselor specifically for hepatitis B may not be feasible for most clinics, but the counselor can be utilized for other services as well.



- ◆ HIV counselors can be cross-trained to discuss hepatitis A and B vaccination
- ◆ STD counselors can also discuss vaccination services
*See **Section IV-D, pp. 63** for more detail on the information counseling done in San Diego.*

- ◆ Family planning counselors should discuss STD prevention, including hepatitis B vaccination, during patient education sessions.
- ◆ Clinic nursing staff, clinicians, and others can offer patients vaccination, and if the patients have questions, staff members can give them 20-30 second messages on why they should get vaccinated now.
- ◆ Create an atmosphere in which every individual in the clinic who has contact with the clients brings up the issue of HBV vaccine. Many clients will initially think they don't want the vaccine, but will change their minds as they learn more about the benefits and safety of the vaccine.
 - In San Diego, 40% of those who started the vaccination series originally noted on their risk assessment form "no" or "not sure" when first asked if they wanted the vaccine.
- ◆ If you are offering the vaccine at no or low fee, mention the actual cost of the vaccine. Placing a dollar value on the service often makes it more appealing to the clients.



The vaccine message:
It's safe and protects against a potentially fatal disease

IMPLEMENTATION

POLICIES AND PROCEDURES



The policies and protocols should be written and made available to all staff before administering the first dose of hepatitis B vaccine. Depending on the standard practices of the particular agency, these may need to be reviewed and signed off by administrators within the organization. Or, they may be something that only the clinic medical director needs to review.

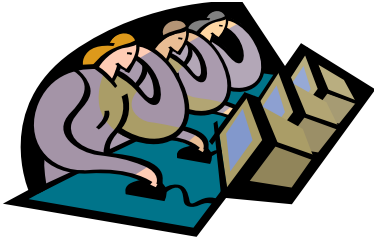
Who is responsible for writing them will also vary with each site — it may be the clinic manager, the Chief of the STD Program, a staff nurse, or it may be a group activity accomplished during working meetings. Depending on the policies and procedures already in place within the clinic, the addition of hepatitis B vaccination may require only simple amendments to certain sections of the document, or it may require a comprehensive component addressing all aspects of immunization practices.

There are a number of issues which will need to be included in your policies and procedures, including:

- ◆ Will pre-vaccination testing for prior infection be performed before the first dose is administered?
- ◆ Will documentation of prior vaccination (either complete series or doses received to date) be required?
- ◆ Will HBV vaccine be offered to all clients, to “high risk” persons, or just adolescents?

Have you thought
of this?

TRACKING



How do we keep track of patients? How do we get them to return for their next dose? The answer to these questions is dependent on many factors unique to each site. Issues such as staff resources, level of computerization in the clinic, appointments versus walk-in service, and philosophy toward client responsibility will play into how these issues are resolved. Following are some key considerations.

STAFF RESOURCES:

Ideally, the clinic will have clerical/support staff to mail or telephone reminder messages. If mail reminders are used, have the patients address their own postcards when they receive the previous dose; these could be kept in a “tickler box” by date of return and dropped in the mail at the appropriate time.



With a typical STD clinic patient population, many mailings will be returned for incorrect address. Additionally, phone calls will yield an abundance of “disconnected” or “wrong number” results. How far staff is instructed to go in pursuing more updated information from the patient will be an individual clinic decision.

KEY MESSAGES

- ◆ “It’s never too late to get your 2nd or 3rd dose of vaccine.”
- ◆ “Power to the Patient”
- ◆ “You need all 3 doses to be fully protected”

An even easier technique is to give patients an appointment reminder card at the time they receive each dose. This method puts the responsibility for remembering on the client — which may be congruent with a “take charge of your health” philosophy espoused at some clinics. The return appointment card should clearly state that if the patients misses their “appointment,” they can still get the next dose at a later date. Many patients believe that it is “too late to continue the vaccine series” if they have missed their return appointment.

IT’S NEVER TOO LATE TO GET THE NEXT DOSE!

It is vital that the clinic staff emphasize the importance of receiving all three doses of vaccine to ensure full protection. This message should be stated several times during each clinic visit. Posters on the wall and a similar message on the “next appointment” card will reinforce this fact. However, keep in mind that one dose is better than none and still provides some level of protection.

Client Sensitivity:

- ◆ Keep in mind the sensitive nature of the client visit
- ◆ Don’t use **STD Clinic** for return address or when leaving a phone message

COMPUTERS & OTHER TECHNOLOGICAL ADVANCES:

If the clinic has a computerized patient registry and management systems in place, it will be quite easy to generate lists of patients who are due or overdue for doses 2 or 3. The computer program may also be able to generate a personalized reminder letter. Staff resources will again need to be addressed, as state-of-the-art systems require some allocation of staff to extract the list or write the program which will produce letters.

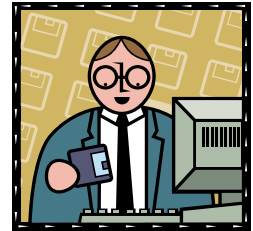


Today, automated telephone call generating systems are available. If the clinic has access to such a system, calls can be made to remind clients of their next dose appointment or that they missed their appointment.

COMPUTERIZED TRACKING SYSTEMS

◆ **State Immunization Registry**

Many states now have an immunization registry used to keep track of childhood vaccinations. If your county or city uses this system it may be possible to use it for tracking adult vaccinations. Most systems can run reports on doses given and patients that are overdue for the next dose.



◆ **VacTrac**

This program was designed by Glaxo SmithKline Pharmaceuticals and is free. It is worth a try, particularly in a clinic that does not have another tracking system. The program has report generating capabilities that include:

- Doses given
- Overdue patients
- Letter writing



WE'RE ALL ADULTS:

AKA - Do Nothing

The assumption is made that clients need to be responsible for their own health. Therefore, beyond any reminders (written or verbal) given at the last visit, the clinic staff takes no further action. The experience in pilot projects shows that at least 50% of clients will come back on their own for dose #2 and 25% for dose #3. **Others will be vaccinated for dose 2 or 3 when they return for a new STD event many months or even years later.**

Remember, there is no maximum time period between doses.

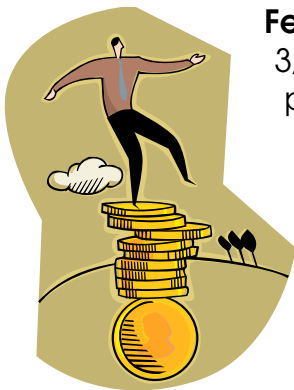
MISSED OPPORTUNITIES:

Whatever strategy is utilized for increasing vaccine series completion, one thing to be avoided is “missed opportunities.” This is a term used frequently in childhood immunization coverage studies: the patient was in the office/clinic, was due or overdue for a vaccination and walked out without it! This is really a staff training issue — all clinical staff should receive constant reinforcement to review and note every patient’s vaccination status.

Tips on AVOIDING Missed Opportunities:

- ◆ Put “consent form” in easily viewed location of chart to remind clinician to check vaccination status
- ◆ Add a hepatitis B check off box to your list of services available to patient
- ◆ Flag charts with a specific color for patients who have started the vaccine series

H A N D L I N G P A T I E N T F L O W



Feast or famine — one day no patients are returning for doses 2 and 3, while the next day the line is out the door with “vaccine only” patients and two of your nurses are out with the flu. If there was a foolproof solution to this problem, the world would be beating a path to our door. Here are some less than foolproof suggestions.

Hours/Days: If the available nursing staff is adequate, the clinic might establish “immunization days or hours” — that is, certain times that a nurse is dedicated to giving doses 2 and 3 only; clients would be instructed to return at those times if they only need vaccine (no other STD services would be available at that time.) Each clinic knows its usual patient load and can best direct dose 2 and 3 patients to the clinic’s less busy times. Giving dose 2 or 3 usually only takes five minutes once the client arrives at the nursing station.

Extended hours: Clinic hours can be extended to evenings or Saturdays, and strictly for vaccinations. This will relieve the burden during regular clinic hours.



Nursing staff: If there is additional funding to enhance staffing for this activity, the ideal use would be for an immunization nurse or licensed vocational nurse (the least costly staff permitted to give immunizations). This individual may also be able to assist with callback activities and paperwork related to hepatitis B vaccination.

FREQUENTLY ASKED QUESTIONS:



- ◆ **My patient said he received two doses of vaccine three years ago, do they still count?**

The series never has to be started over!

If the patient truly received two doses of hepatitis B vaccine three years ago, it would be appropriate to give him/her the third dose and consider the series complete.

According to medical guidelines there is no need to start the vaccine series again, regardless of how much time has elapsed between doses.

- ◆ **Do we need documentation?**

The real issue here is your clinic's policy on accepting the patient's statement if they have no documentation. It may be that the patient's verbal history would be accepted if they could give a reasonable history such as why they had the shots and approximately how long ago. From this history, it should be clear whether or not the patient is confusing hepatitis A vaccine and hepatitis B vaccine. Some clinics may decide that they would want more substantial evidence of previous doses (e.g., a vaccine record) and err on the side of giving an extra dose.

Hepatitis B vaccine is given to some members of the military but it is not a routine vaccination.

◆ **People who don't want a STD exam have heard they can get hepatitis B vaccine at the STD clinic; how do we handle that situation?**

Word will soon get out in the community that hepatitis B vaccine is available at no cost (or low cost) at the STD clinic. Clinic policy should be clearly in place from day one as to how to handle this situation. It may be necessary to institute an inflexible rule that only clients receiving an STD examination are eligible for the vaccine. To avoid public relations problems and irate clientele, *all* staff must adhere to this policy and state the rule to every walk-in or telephone inquiry. It would be advisable to post this policy in the STD waiting room where all existing and future clients can read it.

It also needs to be clarified as to what comprises a "STD exam" at the clinic. At the minimum, the clinic may require completion of a sexual history questionnaire and a urine specimen for chlamydia and gonorrhea screening.



◆ **OH NO! We gave dose #2 only 14 days after dose #1. What do we do now?**

This can happen in any clinic. The clinic's medical director should establish procedures to be followed in such instances.

Since the vaccine has not been tested and proven effective for such a short interval, it is recommended that the dose given too early be ignored. Act as if it never happened and put the patient back on the correct schedule. The patient must be informed of the error and instructed to return for the remaining doses on the original schedule.

It is trickier when the case is that the early dose is #3 and it was only 14 days early. While some medical providers believe that the dose's effectiveness will not be impacted by being administered two weeks early, the efficacy of the dose is as yet unknown. The safest route is to inform the patient and offer him or her another dose #3 at the correct interval.

If the dose has been given too early...

Is it a training issue?

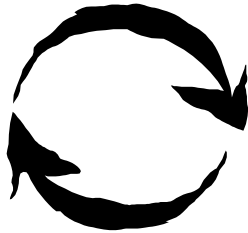
What will the clinic do to ensure this doesn't happen again?

◆ **Do we need parental consent for patients under 18 years old?**

Most states have a law that allows minors to consent for STD services. However, whether hepatitis B vaccine is considered a “STD service” is interpreted differently by everyone. Most jurisdictions consider hepatitis B vaccine as STD treatment, but to determine if minors require parental consent, check with the local authority.

Remember:
Every dose of hepatitis B vaccine given to an adult or child requires a signed informed consent that they were given the VIS statement.

ONCE THE PROTOCOL IS WRITTEN, IS THAT THE END OF IT?



The clinic protocol should be an ever-evolving document. New situations arise that need to be addressed, policies change and staff members leave. Even if none of these changes occur, the protocol should be reviewed at least once per year. Also, staff should be required to attend training or reacquaint themselves with the protocol annually, to ensure that staff members are actually following protocols correctly. Often, policies are not followed as written, so it is important to monitor practice versus policy regularly. Frequently, practices that deviate from policy prove to be a better way to do things; when this happens, the policy should be updated accordingly.

While it is hoped that no adverse event ever occurs in a clinic, the reality is that clinic protocol is a document which should accurately reflect procedures and staff responsibilities. Should an adverse event occur the protocols become important legal documents. Staff members should be encouraged to refer to the protocol in unusual situations or whenever an issue arises.

The following section, “The San Diego Experience”, will illustrate how hepatitis B immunization was successfully integrated into a well-established STD Clinical Service. Examples of data collection tools, health education materials, and training materials are included for your reference and use.

CASE STUDY

HEPATITIS B IMMUNIZATION IN A STD CLINIC

THE SAN DIEGO EXPERIENCE

