

Chapter 9

Case Management



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What is Case Management?

Case management is an organized and coordinated service delivery approach, tailoring individualized and specific services to the needs of the client in order to facilitate continued support.

The DSHS HSR PHBPP Coordinators and LHD case managers should conduct case management on HBsAg-positive mothers, their infant(s), and household contacts ≤ 24 months of age according to the PHBPP guidelines.

Case management in the PHBPP involves:

- 1) Interviewing HBsAg-positive mothers and performing tasks such as providing information (brochures).
- 2) Educating HBsAg-positive women and their families.
- 3) Making recommendations for referral.
- 4) Collecting contact information (sexual and household) for appropriate referrals.

There are varying degrees of case management and each case may require different levels of involvement from the DSHS HSR and / or LHD staff. If the mother decides to follow-up with her private physician, this is acceptable and should be encouraged. However, the DSHS HSR and LHD staff still have the responsibility of gathering all medical information from the provider such as dates of vaccine administration (if applicable) and serology testing results. There can be many challenges and obstacles to case management such as refusal of services by the client. Any problems encountered and efforts made to overcome those obstacles should be documented in the case manager's notes.

Some clients may prefer or require more direct services, which may involve home visits to administer vaccines or to draw blood for testing. These services are provided by the PHBPP at no cost to the client. Services that are available to the HBsAg-positive pregnant woman, infant, and contacts will be discussed further in this chapter.

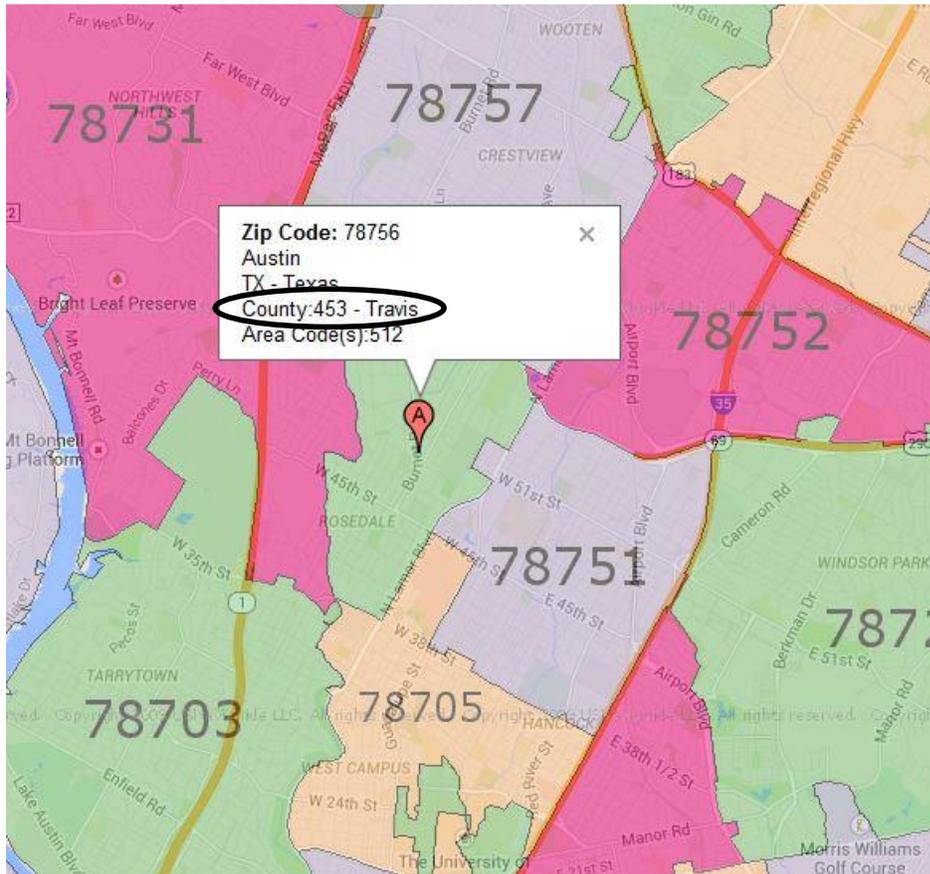
The DSHS HSR PHBPP Coordinators should review all case reports for completion prior to submission to the DSHS Immunization Branch PHBPP. Reporting forms are available at www.texasperinatalhepb.org.

Assigning a Case to the Appropriate Jurisdiction by Federal Information Processing Standards Code

The appropriate method to determine case jurisdiction is by using the Federal Information Processing Standard (FIPS) codes. FIPS codes can be found using the zip code or the patient's street address (with city) at the following website: <http://www.zipmap.net/Texas.htm>.

- Enter the zip code or street address with city and click "Find Zipcode".
- Once you click "Find Zipcode," a red balloon will be located on a map within a colored zip code.
- Click on the red balloon to display additional information.
- The FIPS code is displayed as: County: *Number - County Name*.

Please see example below. For more information on FIPS code(s) for your jurisdiction, please contact the DSHS Immunization Branch PHBPP Coordinator at (800) 252 – 9152.



As you can see on this map, the Zip Code of DSHS Immunization Branch was entered as 78756.

The information displayed and highlighted within the black oval is the information needed for assigning a case to the appropriate jurisdiction. The FIPS code displayed for Zip Code 78756 is **453**.

Assigning a Case Identification Number (PHBPP Use Only)

A new identification number (ID #) must be assigned to each pregnancy by program staff at the DSHS HSR or LHD level. This information should be documented in the top right corner of all case management forms.

The format for the ID # is: *yr/county/mother/hh###*

An ID number is assigned by using the following:

- **yr:** year client identified in the PHBPP (i.e., 2013, 2014, etc.)
- **county:** three-digit FIPS* county code
- **mother:** three-digit individual code as assigned by the case manager (this is a chronological number unique to each individual).
- **hh##:** two-digit number identifying the relationship to the mother. The mother's ID must end with "00".
 - Infant: 01 - 09 (based on current pregnancy only)
 - Contacts ≤ 24 months of age only: ≥ 10

Examples of client identification (ID) numbers

- 2014/000/001/00 – mother (index case)
- 2014/000/001/01 – infant born to HBsAg-positive mom
- 2014/000/001/10 – first contact ≤ 24 months of age
- 2014/000/001/11 – second contact ≤ 24 months of age

The Initial Record

Upon opening a case, mother's case management form should be filled out with available information and submitted to the DSHS HSR PHBPP Coordinator **within 15 days**. All forms can be found online at www.texasperinatalhepb.org. When initially submitting the form, the required information for opening a case is:

- Case identification (ID) number
- Initial report date
- Initial contact date
- Mother's full name
- Mother's DOB
- Demographics, including address
- Provider information (name and contact info)
- Estimated Date of Delivery / Estimated Due Date (EDD) or infant DOB and pregnancy outcome
- HBsAg + lab report (with confirmation)

Preferred information, but not required for initial submission of form within 15 days, is:

- Phone number
- Country of birth
- Mother's maternal grandmother's country of birth
- Planned delivery hospital
- Race
- Preferred language
- Insurance information

Contacting the HBsAg-Positive Pregnant Woman

Establishing contact and a trusting relationship with the HBsAg-positive pregnant woman is critical and is the first step in the case management process. The client should be contacted as soon as possible following identification, preferably, by phone.

Tip: *Contact the provider first to find out whether or not they have notified the client of the positive HBsAg result and provided any counseling or education. If they have not, request that they contact the client with her results and let her know that the DSHS HSR or LHD will be contacting her. Call the provider again to verify that they have notified the client.*

In order to establish a trusting relationship with the client, advise her that all information that she provides will be kept confidential as required by law. In the event that the client is reluctant to provide information, the physician's office can be contacted to provide the needed information. Remember, **client consent is not required to obtain laboratory confirmed HBsAg test results from the provider.**

Once the client has been contacted, please see further guidance in this chapter on case management of HBsAg-positive pregnant women. If you are having difficulty when attempting to contact the client for case management services, please utilize the chart on the following page for help and actions to take.

Filing System

A filing or "tickler" system should not be your main source for your case management tracking. Rather, it should complement your electronic database and reminder / recall system(s) in order to create an effective PHBPP. One file should be created for each index case (mother) and her associated infant(s) and contact(s) within the program for each of her pregnancies. It is recommended that cases be filed according to their unique case identification number (*yr/county/mother/hh#*) so that any case manager can easily access a case when necessary.

Reminders / Recalls

Due to the critical need to complete the hepatitis B vaccine series and PVST on time, reminders are required to inform parents as to when vaccinations and serology testing for their infant(s) is due. It should never be assumed that all parents use effective methods of reminders for themselves nor can you rely on the physician's office for repeated notification of appointments. In order to be effective, the system should be set up in a way that makes it easy to remind the coordinators, who can then notify clients when an immunization or test is due. A good tracking system should notify parents and providers at least one week prior to hepatitis B vaccine and / or PVST due date(s).

Systems that work best:

- Notification(s) may be in the form of:
 - Phone call(s) with messages if no answer – *preferred method*;
 - Letter(s) sent to parent(s); or
 - Computer / phone system that automatically calls patients.
- Remind / notify parents and provider one week before immunization visit(s).
- Contact provider within one day of scheduled appointment to ensure that patient received necessary vaccine(s) / PVST.
- If appointment was missed, contact parent(s) immediately to make arrangements for follow-up visit or a home visit.

Problems Contacting the HBsAg-positive mother	
Problem	Action
No answer	Make at least five attempts to call on different days of the week at different times of the day.
Phone is disconnected	Contact the physician to verify patient's contact information. Inquire as to how they are contacting her for remind / recall. Is there a cell phone number? If new number obtained, please follow steps above "No Answer." If no new number has been obtained, a first class letter should be sent to the client's home address including your contact information. Your letter should request that the client contact you directly regarding a recent health issue (do not discuss HBsAg results in letter).
No response to first class United States Postal Service (USPS) letter	Certified letter requiring a signature should be sent to the client's home address including your contact information. Your letter should request that the client contact you directly regarding a recent health issue (do not discuss HBsAg results in letter).
Certified letter returned with "Forwarding Address Requested" stamp	Certified letter requiring a signature should be sent to the client's forwarding address including your contact information. Your letter should request that the client contact you directly regarding a recent health issue (do not discuss HBsAg results in letter).
No response after certified letter sent to forwarding address	Try visiting the residence or the home to conduct a home visit and provide education. Know the patient's preferred language.
Unsuccessful home visit / no one home	Work directly with the physician's office to manage the case. Request that the physician educate the patient regarding the importance of the DSHS HSR or LHD role in preventing transmission of the virus to her infant.
Inability to contact client after exhausting all above options	Do not close as 'lost to follow-up.' If the patient cannot be contacted but you have an EDD and a planned delivery hospital, attempts must still be made to locate the infant around the time of delivery.
Client moved to another jurisdiction / state	Obtain accurate location information, complete the appropriate Transfer form and fax to the DSHS Immunization Branch PHBPP at (512) 776 - 7544. The PHBPP will forward the transfer information to the new jurisdiction.

Other methods that may be used to locate the client include:

- Contact the post office to see if there is a forwarding request for the client;
- Make a home visit to the address you've obtained, if no response to certified letters;

Tip: Find out from the physician what the patient's preferred language is to avoid any barriers when first contacting the patient.

- Contact the laboratory providing the test results for contact information on the patient; or
- Access Accurint, which is an online searchable database available to law enforcement, and government agencies. Accurint includes the postal addresses, driver's licenses, property ownership, and criminal records. To use this database you must request the assistance of the DSHS HSR or LHD Sexually Transmitted Disease (STD) program person.

A case cannot be closed as 'lost to follow-up' until all avenues have been exhausted. Additionally, the patient must no longer be receiving any known services from an OB-GYN due to the physician's inability to locate or contact the client for services. However, if the patient cannot be contacted, but you have an EDD and a planned delivery hospital (from client or physician), attempts must still be made to locate the infant around the time of delivery before the case can be closed.

Patient Education

A critical aspect of the PHBPP is patient education. It is extremely important that PHBPP staff explain to HBsAg-positive pregnant women and new mothers about the serious consequences of HBV infection (refer to Chapter 2), the lifesaving importance of hepatitis B biologics (HBIG & hepatitis B vaccine) administered to their infants, and the necessity of PVST after completing the vaccine series. The DSHS Immunization Branch PHBPP has developed educational materials for HBsAg-positive women and their health care providers. Materials can be found at www.texasperinatalhepb.org.

Case Management of HBsAg-Positive Pregnant Women

Each DSHS HSR and LHD staff involved with the interviewing of clients should explain the services provided by the PHBPP and assure the client that her medical history (including her household contacts \leq 2 years of age) will be handled confidentially by the PHBPP staff. Complete the *Mother Case Management Report* (Stock # EF11-10932). The report form can be accessed at www.texasperinatalhepb.org. It should be completed and submitted within **15 days** to the DSHS HSR PHBPP Coordinators for review who will submit the completed forms by mail or fax to:

**Texas Department of State Health Services
Perinatal Hepatitis B Prevention Program
MC – 1946
P.O. Box 149347
Austin, Texas 78714 – 9347
Telephone: (800) 252 – 9152
Fax: (512) 776 – 7544**

Every time the form is updated, it should be **immediately submitted** to the DSHS HSR PHBPP Coordinator who will send to the DSHS Immunization Branch PHBPP Database Manager. The procedures outlined below should be followed when a pregnant woman is identified as HBsAg-positive. You may receive the report from the provider, the laboratory, or through National Electronic Disease Surveillance System (NEDSS). Occasionally, positive lab results will be submitted to the health department without contact information for the client. In that case, you will have to contact the provider first to obtain that information.

- 1) Contact the provider first to obtain the following information:
 - OB-GYN medical records
 - HBsAg lab result(s) with positive confirmatory test
 - EDD
 - Planned delivery hospital
 - Vaccination history (if available)
 - Pregnancy history (if applicable)
 - Treatment(s) and/or medication(s) for hepatitis B
 - Any referrals to specialist(s) for hepatitis B
 - Face sheet showing patient's contact and insurance information
- 2) Verify that the provider has notified the client of her positive HBsAg result. Establish the client's preferred language before contacting her. Utilize translation language services when appropriate. A family member that is ≥ 18 years can provide translation.
- 3) Contact the client to obtain pertinent medical history, personal information, and type of insurance (Medicaid, private insurance, no insurance). All efforts should be made to obtain patient insurance information, otherwise; you should document the reason for not obtaining the insurance status.

Tip: *You can usually obtain insurance information from the provider by requesting a "face sheet."*
- 4) Educate client about HBV, communicability of the virus, and the importance of protecting her infant from HBV transmission through the use of HBIG and hepatitis B vaccine;

Tip: *HBV education regarding routes of HBV transmission should be done prior to requesting information on all sexual partners and household contacts.*
- 5) Services that will be provided by the DSHS HSR and / or LHD should be explained to the client and, if needed, a face-to-face visit should be arranged. If the client is unable to travel to a DSHS HSR or LHD, the PHBPP staff should conduct home visits to provide these services, only if absolutely necessary.
- 6) Provide patient educational brochure to the client (*Stock # E11-11444*) which is available through the DSHS Immunization Branch PHBPP at <https://secure.immunizetexasorderform.com/default.asp>. Ensure that all educational materials are provided in a culturally sensitive manner.
- 7) Information about the woman's alcohol and drug (illegal / non-prescription) use should be acquired in a non-intimidating manner.
 - If the patient answers yes to the use of alcohol and / or drugs, ask if she would like a referral to the nearest Substance Abuse Program.
 - DSHS funded Substance Abuse Services can be found by a County search at www.dshs.state.tx.us/treatment/ or by calling 1-877-9-NO-DRUG (1-877-966-3784).
 - If so, give a brief overview on the role of the Substance Abuse Program and the address to the nearest location in her area.

- Provide her with the brochure that describes the program and ensure that she has the needed contact information; allow the patient to make the decision on her own to call and request help from the Substance Abuse Center, unless she requests your assistance in doing so.
 - Substance abuse brochures can be obtained from your nearest Substance Abuse Program clinical site.
- 8) Refer the HBsAg-positive pregnant woman to her health care provider for further medical evaluation and appropriate health care management. Document her provider's name, telephone number, address and specialty. See further guidance under the Provider Education Section of this chapter.
- Note:** *The health care provider or the OB-GYN might refer the HBsAg-positive pregnant woman to a gastroenterologist, hepatologist, or an infectious disease specialist. Her case should still be managed regardless of which specialty is following her.*
- When the HBsAg-positive pregnant woman is being monitored for hepatitis B by a physician, information regarding supportive care and treatment must be noted in the patient's medical chart. The information must include:
 - the type of supportive care
 - treatment or antiviral agents (brand and dose)
 - date antivirals were initiated
- 9) After the initial interview with the pregnant woman, program involvement may be minimal. However, because the client may be newly diagnosed, program personnel should remain available to offer counseling or advice and to answer any questions or concerns she may have.
- 10) Notify the client's health care provider (or other specialty) of the role of the DSHS HSR and / or LHD, including the case management services that will be provided to the newborn and household contacts ≤ 24 months of age.
- 11) Complete and submit the *Mother Case Management Report* to the DSHS HSR PHBPP Coordinator **within 15 days**. This form is available at www.texasperinatalhepb.org.
- 12) Identify all household contacts who are ≤ 24 months of age, sexual partner(s), and household contacts > 24 months of age.
- PHBPP case management services should be provided for all household contacts ≤ 24 months of age.
 - All sexual partners and contacts > 24 months of age should be referred to a health care provider for follow-up and evaluation. Adult contacts without health insurance who are found to be susceptible to hepatitis B, can be vaccinated through the Adult Safety Net (ASN) Program. Please contact your DSHS HSR or LHD for additional information.
- 13) Notify the delivery hospital where the client plans to deliver her infant(s) **at least two months prior** to her estimated date of delivery.
- 14) Ensure that the hospital has HBIG and hepatitis B vaccine available in advance no less than seven days before her estimated date of delivery.

- 15) Review with the Newborn Nursery their standing orders and written policies pertaining to the administration of HBIG and hepatitis B vaccine birth dose in addition to testing the infected mother for HBsAg upon delivery.
- 16) Periodically contact the hospital (delivery unit or newborn nursery) to inquire as to whether or not the mother has delivered yet.
- 17) Once the infant has been born, complete and submit the initial *Infant Case Management Report* within **15 days after the birth of infant** to the DSHS HSR PHBPP Coordinator. This form is available at www.texasperinatalhepb.org.

Note: Case management on HBsAg-positive women with a stillbirth or miscarriage will be eligible for the program; however, they should be referred to a health care provider for health care to delay further injury to the liver. The case management report is coded as referred to medical follow-up and status code is noted as infected.

Provider Education

Patients who have acute and chronic HBV infection require medical evaluation and regular monitoring. PHBPP case managers should refer all HBsAg-positive pregnant women to medical providers for supportive and / or therapeutic treatment to prevent the progression of liver damage. If not already familiar in doing so, the provider should be educated as to:

- interpretation of serology results (refer to Appendix C);
- monitoring patients for disease progression and prevention; and
- identifying the need for specialized consultation.

If the pregnant woman's infection has been verified as being chronic, the PHBPP staff should identify available medical resources for chronic hepatitis B infections and ensure that the medical providers are trained on risk-factors for HBV infection in pregnant women, their infants, sexual partners, and household contacts; if needed, staff should train the providers. Pregnant women, infants, sexual partners, and household contacts > 24 months of age should be referred to a FQHC or a RHC for appropriate medical management if they do not already have a health care provider.

Case Management of Infant(s) Born to HBsAg-Positive Pregnant Women

Case management of infants born to HBsAg-positive women is labor intensive. Adequate case management should require no more than nine months to complete perinatal hepatitis B prevention case management services once the infant has been born (Refer to Guideline 3 in Appendix B). For children who do not adequately respond to the vaccine series and who are also not infected with HBV, case management services could take up to 17 months to complete.

- 1) It is imperative that the case manager informs labor and delivery staff (at planned delivery hospital) of the woman's HBsAg-positive status at least two months prior to her expected delivery date.
 - Staff should ensure that the delivery hospital has both HBIG and hepatitis B vaccine ready for administration to the newborn immediately after delivery (within 12 hours).

- Hospitals may order HBIG and hepatitis B vaccine directly from the manufacturer.
 - HBIG can be ordered through the DSHS Immunization Branch only in emergency situations. Please see guidelines later in this chapter.
- 2) Within 12 hours of delivery, appropriate PEP treatment should be administered. Infants born to HBsAg-positive women should not be placed in special isolation. For additional guidance on PEP and vaccine schedules, please refer to Appendix A. HBsAg-positive mothers can breastfeed their infant without delay unless there is significant breast pathology. For additional information, please refer to 'Perinatal Transmission' in Chapter 2.
- Born to HBsAg-positive woman:
 - Administer HBIG within 12 hours
 - Administer first dose (birth dose) of hepatitis B vaccine within 12 hours
 - Born to HBsAg status unknown woman:
 - Administer first dose (birth dose) of hepatitis B vaccine within 12 hours
 - If unknown at discharge, administer HBIG before discharging infant
 - If HBIG was not given before discharge and the HBsAg result later comes back as positive:
 - Administer HBIG, no later than seven days
 - If the infant has already been discharged, it is the delivery facility's responsibility to recall infant and administer
 - Discrepant prenatal and delivery HBsAg results:
 - If any HBsAg test has been positive, administer:
 - HBIG within 12 hours
 - First dose (birth dose) of hepatitis B vaccine within 12 hours
- 3) The case manager should obtain all necessary information (below) about the first dose of the HBIG and hepatitis B vaccine from the delivery hospital.
- Lot number
 - Manufacturer / Brand
 - Dose
 - Date and time of administration
- 4) Information should be documented on the *Infant Case Management Report (Stock # EF11-10931)* which can be found at www.texasperinatalhepb.org. The form must be completed and submitted **within 15 days** of infant birth to the DSHS HSR PHBPP Coordinator for review who must submit the *Infant Case Management Report* by mail or fax to:

**Texas Department of State Health Services
Perinatal Hepatitis B Prevention Program
MC – 1946
P.O. Box 149347
Austin, Texas 78714 – 9347
Telephone: (800) 252 – 9152
Fax: (512) 776 – 7544**

- 5) Before the infant leaves the hospital, discharge planning should begin. The case manager should find out from the delivery hospital which pediatrician the infant is being discharged to.

Once that information is known, arrangements should begin to ensure the timely administration of the second and third doses of hepatitis B vaccine.

- 6) Reminders should be sent to the family and pediatric health care provider to notify them when vaccines and PVST are due. For additional information, please refer to the *Reminders / Recalls* section of this chapter as discussed previously.
- 7) Infant should complete the hepatitis B vaccine series on time
 - Dose # 2: one month of age (no later than two months of age)
 - Dose # 3: six months of age

Please refer to Appendix A for further guidance on vaccine schedules. The infant should be vaccinated through his / her pediatrician. If the child is unable to be vaccinated by the pediatrician, the case manager should arrange work with the DSHS HSR PHBPP Coordinator and / or the DSHS Immunization Branch to obtain the vaccine. Infants born to HBsAg-positive mothers can receive DSHS Immunization Branch-supplied vaccine even if they receive health care in the private sector.

- 8) The immunization information should be obtained from the infant's health care provider and be documented on the *Infant Case Management Report form*. If the parents consented to ImmTrac, vaccine information can also be obtained from this system. Every time the form is updated, it should be **immediately submitted** to the DSHS HSR PHBPP Coordinator who will send to the DSHS Immunization Branch PHBPP Database Manager. Below is the information to be documented:

- date administered
- dose administered
- formulation (i.e., Pediarix®, Engerix-B®, Recombivax HB®, etc.)
- manufacturer
- lot number
- provider / clinic that administered the dose

- 9) Contact the parent or guardian by phone or mail to remind him / her about PVST at the child's nine month wellness visit.

- 10) The PVST should be performed to determine the success of PEP.

- **No earlier than nine months of age**
- **At least one to two months after completion of hepatitis B vaccine series**
- HBsAg
- anti-HBs
- Test at the next well-child visit at nine months

Tip: Request that the pediatrician and / or nurse make a note and flag the child's medical record indicating that the PVST (HBsAg and anti-HBs) is due at the next well child visit (see guidance above for timing). If an appointment date has not been scheduled, follow-up with the parent or guardian to schedule an appointment with the provider.

A release of information is not needed from the parent(s) / guardian(s) to request that the pediatrician perform PVST on the infant. Hepatitis B, identified prenatally or at delivery, is a

reportable condition and is protected under Texas statutes and rules. Because of the significant health risks posed to the infant if proper care is not obtained, a release of information is not required to release this information to the infant's care provider. Ideally, the hospital and / or DSHS HSR or LHD should notify the infant's care provider immediately after birth.

A PVST is not recommended before the age of nine months to avoid possible detection of anti-HBs from HBIG administered during infancy and to maximize the likelihood of detecting late HBV infection. Quantitative antibodies for surface antigen are preferred because they give a level of immunity with which to measure the immunity of the infant. Anti-HBc testing of infants is not recommended because passively acquired maternal anti-HBc might be detected up to age 24 months in infants born to HBV infected mothers.

The results of the tests should be recorded on the *Infant Case Management Report form* and the form should be **immediately submitted** to the DSHS Immunization Branch PHBPP along with a copy of the infant's results.

Perinatal Hepatitis B Virus Infection Case Definition

The case definition for perinatal hepatitis B virus infection is HBsAg positivity in an infant aged 1 - 24 months born in the US or US territories to an HBsAg-positive mother. An infant who is determined to be HBsAg-positive will be classified as a case of perinatal hepatitis B virus infection. Perinatal hepatitis B infection in the newborn may range from asymptomatic to fulminant hepatitis. All laboratory-confirmed perinatal hepatitis B virus infections must be reported to the DSHS through NEDSS. It is the responsibility of the DSHS HSR and LHD program staff to obtain a copy of the laboratory report, update the *Infant Case Management Report form*, and submit both forms to the DSHS Immunization Branch PHBPP Coordinator **within one working day** of notification.

Case Management of Contact(s) ≤ 24 months of age to HBsAg-Positive Pregnant Women

Household contacts are defined as persons ≤ 24 months of age currently residing in the home of the HBsAg-positive pregnant woman. Household contacts > 24 months of age and sexual contacts are not eligible for the program and should be referred to a health care provider. The *Contact ≤ 24 Months Case Management Report form* should be completed for all contacts identified who are ≤ 24 months of age and case management should be completed.

These case management procedures should be followed when a contact ≤ 24 months of age is identified as born to a positive HBsAg mother.

- 1) Educate parent / guardian on the consequences and risks of HBV infection.
- 2) Complete the *Contact ≤ 24 months of age Case Management Report Form (Stock # EF11-1093)* for each contact ≤ 24 months of age identified **within 15 days** of identification. This form, along with instructions is available at www.texasperinatalhepb.org.
- 3) Obtain vaccine and serology history on all contacts ≤ 24 months of age. A reliable vaccination history for each dose administered to complete the hepatitis B vaccine series should be obtained, if applicable. Serology history consists of a written and dated laboratory report; verbal reports are not acceptable. Case management is initiated based on vaccine results and serology history.

- If contact ≤ 24 months of age has no documentation of immunity by serology, the contact should be tested for HBsAg and anti-HBs. Once the results are obtained*, follow guidance of the following chart. HBsAg-positive results must have confirmatory testing performed.

* The contact's HBV status may be provided by phone only after confirmation of the contact's identity with multiple identifiers, if permissible by your agency's policies and procedures. Serology results should not be mailed due to possible breach in confidentiality.

Actions after 1st PVST Results			
HBsAg	Anti-HBs	Status	Action
Negative	Negative	Susceptible	Proceed to Step # 4 below.
Negative	Positive	Immune	Submit form and documentation to DSHS HSR PHBPP Coordinator.
Positive	Negative	Infected	Refer to physician for follow-up and evaluation.

- 4) If needed, ensure initiation and completion of hepatitis B vaccine series.
- 5) All updates to the *Contacts ≤ 24 months of age Case Management* form should be **submitted immediately**. DSHS HSR PHBPP Coordinators must submit reports to the DSHS Immunization Branch PHBPP Coordinator.
- 6) Perform PVST one to two months after completing the vaccine series to determine if adequate protection has been achieved with one complete series of vaccine. Please keep in mind that PVST should not be done before nine months of age.
- 7) If adequate protection was not demonstrated on the PVST, repeat the hepatitis B vaccine series and repeat PVST one to two months after completion of the second series. Be sure that HBsAg-positive results are being interpreted from confirmatory testing.

Actions after 2nd PVST Results			
HBsAg	Anti-HBs	Status	Action
Negative	Negative	Susceptible / Non-responder	Provide counseling and refer to provider.
Negative	Positive	Immune	Submit form and documentation to DSHS HSR PHBPP Coordinator.
Positive	Negative	Infected	Refer to physician for follow-up and evaluation.

- 8) Record all information on the Contact Case Management Report form. Any updates should be submitted immediately to the DSHS HSR PHBPP Coordinator.

Note: Reporting of adequate and inadequate is acceptable only if your lab is using mIUs as the measurement for anti-HBs and the cut off is < 10 for reporting inadequate anti-HBs, and ≥ 10 for reporting adequate anti-HBs. Check with your lab to be certain of results.

Case Management Report Submission Guidelines

Initial identification of cases should be submitted on their respective case management reporting forms **within 15 days** to the DSHS HSR PHBPP Coordinator.

All case management report updates must be **submitted immediately** to the DSHS HSR PHBPP Coordinator for the following events:

- Administration of *any* dose of hepatitis B vaccine doses;
- Completion of PVST;
- Any added or updated information to *any* part of the form; and
- Closure of a case.