



Bridging Science, Policy and Public Health

Introduction to NASTAD

*National Viral Hepatitis Technical Assistance Meeting
September 29, 2008*

NASTAD 101

- **History**
- **Structure and Governance**
- **Programs**
- **Viral Hepatitis Program**

NASTAD History

- **First “AIDS directors” coordinate early efforts (1982-86)**
- **CDC funds all states (1987); “AIDS director” position established**
- **Many AIDS directors responsible for other program areas (i.e. surveillance, STD, TB, communicable disease)**
- **Passage of Ryan White CARE Act (1990) and cuts in prevention funding (1991) prompt AIDS directors to organize**

NASTAD History

- **Founded in 1992; Received first federal funds from CDC in 1993 and HRSA in 1994**
- **1996 – First ADAP Monitoring Reports issued (HRSA)**
- **1999 – First Minority AIDS Initiative funds received (CDC)**
- **2000 – Budget nearly doubles with funding for global and viral hepatitis programs (CDC)**
- **2001 – MSM Call to Action issued**
- **2001 – African American Monograph issued**
- **2002 – ADAP Crisis Task Force formed to negotiate with makers of ARVs**

NASTAD History

- **2002 – Coalition for Safe Needle Disposal founded**
- **2003 – Viral Hepatitis Integration Guide released**
- **2003 – Latino policy document issued**
- **2003 – National Viral Hepatitis Roundtable (NVHR) founding member**
- **2004 – Hepatitis C Appropriations Partnership founded**
- **2004 – Viral Hepatitis Integration Guide updated**
- **2005 – African American Call to Action issued**
- **2005 – Hepatitis Advocacy Fly-in Training held**

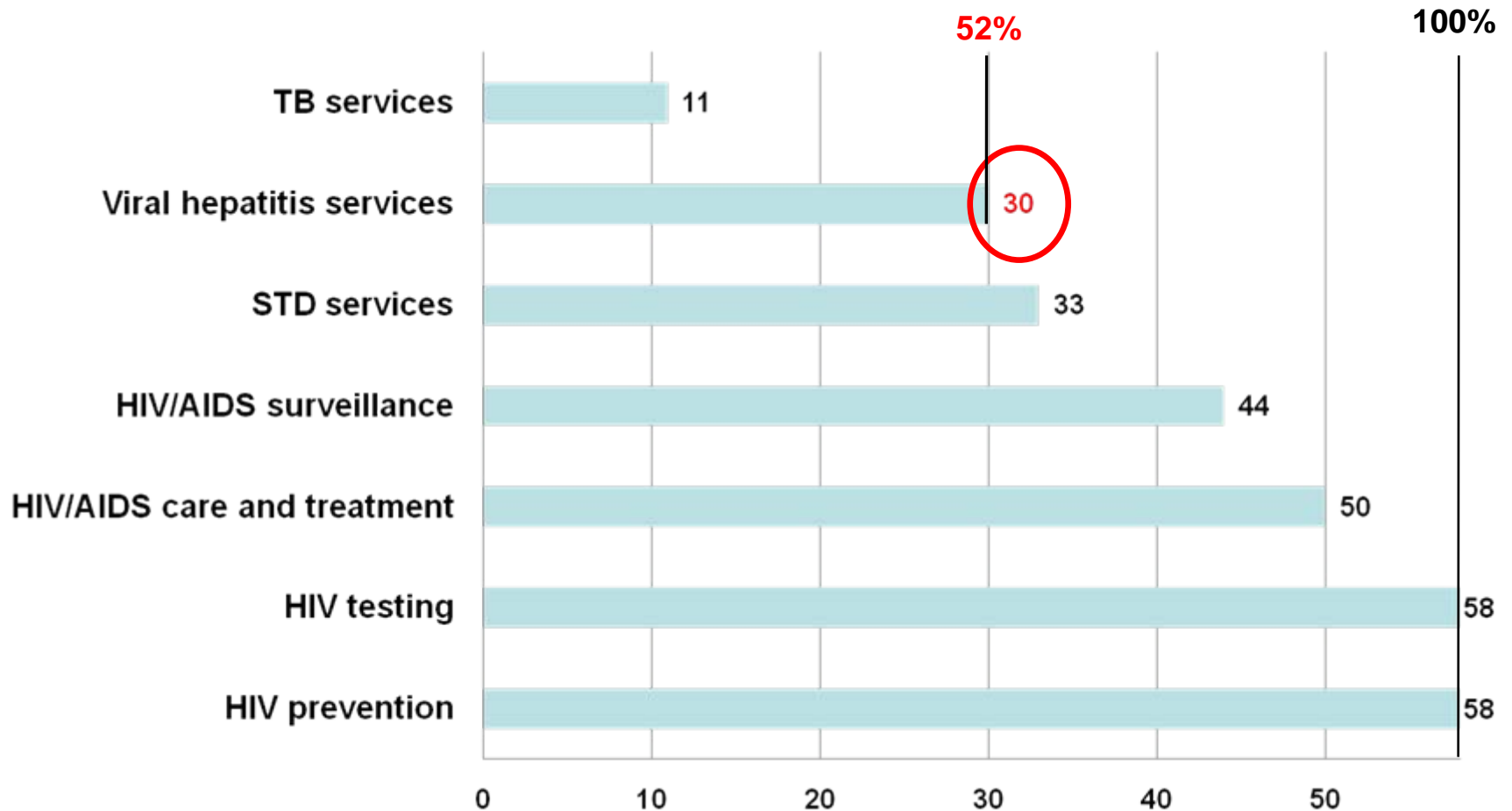
NASTAD History

- **2006 – Hepatitis Emphasized in NASTAD Strategic Map**
- **2007 – NASTAD Continues Hepatitis Program without CDC funds; States Begin Paying Viral Hepatitis dues (37)**
- **2008 – Hepatitis C Advocates UNITED founded**
- **2008 – NASTAD awarded CDC Viral Hepatitis Networking, Education and Training Cooperative Agreement**
- **2008 – National Viral Hepatitis Technical Assistance Meeting**

Structure and Governance

- **Governed by 20 member elected Executive Committee (EC)**
- **EC conference calls every two weeks**
- **Large EC helps ensure representation (geographic & disease burden)**
- **Operate by consensus and guided by Principles for Public Policy Decision Making**
- **EC Liaisons to Programmatic Work Groups**
 - **Peter Whitarcar (HI) – Viral Hepatitis Work Group**

Current AIDS Director Purview States, DF Cities, PR and DC (n=58)



NASTAD Programs

- **Domestic**
 - **Care and Treatment**
 - **Prevention and Surveillance**
 - **Racial and Ethnic Health Disparities**
 - **Viral Hepatitis**
- **Global Technical Assistance**
- **Government Relations**
- **Operations**

NASTAD's Strategic Map

- **Central challenge: Assert the role of state public health in addressing the HIV/AIDS and viral hepatitis epidemics.**
- **Overarching strategic priority: Address racial and ethnic disparities in the HIV/AIDS and viral hepatitis epidemics.**

Assert the Role of State Public Health in Addressing the HIV/AIDS and Viral Hepatitis Epidemics

Address Racial/Ethnic Disparities in the HIV/AIDS and Viral Hepatitis Epidemics

Influence Direction of HIV/AIDS and Viral Hepatitis Policy

Prioritize HIV/AIDS and Viral Hepatitis with Policymakers

Advocate for Increased HIV/AIDS, Viral Hepatitis, and Other Health-Related Funding; Promote Equitable Resource Allocation

Promote the Role of State HIV/AIDS, Viral Hepatitis, and Other Appropriate Health-Related Programs

Increase Policy and Legislative Activities Related to Racial and Ethnic Disparities

Monitor and Participate in Global HIV/AIDS Policy

Prioritize Alliances With Organizations to Yield Effective Partnerships

Strengthen State-Based HIV/AIDS and Viral Hepatitis Program Effectiveness

Build Evaluation Capacity for State Programs That Reflects Accountability

Position State Public Health to Effectively Address Racial and Ethnic Disparities

Position State Public Health to Effectively Address the Needs of MSM & Substance Users

Strengthen Cross-Program Collaboration and Integration Activities (including Mental Health, STDs, Substance Abuse and Other Multiple Occurring Issues)

Assist States in Implementing the Reauthorized CARE Act

Enhance and Promote Peer- based TA in Key Program Areas

Enhance Member Leadership and Effectiveness

Offer Member Services Programs that Develop Leadership Skills and Expertise

Build and Ensure Cultural Competency Related to Racial/Ethnic and MSM Communities & Substance Users

Maximize Domestic and Global Peer-Based TA to Yield Bi-Directional Benefit

Increase Leadership Opportunities for Minority Health Department Staff

Strengthen Health Department Capacity in Policy and Advocacy Activities

Enhance Health Department Collaborative Activities with Community Alliances

Strengthen NASTAD's Organizational Effectiveness

Strengthen Staff Leadership, Management and Supervisory Expertise

Increase Leadership Opportunities for Minority Staff

Enhance Development Capability and Diversify Funding, Coordinated Across Programs

Ensure Management Continuous Quality Improvement (CQI)

Enhance Communications, Public Relations and Marketing Efforts

How does NASTAD impact national HIV and viral hepatitis policy and programs?

- **NASTAD staff develop policy/program recommendations based on input from the EC and members.**
- **Work groups of health department program staff guide programs and ensure products reflect needs/concerns of members.**
- **Use “peer” technical assistance model to link health department staff and to share expertise across jurisdictions.**

How does NASTAD impact national HIV and viral hepatitis policy and programs?

- **We work with:**
 - Executive Branch agencies (HHS, CDC, HRSA) to influence policies that impact state programs
 - Congress to influence Executive Branch agencies, provide funding, develop sound legislation
 - Coalitions to influence both Congress and the Executive Branch
- **We communicate positions through:**
 - Meetings, letters, position statements, issue briefs, reports, assessments of state policies and programs, etc.
- **State AIDS directors visit Members of Congress and meet with the leadership at HHS, CDC, and HRSA on a periodic basis.**

Lessons Learned

- Investment of time and energy from health departments essential
- Accurate and timely communication is key to member buy-in
- Strategic focus important for impact
- Key “deliverables” contribute significantly to fundraising efforts
- Federal partners value NASTAD direct access to and input from state HIV and hepatitis programs
- Unified “voice” in advocacy is key

NASTAD Viral Hepatitis Program

- The goal of the NASTAD Viral Hepatitis Program is to support health department HIV/AIDS and hepatitis programs to increase their capacity to effectively deliver prevention and care and integrate viral hepatitis into existing programs.
- There are three primary components of the project:
 - Technical Assistance
 - Public Policy
 - Coalition Building



Technical Assistance


- **Goals:**
 - To assert role of health departments with federal agencies and develop collaborative relationships
 - To support Adult Viral Hepatitis Coordinators/ other health department hepatitis personnel
 - To facilitate information sharing, technical assistance and support
 - To partner effectively with the NYS National Hepatitis TA Center

Technical Assistance

- **NASTAD uses a peer-based approach to work with Adult Viral Hepatitis Coordinators including:**
 - **Monthly conference calls with AVHCs for information sharing, programmatic advice, policy updates, and sharing of lessons learned**
 - **Ad-hoc, issue-specific work groups; past groups have focused on clarifying issues with CDC**
 - **Sharing of resources and materials (e.g., web-based resource bank)**
 - **Communication network for AVHCs (e.g., listserv)**

NASTAD Hepatitis Resources

Raising the Profile,
Raising Your Voice:
A Primer on Viral Hepatitis Policymaking
and Programs at the Federal Level



NASTAD
NATIONAL ALLIANCE OF STATE
& TERRITORIAL AIDS DIRECTORS

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Viral Hepatitis and HIV/AIDS Integration

- A Resource Guide
for HIV/AIDS Programs

APRIL 2006

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NATIONAL ALLIANCE OF STATE
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Viral Hepatitis Prevention Unmet Needs for States

FY2006 NASTAD Request: \$50 million
FY2006 President's Budget: \$17.5 million
FY2005 Appropriations: \$17.5 million

an estimated 61,000 new HAV infections reported in 2005.⁶ Each year, 11-22% of persons infected are hospitalized, and approximately 100 cases result in death.⁴ The U.S. Centers for Disease Control and Prevention's (CDC) Division of Viral Hepatitis (DVH) responds to HAV outbreaks and assists health departments in vaccine delivery.

Prevention programs developed in response to the HIV/AIDS epidemic have identified large numbers of people at risk for HIV, hepatitis A virus (HAV), hepatitis B virus (HBV), and hepatitis C virus (HCV) infection, which are the most common types of viral hepatitis in the U.S. These viruses impact many of the same populations who are at risk of or infected with HIV: at least one-quarter of persons living with HIV are co-infected with HCV, and up to 10% of persons infected with HIV are also infected with HBV.^{1,2} An estimated 4 million Americans have been exposed to HCV at some time, and 2.7 million are chronically infected, making it the number one blood borne disease in the U.S.³ Further, although safe and effective vaccines to prevent hepatitis A and hepatitis B have been available for over 10 years,^{4,5} limited funding has slowed implementation of vaccination initiatives, and every year thousands of Americans become infected with these diseases.⁶

NEED FOR SERVICES
The following statistics demonstrate the significant burden of viral hepatitis on our nation's public health system and the need to direct additional resources to prevent transmission.

HEPATITIS A VIRUS
Hepatitis A virus remains one of the most frequently reported vaccine-preventable diseases in the U.S., with

HEPATITIS B VIRUS
Approximately 1.25 million Americans suffer from chronic hepatitis B virus infection, with an estimated 73,000 new HBV infections reported in 2005.⁶ Approximately 5,000 deaths from acute or chronic HBV infection occur each year,⁷ and HBV infections result in an estimated \$658 million in medical costs and lost wages annually.⁸ Although the cost-effectiveness of hepatitis B vaccination for at-risk adults has been demonstrated, implementation has not occurred.⁹

While the incidence of HBV has decreased dramatically among children and adolescents as a result of routine hepatitis B immunizations,¹⁰ the highest rate of HBV is found in 20-49 year olds.^{11,12} Vaccinating adults who have not benefited from routine childhood and adolescent immunization programs would be short-term and cost-effective.

HEPATITIS C VIRUS
Currently, approximately 4-5 million Americans are infected with hepatitis C virus and at least 2.7 million are chronically infected, nearly three times the number of individuals infected with HIV/AIDS.¹³ In addition, an estimated 39,000 new individuals were infected with

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Public Policy

Goals:

- Increased funding for hepatitis prevention through CDC DVH
- Increased funding for vaccine for high risk adults
- Support for diagnostic, vaccine and treatment coverage for persons co-infected with HIV and HBV or HCV
- Care for the mono-infected and coverage/adequate reimbursement for diagnostics

Coalition Building

- **Facilitate the Hepatitis C Appropriations Partnership**
 - Established in 2004 with single focus of increased funding
 - Includes HBV messaging – working to fully integrate HBV
- **National Viral Hepatitis Roundtable (NVHR) Chair**
 - Seeking greater cohesion and common agenda for hepatitis B and C
- **317 Coalition and Adult Vaccine Coalition Member**
 - Seeking to increase HAV/HBV vaccine for high risk adults
- **Participating in state meetings to demystify advocacy and to support AVHCs in developing grassroots**
- **Coordinated the first Viral Hepatitis Grassroots Training and Hill Education Day**
- **Advocated for hepatitis B and C co-infection services in Ryan White**

NASTAD and NVHR

- **NASTAD received 5 year Cooperative Agreement from CDC Division of Viral Hepatitis to address six critical national needs:**
 - **Sharing a common message and collective voice**
 - **Bridging the divide between HBV and HCV**
 - **Engaging public health allies**
 - **Supporting multiple disciplines in carrying the viral hepatitis message**
 - **Enhancing coordination on the state and local levels**
 - **Increasing funding and eliminating restrictive policies**

Welcome to Washington, DC



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