

Adult Hepatitis A and B Vaccination in Traditional and Non-Traditional Sites, North Carolina

Beth Rowe-West, Head
Immunization Branch
Division of Public Health
NCDHHS

Overview

- Historic vaccination efforts – children and adults
- Current vaccination efforts – focus on adults
- Who is at risk???
- Impact on morbidity and mortality
- Challenges
- Plans for the future
- Recognition of players

Hepatitis B Vaccine

- Hepatitis B vaccine available for high risk individuals only, including contacts to confirmed cases
- Reporting
- Expansion
- 1993 – school pilots: California and NC
- 1994 – requirements for NC
- 1995 – statewide school site expansion

Hepatitis A Vaccine

- 1995 - The Advisory Committee on Immunization Practices (ACIP) recommended that people at risk receive hepatitis A vaccination
- 1999 – The ACIP expanded recommendations to include children living in states with high hepatitis A incidence rates (NC was not included)
- 2002 – Implementation of Adult vaccination program for those at highest risk
- 2006 – The ACIP expanded recommendations to include all children

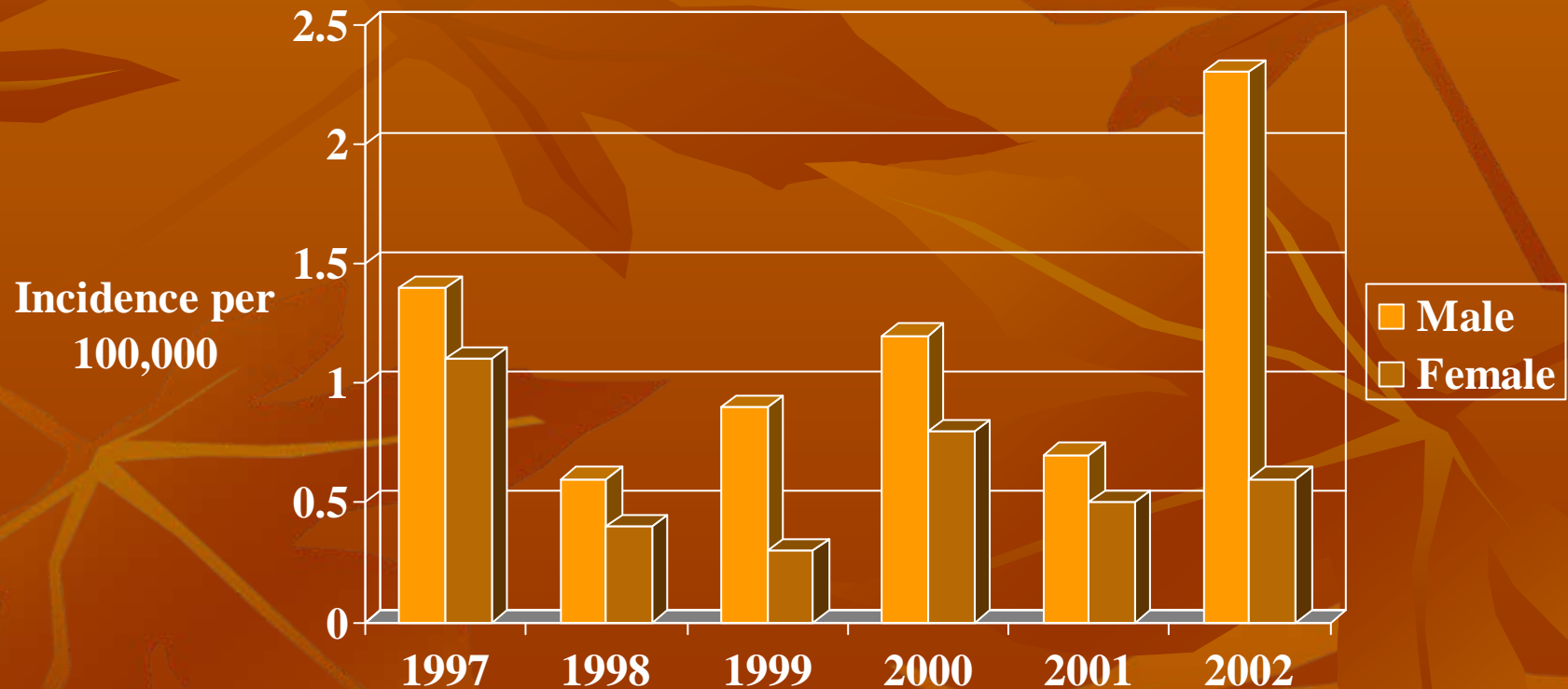
Hepatitis A/B Vaccination Initiatives

Identifying the Need in North Carolina

- A 4.5 fold increase in the number of men self-reporting recent sexual contact with men was noted in 4 large counties from 1997 to 2001
- A corresponding increase in HAV noted during the same time period

Hepatitis A Rates by Gender

North Carolina, 1997-2002



Demographic Characteristics of Hepatitis A cases

North Carolina, 1997-2001

	1997	1998	1999	2000	2001
Total cases	194	135	183	139	266
Sex					
Male cases (%)	112 (58)	83 (62)	133 (73)	64 (46)	194 (73)
Female cases (%)	82 (42)	42 (39)	50 (27)	75 (54)	72 (27)
White (%)	154 (79)	107 (79)	154 (84)	103 (73)	195 (73)
Black (%)	12 (24)	22 (16)	16 (9)	24 (17)	24 (17)
Asian (%)	4 (2)	4 (3)	7 (4)	3 (2)	3 (2)
American Indian (%)	5 (3)	0	0		
Unknown (%)	8 (4)	2 (2)	7 (4)	2 (1)	2 (1)
				7 (5)	7 (5)

Distribution of Hepatitis A Acute Cases Among Males by Self-Identified Sexual Preference, North Carolina, 1997-2002

Year	Total # cases studied	Male (% of total cases)	Heterosexual (% of male cases)	Homosexual or bisexual (% of male cases)
1997	94	51 (54)	21 (55)	8 (21)
1998	44	23(56)	11 (68)	4 (25)
1999	51	36 (71)	15 (51)	9 (31)
2000	84	48 (57)	12 (34)	16 (17)
2001	49	28 (57)	14 (63)	2 (9)
2002	118	93 (79)	30 (38)	26 (33)

Provision of Adult Hepatitis A/B Vaccine – the Barriers

- Funding
- Competing priorities
- Poor overall adult immunization rates
- Deficits in Education and Awareness
- Limitations in Documentation/Reporting
- Inappropriate Storage and Handling Facilities
- Capacity in Recruiting
- Capacity to Vaccinate
- Capacity for tracking and follow-up
- Political Will

Overcoming Barriers

- Funding
 - Supplemental 317 funds
 - HIV/STD funds
 - State funds
- Competing priorities
 - Childhood vaccine needs
- Poor adult immunization rates
 - Non-traditional settings
- Deficits in Education and Awareness
 - Shifting operational efforts

Overcoming the Barriers

- Documentation/Reporting in Non-Traditional Sites
 - Registries vs paper-based reports
 - Stressing the importance of accountability
- Inadequate Storage and Handling Facilities in Non-Traditional Sites
 - Shifting educational resources at state immunization programs
- Recruiting
 - Shifting resources at state immunization programs
 - Easy transition for existing public health clinics
 - Cold calls to non-traditional sites

Overcoming the Barriers

- Site visits
 - Shifting resources at state immunization programs
- On site Resources – capacity to store, administer and report
 - Local operating funds needed
- Political Will
 - Local sites and their supporters must want to dedicate existing resources to this effort

Implementation of Adult Hepatitis A/B Vaccine

- 2002 – Pilot in 4 counties with highest incidence of hepatitis A/B
- 2004 - Combination hepatitis A/B vaccines made available to all local health department HIV/STD clinics
 - Breaking the bank?
 - Slow uptake
 - Increased education to providers
- 2006 – Notable increased uptake in of hepatitis A and B vaccinations at local health departments

Risk Factors/Demographics of those receiving dose 1 hep A/B vx (n=310) in pilot counties

Risk Factor	Age	Gender	Race
MSM – (71%) 20	18-33 (43%) 133	Male (85%) 263	White (65%) 201
MSP – (13%) 40	34-53 (51%) 158	Female (15%) 47	Black (26%) 81
HCV – (9%) 28	>54 (6%) 19		Hispanic (7%) 22
IDU – (7%) 22			Other (2%) 6

Two of the four sites offered enhanced interventions

- Utilize skills of registered nurse
- Provide more personalized counseling
- Encouraged testing and vaccination
- Administered the vaccine
- Provide follow up, test results, and referral
- Track clients to see if referrals were utilized

Who Did We Target?

- HIV positive status
- HCV positive status
- IDU
- MSM
- MSP
- History of incarceration

Where Did We Target?

- HIV/STD Clinics
- Drug Treatment Centers
- Methadone Clinics
- Prisons/Jails
- Homeless shelters
- Public Health Clinics
- FQHCs and RHCs (added in 2007)
- FP Clinics (added in 2008)

Let's Look More Closely at HIV/STD Clinics

- Studies show high percentage of those seen in HIV/STD Clinics will be vaccinated
- Infrastructure to integrate all hepatitis services
 - Prevention
 - Testing
 - Control Measures
 - Treatment Referrals
- Skilled staff

Total doses ordered by 93 local and regional health departments, DOC, Drug Treatment Centers

■ 2002-2004.....	15,695 (includes pilot project period)
2005.....	13,685
2006.....	12,585
2007.....	26,750
2008 (Jan – June).....	12,940
2008 (July-Dec projected)....	25,880

If all vaccine recipients received the required 3 dose series * of Hepatitis A and B vaccine, the following number of clients would be vaccinated:

2004.....	5,230
2005.....	4,529
2006.....	4,195
2007.....	8,917
2008.....	8,627 (Estimated for the year)

- However, reporting data less than desirable!

Show Me the Money

- Immunization Programs WANT to vaccinate more individuals
- Immunization Programs primarily funded for childhood vaccinations
- Flat levels of discretionary funding
- Generosity of HIV/STD
- Special CDC allocations

Planning for Better Outcomes

Objectives

- Increase the acceptance rate of high risk who are offered the vaccine
- Increase the percentage of clients who complete the vaccine series
- Offer and provide HCV testing to those assessed to be at high risk for Hepatitis C
- Provide a comprehensive referral packet to those who test positive for HCV

Keys to Success

- Begin with traditional sites familiar with vaccine management, assessment, counseling, storage and handling, reporting, tracking and follow up: local health departments
- Focus on HIV/STD clinics Collectively serve ~ 36,000 clients annually
- Intensive staff training
- Integration of hepatitis services into HIV/STD clinics, including HCV testing
- Provision of vaccine
- The rural South leads the nation in reported cases of STDs, (syphilis, chlamydia and gonorrhea) and HIV/AIDS.

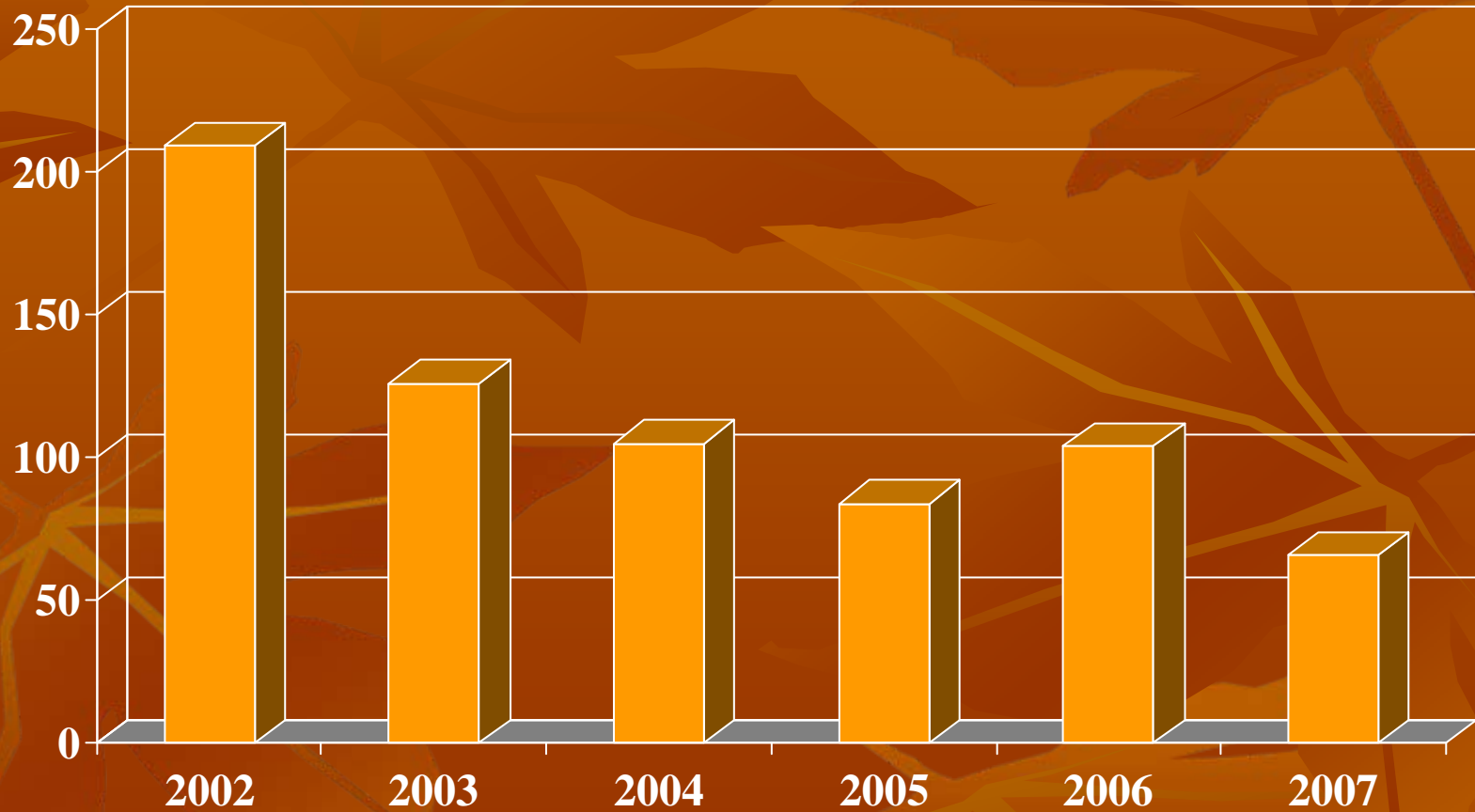
Success

- 136 participating sites
- Collectively serve ~ 36,000 clients annually
- True measure, of course, is impact on disease burden

Hepatitis A

Reported Cases

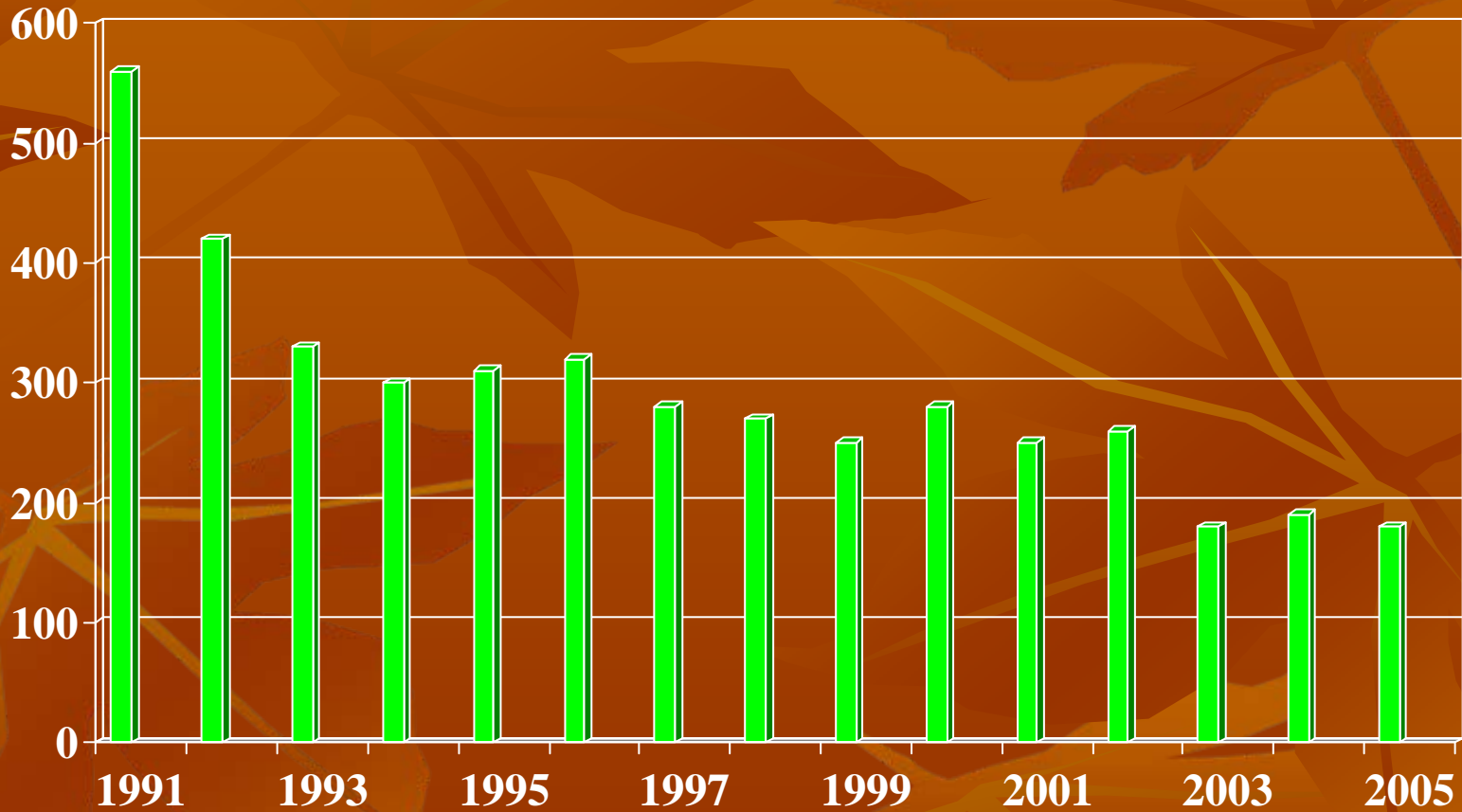
North Carolina 2002-2007



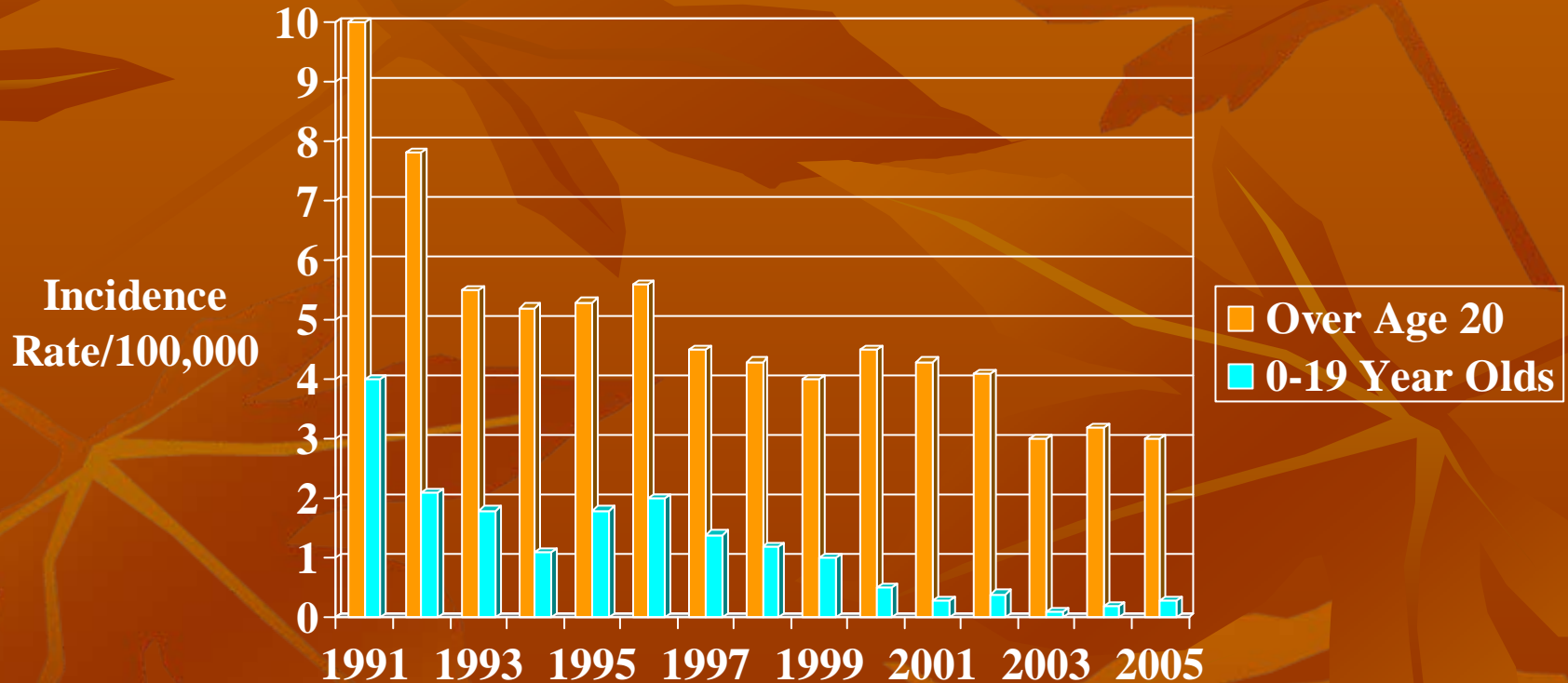
Hepatitis B, Acute

Reported cases, North Carolina

1991-2005



Hepatitis B, Acute Incidence Rate by Age North Carolina, 1991-2005



Hepatitis A/B vaccine – Future Plans

- Possible expansion to mental health inpatient facilities
- Primary focus will be on current sites: increasing uptake, completion rates and improving accountability

The Take Home Message:

Disease is
Bad!

Vaccine is
Good!



QUESTIONS?

