

# BREAKING THE SILENCE ON AN EPIDEMIC

## Policy Recommendations To End Viral Hepatitis



### THE PROBLEM: THE SILENT EPIDEMICS

In the United States there are approximately 5.3 million people living with chronic hepatitis B (HBV) and/or hepatitis C (HCV), with 15,000 deaths annually attributed to hepatitis-related liver disease or liver cancer. These figures are based on National Health and Nutrition Examination Survey (NHANES) data, which does not include homeless individuals, those with unstable housing, the incarcerated, and many immigrant and migrant populations – populations disproportionately affected by viral hepatitis.

While we have generally seen decreases in acute viral hepatitis infections, chronic viral hepatitis continues to affect millions of Americans. In the United States, an estimated 1.4 million persons are living with chronic HBV infection and an estimated 3.9 million persons are chronically infected with HCV, according to the Centers for Disease Control and Prevention (CDC). Of these, 65-75% do not know their diagnosis and are not receiving the appropriate care and treatment. Without a confirmed diagnosis and linkage to and retention in care, 15-40% of those living with viral hepatitis will eventually develop liver cirrhosis or hepatocellular carcinoma. In 2010 alone, the CDC estimated that 35,000 Americans were newly infected with HBV and 17,000 with HCV. Unfortunately, due to the lack of an adequate surveillance system, these estimates are likely only the tip of the iceberg.

Additionally, viral hepatitis disproportionately impacts several communities, particularly:

- People who inject drugs (PWID)
- Men who have sex with men (MSM)
- Africans and African Americans
- Asian Americans
- Latinos
- Residents of rural and remote areas

Persons born between 1945 and 1965 have the greatest risk for HCV-related morbidity and mortality and CDC released new HCV screening guidelines in 2012 recommending that providers offer the screening to anyone born in this birth cohort. Additionally, recent alarming epidemiologic reports indicate a rise in HCV infection among young people throughout the country. Some jurisdictions have noted that the number of people ages 15 to 29 being diagnosed with HCV infection now exceeds the number of people diagnosed in all other age groups combined.

## THE SOLUTION: OUR NATION'S HEALTH DEPARTMENTS

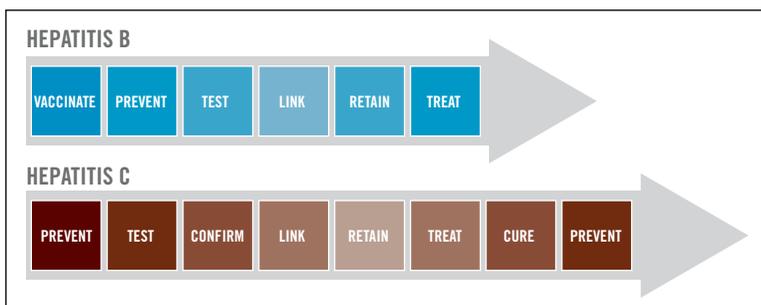
The Institute of Medicine report, Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C, and the Viral Hepatitis Action Plan, the federal interagency road map to address viral hepatitis, set prevention goals, established program priorities and assigned responsibilities for actions to the Department of Health and Human Services (HHS) and federal operating divisions, including CDC. In turn, CDC provides funds to state and local health departments, the cornerstone implementers of national public health policies, to coordinate statewide efforts via the Viral Hepatitis Prevention Coordinator Program (VHPC).

Health departments are at the forefront of our nation's efforts to prevent new infections and create systems of care for people living with chronic viral hepatitis. Health departments, however, are at a critical transition point as implementation of the Affordable Care Act (ACA) continues and more effective treatments for HCV come to market – a transition that requires federal investment in national and state-specific public health infrastructure in order to meet the changing needs of people living with and at-risk of viral hepatitis. The following recommendations will better equip state and local health departments to provide the basic, core public health services to combat viral hepatitis; increase surveillance, testing and education efforts nationwide; and effectively implement the recommendations set by the IOM, the Action Plan and the CDC testing guidelines.

## THE ACTION: POLICY RECOMMENDATIONS TO END THE EPIDEMICS

### Continue to Support the Viral Hepatitis Prevention Coordinator Program and Increase Funding

For over a decade, the VHPC program has been and remains the only national program dedicated to the prevention and control of the viral hepatitis epidemics. VHPCs provide technical expertise necessary for the management and coordination of activities to prevent viral hepatitis infection and disease. Further, these coordinators help integrate viral hepatitis prevention services into health care settings and public health programs (e.g., HIV, STD, immunization, prison health, substance abuse treatment, syringe services programs) that serve adults at risk for viral hepatitis. In FY2013, the VHPC program received \$5.3 million to fund positions in a total of 52 jurisdictions, but no funds for the provision of public health prevention services, such as testing and hepatitis A and B vaccinations. Even without funding for programmatic activities, coordinators administered nearly 90,000 HCV tests nationwide in FY2011. In jurisdictions without state funding for

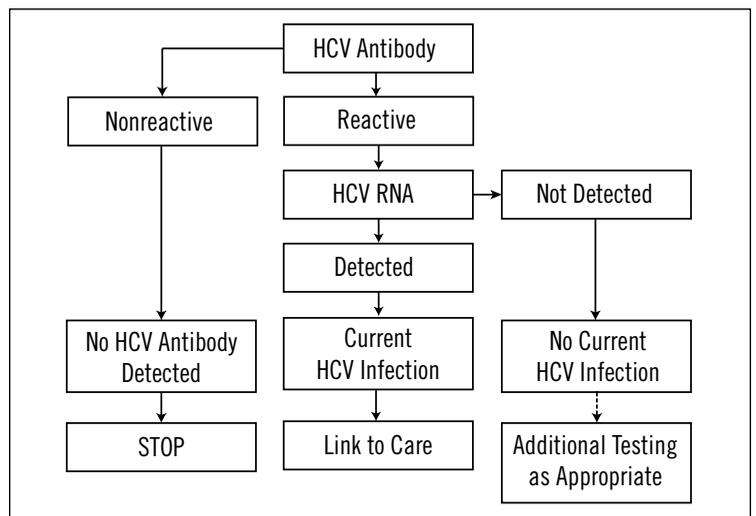


viral hepatitis prevention, the VHPC program provides the only public health infrastructure for the prevention and identification of viral hepatitis and the linkage to care and treatment services. In order to meet the goals established by the Action Plan, the VHPC program must continue to be funded in all existing jurisdictions and increased resources are necessary to coordinate prevention efforts at the state and local levels.

### Increase funding for viral hepatitis screening and confirmatory testing

At present, only 25-35% of people living with chronic viral hepatitis are aware of their infection. According to the CDC professional judgment budget for viral hepatitis, the top priority is to identify persons with viral hepatitis early and refer them to care by strategically increasing access to testing nationwide. The Action Plan established a goal of increasing the proportion of persons who are aware of their HBV infection from 33% to 66% and from 45% to 66% for HCV. In addition to increasing access to tests for HBV and HCV, it is imperative that individuals who test positive in an antibody test also receive a confirmatory RNA test. There is very little funding for health departments to provide screening for viral hepatitis, with the exception of a few local and state health department sites funded through the Prevention and Public Health Fund in FY2012, which continued in FY2013 through a Secretary transfer, and even less funding for confirmatory testing. In FY2011, with no federal categorical funding for HCV testing, health departments leveraged other resources to administer nearly 90,000 HCV tests nationwide. Given the existing infrastructure and expertise, funding for viral hepatitis testing and confirmatory testing must be prioritized for health departments and VHPCs in order to garner higher administration of tests, linkage to confirmatory tests and linkage to care.

### Recommended testing sequence for identifying current hepatitis C virus (HCV) infection



### Invest in the creation of a national viral hepatitis surveillance system to monitor acute and chronic infections

There are currently no funds for a national surveillance system of chronic viral hepatitis, limiting the access to information about viral hepatitis available to states, health departments, policy

makers, and service providers. CDC currently funds four state health departments and two local health departments to create surveillance systems for their jurisdictions. A national surveillance system will provide stakeholders with information that is critical to understanding the impact of the hepatitis epidemics, identifying and averting outbreaks, and targeting resources to the most impacted communities. CDC and state health departments rely on surveillance data to track the incidence of acute infection, guide development and evaluation of programs and policies designed to prevent infection and minimize the public health impact of viral hepatitis, and monitor progress towards achieving goals established for these programs and policies. Effective systems for conducting surveillance for chronic HBV and HCV infections are needed to ensure accurate reporting of all cases and to support and evaluate prevention activities.

### **Decrease new infections among disproportionately affected racial and ethnic populations, particularly Asian Americans and Pacific Islanders, African Americans and Latinos**

In order to effectively combat the rising incidence of viral hepatitis among disproportionately impacted populations, in particular communities of color and immigrant populations, it is critical to provide additional funding to the HHS Office of Minority Health to increase activities targeting racial and ethnic minorities who bear a disproportionate burden of viral hepatitis infection, particularly in the areas of screening, vaccination, and linkage-to-care. Funding should also reflect changing demographics and the need for language accessibility for patients and providers. These additional funding streams should also increase programs targeting providers whose patient populations are primarily racial and ethnic minorities, and help build the capacity for provider education and cultural competence.

### **Direct resources and funding at the Substance Abuse and Mental Health Services Administration (SAMHSA) to identify, link and treat persons who inject drugs living with or at-risk of viral hepatitis**

Persons who use drugs are disproportionately impacted by HBV and HCV. SAMHSA's Center for Substance Abuse Prevention (CSAP) and Center for Substance Abuse Treatment (CSAT) are uniquely positioned to reach populations at risk for HBV and HCV. The existing infrastructure of substance abuse prevention and treatment programs in the United States provides an important opportunity to reach individuals at risk or living with viral hepatitis and is an example of the cross-agency collaboration outlined by the Action Plan. Additionally, in June 2013, the U.S. Preventive Services Task Force recommended, with a "B" grade, HCV screening of persons who inject or have injected drugs. In addition to becoming infected with HCV, people who inject drugs are fatally overdosing at elevated rates, despite available prevention tools. Access to substance use treatment is limited and overdose prevention efforts rarely have a "home" in state drug and alcohol, injury prevention or public health agencies. However, in



FY2013, SAMHSA announced funding for a one-year initiative for Opiate Treatment Programs (OTPs) to identify and refer individuals living with HCV via rapid tests. Although this funding is a tremendous step forward in combating the epidemic among persons who use drugs, it is only a one-year initiative and will require funding past FY2013 to ensure that the gains made are long lasting.

### **Increase capacity-building and support for implementation of the Affordable Care Act**

The ACA provides opportunities to increase access for many persons living with viral hepatitis to the care and prevention services needed to help end the epidemics. However, health departments require assistance in capacity-building support in order to create new infrastructure and leverage existing systems to ensure continuous, high quality care for people living with viral hepatitis, while preventing new infections. Additionally, the ACA promotes investment in preventive measures, including HAV and HBV vaccination and screening for at risk populations. Though some viral hepatitis screening will be covered through insurance, the >>

burden of testing and coordination of information associated with positive test results, including case management, linkage to care and referrals, as well as testing of people who will not have insurance coverage through the ACA, will continue to fall on health departments. Additional funding is needed for health departments to coordinate their programs to meet the goals of the Action Plan and the goals of Healthy People 2020.

### **Allow states and localities the discretion of using federal funds to support cost-effective and scientifically proven, syringe services programs**

More than 55 percent of HCV cases are directly or indirectly related to injection drug use. Overwhelming, scientific evidence has shown syringe services programs (SSP) and access to sterile syringes are an evidenced-based and cost-effective means of lowering HCV infection rates, reducing use of illegal drugs and helping connect people to HCV and medical treatment, including substance abuse treatment. It is imperative to lift the ban on the use of federal funds for the purchase of syringes and oppose any federal actions which ban or increase the bureaucratic, regulatory and reporting requirements on syringe access beyond those already in place at the state and local levels.

### **Prepare public health programs for a changing treatment paradigm for hepatitis C**

Research advances have the potential to drastically change the public health response to the HCV epidemic, with HCV treatments improving and new reports of successful, sustained virologic responses (SVR) to all oral, interferon-free treatments with over 90% success rates. While these treatments present a great opportunity for cure as a means of preventing new HCV infections, guaranteeing that they make their way to people living with viral hepatitis at affordable prices may prove to be more difficult. Ensuring that the thousands of people who know their HCV status

but are “warehoused,” not receiving treatment because of the cost and detrimental side effects of current therapies, are linked to and provided with quality care and treatment that will effectively cure them still requires investment in health departments and their infrastructure. It will also be critical that, once approved, these therapies are added to the appropriate insurance formularies in timely manner to ensure that clients can access them via public or private insurance markets.

### **Update treatment guidelines for hepatitis C**

Standard of care for HCV is evolving rapidly with dozens of new, more effective, oral direct-acting antivirals currently in late-stage clinical trials, and some are currently under review by the FDA. With the opportunity to improve the health outcomes of millions of patients, evidence-based recommendations are needed to help expand the pool of qualified providers and guide medical practice in the United States. It is critical for HHS to convene an ongoing, multidisciplinary treatment guidelines panel or other mechanism to issue periodically updated recommendations for the treatment of HCV infection.

### **Increase access to vaccines for children and at-risk adults through the 317 program and the CDC National Center for Immunization and Respiratory Diseases (NCIRD)**

Although we have made great strides in reducing the burden of HBV among newborns and young people, due in part to the success of the Perinatal Hepatitis B Coordinator program at NCIRD, the greatest remaining challenge for hepatitis A and B prevention is the vaccination of high-risk adults. High-risk adults account for more than 75% of all new cases of HBV infection each year, despite the fact that HBV is preventable. A vaccine against HBV has existed for more than 25 years and it is time that we support a national adult vaccination program.



#### **ABOUT NASTAD**

The National Alliance of State & Territorial AIDS Directors (NASTAD) represents the nation's chief state health agency staff who have programmatic responsibility for administering HIV/AIDS and viral hepatitis health care, prevention, education and support service programs funded by state and federal governments. NASTAD represents the Viral Hepatitis Prevention Coordinators (VHPCs) as part of our membership.

For more information on NASTAD's work on viral hepatitis policy and programs and a listing of Viral Hepatitis Prevention Coordinators, go to [www.NASTAD.org](http://www.NASTAD.org).

**Julie Scofield, Executive Director**

**Dawn Fukuda, Massachusetts, Chair**

OCTOBER 2013