Hepatitis C Plan
Report to the 82nd Legislature

October 2010

Texas Department of State Health Services

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Executive Summary

Infection with the hepatitis C virus (HCV) is the most common bloodborne illness in the United States and in Texas. Because persons with newly acquired hepatitis C infection usually have no symptoms or have mild symptoms, most people infected with the virus are not aware until they are diagnosed with cirrhosis or other liver irregularities many years later. An estimated 150,000 people in the United States will die from liver cancer and end-stage liver disease associated with chronic hepatitis C in the next ten years.[1] Since there is no vaccine for hepatitis C, it is essential that:

- those infected with the virus learn their status as early as possible;
- those at increased risk of hepatitis C adopt behaviors to prevent infection; and
- those infected are able to access medical care to monitor the progression of the disease.

In the Texas Administrative Code (Title 25, Rule 97.3), the Texas Department of State Health Services (DSHS) requires certain providers and entities to report confirmed or suspected human cases of acute hepatitis C. However, chronic hepatitis C is not a reportable condition and statewide chronic hepatitis C surveillance is not routinely conducted or supported in Texas. As a result, accurate estimates of the burden of disease in Texas are insufficient for planning, intervention and evaluation.

Funding for viral hepatitis prevention and treatment activities in Texas is not at optimal levels. Yet there have been some notable achievements in viral hepatitis prevention and treatment since the last legislative plan was submitted in 2008, such as:

- An increase in the understanding of the scope of hepatitis C prevention and treatment resources in Texas leading to improved ability to link persons at risk for or infected with hepatitis C to services.
- An increase in hepatitis C testing for specific risk groups.
- An increase in collaborative activities among viral hepatitis stakeholders and care providers.
- An increase in education and awareness activities regarding hepatitis C.

Most of these achievements resulted from programmatic integration, stakeholder collaboration and Web-based technological solutions. The addition of an Adult Viral Hepatitis Prevention Coordinator (AVHPC) at DSHS in 2009 provided a "point person" to assist with these activities.

Even though there has been an increase in hepatitis C testing, resources available to those who receive a positive test result have not kept up with the increased demand. These individuals need additional diagnostic tests to determine the extent of disease progression in their liver. Those without medical insurance are left with few options for treatment. The AVHPC is working with other stakeholders to identify treatment resources and support groups. The potential effects of healthcare reform on prevention and treatment of viral hepatitis has not yet been determined.

[1] Heather M. Colvin and Abigail E. Mitchell, eds., *Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C*, (Washington, D. C.: The National Academic Press, 2010), p. 1.

Introduction

Background

Senate Bill (S.B.) 338 was passed in 2001 during the 77th Session of the Texas Legislature. This statute requires DSHS to develop a state plan for HCV prevention and treatment and to update the plan biennially. Activities identified in S.B. 338 have been codified in Chapter 94 of the Texas Health and Safety Code.[2] In addition to the state plan, other activities in the statute include:

- Development of programming to heighten awareness and enhance the understanding and knowledge of HCV.
- Administration of blood sample studies to estimate the impact of HCV on the state.
- Establishment of voluntary HCV testing programs.
- Development and offering of training for persons providing HCV counseling at test sites.

State general revenue funds for HCV activities were largely eliminated in 2003 during the 78th Legislative Session. Reductions in these resources eliminated most of the ability to do large-scale HCV awareness education and testing/counseling, as well as to support adequate HCV reporting and surveillance. A drop in the number of reported cases coincides with the reduction in funding.[3] In 2007, disease reporting rules in the Texas Administrative Code were amended to eliminate chronic hepatitis C from the reportable disease list. Acute hepatitis C infection remains on the list of reportable diseases and conditions.

In accordance with S.B. 338, DSHS submitted a hepatitis C plan in December 2008. The *Hepatitis C Plan Report to the 81st Legislature* described five goals for addressing HCV in Texas based on prevention, testing, care and surveillance. The goals are as follows:

- engage internal and external stakeholders to plan and coordinate approaches to HCV testing, prevention and treatment;
- increase understanding of current HCV prevention activities;
- improve surveillance and prevention data systems for HC;.
- increase access to HCV testing; and
- increase access to HCV prevention interventions.

This hepatitis C plan will report on the progress made on each of these goals as well as the existing barriers to conducting activities related to each goal.

[2] Texas Statutes. (2010). Texas Health and Safety Code, Chapter 94 Retrieved June 14, 2010 from http://www.statutes.legis.state.tx.us/Docs/HS/pdf/HS.94.pdf

[3] Texas Department of State Health Services. (2007). *Hepatitis C Plan: 2006 Update*. Austin, Texas

Hepatitis C Virus Transmission and Treatment

HCV is spread through contact with infected blood via contaminated needles, razors, tattoo/body piercing tools, accidental occupational exposures and, although rare, by infected mothers to newborns.

HCV is not easily spread through sexual activity. Unlike hepatitis A and B, there is no vaccine to prevent HCV infection. Many, but not all, medical and public health groups recommend HCV screening for adults at high risk. Those at high risk include:

- current and former injecting drug users;
- recipients of clotting factor made before 1987;
- hemodialysis patients;
- recipients of blood and solid organs before 1992;
- people with undiagnosed liver problems;
- infants born to infected mothers;
- healthcare and public safety workers;
- people with 50 or more lifetime sex partners; and
- people having sex with an HCV-infected steady partner.

Persons with acute hepatitis C virus infection are generally contagious from one or more weeks before the onset of symptoms.[4] Acute HCV infection is a short-term illness that occurs within the first six months after one is exposed to the virus. About 20-25% of persons infected with HCV will clear the virus from their bodies without treatment. The remaining 75% to 80% will be chronically infected with HCV, which can cause liver inflammation with serious long-term consequences. About 60% to 70% of persons with chronic HCV infection will go on to develop chronic liver disease, and about 5% to 20% will develop cirrhosis over a period of 20 to 30 years. Between 1% and 5% of persons with chronic HCV infection will die from cirrhosis or liver cancer. Chronic HCV infection is the leading cause of chronic liver disease and liver transplantation in the United States.[5]

Although they produce some successful results, current treatments for chronic hepatitis C infection are lengthy and costly. Approximately half of patients receiving treatment permanently clear detectable virus from their bodies. HCV treatment success depends on viral genotype, virus levels, stage of fibrosis on the liver biopsy, and ability to tolerate therapy.[6] Most individuals with HCV go untreated because their disease has gone unrecognized. Others go untreated because they have contraindications to treatment regimens, or are unable to afford treatment.

[4] New York State Department of Health, Hepatitis C Fact Sheet (October 2008). Retrieved June 14, 2010 from http://www.health.state.ny.us/diseases/communicable/hepatitis/hepatitis_c/fact_sheet.htm

[5] Wong JB et al. International Hepatitis Interventional Therapy Group. (2003). Economic and Clinical Effects of Evaluation Rapid Viral response to Peginterferon Alfa-2b plus Ribavirin for the Initial Treatment of Chronic Hepatitis C. *American Journal of Gastroenerology*, November;98(11):2354-62.

[6] Yalamanchili, K. et al. (2005). The Prevalence of Hepatitis C Virus Infection In Texas: Implications For Future Health Care. *BUMC Proceedings 2005;18:3-6.*

These untreated individuals are a potentially persistent source of infection to others. Societal costs are significant. Studies have projected complications of HCV will double in coming years.

Epidemiology of HCV

In 2006, DSHS estimated that as many as 300,000 Texans (about 1.3% of the population) were chronically infected with HCV.[8] Between 2000 and 2006, 176,938 cases of chronic HCV were reported. In those same years, 889 acute HCV cases were reported.[9] [10]

A 2005 Baylor University Medical Center study showed a somewhat higher estimate of 387,395 Texans (1.79%) infected with HCV.

The study found minority populations to be disproportionately burdened by HCV infection, with infection rates of 1.38% among whites, 2.82% among non-Hispanic blacks and 2.00% among Hispanics. The greatest concentrations of HCV cases were located in or near major Texas cities.

Estimated county prevalence varied from 1.24% to 2.63%, with higher rates concentrated along the U.S.-Mexico border. Additional estimates indicated that males carry the greater burden of HCV with 66.8% of cases. By age, estimated cases peaked among ages 40 to 49. Study findings also suggested a gradual decline in the total numbers of acute infection. There has also been a decline in non-hepatic deaths of aging patients with chronic HCV. The duration of infection in the surviving cohort of patients with chronic HCV has increased, resulting in growing proportion with more advanced liver disease.[11]

Many individuals at highest risk for HCV are also at risk for Human Immunodeficiency Virus (HIV) and other bloodborne diseases. HIV/HCV co-infection is most common among individuals who inject drugs. An estimated 50%-90% of HIV-infected persons who use injection drugs are also infected with HCV.[12] Approximately one quarter of HIV positive persons are also infected with HCV. Individuals who are co-infected with HIV and HCV experience more rapid liver damage with more serious complications.

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[8] Texas Department of State Health Services. (2007). *Hepatitis C Plan: 2006 Update*. Austin, Texas.

[9] Texas Department of State Health Services. (2007). Epidemiology in Texas 2006 Annual Report: Supplement Number 64-1/ October 29,2007. Retrieved June 14, 2010 from http://www.dshs.state.tx.us/idcu/data/documents/2006_Binder10.pdf

[10] For 2000 - 2006, chronic and acute HCV infections were reportable, but due to a concern with reporting burden at a local level, rules were revised to require reporting of only acute HCV infections beginning in 2007.

[11] Yalamanchili, Kanthi, Saadeh, Sherif, Lepe, Rita and Davis, Gary L (2005). The Prevalence Of Hepatitis C Virus Infection In Texas: Implications For Future Health Care. *BUMC Proceedings 2005;18:3-6.*

[12] Centers for Disease Control and Prevention. (2008). *FAQs for the Public.* Retrieved June 14, 2010 from http://www.cdc.gov/hepatitis/C/cFAQ.htm

Update on State Hepatitis C Plan Activities

Limited resources continue to present a challenge to initiating a robust and comprehensive public health response to address HCV prevention and treatment needs in Texas. Current HCV activities at the state level are fragmented across several DSHS organizational units. DSHS works with 15 local HIV prevention programs to integrate HCV education and testing into their respective programs.

In 2009, DSHS hired an AVHPC with funding received from the Centers for Disease Control and Prevention (CDC). The AVHPC works with other state programs, local health departments, advocacy organizations and healthcare providers to promote HCV awareness and to integrate HCV prevention and treatment into their program activities. The purpose of integration is to maximize public health impact through new and established linkages between related health programs. This will assist in the delivery of HCV prevention and treatment services.

Achieving the goals delineated in the 2008 Hepatitis C Plan will depend on successful integration efforts as well as the identification of additional resources. Below is an update of activities for each of the five goals in the 2008 Hepatitis C Plan.

Goal 1: Engage internal and external stakeholders to plan and coordinate approaches to HCV testing, prevention and treatment.

Internal DSHS Activities

DSHS formed an internal Viral Hepatitis Integration Workgroup, made up of representatives from state health department programs (see Appendix I), which began meeting in April 2009. The purpose of the workgroup was to provide a forum for DSHS programs to develop strategies to increase hepatitis C testing, improve surveillance, identify collaborative opportunities to increase immunization and treatment, and write a final plan with specific objectives.

The viral hepatitis integration plan, completed in December 2009, contains strategies and objectives for integrating HCV testing and hepatitis A and B vaccinations into appropriate DSHS programs. The workgroup was able to develop goals and objectives that would be accomplished by the end of 2010. The objectives in the plan will be evaluated and reassessed at the end of this year and the plan will be periodically updated. A key task for the committee was to conduct a survey of DSHS providers to collect baseline data, which is discussed in Goal 2.

Interagency Activities

On September 1, 2007, House Bill 1370 took effect, re-authorizing the *Interagency Coordinating Council for HIV and Hepatitis*. The council is comprised of representatives from 14 state agencies, including DSHS (see Appendix II. Interagency Council on HIV and Hepatitis Agency Representatives). The council was established to provide a forum for communication and coordination among the member agencies concerning the agencies' programs for prevention and services related to HIV, AIDS and viral hepatitis A, B and C.

By September 1 of each year, DSHS must file a report with the Texas Legislature and the governor of Texas. This report contains policy recommendations based on the information reported to the council related to prevention of HIV and hepatitis and the delivery of health services to individuals living with HIV, hepatitis B and/or hepatitis C.

Below are the ten policy recommendations developed by the council, which include both viral hepatitis and HIV strategies:

1. Increase earlier diagnosis of HIV infection by promoting routine testing for HIV in a variety of acute care settings in areas of Texas with high prevalence.
2. Increase hepatitis B immunization to avoid vaccine preventable infections for children and at-risk adults.
3. Increase early diagnosis and intervention of HIV/AIDS and hepatitis B and C through coordination among state agencies and expansion of current programs.
4. Continue to invest in core public health activities such as public health follow-up and partner services.
5. Address the fragmented nature of viral hepatitis prevention and treatment services.
6. Develop new prevention and treatment strategies that address the health disparities associated with HIV/AIDS and hepatitis infection, and increase access to existing prevention and treatment programs.
7. Commit to continued investigation of issues identified as needing further study.
8. Expand implementation of behavioral interventions with demonstrated evidence of effectiveness in reducing risk for HIV and hepatitis.
9. Improve viral hepatitis surveillance.
10. Explore structural interventions that address underlying vulnerabilities among risk groups for HIV and viral hepatitis.

The full report can be accessed at the DSHS website:
dshs.texas.gov/hivstd/reports/InteragencyCouncilReport.pdf.

The council continues to explore ways to coordinate HIV and viral hepatitis awareness activities between member agencies. For example, in May 2010, the council assisted in the dissemination of a brochure containing basic information regarding viral hepatitis in the workplace. This information was shared with member agencies on the council to share with their respective employees (see Appendix II for a list of state agencies on the council and their members).

External Community Activities
In order to raise awareness and increase education about viral hepatitis issues in Texas, DSHS worked with the City of Houston Health and Human Services and the Texas Liver Coalition to convene a statewide meeting in Austin. The 2009 Texas Viral Hepatitis Summit was held on October 29, 2009 and targeted community and external partners who are leaders in addressing viral hepatitis in their respective communities. The specific objectives for the event were to:

- assist participants in describing the need for a coordinated statewide response to chronic viral hepatitis B and C; and
- assist participants in determining their role and next steps for addressing hepatitis B and C in their communities.

The one-day event was attended by 45 participants, including community advocates, hepatitis patients, pharmaceutical representatives, and state and local health department staff. The group developed strategies to address the identified barriers to hepatitis prevention efforts and to provide of care for those in need of treatment. Given the few resources available, summit organizers stressed that successful achievement of strategies will only occur if community members provide leadership on these issues. All summit attendees agreed to continue participating in this ongoing interaction of community members.

As a follow up to the October meeting, another summit was held on April 16, 2010 in Houston. The one-day format was similar to the previous summit, with educational presentations in the morning and smaller discussion groups in the afternoon. The attendees reviewed the Institute of Medicine's national strategic plan developed to address viral hepatitis and developed strategies for addressing viral hepatitis in their communities. The strategies fell into four categories:

- education and awareness;
- immunization;
- testing and treatment; and
- surveillance.

The event was attended by 101 participants, more than double the attendance of the first summit.

Goal 2: Increase understanding of current HCV prevention activities.

Conducting a Needs Assessment of Selected DSHS Service Providers
The internal workgroup conducted a survey of DSHS service providers in order to assess their level of hepatitis prevention and referral activities. In July and August 2009, the workgroup sent the survey to service providers, such as HIV and sexually-transmitted disease (STD) testing sites and clinics. DSHS Hepatitis Services Survey had four parts:

- questions on hepatitis vaccination services;
- questions on hepatitis testing services;
- questions on other hepatitis services, such as education and referral; and
- questions on technical assistance or training needed to conduct hepatitis prevention services.

The survey was sent to 191 DSHS-funded HIV prevention providers, HIV care providers, STD clinics, substance abuse facilities, methadone clinics, federally qualified health centers (FQHCs) and family planning clinics. Seventy-nine sites completed the survey for a 41% response rate. Forty percent of the respondents indicated they were an HIV prevention and/or care provider.

Forty six respondents were not providing hepatitis testing but were interested in doing so. Most respondents indicated that they need resource assistance to pay for hepatitis tests and vaccines.

The results of the survey will be used to create a Web-based resource directory. DSHS will periodically repeat the survey to update the results and identify additional viral hepatitis resources.

Goal 3: Improve surveillance and prevention data systems for HCV.

DSHS systems for gathering and reporting HCV surveillance data have been inadequate because of limited resources. As stated earlier in this plan, state disease reporting rules were amended in 2007 to remove chronic hepatitis C from the reportable disease list. However, acute hepatitis C remains on the list of reportable diseases and conditions.

The result of removing chronic hepatitis C from the reportable diseases list is that there is little surveillance reporting conducted at the state level. A few local health departments, such as the El Paso City-County Health Department, have continued to collect chronic hepatitis C data, but general reporting is sporadic and incomplete.

Establishing a statewide surveillance system for reporting chronic hepatitis would be resource intensive. Instead, DSHS is examining other methods for gathering data on HCV prevalence, such as creating sentinel surveillance sites and conducting blood sample studies. However, these activities will depend on the identification of additional funds.

Goal 4: Increase access to HCV testing.

HCV testing at DSHS-funded methadone clinics
Currently, hepatitis B and C testing is not routinely conducted at DSHS-funded facilities providing opiate substitution therapies (methadone clinics). Hepatitis testing is usually conducted through a variety of means, sometimes depending on an outside entity to make periodic visits to provide this service. DSHS has been working with these methadone clinics to make hepatitis B and C testing a routine part of the client intake process, along with HIV and syphilis testing and hepatitis A and B vaccinations.

Beginning in July 2010, DSHS-funded methadone clinics will have an opportunity to participate in a program that will fully reimburse them for the cost of providing comprehensive, diagnostic testing at patient intake, including viral hepatitis testing. Three methadone clinics have indicated that they will participate in this program. DSHS plans to expand the screening to all 14 funded sites as resources are available.

HCV testing at DSHS-funded HIV testing sites
In 2009, DSHS maintained contracts with 11 HIV testing and counseling agencies to assess clients' HCV risks and offer HCV testing as appropriate. Each program must submit specimens to the DSHS laboratory and establish referral networks for HCV assessment and treatment, hepatitis A and B immunization, and substance abuse treatment and counseling. The programs were selected to provide HCV testing based on the presence of injecting drug users (IDU) within their client profile and their geographic location.

Continuing and expanding HCV testing in HIV testing locations and other sites is dependent on the availability of other funds to purchase test kits for the DSHS laboratory. Using these other dedicated funds results in the reduction of services in another area. Testing volume continues to increase dramatically with each reporting period. Funding to expand the testing effort continues to be an issue. During the most recent complete reporting period (November 2008-October 2009), program data indicated that 2,983 HCV tests were conducted by the 11 contracting sites. This represents more than double the amount of HCV tests that were conducted in the previous reporting period (November 2007-October 2008) in which 1,378 tests were conducted. Sixty-two percent of those tested during the reporting period that ended in October 2009 were men, which was about the same amount as the period before. A little over 50% of all clients tested for HCV were white, followed by Hispanic (30%), and black (16%).

During this reporting period, program data indicates that 493 HCV tests were antibody positive. This equates to a 17% positivity rate, compared to a 15.9% positivity rate during the last reporting period.

Beginning in 2010, the TB/HIV/STD Unit at DSHS earmarked $25,000 of the HIV prevention base award amount from CDC to purchase HCV tests to continue offering testing. The AVHPC is expanding the number of HCV testing sites and to expand the number of tests to include not only IDUs but other high risk groups as well. By the end of 2010, the objective is to increase the number of DSHS providers that offer the HCV antibody test from 11 testing sites to 15 testing sites. The objective is to also increase the annual number of HCV tests provided at DSHS-funded facilities from almost 3,000 tests to 5,000 tests.

HCV testing at HIV and Hepatitis Testing Events
DSHS is seeking approval from CDC to purchase additional tests to be used at specific, one-time testing events. These tests will be made available to local health departments and community based organizations to use at health fairs and neighborhood wellness events.

Goal 5: Increase access to HCV prevention interventions.

Integrated Individual, Group and Community Interventions
DSHS uses federal and state general revenue funds to support local health departments and community-based organizations to help people change their behaviors that put them at risk for infection with HIV, STDs, and hepatitis B and C. These health departments and organizations use a variety of evidence-based programs that are directed at individuals, groups, and communities. The programs provide educational information about these diseases, their transmission, and how to avoid infection. However, information and education alone are not enough to result in changes in ingrained or addictive behaviors. Additionally, the programs use a variety of techniques to help people understand their level of personal risk and to make achievable plans for reducing or eliminating risk.

Often, clients need help developing skills that will assist them in changing behaviors (e.g., negotiating skills to help avoid risky sexual behavior). Sometimes behavior change efforts require sustained contact and counseling with clients to support them in maintaining healthy behaviors. Most clients also need additional services or referrals to help them be successful

(e.g., substance abuse services, mental health services), and the programs are expected to link clients to these additional services as needed. Some of the programs focus on changing the norms in communities that are disproportionately affected by these diseases by working to change knowledge, attitudes and beliefs within the targeted community.

Prevention for Substance Abusers

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) supports prevention of blood borne diseases, such as hepatitis B, C and HIV, through funds provided directly to Texas providers and through block grants administered by the DSHS Community Mental Health and Substance Abuse Program. Both direct grants and block grants fund and support a wide variety of prevention services. This includes health education, outreach, risk reduction counseling, referrals for treatment and other needed services, and prevention skills building. Case management is also provided for HIV-positive persons with substance abuse issues and treatment needs. A high proportion of these clients are HCV-infected or at risk of acquiring HCV.

HCV Training of Providers Activities

Staffs at all DSHS-funded HIV counseling and testing programs receive training that includes information about HCV acquisition and health effects. Counselors also receive training on HCV risk assessment and HCV testing protocols, including how to inform clients of non-reactive and reactive HCV test results. Content on viral hepatitis is also included in a DSHS course entitled *STD Facts and Fallacies*, which is required of all counseling and testing contractors. The course details such topics as hepatitis risk factors, signs/symptoms, testing, treatment, prevention and perinatal issues, among others.

Online Hepatitis Training

To assist in meeting training needs across Texas, DSHS developed a Web-based hepatitis training. The online course entitled, "It's Time! Integrate Viral Hepatitis into Your Work" is based on a curriculum developed by the New York State Department of Health National Viral Hepatitis Technical Assistance Center. The four-hour training covers basic information regarding the functions of the liver and basic information regarding hepatitis A, B and C. The course is offered at no charge through TRAIN Texas, a public health training site.

DSHS Viral Hepatitis Community Resource Directory

The DSHS is partnering with the Texas Liver Coalition and other viral hepatitis stakeholders to develop a Web-based hepatitis resource directory. The Texas Liver Coalition received funding to develop the directory and interactive Website through a grant from Vertex, a pharmaceutical company. The Texas Hepatitis Network Website was launched at the Texas Hepatitis Summit in Houston on April 16, 2010. The Texas Liver Coalition, DSHS and the City of Houston Health and Human Services are working with community stakeholders to populate the Website with organizations and agencies that provide viral hepatitis prevention and treatment services, as well as other information helpful to patients, providers and advocates. The Website can be found at: http://www.texashepatitisnetwork.com/index.php

Conclusion

The lack of timely, comprehensive surveillance information, along with limited resources for those who test positive for HCV are significant barriers to addressing hepatitis C in Texas.

This plan highlights some of the successes realized within the past two years. There has been an increase in HCV testing, education and awareness activities. Collaboration with community stakeholders to identify issues and develop strategies for addressing hepatitis C has also increased and been successful.

Further study is needed to fully understand the future effects of federal health care changes on those in need of hepatitis C treatment services in Texas.

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Appendix II. Interagency Council on HIV and Hepatitis, Member Agencies and Representatives

Agency Name	Agency Contact
Texas Health and Human Services Commission	Tom Valentine, Chair
Board of Dental Examiners	Lisa Hoyt
Texas Board of Nursing	Denise Benbow
Department of Aging and Disability Services	Don Henderson
Department of Assistive and Rehabilitative Services	Jan Skinner
Department of Family and Protective Services	Dr. James Rogers
Texas Department of State Health Services	Ann Robbins
Texas Department of Criminal Justice	Dr. Kate Hendricks
Texas Education Agency	Omnalita Sutton
Texas Higher Education Coordinating Board	Donna Carlin
Texas Juvenile Probation Commission	Steve Spencer
Texas Medical Board	Leigh Hopper
Texas Workforce Commission	Catherine L. Bingle
Texas Youth Commission	Rajendra C. Parikh