

Strategic Plan for the Addressing Hepatitis C (HCV) in Rhode Island

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January, 2016

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Background

Hepatitis C (HCV) is the most common blood-borne infection in the US. It is estimated that five to ten million Americans are chronically infected; chronic HCV infection increases the risk for hepatic fibrosis, cirrhosis and hepatocellular carcinoma and is the leading cause of liver transplantation. HCV-attributable deaths increased significantly between 1999 and 2007, and HCV is now a leading infectious cause of death in the U.S., claiming the lives of 12,000–18,000 Americans each year.

The populations at highest risk for infection include current or former injection drug users, the baby boomer cohort (people born in the United States between 1945 and 1965), anyone receiving blood transfusions or organ donations before 1992, hemodialysis patients, persons with HIV, and persons with known exposure to HCV. Although there is no preventive vaccine for HCV, early diagnosis and treatment of hepatitis C can help prevent complications such as liver cancer and cirrhosis.

The Centers for Disease Control and Prevention (CDC) recommends one-time screening for HCV for all individuals born between 1945 and 1965 and ongoing screening for other high-risk populations. Screening in clinical settings may not reach individuals at highest risk, and surveillance systems often do not accurately capture acute HCV infection, thereby underestimating true HCV prevalence. Further, only half of individuals who test positive for antibody to HCV (anti-HCV) undergo confirmatory RNA testing.

The US Preventive Services Taskforce recommends 1-time HCV screening for baby boomers, and more regular screening persons at high risk for infection. With the advent of new, all-oral antiviral medications, hepatitis C is now a curable disease and new HCV treatments present important public health opportunities to reduce HCV-related morbidity and mortality. At the time of publication of this report, the American Association for the Study of Liver Diseases (AASLD) recommended treatment for all patients with chronic HCV infection, except those with short life expectancies that cannot be remediated by treating HCV, by transplantation, or by other directed therapy.

In spite of the public health opportunity associated with treating HCV, there are many challenges with diagnosing and curing people living with HCV. Too few health care providers are knowledgeable about the disease. Little routine HCV screening takes place in Rhode Island. Few physicians are appropriately trained in HCV treatment and care (though regimens are becoming increasingly more simple and could be used by primary care physicians). Even when individuals are insured, insurance programs may not cover all necessary HCV services, particularly new and costly all-oral HCV regimens.

HCV in Rhode Island

A recent modeling study in Rhode Island estimated approximately 16,603 to 22,660 individuals, or just under 2% of Rhode Islanders, are currently chronically infected with HCV. Current HCV surveillance infrastructure in Rhode Island is fragmentary; these estimates are based on a combination of NHANES extrapolation and modeling exercises rather than data gleaned from HCV surveillance systems. Understanding HCV trends through enhanced surveillance could help enhance HCV screening, treatment and cure.

Rhode Island is currently experiencing a syndemic of opiate dependence and overdose stemming from heroin use. Rhode Island ranks seventh in the nation in drug overdose death rates and first in New England; there were 239 confirmed unintentional overdose deaths in Rhode Island in 2014, as compared to 137 in 2009. Through June 2015, 119 individuals overdosed in Rhode Island, suggesting 2015

overdose deaths will surpass those in 2014⁶. With a fatal overdose rate of 19.4 per 100,000 people, Rhode Island surpasses all other New England states and has a rate substantially higher rate of overdose than the national average of 13.4 per 100,000 individuals⁷. As found in both Appalachia and in Massachusetts⁸, the syndemics of acute HCV, opiate dependence, heroin use and overdose in Rhode Island are concomitantly increasing and are likely driven by increases in injection drug use. HCV is another infectious consequence of increasing rates of illicit heroin use, and the Centers for Disease Control and Prevention (CDC) recommends addressing these syndemics in tandem. However, these syndemics are not yet well understood in Rhode Island and warrant further public health action.

This document provides an overview of Rhode Island’s strategic plan for addressing the HCV epidemic. This action plan identifies several public health objectives to reduce HCV-related morbidity and mortality in Rhode Island. They will be prioritized depending on available resources.

Rhode Island Strategic Plan Goals and Objectives

Given the severity of the hepatitis C epidemic in Rhode Island and the timely advent of biomedical advances in the treatment of the disease, the Rhode Island Department of Health proposes a public health model designed to reduce morbidity and mortality from hepatitis C virus. **This document will be continually updated and amended to reflect the changing landscape of the epidemic; it will be publically available and will be considered the backbone of the effort to eliminate hepatitis C in the state of Rhode Island.**

Overarching Goals:

- Prevent HCV transmission and new infections;
- Screen every Rhode Islander for hepatitis C at least once in their lifetime, and diagnose every case of hepatitis C;
- Link every case of hepatitis C to a provider who can care for and treat hepatitis C;
- Ensure equitable access to hepatitis C treatment for all individuals who are living with hepatitis C; and
- Cure as many cases of Hepatitis C as possible

Strategic Plan Outcomes

Successful implementation and execution of the proposed objectives and action items will result in the following short term and long-term outcomes.

- New transmissions of HCV will be reduced;
- Screening for HCV will be expanded in clinical and non-clinical settings;
- Increasing numbers of people living with HCV will be cured;
- Co-morbidities associated with hepatitis C virus will be mitigated; and
- Disparities in HCV prevalence and access to screening, treatment and care will be reduced.

Achieving these outcomes will require concerted coordination of state agencies, government, private payers, hospital systems, and non-governmental service agencies.

The tables below outline specific objectives and action plans to advance HCV surveillance, screening, treatment and cure in Rhode Island.

**Rhode Island Strategic Plan for Addressing Hepatitis C
Objectives and Action Steps**

Objectives	State Agencies	Healthcare Systems, Hospitals and Providers	Community-Based Organizations
<p>Objective 1: To enhance understanding of HCV infection, treatment and cure trends in RI by developing a comprehensive HCV surveillance system.</p>	<ul style="list-style-type: none"> • Collaborate with hospital, academic and community agencies regularly to develop datasets, paying special attention to identifying disease burden, progression and treatment. • Include basic demographic and behavioral characteristics of HCV cases in reporting protocols. • Regularly enforce reporting mandates from healthcare systems, hospitals and providers. • Utilize HCV data related to demographic and behavioral characteristics of HCV patients in order to target future outreach most appropriately. • Develop new infrastructure to facilitate electronic HCV case reporting 	<ul style="list-style-type: none"> • Report HCV cases to the Department of Health from clinical screening sites according to established protocols. • Develop and implement systematic training on HCV case reporting for providers - including physicians, nurse practitioners, nurse managers and medical assistants. • Providers remain current on all standards related to required reporting of HCV cases. • Identify areas where HCV case reporting can be improved • Hospital Management and Leadership diligently enforce HCV case reporting among staff and provide additional training when necessary. 	<ul style="list-style-type: none"> • Continue to collaborate in data collection from HCV cases in all non-clinical, or community settings • Provide incentives for screeners and providers in non-clinical settings to regularly report HCV cases.
<p>Objective 2: To promote HCV screening and adopt AASLD, DCD and USPSTF routine screening guidelines, with a focus on baby-boomers and people who inject drugs (PWID), and to rapidly link individuals to confirmatory screening and care.</p>	<ul style="list-style-type: none"> • Use the AASLD and USPSTF routine screening guidelines as a model when implementing clinical and nonclinical screening protocols. • Encourage quality improvement assessments among institutions on their screening progress. • Collect counseling, screening and referral data on provision of confirmatory test results as it is a commonly cited barrier to engagement in care and progression to treatment and cure. 	<ul style="list-style-type: none"> • Implement system-wide electronic medical record (EMR) prompted HCV screening. • Establish or enforce provision of same-day confirmatory HCV RNA assay procedures for all persons who test antibody positive for HCV in hospital or clinic settings. • Develop EMR prompts to encourage HCV screening during routine clinical care. • Train providers in HCV screening and facilitate linkage to HCV care for all patients diagnosed with HCV. 	<ul style="list-style-type: none"> • Develop systems to conduct HCV screening for at risk individuals in non-clinical, community-based settings. • Enhance current linkage to care protocols for community based HCV screening. • Track HCV cure outcomes for individuals linked to care.

<p>Objective 3: To reduce racial, ethnic, socio-economic, geographic disparities in HCV screening, treatment, care and cure, especially among marginalized and stigmatized populations through population-based public health intervention and improvements to health care systems.</p>	<ul style="list-style-type: none"> • Work with private and state agencies to create tailored media and educational campaigns to reach those most at risk and who may not know they are infected. • Develop and support policies for HCV prevention, screening and care that are supportive and inclusive of drug users, those involved in the corrections system (at the ACI or on probation or parole), and other especially vulnerable populations. • Increase screening and treatment for incarcerated populations. • To support surveillance that explores demographic characteristics of persons living with HCV to identify and address health disparities in infection, disease progression and treatment. 	<ul style="list-style-type: none"> • Ensure that all training protocols regarding HCV screening, treatment and care are culturally competent and inclusive • Providers adhere to practice standards that are designed to enhance provider knowledge of HCV risks, screening, treatment and care. • Discuss and address reported barriers that staff have to offering opt-out, risk-based screening • Adopt training for care of HCV patients that is non-judgmental, non-discriminating and inclusive • Increase awareness among primary care providers of the need for screening, especially among vulnerable populations. Many people are engaged in primary care but have never been screened for hepatitis C. • Hospital leadership and providers ensure that all newly diagnosed patients - regardless of drug use history, addiction, comorbidities, economic or insurance status, or other barriers – receive hepatitis C education, risk-reduction counseling, and care if they test positive. 	<ul style="list-style-type: none"> • Enhance outreach and engagement of “hard to reach” vulnerable populations who are not engaged in health care. Focus resources on engaging these people in screening, and ensure that cases that are identified are engaged in comprehensive services to address HCV comorbidities. • Ensure that all HCV cases identified are engaged in risk-reduction, primary care services, and other social services to augment engagement in care.
<p>Objective 4: To work collaboratively with state Medicaid and private third-party-payers to promote equitable and fair access to HCV screening and treatment.</p>	<ul style="list-style-type: none"> • Work with Medicaid to ensure that formularies are updated to reflect the most recent developments in HCV treatment and care. • Help promote evidence-based practice policies related to all-oral HCV regimens 	<ul style="list-style-type: none"> • Disseminate regular reports on current best practices in HCV treatment guidelines to all relevant staff and providers. • Ensure that all staff and providers have the support they require to complete prior authorization processes for HCV drug approval. • Engage in dialogue about experiences and barriers to treatment of HCV patients within their networks and to state agencies and advocacy groups. This would include prior authorization processes, denials for treatment coverage claims, and staff time and any additional information to describe the current treatment landscape to policy makers and patient advocates. • Share best practices for curing patients living with HCV 	<ul style="list-style-type: none"> • Serve as patient and provider advocates to ensure that patients receive treatment regimens and care that is appropriate, safe, and affordable.
<p>Objective 5: To provide comprehensive, standardized education training for a range health care providers to be able to screen for and treat HCV in accordance with CDC,</p>	<ul style="list-style-type: none"> • Support hospitals and health care systems in developing and implementing provider education and training for HCV screening and treatment. • Evaluate provider training on a regular basis to ensure training is in alignment with current CDC screening and treatment guidelines. 	<ul style="list-style-type: none"> • Develop and administer standardized training around HCV screening, treatment and care for all medical staff, from Medical Assistants to specialists • Utilize telemedicine where applicable to supplement training for all levels of providers, to ensure the most current guidelines are being practiced in clinical settings. • Providers collaborate across sectors – from Primary Care, Hepatology, Gastroenterology, and 	<ul style="list-style-type: none"> • Develop and provide standardized training about HCV screening, treatment and care for all staff • For agencies who provide primary prevention or HCV care and services, ensure that all continued quality best practices are being followed

AASLD and USPSTF guidelines.		Infectious Disease – to maintain knowledge current on CDC and AASLD screening and treatment guidelines for HCV.	
Objective 6: To promote primary prevention efforts, including needle exchange programs and educational initiatives.	<ul style="list-style-type: none"> Continue to provide funding and support for state-run primary prevention efforts. Continue to report back to community partners with successes and barriers these efforts are experiencing on a regular basis. Enhance HCV reporting by building infrastructure for community based agencies to report HCV screening, treatment and cure outcomes. 	<ul style="list-style-type: none"> Have standardized protocols in place for making referrals to primary prevention and risk-reduction for all persons screened for HCV and those who opt-out of screening. Track referrals to these services to determine efficacy and needs in the community Providers commit to hospital and hospital system protocols around referral to primary prevention resources for any patient who is at risk for HCV. Providers and hospital management develop relationships with agencies that provide primary prevention so that referrals can easily be made on a patient by patient basis. 	<ul style="list-style-type: none"> Have standardized protocols in place for making referrals to primary prevention and risk-reduction for all persons screened for HCV and those who opt-out of screening. Report screening, confirmatory testing, linkage and retention in care outcomes, as well as
Objective 7: To develop linkage to care standards and policies for people with prior HCV infection and new diagnoses, and to build clinical capacity to treat persons with chronic HCV.	<ul style="list-style-type: none"> Support programs that provide funding and infrastructure for linkage to care of people who are newly diagnosed or are being re-engaged in HCV care. Ensure linkage to care success (using the HCV care continuum model). 	<ul style="list-style-type: none"> Implement system- or hospital-wide patient navigation model to provide immediate linkage to care for persons with confirmed HCV infection. Secure funding to support linkage and retention in care infrastructure, staff time, training and other resources to be able to have a sustained linkage to care effort throughout hospitals and hospital systems. Extend these resources and infrastructure to community-based agencies that lack the funding to do so. Providers maintain strong provider referral networks for HCV patients so that commonly cited comorbidities are prevented and treated as patient undergoes treatment for the disease. 	<ul style="list-style-type: none"> Utilize patient navigation model to develop or enhance linkage to care protocols in non-clinical settings to ensure that all persons who test positive for HCV are linked to a continuous care with a trained provider.
Objective 8: To support state and local policies that protect and care for persons with HCV or who are at risk for HCV infection, including access to drug treatment regimens.	<ul style="list-style-type: none"> Develop more robust, publicly accessible online resources for HCV education, care, and treatment resources to reflect current guidelines and statistics. Promote the 2014 Strategic Plan goals and objectives in partnership with other state and community agencies. 	<ul style="list-style-type: none"> Ensure that provider training for HCV care, including liver care and care for other comorbid conditions is standardized across disciplines and settings. All providers annually screen HCV patients with cirrhosis for hepatocellular carcinoma and end-stage liver disease. 	<ul style="list-style-type: none"> Community agencies should provide continued feedback and support to state government as policies for screening, treatment and care of persons with HCV evolves.