

**First Biannual Los Angeles Viral Hepatitis Coalition
July 16, 2008**

**Los Angeles County Department of Public Health Office of AIDS Programs and Policy, Multipurpose Room 907 A/B
MEETING NOTES**

TOPIC	PRESENTER	DISCUSSION/RECOMMENDATION	ACTION/FOLLOW-UP
Guest lecture with luncheon: Treatment of Hepatitis C in HIV Infected Persons	Laveeza Bhatti, MD, PhD	Powerpoint Presentation with Q and A session	Please refer to handout in meeting folder
Welcome Remarks	Brian Risley, MA Shobita Rajagopalan, M.D.	Attendees were welcomed and oriented to the meeting events. They were requested to sign in, provide feedback regarding the mission/vision statements and to complete evaluations at the conclusion of the meeting	Informational
Burden of Disease and Epidemiology of Hepatitis A, B, and C in Los Angeles County	Elizabeth Bancroft, MD	Powerpoint Presentation with Q and A session	Please refer to handout in meeting folder
LAC Adult Viral Hepatitis Prevention Coordinator Position	Pierre W. Nsilu, RN, MPA	Powerpoint Presentation with Q and A session	Please refer to handout in meeting folder
California Adult Viral Hepatitis Prevention Coordinator Position	Rachel McLean, MPH	Powerpoint Presentation with Q and A session	Please refer to handout in meeting folder
Progress in Viral Hepatitis Coordination: Successes and Challenges in Los Angeles	Robert Kim-Farley, MD, MPH	Powerpoint Presentation with Q and A session	Please refer to handout in meeting folder
Creating a Viral Hepatitis Prevention Plan for Los Angeles	Pierre W. Nsilu, RN, MPA	Key goals and objectives and 5 principal topic areas (see below) with recommended action steps for the development of a Prevention Plan were highlighted	Attendees were to join one of 5 breakout groups of their interest; each group had a pre-assigned Facilitator, Resource and Presenter. The Facilitator was provided a handout of key points in advance to direct a focused discussion

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A. Identification, Education and Training

Facilitator: M. Squires

Presenter: B. Risley

Resource: E. Freudma

- Who is at risk
 - Inmates in LAC jails
 - Homeless shelters
 - Nursing homes
 - CSVJ (need clarification)
 - Sex workers
 - Beauty parlors/nail salons
 - Immigrants without access to services

- Whom should we educate
 - Health care workers
 - "Docs in a box"
 - Outreach workers
 - Juvenile/detention facilities
 - Sheriff/Staff in jail
 - Accupuncturists
 - Mandated training of County contracted/employed staff

- Resources for screening/treatment are limited
- Models of intervention:
 - Cal State University/University of California recommends HAV/HBV vaccine
- Many people just go to urgent care - issue:
 - Primary care screening, understanding of treatment
- Need for:
 - Social marketing campaign for vaccine awareness for adults
 - Social marketing campaign for screening
 - Social marketing campaign for access to treatment
 - "The New ABC's"
- Issues:
 - Difference between HAV/HBV/HCV
 - Urgent need to treat A and B

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- PSA's

Who is at Risk?

- Hep ABC
 - Immigrants without access to services
 - Who and where are providers/community leaders that may help (resource)
 - Inmate
 - Homeless shelters (+ resource)
 - Nursing homes
 - CSV
 - Sex Workers
 - Beauty Parlors (+ Resource)
 - People with HIV
 - Health workers (resource)
 - Non-English speaking
 - Homeless youth/runaways

Who should we educate?

- HCW
- Primary, other, "docs in boxes"
- Herbal schools
- Reach certain cultures (ie.Asian)
- Acupuncturists
- Outreach workers/MTU staff
- Sheriffs and staff in jails
- Juvenile/detention facilities
- Mandated training to County contracted/employed staff

Issues

- Difference between HAV, HBV and HCV
 - Urgency and need to treat A vs. B
 - Cal State University and University of California recommend HAV and HBV vaccine
- Resources for screening are limited
 - Treatment is limited

Strategies – information to population

- Need for social marketing campaigns (one or many?)
 - For vaccine prevention of hepatitis
 - Encourage adults to get vaccinated

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- Advocacy for public money
- Hep A/B/C fact booklet for all Los Angeles households
 - Possible barriers:
 - Multiple languages needed
- Link to County or other websites
 - Hotlines
- All groups with members associated to Coalition – link website to a “Hepatitis” website

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B. Prevention and Outreach

Facilitator: A. Nelson

Presenter: M. Malek

Resource: Maggie Esquivel (for Sophia Rumanes)

- Importance of making a Plan:
 - Know how to direct resources
 - Identify any common themes
 - Prioritize
- Vaccines are the greatest public health intervention
 - Hep A/B – can have great impact just by targeting high-risk
 - Kids should get 1 dose = 95% immunity
 - Hep B: target adults now because targeting kids was very successful
 - Vaccine for Children (VFC)
 - How to realize similar results among adults now?
 - Make hep A/B vaccine available
- Include other groups into Task Force
 - Occupational Health Professionals: can target workers for vaccination
 - Teachers
 - Private insurance providers: to cover cost
 - therefore some are self-empowered, but many don't
 - Public Health funds for those populations of low income
 - Contrast to VFC – specific funding but no such programs for adults
 - No tracking
- County-wide education of those who are at risk
- Cost
 - Who?
- Data
 - Vaccine is best
- Money needs to be allocated at various levels:
 - Local
 - State
 - Federal
- Improve/create standard protocol in [hepatitis] C infrastructure
 - Compliance with multiple vaccinations

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- Dose 1 – 100%, dose 2 – 50%, dose 3 – 25%
 - *See hand written notes, not completely understood
- Drug rehab, much better uptake
- AASLD – special recommendations (hepatologist recommended vaccinations)
 - Statewide initiative but target high-risk populations and their partners
 - Gay and Lesbian
 - Incarcerated
 - IDU
 - Asian American (hepatitis B)
 - Oregon, Idaho, and Montana have Vaccine for Adults (VFA) available at any public health clinic
 - VFA funding will go down over time
 - Awareness and support for standards – high risk need to be vaccinated
 - Government requirements: How to enact/realize that goal if it becomes standard of practice
 - Audits to include
- Recommendations:
 - Is Opt-Out better?
 - System must be in place for the poor
 - Comprehensive education, web-enabled (insurance information and medical records)
 - Harm Reduction in general
 - Vaccine – people in harm reduction
 - Language services
 - Services to get patients/clients into care
 - NIP/Congress – mandated programs
 - Target risk groups
- Efficient use of current resources and targeting – innovative or efficient
 - Cost savings:
 - Where and how to advocate
 - Appropriation of existing public health litigation
 - Federal
 - Los Angeles Courts
 - State
 - “Keep asking and will say yes”
 - Professional associations
 - Pierre to advocate that this be considered standard
- ◆ Hep C
 - Secondary and tertiary prevention of hep C transmission
 - Vaccination for hep A and B
 - HIV Transmission

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- Discussion and standardize harm reduction (example of pharmacies)
- Findings: Cost saving studies exists therefore advocacy

- Importance of a plan: to direct resources
- Emulate the success of the VFC program for adults
- Create infrastructure for prevention including Harm Reduction
 - Vaccines – need stable funding
- Education
 - *Could not make out the writing...* regarding health insurance and medical records
- Targeting risk groups
 - Linking shared risk groups
- Secondary and tertiary prevention for Hep C and access to care, education, liver clinics
- Seek funding from congress, State, and local Board of Supervisors
- Advocacy and setting of standards with professional health associations
- Earmarks for funding on other bills
- Promulgate cost savings studies
 - Re: Prevention vs. Treatment
 - Eg: Pharmacies as distributors of vaccines

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C. Counseling, Care and Treatment

Facilitator L. Burwell

Presenter: L. Bhatti

Resource: M. Chang

Counseling

- Prior to testing:
 - Define “patient” – offer testing to everyone?
 - Take risk factors into account: IUDA, tattoos, blood transfusions, African American community, HIV
- At diagnosis
 - Prescription plan for disease
 - Refer
 - Explain treatment process
 - Crisis counseling in person (voluntary)
 - Support (e.g. groups)
 - Psychiatric counseling (6 evaluations)
 - Where do patients get treatment and medications
- Just before treatment
 - Explain disease **again**
 - [Assess] providers attitude towards prescription
 - Advise patient to get secondary opinion
 - Educate
 - Alcohol and drug counseling
 - Prevention of transmission
 - Weight reduction and general health
- Pregnancy intervention

Care

- Time between learning diagnosis and starting treatment
- Nutrition, health, anti-depressant, alcohol use
- Side effects of care: family, counseling, care management
- Complementary therapy – yoga, acupuncture, recommend strategies that can do no harm

Treatment

- Hep A
 - No prescription
 - Check DNA, liver profile
- Hep B

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- Oral medications – very good
- If HIV [co-infection], combine prescription
- Advice vaccination for baby – ? Immunoglobulins
- o Hep C
 - Check PCR, Genotype, Diagnose and treat infection
 - Need evaluation
 - Not everyone needs treatment
 - Two very diverging views on discussion of treatment for Hep C

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D. Advocacy and Policy

Facilitator: W. Berger

Presenter: D. Jenkins

Resource

What is advocacy?

- Draw public attention to 'cause' or health problem
- Increase community awareness
- Provider education
- Ignite a response
- "Call-to-Action" – inspire others to join cause or get involved
- Mobilize communities

To whom do we advocate our cause?

- Elected officials, e.g., decision-makers
- Funding agencies (e.g., people with \$).

What problems are we advocating to change? Identify our advocacy goals and the problems we seek to improve (change):

Goal 1. Improve surveillance of *chronic* viral hepatitis in LA County

- Improve surveillance of chronic viral hepatitis to document burden of disease and the populations most affected.
- Medical providers do not uniformly screen groups at higher risk for chronic hepatitis B.
- Promote a standard of care amongst medical providers to report viral hepatitis to the health department.

Goal 2. Improve Counseling & Treatment

- **Problem:** High costs related to treatment for viral hepatitis especially for the uninsured.
- **Problem:** Limited access to care and resources for treatment of the uninsured, e.g., few gastroenterologists available/willing to treat uninsured or underinsured and the wait time to see a liver specialist (hepatologist) at the county USC liver clinic could be up to one year.
- **Problem:** Community unaware of differences between Viral Hepatitis A, B,C. Improve knowledge among community about the differences between Hep A, B, C and treatment resources.
- **Problem:** Service delivery gaps exist, e.g., access to adult hepatitis B vaccine is limited (or not offered at all) as well as treatment for the uninsured LA County population infected with viral hepatitis;

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Goal 3. Improve Education & Outreach

- Target physicians to promote early detection of high-risk groups.
- Improve awareness of viral hepatitis through social marketing principles at both the medical and general community levels.
- Educate elected officials about disease burden and groups most affected;
- Develop a fact sheet for elected officials on the cost/benefits of prevention/early detection of viral hepatitis.
- Develop a viral hepatitis educational packet to promote visibility of the DPH Viral Hepatitis Coalition. Distribute packet during legislative visits and to key stakeholders, e.g., media, community leaders.

Goal 4. Prevention

- Encourage viral hepatitis prevention and early detection.
- Improve access to viral hepatitis resources for vulnerable populations to improve the standard of medical care in LA County.

Who are our Allies?

- | | |
|-----------------------------------|---|
| Cal Hep | Clinics & Hospitals |
| Hep Team LA | Veterans Administration (VA) |
| DPH and DHS | Lobbyists |
| Health Plans | HIV coalitions |
| Other Hepatitis Task Forces | LACMA |
| Non-Profits (also Community Based | CCLHO (CA Coalition of Local Health Officers) |
| Organizations (CBOs) | CSAM (CA Society of Addiction Medicine) |
| Universities | CA Nurses Association |
| Homeless Health Coalition | Pharmaceutical Companies |
| Faith based Organizations | Elected Officials |
| | Community Members |
| | Media |

Who are the Experts to help our cause?

- Identify, gather, and mobilize

Advocacy Evaluation Indicators

How will we monitor or evaluate our advocacy efforts? What measureable indicators will demonstrate that we are meeting our advocacy goals?

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- Number of legislative visits, number of materials developed
- Number of audits in provider offices to see if screenings are increasing
- Increased funding appropriated for viral hepatitis prevention and early detection programs in LA County.
- Declining rates of disease, increased numbers of vulnerable populations screened and vaccinated
- Improved surveillance of chronic hepatitis B

Proposed Advocacy Activities:

1. Build relationships with local elected officials to educate them about viral hepatitis. Emphasize the challenges we face (see above) and the opportunities available to reduce disease morbidity and mortality from viral hepatitis.
2. Collaborate with both official and community grass roots groups, e.g., HIV, Tobacco, Alcohol & Drug, CA Hepatitis Alliance to possibly leverage resources for coalition activities.
3. Improve Viral hepatitis Surveillance system

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E. Screening, Testing and Surveillance

Facilitator: J. Rurangirwa

Presenter: E. Bancroft

Resource: A. Kollipara,

Screening, Testing and Surveillance

General Topics of discussion

Screening and Testing

1. Is the focus prevention of acute cases or prevention to progression of chronic disease?
 - a. Resolution: Both -primary prevention includes vaccines and behavioral changes and secondary prevention focuses on stopping morbidity among individuals with HBV or HCV
2. More testing is needed – increase awareness within the community and among providers to get routine testing for HCV
3. Increase HCV testing
4. What types of viral hepatitis screening and testing is available if funding was available?
5. Can screening occur with outreach activities?
6. Overview of where we are going with screening
7. Access to services after screening
8. HCV testing – there are currently multiple tests available for HCV testing. Current algorithm for HCV testing includes an initial antibody test, and if that is positive a confirmatory test is performed. However, labs do not have to perform the confirmatory test.
9. Signal to cut-off ratios for the HCV screening antibody tests are provided to physicians by the labs. A signal to cut-off ratio of 1 or greater in collaboration with patient history is used to diagnose chronic HCV.

Surveillance

10. Department of Public Health (DPH) does passive surveillance for chronic HBV and HCV
11. Lab reporting is getting better with electronic linkages
12. DPH does active surveillance for HAV since the screening test is not very specific and has a high rate of false positives
13. Lab reporting is getting better with electronic linkages

Issues Identified

Screening and Testing

1. Lax attitude among physicians and other healthcare providers regarding hepatitis screening.
2. Healthcare and allied care providers need additional correct information on:
 - a. Viral hepatitis A, B, and C
 - b. Type of screening and additional tests available
 - c. Resources available to individuals who screen positive
3. Can screening be incorporated with giving vaccines?

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Surveillance

4. No full time staff or resources dedicated within Public Health to follow-up on chronic HBV and/or HCV cases reported to Public Health
5. Race/ethnicity is not included in the lab reports for HBV and HCV
6. Addresses are often missing in laboratory reporting for chronic HCV and HBV making it difficult to de-duplicate cases.
7. How do we get labs to routinely report the EIA signal to cut-off ratios for HCV tests to DPH even though it is currently mandated in California? With this information, chronic HCV cases would be classified if the HCV antibody test had a signal to cut-off ratio of 3 – 4.
 - a. Also DPH is in the process of modifying their data collection system to incorporate this information

Immediate Recommendations from Session Participants

1. Create a single viral hepatitis A-C guideline for healthcare providers that will include:
 - a. Information on who to screen,
 - b. What tests to use
 - c. Interpretation of results
 - d. And if results are positive, available resources for the patient
 - e. Clear guidelines on data collection e.g. demographic and address information
 - i. Including completing the above information on lab slips so that it will be transmitted to DPH by the laboratory running the test
2. Create a single viral hepatitis A-C guideline for CBO's providing small scale screening activities with very limited resources that includes the following information:
 - a. Type of screening tests – including pros and cons of using that particular test
 - b. Minimum basic information to collect on each patient

Resources need to implement the above recommendations:

Personnel time to create and distribute the guidelines.

Additional Points

- Transmission through receipt of blood products has virtually been eliminated in the U.S through donor screening
- The EIA is used as a screening test to detect HCV antibodies in the blood. There are false positive EIAs; therefore, a positive test must be confirmed by the RIBA, or in high-risk groups, by proceeding directly to the PCR, which is required to differentiate acute or chronic infection from a past infection.
- Hepatitis A, B, and C have similar symptoms; which is why testing is important for diagnosis. More importantly, serologic confirmatory testing should be conducted. The HAV IgM antibody test is the most commonly used test to diagnose acute HAV infection.
- Serologic testing is required to make the definitive diagnosis of HBV. Hepatitis B surface antigen (HBsAg) is present in either acute or chronic infection.
- Two main types of testing are available for the detection of the anti-HCV antibody: enzyme immunoassay (EIA) and recombinant immunoblot assay (RIBA). Although these tests are useful in detecting antibodies for hepatitis C virus, they do not distinguish between acute, chronic, or resolved infection.

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- In order to determine the presence or absence of HCV RNA circulating in the blood, HCV PCR testing must be conducted. PCR testing plays an important role in the monitoring of HCV treatment and is more useful in diagnosing acute infection
- There are two types of PCR testing, qualitative and quantitative. Qualitative PCR determines the presence or absence of circulating virus. Quantitative PCR determines the actual number of viral particles and is used to determine the likelihood of response to treatment.
- Challenges to Surveillance:

Educating health care professionals

The main goal of education and training health care providers is to increase the knowledge level and awareness among clinicians and health services providers. Physicians and other professionals such as nurses, social workers, and counselors, need to be better informed on the current screening, testing, counseling, vaccination, medical management, and treatment protocols for viral hepatitis. Education and training materials should include