Viral Hepatitis Prevention and Control

An Action Plan for Maine

2005-2007

Viral Hepatitis Prevention and Control: An Action Plan for Maine

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For additional copies of this Plan check out: www.mainepublichealth.org. Click on "Publications."

For assistance implementing this Plan, please contact the Maine DHHS, Bureau of Health, Division of Disease Control, Hepatitis Coordinator at 1-800-821-5821.

John Elias Baldacci
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Commissioner

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Bureau of Health – Office of the Director

December 1, 2004

Dear Friends of Public Health:

On behalf of the Maine Department of Health and Human Services, Bureau of Health, I am pleased to provide you with this copy of *Viral Hepatitis Prevention and Control: An Action Plan for Maine.* The purpose of this document is to serve as a planning tool to address viral hepatitis A, B, and C in Maine over the next three years.

Viral hepatitis is important to Maine because it can result in severe disability, decreased quality of life, or even death. There are an estimated 20,000 people in the State who have past or current hepatitis C virus infection. Although the numbers are smaller, the incidence of hepatitis A and hepatitis B cases indicate there is still an ongoing need for education and vaccination.

This document is a logical next step in a series of activities that have occurred over the last five years. With little or no external resources, the Bureau of Health along with local and state partners has worked diligently to raise awareness about viral hepatitis and to provide testing and vaccination services. A hepatitis program has existed since 2002 due to the development of hepatitis C legislation in Maine, the receipt of grants and in-kind donations, private and public collaborations, and tireless support from the community.

To determine the best strategies to prevent and control viral hepatitis in Maine, the Bureau of Health brought together public health partners from across the State to develop and prioritize goals, objectives, and action steps for five key areas:

- Advocacy and Funding
- General Public Education
- Clinical and Medical
- Priority Populations
- Care and Support

Of particular importance are the associated goals and objectives that complement the Essential Services of Public Health and keep us on track to meet the *Healthy Maine 2010* objectives.

I wish to gratefully acknowledge the conference planning committee, the conference participants and invited speakers, the breakout group facilitators, the draft reviewers, the writer, and the technical editor for their hard work and dedication to creating this Plan. I would also like to thank the Council of State and Territorial Epidemiologists for providing the grant that supported the planning process.

It is our hope that you will take these recommendations and work with your local community partners to develop programs, support grant requests, set programmatic priorities, evaluate existing programs, and advocate for viral hepatitis funding. For assistance in implementing this Plan, please contact the Bureau of Health Hepatitis Coordinator at 1-800-821-5821.

Sincerely,

Dora Anne Mills, M.D., M.P.H.
Director
Bureau of Health

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Acknowledgments

Viral Hepatitis Prevention and Control: An Action Plan for Maine was made possible thanks to the dedication and support of the conference planning committee, conference participants and invited speakers, the breakout group facilitators, and the draft review committee. Their time, insightful comments, and commitment to moving theses issues forward was invaluable.
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Executive Summary

Viral hepatitis refers to several different viruses that affect the liver: hepatitis A, B, C, D, and E. All of these viruses cause acute, or short-term viral hepatitis. The hepatitis B and C viruses can also cause chronic or long-term hepatitis.

Each year, approximately 1,300 cases of acute and chronic hepatitis A, B, and C are reported to the Maine Department of Health and Human Services, Bureau of Health (BOH). Chronic hepatitis C accounts for the majority of the reported cases and greatest burden of disease. With an estimated 20,000 persons in Maine infected, fewer than 30 percent are aware of their hepatitis C infection status. As a result, opportunities for preventive and therapeutic care that could slow or eliminate the progression of the disease are lost. With the potential for outcomes such as cirrhosis, liver cancer, or death, earlier rather than later intervention is essential.

In 2003, the BOH received a grant from the Council of State and Territorial Epidemiologists (CSTE) to develop a state plan to address viral hepatitis A, B, and C in Maine. During a one-day conference, stakeholders from around the state developed and prioritized feasible, specific and relevant goals and objectives for this Plan. To help guide their efforts, the conference planning committee developed five broad topic areas for discussion in breakout workgroups: Advocacy and Funding, General Public Education, Clinical and Medical, Priority Populations, and Care and Support.

A brief summary of the characteristics of the principle forms of viral hepatitis is located in Appendix A. Details include: transmission, signs and symptoms, prevention messages, risk groups, vaccine recommendations, treatment options, and burden of disease in Maine and the U.S.

This Plan is designed to:

- Reduce the incidence and prevalence of viral hepatitis in Maine through primary and secondary prevention strategies.
- Provide the history and current status of viral hepatitis activities in Maine and in the U.S.
- Provide a framework for collaboration among agencies working with the same high-risk or priority populations.
- Assist state and local agencies with identifying, adopting, and implementing specific goals and objectives identified by stakeholders.

This Plan can be used:

- To support funding applications.
- To identify how to enhance social services by integrating viral hepatitis activities.
- To raise awareness among elected officials.
- To help the people of Maine identify ways to make a difference locally.
- To prioritize activities in an era of limited funding.
- To heighten awareness in the general public about the significance of viral hepatitis.

Audience for this Plan:

- Elected officials in Maine and at the national level
- People working directly or indirectly with persons at high risk for viral hepatitis
- Health professionals
- Public health agencies
- People infected or affected by viral hepatitis
- Other states
- Business leaders
- Media
- Health insurance companies

Guiding Principles

Core concepts to consider when implementing the objectives and action steps found in this Plan:

- Integrate viral hepatitis services into existing prevention programs that serve persons at high risk for HIV, STD, and TB.
- Build on what is already working well.
- Ensure that education efforts are culturally, linguistically, and literacy level appropriate with a particular sensitivity to stigma and lack of awareness in the general public.
- The public and private sectors share responsibility for hepatitis prevention.
- Affected and infected persons should be included in the development and implementation of viral hepatitis activities.
- Implementation of this Plan is not contingent upon funding.
- Whenever possible, a comprehensive approach to HIV, STD, TB, and Viral Hepatitis should be included in both medical assessments and educational messages.

Goals and Objectives

It is important to note that although the need is great, there is currently no funding specifically designated to support the activities outlined in this Plan.

The following goals and objectives for the Plan are for a three-year timeframe: January 1, 2005-December 31, 2007.

Advocacy and Funding

Goal: Maine will have a formally funded, structured, and institutionalized statewide advocacy network to support viral hepatitis activities.

Objective #1: Develop a State ombudsman program for viral hepatitis.

Objective #2*:* Create a statewide grassroots advocacy network for hepatitis C.

Objective #3*:* Create a statewide viral hepatitis coalition to increase funding for prevention, testing, and treatment.

General Public Education

Goal: The people of Maine will have, at minimum, a basic knowledge of viral hepatitis prevention, treatment, and resources.

Objective #1: Develop a statewide viral hepatitis media campaign.

Objective #2: Develop a pilot community health advisor program.

Objective #3*:* Educate persons working with middle and high school age children about viral hepatitis prevention, treatment, and resources.

Clinical and Medical

Goal #1: All Maine **H**ealth care providers, **S**ocial service providers, and **A**llied health workers (HSA) will have knowledge of viral hepatitis prevention, testing and counseling, diagnosis, treatment, and resources.

Objective #1: Assess Maine health care provider, social service provider, and allied health worker knowledge of viral hepatitis.

Objective #2*:* Develop and disseminate a comprehensive continuing education curriculum for HSA on viral hepatitis prevention, testing and counseling, diagnosis, treatment, and resources.

Objective #3*:* Provide accessible, user-friendly viral hepatitis resources for HSA that include current guidelines for an integrated approach to screening, patient education, and treatment.

Goal #2: Maine will have a comprehensive, integrated standard of care/clinical pathway for viral hepatitis.

Objective #1: Create a comprehensive patient risk assessment tool for use by HSA and emergency response personnel.

Objective #2: Create a clinical pathway that includes but is not limited to prevention, testing and counseling, diagnosis, treatment, support, and a comprehensive approach to services.

Objective #3: Create Regional Centers of Excellence (RCE) for primary health care providers to obtain clinical guidance on complex viral hepatitis cases (similar to the Virology Treatment Center at Maine Medical Center).

Priority Populations

Priority Populations are defined as people who practice (or have practiced) certain behaviors or have had other exposures that place them at an increased risk for viral hepatitis. High-risk status is defined in guidelines published by the Centers for Disease Control and Prevention (see Appendix A).

Goal #1: Decrease the incidence and prevalence of viral hepatitis in Priority Populations in Maine.

Objective #1: Educate Priority Populations about viral hepatitis.

Objective #2: Educate social service providers working with Priority Populations about viral hepatitis.

Objective #3*:* Increase hepatitis C testing in Priority Populations.

Objective #4: Increase hepatitis A and B vaccination in Priority Populations.

Objective #5*:* Establish peer support groups designed for members of Priority Populations.

Objective #6: Educate primary health care providers to work more effectively with Priority Populations.

Care and Support

Goal: Maine will have an Integrated, Coordinated, Comprehensive System (ICCS) of care and support available for people at risk for and/or infected with HCV.

Objective #1: Define the components of an ICCS for Maine.

Objective #2: Address the gaps of ICCS elements by region.

Objective #3*:* Plan for implementation of the ICCS system.

Purpose of the Plan

The purpose of ***Viral Hepatitis Prevention and Control: An Action Plan for Maine*** is to serve as a planning tool to address viral hepatitis A, B, and C in Maine. A brief summary of the characteristics of the principle forms of viral hepatitis is located in Appendix A. Details include: transmission, signs and symptoms, prevention messages, risk groups, vaccine recommendations, treatment options, and burden of disease in Maine and the U.S.

The Plan is designed to:

- Reduce the incidence and prevalence of viral hepatitis in Maine through primary and secondary prevention strategies.
- Provide the history and current status of viral hepatitis activities in Maine and in the U.S.
- Provide a framework for collaboration among agencies working with the same high-risk or priority populations.
- Assist state and local agencies with identifying, adopting, and implementing specific goals and objectives identified by stakeholders.

The Plan can be used:

- To support funding applications.
- To identify how to enhance social services by integrating viral hepatitis activities.
- To raise awareness among elected officials.
- To help the people of Maine identify ways to make a difference locally.
- To prioritize activities in an era of limited funding.
- To heighten awareness of the general public about the significance of viral hepatitis.

Audience for the Plan:

- Elected officials in Maine and at the national level
- People working directly or indirectly with persons at high risk for viral hepatitis
- Health professionals
- Public health agencies
- People infected or affected by viral hepatitis
- Other states
- Business leaders
- Media
- Health insurance companies

Challenges and Strengths

Because Maine is a largely rural state with a low population density, several challenges exist in the effort to prevent and control viral hepatitis. For example, there are very few local health departments in the State. In Maine, local community organizations and individual health care providers with wide geographic coverage areas and limited resources deliver most health and social services. The people of Maine living in areas outside of Bangor, Lewiston, and Portland have long distances to travel to reach the few specialists treating viral hepatitis and to access free State-sponsored services. Other constraints include the lack of public transportation in

most rural areas. Anecdotal evidence supports the presence of a hidden epidemic of injection drug use in the State, a behavior that facilitates viral hepatitis transmission.
Although the need for viral hepatitis prevention and control interventions is great, funding remains limited. There is currently no funding specifically designated to support the activities outlined in this Plan.

Strengths to support implementation of a viral hepatitis plan include the considerable groundwork already laid by both the HIV community and viral hepatitis advocates (see Appendix B). Experienced educators familiar with the multiple challenges facing public health programs provide the existing services reaching high-risk populations. Opportunities for collaboration among agencies with similar missions exist and have already been implemented in some areas. The Bureau of Health has a CDC trained hepatitis C coordinator and a medical epidemiologist who holds a national leadership position focusing on viral hepatitis. The Bureau of Health has surveillance systems to track the number of cases of viral hepatitis and trained experts to conduct investigation and outbreak response. The State has some funding and will continue to seek out resources to support Plan activities. The recent addition of a hepatitis B immunization requirement to the day care rules and the passage of hepatitis C legislation have helped to raise awareness and support for the issues.

Goals and Objectives

This Plan was conceived with the intent of creating feasible, specific and relevant goals and objectives. Professional and community stakeholders working directly or indirectly with persons infected or affected by viral hepatitis developed and prioritized goals, objectives, and action steps. For more information on this process, see Appendix C.

In order to effectively prevent and control viral hepatitis in Maine, a variety of strategies and key collaborations are necessary. This Plan is divided into five areas of concentration: Advocacy and Funding, General Public Education, Clinical and Medical, Priority Populations, and Care and Support. The goals and objectives for this Plan are for a three-year timeframe: January 1, 2005—December 31, 2007. It is the hope of the stakeholders that all persons in a position to implement any part of this Plan will keep the following guiding principles in mind when implementing the strategies outlined in this road map.

Guiding Principles

Core concepts to consider when implementing the objectives and action steps found in this Plan:

- Integrate viral hepatitis services into existing prevention programs that serve persons at high risk for HIV, STD, and TB.
- Build on what is already working well.
- Ensure that education efforts are culturally, linguistically, and literacy level appropriate with a particular sensitivity to stigma and lack of awareness in the general public.
- The public and private sectors share responsibility for hepatitis prevention.
- Affected and infected persons should be included in the development and implementation of viral hepatitis activities.

- Implementation of this Plan is not contingent upon funding.
- Whenever possible, a comprehensive approach to HIV, STD, TB, and Viral Hepatitis should be included in both medical assessments and educational messages.

Advocacy and Funding

Advocacy and Funding were identified as a priority issues for inclusion in this Plan for the following reasons:

- There is currently no formal advocacy organization in the State of Maine that supports viral hepatitis issues.
- The Bureau of Health hepatitis C coordinator has multiple competing responsibilities, which leaves a minimal amount of time to focus on advocacy and funding initiatives.
- Organizations that have a similar mission (e.g. focus on other bloodborne pathogens) are not funded to focus on viral hepatitis and therefore unable to advocate for or raise awareness on a broad scale.
- Due to a variety of reasons, perhaps including stigma or failing health, patient advocates have been unable to organize around the issues.
- Funding for viral hepatitis at the national level and in Maine has been scarce. To continue to expand viral hepatitis services in Maine, advocating for, identifying and securing consistent sources of funding is essential.

Goal: Maine will have a formally funded, structured, and institutionalized statewide advocacy network to support viral hepatitis activities.

Objective #1: Develop a State ombudsman program for viral hepatitis.

Action Steps:

- ***Identify natural allies and partners in the community to champion the development of a state-level viral hepatitis advocacy and funding program i.e.:***
    - ***Health professionals***
    - ***Elected officials***
    - ***Media***
    - ***Social service providers working with affected persons***
    - ***General public***
    - ***Employers***
    - ***Persons infected/affected by viral hepatitis***
- ***Define the role of a viral hepatitis ombudsman--i.e. viral hepatitis advocacy/leadership position vs. someone responsible for investigating and resolving complaints from the public (which is a typical role for an ombudsman).***
- ***Examine the role of the Bureau of Health hepatitis C coordinator and how it complements and contrasts with the projected role of the viral hepatitis ombudsman.***
- ***Assess the capacity of State resources to develop a new hepatitis leadership position vs. enhancement of existing positions.***
- ***Investigate potential funding sources to support these initiatives.***

Objective #2: Create a grassroots statewide advocacy network for hepatitis C.

Action Steps:

- ***Create a working list of hepatitis C contacts (e.g. professionals, persons infected/affected by hepatitis C, etc.).***
- ***Designate a facilitator for development of the advocacy network.***
- ***Research other hepatitis C or related advocacy networks that might serve as models.***
- ***Conduct strategic planning sessions with advocacy network participants to determine the mission and goals of the network.***
- ***Assess the skills and resources of network participants to aid in the network mission.***
- ***Schedule a predictable, ongoing forum for participants' continued engagement e.g. regular meetings or annual conferences.***
- ***Assess the best mode of communication for the network participants (e.g. email list, conference call, telephone tree, or meetings).***
- ***Research, obtain, and/or develop advocacy literature for the network.***

Objective #3: Create a statewide viral hepatitis coalition to increase funding for prevention, testing, and treatment.

Action Steps:

- ***Convene state and local viral hepatitis partners and advocates to discuss the development of a funding strategy.***
- ***Research funding mechanisms and fundraising strategies used by non-profit organizations with similar public health missions.***
- ***Examine opportunities for partnership with nonprofit organizations that have similar public health missions.***
- ***Build relationships with volunteer and business organizations (e.g. chamber of commerce, large corporations, Elks Club, Rotary) to raise awareness about viral hepatitis, to provide a forum for raising donations, and to serve as partners in the statewide viral hepatitis coalition.***
- ***Research grants for application.***
- ***Identify potential grant writers.***
- ***Develop an educational packet for targeted funders.***
- ***Develop a list of priorities for funding.***

General Public Education

General Public Education was prioritized for inclusion in this Plan for the following reasons:

- The 2001 hepatitis C needs assessment, "At the Crossroads: Hepatitis C Infection in Maine" identified a significant need for increasing public awareness about hepatitis C.
- To date, the only broad-based hepatitis C public awareness activities in Maine have been limited to a 4-month TV/radio public service announcement campaign and occasional publications of articles in local newspapers.
- Public education about hepatitis B has been limited to child and adolescent immunization.
- Public education about hepatitis A occurs only in the setting of disease outbreaks.
- In Maine, and in the nation as a whole, confusion about the differences between hepatitis A, B, and C continues.

Goal: The people of Maine will have, at minimum, a basic knowledge of viral hepatitis prevention, treatment, and resources.

Objective #1: Develop a statewide viral hepatitis media campaign.

Action Steps:

- ***Evaluate existing public service announcements for potential adaptation to Maine audiences.***
- ***As needed, create public service announcements (radio + TV) that provide information on viral hepatitis (prevention, transmission and resources) targeted to the people of Maine.***
- ***Develop a Maine specific brochure(s) on viral hepatitis.***
- ***Ensure that public service announcements and brochures are literacy and culturally appropriate.***
- ***Pilot test public service announcements and brochures with representatives from target groups and make adjustments based on feedback.***
- ***Disseminate radio and TV public service announcements statewide.***
- ***Create and implement an innovative plan to disseminate the brochures in places "where the people are."***

  Some examples of places to distribute educational information:
  - ***Newspapers (ads + inserts)***
  - ***Libraries***
  - ***Grocery stores***
  - ***Laundromats***
  - ***Doctors' offices***
  - ***Restaurants***
  - ***Churches***
  - ***Government agencies (Department of Motor Vehicle, post offices, DHHS regional offices)***
  - ***Schools (college + high school)***
- ***Evaluate the media campaign.***

Objective #2*:* Develop a pilot community health advisor program.

A community health advisor is a trusted individual who provides health information to members of the community. Most often, it is a local woman (or man) who shares cultural or ethnic characteristics with the target population. A community health advisor provides support and health education to family, friends, neighbors and other community members in need of health improvement.

Action Steps:

- ***Define the role of a community health advisor.***
- ***Identify health care providers and social service providers with the skills/knowledge to train local community health advisors about viral hepatitis prevention, treatment and resources.***
- ***Form a committee of community leaders to identify potential community health advisors.***
- ***Recruit community health advisors for a pilot program.***
- ***Train community health advisors to provide viral hepatitis education and referral in their communities in accordance with their language, cultural needs, and customs.***
- ***Evaluate the pilot program.***

Objective #3*:* Educate persons working with middle and high school age children about viral hepatitis prevention, treatment, and resources.

Action Steps:

- ***Enlist the support of the Maine Principals Association (or equivalent for Superintendents) to help highlight the importance of viral hepatitis education.***
- ***Work with the Department of Education to assess existing school health curricula (for the inclusion of viral hepatitis modules).***
- ***As needed, integrate viral hepatitis information into the school health curricula.***
- ***Evaluate the impact of integrating viral hepatitis into the school health curricula.***
- ***Assess school nurse, school health teacher, and youth social service provider knowledge of viral hepatitis prevention, treatment, and resources.***
- ***Provide comprehensive trainings in response to assessment results.***
- ***Evaluate the impact of the trainings.***

Clinical and Medical

The decision to include a Clinical and Medical topic in this Plan was based on several key findings:

- A survey of a sample of Maine primary care providers conducted in association with the 2001 hepatitis C needs assessment, "At the Crossroads: Hepatitis C Infection in Maine," identified a significant need for accurate and up-to-date primary care provider education on risk assessment, diagnosis, and treatment of hepatitis C.
- This finding is further supported by hepatitis C infected patients' descriptions of encounters with medical providers unable to provide them with basic information about the virus.
- To date, there has been no coordinated or comprehensive effort to educate primary health care providers, social service providers or allied health workers in Maine about viral hepatitis.
- Less than 30% of people infected with hepatitis C in Maine are aware of their infection. Given this circumstance, Maine primary health care providers will continue to serve a key role in identifying and diagnosing persons at risk for hepatitis C infection.

Although the numbers are relatively small in comparison to hepatitis C, hepatitis A and B are included in this section because of similarities in risk groups, transmission (in some cases), and because discussion about one of the hepatitis viruses often warrants discussion about the others.

Goal #1: All Maine **H**ealth care providers, **S**ocial service providers, and **A**llied health workers (HSA) will have knowledge of viral hepatitis prevention, testing and counseling, diagnosis, treatment, and resources.

Objective #1: Assess HSA knowledge of viral hepatitis.

Action Steps:

- ***Research existing viral hepatitis knowledge survey tools.***
- ***Consult with local HSA representatives on the development/adaptation of a viral hepatitis survey.***
    - ***Provide the survey tool in a variety of formats (e.g. electronic, paper, or web-based).***
- ***Conduct a pilot test of the survey with a sample of HSA.***
- ***Incorporate group feedback into the survey.***
- ***Distribute the survey to HSA.***
- ***Analyze survey data.***
- ***Share survey data results with participants and stakeholders.***

Objective #2: Develop and disseminate a comprehensive continuing education curriculum for HSA on viral hepatitis prevention, testing and counseling, diagnosis, treatment, and resources.

Action Steps:

- ***Research existing viral hepatitis curricula targeting HSA.***
- ***Consult with representatives from HSA and Priority Populations on the development of the curriculum.***
- ***Use HSA survey data to inform the development of the curriculum.***
- ***Create a curricula tailored to HSA that includes a variety to teaching approaches such as:***
  - ***Presentations***
  - ***Print***
  - ***Training website***
  - ***Teleconferencing/videoconferencing***
  - ***Self-study modules (print or web)***
  - ***CD-ROM***
- ***Develop corresponding evaluation measures for each module to determine achievement of objectives.***
- ***Apply for continuing education units (CEU) and continuing medical education (CME) hours.***
- ***Partner with respective professional organizations to develop strategies for reaching their members (e.g. conferences, grand rounds, training courses, seminars, etc.).***
- ***Evaluate the effectiveness of the training and recruitment strategy.***

For more information about educating primary health care providers, see the *Priority Populations* section.

Objective #3: Provide accessible, user-friendly viral hepatitis resources for HSA that include current guidelines for an integrated approach to screening, diagnosis, patient education, and treatment of viral hepatitis.

Action Steps:

- ***Assess existing resources available for HSA on viral hepatitis.***
- ***Survey HSA to determine best media for accessing resources.***
- ***Consult with representatives from HSA on the development of a comprehensive viral hepatitis tool kit that includes user-friendly educational materials (which may be adapted from the training curriculum) and patient resources.***
- ***Create a central location (such as a website) from which to access and disseminate basic hepatitis information, educational materials, and information on referrals and support groups in Maine.***
- ***Advertise and disseminate the tool kits by partnering with HSA professional organizations to learn the best strategies for reaching their members.***

Goal #2: Maine will have a comprehensive, integrated standard of care/clinical pathway for viral hepatitis.

Objective #1: Create a comprehensive patient risk assessment tool for use by HSA and emergency response personnel.

Action Steps:

- ***Research existing integrated risk assessment tools.***
- ***Create a committee of HSA stakeholders to provide input into the development of a risk assessment.***
- ***Develop a risk assessment tool that is practical and easy to use/administer***
- ***Recruit a small group of HSA to pilot test the risk assessment with their patients.***
- ***Provide training to HSA on how to use the risk assessment.***
    - ***Include counseling information that is tailored to working with Priority Populations and uses a harm reduction approach.***
- ***Distribute the risk assessment to HSA and their respective professional organizations.***
- ***Evaluate the impact of using the risk assessment.***

Objective #2: Create a clinical pathway that includes but is not limited to prevention, testing and counseling, diagnosis, treatment, support, and a comprehensive approach to services.

Action Steps:

- ***Create an expert viral hepatitis committee to develop a clinical pathway.***
- ***Research existing clinical pathway resources.***
- ***Draft a Maine specific clinical pathway that applies to multiple types of health care provider settings (private offices, Department of Corrections, substance abuse treatment centers, hospitals, etc.).***
- ***Build in a process for a periodic (e.g. annual) review of recommendations for any necessary modifications.***
- ***Distribute a draft of the clinical pathway to the expert viral hepatitis committee and external reviewers for feedback.***
- ***Disseminate to Maine health care providers.***

***Objective #3*:** Create Regional Centers of Excellence (RCE) for primary health care providers to obtain clinical guidance on complex viral hepatitis cases (similar to the Virology Treatment Center at Maine Medical Center).

Action Steps:

- ***Recruit specialists treating viral hepatitis in Maine to serve on an education/consultation committee.***
- ***Investigate the feasibility of replicating the Virology Treatment Center model in other parts of the State.***
- ***Apply for funding to create Regional Centers of Excellence.***

- ***Develop an interim model or short-term consultation plan for use while Regional Centers of Excellence are in the development phase.***
- ***Ensure coordination with care and support systems (see Care and Support section).***

Priority Populations

Priority Populations are defined as people who practice (or have practiced) certain behaviors or have had other exposures that place them at an increased risk for viral hepatitis. High-risk status is defined in guidelines published by the Centers for Disease Control and Prevention (see Appendix A).

Priority Populations warrant an entire section in this Plan for several reasons:

- Because they have a demonstrated increased risk for viral hepatitis (based on participation in certain high-risk behaviors).
- They have higher viral hepatitis infection rates than the general population and there is a high probability they are uninsured or underinsured and do not access healthcare services regularly.
- Based on lessons learned from HIV prevention strategies, to reach Priority Populations, targeted health education messages and tailored outreach strategies are essential.
- In addition, Priority Populations need comprehensive, coordinated services that are accessible and culturally competent.

Goal #1: Decrease incidence and prevalence of viral hepatitis in Priority Populations in Maine.

Objective #1: Educate Priority Populations about viral hepatitis.

Action Steps:

- ***Choose one or more Priority Population on which to focus intervention efforts.***
- ***Conduct a materials review to gather information about pre-existing integrated educational tools that are easy to use, population based, credible, and use a harm reduction approach.***
- ***As needed, tailor educational materials to create Maine specific educational brochures, flyers, posters, etc.***
- ***Ensure that members of the targeted Priority Populations participate in the development and/or approval of materials.***
- ***Consult with members of the targeted Priority Populations to develop an outreach strategy and materials dissemination plan to reach peers "where they are, when they are" i.e. bars, substance abuse clinics, shelters, emergency rooms, etc. Consider using "peer to peer" strategies.***
- ***Promote existing viral hepatitis resources to Priority Populations.***
- ***Evaluate the effectiveness of the outreach/dissemination strategy.***

Objective #2: Educate social service providers working with Priority Populations about viral hepatitis.

Action Steps:

- ***Gather information about existing trainings for social service providers that include medical/clinical aspects of the hepatitis viruses, cultural competence, training on how to conduct an accurate risk assessment, using a harm reduction model, interviewing skills, and a written manual.***

- ***Collaborate with state agencies (Bureau of Health, Department of Corrections, Office of Substance Abuse, and other relevant agencies) to ensure the trainings include concepts appropriate for each setting.***
- ***Create or adapt a standard viral hepatitis training manual for the State of Maine.***
- ***Recruit social service providers to attend the trainings (making sure to include continuing education credits for the training).***
- ***Implement trainings.***
- ***Establish an annual conference on viral hepatitis prevention and control for social service providers (make sure to include diverse speakers, and varied educational methods and topics).***

Objective #3*:* Increase hepatitis C testing in Priority Populations.

Action steps:

- ***Evaluate existing state-funded HCV testing sites to assess the volume of high-risk patients, prevalence of disease, appropriateness of setting, and barriers to implementation (funding to provide testing, liability insurance, lack of phlebotomy training, etc.).***
- ***Assess consumer barriers to accessing HCV testing.***
- ***Make modifications based on the evaluation.***
- ***Re-evaluate the existing high-risk criteria for HCV testing in State-funded sites.***
- ***Investigate feasibility of offering testing in non-traditional, non-clinical settings frequented by high-risk individuals (e.g. drug treatment facilities, jails, homeless shelters, recreational venues, etc.).***
- ***Research the availability of funding necessary to support the expansion of testing sites.***
- ***Implement testing programs in feasible "non-traditional testing sites."***
- ***Provide continuing education to professionals working at sites that provide hepatitis C counseling, testing, and referral services.***
- ***Advertise viral hepatitis services to Priority Populations and to agencies that serve them.***
- ***Create a comprehensive viral hepatitis resource guide.***

Objective #4: Increase hepatitis A and B vaccination in Priority Populations

(See Appendix A for a listing of persons recommended to receive hepatitis A/B vaccination)

Action Steps:

- ***Evaluate existing State-funded hepatitis A and B vaccine sites to assess the volume of high-risk patients, appropriateness of setting, and barriers to implementation (funding to provide vaccine, liability insurance, lack of trained staff, etc.).***
- ***Assess barriers to vaccine acceptance.***
- ***Make modifications based on the evaluation.***
- ***Re-evaluate existing eligibility criteria for free hepatitis A and B vaccine (State funded sites).***

Objective #5: Establish peer support groups designed for members of Priority Populations.

Action Steps:

- ***Survey social service providers and health care providers to determine which communities are most in need of support groups.***
- ***Conduct a survey of a sample of members of Priority Populations to assess their needs for support groups.***
- ***Recruit and train support group facilitators.***
- ***Identify locations for support groups.***
- ***Advertise support group locations and promote the formation of new groups.***
- ***Assess barriers to attendance at support groups i.e.***
    - ***Scheduling***
    - ***Child care***
    - ***Transportation***
- ***Work with support group members to identify ways to reduce barriers to participation.***
- ***Evaluate the impact of offering peer support groups.***

Objective #6: Educate primary health care providers to work more effectively with Priority Populations.

Action Steps:

- ***Identify professionals with experience caring for Priority Populations.***
- ***Identify existing trainings for health care providers on conducting risk assessments, cultural competence, harm reduction, and viral hepatitis.***
- ***Develop or adapt the curricula for Maine primary health care providers.***
- ***Provide training on how to conduct a risk assessment during a primary care visit (using a practical, easy-to-administer tool).***
- ***Provide training on cultural competence.***
- ***Provide training on harm reduction.***
- ***Educate health care providers about community-based viral hepatitis resources.***

For more information about educating primary health care providers, see the *Clinical and Medical section.*

Care and Support

One of the most significant challenges for a person exposed to or diagnosed with hepatitis C is navigating the complex, expensive, disconnected, and often-incomplete web of services available in Maine. The 2001 hepatitis C needs assessment, "At the Crossroads: Hepatitis C Infection in Maine" recommended the creation of a comprehensive system of care, including, at minimum, medical, mental health, and substance abuse treatment services. Participants at the *Viral Hepatitis Prevention and Control: An Action Plan for Maine* conference reiterated this recommendation and suggested the strategy outlined in this section to help make a comprehensive system of care a reality.

Goal: Maine will have an Integrated, Coordinated, Comprehensive System (ICCS) of care and support available for people at risk for and/or infected with HCV.

Objective #1: Define components of an ICCS for Maine. The ICCS must include the following elements:

- Affordable and accessible counseling, testing, and referrals
- An integrated approach to HIV, STD, TB, and Viral Hepatitis
- Medical evaluation and treatment (HCV clinical pathway/standard of care)
- Consultation/expert care services
- Information and resources
- Post-exposure prophylaxis
- Case management (include standards that will help to decrease the number of people who “fall through the cracks”)
- Pharmaceuticals access
- Psychosocial support
- Mental health services
- Substance abuse treatment/counseling
- Education for patients and providers
- A plan to evaluate the system

Action steps:

- ***Assess existing viral hepatitis ICCS elements/services in the State.***
- ***Examine the feasibility of offering regional ICCS systems.***
- ***Identify a coordinator in each region of the State for these activities.***
- ***Conduct a resource inventory of ICCS elements by region.***
- ***Conduct an analysis of the ICCS gaps in each region.***
- ***Assess patient barriers to prevention, testing, and treatment by a limited survey of diagnosed patients and their providers.***

Objective #2: Address the gaps of ICCS elements by region.

Action steps:

- ***Create a plan to develop resources to fill in the gaps identified in each region.***
- ***Identify activities that could be centralized to benefit the ICCS, i.e. create warmline/hotline model, in partnership with the Bureau of Health where patients can access basic information and referrals to Regional Centers of Excellence or clinics for testing, diagnostics, treatment, and support programs.***
- ***Partner with stakeholders in each region to devise a coordinated, multi-tiered approach--including minimum elements necessary for an ICCS system.***

Objective #3*:* Plan for implementation of the ICCS system.

Action Steps:

- ***Using information gathered through the assessments and surveys conducted statewide, apply for funding to support the ICCS system.***
- ***Create a plan for implementation that includes a step-wise approach.***
- ***Work with Regional Centers of Excellence to begin implementation of the ICCS.***

Glossary

Acute: A short-term, intense health effect. For purposes of this Plan, acute hepatitis A, B or C reflects newly acquired infection.

Advisory Committee on Immunization Practices (ACIP): A committee made up of 15 experts in fields associated with immunization who have been selected by the Secretary of the U. S. Department of Health and Human Services to provide advice and guidance to the Secretary, the Assistant Secretary for Health, and the Centers for Disease Control and Prevention (CDC) on the most effective means to prevent vaccine-preventable diseases.

Allied Health Professional: A person involved with the delivery of health or related services pertaining to the identification, evaluation and prevention of diseases and disorders; dietary and nutrition services; rehabilitation and health systems management, among others. Allied health professionals, to name a few, include dental hygienists, diagnostic medical sonographers, dietitians, medical technologists, occupational therapists, physical therapists, registered nurses, radiographers, respiratory therapists, and speech language pathologists. See http://www.asahp.org/definition.html for more information.

Chronic: Term used to describe a disease of long duration. For chronic hepatitis B and C, chronic is specified as persisting infection for 6 months or longer.

Community Health Advisor: A community health advisor is a trusted individual who provides health information to members of the community. Most often, it is a local woman (or man) who shares cultural or ethnic characteristics with the target population. A community health advisor provides support and health education to family, friends, neighbors and other community members in need of health improvement.

Consumer: A person in the community who receives services from a health or social service provider.

Council of State and Territorial Epidemiologists (CSTE): An organization for epidemiologists that promotes the effective use of epidemiologic data to guide public health practice and improve health.

Clinical pathway: A patient-focused tool, which describes the timeframe and sequencing of routine, predictable multidisciplinary interventions and expected patient outcomes for a group of patients with similar needs.

Epi-Gram: A Maine Department of Health and Human Services, Bureau of Health, Division of Disease Control publication that contains timely and science-based information to guide Maine's healthcare professionals in issues of public health and infectious disease importance and to promote statewide infectious disease surveillance.

Goal: A broad, brief statement of intent that provides focus or direction for the work. A goal is non-specific, non-measurable, and is rarely attainable.

Guiding Principles: Beliefs and values to keep in mind when implementing activities outlined in *Viral Hepatitis Prevention and Control: An Action Plan for Maine*.

Harm Reduction: A set of practical strategies, including clean needle and syringe exchange, that reduce negative health consequences of drug use, incorporating a spectrum of approaches from safer use, to managed use, to abstinence.

Health care provider: An individual licensed to diagnose and treat disease such as a physician, a nurse practitioner or a physician assistant. Primary health care providers and specialists are included in this category.

HSA: Abbreviation for Health care providers, Social service providers, and Allied health professionals.

ICCS: The Integrated, Coordinated, Comprehensive System of care and support described in the *Care and Support* section of this Plan.

Incidence: The number of new cases of a condition that occur in a given population over a period of time.

Integration: A comprehensive approach to providing multiple prevention services at a single client visit. Prevention services may include counseling, testing, prevention education, immunization, and treatment services. The similar modes of transmission of HIV, HCV, and HBV present a unique opportunity to provide integrated services. Integration may also include prevention services for tuberculosis.

Objective: A statement that provides realistic steps toward attaining a goal. For this Plan, conference participants were asked to come up with specific, relevant, and feasible objectives.

Prevalence: The number of infected individuals in a population at a given point in time.

Primary care provider: A health care provider responsible for general/basic health care including practitioners in internal medicine, family practice, pediatrics, or OB/GYN. This is opposed to a specialist, such as a gastroenterologist, who does not provide general medical care.

Primary interventions: Strategies (such as providing educational materials and counseling) designed to prevent uninfected persons from becoming infected with a virus, in this case, the viruses that cause viral hepatitis.

Priority Populations: Priority Populations are defined as people who practice (or have practiced) certain behaviors or have had other exposures that place them at an increased risk for viral hepatitis. High-risk status is defined in guidelines published by the Centers for Disease Control and Prevention (see Appendix A).

Regional Center of Excellence (RCE): A hospital-based center staffed by health care providers that have experience diagnosing and treating viral hepatitis (as described in the *Clinical and Medical* section of this plan). The purpose of the center is to provide state-of-the-art care for patients and to offer primary health care providers with clinical guidance on complex viral hepatitis cases (similar to the Virology Treatment Center at Maine Medical Center).

Regions

Northern Maine: Aroostook, Hancock, Penobscot, Piscataquis, and Washington Counties

Central Maine: Androscoggin, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset, and Waldo Counties

Southern Maine: Cumberland and York Counties

Secondary interventions: Strategies used to identify, counsel, and test individuals most likely to be infected with a particular virus, in this case, viruses that cause viral hepatitis. The goal of secondary interventions is to provide or refer consumers to the appropriate medical or social services that will help prevent progression of the disease.

Social service providers: social workers, counselors, mental health professionals, substance abuse counselors, health educators, and disease intervention specialists.

References and Resources

The following sources were used to inform the development of *Viral Hepatitis Prevention and Control: An Action Plan for Maine.* A special thanks to the States of Massachusetts, Vermont, Wisconsin, Colorado, Minnesota, Connecticut, New York, and California for sharing copies of their hepatitis state plans and lessons learned.

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Centers for Disease Control and Prevention. 2002 guidelines for treatment of sexually transmitted diseases. MMWR 2002;51(No. RR-06); 1-80.

Centers for Disease Control and Prevention. Hepatitis B virus: a comprehensive strategy for eliminating transmission in the United States through universal childhood vaccination--- recommendations of the Immunization Practices Advisory Committee (ACIP). MMWR 1991;40(No. RR-13).

Centers for Disease Control and Prevention. Immunization of adolescents: recommendations of the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, the American Academy of Family Physicians, and the American Medical Association. MMWR 1996;45:1-5.

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Centers for Disease Control and Prevention. Prevention of hepatitis A through active or passive immunization: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1999;48(No. RR-12).

Centers for Disease Control and Prevention. Recommendations for prevention and control of hepatitis C virus (HCV) infection and hepatitis C-related chronic disease. MMWR 1998; 47(No. RR-19): 1-39.

Immunization Action Coalition. Hepatitis A, B, and C: Learn the Differences. October 2003. Available online at: www.immunize.org.

Maine Hepatitis C Infection Needs Assessment Steering Committee. At the crossroads: hepatitis C infection in Maine. February 2001. Available online at: http://www.maine.gov/dhs/boh/ddc/indexnew.htm. Click on “Publications.”

Resources

American Association for the Study of Liver Diseases: https://www.aasld.org/eweb/StartPage.aspx

American Liver Foundation: www.liverfoundation.org

Centers for Disease Control and Prevention Division of Viral Hepatitis: www.cdc.gov/hepatitis

Centers for Disease Control and Prevention, IDU/HIV Prevention: Viral Hepatitis and Injection Drug Users: http://www.cdc.gov/idu/hepatitis/index.htm

Harm Reduction Coalition: http://www.harmreduction.org/

Hepatitis Foundation International: www.hepfi.org

Hepatitis B Foundation: www.hepb.org/

HIV/HCV Coinfection Center for Excellence: http://www.uchsc.edu/mpaetc/coinfection/

Maine Department of Health and Human Services, Bureau of Health: www.mainepublichealth.org

National Institute of Diabetes and Digestive and Kidney Disease: www.niddk.nih.gov

Veterans Affairs National Hepatitis C Program: http://hepatitis.va.gov/

Appendix A: Overview of Hepatitis A, B, and C

HEPATITIS A (HAV)	HEPATITIS B (HBV)	HEPATITIS C (HCV)
HOW IS IT SPREAD?		
HAV is found in the stool (feces) of HAV-infected persons and is transmitted through a fecal-oral route. HAV is usually spread by either person-to-person contact or ingestion of contaminated food or water. This can happen when HAV-infected people do not wash their hands after using the toilet and then touch other people's food.	HBV is found in blood and certain body fluids. It is spread when blood or body fluids from an infected person enters the body of a person who is not immune. HBV is spread through having sex with an infected person without a condom, sharing needles or "works" when shooting" drugs, needlesticks or sharps exposures on the job, or from an infected mother to her baby during birth. Exposure to blood in ANY situation can be a risk for transmission.	HCV is found in the blood and certain body fluids. It is spread when blood or body fluids from an infected person enters another person's body. HCV is spread through sharing needles or "works" when "shooting" drugs, through needlesticks or sharps exposures on the job, or sometimes from an infected mother to her baby during birth. It is possible to transmit HCV during sex, but it is uncommon.
WHAT ARE THE SIGNS AND SYMPTOMS?		
Viral hepatitis symptoms are similar no matter which type of hepatitis a person has. If symptoms occur, a person may have one or more of the following: jaundice (yellowing of the eyes, skin), fever, loss of appetite, fatigue, dark urine, joint pain, abdominal pain, diarrhea, nausea, and vomiting. Note: many people infected with viral hepatitis have no symptoms. Diagnosis is made after blood tests for each virus (A, B, and C) have been completed.		
WHO IS AT RISK FOR INFECTION AND IS RECOMMENDED FOR TESTING?		
Household contacts of infected persons; sex partners of infected persons; persons, especially children, living in regions of the U.S. with consistently elevated rates of hepatitis A; persons traveling to countries where hepatitis A is common (everywhere except Canada, Western Europe, Japan, Australia, and New Zealand); men who have sex with men; injecting and non-injecting drug users.	Persons with more than one sex partner in a six-month period; persons diagnosed with a sexually transmitted disease; men who have sex with men; sex partners of infected persons; injecting drug users; household contacts of infected persons; infants born to infected mothers; infants/children of immigrants from areas with high rates of HBV*; health care and public safety workers who are exposed to blood; hemodialysis patients. Note: All of these persons are recommended to receive the hepatitis B vaccine.	Injecting drug users and recipients of clotting factors made before 1987 are at high risk for infection. **Persons for whom testing is recommended include:** Injecting drug users; recipients of clotting factors made before 1987; hemodialysis patients; recipients of blood/solid organs before 1992; people with undiagnosed liver problems; infants born to infected mothers (after 12-18 months of age), healthcare/public safety workers (only after a known exposure). **Persons for whom testing may be indicated**: Persons having sex with multiple partners; persons having sex with an infected steady partner.
TRENDS AND STATISTICS		
Occurs in epidemics both nationwide and in communities. During epidemic years, the number of reported cases reached 35,000. In the late 1990s, hepatitis A vaccine was more widely used and the number of cases reached historic lows. One-third of Americans have evidence of past infection (immunity).	The number of new infections per year has declined from an estimated 260,000 in the 1980s to about 78,000 in 2001. The highest rate of disease occurs in 20-49 year olds. The greatest decline has happened among children and adolescents due to routine hepatitis B vaccination. There are an estimated 1.25 million chronically infected Americans, of whom 20-30% acquired infection during childhood.	The number of new infections per year has declined from an average of 240,000 in the 1980s to about 25,000 in 2001; most infections are due to injection drug use; many transfusion-associated cases occurred prior to blood donor screening – this now occurs in less than one per million transfused unit of blood. An estimated 3.9 million (1.8%) Americans have been infected with HCV, of whom 2.7 million are chronically infected.

HEPATITIS A (HAV) Continued…	HEPATITIS B (HBV) Continued…	HEPATITIS C (HCV) Continued…
In Maine, the five-year mean (1998-2002) of acute hepatitis A cases is 18.	In Maine, the five-year mean (1998-2002) of acute hepatitis B cases is 7. (Note: these data do not include chronic hepatitis B infection, which is estimated at >300 cases).	In Maine, the five-year mean (1998-2002) of acute hepatitis C cases is <3. However, an estimated 20,000 people have past or current HCV infection.
LONG-TERM EFFECTS		
Incubation period: 15-50 days. There is no chronic (long-term infection); once you have hepatitis A, you cannot get it again. About 15% of people infected with HAV will have prolonged illness or relapsing symptoms over a 6-9 month period.	**Incubation period**: 45-160 days, average 90 days. Chronic infection occurs in: 90% of infants infected at birth; 30% of children infected at age 1-5 years; 6% of persons infected after 5 years. Death from chronic liver disease occurs in15-25% of chronically infected persons.	**Incubation period**: 14-180 days, average 45 days. Chronic infection occurs in 75-85% of infected persons; chronic liver disease occurs in 70% of chronically infected persons; death from chronic liver disease occur in 1-5% of persons infected; HCV is the leading reason for liver transplantation in the U.S..
WHAT TREATMENT HELPS?		
There is no treatment for hepatitis A, which eventually resolves on its own. Avoid drinking alcohol during illness – it can make liver problems worse.	HBV infected persons should be evaluated by a doctor for liver disease. Alpha-interferon, lamivudine, and adefovir are the three drugs currently licensed for the treatment of persons with chronic hepatitis B. These drugs are effective in up to 40% of patients; pregnant women should not use these drugs. Avoid drinking alcohol – it can make liver problems worse.	HCV infected persons should be evaluated by a doctor for liver disease. Interferon, peglyated interferon, and ribavirin are the only drugs licensed for the treatment of persons with chronic hepatitis C. Interferon can be taken alone or in combination with ribavirin. Combination therapy, using pegylated interferon and ribavirin is currently the treatment of choice. Combination therapy can get rid of the virus in up to 5 out of 10 persons for genotype 1 and in up to 8 out of 10 persons for genotype 2 or 3. Get vaccinated against hepatitis A, and hepatitis B if applicable. Avoid drinking alcohol – it can make liver problems worse.
HOW TO PREVENT VIRAL HEPATITIS		
Hepatitis A vaccine is the best protection. Short-term protection against HAV is available from immune globulin (IG). It can be given before and within 2 weeks after coming in contact with HAV. Always wash your hands with soap and water after using the bathroom, changing a diaper, and before preparing and eating food.	Hepatitis B vaccine is the best protection. If you are having sex, but not with one steady partner, use latex condoms** correctly every time you have sex. If you are pregnant, you should get a blood test for HBV. Infants born to HBV-positive mothers should be given hepatitis B immune globulin (H-BIG) and vaccine within 12 hours after birth. Do not shoot drugs – if you shoot drugs, stop and get into a treatment program; if you can't stop, never share needles, syringes, water, or "works," and get vaccinated against hepatitis A and B. Do not share personal hygiene items that might have blood on them. Consider the risks if you are thinking about getting a tattoo or body piercing – you might get infected if the tools have someone else's blood on them or if	There is no vaccine to prevent HCV. Do not shoot drugs – if you shoot drugs, stop and get into a treatment program; if you can't stop, never share needles, syringes, water, or "works," and get vaccinated against hepatitis A and B. Do not share personal hygiene items that might have blood on them (razors, toothbrushes, etc.). If you are a healthcare or public safety worker, always follow barrier precautions, and safely handle needles and sharps. Get vaccinated against HBV. Consider the risks if you are thinking about getting a tattoo or body piercing – you might get infected if the tools have someone else's blood on them or if the artist or piercer does not follow good health practices. Although the risk is low, HCV can be spread by sex.

HEPATITIS A (HAV) Continued…	HEPATITIS B (HBV) Continued…	HEPATITIS C (HCV) Continued…
	the artist or piercer does not follow good health practices. If you have or have had hepatitis B, do not donate blood, organs, or tissue. If you are a healthcare or public safety worker, get vaccinated against hepatitis B, and always follow routine barrier precautions and safely handle needles and other sharps.	with more than one steady partner, use condoms** correctly and every time to prevent the spread of sexually transmitted diseases. Get vaccinated against hepatitis B. If you are HCV positive, do not donate blood, organs, or tissue.
VACCINE RECOMMENDATIONS		
Vaccine is recommended for the following persons 2 years of age and older: travelers to areas with increased rates of hepatitis A; men who have sex with men; injecting and non-injecting drug users; persons with clotting-factor disorders (e.g. hemophilia); persons with chronic liver disease; children living in areas with increased rates of hepatitis A during the baseline period from 1987-1997*.	Routine vaccination of 0-18 year olds. Vaccination of high-risk persons of all ages (see section on "Who is at risk for infection?").	There is no vaccine to prevent hepatitis C.
*See www.cdc.gov/hepatitis and click on the respective fact sheet for more information. **Efficacy of latex condoms in preventing HBV and HCV infection is unknown, but their proper use may reduce transmission. Adapted from the Immunization Action Coalition "Hepatitis A, B, and C: Learn the Differences. Found online: www.immunize.org and the Centers for Disease Control and Prevention Division of Viral Hepatitis. Found online: www.cdc.gov/hepatitis		

Appendix B: National and State Background

Viral Hepatitis Prevention and Control: An Action Plan for Maine is the result of a convergence of viral hepatitis activities on a state and national level.

Hepatitis A and Hepatitis B

Hepatitis A

Despite the availability of vaccine, hepatitis A is one of the most frequently reported vaccine-preventable diseases in the United States. Over the last 10 years, public health emphasis has been on the importance of hepatitis A vaccine in preventing the spread of the infection. Other preventive measures include improved sanitation (e.g. of water sources and in food preparation) and attention to personal hygiene, (e.g. washing hands after diaper changes in child care settings) as well as the administration of hepatitis A Immune Globulin (IG) for pre- or post-exposure situations.

Since 1996, the Advisory Committee on Immunization Practices (ACIP) has been recommending vaccination for persons in groups shown to be at high-risk for hepatitis A infection (See Appendix A). In addition, the 2002 Sexually Transmitted Disease (STD) Treatment Guidelines issued by CDC recommend that high-risk persons (e.g., men who have sex with men (MSM) and injection drug users) should be considered as candidates to receive hepatitis A vaccine. This recommendation is part of an overall strategy to approach STD interventions in an integrated and comprehensive way. As hepatitis C testing and counseling is integrated into STD clinic settings, the availability of hepatitis A vaccine on-site has helped to increase access to consumers who might not ordinarily have the resources to obtain it. (CDC recommends that susceptible persons infected with HCV receive hepatitis A vaccine).

Hepatitis B

Since ACIP issued a comprehensive immunization strategy for the United States in 1991, the incidence of hepatitis B has been on the decline. Key components of this strategy include the routine immunization of infants, children, adolescents, and adults at increased risk for infection (see Appendix A); routine screening for hepatitis B infection of all pregnant women and appropriate post-birth treatment of children born to hepatitis B-infected mothers. Also recommended is the routine immunization of all infants, and routine immunization of adolescents who have not been previously immunized.

Other factors that may contribute to a decline in hepatitis B incidence include the 1992 Occupational Safety and Health Administration (OSHA) requirement that all health care workers and persons with direct occupational exposure to blood be offered hepatitis B vaccine.

Many states have implemented school entry requirements to help immunize adolescents who missed the birth requirement. However, Maine is one of only four states in the country that has yet to create such a rule.

In addition, the 2002 Sexually Transmitted Disease Treatment Guidelines issued by CDC recommend that every person seeking treatment for an STD be considered a candidate for hepatitis B vaccine.

While these strategies have made a tremendous impact in preventing and controlling hepatitis A and B, transmission continues to occur. There is still a large majority of persons at-risk who remain unvaccinated for hepatitis A and B.

Hepatitis C

For many years, illnesses now known to have been caused by HCV were referred to as hepatitis "non-A, non-B." In July 1992, the implementation of a screening test for the hepatitis C virus antibody provided the first diagnostic tool to help identify infected persons. Since many HCV-infected persons have been infected for 20 or 30 years, today the great burden of disease reflects chronic or (long-term) cases. Recognizing the need to devote more resources to this issue, the Centers for Disease Control and Prevention has worked to place a hepatitis C coordinator in every state.

Since 2000, hepatitis C coordinators have focused on preventing and controlling hepatitis C virus infection. This has been done in coordination with the development of the *CDC National Hepatitis C Prevention Strategy*. A core concept from the *Strategy* is the focus on an integrated approach to services. "The most effective means to prevent HCV infection and its consequences is to integrate HCV prevention activities into existing services, such as those for the prevention and treatment of human immunodefiniciency virus (HIV), sexually transmitted diseases (STDs), and substance abuse."

Components of the Strategy include: education of health care and public health professionals, educating the public and those at risk for hepatitis C, the development of clinical and public health activities to identify, counsel and test persons at risk for HCV infection, and medical evaluation or referral for those found to be infected. The *National Strategy* also emphasizes the need for outreach and community-based programs to prevent practices that put people at risk for HCV infection. To support programmatic activities, the *Strategy* highlights surveillance to monitor acute and chronic HCV and to evaluate the effectiveness of prevention and medical care activities. Research to better guide prevention efforts is also mentioned.

The similarities between behavioral risk groups served by immunization, sexually transmitted disease, and HIV programs are the basis for a move toward integrated services. Collaboration, though still in early stages, has appeared in letters signed by CDC Center directors from each respective area promoting integration and hepatitis language has recently appeared in HIV and Immunization requests for proposals. While there is still much work to be done, pending legislation in the House and Senate such as the Hepatitis C Epidemic Control and Prevention Act, and the formation of the National Viral Hepatitis Roundtable, (a coalition of public, private, and voluntary organizations dedicated to reducing the incidence of infection, morbidity, and mortality from viral hepatitis in the United States), demonstrate increasing momentum and support for viral hepatitis initiatives. While a national viral hepatitis plan does not exist, CDC and the Council of State and Territorial Epidemiologists have collaborated to provide funding for individual states to create such plans.

Activities in Maine

During this time, the people of Maine have been very active in laying groundwork that parallels the momentum on the national level. The timeline below provides an overview of selected Maine viral hepatitis activities since the 1990's. These activities help give a context for this Plan and exemplify how its creation is a logical next step in a series of initiatives.

1993

The Bureau of Health and partners worked to support legislation to enable the nonprescription sale of hypodermic needles (32 MRSA section 13787-A).

1994

Policy statement guidelines were developed to prevent transmission of HIV and hepatitis B through medical and dental procedures.

1997

A coalition of HIV advocates and Bureau of Health representatives supported decriminalization of the possession of up to 10 hypodermic syringes (17-A MRSA section 111) and helped start a process to permit needle exchange programs in the State (22 MRSA section 1341). Both subsequently became law.

The Bureau of Health required reporting of hepatitis C positive laboratory reports

The Hepatitis C Working Group was established.

1998

The City of Portland, Public Health Division was certified to begin a needle exchange program.

1999

The Maine Pharmacy Association clarified its position on the laws concerning sale of syringes by supporting full implementation of the syringe laws for legitimate public and individual health reasons. They ruled that any pharmacist refusing to sell syringes must be ready "to justify that decision in light of both the statue's (32 MRSA section 13787-A) broad sweep and its statutory intent."

A subgroup of the HCV working group formed to create the Hepatitis C Steering Committee. This group created a plan for a statewide needs assessment. In conjunction with the needs assessment, a survey of primary care provider and gastroenterologist 2001 knowledge, attitudes, beliefs and practices was conducted.

After an increase in the incidence of hepatitis A among men who have sex with men, programs within the Bureau of Health (Immunization and HIV/STD), collaborated to make hepatitis A and B vaccine available to high-risk persons seen at STD clinics. Vaccine was

offered free of charge through STD clinics in the City of Bangor, the City of Portland, and through Western Maine Tri-County Services.

"At the Crossroads: Hepatitis C Infection in Maine," (a statewide needs assessment) was published.

LD 686, (an unfunded bill directing the Bureau of Health to create a plan to address hepatitis C) was passed.

LD 1292, (an unfunded bill requiring the Department of Corrections to provide voluntary testing for hepatitis C in the prisons) was passed.

The Bureau of Health developed a three-tiered budget defining the costs of implementing the hepatitis C needs assessment recommendations.

The Bureau of Health released a report entitled, "Assessing Sexually Transmitted Disease Prenatal Screening Rates in Maine." The report included details of an assessment of prenatal patient records in all birthing hospitals in Maine including a review of screening practices for HIV, syphilis, gonorrhea, chlamydia, and hepatitis B. Despite recommendations from many public health and professional organizations to screen 100% of pregnant women for hepatitis B, the assessment found only 89% of pregnant women in Maine are screened. A follow-up survey is currently underway.

2002

LD 1858, (Resolve to improve the health of Maine citizens through hepatitis C prevention and detection) was passed. Although it was not funded, it allowed for the implementation of a limited program to raise public awareness about hepatitis C and the acceptance of federal funds for the hepatitis C coordinator position.

At the same time, the Bureau of Health advocated for and achieved implementation of a hepatitis B immunization requirement for entry into day care (DHHS, 10-148 Chapter 32, Rules for the Licensing of Child Care Facilities).

The Eastern Maine AIDS Network in Bangor began operation of a needle exchange program.

A pilot hepatitis C testing and counseling program was implemented in 12 of the 16 Maine counties. Through this State funded program, persons at high-risk for hepatitis C are able to receive HCV antibody testing for free. In three of the sites, eligible consumers can also obtain free hepatitis A and B vaccine.

"HIV Prevention and Injection Drug Use in Maine: A Statewide Needs Assessment" was released. The needs assessment describes the scope of injection drug use in Maine (trends, areas most affected) and the HIV prevention needs of injection drug users in the State.

In the summer of 2002, the Bureau of Health collaborated with the City of Portland, Public Health Division and Maine Medical Center on a grant application from the Maine Health Access Foundation. This grant provided for hepatitis C educational materials, testing, and

capital improvement costs for the development of a Virology Treatment Center at Maine Medical Center.

2003

In May of 2003, the collaboration between Maine Medical Center, the Bureau of Health, and the City of Portland, Public Health Division was highlighted in a press release in the Portland area. It all coincided with the release of radio and TV public service announcements about the risks for hepatitis C..

2004

As of June 2004, the Bureau of Health has certified four organizations to establish and maintain needle exchange programs: the City of Portland, Public Health Division, Eastern Maine AIDS Network in Bangor, Down East AIDS Network (DEAN) in Ellsworth, and PreventionWorks in Lewiston. (Note: DEAN is certified but not yet operational due to funding constraints).

Appendix C: The Planning Process

In early 2003, the Bureau of Health received a planning grant from the Council of State and Territorial Epidemiologists to develop a viral hepatitis prevention and control plan.

In October 2003, the Viral Hepatitis Prevention and Control Conference Planning Committee met for the first of four meetings. The aim of the group was to plan a statewide conference that was structured to gather input from stakeholders about the goals and objectives of a State plan.

The group included representatives from the Bureau of Health, the Department of Corrections, Correctional Medical Services, City of Portland Public Health, Maine Medical Center, the HIV Community Planning Group, a patient advocate, and the Office of Substance Abuse. Using guidance from the Council of State and Territorial Epidemiologists' grant submitted by the Bureau of Health, the Planning Committee developed the agenda, topics for the breakout sessions, format and overall structure of the conference.

There were sixty attendees (out of 120 persons invited) from a wide array of geographic locations and professions. The conference was targeted to people who worked directly or indirectly with persons at high-risk for viral hepatitis. The format for the conference was a one-day meeting with the morning session largely didactic and the afternoon session designed to elicit feedback and input from the participants. The Mission for the conference: to engage stakeholders in strategic planning around the development of a statewide viral hepatitis prevention and control plan.

In the morning, the Acting Director of the Division of Disease Control opened the conference with an overview of "Viral Hepatitis Activities in Maine," and was followed by a talk on "The A, B, C's of Viral Hepatitis with Maine Specific Data." An epidemiologist from the Centers for Disease Control and Prevention spoke on "Viral Hepatitis--A National Perspective." A patient advocate spoke about her experiences with hepatitis C and how a state plan could help advance support for hepatitis C in Maine. The conference participants were provided with an overview of the purpose of the breakout sessions. They were given the opportunity to focus on the general topic of viral hepatitis or on just one specific infection. A total of three work sessions took place during the late morning and afternoon and concluded with a report back to the larger group. The topics for the breakout sessions were: Advocacy and Funding, Clinical/Medical, Priority Populations, General Public Education, and Care and Support.

The participants were asked to select a first and second choice breakout session. The conference-planning group chose to keep the groups small and manageable and representative of diverse opinions. Volunteer facilitators from the Bureau of Health (Regional Epidemiologists, HIV/STD Program Staff), and an external partner--Southern Maine EMS facilitated the breakout sessions. Due to a high degree of interest, two of the topics Clinical/Medical and Priority Populations-- were broken down into two groups i.e. Clinical/Medical groups #1 and #2. The first session was an opportunity to brainstorm goal topics. Using a predetermined voting process, each group came to "agreement" on the topics. During the second and third sessions, participants developed objectives for a 3-year plan and prepared for the report back. The participants were asked to develop specific, relevant, and feasible objectives. Keeping in mind "what we want to do" and "how we want to get there."

The goals, objectives, and ancillary notes created during the breakout sessions were

used to develop this plan. At the conclusion of the conference, participants were given the opportunity to serve on a plan "Draft Review Committee" and also given the opportunity to sign up for a work group based on their breakout topic to work on implementation of the Plan. The Draft Review Committee was given two opportunities to provide written and oral feedback on the draft of the Plan.

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