Hepatitis in Oregon: 2019 in Review

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Overview

I. Trends in hepatitis A in Oregon

- II. Vulnerability Assessment:
 - Which counties are at highest risk?

III. Planning for HCV Elimination



State-Reported Hepatitis A Outbreak Cases as of December 20, 2019



- Since 2016
 - 29,300 cases
 - 17,800 hospitalized
 - 298 deaths

- Risk factors
 - Injection or non-injection drug use
 - Persons experiencing homelessness
 - Related to crowding, poor hygiene

Reported cases of hepatitis A, Oregon, 2013-2019





Hepatitis A risk factors, Oregon, 2017-2018, (n=43)



- One cluster of 4 cases in PWIDS in Klamath and Deschutes
- Deschutes provided vaccinations in county jail, homeless camps

OHA Immunization Program Response

- > \$300,000 recently awarded to Clackamas, Deschutes, Douglas, Harney, Lane, Malheur, Multnomah and Washington counties received to vaccinate high risk populations
 - Corrections, SSPs, housing services, community health centers, addiction treatment and recovery support
 - Several other counties have received 317-funded vaccine
- Working with 12 hospitals along I-5 corridor to use HAV vaccine for high risk patients in EDs



II. Oregon Vulnerability Assessment

- HIV outbreak in rural Indiana prompted CDC to develop a framework for identifying US communities at risk for HIV and HCV
- CDC's model identified following risk factors for outbreaks:
 - overdose deaths, prescription opioid sales, income, white race, unemployment, and buprenorphine prescribing potential by waiver
 - Then used the results to predict counties that are most at risk
- In 2019, CDC funded states through opioid response funding to conduct their own analyses to identify risks



Oregon approach

- Identify county-level risk factors that predict which counties have high rates of HCV in people < 30, a good marker for recent acquisition of HCV and injection drug use
- Explored a number of factors that might impact the risk of spread of injection-drug related infections
 - Measures of social vulnerability, like housing and food insecurity
 - Drug overdose hospitalizations and deaths
 - Access to prescription opioids
 - Availability of medical and behavioral health care
 - Drug related criminal activity
 - Rural/urban designation, years of potential life lost, income, employment, race/ethnicity



Why develop a vulnerability assessment?

Although individuals with positive lab tests for HCV are reported to the OHA, not everyone who has HCV gets tested, so just looking at where cases of HCV have been reported does not tell the whole story. Rate of Newly Reported Cases of Chronic HCV among Oregon Residents under Age 30, 2012-2016



Model results



Best predictors of risk for HCV

HIDTA



Premature Death



Chronic HCV < 30



Risky Prescribing



Lack of Transportation



What do the results mean?



- Calculate a score for each county that predicts their risk of an HCV outbreak—the higher the score, the bigger the risk of having an outbreak.
- For several counties, the vulnerability index score indicated a higher risk of an outbreak than would have been expected from just reviewing reported rates of HCV

Vulnerability								
Highest	High	Mid-Range	Lower	Lowest				
Douglas Coos Multnomah Malheur Curry	Jackson Lane Lincoln Clatsop Linn Jefferson Tillamook Josephine Umatilla	Lake Klamath Baker Marion Sherman Clackamas Harney	Wasco Crook Union Columbia Gilliam Deschutes Washington Wallowa	Yamhill Polk Morrow Grant Wheeler Hood River Benton				



Fact Sheet developed for OR-Hope intervention counties and shared with community action teams and other stakeholders to inform local prevention efforts and guide decisionmaking

Using the Vulnerability Assessment Results Providing Data to Counties



III. Planning for HCV Elimination

- Received small grant from Association of State and Territorial Health Officials (ASTHO) for technical assistance for elimination planning
- Center for Disease Analysis Foundation coordinated a multi-stakeholder effort to assess the burden of HCV in Oregon and answer basic questions for policy development
- Partners: OHA, OHSU, Providence Health Systems, Department of Corrections, OR Medicaid Program, Portland Area Indian Health Board, ASTHO and CDC



Oregon's Care Cascade, 2018



Data sources: 1) OR surveillance data; 2) OR death certificates; 3) Treatment data from APAC, VA, and DOC Assumptions: 1) 75% of reported patients are viremic; 2) 63% of cases diagnosed; 3) 95% of patients cured using currently available DAAs

Characteristics of persons with HCV (viremic), Oregon, 2018 (N=57,200)

Characteristic	Percent		
1945-1965 birth cohort	57%		
Women of child-bearing age	13%		
People who currently inject drugs	11%		
Incarcerated	4%		
Enrolled in OR Medicaid	20%		



WHO targets to eliminate HCV by 2030

- 80% reduction in new cases
- 90% diagnosis of all infections
- 65% reduction in liver-related mortality



How to do it

- Current standard of care will reduce number of viremic infections and deaths, but not meet WHO targets
- WHO-Plan A
 - Use combination of treatment and harm reduction (enough to prevent 20% of new infections)
- WHO-Plan B
 - No harm reduction, but more patients treated



Strategies for HCV elimination by 2030

Strategy	Target	2019	2020	2021-23	<u>≥</u> 2024
Standard of Care	New infections	1,400	1,400	1,300	1,300
	# Treated	4,500	3,200	2,800	2,500
Plan A: <i>Harm</i> <i>reduction</i> + <i>RX</i>	New infections	1,400	1,200	900	470
	# Treated	4,500	3,200	3,200	3,200
Plan B: <i>RX only</i>	New infections	1,400	1,400	1,300	1,100
	# Treated	4,500	5,000	5,000	5,500





Number of Oregon Health Plan clients receiving treatment for hepatitis C by quarter, Oregon 2017— Q3 2019





Summary

- Local data for action and data-driven approach to prioritizing resources
- Treatment as prevention is a viable strategy in Oregon (> 1,000 Medicaid patients treated in 2019)
- Need for improved access to harm reduction services
 - SSPs, Peer-driven interventions, MAT, naloxone, wound care services



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Questions



