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>> Oregon Viral Hepatitis Elimination Plan

2024-2030



Oregon
Health
Authority
PUBLIC HEALTH DIVISION

Contents

» Executive summary.....	4
» Goal 1: Prevent new hepatitis infections.....	8
» Recent trends in Oregon.....	8
» The rationale for proposed objectives and strategies.....	9
» Harm reduction strategies.....	9
» Vaccination.....	9
» Strategies.....	10
» Objective 1.2 Increase hepatitis A and B vaccination rates.....	12
» Strategies.....	12
» Goal 2: Improve health outcomes.....	14
» Recent trends in Oregon.....	14
» The rationale for proposed objectives and strategies.....	17
» Objective 2.1 Increase screening and diagnosis of hepatitis B and C.....	18
» Strategies.....	18
» Objective 2.2 Increase treatment and monitoring of chronic hepatitis C.....	20
» Strategies.....	20
» Objective 2.3 Increase treatment and monitoring for chronic hepatitis B.....	21
» Strategies.....	21
» Goal 3: Eliminate health disparities and inequities.....	23
» Recent trends in Oregon.....	23
» The rationale for proposed objectives and strategies.....	27

- » Objective 3.1 Eliminate disparities faced by people with and at risk for viral hepatitis in health care settings27
 - » Strategies.....27
- » Objective 3.2 Reduce disparities in the diagnosis of viral hepatitis, knowledge of status, engagement with care and community stigma around diagnosis.....28
 - » Strategies.....28
- » Goal 4: Improve surveillance and data usage30
 - » The rationale for proposed objectives and strategies.....30
 - » Objective 4.1 Monitor and control the spread of viral hepatitis33
 - » Strategies.....33
 - » Objective 4.2 Monitor racial and ethnic disparities34
 - » Strategies.....34
 - » Objective 4.3 Measure morbidity and mortality due to viral hepatitis and track access to testing and treatment.....34
 - » Strategies.....34
- » Conclusion35

Executive summary

Vision

The Oregon Health Authority is committed to the elimination of viral hepatitis and viral hepatitis-related health inequities in Oregon by:

- Promoting vaccination and harm reduction
- Making testing and treatment widely available
- Reducing stigma and discrimination against persons at risk, and
- Using high-quality data to inform elimination goals.

Viral hepatitis can erupt in large outbreaks. It can also pass silently between people who do not realize they have an infection until they develop signs of cirrhosis or liver cancer decades later. It is a serious public health threat — but a preventable one. Oregon’s viral hepatitis elimination plan addresses the three most common types:

- Hepatitis A
- Hepatitis B, and
- Hepatitis C.

Vaccination can prevent two of the three, hepatitis A and B. There is a cure for the third type, hepatitis C, with a short course of treatment.

Although rates of hepatitis A declined dramatically in Oregon since the vaccine became available in 1995, several large outbreaks occurred in the US between 2016 and 2019. These large outbreaks disproportionately affected:

- Persons who use drugs (PWUD)
- Persons experiencing unstable housing or homelessness
- Men who have sex with men (MSM)
- Persons currently or recently incarcerated, and
- Persons with chronic liver disease such as cirrhosis, hepatitis B or hepatitis C.

Maintaining low rates of hepatitis A in Oregon will require the promotion of routine vaccination of children and outreach efforts to vaccinate at-risk adults.

New cases of hepatitis B have become rare in Oregon due to routine vaccination of children. However, an average of 404 chronic cases were reported yearly between 2016 and 2020. Non-U.S.-born people are disproportionately affected by chronic hepatitis B. People from Asia, the Pacific Islands and Africa, where the overall prevalence of chronic hepatitis B is considered moderate to high, are most impacted. Although treatment does not completely cure hepatitis B, it:

- Reduces levels of the virus enough to prevent transmission, and
- Reduces the risk of cirrhosis and liver cancer.

Hepatitis B can pass from mother to child. This makes efforts promoting routine vaccination at birth important, along with:

- Maintaining high rates of vaccination in children
- Promoting vaccination to high-risk adults
- Increasing rates of screening, and
- Linking infected persons to treatment.

The prevalence of hepatitis C in Oregon and mortality related to hepatitis C are among the highest in the country.

Over the past 10 years, the epidemic of opioid and methamphetamine use has contributed to increasing rates of hepatitis C among persons younger than age 30 due to injection drug use. In addition to screening adults and linking them to care, elimination efforts require a syndemic approach. Oregon needs to:

- Increase the availability of harm reduction services and substance use treatment programs, and
- Train more providers to offer medications for opioid use disorder (MOUD) treatment as well as hepatitis C.

Elimination efforts must also engage the social and structural barriers, including structural racism, that prevent people from engaging with care and completing treatment. Many people at risk for viral hepatitis or currently infected with hepatitis B or C are not engaged with the health care system due to multiple factors, such as poverty, homelessness, transportation issues, mental illness, stigma surrounding substance use and a lack of access to culturally and linguistically responsive providers.

In 2016, the World Health Organization (WHO) endorsed the elimination of hepatitis B and C by 2030. That same year, Oregon's Viral Hepatitis Collective set out to define goals and strategies necessary for the elimination of viral hepatitis in Oregon by 2030. The Viral Hepatitis Program of the Oregon Health Authority

(OHA) has built upon these strategies to develop a formal elimination plan. After internal OHA partners (Oregon Immunization Program; Health Security, Preparedness and Response Program; and HIV, Sexually Transmitted Infection, and Tuberculosis Program) initially reviewed the plan, we then presented it for feedback to a broader group of partners, including the following:

- Health care providers
- Advocacy groups
- Harm reduction specialists, and
- Representatives from other state agencies and local public health authorities.

The purpose of Oregon’s viral hepatitis elimination plan is to present evidence-based strategies for the elimination of viral hepatitis B and C (and the control of hepatitis A). The plan outlines four main goals:



1: Prevent new infections



2: Improve health outcomes



3: Eliminate health disparities and inequities



4: Improve the use of surveillance and data

Under each goal are objectives and strategies which may be employed by the following:

- Health care systems
- Mental health and substance use disorder treatment providers
- Community-based organizations (CBOs) serving persons at risk for viral hepatitis

- Carceral settings
- Local public health authorities
- Harm reduction service organizations, and
- All other partners involved in preventing viral hepatitis and caring for people with chronic infection.

Objectives

Objectives focus on key outcomes and key process points. These are outlined for each overarching goal.

Strategies

Strategies suggest ways to meet objectives. These can be measured to ensure we stay on track to meet our goals by 2030.



Goal 1: Prevent new hepatitis infections

Recent trends in Oregon

- Between 2016 and 2020 in Oregon, new cases of hepatitis A virus (HAV) and hepatitis B virus (HBV) were highest in people older than age 30. However, new cases of hepatitis C virus (HCV) were most common in people aged 20-29 years. (Figure 1)
- The proportion of chronic hepatitis C cases among people in their 20s tripled between 2010 and 2019. (Figure 2)
- Of children born to pregnant people with hepatitis B in 2019 and 2020, 88% received vaccine prophylaxis at birth. Seventy-eight percent finished the 3-dose series within eight months.



Objectives

- 1.1 Expand the availability of harm reduction services.
- 1.2 Increase HAV and HBV vaccination rates.

Figure 1: Age group of cases of acute hepatitis, 2016-2020, Oregon

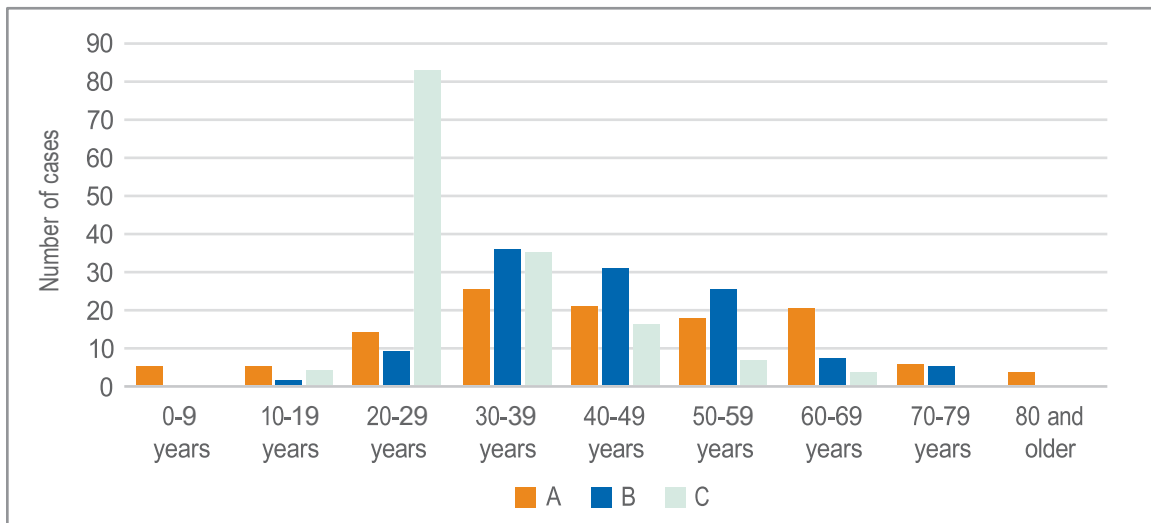
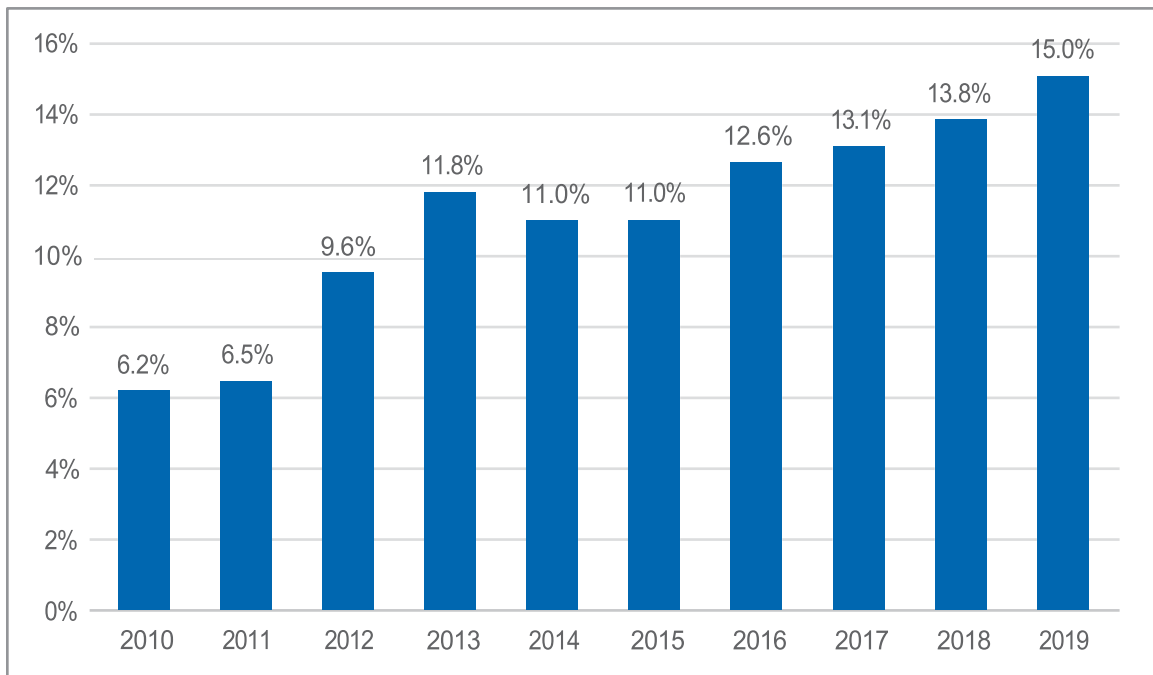


Figure 2: Proportion of chronic hepatitis C cases in persons aged 20-29 years, Oregon, 2010-2019



The rationale for proposed objectives and strategies

Harm reduction strategies

- Currently, there is no vaccine for hepatitis C. So, the most important way to prevent new hepatitis C infections is to increase:
 - » Accessibility of harm reduction services, and
 - » Treatment of opioid use disorder (including medications for opioid use disorder [MOUD]).
- The combination of syringe service programs (SSPs) and substance use disorder treatment programs can [prevent 75% of new infections](#).

Vaccination

- Safe and effective vaccines for HAV and HBV have been available for over two decades. Infants, children, and high-risk adults receive these vaccines routinely.

Table 1: Goals and objectives to prevent new hepatitis infection.

Goals	1. Prevent new hepatitis infections	
Objectives	1.1 Expand the availability of harm reduction services.	1.2 Increase HAV* and HBV† vaccination rates.
Secondary objectives	1.1.1 Expand harm reduction in health care and community settings.	1.2.1 Increase vaccination of high-risk adults.
	1.1.2 Improve hygiene and sanitation for persons experiencing homelessness (PEH).	1.2.2 Increase uptake of HBV vaccine birth dose for newborns.
	1.1.3 Use of MOUD and substance use disorder (SUD) treatment among people who use drugs.	1.2.3 Support routine vaccination of children.

Objective 1.1 Expand the availability of harm reduction services

Strategies

1.1.1 Expand harm reduction options in health care and community settings.

- Expand the number of syringe services programs (SSPs) as well as operating days and hours in every county.
- Expand the use of peer recovery specialists in the community, health care settings, behavioral health, and MOUD and SUD treatment settings.
- Improve access to harm reduction supplies in:
 - » Pharmacies
 - » Emergency departments
 - » Health care clinics
 - » SUD and MOUD clinics
 - » Community settings such as:
 - > Food pantries
 - > Bottle drops
 - > Homeless encampments, and
 - > Free harm reduction vending machines.

* Hepatitis A vaccine information statement from CDC

† Hepatitis B vaccination of adults from CDC

- Increase promotion of harm reduction via social media and provider newsletters.
- Increase the availability of syringe disposal in pharmacies, emergency departments, schools and community settings.
- Advocate for changes to Oregon state paraphernalia laws so that all necessary harm reduction supplies are legal and can be purchased with state funds.

1.1.2. Improve access to hygiene and sanitation services for persons experiencing homelessness (PEH).

- Increase access to toilets, soap and running water.
- Provide garbage disposal services at houseless camps.
- Increase access to mobile laundry and showers.
- Increase access to surface disinfectants, hand sanitizers, disposable wipes and hygiene products.
- Increase partnerships between clinics, harm reduction organizations and local warming shelters.
- Connect PEH to Behavioral Health Resources Network (BHRN) providers in their community.

1.1.2. Increase access to MOUD and substance use disorder (SUD) treatment in PWUD.

- Provide training through professional organizations and OHSU's Extension for Community Healthcare Outcomes (Project ECHO) to primary care providers on delivering MOUD treatment, especially in underserved and rural areas.
- Scale-up implementation of peer-supported interventions to increase access to MOUD and SUD treatment.
- Assist people leaving carceral settings to access MOUD and SUD treatment through the use of community health workers (CHWs), peer recovery specialists, coordinated care organizations (CCOs) and Medicaid fee-for-service providers.
- Increase telemedicine options for MOUD.
- Provide training to primary care and obstetrical providers to provide harm reduction counseling and prescribe naloxone.

Objective 1.2 Increase HAV and HBV vaccination rates

Strategies

1.2.1 Increase vaccination of high-risk adults.

- Recruit and maintain a network of public and private providers to administer Section 317- and state-funded (if applicable) vaccines to eligible adult populations.
- Promote routine vaccination in clinical settings for hepatitis B for all adults:
 - » Ages 19-59, and
 - » Ages 60 and older with risk factors.
- Increase vaccination rates:
 - » In carceral settings
 - » In adult community-based facilities serving people with psychosocial disabilities, and
 - » Where there are persons experiencing homelessness.
- Promote educational programs for high-risk adults to increase vaccine confidence.
- Increase vaccination through:
 - » Behavioral health and substance use disorder settings
 - » Pharmacies
 - » Dentists
 - » Health fairs, and
 - » Community outreach settings, such as SSPs.
- Increase vaccination rates among people living with disabilities who are homebound.

1.2.2 Increase uptake of hepatitis B vaccine birth dose for newborns.

- Develop and disseminate culturally and linguistically appropriate education to select providers to increase vaccine confidence in pregnant people.
- Support implementation of Oregon's Pregnancy Immunization Toolkit.
- Ensure partners within Oregon's Public Health Home Visiting System for maternal and child health promote and provide newborn doses of hepatitis B vaccine.
- Develop culturally and linguistically appropriate education for providers and families on the importance of newborn doses of the hepatitis B vaccine.

- Provide culturally and linguistically appropriate case management of infants born to HBV-infected mothers to ensure appropriately timed doses of vaccination and follow-up testing.
- Monitor hepatitis B vaccine administration data in the state immunization registry to monitor coverage of infants.
- Address system changes to ensure hospitals administer birth doses. Do so by increasing the number of birthing hospitals that:
 - » Track hepatitis B birth dose coverage, and
 - » Enroll as Vaccines for Children (VFC) providers.

1.2.3 Support routine vaccination of children.

- Recruit and maintain a network of public and private providers to administer:
 - » VFC vaccines to program-eligible populations, and
 - » Section 317- and state-funded (if applicable) vaccines to eligible pediatric populations.
- Ensure partners within the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program promote and provide hepatitis A and B vaccines to families and children.
- Support Immunize Oregon to expand educational programs for parents to promote vaccine confidence.
- Support [Boost Oregon](#) to expand peer-based educational programs for parents and teens to promote vaccine uptake.
- Monitor hepatitis vaccine administration coverage of infants, children and adolescents in the state immunization registry.



Goal 2: Improve health outcomes

Recent trends in Oregon

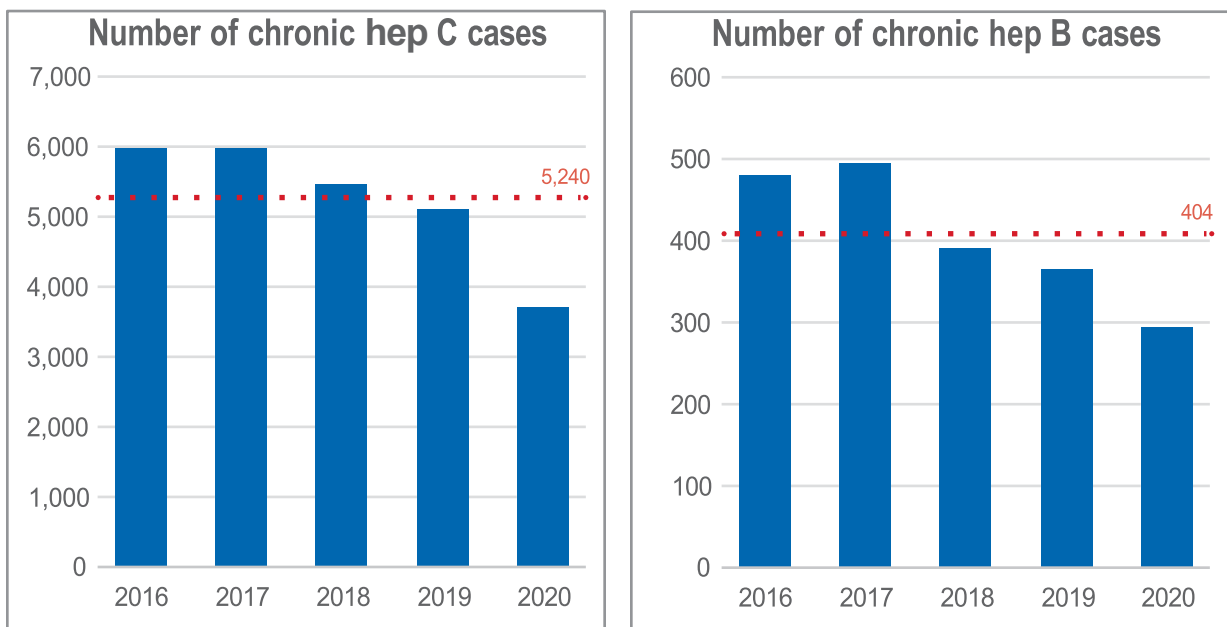
- Each year between 2016 and 2020 Oregon averaged:
 - » 5,240 newly reported cases of chronic hepatitis C and 404 cases of chronic hepatitis B (Figure 3)
 - » 2,165 hospitalizations related to hepatitis C and 194 to hepatitis B (Figure 4)
 - » 460 deaths related to hepatitis C and 32 from hepatitis B (Figure 4)
- Rates of HCV screening and treatment rose dramatically between 2011 and 2019. However, fewer young adults received treatment than baby boomers (Figure 5a, 5b, 6a, 6b).



Objectives

- 2.1 Increase screening and diagnosis of hepatitis B and C.
- 2.2 Increase treatment and monitoring of chronic hepatitis C.
- 2.3 Increase treatment and monitoring for chronic hepatitis B.

Figure 3: Annual number of cases chronic hepatitis C and B*, Oregon, 2016-2020



*Annual case counts may be impacted by increases or decreases in testing. Some of the decline seen in 2020 may be due to reduced testing during the COVID-19 pandemic.

Figure 4: Annual hepatitis C-associated hospitalizations and deaths, Oregon, 2016-2020

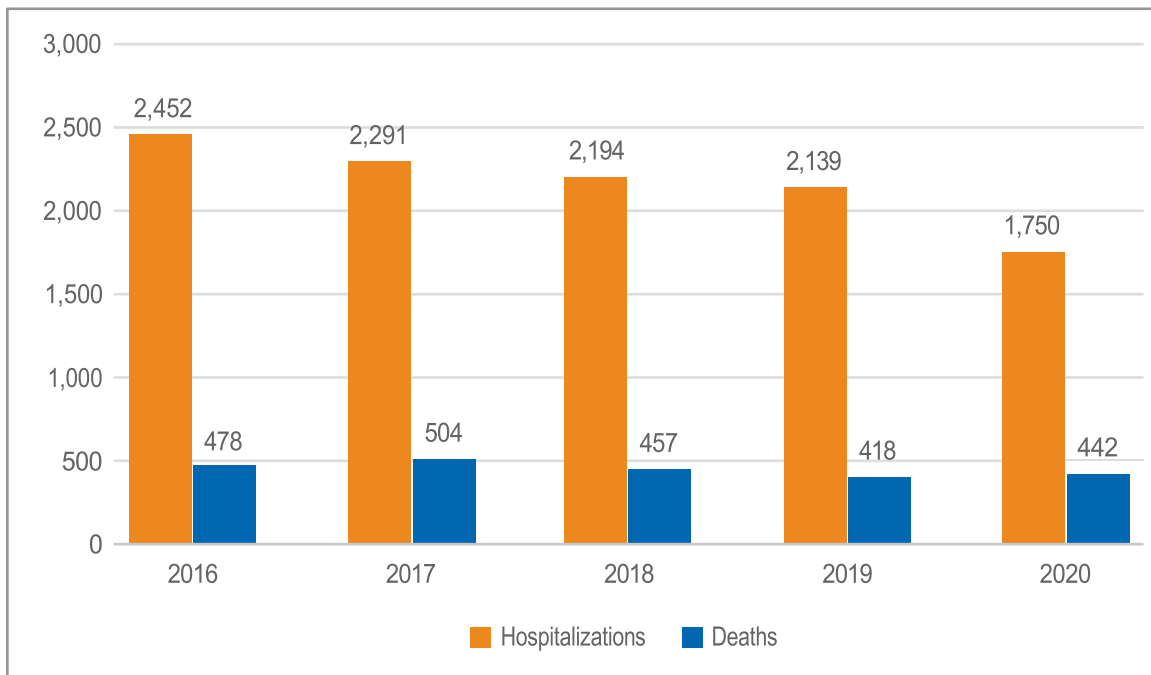
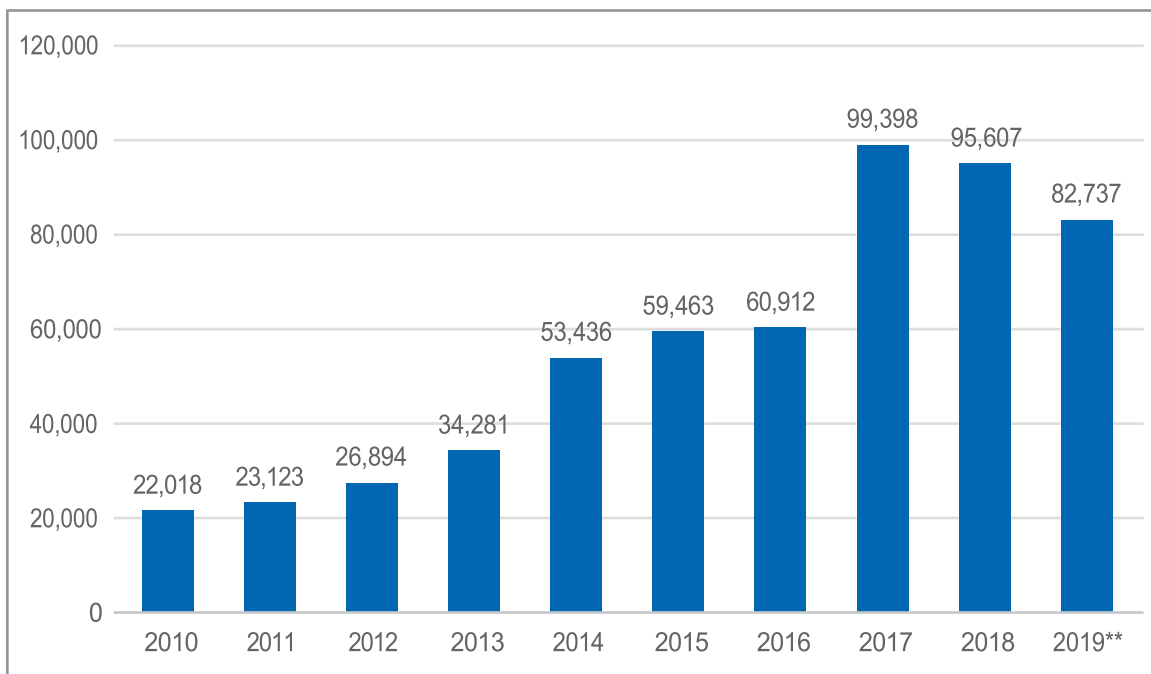


Figure 5a: Number of people screened for HCV*, Oregon 2010-2019 (N = 557,869)



All Payer All Claims Data, Office of Health Analytics

* Had HCV test performed and didn't have HCV diagnosis in previous 2 years

** Medicare data incomplete for 2019

Figure 5b: Age group of persons screened for HCV, Oregon 2010-2019

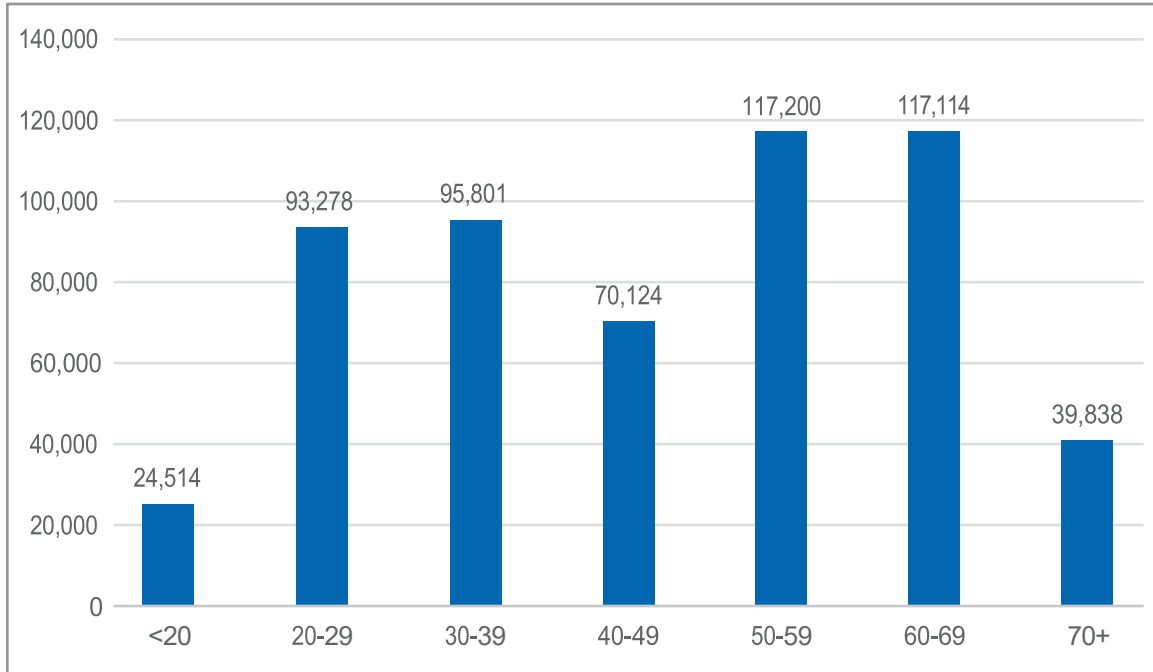


Figure 6a: Number of people initiating treatment for HCV, Oregon, 2010-2019

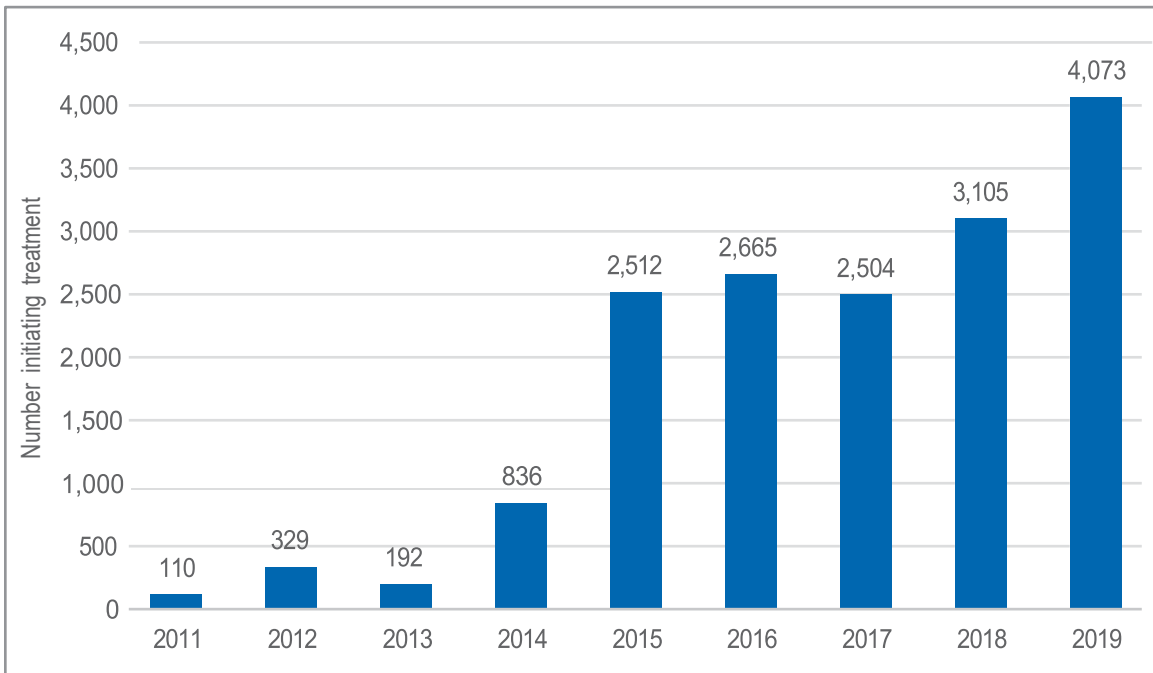
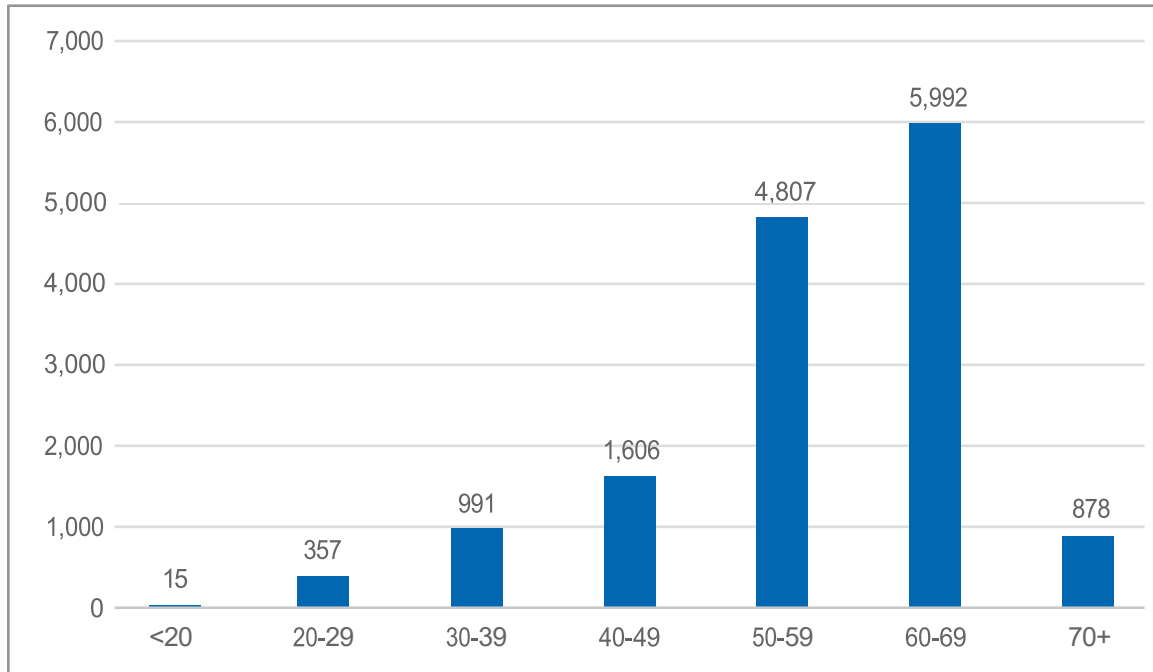


Figure 6b: Age group of persons initiating treatment for HCV, Oregon 2010-2019



The rationale for proposed objectives and strategies

- CDC now recommends:
 - » A one-time universal screening of all adults for HBV and HCV
 - » Screening with every pregnancy, and
 - » Repeated screening of people at high risk.^{*,†}
- The new generation of hepatitis C direct-acting antivirals (DAAs) are safe, simple and highly effective at curing hepatitis C in most people.
- Treatment of people who actively inject drugs reduces transmission among people most likely to spread HBV and HCV.
- Although not curative, treatment for hepatitis B:
 - » Reduces viral load
 - » Lowers the risk of transmission, and
 - » Lowers the risk of conditions such as liver cancer and cirrhosis.

* [Recommendations for Routine Testing and Follow-up for Chronic Hepatitis B Virus \(HBV\) Infection](#)

† [CDC Recommendations for Hepatitis C Screening Among Adults — United States, 2020](#)

Table 2: Goals and objectives to improve health outcomes.

Goals	2. Improve health outcomes		
Objectives	2.1 Increase screening and diagnosis of HBV and HCV.	2.2 Increase treatment and monitoring of chronic HCV.	2.3 Increase treatment and monitoring for chronic HBV.
Secondary objectives	2.1.1 Implement universal one-time screening of persons older than 18 for HBV and HCV.	2.2.1 Increase the number of patients diagnosed and linked to HCV care.	2.3.1 Increase the number of patients diagnosed and linked to HBV care.
	2.1.2 Increase screening of pregnant women and children exposed to mothers with viral hepatitis during pregnancy.	2.2.2 Increase the number of primary care providers (PCPs) providing HCV treatment.	2.3.2 Increase the number of PCPs who can facilitate the treatment of Hep B and provide long-term management, such as screening for liver cancer.
	2.1.3 Increase periodic screening for people with ongoing risk factors.	2.2.3 Increase patients with chronic HCV linked to a medical home.	2.3.3 Increase the number of patients with chronic HBV linked to a medical home.

Objective 2.1 Increase screening and diagnosis of hepatitis B and C

Strategies

2.1.1 Implement universal one-time screening for persons older than 18 for HBV and HCV.

- Implement opt-out one-time HBV/HCV/HIV screening of adults in health care systems.
- Promote the availability of HCV testing outside of health care systems, such as outreach settings or home test kits.
- Ensure all labs and health systems conduct automatic reflex HCV RNA testing on specimens positive for anti-HCV antibodies.
- Promote clinician training on new recommendations for universal screening for HBV.

- Encourage the use of:
 - » Clinical decision support tools, and
 - » Quality improvement initiatives to improve adherence to HBV and HCV screening guidelines.

2.1.2 Increase screening of pregnant women and children exposed to mothers with viral hepatitis during pregnancy.

- Standardize HCV screening as part of:
 - » Prenatal lab panel, and
 - » Admission to labor and delivery if not done during pregnancy.
- Educate pediatric providers about the need to screen infants born to mothers who were HCV-positive during pregnancy.
- Promote clinical decision support tools to track infants born to women positive for HCV during pregnancy to ensure appropriate testing and follow-up by age 18 months.
- Screen infants exposed to HBV one to two months after the third dose of HBV vaccine.
- Document pregnancy status on labs positive for HBV or HCV.

2.1.3 Increase periodic screening for people with ongoing risk factors.

- Increase screening at community sites, health fairs, and outreach programs serving persons who inject drugs (PWID) such as SSPs, houseless camps and shelters.
- Post information about testing and treatment services on websites frequented by persons at high risk for HCV, such as:
 - » PWID
 - » Persons on hemodialysis, or
 - » Persons with high-risk sexual behaviors, such as sex workers.
- Promote accessibility to information about risk, transmission, testing or treatment through technological services, such as:
 - » Real-talk chatbots
 - » Hot lines, and
 - » Text lines.
- Increase availability of dried blood spot testing to ensure quick access to results and minimize loss of follow-up.
- Provide policies and procedures for local public health agencies (LPHAs) and other community-based agencies to provide point-of-care testing.

- Develop media campaigns around the importance of screening and availability of treatment for HBV and HCV.
- Promote opt-out onsite HBV/HCV screening for those accessing behavioral health or substance use disorder or opioid treatment programs.
- Promote opt-out HBV/HCV screening in carceral settings.
- Offer HBV and HCV screening in high-risk settings wherever HIV and STI screening is routinely performed.

Objective 2.2 Increase treatment and monitoring of chronic hepatitis C

Strategies

2.2.1 Increase the number of patients diagnosed and linked to hepatitis C care.

- Expand the use of telemedicine to increase HCV treatment in the entire state. This includes non-traditional care settings such as SSPs, MOUD and SUD treatment centers.
- Promote the use of peer recovery specialists or peer navigators in both community and health care settings to:
 - » Facilitate linkage to care
 - » Assist with transportation issues
 - » Provide ongoing support, and
 - » Improve adherence to medications among high-risk patients.
- Promote cross-system collaboration to treat HCV among people with all forms of disability, including psychosocial disability.
- Promote the use of clinical decision support tools and quality improvement projects in health care settings that assure diagnosis and linkage to care.
- Initiate same-day treatment for persons with confirmed HCV.
- Ensure that treatment for HCV continues during incarceration.

2.2.2 Increase the number of providers administering HCV treatment.

- Promote awareness of high effectiveness and ease of treatment with DAAs among all clinicians.
- Provide training in collaboration with Project ECHO and the AIDS Education and Training Center (AETC) for allopathic and non-allopathic primary care providers (PCPs), on evaluation and treatment of HCV.

- Encourage health systems to provide clinician education on HCV treatment as part of mandatory training or continuing education.
- Implement a “clinic champion model” (designated PCPs trained to treat HCV) within all primary care systems.
- Promote the use of specialty pharmacies in:
 - » Linking patients to care
 - » Providing HCV treatment in collaboration with PCPs, and
 - » Tracking treatment outcomes.

2.2.3 Increase the number of patients with chronic HCV linked to a medical home.

- Assure that patients with HCV receive care management, which includes long-term management and surveillance for liver disease.
- Offer care navigation in outreach settings to help people at high risk for HCV to enroll in a health plan.
- Increase support groups for people diagnosed and receiving treatment for HCV.

Objective 2.3 Increase treatment and monitoring for chronic hepatitis B

Strategies

2.3.1 Increase the number of patients diagnosed and linked to care.

- Promote the use of clinical decision support tools and quality improvement projects in health care settings that assure diagnosis and linkage to care.
- Reduce stigma around a diagnosis of HBV through social marketing and storytelling from people with lived experience.
- Promote the use of peer recovery specialists or peer navigators in community and health care settings to:
 - » Facilitate linkage to care, and
 - » Improve adherence to medications.

2.3.2 Increase the number of PCPs who can facilitate the treatment of HBV and provide long-term management.

- Expand telehealth support for PCPs managing patients with HBV.
- Provide training in collaboration with OHSU ECHO, Indian Country ECHO and AETC for primary care providers on HBV screening and co-management of treatment with subspecialists.
- Encourage health systems to provide clinician education on:

- » HBV co-management, and
- » Long-term surveillance for cirrhosis and liver cancer.

2.3.3 Increase patients with chronic HBV linked to a medical home.

- Increase linkage to a PCP or medical home from outreach sites with HBV testing.
- Assure patients with HBV receive care management or patient navigation services, which include long-term management and surveillance for liver disease.



Goal 3: Eliminate health disparities and inequities

Recent trends in Oregon

- Oregon continues to see health disparities and inequities in viral hepatitis. To eliminate these inequities, we must address the social and structural barriers, including structural racism, that prevent people from engaging with care and completing treatment.
- Between 2016 and 2020, rates of cases of acute HBV were over four times higher in Native Hawaiian and Pacific Islander persons than the state average. (Figure 7)
- Forty-eight percent of cases of chronic HBV in Oregon between 2016-2020 were among foreign-born persons.
- Rates of chronic HBV are highest in:
 - » Asian persons (35 times higher than white persons)
 - » Native Hawaiian and Pacific Islander persons (31 times higher than white persons), and
 - » Black and African American persons (11 times higher than white persons). (Figure 8)



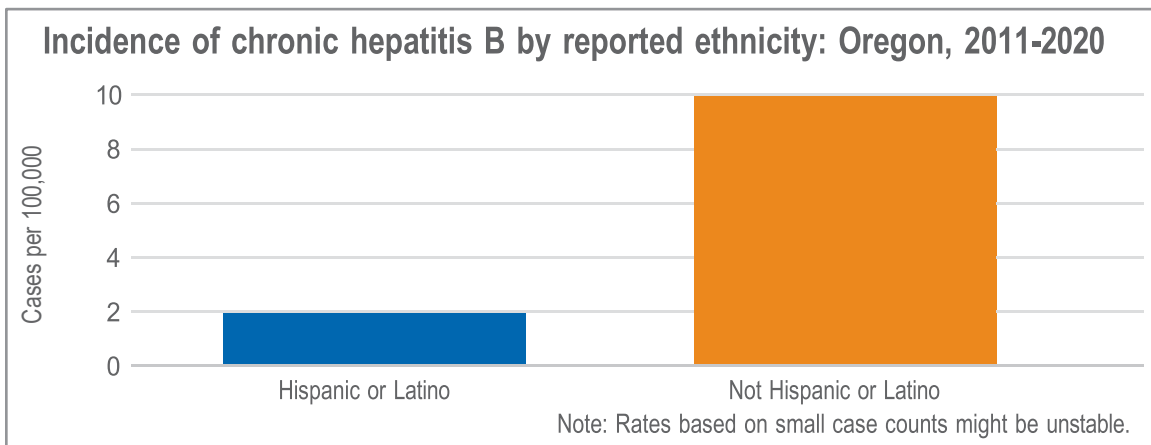
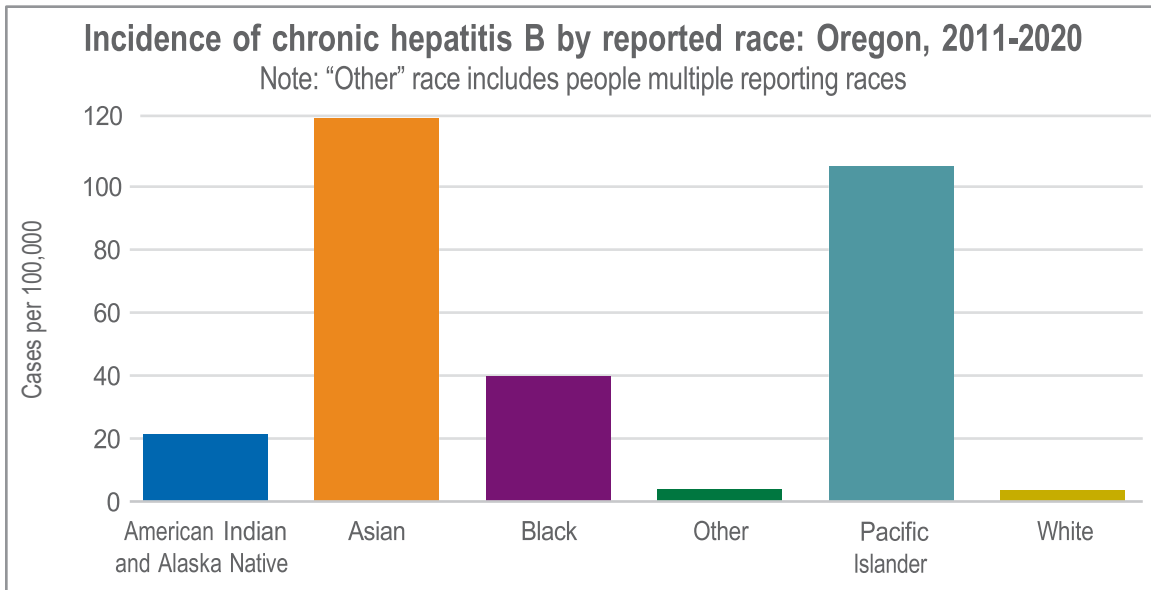
Objectives

- 3.1 Reduce stigma and discrimination in health care settings faced by people with or at risk for viral hepatitis.
- 3.2 Reduce disparities in diagnosis of viral hepatitis, knowledge of status, engagement with care and community stigma around diagnosis.

Figure 7: Race and ethnicity of cases of acute hepatitis, 2016-2020, Oregon

Race	HAV	HBV	HCV	Population of Oregon
American Indian and Alaska Native	1%	1%	3%	2%
Asian	5%	5%	3%	5%
Black	1%	1%	5%	2%
Pacific Islander	2%	4%	0%	0.5%
White	76%	74%	72%	75%
Multiple	4%	1%	3%	4%
Other or unknown	12%	15%	16%	—
Ethnicity				
Hispanic or Latino	12%	7%	7%	13%

Figure 8: Rates of chronic HBV cases by race and ethnicity, Oregon, 2011-2020



- American Indian, Alaska Native and Black persons have higher rates of acute and chronic HCV compared to the state average. (Figure 7, 9)
- Rates of deaths related to HCV are twice as high among Black, American Indian and Alaska Native persons than the state average. (Figure 10)
- Between 2016 and 2020:
 - » 26 percent of cases with acute HBV reported recent injection drug use, and
 - » 62 percent of those with acute HCV reported acute injection drug use. (Figures 11a, 11b)
- In 2019-2020:
 - » 28 percent of people in Oregon with acute HBV were houseless, and
 - » 40 percent of people in Oregon with acute HCV were houseless.

Figure 9: Rates of chronic HCV cases by race and ethnicity, Oregon, 2011-2020

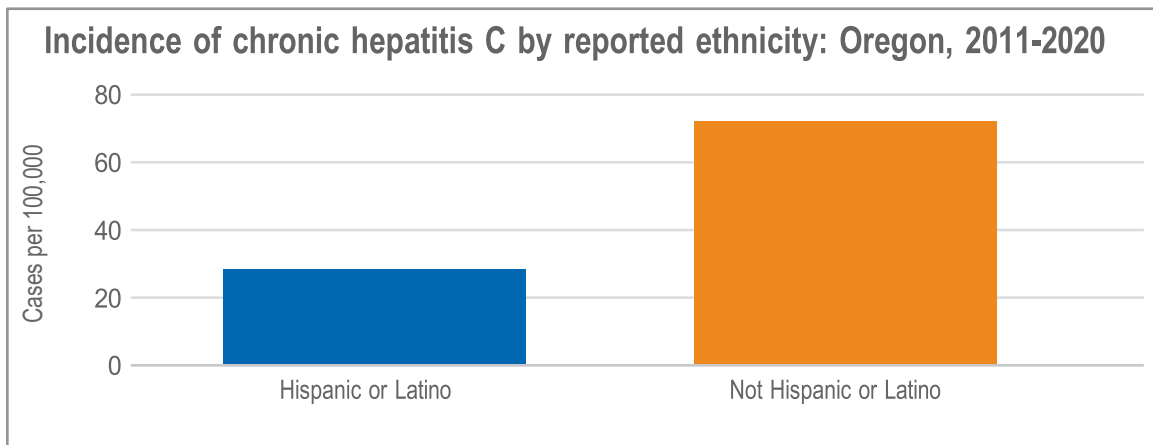
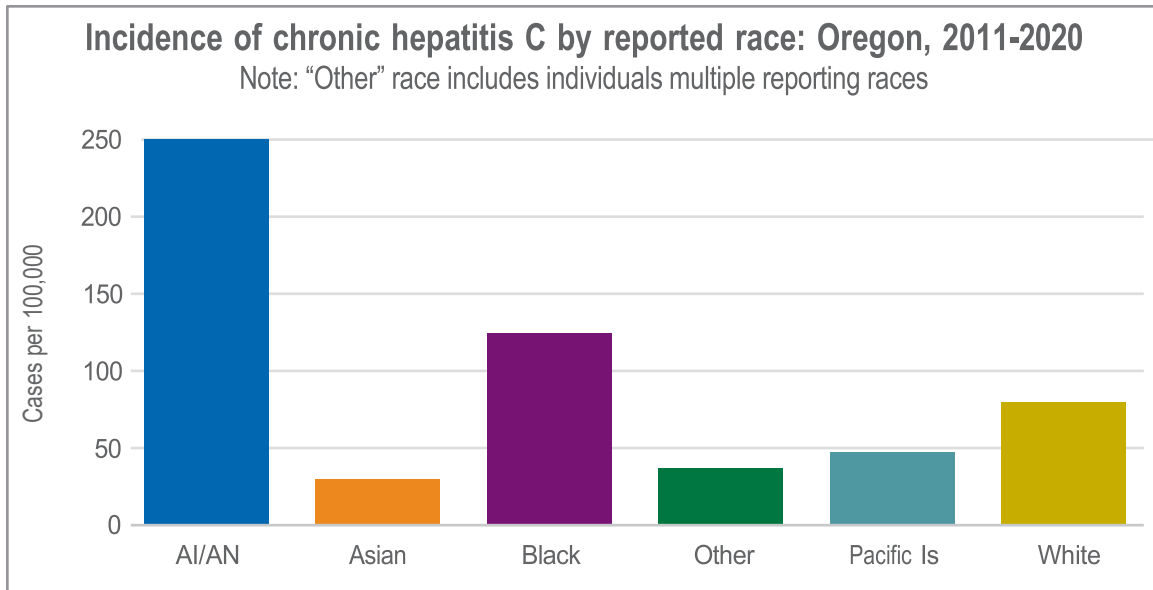


Figure 10: Average rates of chronic HCV-related deaths by race and ethnicity, Oregon, 2016-2020

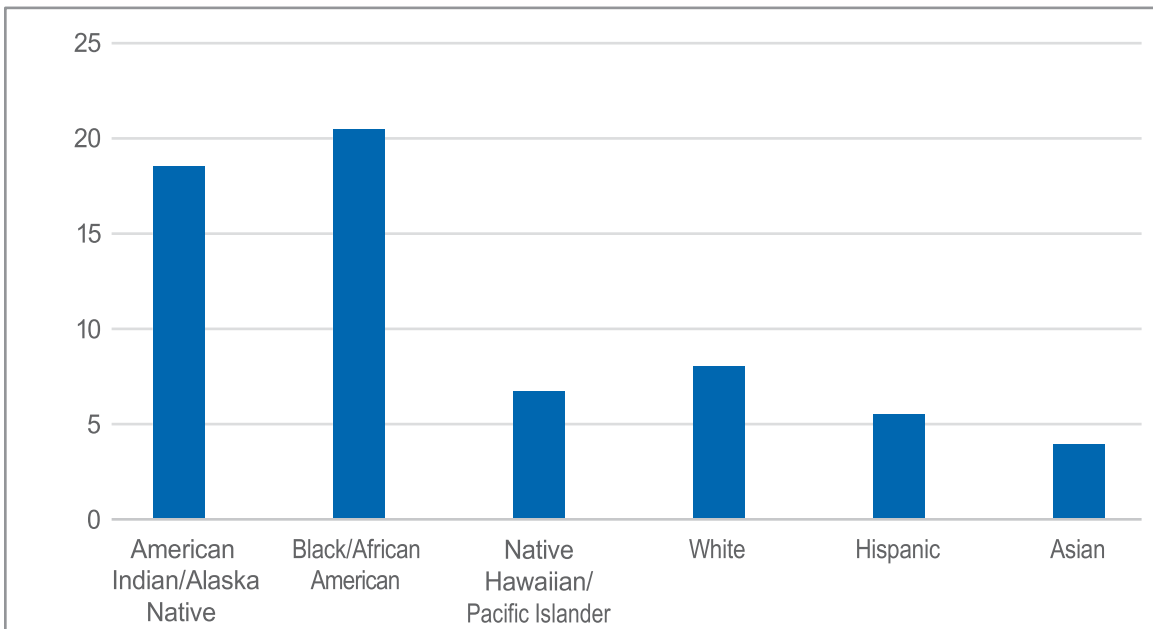


Figure 11a: Risk factors for acute cases of HBV, 2016-2020

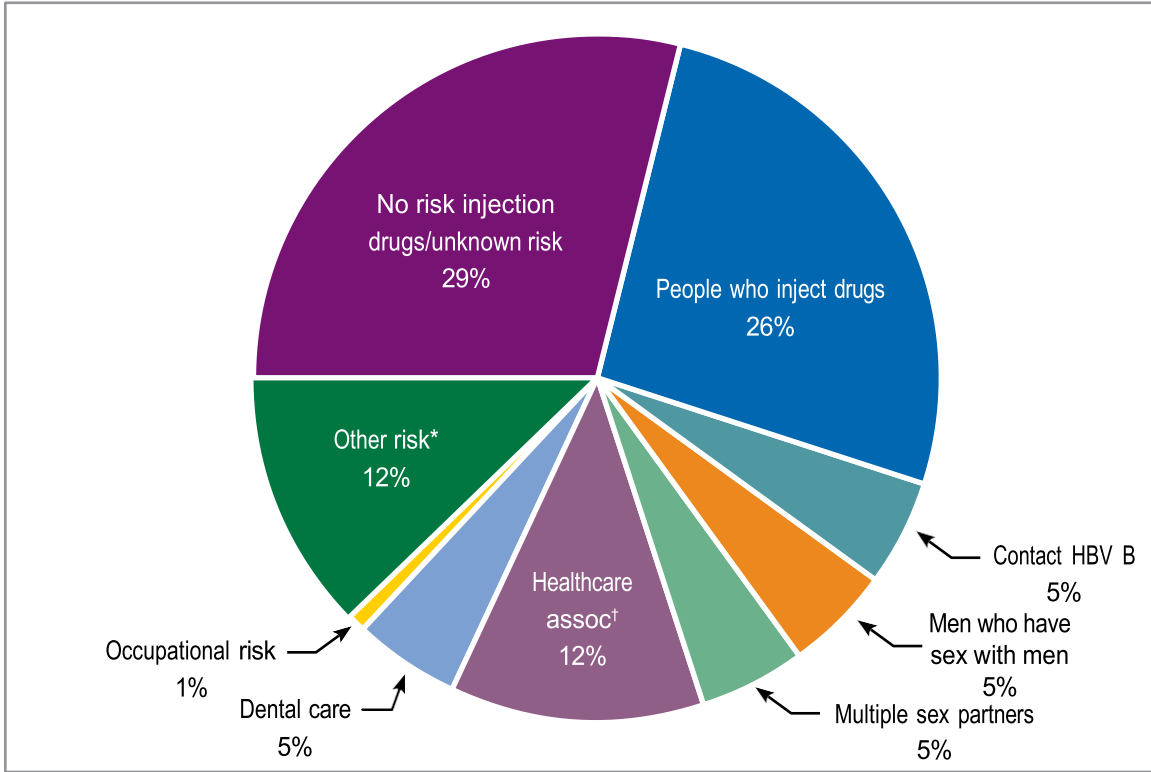
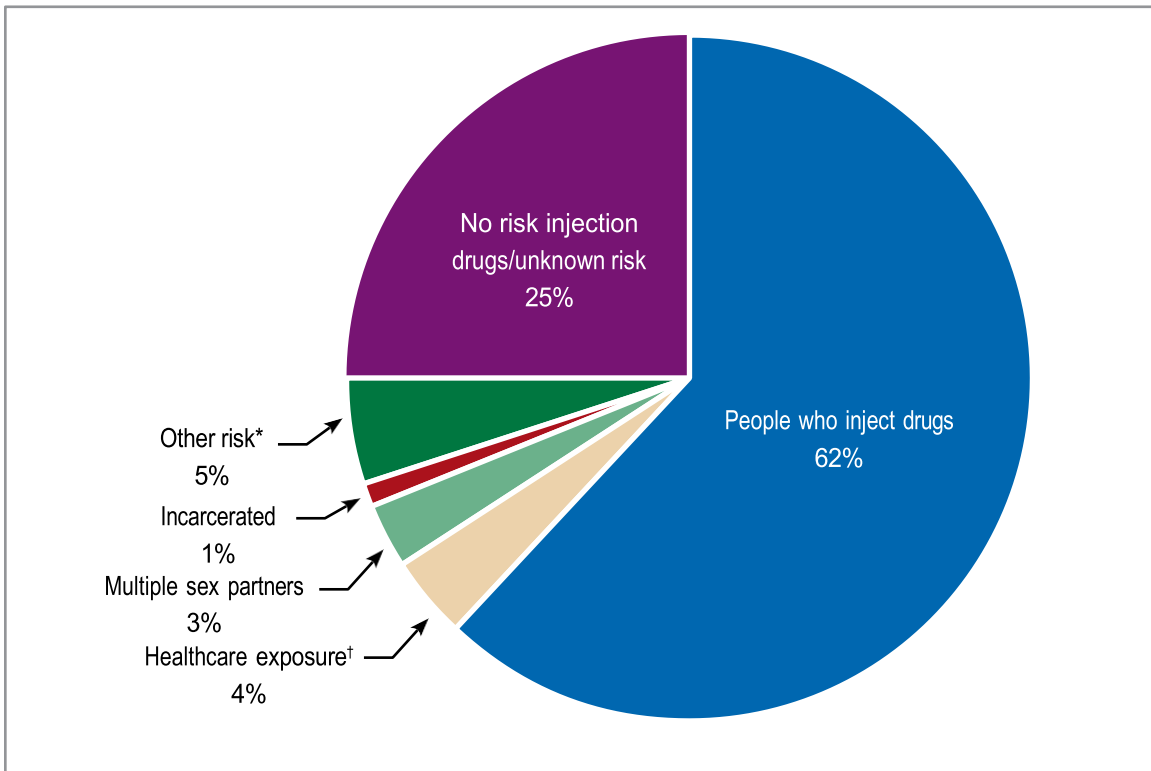


Figure 11b: Risk factors for acute cases of HCV, 2016-2020, Oregon



* Illicit drugs, needlestick, tattoo, pierce, other blood exposure

† Transfusion, infusions, dialysis, surgery

The rationale for proposed objectives and strategies

- Viral hepatitis disproportionately impacts specific groups of people, many of whom experience discrimination and stigma.
- Elimination of viral hepatitis requires engaging communities experiencing health disparities.
- Community-led groups are more likely to:
 - » Be culturally and linguistically responsive, and
 - » Provide accurate information and services in their native languages.
- Health care systems and professionals must provide culturally and linguistically appropriate education, counseling and care to persons at risk of or infected with chronic viral hepatitis.

Table 3: Goals and objectives to eliminate health disparities and inequities.

Goals	3. Eliminate health disparities and inequities	
Objectives	3.1 Reduce stigma and discrimination in health care settings faced by people with or at increased risk for viral hepatitis	3.2 Reduce disparities in the diagnosis of viral hepatitis, knowledge of status, engagement with care and community stigma around diagnosis
Secondary objectives	3.1.1 Address stigma, unconscious bias and discriminatory practices at health care delivery sites	3.2.1 Strengthen and build partnerships with organizations serving communities at risk for viral hepatitis
	3.1.2 Expand culturally competent and linguistically appropriate care, treatment and prevention services	3.2.2 Engage community leaders and people with lived experience to dispel viral hepatitis-related stigma

Objective 3.1 Eliminate disparities faced by people with and at risk for viral hepatitis in health care settings

Strategies

3.1.1 Address stigma, unconscious bias and discriminatory practices at health care delivery sites.

- Increase culturally competent care navigation services and care management in primary care and emergency department settings.

- Promote recruitment of culturally and linguistically diverse community health workers (CHWs) to provide care navigation.
- Provide training on implicit bias and microaggression for clinic staff working in communities of color and caring for marginalized populations, such as:
 - » LGBTQIA2S+
 - » Persons experiencing homelessness
 - » Persons who use drugs
 - » Persons experiencing severe mental illness, and
 - » Sex workers.
- Foster collaboration between health care systems and community-based organizations that serve priority populations to implement effective strategies to improve viral hepatitis care and treatment.

3.1.2 Expand culturally competent and linguistically appropriate care, treatment and prevention services.

- Promote recruitment of linguistically and culturally diverse staff in health care and MOUD and SUD treatment sites.
- Ensure that hepatitis and substance use recovery materials are available and translated into languages that represent the populations using clinic services.
- Develop culturally and linguistically responsive educational materials tailored to communities with a high prevalence of viral hepatitis, HIV and STIs using tools, such as:
 - » Videos
 - » Infographics
 - » Audio materials for radio or podcasts, and
 - » Social media messaging.
- Ensure interpreter service is available at health care and MOUD and SUD treatment facilities.

Objective 3.2 Reduce disparities in the diagnosis of viral hepatitis, knowledge of status, engagement with care and community stigma around diagnosis

Strategies

3.2.1 Strengthen and build partnerships with organizations serving communities at risk for viral hepatitis.

- Foster partnerships with organizations that serve disproportionately affected populations to raise awareness of viral hepatitis, including:
 - » Community organizations
 - » Provider organizations
 - » Academic institutions, and
 - » Offices of equity and inclusion.
- Promote hepatitis prevention education, hepatitis treatment and MOUD and SUD treatment for persons in carceral settings.

3.2.2 Engage community leaders and people with lived experience to dispel viral hepatitis-related stigma.

- Employ peer educators to raise awareness about HCV:
 - » Prevention, and
 - » Availability of a cure in their respective communities.
- Share facts, recommendations and personal stories in community settings and in the media to reach all people, especially those in disproportionately affected communities.
- Increase social media campaigns that highlight:
 - » Treatment for HCV, and
 - » Experience of living with chronic hepatitis.
- Develop educational programs that promote culturally and linguistically appropriate vaccine confidence among:
 - » Black and African American communities
 - » American Indian and Alaskan Native communities
 - » Native Hawaiian and other Pacific Islander communities
 - » Asian communities
 - » Hispanic, Latino, Latina or Latinx communities
 - » Diverse LGBTQIA2S+ communities
 - » People impacted by carceral systems
 - » Diverse geographic communities, and
 - » Persons with religious or philosophical concerns about vaccines.



Goal 4: Improve surveillance and data usage

The rationale for proposed objectives and strategies

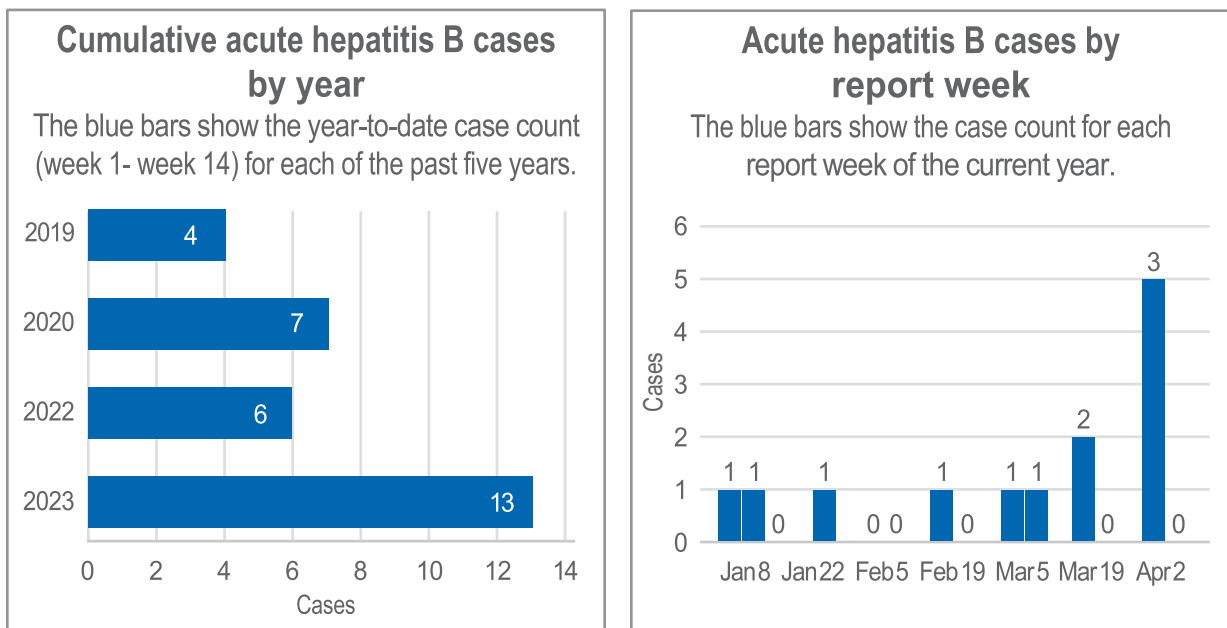
- Routine surveillance data from case investigations of viral hepatitis are useful for monitoring trends in the transmission of viral hepatitis. These data also help local and state public health agencies develop better prevention and control strategies. (Figure 12)
- Data from hospitals, the Oregon State Cancer Registry (OSCaR), and death certificates can provide important information about complications of liver disease in:
 - » Hospitalized patients
 - » Cases of liver cancer, and
 - » Deaths associated with chronic viral hepatitis. (Figure 13, 14)



Objectives

- 4.1 Monitor control and spread of viral hepatitis.
- 4.2 Monitor racial and ethnic disparities.
- 4.3 Monitor morbidity and mortality due to viral hepatitis and track access to testing and treatment.

Figure 12: Weekly and cumulative acute cases of HBV, Oregon, 2019-2023



- Health agencies and OHA can use insurance claims data to track how many Oregonians are getting tested and treated for chronic viral hepatitis. (Figure 15)
- These data help public health, health systems and community partners to:
 - » Reach persons at risk for viral hepatitis
 - » Ensure that progress is made toward eliminating racial and ethnic disparities
 - » Provide testing and treatment, and
 - » Monitor long-term complications of viral hepatitis.
- Sharing data annually will allow OHA, local public health agencies and health systems to track our efforts toward the elimination of chronic viral hepatitis in Oregon.

Figure 13: HCV-related deaths by age and gender, Oregon, 2020

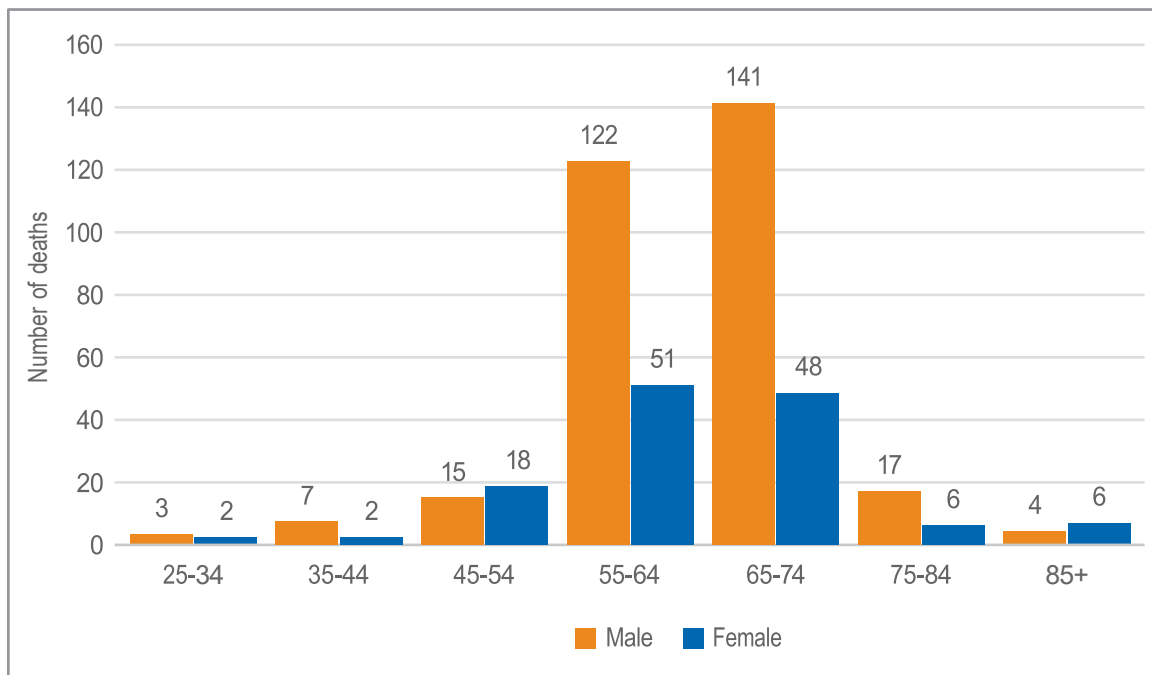


Figure 14: HCV-related hospitalizations by cause and year, Oregon, 2016-2020

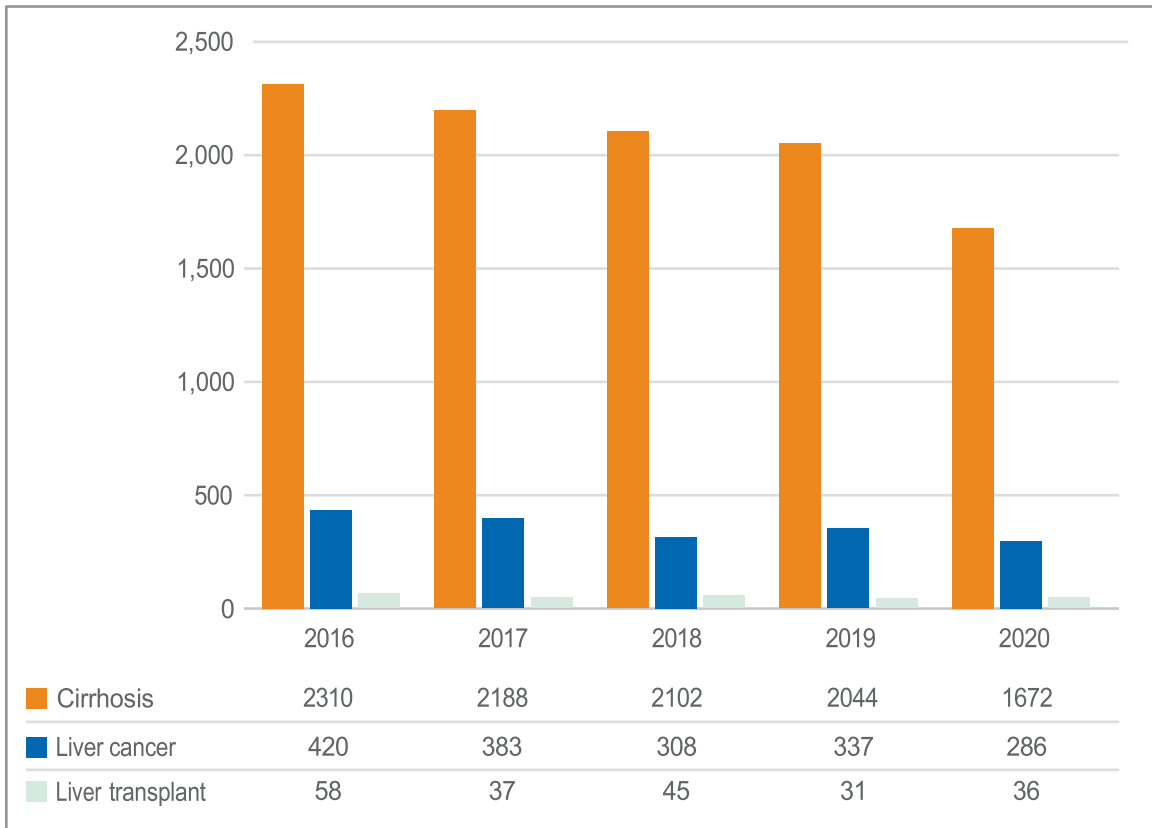


Figure 15: Payer status of persons screened and treated for HCV, Oregon 2010-2019

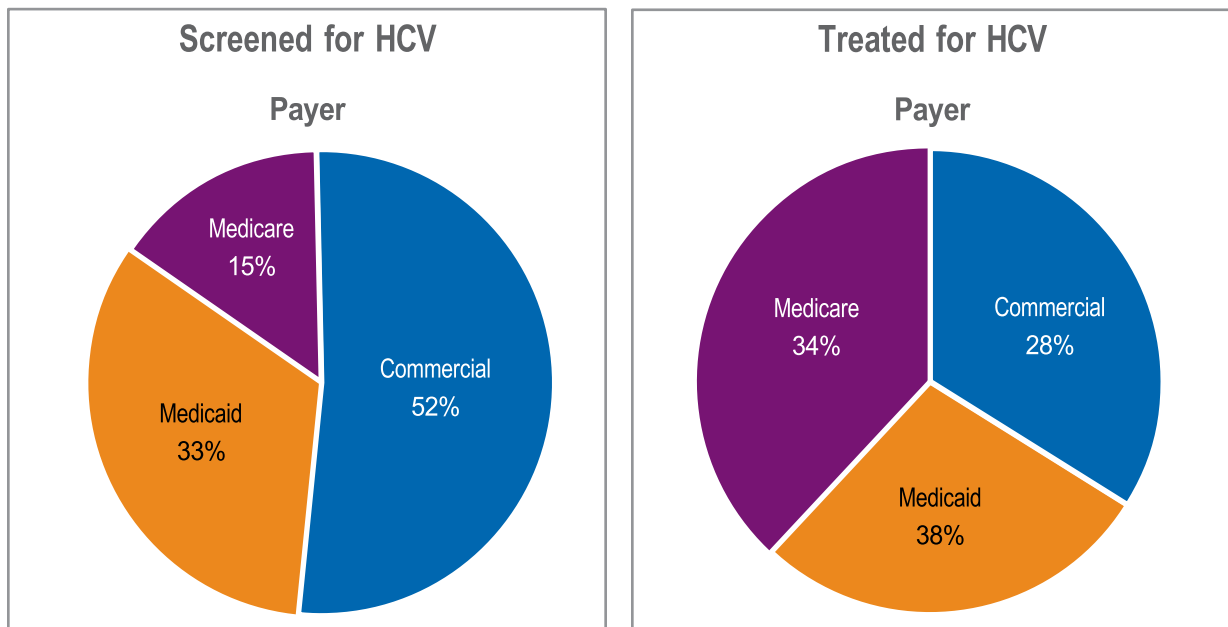


Table 4: Goal and objectives to improve surveillance and data usage.

Goals	4. Improve surveillance and data usage		
Objectives	4.1 Monitor and control the spread of viral hepatitis.	4.2 Monitor racial and ethnic disparities.	4.3 Monitor morbidity and mortality due to viral hepatitis and track access to testing and treatment.
Secondary objectives	4.1.1 Investigate and implement control measures for acute cases of HAV, HBV, HCV and chronic cases of HBV.	4.2.1 Improve collection of data on gender, race, ethnicity, language and disability.	4.3.1 Monitor rates of hospitalizations, cases of liver cancer and deaths related to viral hepatitis.
	4.1.2 Identify and respond to clusters of chronic HCV.	4.2.2 Launch public dashboard with rates of viral hepatitis by age, gender, race, ethnicity, language, disability and county.	4.3.2 Track numbers of persons with chronic HCV who receive confirmatory testing and initiate treatment.

Objective 4.1 Monitor and control the spread of viral hepatitis

Strategies

4.1.1 Investigate and implement control measures for acute cases of HAV, HBV, HCV and chronic cases of HBV.

- Conduct timely and complete investigations of cases and outbreaks of acute viral hepatitis.
- Assure that persons tested in outreach settings using point-of-care tests are reported to OHA.

4.1.2 Identify and respond to clusters of chronic HCV.

- Develop protocols and identify resources to assist with responding to clusters of chronic HCV.

Objective 4.2 Monitor racial and ethnic disparities

Strategies

4.2.1 Improve collection of data on gender, race, ethnicity, language and disability.

- Train LPHA and OHA staff in the use of new standards and instruments for collecting data on:
 - » Race, ethnicity, language and disability (REALD), and
 - » Sexual orientation and gender identity (SOGI).
- Phase in Oregon administrative rules (OARs) requiring providers to collect and report REALD and SOGI data.

4.2.2 Launch public dashboard with rates of viral hepatitis by age, sex, race, ethnicity and county.

- Create an OHA data mart to mine REALD and SOGI data from health systems data.
- Display racial, ethnic, and disability-related disparities when available.

Objective 4.3 Measure morbidity and mortality due to viral hepatitis and track access to testing and treatment

Strategies

4.3.1 Monitor rates of hospitalizations, cases of liver cancer and deaths related to viral hepatitis.

- Post annual burden-of-disease reports on the OHA website.
- Update the Oregon Viral Hepatitis Report every three to five years.
- Monitor racial, ethnic and disability-related disparities.

4.3.2 Track numbers of persons with chronic HCV who receive confirmatory testing and initiate treatment.

- Pilot voluntary reporting of negative HCV RNA results to estimate the number of persons receiving confirmatory testing and treatment.
- Analyze data from the All Payer All Claims (APAC) reporting system to estimate the number of people in Oregon tested for HBV and HCV and treated for HCV annually.
- Post cascade of care data annually on the OHA website.

Conclusion

OHA will need help from many partners to eliminate viral hepatitis in Oregon. The Viral Hepatitis Program at OHA will work with public health, healthcare systems, community agencies, and Tribal partners across Oregon to:

- Make vaccinations and treatment for viral hepatitis widely available.
- Link every individual confirmed with HCV to treatment.
- Address the shortage of healthcare providers who can care for patients with viral hepatitis.
- Make people aware of the need to address both the epidemics of hepatitis and drug use in our state.
- Promote health equity for all people in Oregon recognizing and addressing structural racism, stigma and other forms of bias as drivers of health inequities.



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