Hepatitis C Town Hall Questions and Responses

Hepatitis C town Hall in Hazard on July 28th, 2016 was an opportunity for individuals to hear from national, state and local health leaders on the prevention, detection and treatment of Hepatitis C. Questions were compiled from initial registration through the end of the event. SOAR has compiled all the questions and answers into this report. Answers were provided by numerous sources.

Education:

Q- How open do you think the schools are to education about drug abuse and avoiding it, starting at young ages- such as 3rd and 4th grade? Are they already doing it?

A- Not very open. There is too much already being asked during the school day and it's hard to do more. The best hope will be to address through program review. However, every Youth Service Center (middle/high) in the state (which is most schools) has a required component for "substance abuse education and counseling". So, there is a definite way to improve this and it will begin with Youth Service Centers.

Economic impact:

Q- Do you believe that Hep C, HIV, and intravenous drug use in general are going to impede our abilities to be a competitive workforce and to utilize the opportunities we do have in technology and other areas?

A- The lack of economic opportunity in the region is one of the factors of the elevated negative health indicators in our region. The employers that provide economic opportunities that are sustainable for a family, have consistently provided tremendous testimonials on our workforce. I think that as we have more economic opportunities within the region, it will begin to impact the negative health indicators in the region. To be more concise, I believe it must be a contemporaneous effort to improve the health of our workforce and create economic opportunity, not either one before the other.

-Jared Arnett, MBA, IOM
SOAR Executive Director

A- I do not believe that the infections of Hep B or HIV will impede our ability to have a competitive workforce. Actually, it is our ability to respond and treat, drug addiction, HepC and HIV that will allow us to remain competitive. We must keep our citizens healthy by giving access to healthcare in order to sustain our viability.

–Maria Braman, MD
VP, Appalachian Regional Hospitals

A- HIV and HCV, if untreated, can certainly have a negative impact on the workforce due to illnesses and deaths. The same can be said for injection drug use.

-Greg Lee, CHFS PH
KY Department for Public Health

Health:

Q- Is it needle users who started this epidemic or was it casual, unprotected sex?

A- Hepatitis C Virus (HCV) has been around for many years now in Kentucky. Many "baby boomers" (people born between 1946 and 1964) were infected with HCV when they were young, before we even knew that HCV existed. With so many infected for decades already, it would be unfair to claim any recent infections "started" the HCV epidemic. What is fair to say is that we know at least 60% of new HCV infections are directly related to sharing syringes to inject drugs. HCV, unlike HIV, is generally NOT transmitted sexually. But HCV is extraordinarily infectious in even the smallest amount of blood. HCV can remain infectious outside the body at room temperature on environmental surfaces for up to 3 weeks. So, HCV is also transmittable (much more so than HIV) when people are sharing razors, toothbrushes, tattooing needles and inks if not used properly per regulations, providing healthcare or first aid without gloves, etc. Many babies are also infected with HCV at birth from their HCV positive mothers.

<table>
<tr><th>Human Immunodeficiency Virus (HIV)</th><th>Hepatitis C Virus (HCV)</th><th>Hepatitis B Virus (HBV)</th></tr>
<tr><td>HIV transmission has not been reported as a consequence of contact with spillages of blood, semen or other body fluids. Generally HIV doesn't survive outside the body for more than a few moments. However, HIV can remain infectious outside the body at room temperature on environmental surfaces for up to 5 or 6 days provided the optimal temperatures (39º F or lower) and pH level (between 7 and 8) is maintained. Inside a needle, HIV can remain infectious up to 48 days under optimal conditions. HIV does not survive in a needle above 80.6º F for more than 7 days. One important fact is that the amount of HIV in blood is significantly lower than that of HCV or HBV. The risk of becoming infected with HIV by sharing a needle with a person already infected with HIV is estimated to be 0.67% for each time a needle is shared.</td><td>HCV can remain infectious outside the body at room temperature on environmental surfaces for up to 3 weeks. Inside a needle, HCV can remain infectious up to 63 days.

Keep in mind that HCV is not only transmitted from a shared needle, but is also transmitted by sharing any of the supplies used in preparing and injecting drugs. This includes shared cookers, shared cottons, shared tourniquets, and shared water used to prepare drugs or needles.</td><td>HBV can remain infectious outside the body at room temperature on environmental surfaces for up to 7 days.

Keep in mind that HBV is not only transmitted from a shared needle, but is also transmitted by sharing any of the supplies used in preparing and injecting drugs. This includes shared cookers, shared cottons, shared tourniquets, and shared water used to prepare drugs or needles.</td></tr>
<tr><td>HIV is primarily transmitted through blood, seminal fluids, and vaginal/anal secretions. Relative risks are listed below. By comparison, blood concentrations of HIV are much lower than that of HCV or HBV.

<table><tr><th>HIV Exposure Route</th><th>Estimated infections per 10,000 exposures to an infected source</th></tr><tr><td>Blood Transfusion</td><td>9,000</td></tr></table></td><td>HCV is transmitted through blood and is generally not sexually transmitted. HCV concentrations in blood are about 10 times that of HIV.</td><td>HBV is 50-100 times more infectious than HIV and can be passed through the exchange of body fluids, such as semen, vaginal fluids, and blood. HBV is transmittable through sex and sharing needles.</td></tr>
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Childbirth	2,500		
Needle-sharing injection drug use	**67**		
Receptive anal intercourse without condom	50		
Percutaneous needle stick	30		
Receptive penile-vaginal intercourse without condom	10		
Insertive anal intercourse without condom	6.5		
Insertive penile-vaginal intercourse without condom	5		
Receptive penile-oral sex	1		
Insertive penile-oral sex	0.5		

-Greg Lee, CHFS PH
KY Department for Public Health

Q- What is currently being done to address the extremely high rate of hepatitis in our community?

A- Kentucky Counties can now establish syringe exchange programs. Sharing syringes is contributing over 60% of new HCV infections. People with HCV can be treated, rendering them non-infections.

-Greg Lee, CHFS PH
KY Department for Public Health

Q- What screening and treatment sites are available in Eastern Kentucky?

A- In Emergency Rooms, all high risk individuals are being screened.

-Maria Braman, MD
VP, Appalachian Regional Hospitals

A- All local health departments provide HIV and HCV testing.

- Greg Lee, CHFS PH
KY Department for Public Health

A- A Work Group was established and there are ongoing meetings and communications to address the HIV/ HCV rates in the region. This Work Group consists of community leaders and KY Department for Public Health infectious disease programs. Community education, Awareness campaigns, and prevention messages targeting young adolescents and high risk groups are imperative in preventing further outbreaks of the HCV epidemic in the region.

- Kathy Sanders, Viral Hepatitis Coordinator, KY Department for Public Health

Q- If physicians will not provide HCV treatment to active drug users and substance abuse treatment remains inaccessible and unaffordable, how can we curb the HCV epidemic in Kentucky?

A- HCV is more infectious than HIV. Transmission of HCV can be significantly reduced by the combined provision of SSP and substance abuse treatment program. This combined approach has been shown to reduce risk of HCV transmission by up to 50-80%. The role of SSP alone on prevention of HCV is controversial but with easy access and broad availability to SSP HCV transmission could be reduced. The point is that there should be good access so that sharing will not occur. It's important SSPs operate accessible hours and offer ancillary injection equipment such as cookers in addition to syringes. Pharmacy sales can help improve access to sterile syringes as well. In the end, it will be far cheaper to spend public health dollars on SSPs and treatment than chronic HCV. The use of small dead space syringes can also help to reduce transmission in programs that provide good access to syringes. The role of HCV treatment alone in a highly injecting and sharing group is minimum. However, when combined with the SSP and substance abuse treatment, HCV treatment could further reduce HCV transmission. Education is really important. Public health campaigns to let PWID know about the risks of sharing all equipment, not just needles, is essential. And there should also be efforts to educate pubic officials so that there can be improvements to substance treatment access and SSPs.

- CDC Division of Viral Hepatitis

Q- Does sharing snorting straws transmit HCV?

A- There are few studies where HCV transmission has occurred among persons who use drugs in a route other than injecting. Injection remains the most significant risk. Few studies published in the past have demonstrated HCV virus in straws used for snorting drugs.

- CDC Division of Viral Hepatitis

A- Reference Article: http://www.ncbi.nlm.nih.gov/pubmed/27400008
Obstet Gynecol. 2016 Aug;128(2):234-7. doi: 10.1097/AOG.0000000000001507.
Sharing of Snorting Straws and Hepatitis C Virus Infection in Pregnant Women.
Fernandez N[1], Towers CV, Wolfe L, Hennessy MD, Weitz B, Porter S.

- Link provided by Kathy Sanders, Viral Hepatitis Coordinator, KY Department for Public Health

Needle Exchange:

Q- How can a needle exchange program help in stopping Hep C from spreading?

A- Over 60% of new HCV infections are from people who are sharing needles. Needle exchange programs can eliminate the need for people who inject drugs to share their needles and related equipment.

Q- Does a needle exchange program have people in the waiting rooms helping addicts get into treatment?

A- Needle exchange programs encourage and refer people to treatment when the client is ready. The program will call treatment providers on the spot and may even provide immediate transportation to treatment, but representatives from other agencies are not hanging out in the waiting room.

Q- Should all KY local health departments be offering needle exchange, as a gateway to treatment for addition and a risk reduction measure for Hep C/HIV transmission?

A- Probably. There is not one county in Kentucky without people who inject drugs. All counties have people with HCV, HBV, and most likely HIV. However, Kentucky law requires this decision to be made locally between the board of health, the municipality and county governments.

Q- Would a needle exchange for the drug addicted needle users help or hurt us?

A- Needle exchanges would only help us. Fewer people who inject drugs would become infected with HCV, HBV, and HIV. Clients of needle exchange programs are 4 times more likely to get into drug treatment. Every dollar spent on a needle exchange saves $7 dollars in treating HIV or HCV.

Q- How do we encourage communities to adopt clean needle exchange programs and releasing the stigma around such programs?

A- The more communities know about needle exchange programs and about the many studies done on them for 30 years already, the more they realize that these programs do nothing but good for their community. Stigma around the needle exchange programs is really just stigma around people with substance use disorders.

Q- How are local health departments helping with needle exchange? How are needle exchanges being funded? Who does education with NE?

A- It is up to the local board of health to determine whether or not their county would benefit from a needle exchange program. Once the board of health has agreed, they also need acceptance by the municipality where the program would be, as well as the county court. Health departments are heavily involved in educating officials and communities on the long-proven benefits of needle exchange programs. Local funds support these programs, whether local taxes, ASAP grants, or philanthropists. Education to needle exchange programs is provided by staff, usually nurses, social workers, or certified alcohol and drug counselors. Education on needle exchange to the community is provided by Kentucky Harm Reduction Coalition, many local health departments and the Kentucky Department for Public Health.

Q- Is Naloxone available at needle exchange sites? Price? Free? Training Provided?

A- Naloxone is available at some of the needle exchanges. Often for free through Kentucky Harm Reduction Coalition, local ASAP boards, etc. By law, training must always be provided when dispensing Naloxone.

Q- Our Owsley Co. local health department voted unanimously to approve needle exchange program. Our Fiscal Court followed suit and also voted for the program. Pharmacy agreed to run the program and they were going to cover the cost. Now we are told we cannot do the program

because there is no one working at the local health department with at least a degree in psychology. What regulations can be changed to where we can move forward with needle exchange? According to experts – we are most apt to become infected than most any county.

A- Congratulations on the approval in Owsley County! SB 192 does not require health departments to have a psychiatrist on board. A syringe exchange program could perhaps be operated contractually through and memorandum of understanding between the health department and a pharmacy. Louisville's health department has an agreement with Volunteers of America – Mid-states to run syringe exchanges.

-Greg Lee, CHFS PH
KY Department for Public Health

Here is a download link to Greg Lee's PowerPoint shown at the Hazard Town Hall meeting: https://drive.google.com/file/d/0B5TcK68_Fm9CSDk3bE9JZ1luRE0/view?usp=sharing

Community Awareness:

Q- What can help us and our community grow stronger from this? How can we help those infected and protect ourselves as well?

A- We need to stop judging how people became infected. As health care providers and community members we need to focus on treatment and prevention.

Q- How do we keep our small and school aged children safe from the recent epidemic of HIV and AIDS?

A- Education about personal health and how to keep yourself safe. Opportunities and access to education and jobs as they get older.

Q- What resources are lacking in your community that would help to address the Hep C crisis?

A- Needle exchange, rehab

Q- What do you see as the local hospital's role in this whole issue? Screening, referring, increasing awareness?

A- All of the above. We would also like to establish an infectious disease clinic. We are actively recruiting so that we can make that happen.

-Maria Braman, MD

Q- What are we doing to hold drug companies and pharmacies accountable?

A- CDC are engaged in HHS-wide discussions about how to address the high cost of treatment.

– CDC Division of Viral Hepatitis

Q- What percent of people convert on their own back to negative after previously testing positive (without treatment) and how does this happen?

A- All HCV infections do not lead to chronic infections. There are many factors that determine the progression from acute HCV infection to chronic infection. On average, 15-25% of acute infections resolve. However, these persons with resolved infection are at-risk for infection (i.e., are not protected) if they are exposed again. All

people who are exposed to HCV mount an immune response to the virus. Although the exact mechanisms for clearance are not well-understood, we know that women are three more times likely than men to clear, those with the CC (vs CT or TT) genotype of IL-28B are more likely to clear, and people with HLA B-57 are also more likely to clear. Despite that, reinfection is always possible.

– CDC Division of Viral Hepatitis

Q- What are some ideas for community awareness in our area?

A- Persons who inject drugs are at-risk for HCV infection. HCV infection is acquired in the early years of initiation of the injection behavior. Persons who ever inject drugs should be tested for HCV infection. Community testing days can be effective. Persons who inject drugs should not share syringes/needles or any other paraphernalia used for preparation and injection of the drug. Community awareness campaigns could come in the form of billboards, radio ads, television ads, and bus stop advertisements. Starting education in high school or earlier might have the benefit of reaching people before they start injecting. Make sure there are educational pamphlets about safer injection and HCV infection at SSPs.

– CDC Division of Viral Hepatitis

Q- How do we prevent this from being a greater problem any further in our community?

A- HCV could be prevented as above. However HCV is the tip of the iceberg. All partners should come together to prevent behaviors that eventually lead to injecting drug use. This should start education students at young age including risk of addiction to prescription opioids, transitioning to other opioids including heroin, and injecting these opioids. Scaling-up drug treatment and HCV treatment will be most effective.

– CDC Division of Viral Hepatitis

Drug Treatment:

Q- What can be done to improve HCV treatment access in Eastern Kentucky for people who use drugs?

A- Access to care treating those who are actively using IV drugs perinatal screening and treatment during third trimester of pregnancy

-Maria Braman, MD
VP, Appalachian Regional Hospitals

Medicaid:

Q- How will Governor Bevin's proposals to overhaul Kynect affect our ability to prevent and treat HCV in Eastern Kentucky?

A- Newly elected Governor Bevin established a team of experts to review the overall effectiveness and viability of the KYnect Program. It is too early in the process to

determine how the overhaul of KYnect will affect HCV in Eastern Kentucky or in fact, anywhere throughout the Commonwealth

-Kathy Sanders, Viral Hepatitis Coordinator, KY Department for Public Health

Q- How might the changes to Kentucky's Medicaid expansion affect the treatment of Hep C in the region?

A- As stated above, there are ongoing changes and recommendations by the experts selected by Governor Bevin to review the overall effectiveness and viability of the KYnect Program. It is too early in the process to determine how the changes to Kentucky's Medicaid expansion might affect the treatment of Hep C in the region.

-Kathy Sanders, Viral Hepatitis Coordinator, KY Department for Public Health

Q- I am unable to get insurance and Medicaid to cover the prescription for Hep C medication. How can the CDC help the state in getting medicines DAA for these patients before it is spread it to others?

A- Each state operates its own Medicaid system but must conform to federal guidelines. A state Medicaid program can establish limitations on coverage of prescription drugs. However, those limitations cannot result in the denial of access to treatment that is medically necessary and clinically appropriate. Recently, a federal judge ruled that Washington's Medicaid agency's policy did not meet the Medicaid medical necessity requirements and ordered Washington state's Medicaid program to cover HCV drugs for all patients with hepatitis C, regardless of fibrosis score.

- CDC Division of Viral Hepatitis

Q- Can the CDC or the federal government convince Kentucky State Medicaid to allow providers to treat chronic HCV at any stage (F0-F4)?

A- In a November 2015 letter to state Medicaid directors, CMS expressed concerns about unwarranted restrictions on access to hepatitis C treatments under some Medicaid programs, and reminded directors "of their obligation to provide access to these promising therapies based on the medical evidence," according to CMS acting administrator Andy Slavitt. The letter noted several types of conditions for coverage "that may unreasonably restrict access" to hepatitis C treatments, including restricting access to beneficiaries with advanced liver disease and requiring a period of abstinence from drug and alcohol abuse.

Q- Can the CDC also convince Medicaid to allow treatment of patients irrespective of the results of the urine drug screen (sometimes it is only THC). Medicaid is denying treatment when UDS is positive.

A- Each state operates its own Medicaid system but must conform to federal guidelines. A state Medicaid program can establish limitations on coverage of prescription drugs. However, those limitations cannot result in the denial of access to treatment that is medically necessary and clinically appropriate. Recently, a federal judge ruled that Washington's Medicaid agency's policy did not meet the Medicaid medical necessity requirements and ordered Washington state's Medicaid program to cover HCV drugs for all patients with hepatitis C, regardless of fibrosis score.

Q- What changes in substance abuse treatment will be included in the proposed 1115 Medicaid waiver?

A- 5.1.1 *Substance Use Disorder Delivery System Reform Pilot Program*

A report from the Substance Abuse and Mental Health Services Association (SAMHSA) estimated the prevalence of SUD among Medicaid eligible adults at 21%.43 Applied to Kentucky's expansion population, it is estimated that nearly 90,000 newly enrolled Kentuckians may have a SUD requiring treatment. In 2014 with the expansion of Medicaid, Kentucky greatly expanded coverage to mental health and SUD treatment options, allowing Medicaid recipients to receive coverage for the full spectrum of inpatient and outpatient SUD services. However, coverage of benefits means little without access to providers. Federal law generally prohibits federal financial participation for medically necessary Medicaid services provided to adults aged 21 through 64 in certain facilities that meet the federal definition of an institution for mental disease (IMD), specifically, free-standing psychiatric hospitals with more than 16 beds. In Kentucky, there are 26 qualified mental health facilities capable of providing covered mental health and SUD services to Medicaid recipients with SUD, however, they are prohibited from doing so due to the IMD exclusion. Instead, individuals in need of mental health or SUD inpatient services must either travel long distances out of their communities to access services and/or experience long wait times for a bed to open, putting the individual at risk of experiencing a crisis and ending up in either the criminal justice system or high-cost hospital emergency departments. Kentucky currently faces a drug abuse epidemic, and access to the Medicaid program's comprehensive mental health and SUD benefits is critical. In July 2015, CMS issued a letter indicating a willingness to offer states a waiver of the IMD exclusion, provided the State also develops broad based reforms regarding the provision of SUD services to Medicaid recipients. The State will explore this opportunity through pilot programs in ten to twenty select high-risk counties. Counties will be identified based on the recent CDC HIV/hepatitis C outbreak study described in *Section 1*, the State's existing Shaping Our Appalachian Region (SOAR) initiative,44 and public input received during the demonstration waiver public notice and comment period. The pilot program will seek to increase access to mental health and

SUD services through a waiver of the IMD exclusion to allow federal financial participation for covered services provided to Medicaid eligible adults ages 21 through 64 residing in an IMD for short-term residential stays of up to thirty days. The pilot programs are intended to evaluate the impact of increased access to treatment in IMD's. The State will work with CMS in the design of the pilot project, examining the current mental health and SUD delivery system for best practice improvements related to standards of care, inclusion of recommended SUD as well as HIV quality indicators, care coordination between levels and settings of care, and strategies to address prescription drug abuse and opioid use disorder. In addition, Kentucky intends to align standards of care for SUD treatment with the national best practice criteria set forth by the American Society of Addiction Medicine in the pilot counties. To further improve the quality and consistent delivery of these services, the State will also require certain SUD treatment providers to become accredited.

- The entire document "Helping to Engage and Achieve Long Term Health" can be found at http://chfs.ky.ogv/dms/hg