HCV Overview

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HCV quick transmission overview

- Sharing needles, syringes, or other equipment to prepare or inject drugs
- Needlestick injuries in health care settings
- Being born to a mother who has hepatitis C (6 in 100)

Less commonly, a person can also get hepatitis C virus through

- Sharing personal care items that may have come in contact with another person's blood, such as razors or toothbrushes
- Having sexual contact with a person infected with the hepatitis C virus
- Getting a tattoo or body piercing in an unregulated setting

HCV long term overview

Of every 100 people infected with HCV, approximately:

- 75-85 will go on to develop chronic infection
- 10-20 will go on to develop cirrhosis over a period of 20-30 years

Among patients with cirrhosis, there is:

- 1-5% annual risk of hepatocellular carcinoma
- 3-6% annual risk of hepatic decompensation, for which the risk of death in the following year is 15-20%

HCV-nationally

- Estimated 3.5 million persons with chronic HCV

Edlin BR, Eckhardt BJ, Shu MA, Holmberg SD, Swan T. Toward a more accurate estimate of the prevalence of hepatitis C in the United States. Hepatology. 2015:62(5):1353-63.)

- An estimated 41,200 acute hepatitis C cases occurred in 2016

(CDC surveillance report)

- HCV infection prevalence among PWID point estimate of 53.1%, with a range of 38.1% to 68.0%

Degenhardt L, Peacock A, Colledge S, Leung J, Grebely J, Vickerman P, Stone J, Cunningham EB, Trickey A, Dumchev K, Lynskey M, Griffiths P, Mattick RP, Hickman M, Larney S. Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review. Lancet Global Health. 2017;5(12):e1192-1207.

HCV-AI/AN nationally

- HCV related mortality rate among AI/AN ***decreased*** for the first time from 2015 (12.95/100,000) to 2016 (10.75/100,000)
- Remains more than double national rates (dropped from 4.91/100,000 in 2015 to 4.55/100,000 in 2016)
- AI/AN have highest rates acute HCV, liver cancer increases by race/ethnicity

HCV in IHS, 2005-2014

- Cumulative
- By sex, birth cohort, region
- National Data, using ICD/POV codes

HCV diagnoses in IHS, 2005-2014, (1 of 3)

Sex	number (rate per 100,000)	Rate ratio (95% CI)	
Male	15,362 (193)	Reference	
Female	14,441 (166)	0.86 (0.84-0.88)	

HCV in IHS, 2005-2014 by birth cohort (2 of 3)

Birth Cohort	Number (rate per 100,000)	Rate ratio (95% CI	
Born Before 1945	1,118 (101)	0.21 (0.20-0.22)	
Born 1945-1965 (Baby Boomers)	15,900 (478)	Reference	
Born After 1965	12,785 (105)	0.22 (0.21-0.22)	

Region	N (rate per 100,000)	Rate ratio (95% CI)	
Alaska	2,743 (179)	0.81 (0.77-0.84)	
East	1,051 (197)	0.89 (0.84-0.95)	
Northern Plains East	1,875 (166)	0.75 (0.71-0.79)	
Northern Plains West	4,801 (224)	1.01 (0.98-1.05)	
Southern Plains	7,986 (221)	Reference	
Southwest	5,538 (98)	0.44 (0.43-0.46)	
West	5,809 (286)	1.29 (1.25-1.34)	

HCV state of Montana data (verbatim)

In 2016, 1,664 chronic HCV cases were reported in Montana. Most of the cases were among whites(67%) followed by persons who identified as American Indian (19%).

The median age of chronic HCV cases was 44 years.

Twenty-five percent of newly reported cases of HCV infection were in persons aged 51–60 years, the most common age group. Persons aged 20–39 years accounted for nearly 42% of the cases.

About 45% of the reported cases were among men.

https://dphhs.mt.gov/Portals/85/publichealth/documents/HIVSTD/CommunicableDiseaseInMT2016.pdf

HCV, IHS screening of boomers as of 6/2017

- National: 56,337/103,734 (54.3%) ever screened
- increase from 11% in 2012)

Billings SUs	% Boomers ever screened	Numerator/denominator
Site 1	**39.9%**	**391/980**
Site 2	**55.6%**	**484/871**
Site 3	**29.8%**	**633/2122**
Site 4	**38.8%**	**775/1997**
Site 5	**18.2%**	**160/881**
Site 6	**53.8%**	**734/1364**
Total	**38.7%**	**3177/8125**

National HCV "cascade of care" national (2014)

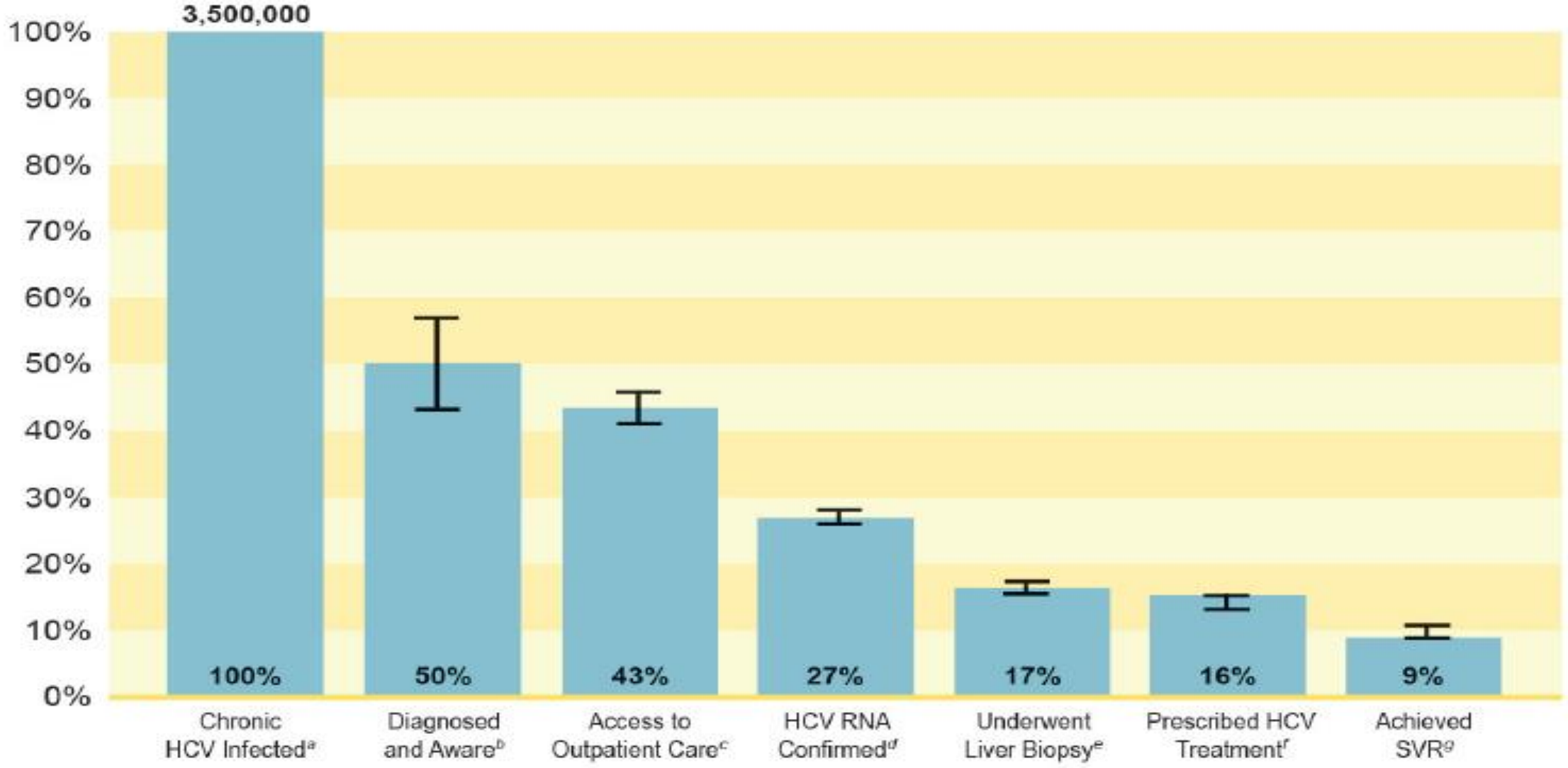
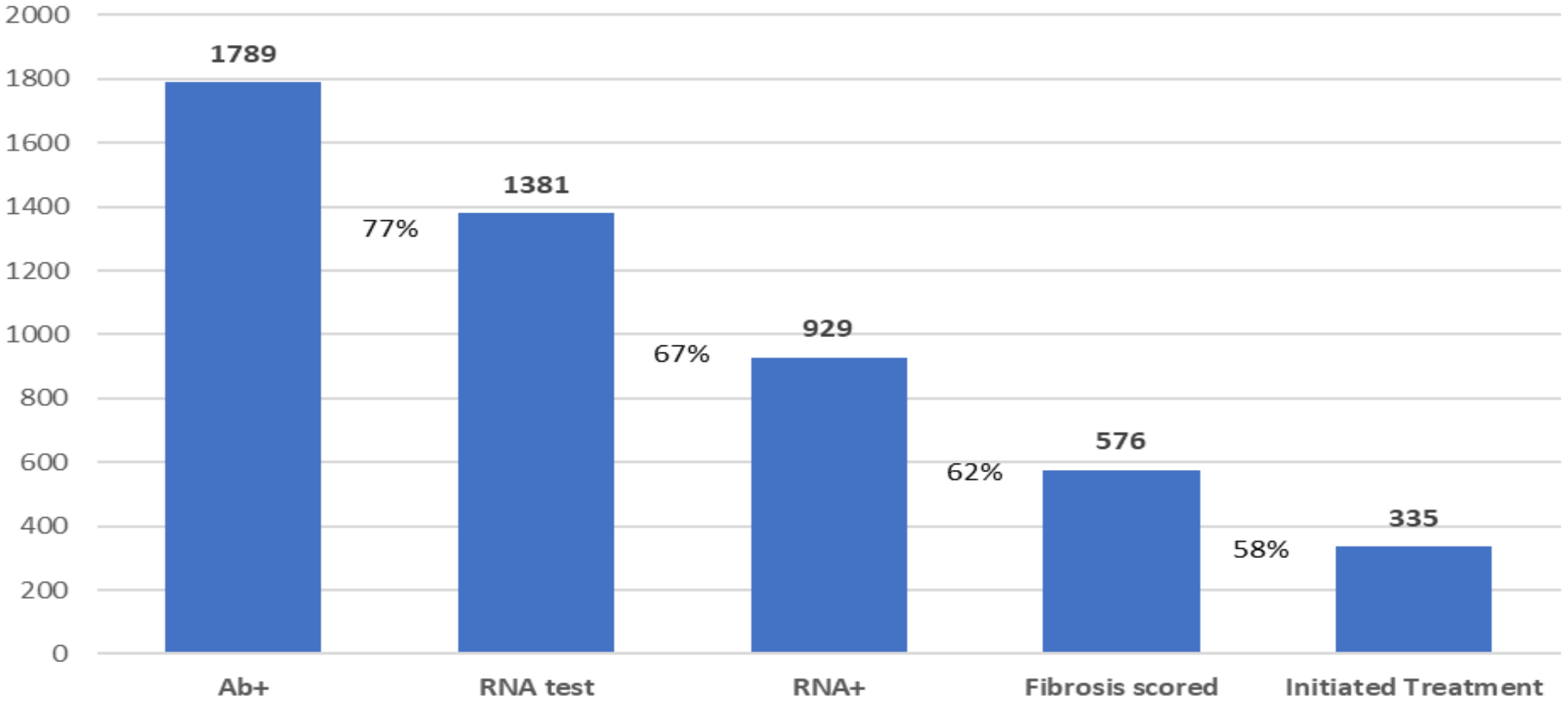


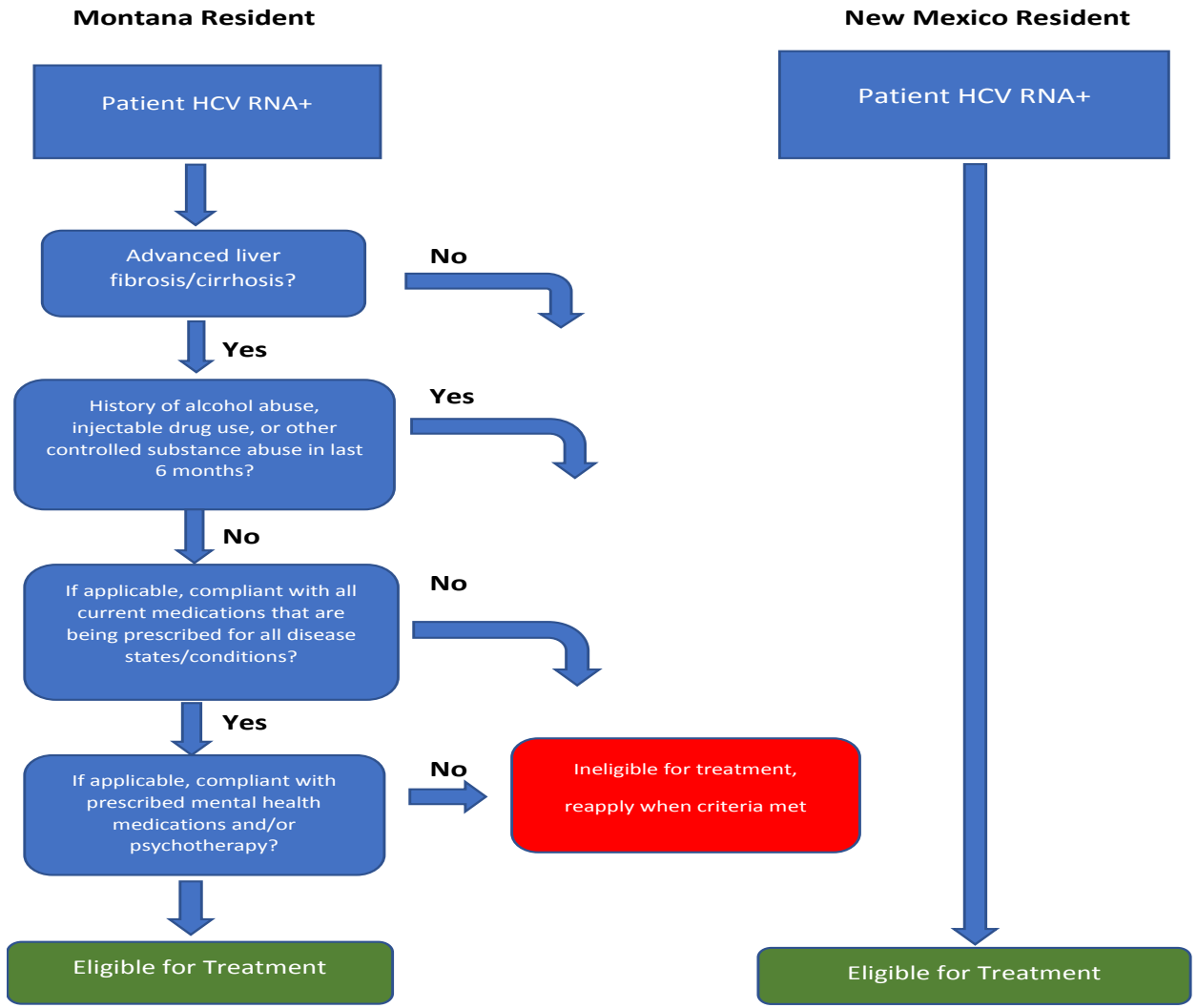
Figure 1. Hepatitis C Cascade of Care, 12 facilities in OK/KS, all known patients through 2017, Indian Health Service



MT Medicaid: worst in the nation

Figure 1. HCV Treatment Eligibility Requirements

Montana and New Mexico Medicaid Programs



Challenges

- Time to provide HCV services
- Drug acquisition
- Patient management/empanelment
- Linkage to care for historical and new patients with HCV Ab+ and RNA+

Successes

- Patient empanelment tools
- Linkage to care improvements (community hears of treatment program, de-stigmatizes HCV, active outreach)
- TeleECHO for specialist input
- Sharing of knowledge for drug acquisition strategies
- More support from leadership to treat HCV and time for ECHO clinics
- Reminder, standing protocols for HCV screening
- Wider HCV screening as determined locally