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Hepatitis C screening and testing: A call for a national response

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Executive Summary

The purpose of this brief is to convey the immediate need to coordinate and integrate hepatitus C virus (HCV) screening and testing for HIV co-infected and HCV-infected clients, into primary care. In 2000, 1.25 million persons were estimated to be chronically infected with hepatitus B virus (HBV), and 2.7 million are chronically infected with HCV.[1] Furthermore, 55% to 85% of new HCV infections become chronic.[2] Of the 1.0 million people chronically infected with HIV, 250,000 also have HBV, and ~ 50,000 also have HCV, the leading cause of hepatocellular carcinoma. Liver disease is now the leading cause of death in Americans with HIV infection.[3] A key barrier to hepatitis prevention has been surveillance. According to the Centers for Disease Control and Prevention (CDC), recommendations include establishing a computerized database to facilitate surveillance of persons with *chronic* HBV and HCV infections, in addition to those with *acute* infections.[2] The current viral hepatitis surveillance system in the United States is highly fragmented and poorly developed. As a result, surveillance data do not provide accurate estimates of the current burden of disease, are insufficient for program planning and evaluation and do not provide the information that would allow policy-makers to allocate sufficient resources to viral hepatitis prevention and control programs.[4] Although surveillance infrastructure is in place for reporting of acute infection, reports of *chronic* HBV and HCV, which account for the greatest burden of disease, are not submitted by most states.[4] A national effort is recommended to ensure accurate surveillance as a step toward appropriate prevention, treatment and evaluation of efforts.

Background and Problem Identification

Recent trends in decreased incident cases of HCV have cloaked the increased burden of mortality in individuals who are chronically infected and require treatment and services for end-stage liver-disease complications.[5] In the next 10 years, about 150,000 people in the United States will die from liver cancer and end-stage liver disease associated with chronic HBV and HCV.[4] In 2011 The American Association for the Study of Liver Diseases (AASLD) published a practice guideline for Genotype 1 chronic HCV.[6] In 2005 the CDC published guidelines for viral hepatitis surveillance and case management. At that time the strongest recommendation was made to stop using outdated paper-based reporting and to move to the National Electronic Disease Surveillance System (NEDSS), which includes standards for electronic transfer of data, all reporting of viral hepatitis case data, including risk factor information. Those changes would allow state health departments to report to the CDC, weekly, confirmed cases of acute hepatitis A, B, C and confirmed cases of perinatal HBV infection. There has been poor compliance with this guideline and the recommendations. The Patient Protection and Affordability Care Act (PPACA) of 2010 has made some revisions in efforts to remove barriers to preventive services. According to CMS in January 2011, a waiver of copayment and deductible was put into place for certain HIV screening tests and for HBV vaccination provision.[7]

Current and significant barriers include:

- Lack of clarity regarding how “acute” HCV cases are defined and used for surveillance.
- Only 7 of 50 states receive federal assistance to provide enhanced surveillance services.[4]

  Other states may receive funding through related federal programs, such as the Immunization Services Division (related to perinatal HBV), and the Epidemiology and Laboratory Capacity for Infectious Diseases program. Each state varies regarding the type and amount of funding as well as structures and systems designated for surveillance activities.
- No universal immunization registry system now exists. Registries in one state or area may not be compatible with other registries, and information

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may have to be manually transferred from registry to registry. Information for the homeless and incarcerated should optimally be placed in a state registry system but currently is not.

- Since the economic downturn began, some state departments of public health are no longer able to routinely provide hepatitis A and HBV vaccines for adults (over age 19) seen at Federally Qualified Community Health Centers (CHCs) and only a very limited supply of vaccine based on the percent of adult patient population who are uninsured (MADPH, 2011).[8]

Position Statement of the Emerging Infectious Disease Expert Panel of the American Academy of Nursing

The Emerging Infectious Disease Expert Panel of the AAN recommends that *all* public health and care settings in the United States adopt both the National Guideline for Treatment for Genotype 1 Chronic HCV and the IOM Report on a National Strategy for Prevention and Control of Hepatitis B and C. To date we have actually seen a reduction in available resources for screening and no improvements in systematic surveillance.

Specifically we urge: 1) The development and execution of a universal surveillance system; 2) The development and execution of a universal immunization registry; 3) Availability of adult hepatitis A and HBV vaccine to all care providers; and 4) Public and professional education. Nurses at all levels of practice are in the best position to communicate and translate these guidelines and recommendations. We urge that the necessary resources be allocated from the National Prevention, Health Promotion and Public Health Council as outlined in the July 2011 National Prevention Strategy.[9]

- Constituency groups can transform health care by conveying important information and encouraging policy change to their state legislature specific to surveillance of HCV and related infectious diseases. The impact of improved systems is to improve impacts of chronic illness and mitigate the spread of disease.
- Constituency groups can disseminate a survey to special-interest provider organizations to determine: an estimate of HIV-coinfected and HCV -infected clients seen in their practices, how many have been screened and placed in treatment, and how treatment is being paid for.

Leveraging local, state and federal resources as well as the expertise of advanced practice nurses and RNs can provide accurate education, information regarding screening, testing, surveillance and evaluation of impact of strategies. Nurses, and their vast health promotion networks, are poised to best assess, intervene and evaluate the impact of enforcing these recommendations.

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