NACCHO
National Association of County & City Health Officials

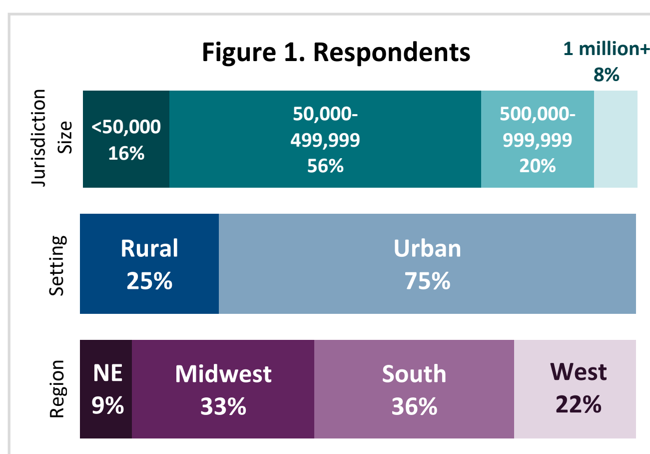
Report: Local Health Departments as Leaders in the Prevention & Elimination of Viral Hepatitis

December 2020

Background & Methods

Viral hepatitis is a leading public health threat in the United States, contributing to cirrhosis, liver cancer and transplants, and more deaths than any other infectious disease. Local health departments (LHDs) are leaders in the fight against viral hepatitis, engaged in surveillance, prevention, diagnosis, and treatment. The National Association of County and City Health Officials (NACCHO) is the national leader for local public health, serving as a leader, partner, catalyst, and voice for LHDs.

Between July and August 2020, NACCHO surveyed its HIV, STI, & Viral Hepatitis Sentinel Network (Sentinel Network) to better understand LHD hepatitis programs and services. The Sentinel Network is a convenience sample of 130 LHDs from over 40 states recruited through NACCHO's communications channels and direct outreach to LHDs in geographic areas underrepresented in the Sentinel Network. Although not nationally representative, members work in LHDs of varied sizes, geographic locations, and settings. The survey was administered through Qualtrics, a web-based survey platform, and assessed hepatitis activities and services, the impact of COVID-19 on hepatitis programs, the integration of hepatitis services in priority settings, and factors that affect this work, including resources, barriers, and needs. In total, 64 Sentinel Network members responded for a 49% response rate (additional information on respondents included in Figure 1). **The survey revealed that LHDs lead a coordinated response to the syndemic of hepatitis, HIV and other STIs, and substance use at the local level, but limited funding, staffing challenges, and the COVID-19 pandemic impact LHDs' ability to prevent and eliminate viral hepatitis.**



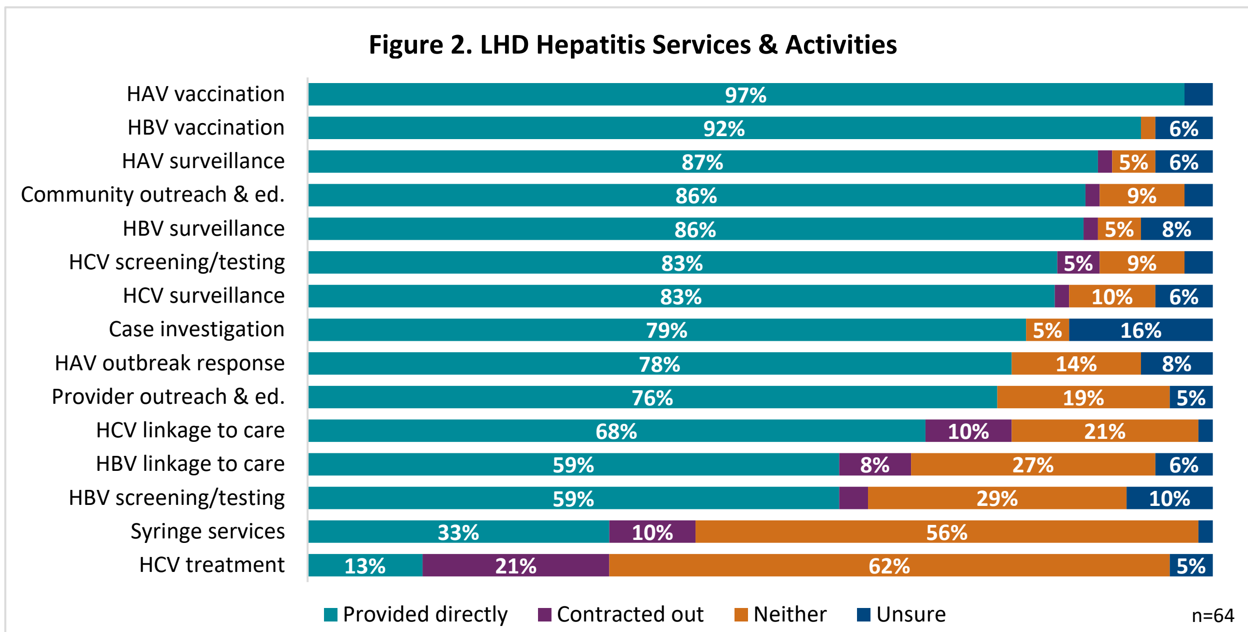
LHD Hepatitis Services & Activities

LHDs play a critical role in the prevention and control of viral hepatitis (see Figure 2). Nearly all Sentinel Network members reported providing hepatitis A (HAV) and B (HBV) vaccination (97%, 92%) in the past year[1] and most conduct surveillance for HAV (87%), HBV (86%), and hepatitis C (HCV) (83%). More than three-fourths (79%) conduct case investigation, and of those, 76% investigate all HAV cases; 74% investigate all or most HBV cases and an additional 12% (i.e., 86%) investigate all perinatal HBV cases; and 66% investigate all or most HCV cases, with an additional 2% (i.e., 68%) investigating all perinatal HCV cases.[2] Additionally, more than three-fourths (78%) responded to HAV outbreaks in the past year.

LHDs are local leaders in the detection and treatment of viral hepatitis. Nearly two-thirds offer or fund HBV testing (59% provide directly, 3% contract out) and nearly 90% offer or fund HCV testing (83% provide

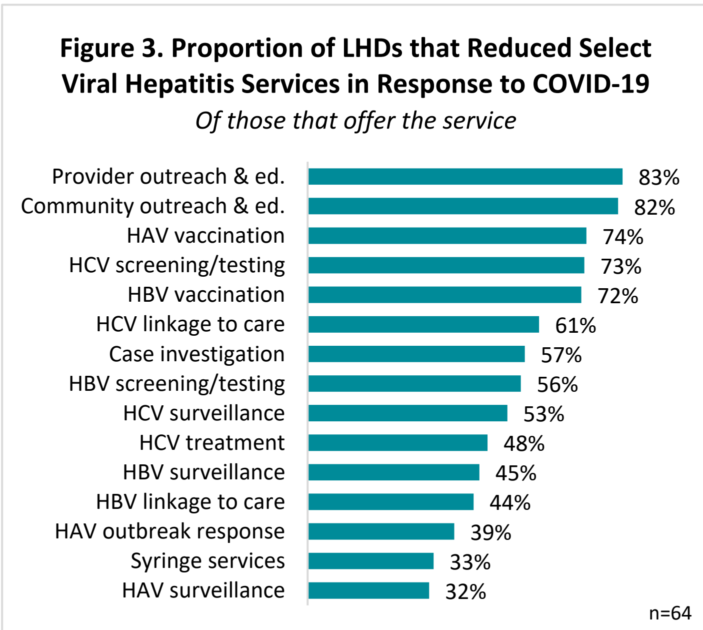
[1] Fiscal year 2020 (July 2019 through June 2020)
[2] Most respondents did not differentiate between acute and chronic cases

directly, 5% contract out). While only 13% provide HCV treatment, an additional 21% contract other entities to provide HCV treatment. Additionally, two-thirds provide (59%) or fund (8%) HBV linkage to care and more than three-fourths provide (68%) or fund (10%) HCV linkage to care. LHDs also promote hepatitis services by conducting outreach and education to the community (88%) and local healthcare providers (76%). Additionally, one-third (33%) of respondents offer syringe services and an additional 10% contract other organizations to provide these critical harm reduction services.



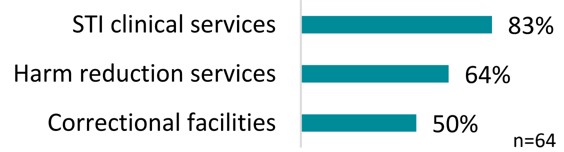
Impact of COVID

LHDs are on the frontlines of the COVID-19 pandemic and many hepatitis staff have been pulled from their normal work duties and reassigned to meet the demands of the pandemic. Overall, the survey results indicate that all LHD hepatitis services have been significantly reduced (see Figure 3). Prevention and health promotion services have been hardest hit, with provider and community outreach and education activities reduced by more than 80%, and HAV and HBV vaccination reduced by nearly three-fourths. More than half of LHDs reduced case investigation (57%) and HBV and HCV testing (56%, 73%), and surveillance, linkage to care, and treatment services were also notably reduced. Even the least impacted services were still significantly reduced, with HAV surveillance and outbreak response and syringe services down by approximately one third (32%, 39%, 33%). (See Appendix 1 for the current status of hepatitis services and activities at all respondent LHDs, i.e., the integration of the data included in Figures 2 and 3).

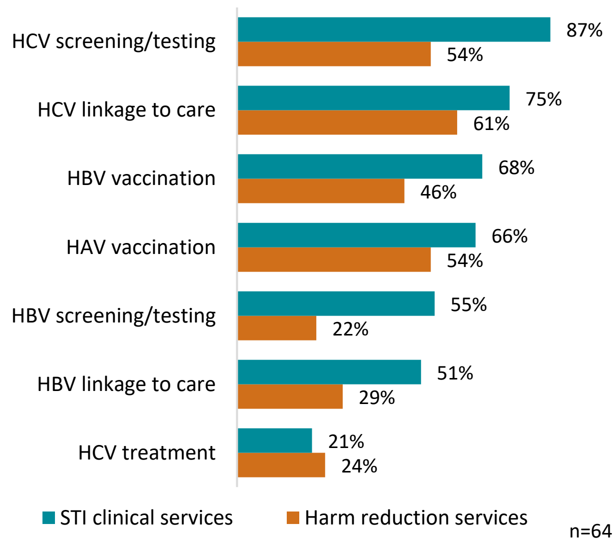


Provision of Hepatitis Services in Priority Settings

LHDs are taking a coordinated approach to address the syndemic of substance use, HIV, STIs, and viral hepatitis. Most (83%) offer hepatitis services in STI clinical services, nearly two-thirds (64%) offer hepatitis services in harm reduction settings, and half (50%) offer hepatitis services in correctional facilities.



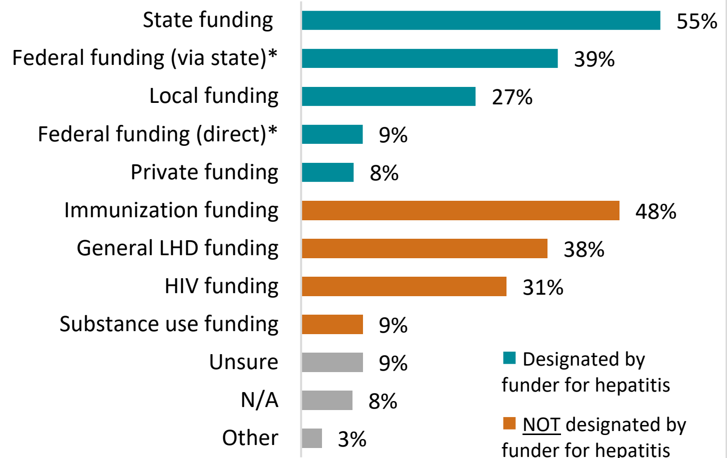
Of those that offer any hepatitis services in STI clinical settings, 87% provide HCV screening/testing, 75% provide HCV linkage to care, and approximately two-thirds provide HAV and HBV vaccination (68%, 66%). Additionally, just over half provide HBV screening/testing (55%) and linkage to care (51%) and 21% provide HCV treatment in STI clinical settings.



Of those that offer any hepatitis services in harm reduction settings, the most common services provided are HCV screening/testing (54%) and linkage to care (61%) followed by HAV and HBV vaccination (54%, 46%). Additionally, 22% offer HBV screening/testing and 29% offer HBV linkage to care in harm reduction settings. Finally, one-fourth (24%) provide HCV treatment in harm reduction settings. (See Appendix 2 for the overall proportion of LHDs that offer select viral hepatitis services in STI and harm reduction settings, i.e., the integration of data in Figures 4 and 5).

Funding

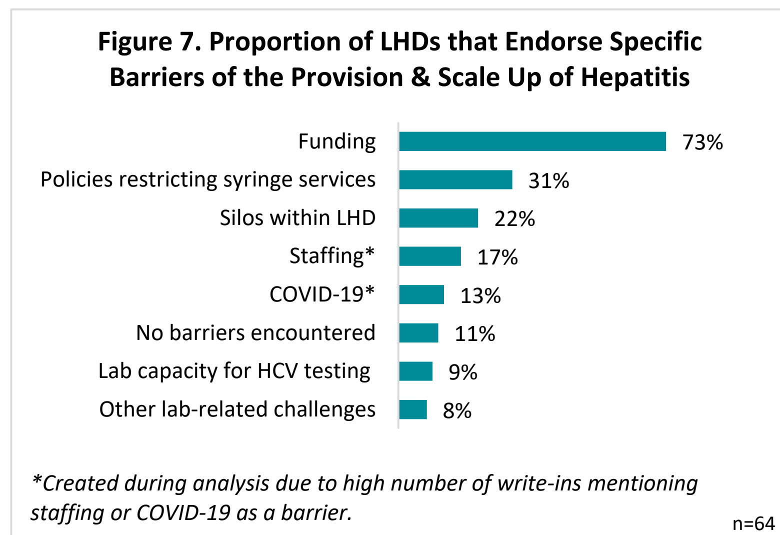
Nearly three-fourths (73%) of respondents indicated that funding is a barrier to the provision and scale up of hepatitis services (see Figure 7). Most LHDs receive inadequate funding—and often, no funding—for the prevention and control of hepatitis. Consequently, LHDs leverage immunization funding (reported by 48% of respondents), general health department funding (38%), or HIV program funding (31%) to support hepatitis efforts. Just over half (55%) receive state funding for hepatitis and one-fourth (27%) receive local funding. Additionally, 39% receive federal funding that is passed through



the state health department or other state agencies, and 9% receive funding directly from the federal government (See Figure 6).

Barriers & Needs

In addition to funding, LHDs reported myriad barriers to the provision and scale up of hepatitis services. The most common barriers are policies that restrict LHDs' ability to offer syringe services (reported by 31% of respondents) and silos within the health department (22%). Seventeen percent of respondents wrote in that staffing was a major barrier and 13% did the same for COVID-19. As these variables were created during analysis due to the high number of write-in responses, the actual proportion of LHDs that face these barriers is likely much higher.



LHDs also had the opportunity to share what they need and what barriers they face, in their own words. The most common responses were funding and staffing—or as one explained, "funding to support staffing." Others shared how the COVID-19 pandemic exacerbated existing challenges, including that staff were pulled to respond to the COVID-19 pandemic or services had been cut during the pandemic. Several shared that the pandemic limited access to priority populations such as people who inject drugs or people who are incarcerated, and one lamented, "It has been really hard, especially seeing the new young cases roll in."

Several shared challenges related to HCV treatment, including the cost of treatment, limited access in corrections facilities, and a lack of providers, with one explaining "we moved away from screening for Hepatitis because it was too difficult to close the loop on care." Additional workforce challenges include a "statewide hiring freeze," "an aging workforce," and lack of staff comfort and knowledge related to hepatitis.

Conclusion

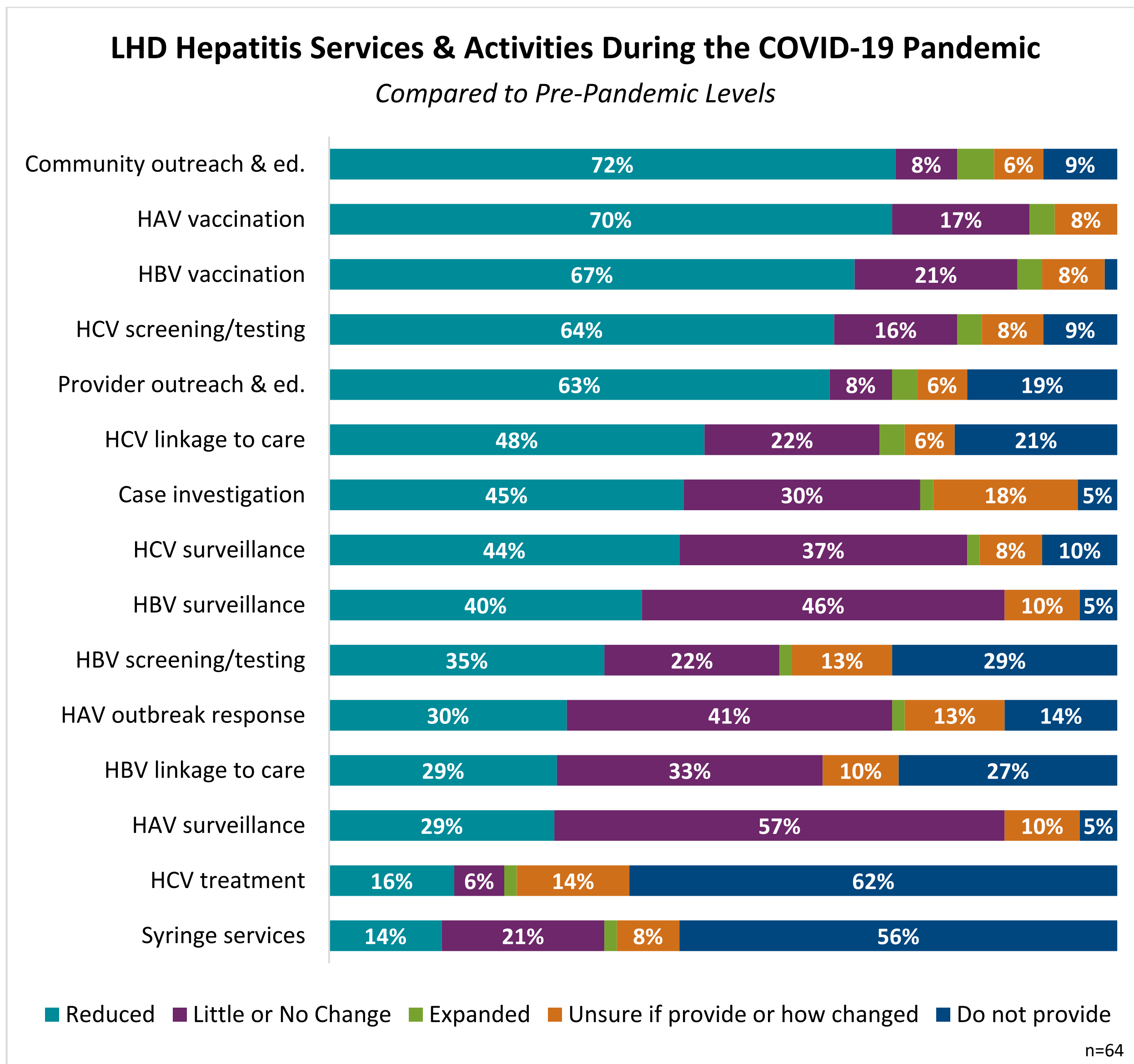
LHDs are leaders in the prevention and control of viral hepatitis, conducting surveillance and case investigation, educating providers and their communities, and providing a range of prevention, detection, and treatment services. For more than a decade, LHDs have experienced declining budgets while facing new challenges, from the opioid epidemic to the STI crisis, and now the COVID-19 pandemic. LHDs are taking a coordinated approach to the syndemic of viral hepatitis, HIV and STIs, and substance use, but limited funding and staffing have undermined their ability to scale up the response. As the COVID-19 pandemic has forced LHDs to reduce hepatitis services and activities, communities across the country are likely to see a surge in new cases. We must ensure that LHDs have adequate resources and support to prepare for and respond to anticipated HAV outbreaks and to scale up existing HBV and HCV services, if we are to achieve viral hepatitis elimination in the United States.

For additional information, contact Kat Kelley, Senior Program Analyst, HIV, STI, & Viral Hepatitis at NACCHO at kkelley@naccho.org or 202-507-4223.

Appendix 1. Current Status of Hepatitis Activities at Respondent LHDs

This chart is intended to complement Figures 2 and 3 by combining the responses from two separate survey questions regarding the provision and impact of COVID-19 on hepatitis activities and services to characterize the current state of hepatitis services and activities at all respondent LHDs.

For each service or activity, you can see the percentage that indicated they provided that service or activity in the past year (July 2019 to June 2020), disaggregated by whether that service has been reduced, maintained, or expanded during COVID-19. The "unsure" responses from both questions are combined into one variable indicating the proportion of respondents that were either unsure whether their LHD provided a given service or activity or whether that service had been impacted by COVID-19.



Appendix 2. Integration of Select Hepatitis Services in Priority Settings

These charts are intended to complement Figures 4 and 5 by combining the responses from two separate survey questions, the first of which assessed whether LHDs provide *any* hepatitis services in STI clinical or harm reduction settings, and the second of which assessed which services were provided in these settings.

The first and second charts below characterize the provision of select hepatitis services in STI clinical services and harm reduction settings, respectively. The "no" responses in each chart include both respondents who indicated that they don't offer any hepatitis services in that setting and respondents who indicated that they don't offer the specifically indicated hepatitis service in that setting. The "unsure" responses in each chart include both respondents who indicated that they are unsure whether their LHD offers any hepatitis services in that setting and respondents who indicated they are unsure if their LHD offers the specifically indicated hepatitis service in that setting.