Chronic Hepatitis C Follow Up for Priority Populations

Guidelines for Local Health Jurisdictions in California

Contents

Prepared by California Department of Public Health, Sexually Transmitted Diseases Control Branch, March 2022

I. Background

Hepatitis C is a leading cause of liver disease, liver cancer, and liver transplantation. Yet many people with hepatitis C remain unaware of their status or have been diagnosed but not treated despite the availability of direct-acting antivirals (DAAs) that can cure hepatitis C infection in 8-12 weeks. Effective January 1, 2022, California law requires primary care settings to offer adults screening for hepatitis C infection.[1] The advent of DAAs, along with the increased availability of hepatitis C virus (HCV)-related federal, state, and/or local resources in some local health jurisdictions (LHJs), presents an opportunity to ensure people with hepatitis C are aware of their status, treated, and cured—and to interrupt secondary transmission.

Local capacity and resources for following up on newly reported chronic hepatitis C infections vary--few LHJs have capacity to follow up on all hepatitis C cases. Most LHJs will need to prioritize certain cases for follow up, such as acute[2] and perinatal[3] hepatitis C infections and people most likely to transmit HCV to others. Groups prioritized for public health follow up may change in response to state and local trends.

Priority populations for chronic hepatitis C public health case follow up in California include:

1. **People with infection disease comorbidities that also lead to rapid liver disease progression:**
    a. **People with HIV/HCV coinfection**, who are at increased risk of sexual HCV transmission, reinfection, and, if pregnant, vertical HCV transmission to their infants at birth.
    b. **People with hepatitis B virus (HBV)/HCV coinfection** can also be considered for case follow up.
2. **Young people 15-29 years of age with hepatitis C**, who may be at increased risk of transmitting HCV to others, such as through sharing injection drug use equipment or, if pregnant, through vertical transmission, and who are most likely to be out of hepatitis C care.
3. **People of all ages with hepatitis C infection who are pregnant,** especially if/when prophylactic treatment to prevent vertical HCV transmission during pregnancy becomes available.
4. **People who can become pregnant,** including women of childbearing age; treating hepatitis C before pregnancy can prevent vertical transmission when a person later does become pregnant.
5. **People with ongoing risk factors** (such as homelessness, injection/non-injection drug use, and/or incarceration) who may be at high risk of transmitting hepatitis C to others and most likely to be out of hepatitis C care. This population particularly benefits from additional HCV navigation support.

Complementary active case finding in settings serving people at high risk for hepatitis C (such as syringe service programs, jails, drug treatment programs, and emergency departments) is also helpful, and may yield greater success than using public health surveillance data to locate people with unstable housing.

These guidelines provide a resource to inform LHJ case follow up among priority populations with hepatitis C infection using routinely reported public health surveillance data (such as electronic laboratory reports

[1] California Health and Safety Code Section 1316.7. For more information on this new law, see also CDPH All Facilities Letter 21-50.
[2] For more information on case follow up for acute hepatitis C infections, see the Acute Hepatitis B and C Public Health Investigation Quicksheet.
[3] For more information on case follow up of infants born to people with hepatitis C to identify possible perinatal hepatitis C infections, see the Perinatal Hepatitis C Public Health Investigation Protocol on the STD Control Branch CalREDIE Resources website.

and confidential morbidity reports reported via the California Reportable Diseases Information Exchange [CalREDIE]). Jurisdictions should **customize the guidelines** to align with local disease investigation policies and procedures, including integrating with existing processes. This may include integrating with existing HIV and sexually transmitted infection follow up procedures, including for people with HIV coinfection.

II. Guideline Objectives

1. Collect information from reporting healthcare providers to assure priority populations with chronic hepatitis C infection are diagnosed, linked to care, and treated;
2. Gather missing patient demographic data (such as race, ethnicity, sexual orientation, and gender identity) needed to evaluate and address important health disparities, where feasible;
3. Contact people with current hepatitis C infection to assure linkage to care and treatment;
4. Link people at ongoing risk for hepatitis C (re)infection to preventive services (such as medication for opioid use disorder and syringe service programs); and
5. Promote testing, linkage to care, and treatment among the sexual, household, and injection drug use partners of people diagnosed with hepatitis C infection (partner services).

III. Chronic Hepatitis C Public Health Investigation Protocol for Priority Cases

1. Use existing data to identify patients that are HCV Viremic[4]/HCV High Priority.

- The California Department of Public Health (CDPH) Sexually Transmitted Diseases Control Branch (STDCB) can provide LHJs with monthly line lists of cases in special populations (i.e., people with HIV/HCV coinfection and young people with chronic hepatitis C who are 15-29 years of age) to indicate their HCV care status. Within each line list, care status is defined as either:
  - **i.** HCV viremic/high priority (HCV RNA positive, no evidence of clearance or cure, follow up recommended to assure care and treatment)
  - **ii.** HCV antibody only/medium priority (HCV antibody positive, HCV RNA status unknown, follow up suggested if resources allow to assure diagnostic testing and, if indicated, treatment)
  - **iii.** Cleared/cured (Known negative HCV RNA results indicate the patient has been cured or has cleared infection on their own, monitor for reinfection as needed)
  - **iv.** Insufficient data (Not enough information is known from HCV lab results to assess care status, monitor for additional information as resources allow).
- Email CDPH.HEP@cdph.ca.gov to request access to the line list of people 15-29 years of age with hepatitis C infection in your jurisdiction. Contact your jurisdiction's HIV surveillance coordinator to request access to the line list of people with HIV/HCV coinfection.
- When viewing the HIV out of care line list, please check across all tabs for high priority HCV cases.

[4] Viremic individuals have evidence of detectable HCV RNA results indicating current hepatitis C infection but no evidence of cure or viral clearance. Clinical guidelines recommend treating and curing hepatitis C infection, rather than monitoring HCV viral load.

2. **Look in the electronic health record or contact the most recent ordering provider for the following information:**[5]
    - Ask provider: *Is this your patient?* If yes and test is recent: *Is the patient aware of their HCV status?*
        - If patient is not aware of their status and may be hard to reach, ask the provider: *Can I contact the patient to notify them of their test result*?
    - Confirm or collect any missing patient demographic data and contact information: race, ethnicity, sex at birth, gender identity,[6] primary language, pregnancy, housing status, insurance status, risk factors, patient address, email(s), phone number(s), and other means of reaching patient.
    - Ask provider: *Is patient in HCV care? Have they started HCV treatment? Do you plan on treating the patient for hepatitis C?* If yes, record treatment start date and completion date if known.[7]
    - If patient is not in HIV or HCV care (including unaware of HCV status), and if the LHJ or community-based organizations (CBOs) plan to contact the patient, ask provider: *What are patient's potential barriers to initiating or remaining in care (e.g., mental health, substance use, housing, incarceration)?*
    - If the patient was not treated for HCV (including unaware of HCV status), ask if provider is trained to treat HCV and if the provider could initiate hepatitis C treatment.
        - If not, assess provider need or interest in learning how to treat HCV in a non-specialty care setting and/or assistance with specialty referrals. Share resources for HCV clinical education (e.g., clinical consultation line or Project Extension for Community Health Outcomes [ECHO]) or provide a list of local specialists or primary care providers who treat HCV, where available.

3. **Recommended: Follow up with patients.**
    - Make at least three attempts during different times of day to contact HCV Viremic/HCV High Priority patients using information available (and in partnership with CBOs, if appropriate data-sharing agreements are in place).
        - If English is not the primary language, follow existing LHJ language access protocols.
        - Follow local protocols and best practices for protecting confidentiality when contacting patients (and partners) using technology such as text messages and dating apps.[8]
        - If unable to contact the patient within 30 days or if the patient refuses communication, select the appropriate disposition status in CalREDIE and close the case.
        - Consider maintaining a list of individuals who were not located, in case LHJ staff or CBO partners encounter them during outreach.

[5] Among the high priority cases, consider sorting by most recent provider to identify whether there may be opportunities to contact one provider regarding multiple patients.
[6] Confirm race, ethnicity, sex at birth, and gender identity even if listed.
[7] A local health department case follow up tab is now available in CalREDIE to record demographics, risk factors, linkages to care, treatment, and other information collected while following up on priority chronic hepatitis C infections .
[8] For more information on using technology to reach patients and partners, see the U.S. Centers for Disease Control and Prevention (CDC) Toolkit for Technology-Based Partner Services at https://www.cdc.gov/std/program/ips/components.htm#anchor_1587397398460.

- If patient contact is successful, verify their identity and assess whether the patient is aware of their HCV test results. Provide information on the meaning of HCV test results as needed.
- Assess patient priorities/needs; if out of care, ask whether patient would like to initiate care and treatment for HCV. Provide or link to patient navigation to overcome barriers (e.g., transportation, identification, insurance coverage, benefits enrollment) to initiating or remaining in care.
    - If patient mentions significant barriers and is not interested in care at this time, select "competing priorities" disposition in the chronic hepatitis C LHD follow up tab CalREDIE (once the tab goes live). If feasible, maintain a list of people with the competing priorities disposition and follow up in a few months to see if they are interested in treatment.
    - Among people with HIV who are out of HIV care, let the patient choose whether to initiate HCV or HIV care first, since HCV care can sometimes be a way to reengage in HIV care.
- Provide information as needed on new oral HCV medications, which can cure HCV in 8-12 weeks with few side effects; HCV treatment coverage, including for people who inject drugs, by Medi-Cal, major health plans, and if applicable, AIDS Drug Assistance Program (ADAP).
- Link or refer as needed to available services, including naloxone, syringe service programs, substance use disorder treatment, housing, food pantries, CBOs, Medi-Cal/ADAP enrollment workers, HIV pre-exposure prophylaxis (PrEP), STD testing, and hepatitis A and B vaccines, etc.
- Confirm/collect any missing patient demographic data and contact information: race, ethnicity, sex at birth, gender identity, sexual orientation,[9] primary language, pregnancy, housing, insurance status, risk factors, patient address, email(s), phone number(s), and other means of reaching patient (as needed).
- If your jurisdiction will notify partners who may have been exposed in the last six months, elicit sexual and, if applicable, injection partner, non-injection partner, and household contact information. Enter partner or household contact information in CalREDIE LHD follow up tab.
- Consider providing incentives for index patients who initiate treatment or who successfully refer their household contacts or partners get tested for HCV.

4. Recommended: Among index patients that you refer to care, verify linkage to care and treatment.

- Use CalREDIE LHD follow up tab to record hepatitis C treatment start date. Assess treatment end date and, if feasible, evidence of cure (sustained virologic response). Note: Research has shown that as many as 20-30 percent of people on hepatitis C treatment do not return for their test of cure. HCV DAAs remains highly effective even in patients who do not return for test of cure.

5. [If appropriate]: Refer partners and household contacts from the last six months to applicable services.[10]

- Make at least three attempts during different times of day to contact the index patient's partners or household contacts from the last six months.
    - Follow local protocols and best practices for protecting confidentiality when contacting patients (and partners) using technology such as text messages and dating apps.[8]

[9] Race, ethnicity, sexual orientation, and gender identity should be based on patient self-report instead of provider or investigator assumptions.

[10] Jurisdictions with very high HCV prevalence may find focusing on universal testing is more efficient than partner services.

- Refer or schedule partners or household contacts for HIV, HCV, and STD testing, as needed, and if applicable, provide warm handoffs to CBOs for services.
    - If the partner or household contact is interested in HCV testing, ask for their date of birth and which medical provider or CBO they will visit for testing to assist with tracking linkages.
- Refer partners to applicable preventive services, such as HIV PrEP, naloxone, syringe service programs, substance use disorder treatment, other CBOs, etc.

6. **[If appropriate]: Contact the medical provider or CBO to verify partners or household contacts received HCV antibody testing and if necessary, HCV ribonucleic acid (RNA) testing and linkage to care.**

7. **Recommended: Complete the relevant steps above for HCV Antibody Only/HCV Medium Priority patients from the CDPH HCV line list, where feasible.**
    - Search EHR or contact the ordering provider to assess whether the patient received an HCV RNA test and the result (including if negative).
        - If HCV RNA test was negative, enter the RNA result in the CalREDIE Laboratory Information tab and close as not a case.[11]
        - If an HCV RNA test was not conducted, contact provider to recommend HCV RNA testing for this patient.[12] If the provider has already ordered an RNA test, but the patient has not yet been tested, consider helping the patient overcome any barriers to RNA testing.
        - If HCV RNA positive/viremic, proceed with case follow up steps for a **High Priority/HCV Viremic** patient. If necessary, merge the RNA test incident with the antibody test result incident(s).

[11]Some negative HCV RNA results are imported into CalREDIE; CDPH is exploring the feasibility of routinely collecting negative HCV RNA results in CalREDIE to help facilitate ruling out current infection and tracking successful treatment and cure.

[12] If time allows, encourage providers to order HCV antibody testing with a reflex to HCV RNA testing, wherein an HCV RNA test is conducted automatically if the HCV antibody result is reactive. This increases complete diagnostic testing and reduces loss to follow up.

IV. Appendix 1: Strategies for Locating Patients

Creative strategies may be needed to reach a patient if contact information is insufficient, outdated, or incorrect. Since policies may vary by local jurisdiction, check with your supervisors about which types of professionals, CBOs, or partners can help locate the patient. Potential search strategies are listed below.

- Search previous CalREDIE or HIV surveillance database (eHARS [Enhanced HIV/AIDS Reporting System] or LISA [Local Interventional Surveillance Access]) records for additional contact information.
- Search for the patient using Accurint, Google, anywho.com, peoplesearch.com, local public assistance records, Department of Motor Vehicles, or Medi-Cal benefits enrollment records.
- Gather location or "check-in" information from **public** profiles on social media or mobile apps to find a patient or partner for a field visit.
- If the only locating information for a partner is their paid dating app handle/username, the CDPH STD Control Branch may be able to assist with contacting the partner.
- Find the mailing address from court or post office records.
- Consider leaving a sealed referral note at the patient's home or at a location where the patient accesses services marked "personal" and "confidential" if your jurisdiction has a protocol in place for leaving referral notes. Be sure not to reveal any confidential information in the note. Notes can, for example, reference an "important health matter" and recommend the patient contact the LHJ.
- Find county jail custody status using VINELink.com, the California Department of Corrections and Rehabilitation (CDCR) system, or the local County Sherriff's website.

Consider requesting assistance from other service providers, such as those listed below. It can help to build relationships with other entities before inquiring about a specific patient. Unless you have a clear data-sharing agreement or legal protocol in place, do not tell organizations why you are looking for the patient.

- Work with homeless service providers to use Homeless Management Information Systems (HMIS) and other data collection systems or ask about recent shelter visits.
- Request emergency departments, federally qualified health center and other healthcare providers, or the HCV/HIV ordering provider flag the medical record if the patient accesses care.
- Work with CBO partners with whom you have a data-sharing agreement for assistance locating patients.

V. Appendix 2: Patient Referral Resources

1. Hepatitis C Health Information

CDPH Hepatitis C Patient Education Materials (Fact Sheets available in English and Spanish)

CDC Hepatitis C Patient Education Resources (Fact Sheets available in English and Spanish)

Viral Hepatitis Resources

2. Harm Reduction Services

Choose Change California – Substance Use Disorder Treatment Locator

Directory of California Syringe Exchange Programs

Harm Reduction Resources for People Who Use Drugs in California

Mail-based Naloxone Distribution

Naloxone Finder

3. Health Care Services

Family Planning Providers

Federally Qualified Health Center Locator

Get Tested Find Confidential National HIV, STD, and Viral Hepatitis Testing Resources Near You

Hepatitis C Patient Helpline: (877) HELP-4-HEP (877-435-744)

4. Social Services

California Food Bank Directory

California Lifeline (Free Phones for Eligible Low-Income Californians)

Local Homeless Services Continuum of Care Contacts

Medi-Cal Transportation Services