Rhode Island's Comprehensive Strategic Plan for the Prevention and Control of Viral Hepatitis.

Recommendations from the Working Group for the Prevention and Control of Viral Hepatitis in Rhode Island

September 2008

Facilitated by:
Rhode Island Department of Health (HEALTH-RI)
Division of Community, Family Health and Equity
Office of HIV/AIDS and Viral Hepatitis
Integrated HIV CTR and Viral Hepatitis Prevention Services Program

TABLE OF CONTENTS

Executive Summary

The Rhode Island comprehensive strategic plan for the prevention and control of viral hepatitis and its consequences is the outcome of a comprehensive community collaboration discussing the needs of the citizens of Rhode Island. The purpose of this plan is to create a framework for working towards a public health response towards diminishing the burden of disease caused by viral hepatitis in the state of Rhode Island. This program specific strategic plan coincides with "A Healthier Rhode Island by 2010: Your Challenge – A Plan for Action" HEALTH-RI's Strategic Plan 2004-2010 dated December 16, 2003. It is also important to note the plan presented within is compatible and based upon the national Healthy People 2010 goals and objectives.

The term "viral hepatitis" means inflammation of the liver caused by a virus infection. Hepatitis A, B and C viruses are the most commonly reported communicable viral hepatitides in RI and will be the focus of this plan.

Recent national surveillance summaries released by The Centers for Disease Control and Prevention (CDC) reveal that there were 7,844 cases of acute (new) hepatitis B virus (HBV) infections reported in the U. S. in 2001 of which 33 cases were in RI residents. 10% of acute cases go on to retain lifelong chronic infection with an estimated 1 million-1.25 million persons with chronic HBV infection in the United States who are potentially infectious to others. In addition, many chronically infected persons are at risk of long-term consequences such as chronic liver disease and primary liver cancer; each year approximately 4,000-5,000 of these persons die from chronic liver disease. The proportionate HBV burden for RI is estimated to be 5,000 cases. Immunization with hepatitis B vaccine is the most effective means of preventing HBV infection and its consequences. Additionally CDC estimates that nationally 1.8% of the U. S. population was ever infected with HCV with about 2.7 million persons living with chronic Hepatitis C Virus (HCV) infection. The estimated national annual HCV-related chronic liver disease death rate is 8,000 – 10,000 deaths per year. Based on national data, the proportionate burden of HCV disease for Rhode Island is 9600 prevalent cases. The cornerstone of HCV prevention is access to clean syringes and early detection, counseling and treatment of high-risk sub-populations. Nationally there were 13,397 reported cases of acute hepatitis A viral infection (HAV) in 2001 of which 75 were in RI residents. Hepatitis A is preventable by vaccination of high-risk subpopulations as well as post exposure immunizations. RI is a relatively low incidence state for hepatitis A. Thus viral hepatitides present a large burden of disease to the population of the US and RI, and therefore represent a major public health problem worthy of attention.

In 2003, the Rhode Island Viral Hepatitis Advisory Group, a wide-ranging coalition of stakeholders interested in the issues was established. Subsequently, discussions were conducted to gain a better understanding of viral hepatitis prevention, control and medical care resource needs for people living with the disease and the providers who serve them. Many of the components highlighted herein describe the intended goals, objectives and activities associated with a comprehensive approach which includes surveillance to monitor disease trends, promoting access to testing and medical treatment, professional development activities, public education activities, and public health prevention (risk reduction counseling, syringe exchange, case management, vaccination) interventions for viral hepatitis.

The long term use of this plan one hopes is to improve the quality of life and eliminate health disparities for all Rhode Islanders by informing advocates and policy makers, develop programs,

support grant requests, set programmatic priorities and identify activities that should be undertaken to address the occurrence, prevention and control of hepatitis in Rhode Island.

Vision:

The Rhode Island Department of Health (HEALTH-RI) and the Viral Hepatitis Advisory Group envision a coordinated public and private effort that fosters a climate in which all Rhode Islanders will have the opportunity to live a safe and healthy life in a safe and healthy community by preventing the spread of viral hepatitis and limit the complications of hepatitis among Rhode Islanders by promoting access to medical care.

Mission:

The primary mission of the Plan is to shape a coordinated, comprehensive and collaborative public and private partnership to decrease the transmission of hepatitis A, B and C virus through culturally and linguistically appropriate prevention strategies focused on populations at high risk. In addition, the Plan seeks to decrease the complications of hepatitis-related liver disease in RI and to advocate for policies, which will promote access and availability to medical care for all Rhode Islanders, insured and uninsured alike.

Basic Science and Epidemiology of Viral Hepatitis

While all viral hepatitis produce liver inflammation, they differ in their causative agent, epidemiologic (distribution by person, place, and time and transmission dynamics), immunologic, and clinical characteristics. There are also variations in the modes of prevention and control of each virus. Each will therefore be presented separately

Viral Hepatitis A

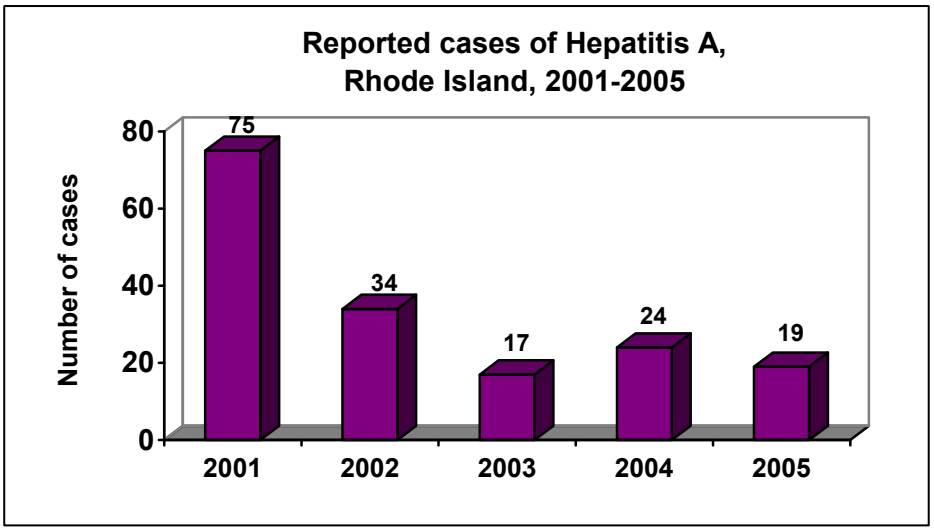
Infectious Agent:
Hepatitis A Virus (HAV), a 27-nm picornavirus (i.e., a positive-strand RNA virus. A hardy virus –it survives in frozen foods. The infectious dose is small and a few virus particles can result in illness.
Mode of Transmission:
HAV is transmitted from person to person by fecal-oral route. Common source epidemics have been related to contaminated water, food contaminated by infected food handlers with poor hand hygiene, including foods that are not cooked or are handled after cooking; raw or under cooked mollusks harvested from fecally contaminated waters; and contaminated produce. A hardy virus –it survives in frozen foods. The infectious dose is small and a few virus particles can result in illness.
Incubation Period:
Fifteen to 50 days, average 28-30 days from exposure to onset of illness in a non-immune person.
Symptoms
Jaundice, fatigue, abdominal pain, loss of appetite, intermittent nausea, and diarrhea. In many cases symptoms may absent or very mild.
Infectious period: Patients shed virus in their stool for 2 weeks prior to onset of clinical jaundice (yellow discoloration of the whites of the eyes) through 5-7 days after onset of jaundice.
Chronic Illness
Virtually all patients have a complete recovery within a few weeks. Rarely death can occur from massive liver failure.
Risk factors: Only the following groups are considered at high risk and for whom pre-exposure vaccination with hepatitis A vaccine is recommended. Vaccine is supplied free of charge by HEALTH-RI to RI residents 2 -18 years of age in these categories.

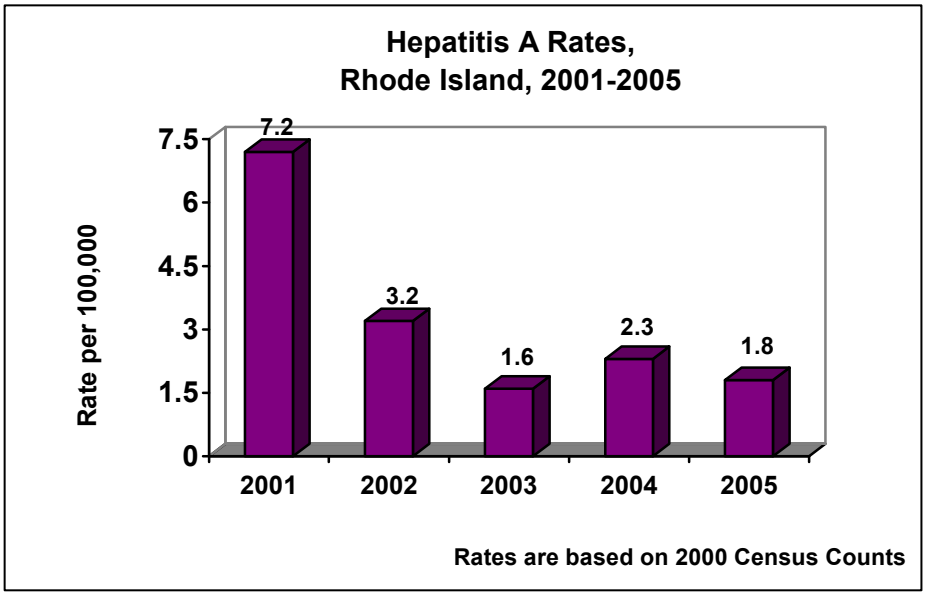
- Persons traveling to or working in countries that have high or intermediate rates of hepatitis A (Children younger than 2 years should only receive immune globulin).
- Children in states, counties, and communities where rates of hepatitis A were/are at least twice the national average during the baseline period of 1987-1997. RI is not such a state.
- Men who have sex with men (should get HBV vaccine as well)
- Illegal-drug users (injecting and non-injecting), should get HBV vaccine as well.
- Persons who have occupational risk for infection (non human primate laboratory workers only)
- Persons who have chronic liver disease
- Persons who have clotting-factor disorders

Prevention and Control Modalities:
Vaccines are also available for long-term prevention of hepatitis A virus infection in persons 2 years of age and older (see above). Post exposure Immune globulin if given within 2 weeks of a point source exposure is effective in preventing the disease.

***Prevention Activities*:** Include promoting hepatitis A vaccine to high-risk groups, real time surveillance for new cases, rapid identification of contacts and post exposure immunization of all identified exposed persons, and control of transmission through isolation of infectious person; exclusion from work of infectious food handlers and day care workers and enteric precautions for hospitalized patients.

Burden of Disease and RI Surveillance Data:
The CDC estimates that 31.3% of the U.S. population was ever infected with Viral Hepatitis A. n RI, anywhere from 20 to 70 cases per year are reported. Outbreaks from contaminated food and water are rare (last one was in 1997). Hepatitis A is reportable by medical providers and laboratories to public health within 24 hours of diagnosis and each case is evaluated for risk of transmission to close contacts and the public and an immediate post exposure immunization response (with IG administration) is implemented for those at risk. These responses may involve immunizing just family members to mass immunization efforts when the general public is put at risk through an infectious food handler.





Viral Hepatitis B

Infectious Agent:

Hepatitis B Virus (HBV), a hepadnavirus, is a 42-nm partially double-stranded DNA virus. Also a hardy virus it survives in body fluids and on wet environmental surfaces for days to weeks.

Mode of Transmission:

Transmission occurs by exposure via percutaneous (needle stick) or permucosal (splashes, sprays) routes of infected body fluids (blood and blood products; including wound exudates; saliva; cerebrospinal fluid; peritoneal, pleural, pericardial and synovial fluid; amniotic fluid; semen and vaginal secretions and any other body fluids containing blood), tissues and organs. In the United States, the most important route of HBV transmission is by sexual contact, either heterosexual or homosexual, with an infected person. Direct parenteral inoculation of HBV by needles during injecting drug use is also an important mode of transmission. Transmission of HBV may also occur by other percutaneous exposures, including tattooing, ear piercing, and acupuncture, and by needle sticks or other injuries from sharp instruments sustained by medical personnel; however, these exposures account for only a small proportion of reported cases in the United States. In addition, transmission can occur perinatally from a chronically infected mother to her infant, most commonly by contact of maternal blood to the infant's mucous membranes at the time of delivery.

Incubation Period:

Usually 45-180 days, average 60-90 days.

Symptoms

Symptoms, if present are similar to HAV; severe disease can lead to liver failure and may be fatal.

Chronic Illness

The risk of chronic infection is age dependent. Infants who become infected by perinatal transmission have a 90% risk of chronic infection and up to 25% will die of chronic liver disease as adults. Of children who become infected with HBV between 1 and 5 years of age, 30 - 50% become carriers. Ninety percent of adults infected will recover fully and have a lifelong immunity to HBV; they are not infectious to others. 10% do not clear the infection and develop either mild chronic persistent HBV or more aggressive chronic active HBV which can lead to cirrhosis and liver cancer. They carry markers in their blood signifying chronic carriage –hepatitis surface antigen (HBsAg) positive.

Infectious period: Lifelong for chronic carriers.

Risk factors: The following populations are considered at high risk and for whom pre-exposure vaccination with hepatitis B vaccine is recommended

- men and women with a history of other sexually transmitted diseases and persons who have a history of multiple sex partners (>1 partner/6 months)
- household contacts and sex partners of persons with chronic HBV infection
- health care, public safety workers and all other occupations who have the potential of exposure to blood or potentially infected material in the workplace
- clients and staff of institutions for the developmentally disabled,
- international travelers who plan to spend >6 months in countries with high rates of HBV infection and who will have close contact with the local population
- international adoptees from high prevalence countries and children 2 years of age and older, born to mothers who are recent immigrants from high prevalence countries
- injecting drug users
- sexually active homosexual and bisexual men,
- recipients of clotting-factor concentrates.
- Patients undergoing hemodialysis

Prevention and Control Modalities: A comprehensive strategy to prevent HBV infection, acute hepatitis B, and the sequelae of HBV infection in the United States must eliminate transmission that occurs during infancy and childhood, as well as during adolescence and adulthood. In the United States it has become evident that HBV transmission cannot be prevented through vaccinating only the groups at high risk of infection. Therefore, new infections can be prevented only by universal childhood vaccinations coupled with targeted interventions to vaccinate the high-risk populations listed above. Post exposure intervention using a combination of hepatitis B immunoglobulin (HBIG) and hepatitis B vaccine is also effective in preventing transmission in perinatal and needle-stick type exposures. Routine visits for prenatal and well-child care can be used to target hepatitis B prevention. A comprehensive prevention strategy includes a) prenatal testing of pregnant women for HBsAg to identify newborns that require immunoprophylaxis for the prevention of perinatal infection and to identify household contacts who should be vaccinated, b) routine vaccination of infants, c) vaccination of adolescents through 18 years of age, and d) vaccination of adults at high risk of infection.

Prevention Activities:
Primary prevention activities include

- universal childhood vaccinations for all infants as part of the routine childhood vaccination schedule; HEALTH-RI makes such vaccine available to all RI children, birth -18 years of age.
- preventing perinatal HBV transmission by screening all pregnant women for hepatitis B surface antigen (HBsAg) and providing hepatitis B immune globulin (HBIG) and hepatitis B vaccine to infants of HBsAg-positive mothers; HEALTH-RI has a tracking program for HbsAg positive mothers.
- making special efforts to provide catch-up vaccination for children in high risk groups, including Alaska Natives, Pacific Islanders and infants of immigrants from countries with a high prevalence of chronic HBV infection;.
- providing hepatitis B vaccine to adolescents through 18 years of age.
- vaccinating adults in high-risk groups listed above.

Secondary prevention activities include

- medical management of infected persons, to lower viral load, prevent progression and delay complications of chronic liver inflammation.
- promotion of harm reduction programs to include syringe exchange
- counseling infected persons to practice safe sex, avoid sharing needles and in the household setting avoid sharing razors and toothbrushes.

Burden of Disease and RI Surveillance Data:
The CDC estimates that 4.9% of the U. S. population was ever infected with HBV with about 1.25 million Americans living with chronic HBV infection. The estimated national annual HBV-related chronic liver disease death rate is 5,000 deaths per year.

In RI every new acute case of hepatitis B reported to HEALTH-RI receives a telephone or face-to-face interview to complete surveillance data forms. Each is also counseled with prevention messages and household and sexual contacts are referred for screening and care. Previously reported cases and chronic cases are recorded in a registry but are not interviewed as the caseload exceeds capacity. Pregnant and delivering women with chronic HBV infection identified through HEALTH-RI's Perinatal Hepatitis B Prevention Program receive comprehensive case management services including

home visits and referrals for testing and immunization of household contacts and sex partners. All infants born to women with chronic HBV infection are followed to ensure they receive appropriate and

Cases of Acute Hepatitis B Infection, in Rhode Island by Year 1998-2005

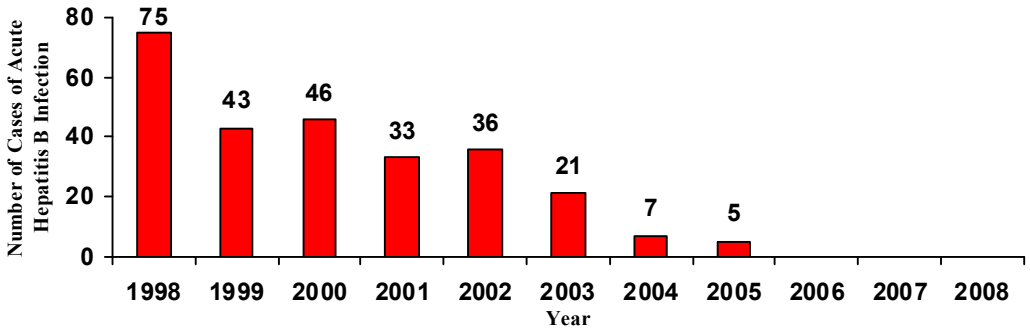
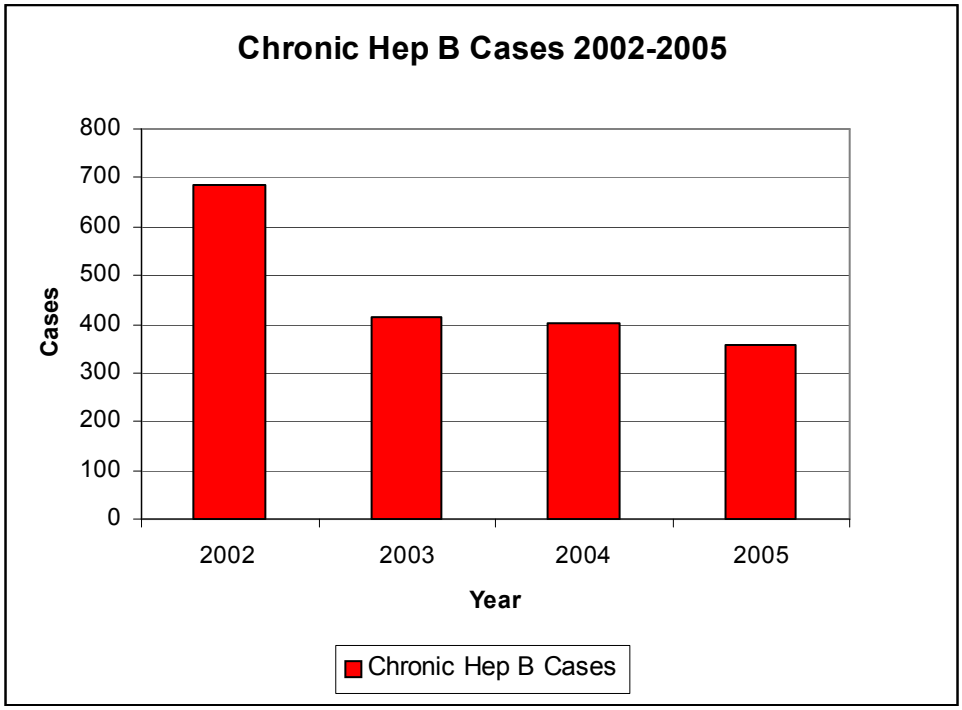


Figure 2. Unduplicated Laboratory Reports of Chronic Hepatitis B, in Rhode Island by Year 2002 - 2005



Viral Hepatitis C

Infectious Agent:
The hepatitis C Virus (HCV) is an enveloped RNA virus classified as a separate genus (Hepacavirus) in the Flaviviridae family. At least six different genotypes and greater than 90 subtypes of HCV exist. The most common genotype in the U.S. is genotype 1.
Mode of Transmission:
HCV is primarily parenterally transmitted. The two most common exposures related to the transmission of HCV are blood transfusion and injecting drug use. Sexual transmission has been documented to occur but is far less efficient or frequent than the parenteral route. HCV is not as hardy as HBV outside the body and on environmental surfaces.
Incubation Period:
Ranges from 2 weeks to 6 months; commonly 6-9 weeks. Chronic infection may persist up to 20 years before the onset of cirrhosis or hepatoma.
Symptoms:
Symptoms similar to HAV and are usually absent or very mild.
Chronic Illness
75%-85% of persons become carriers; of those 10-20% develop significant liver disease, which can lead to cirrhosis and liver cancer. The disease develops slowly, often without symptoms for 10-30 years.
Infectious Period: Lifelong for chronic carriers.

Risk Factors and Testing:

PERSONS	RISK OF INFECTION
Injecting drug users	High
Recipients of clotting factors made before 1987	High
Hemodialysis patients	Intermediate
Recipients of blood and/or solid organs before 1992	Intermediate
People with undiagnosed liver problems	Intermediate
Infants born to infected mothers	Intermediate
Healthcare/public safety workers	Low
People having sex with multiple partners	Low
People having sex with an infected steady partner	Low

Prevention and Control Modalities:
Primary prevention activities include:
Screening and testing of blood, plasma, organ, tissue, and semen donors;

- Virus inactivation of plasma-derived products;
- Harm-reduction counseling and services to disease free high risk individuals; and
- Implementation and maintenance of infection-control practices in health care settings.

Secondary prevention activities include:

- Identification of positives by testing high risk populations (see chart above)

Most people with hepatitis C have not been screened and do not know that they are infected. Screening tests currently approved by the United States Food and Drug Administration measure antibodies to the virus in the blood. The tests are successful in detecting the disease in almost all infected patients. However, this screening test does not indicate the stage to which the disease has progressed. Only a liver biopsy (biological sample of liver tissue that is used to measure the severity of inflammation and health of the liver) can show the extent to which the liver has been affected. Other tests are available for `measuring the type of hepatitis C virus (which gives an indication of how best to treat) and for measuring the extent of virus ("viral load") in the bloodstream and body tissues

- Counseling positives:
- ➢ Do not shoot drugs; if you shoot drugs, stop and get into a treatment program; if you can't stop, never share needles, syringes, water, or "works". Dispose safely all syringes and needles after one use.
- ➢ Do not share personal care items that might have blood on them (razors, toothbrushes etc.).
- ➢ If you are a health care or public safety worker, always follow routine barrier precautions and safely handle needles and other sharps; get vaccinated against hepatitis B.
- ➢ Consider the risks if you are thinking about getting a tattoo or body piercing. You might get infected if the tools have someone else's blood on them or if the artist or piercer does not follow good health practices. Only undergo piercing or tattoos from licensed establishments.
- ➢ HCV can be spread by sex, but this is rare. If you are having sex with more than one steady sex partner, use latex condoms correctly and every time to prevent the spread of sexually transmitted diseases.
- ➢ You should also get vaccinated against hepatitis B and A, and abstain from alcohol.
- ➢ If you are HCV positive, do not donate blood, organs, tissue or semen.

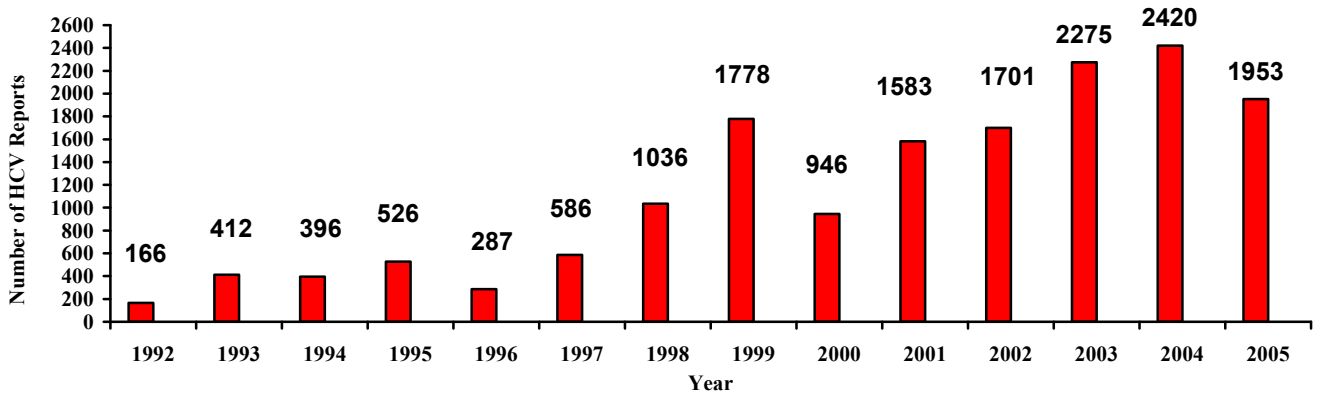
Treatment and management for hepatitis C:
Treatment options and case management are the only options in the absence of a vaccine and confirmation of acute Hepatitis C by testing. Although scientists are reluctant to call it a "cure," treatment is available which can lead to hepatitis C virus being undetectable over the long term. Further, treatment success is associated with improvement in liver biopsies for years after being discontinued. However, on assessment by the physician, not all persons who test positive for hepatitis C are considered good candidates for the current treatment, and some hepatitis C-positive persons elect not to undergo the treatment due to serious side effects or other problems. Case management for patients with chronic hepatitis
C becomes a critical factor in delaying or ameliorating the effects of the disease. Medical case management may include:
_ counseling to reduce the risk of transmitting the disease to others;

_ encouraging abstention from alcohol consumption;
_ referral for substance abuse treatment;
_ vaccination against hepatitis A and B;
_ evaluation for treatment options; and
_ screening for liver cancer.

A biopsy is recommended for evaluating and staging the severity of liver damage before treatment begins. Testing for genetic variation (genotype) of the virus is required as various genotypes respond differently to current treatments. Genotype 1accounts for about 75% of hepatitis C infections in the United States but is less responsive to standard interferon-based treatments. Currently, the goal of treatment is to induce a state where the virus is not detectable in the blood during, at the conclusion of, and for six months after treatment is discontinued. Long-term follow-up studies of patients with such a response to treatment have demonstrated continued undetectability of virus in over 95% of patients, and marked improvement in liver biopsies over time. In recent trials of ribavirin combined with alpha interferon, a sustained virological response has been demonstrated in about 30% of patients infected with genotype 1, and 66% of patients infected with genotypes 2 or 3.

Burden of Disease and RI Surveillance Data:
The CDC estimates that nationally 1.8% of the U. S. population was ever infected with HCV with about 2.7 million Americans living with chronic Hepatitis C Virus (HCV) infection. The estimated national annual HCV-related chronic liver disease death rate is 8,000 – 10,000 deaths per year.

Based on national estimates put forth by the CDC, the Rhode Island Department of Health (HEALTH-RI) estimates that there are 18,000 Rhode Islanders that were ever infected with HCV. From 1992, when surveillance for Hepatitis C first began, through 2005, 16,065 positive HCV laboratory reports have been reported to HEALTH-RI.
Figure 2. Unduplicated Laboratory Reports of Hepatitis C, in Rhode Island by Year 1992-2005



Of the entire positive lab reports reported to HEALTH-RI 65% were males, 34% were females and the remainder were of unknown gender. Figure 2 illustrates the increase in the number of HCV positive lab reports reported to HEALTH-RI over the past 13 years. This increase is believed to be a result of increase in disease awareness on both the provider and the patient levels and hence an increase in testing. The statewide seroprevalence for HCV is unknown but estimated at about 9000.

A sub-set of reports made to HEALTH-RI is targeted for active prevention counseling and social/medical case management. These subpopulations include all cases of hepatitis C from the Adult

Correctional Institution (ACI) and uninsured/underinsured cases that are good candidates for therapy from CODAC a methadone maintenance facility.

Hepatitis D (Delta) Virus (HDV) is a defective virus that requires hepatitis B virus (HBV) to replicate and exist. According to the CDC, HDV infection can be acquired either as a co-infection with HBV or as a super-infection of persons with chronic HBV infection. Persons with HBV-HDV infection may have more severe acute disease and a higher risk of fulminant hepatitis (2% - 20%) compared with those infected with HBV alone; however, chronic HBV infection appears to occur less frequently in persons with HBV-HDV co-infection. The modes of HDV transmission are similar to those for HBV, with percutaneous exposures the most efficient. Sexual transmission of HDV is less efficient that for HBV. Perinatal HDV transmission is rare. In general, the global pattern of HDV infection corresponds to the prevalence of chronic HBV infection, the United States having a very low prevalence of HDV. Because HDV is dependent on HBV to exist, HBV-HDV co-infection can be prevented with either pre- or post exposure prophylaxis for HBV. However, no products exist to prevent HDV super-infection of persons with chronic HBV infection. Thus, prevention of HDV super-infection depends primarily on education to reduce risk behaviors.

Hepatitis E Virus (HEV) is a virus transmitted in much the same manner as hepatitis a virus. HEV is transmitted primarily by the fecal-oral route and most outbreaks are associated with fecally contaminated drinking water. Unlike hepatitis A virus, person-to-person transmission of HEV appears to be minimal and uncommon. HEV does not occur often in the United States. Virtually all cases of acute HEV in the US have been reported among travelers returning from high HEV-endemic areas. Avoidance of drinking water and beverages with ice of unknown purity, uncooked shellfish, and uncooked fruit/vegetables not peeled or prepared by travelers is recommended.

PLAN GOALS, OBJECTIVES AND TIMELINE:

The overall goal of the Plan is to reduce the reported incidences of viral hepatitis A, B and C and the risk of chronic liver disease caused by Hepatitis B and C by 2010, to coincide with the national as well as "A Healthier Rhode Island by 2010: Your Challenge – A Plan for Action". Specifically, the risk factors associated with Hepatitis A, B and C, which coincide with Healthy People 2010 Initiative's goals and objectives that relate to substance use, mental health and sexual responsibility. There are 5 goals and 13 outcome objectives in the Plan: 10 overarching objectives that address more than one type of hepatitis and 3 objectives address hepatitis C only.

Goal 1: Reduction in the transmission of viral hepatitis A, B and C through education and increase in the number or preventive immunizations for hepatitis A and B among all at high-risk individuals, adults and children alike.

Goal 1 Objectives:

1.1 Develop adult and high-risk adolescent Hepatitis A and B vaccination programs that have sites throughout the state by 2010.

Goal 2: Increase the understanding and education of viral hepatitis among health care providers, policy makers and the general public and decrease the current stigma attached to HCV infected individuals.

Goal 2 Objectives:

2.1 Develop a prevention of viral hepatitis marketing plan for providers, policy makers and general public community by December 2010.

2.2 Identify the stigma attached to HCV through focus groups of HCV positive clients and their providers by December 2010.

2.3 Provide annual professional development programs on viral hepatitis to health care providers by December 2010.

2.4 Advocate for more access to medical care with at least 4 policy makers based on action plan by December 2005.

2.5 Train HIV prevention, substance use treatment facilities and other community-based organizations staff to deliver primary and secondary prevention education by December 2005.

2.6 Provide perinatal Hepatitis B and C education and outreach to prenatal and pediatric providers by December 2010.

Goal 3: Provide guidelines for local health care providers and case managers for implementing policies and procedures regarding testing and management of viral hepatitis B and C of high-risk individuals.

Goal 3 Objectives:

3.1 Collaborate with the Department of Corrections on case management and discharge planning for HCV positive inmates by December 2006.

3.2 Collaborate with the Department of Mental Health, Retardation and Hospital's Division of Behavioral Healthcare Services (MHRH) to address and integrate HCV into the discipline of substance using and co-occurring disorders by December 2010.

Goal 4: Increase in accessibility and resources for the provision of testing, care and treatment of viral hepatitis for specialized populations, such as high-risk individuals including women, adolescents, infants, and children; individuals who are uninsured, underinsured, incarcerated, or discharged from prison.

Goal 4 Objectives:

4.1 Train CTR counselors to offer HCV counseling, testing, and referral by incorporating HCV testing into the CTR training by December 2006.

4.2 Integrate perinatal hepatitis C prevention, testing and case management activities into HEALTH-RI's existing Perinatal Hepatitis Prevention Program (PHPP) by December 2010.

Goal 5: Maintain epidemiology functions including case surveillance, outbreak detection, control interventions, evaluation, and planning and publishing data on viral hepatitis to guide policy and prevention interventions.

Goal 5 Objectives:

5.1 The surveillance team by the Rhode Island Department of Health will publish and epidemiological profile on viral hepatitis A, B and C by December 2005.

TIMELINE:

The intent of the Plan is to accomplish these objectives in 6 years. Progress toward meeting the objectives will be evaluated annually, thereby updating the Plan to reflect achievement of objectives, medical advances and changes in policy and resource availability.

2007/2008
Goals and Objectives

GOAL 1: REDUCTION IN THE TRANSMISSION OF VIRAL HEPATITIS A, B AND C THROUGH EDUCATION AND INCREASE IN THE NUMBER OF PREVENTIVE IMMUNIZATIONS FOR HEPATITIS A AND B AMONG ALL HIGH RISK INDIVIDUALS, ADULTS AND CHILDREN ALIKE.

Objectives	Activities	Output/Products	Immediate Outcome (2007/8)	Long Term Outcome (2010)
1.1 Develop adult and high-risk adolescent Hepatitis A and B vaccination programs that have sites throughout the state by **2010**;	• A plan to provide linguistically, culturally and developmentally trained vaccine providers to serve high-risk adolescents by **May 2004**. **(Objective met)** • Provide training for HIV Prevention and CTR vendors, STD clinic and Methadone Treatment sites **December 2004. (Objective met)** • A plan to disseminate evidence-based best clinical performance guidelines and educate providers to assure compliance with health care statutes and regulations by **June 2006. (Objective met)** • Pursue grants and/or other resources from CDC, HEALTH-RI and MHRH to fund vaccines by **2008**. **(Objective met.**	• Vaccine Plan • Community based high-risk vaccine site plan • 10 vaccine provided sites • Grants and/or Resources written	• Collaborate with HEALTH-RI's Family Health program to secure needed vaccines for at-risk adults by **December 2007. Objective met.** • Implementation of Hepatitis A & B Vaccination Plan by **January 2008. Objective met.** • Distribution of HAV and HBV vaccines to eight community based HCV Testing Sites by **January 2008**. **Objective met.**	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	HEALTH-RI Immunization program is collaborating with Viral Hepatitis Program to secure enough vaccines for Program needs.) • Develop HAV and/or HBV vaccination plan with high-risk community members (i.e. such as the "Bath Houses" and Injecting Drug Users (IDU) venues by **March 2006.** **(Objective met)** • A plan to activate ten community-based sites to provide HAV and/or HBV vaccines by **2010.** **(Objective met.)** • Provide 10 sites with HAV and/or HBV vaccines **2010**. **(Objective met.)** • A plan to determine if there is a 10% increase in Hepatitis A and B vaccines being given in Rhode Island by **2010**. • Establish an Adult Vaccination Registry by **2010**. • Develop a plan to obtain vaccination			

	status of discharged Training School individuals by **2010**.			

GOAL 2: INCREASE THE UNDERSTANDING AND EDUCATION OF VIRAL HEPATITIS AMONG HEALTH CARE PROVIDERS, POLICY MAKERS AND THE GENERAL PUBLIC AND DECREASE THE CURRENT STIGMA ATTACHED TO HCV INFECTED INDIVIDUALS.

Objectives	Activities	Output/Products	Immediate Outcome (2006/7)	Long Term Outcome (2010)
2.1 Develop a prevention of viral hepatitis marketing plan for the provider, policy maker and general public community by **December 2010**;	• Collaborate with Viral Hepatitis Advisory Group (VHAG) by **June 2004. (Objective met)** • Develop and Implement a Needs Assessment with health care providers, policy makers and general public by **December 2007.** • Determine what information and dissemination strategies health providers, policy makers and public need and want by **June 2007**. **(Objective partially met. Older physicians prefer hard copies that they can refer to and younger physicians prefer information electronically.)** • Disseminate written viral hepatitis information to community-based	• Needs assessment results • Viral hepatitis resource information/fact sheet at the State House on "Legislative Day" • Blast fax, media, website • Promote ongoing improvement in the quality of health care services and assure compliance with standards fro health care services **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #6).** • Provision of capacity building as needed for providers **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #7).**	• Organize a team to develop the health care providers, policy makers and general public needs assessment by **February 2008**. • Organize a team to determine what information and dissemination strategies health providers, policy makers and public need and want by **June 2008**. • Implement an information/resource table at the State House on "Legislative Day" by **May 2008**. • Pursue a resolution from the RI General Assembly declaring May as Viral Hepatitis Month by **May 2008**. • Present RI's Comprehensive Strategic Plan for the Prevention and Control of Viral Hepatitis to community	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	organizations working with high-risk women and youth by **June 2006.** **(Objective met)** • Develop a plan to promote Viral Hepatitis prevention and treatment with the policy makers by **June 2006**. **(Objective met. A viral hepatitis awareness day was held at the State House and Proclamations declaring viral hepatitis awareness month were sponsored and read in chambers of the House and Senate.)** • Develop a plan to promote Viral Hepatitis prevention and treatment with the providers by **June 2007.** **(Objective met. A Viral Hepatitis Resource and Services Directory was printed and mailed in January, 2006 and Prevention of Perinatal Hepatitis B and C Screening and Referral Guidelines for Pregnant Women and Newborns**		stakeholders and policymakers by **February 2008**.	

	was printed and mailed to physicians.)			
2.2 Identify the stigma attached to HCV through focus groups of HCV positive clients and their providers by **December 2010.**	• Develop Viral Hepatitis questions for focus groups by **December 2006**. **(Objective not met.)** • Identify funding and/or resources for focus groups by **December 2006. (Objective not met.)** • Identify venue for presenting provider with results of focus groups by **2010**. • Develop Viral Hepatitis questions for the Behavior Risk Factor Surveillance Survey (BRFSS) conducted by HEALTH-RI by **December 2006. (Objective not met.)** • Identify funding and/or resources for BRFSS by **December 2006. (Objective met but maybe be overturned due to budgetary restrictions.)** • Identify venue for presenting provider with results of BRFSS by **2010**.	• Questions for focus groups on Website and other venues such as Wellness Connection and School of Nursing. • Viral Hepatitis Questions for BRFSS. • Grants and resources written	• Develop list of questions for focus groups by **February 2008.** • Develop 1 or 2 questions for BRFSS by **March 2008**. **(Objective not met.)** • Identify funding for BRFSS questions by **March 2008.**	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**
2.3 Provide annual professional development	• Collaborate with Brown University	• Contractual agreement with medical education	• Establish meetings between HEALTH-RI	**To decrease the incidence of Viral Hepatitis A, B,**

programs on viral hepatitis to health care providers by **December 2010**;	Medical School to develop a medical education program by **June 2007**. **(Objective not met.)** • Provide viral hepatitis education programs at "Grand Rounds" at area hospitals with emphasis on "birthing" hospitals by **2008**. **(Objective met. Dr. Degli Esposti and Dr. Leilekos have begun integrating viral hepatitis education into Grand Rounds at Hasbro and Women & Infants Hospitals)** • Incorporate HBV/HCV risk behaviors into Bloodborne Pathogens Module by **2010.** • Develop a Viral Hepatitis Clinical Task Force **2006**. **(Objective met and on-going)** • Viral Hepatitis Professional Development Plan for providers (primary care physicians, nurse practitioners, physician assistants and school nurses) by **December 2007**. • HEALTH web page	program • Yearly Professional Development Program on viral hepatitis • HBV and HCV segment for Bloodborne Pathogens Module • Viral Hepatitis Web page for providers • Grants and resources written • Annual HCV and HBV medical education strategy • Viral Hepatitis Center	and Brown Medical School Research Dept. by **April 2008**. • Explore grants and resources – **ongoing.** • Identify funding for provider education by **June 2008 – ongoing.** • Provide a viral hepatitis professional development forum by **June 2008.** • Web page to be operational by **March 31, 2008.** • Establish and facilitate joint meetings with Health Care Insurers and Providers by **October 31, 2008.**	**and C by 2010.**

	development by **January 2006. (Objective partially met. A new Web page is in the process of being designed and should be accessible by December 31, 2007.)** • Identify funding for provider education by **2007. (Objective partially met with the assistance of the American Liver Foundation – New England Chapter.)** • Identify venue for provider education by **2008. (Objective partially met with the assistance of the American Liver Foundation – New England Chapter.)** • Establishment of Viral Hepatitis Center **2010**.			
2.4 Advocate for more access to medical care with at least 4 policy makers based on an action plan by **December 2005**;	• Develop a plan of action to foster advocacy between policy makers and VHAG members by **June 2004. (Objective met)** • Identify policy makers with interest in VHAG's agenda by	• Action Plan • List of policy maker advocates • Publish Single Overriding Health Communication Objective (SOHCO)	• Develop a Single Overriding Health Communication Objective (SOCHCO) by **December 2007**.	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	September 2004. **(Objective met)** • Write a Single Overriding Health Communication Objective (SOHCO) (policy brief) by **December 2006**. **(Objective not met.)**			
2.5 Train HIV prevention, substance use treatment facilities and other community based organizations staff to deliver primary and secondary prevention education by **December 2005**;	• Collaborate with RI Department of Mental Health, Retardation and Hospitals (MHRH) – Division of Behavioral Healthcare Services, Project REACH and Drug and Alcohol Treatment Association (DATA) by **June 2004**. **(Objective met).** • Provide a six-hour or longer cross training for integration into HIV Prevention, STI clinic, Substance Use/Methadone Treatment and prevention sites by **December 2004**. **(Objective met)** • Extend certification credits availability to prevention and treatment counselors by **December 2008**. **(Unable to implement as Drug and Alcohol Treatment**	• Curriculum development team • 6 hour or longer curriculum and trainers • Certification process	• Continue to offer cross training curriculum at least once a year by **July 31, 2008. Objective met.** • Offer a Viral Hepatitis one/two-day training program for HIV, STD and Substance Use Treatment Counselors by **October 31, 2008**. **Objective met.**	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	Association Board of Directors are resistant to plan) • Include cross training issues on substance abuse, HIV, HCV and STI by **December 2004**. **(Objective met)** • Provide a one-day Viral Hepatitis prevention training through REACH before **December 31, 2006.** **(Objective met.)**			
2.6 Provide perinatal Hepatitis B and C education and outreach to prenatal and pediatric providers by **December 2010.**	• Develop guidelines for identification, case management, treatment and referral of women and infants at risk of perinatal transmission **by 2010.** • Provide education at grand rounds at birthing hospitals by **December 2006**. **(Objective met)** • Assess ways to improve current reporting system (providers, labs, birthing hospitals) to identify women with HBV and/or HCV chronic infection by **2010**. • Include HCV related	• Written guidelines • Educational plan • Identification Reporting plan • HCV Question written for PRAMS • Interdisciplinary meetings • Identify morbidity regarding Hepatitis A, B and C among pediatric cases **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #5).** • Promotion of healthy human development through immunization programs, education of providers and families regarding the risk	• Addressing prenatal and pediatric issues **on going through October 31, 2008.** • Identification of Hepatitis B and C positive pregnant women early in pregnancy – **ongoing through October 31, 2008.** • Monitoring and updating guidelines for identification, case management, treatment and referral of women and infants at risk of Perinatal Hepatitis B and/or C transmission **on-going through October 31, 2008.**	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	question to PRAMS (Pregnancy Risk Assessment Monitoring System) by **December 2004**. **(Objective met)** • Develop Prevention subcommittee work group to address pre-natal and pediatric issues by **December 2004**. **(Objective met)** • Collaborate with Women & Infants (W & I) Hospital to identify Hepatitis B & C positive pregnant women early in pregnancy by **December 2004**. **(Objective met)**	factors of viral hepatitis **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #5).**	• Provide viral hepatitis education at "Grand Rounds" at area birthing hospitals **on-going through October 31, 2008.** • Determine gaps and challenges of reporting system by **January 2008.**	

GOAL 3: PROVIDE GUIDELINES FOR LOCAL HEALTH CARE PROVIDERS AND CASE MANAGERS FOR IMPLEMENTING POLICIES AND PROCEDURES REGARDING TESTING AND MANAGEMENT OF VIRAL HEPATITIS B AND C OF HIGH-RISK INDIVIDUALS.

Objectives	Activities	Output/Products	Immediate Outcome (2006/7)	Long Term Outcome (2010)
3.1 Collaborate with the Department of Corrections on case management and discharge planning for HCV positive inmates by **December 2010.**	• Establish relationship with DOC case management and HCV program by **March 2004. (Objective met).** • Identify health care providers who are willing to dedicate themselves to the care and/or treatment of HCV positive individuals upon release from prison by **June 2007. (Objective not met.)** • Develop a program that will ensure that the provider and inmate/patient will develop a relationship thereby reducing the fear of the provider having to deal with a "former inmate", increasing the likelihood that transitional care will be instituted (i.e. the patient understands his/her condition, the options available upon	• Interagency meetings • Plan for servicing former inmates outside the Family Life Service area • Resource Directory • Promote ongoing improvement in the quality of health care services and assure compliance with standards for health care services **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #6).** • Engage the health care sector in preventing and controlling infectious diseases and building capacity of providers **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #7 and #8).** •	• Schedule interagency meetings between RIDOC and HCV program – **ongoing through October 31, 2008**. • Identification of health care providers who are willing to care for HCV positive individuals upon release from prison by **October 31, 2008.**	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	release, and what the possible outcomes are by **2010**. • Develop a plan with DOC for HCV case management outside of the DOC Family Life Services area by **June 2006.** **(Objective partially met. A discharge planner at DOC has been identified and a plan will be developed shortly)** • Develop a program that resembles the Department of Corrections' HIV program whereby health care providers come into the prison to provide services that can be continued upon an inmate's release. This would involve providers applying for funding to provide such services by **2010**. • Development of a Viral Hepatitis Resource and Services Directory by **December 2004. (Objective met)**			
3.2 Collaborate with the Department of Mental Health, Retardation and Hospital's Division of Behavioral Healthcare	• Develop a joint partnership to establish a collaborative work plan by **June 2003**.	• Curriculum development team • 6 hour or longer curriculum and trainers • Certification process • Physicians Group	• Provide of at least one cross training by **June 30, 2008**. **Objective met.** • Establish and	

Services (MHRH) to address and integrate HCV into the discipline of substance using and co-occurring disorders by **December 2010**.	**(Objective met)** • Implement a joint position paper to define roles and activities by **June 2003**. **(Objective met)** • Provide a joint presentation explaining initiative to New England Summer School for Addiction Studies by **July 2003**. **(Objective met)** • Develop e-mail/hard copy lists of names and addresses that both Offices can share by **December 2006**. **(Objective met.)** • Include cross training issues on substance abuse, HIV, HCV and STI by **December 2004**. **(Objective met)** • Provide a six-hour or longer cross training for integration into HIV Prevention, STI clinic, Substance Use/Methadone Treatment and prevention sites by **December 2004**. **(Objective met)** • Extend certification credits availability to prevention and	• Insurers meeting • Vaccine Plan • 10 vaccine provided sites • Grants and/or Resources written	facilitate joint meetings with Health Care Insurers and Providers by **August 2008**. • Continue to explore and pursue grants/resources for funding testing and vaccinations – **ongoing through October 31, 2008**.	

	treatment counselors by **December 2008**. **(Objective not met. Unable to implement as Drug and Alcohol Treatment Association Board of Directors are resistant to plan)** • Develop a MHRH Physician Group with representatives from both departments by **July 2006**. **(Objective not met.)** • Joint facilitation of meetings with Insurers and Providers by **June 2007**. **(Objective not met.)** • A plan to activate ten sites to provide HAV and/or HBV vaccines by **2010.** **(Objective met.)** • Pursue grants and/or other resources from CDC and other Federal agencies to fund vaccines **2008**. (Objective met.)			

GOAL 4: INCREASE IN ACCESSIBILITY AND RESOURCES FOR THE PROVISION OF TESTING, CARE AND TREATMENT OF VIRAL HEPATITIS FOR SPECIALIZED POPULATIONS, SUCH AS HIGH-RISK INDIVIDUALS INCLUDING WOMEN, ADOLESCENTS, INFANTS, AND CHILDREN; INDIVIDUALS WHO ARE UNINSURED, UNDERINSURED, INCARCERATED, OR DISCHARGED FROM PRISON.

Objectives	Activities	Output/Products	Immediate Outcome (2007/8)	Long Term Outcome (2010)
4.1 Train CTR counselors to offer HCV counseling, testing, and referral by incorporating HCV testing into the CTR training by **December 2006**;	• Incorporate HCV testing training into the existing CTR counselor training by **December 2006**. **(Objective met)** • Develop a plan to activate ten sites to provide HCV screening and referral (5 sites in December 2006 and 5 more sites in December 2008). **(Objective met. Six (6) sites are being funded by the State and four other sites are being funded through a research grant.)** • Fund 10 sites to provide HCV screening and referral by **December 2010**. **(Objective met.** Six (6) **sites are being funded by the State beginning and four other sites are being funded through a research grant)**	• Establish a planning group with CTR trainer and HIV staff • CTR/HIV and HCV counselor training curriculum • Grants and resources written • Site plan for high risk individuals	• Develop a training for HCV testing and referral into HIV and STD sites provided by **December 31, 2008. Objective met.** • Integration of HBV testing and counseling into HCV training by **December 31, 2007. Objective met.** • Explore and pursue grants and/or other resources from CDC, Health-RI and MHRH-RI to fund sites annually **ongoing through October 31, 2008.**	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	• Pursue grants and/or other resources from CDC and MHRH to fund sites annually by **2008**. • Develop HCV test site plan with high-risk community members (i.e. such as the "Bath Houses" and Injecting Drug User (IDU) venues by **December 2006**. **(Objective met)**			
4.2 Integrate perinatal hepatitis C prevention, testing and case management activities into HEALTH-RI's existing Perinatal Hepatitis Prevention Program (PHPP) by **December 2010.**	• Provide referral and medical management for women with HBV and/or HCV chronic infection by **January 2005.** **(Objective met)** • Track all infants born to women with HBV and/or HCV chronic infection to ensure appropriate and timely immunoprophylaxis, testing and treatment of infants by **September 2005**.	• Memorandum of Understanding (MOU) for medical management referral services.	• Establish a provision plan for referral and medical management of women with HBV and HCV Chronic infection by **September 30, 2008**. **Objective met.** • Establish a tracking system to ensure immunoprophylaxis, testing and treatment will be instituted by **October 31, 2008**. • Continue meetings with the Perinatal Prevention Subcommittee work group to address perinatal and pediatric issues on a bi-monthly basis through **October 31, 2008**.	

GOAL 5: MAINTAIN EPIDEMIOLOGY FUNCTIONS INCLUDING CASE SURVEILLANCE, OUTBREAK DETECTION, CONTROL INTERVENTIONS, EVALUATION, PLANNING AND PUBLISHING DATA ON VIRAL HEPATITIS TO GUIDE POLICY AND PREVENTION INTERVENTIONS.

Objectives	**Activities**	**Output/Products**	**Immediate Outcome (2007/8)**	**Long Term Outcome (2010)**
5.1 The Surveillance Team by the Rhode Island Department of Health to publish an epidemiological profile on viral hepatitis A, B and C by **2005**;	• The Disease Control Representative will maintain case investigations of acute cases of Viral Hepatitis B and C on an on-going basis. **(Objective met and on-going)** • The Disease Control Representative and the National Electronic Telecommunications System for Surveillance (NETSS) Data Entry Clerk will maintain data entry of acute and chronic cases of Hepatitis B and C into NETSS and the Hepatitis Registry respectively on an on-going. **(Objective met and on-going)** • The National Electronic Disease Surveillance System (NEDSS) Coordinator will facilitate the	• HCV lab reports will be recorded in Chronic Hepatitis Registry HBV and HCV. • Acute HBV and HCV will be reported into NETSS and transmitted weekly to CDC. • NEDSS software to be implemented and staff trained. • New database implemented • Protocol for HBV and HCV data entry written • Evaluation plan for HBV and HCV database established • HBV and HCV data analysis • Expanded HBV and HCV database implemented • Confidentiality forms completed • The epidemiologic report and other	• The Disease Intervention Specialist will maintain case investigations of acute cases of Viral Hepatitis B and C - **ongoing**. • The Disease Intervention specialist and Data Entry Clerk will maintain data entry of acute and chronic cases of Hepatitis B and C into NEDSS – **ongoing through October 31, 2008**. • The surveillance team will implement additional activities that allow for the collection of supplemental information for Viral Hepatitis B and C surveillance ongoing through **October 31, 2008.** • The staff epidemiologist will analyze, present and	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	transition from NETSS to NEDSS **June 2007**. **(Objective met.)** • The staff epidemiologist will implement a new database (based on a review of databases used by other state health departments) for the entry of acute and chronic Viral Hepatitis B and C cases by **December 2006. (Objective met)** • The staff epidemiologist will write a protocol for Viral Hepatitis B and C data entry by **December 2005**. **(Objective not met)** • The staff epidemiologist will construct an evaluation plan to evaluate the performance of the proposed chronic Viral Hepatitis B and C database **December 2005**. **(Objective not met)** • The surveillance team will implement additional activities that allow for the collection of supplemental	information/data pertaining to hepatitis will be utilized to guide policy and program development, implementation, evaluation and retention **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #3).** •	disseminate viral hepatitis surveillance data by **March 2008**. • Maintain current standards of security and confidentiality for Viral Hepatitis B and C data – **ongoing through October 31, 2008.**	

	information for Viral Hepatitis B and C surveillance on an on-going basis by **June 2006.** **(Objective met for surveillance but regulations pertaining reporting of HBV and HCV need to be altered.)** • Maintain current standards of security and confidentiality for Viral Hepatitis B and C data on an on-going basis. **(Objective met and on-going.)**			

2006/2007
Goals and Objectives

GOAL 1: REDUCTION IN THE TRANSMISSION OF VIRAL HEPATITIS A, B AND C THROUGH EDUCATION AND INCREASE IN THE NUMBER OF PREVENTIVE IMMUNIZATIONS FOR HEPATITIS A AND B AMONG ALL HIGH RISK INDIVIDUALS, ADULTS AND CHILDREN ALIKE.

Objectives	Activities	Output/Products	Immediate Outcome (2006/7)	Long Term Outcome (2010)
1.1 Develop adult and high-risk adolescent Hepatitis A and B vaccination programs that have sites throughout the state by **2010**;	• A plan to provide linguistically, culturally and developmentally trained vaccine providers to serve high-risk adolescents by **May 2004**. **(Objective met)** • Provide training for HIV Prevention and CTR vendors, STD clinic and Methadone Treatment sites **December 2004. (Objective met)** • A plan to disseminate evidence-based best clinical performance guidelines and educate providers to assure compliance with health care statutes and regulations by **June 2006. (Objective met)** • Pursue grants and/or other resources from CDC, HEALTH-RI and MHRH to fund vaccines **2008**. **(Objective partially**	• Vaccine Plan • Community based high-risk vaccine site plan • 10 vaccine provided sites • Grants and/or Resources written	• Collaborate with HEALTH-RI's Family Health program to secure needed vaccines for at-risk adults by **September 2006.** • Implementation of Hepatitis A & B Vaccination Plan by **December 2006.** • Distribution of HAV and HBV vaccines to eight community based HCV Testing Sites by **December 2006**.	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	met. HEALTH-RI Immunization program is collaborating with Viral Hepatitis Program to secure enough vaccines for Program needs.) • Develop HAV and/or HBV vaccination plan with high-risk community members (i.e. such ads the "Bath Houses" and Injecting Drug Users (IDU) venues by **March 2006.** **(Objective met)** • A plan to activate ten community-based sites to provide HAV and/or HBV vaccines by **2010.** **(Objective partially met. Eight sites have identified.)** • Provide 10 sites with HAV and/or HBV vaccines **2010**. **(Objective partially met. Eight sites will be administering vaccines by December 2006.)** • A plan to determine if there is a 10% increase in Hepatitis A and B vaccines being given in Rhode Island by			

	2010. • Establish an Adult Vaccination Registry by **2010**. • Develop a plan to obtain vaccination status of discharged Training School individuals by **2010**.			

GOAL 2: INCREASE THE UNDERSTANDING AND EDUCATION OF VIRAL HEPATITIS AMONG HEALTH CARE PROVIDERS, POLICY MAKERS AND THE GENERAL PUBLIC AND DECREASE THE CURRENT STIGMA ATTACHED TO HCV INFECTED INDIVIDUALS.

Objectives	Activities	Output/Products	Immediate Outcome (2006/7)	Long Term Outcome (2010)
2.1 Develop a prevention of viral hepatitis marketing plan for the provider, policy maker and general public community by **December 2010**;	• Collaborate with Viral Hepatitis Advisory Group (VHAG) by **June 2004. (Objective met)** • Develop and Implement a Needs Assessment with health care providers, policy makers and general public by **December 2007.** • Determine what information and dissemination strategies health providers, policy makers and public need and want by **June 2007**. • Disseminate written viral hepatitis information to community-based organizations working with high-risk women and youth by **June 2006. (Objective met)** • Develop a plan to promote Viral Hepatitis prevention	• Needs assessment results • Viral hepatitis resource information/fact sheet at the State House on "Legislative Day" • Blast fax, media, website • Promote ongoing improvement in the quality of health care services and assure compliance with standards fro health care services **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #6).** • Provision of capacity building as needed for providers **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #7).**	• Organize a team to develop the health care providers, policy makers and general public needs assessment by **December 2007**. • Organize a team to determine what information and dissemination strategies health providers, policy makers and public need and want by **June 2007**. • Implement an information/resource table at the State House on "Legislative Day" by **May 2007**. • Pursue a resolution from the RI General Assembly declaring May as Viral Hepatitis Month by **May 2007**. • Present RI's Comprehensive Strategic Plan for the Prevention and Control of Viral Hepatitis to community	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	and treatment with the policy makers by **June 2006**. **(Objective partially met. A viral hepatitis awareness day was held at the State House)** • Develop a plan to promote Viral Hepatitis prevention and treatment with the providers by **June 2007.** **(Objective met. A Viral Hepatitis Resource and Services Directory was printed and mailed in January, 2006 and Prevention of Perinatal Hepatitis B and C Screening and Referral Guidelines for Pregnant Women and Newborns was printed and mailed to physicians.)**		stakeholders and policymakers by **January 2007**.	
2.2 Identify the stigma attached to HCV through focus groups of HCV positive clients and their providers by **December 2010.**	• Develop Viral Hepatitis questions for focus groups by **December 2006**. • Identify funding and/or resources for focus groups by **December 2006.** • Identify venue for presenting provider with results of focus groups by **2010**.	• Questions for focus groups on Website and other venues such as Wellness Connection and School of Nursing. • Viral Hepatitis Questions for BRFSS. • Grants and resources written	• Develop list of questions for focus groups by **December 2006.** • Develop 1 or 2 questions for BRFSS by **December 2006**. • Identify funding for BRFSS questions by **December 2006.**	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	• Develop Viral Hepatitis questions for the Behavior Risk Factor Surveillance Survey (BRFSS) conducted by HEALTH-RI by **December 2006.** • Identify funding and/or resources for BRFSS by **December 2006** • Identify venue for presenting provider with results of BRFSS by **2010**.			
2.3 Provide annual professional development programs on viral hepatitis to health care providers by **December 2010**;	• Collaborate with Brown University Medical School to develop a medical education program by **June 2007**. • Provide viral hepatitis education programs at "Grand Rounds" at area hospitals with emphasis on "birthing" hospitals by **2008**. **(Objective met. Dr. Degli Esposti and Dr. Leilekos have begun integrating viral hepatitis education into Grand Rounds at Hasbro and Women & Infants Hospitals)** • Incorporate HBV/HCV risk behaviors into Bloodborne Pathogens	• Contractual agreement with medical education program • Yearly Professional Development Program on viral hepatitis • HBV and HCV segment for Bloodborne Pathogens Module • Viral Hepatitis Web page for providers • Grants and resources written • Annual HCV and HBV medical education strategy • Viral Hepatitis Center	• Establish meetings between HEALTH-RI and Brown Medical School Research Dept. by **April 2007**. • Develop and distribute toolkit for providers by **June 2007.** • Explore grants and resources – ongoing. • Identify funding for provider education by **June 2007.** • Provide a viral hepatitis professional development forum by **June 2007.** • Web page to be operational by **December 31, 2006.**	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	Module by **2010.** • Develop a Viral Hepatitis Clinical Task Force **2006**. **(Objective met and on-going)** • Viral Hepatitis Professional Development Plan for providers (primary care physicians, nurse practitioners, physician assistants and school nurses) by **December 2007**. • HEALTH web page development by **January 2006. (Objective partially met. The Web page is in the process of being designed and should be accessible by December 31, 2006.)** • Identify funding for provider education by **2007.** • Identify venue for provider education by **2008** • Establishment of Viral Hepatitis Center **2010**.			
2.4 Advocate for more access to medical care with at least 4 policy makers based on an action plan by **December 2005**;	• Develop a plan of action to foster advocacy between policy makers and VHAG members by **June 2004.**	• Action Plan • List of policy maker advocates • Publish Single Overriding Health Communication	• Develop a Single Overriding Health Communication Objective (SOCHCO) by **December 2006**.	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	(Objective met) • Identify policy makers with interest in VHAG's agenda by **September 2004**. **(Objective met)** • Write a Single Overriding Health Communication Objective (SOHCO) (policy brief) by **December 2006**.	Objective (SOHCO)		
2.5 Train HIV prevention, substance use treatment facilities and other community based organizations staff to deliver primary and secondary prevention education by **December 2005**;	• Collaborate with RI Department of Mental Health, Retardation and Hospitals (MHRH) – Division of Behavioral Healthcare Services, Project REACH and Drug and Alcohol Treatment Association (DATA) by **June 2004**. **(Objective met).** • Provide a six-hour or longer cross training for integration into HIV Prevention, STI clinic, Substance Use/Methadone Treatment and prevention sites by **December 2004**. **(Objective met)** • Extend certification credits availability to prevention and treatment counselors by **December 2008**.	• Curriculum development team • 6 hour or longer curriculum and trainers • Certification process	• Continue to offer cross training curriculum 2x a year. • Offer a Viral Hepatitis one-day program for HIV and Substance Use Treatment Counselors.	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	(Unable to implement as Drug and Alcohol Treatment Association Board of Directors are resistant to plan) • Include cross training issues on substance abuse, HIV, HCV and STI by **December 2004**. **(Objective met)** Provide a one-day Viral Hepatitis prevention training through REACH before **December 31, 2006.**			
2.6 Provide perinatal Hepatitis B and C education and outreach to prenatal and pediatric providers by **December 2010.**	• Develop guidelines for identification, case management, treatment and referral of women and infants at risk of perinatal transmission **by 2010.** • Provide education at grand rounds at birthing hospitals by **December 2006**. **(Objective met)** • Assess ways to improve current reporting system (providers, labs, birthing hospitals) to identify women with HBV and/or HCV chronic infection by **2010**. • Include HCV related	• Written guidelines • Educational plan • Identification Reporting plan • HCV Question written for PRAMS • Interdisciplinary meetings • Identify morbidity regarding Hepatitis A, B and C among pediatric cases **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #5).** • Promotion of healthy human development through immunization programs, education of providers and families		**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	question to PRAMS (Pregnancy Risk Assessment Monitoring System) by **December 2004**. **(Objective met)** • Develop Prevention subcommittee work group to address pre-natal and pediatric issues by **December 2004**. **(Objective met)** • Collaborate with Women & Infants (W & I) Hospital to identify Hepatitis B & C positive pregnant women early in pregnancy by **December 2004**. **(Objective met)**	regarding the risk factors of viral hepatitis **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #5).**		

GOAL 3: PROVIDE GUIDELINES FOR LOCAL HEALTH CARE PROVIDERS AND CASE MANAGERS FOR IMPLEMENTING POLICIES AND PROCEDURES REGARDING TESTING AND MANAGEMENT OF VIRAL HEPATITIS B AND C OF HIGH-RISK INDIVIDUALS.

Objectives	Activities	Output/Products	Immediate Outcome (2006/7)	Long Term Outcome (2010)
3.1 Collaborate with the Department of Corrections on case management and discharge planning for HCV positive inmates by **December 2006**;	• Establish relationship with DOC case management and HCV program by **March 2004. (Objective met).** • Identify health care providers who are willing to dedicate themselves to the care and/or treatment of HCV positive individuals upon release from prison by **June 2007.** • Develop a program that will ensure that the provider and inmate/patient will develop a relationship thereby reducing the fear of the provider having to deal with a "former inmate", increasing the likelihood that transitional care will be instituted (i.e. the patient understands his/her condition, the options available upon release, and what the	• Interagency meetings • Plan for servicing former inmates outside the Family Life Service area • Resource Directory • Promote ongoing improvement in the quality of health care services and assure compliance with standards for health care services **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #6).** • Engage the health care sector in preventing and controlling infectious diseases and building capacity of providers **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #7 and #8).** •	• Schedule interagency meetings between RIDOC and HCV program – **ongoing**. • Identification of health care providers who are willing to care for HCV positive individuals upon release from prison.	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	possible outcomes are by **2010**. • Develop a plan with DOC for HCV case management outside of the DOC Family Life Services area by **June 2006.** **(Objective partially met. A discharge planner at DOC has been identified and a plan will be developed shortly)** • Develop a program that resembles the Department of Corrections' HIV program whereby health care providers come into the prison to provide services that can be continued upon an inmate's release. This would involve providers applying for funding to provide such services by **2010**. • Development of a Viral Hepatitis Resource and Services Directory by **December 2004.** **(Objective met)**			
3.2 Collaborate with the Department of Mental Health, Retardation and Hospital's Division of Behavioral Healthcare Services (MHRH) to	• Develop a joint partnership to establish a collaborative work plan by **June 2003**. **(Objective met)**	• Curriculum development team • 6 hour or longer curriculum and trainers • Certification process • Physicians Group	• Provide two cross trainings by **June 2007**. • Establish and facilitate joint meetings with	

address and integrate HCV into the discipline of substance using and co-occurring disorders by **December 2010**.	• Implement a joint position paper to define roles and activities by **June 2003**. **(Objective met)** • Provide a joint presentation explaining initiative to New England Summer School for Addiction Studies by **July 2003**. **(Objective met)** • Develop e-mail/hard copy lists of names and addresses that both Offices can share by **December 2006**. • Include cross training issues on substance abuse, HIV, HCV and STI by **December 2004**. **(Objective met)** • Provide a six-hour or longer cross training for integration into HIV Prevention, STI clinic, Substance Use/Methadone Treatment and prevention sites by **December 2004**. **(Objective met)** • Extend certification credits availability to prevention and treatment counselors by **December 2008**.	• Insurers meeting • Vaccine Plan • 10 vaccine provided sites • Grants and/or Resources written	Health Care Insurers and Providers by **March 2007**. • Continue to explore and pursue grants/resources for funding testing and vaccinations – **ongoing**.	

	(Objective not met. Unable to implement as Drug and Alcohol Treatment Association Board of Directors are resistant to plan) • Develop a MHRH Physician Group with representatives from both departments by **July 2006**. • Joint facilitation of meetings with Insurers and Providers by **June 2007**. • A plan to activate ten sites to provide HAV and/or HBV vaccines by **2010.** **(Objective partially met. To date, eight sites have been identified.)** Pursue grants and/or other resources from CDC and other Federal agencies to fund vaccines **2008**.			

GOAL 4: INCREASE IN ACCESSIBILITY AND RESOURCES FOR THE PROVISION OF TESTING, CARE AND TREATMENT OF VIRAL HEPATITIS FOR SPECIALIZED POPULATIONS, SUCH AS HIGH-RISK INDIVIDUALS INCLUDING WOMEN, ADOLESCENTS, INFANTS, AND CHILDREN; INDIVIDUALS WHO ARE UNINSURED, UNDERINSURED, INCARCERATED, OR DISCHARGED FROM PRISON.

Objectives	Activities	Output/Products	Immediate Outcome (2005)	Long Term Outcome (2010)
4.1 Train CTR counselors to offer HCV counseling, testing, and referral by incorporating HCV testing into the CTR training by **December 2006**;	• Incorporate HCV testing training into the existing CTR counselor training by **December 2006**. **(Objective met)** • Develop a plan to activate ten sites to provide HCV screening and referral (5 sites in December 2006 and 5 more sites in December 2008). **(Objective partially met. Four (4) sites are being funded by the State beginning July 1, 2006 and four other sites are being funded through a research grant)** • Fund 10 sites to provide HCV screening and referral by **December 2010**. **(Objective partially met. Four (4) sites are being funded by the State beginning July 1, 2006 and and four other sites are**	• Establish a planning group with CTR trainer and HIV staff • CTR/HIV and HCV counselor training curriculum • Grants and resources written • Site plan for high risk individuals	• Develop a planning group to design the training for the HCV testing by **December 2006**.	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	being funded through a research grant) • Pursue grants and/or other resources from CDC and MHRH to fund sites annually by **2008**. • Develop HCV test site plan with high-risk community members (i.e. such as the "Bath Houses" and Injecting Drug User (IDU) venues by **December 2006**. **(Objective met)**			
4.2 Integrate perinatal hepatitis C prevention, testing and case management activities into HEALTH-RI's existing Perinatal Hepatitis Prevention Program (PHPP) by **December 2010.**	• Provide referral and medical management for women with HBV and/or HCV chronic infection by **January 2005.** **(Objective met)** Track all infants born to women with HBV and/or HCV chronic infection to ensure appropriate and timely immunoprophylaxis, testing and treatment of infants by **September 2005**.	• Memorandum of Understanding (MOU) for medical management referral services.	• Establish a provision plan for referral and medical management of women with HCV Chronic infection by • Establish a tracking system to ensure immunoprophylaxis, testing and treatment by	

GOAL 5: MAINTAIN EPIDEMIOLOGY FUNCTIONS INCLUDING CASE SURVEILLANCE, OUTBREAK DETECTION, CONTROL INTERVENTIONS, EVALUATION, PLANNING AND PUBLISHING DATA ON VIRAL HEPATITIS TO GUIDE POLICY AND PREVENTION INTERVENTIONS.

Objectives	Activities	Output/Products	Immediate Outcome (2006/7)	Long Term Outcome (2010)
5.1 The Surveillance Team by the Rhode Island Department of Health to publish an epidemiological profile on viral hepatitis A, B and C by **2005**;	• The Disease Control Representative will maintain case investigations of acute cases of Viral Hepatitis B and C on an on-going basis. **(Objective met and on-going)** • The Disease Control Representative and the National Electronic Telecommunications System for Surveillance (NETSS) Data Entry Clerk will maintain data entry of acute and chronic cases of Hepatitis B and C into NETSS and the Hepatitis Registry respectively on an on-going. **(Objective met and on-going)** • The National Electronic Disease Surveillance System (NEDSS) Coordinator will facilitate the transition from NETSS	• HCV lab reports will be recorded in Chronic Hepatitis Registry HBV and HCV. • Acute HBV and HCV will be reported into NETSS and transmitted weekly to CDC. • NEDSS software to be implemented and staff trained. • New database implemented • Protocol for HBV and HCV data entry written • Evaluation plan for HBV and HCV database established • HBV and HCV data analysis • Expanded HBV and HCV database implemented • Confidentiality forms completed • The epidemiologic report and other information/data	• The Disease Control Representative will maintain case investigations of acute cases of Viral Hepatitis B and C - **ongoing**. • The Disease Control Representative and the National Electronic Telecommunications System for Surveillance (NETSS) Data Entry Clerk will maintain data entry of acute and chronic cases of Hepatitis B and C into NETSS and the Hepatitis Registry respectively - **ongoing**. • The National Electronic Disease Surveillance System (NEDSS) Coordinator will facilitate the transition from NETSS to NEDSS by **June 2007**. • The staff epidemiologist will write a protocol for Viral Hepatitis B and	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	to NEDSS **June 2007**. • The staff epidemiologist will implement a new database (based on a review of databases used by other state health departments) for the entry of acute and chronic Viral Hepatitis B and C cases by **December 2006. (Objective not met)** • The staff epidemiologist will write a protocol for Viral Hepatitis B and C data entry by **December 2005**. **(Objective not met)** • The staff epidemiologist will construct an evaluation plan to evaluate the performance of the proposed chronic Viral Hepatitis B and C database **December 2005**.	pertaining to hepatitis will be utilized to guide policy and program development, implementation, evaluation and retention **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #3).** •	C data entry by **December 2006**. • The staff epidemiologist will construct an evaluation plan to evaluate the performance of the proposed chronic Viral Hepatitis B and C database by **December 2006**. • The staff epidemiologist will analyze, present and disseminate viral hepatitis surveillance data by **December 2006**. • The surveillance team will implement additional activities that allow for the collection of supplemental information for Viral Hepatitis B and C surveillance by **June 2007**. • Maintain current standards of security and confidentiality for Viral Hepatitis B and C data - **ongoing**.	

	(Objective not met) • The surveillance team will implement additional activities that allow for the collection of supplemental information for Viral Hepatitis B and C surveillance on an on-going basis by **June 2006.** **(Objective not met)** • Maintain current standards of security and confidentiality for Viral Hepatitis B and C data on an on-going basis. **(Objective met and on-going.)**			

2005/2006
Goals and Objectives

GOAL 1: REDUCTION IN THE TRANSMISSION OF VIRAL HEPATITIS A, B AND C THROUGH EDUCATION AND INCREASE IN THE NUMBER OF PREVENTIVE IMMUNIZATIONS FOR HEPATITIS A AND B AMONG ALL HIGH RISK INDIVIDUALS, ADULTS AND CHILDREN ALIKE.

Objectives	Activities	Output/Products	Immediate Outcome (2005/2006)	Long Term Outcome (2010)
1.1 Develop adult and high-risk adolescent Hepatitis A and B vaccination programs that have sites throughout the state by **2010**;	• A plan to provide linguistically, culturally and developmentally trained vaccine providers to serve high-risk adolescents by **May 2004**. **(Objective met)** • Provide training for HIV Prevention and CTR vendors, STD clinic and Methadone Treatment sites **December 2004. (Objective met)** • A plan to disseminate evidence-based best clinical performance guidelines and educate providers to assure compliance with health care statutes and regulations by **June 2006. (Objective met)** • Pursue grants and/or other resources from CDC, HEALTH-RI and MHRH to fund vaccines **2008**. • Develop HAV and/or	• Vaccine Plan • Community based high-risk vaccine site plan • 10 vaccine provided sites • Grants and/or Resources written	• Work Plan to implement a Hepatitis A & B Vaccination Plan by **December 2006.**	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	HBV vaccination plan with high-risk community members (i.e. such ads the "Bath Houses" and Injecting Drug Users (IDU) venues by **March 2006.** **(Objective met)** • A plan to activate ten community-based sites to provide HAV and/or HBV vaccines by **2010.** • Provide 10 sites with HAV and/or HBV vaccines **2010**. • A plan to determine if there is a 10% increase in Hepatitis A and B vaccines being given in Rhode Island by **2010**. • Establish an Adult Vaccination Registry by **2010**. • Develop a plan to obtain vaccination status of discharged Training School individuals by **2010**.			

GOAL 2: INCREASE THE UNDERSTANDING AND EDUCATION OF VIRAL HEPATITIS AMONG HEALTH CARE PROVIDERS, POLICY MAKERS AND THE GENERAL PUBLIC AND DECREASE THE CURRENT STIGMA ATTACHED TO HCV INFECTED INDIVIDUALS.

Objectives	Activities	Output/Products	Immediate Outcome (2005/2006)	Long Term Outcome (2010)
2.1 Develop a prevention of viral hepatitis marketing plan for the provider, policy maker and general public community by **December 2010**;	• Collaborate with Viral Hepatitis Advisory Group (VHAG) by **June 2004. (Objective met)** • Develop and Implement a Needs Assessment with health care providers, policy makers and general public by **December 2005. (Objective not met)** • Determine what information and dissemination strategies health providers, policy makers and public need and want by **March 2006**. **(Objective not met)** • Disseminate written viral hepatitis information to community-based organizations working with high-risk women and youth by **June 2006. (Objective met)** • Develop a plan to	• Needs assessment results • Viral hepatitis resource information/fact sheet at the State House on "Legislative Day" • Blast fax, media, website • Promote ongoing improvement in the quality of health care services and assure compliance with standards fro health care services **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #6).** • Provision of capacity building as needed for providers **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #7).**	• Organize a team to develop the health care providers, policy makers and general public needs assessment by **November 2005**. **(Objective not met)** • Implement an information/resource table at the State House on "Legislative Day" by **May 2005**. **(Objective met)** • Pursue a resolution from the RI General Assembly declaring May as Viral Hepatitis Month by **May 2005**. **(Objective met)** • Present RI's Comprehensive Strategic Plan for the Prevention and Control of Viral Hepatitis to CDC, community stakeholders and policymakers by **January 2006**. • Determination of information and dissemination	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	promote Viral Hepatitis prevention and treatment with the policy makers by **June 2006**. **(Objective partially met**. **A viral hepatitis awareness day was held at the State House)** • Develop a plan to promote Viral Hepatitis prevention and treatment with the providers by **June 2007.** **(Objective partially met. A Viral Hepatitis Resource and Services Directory was printed and mailed in January 2006.)**		strategies health care providers, policy makers and general public need and want by **June 2006**. **(Objective not met)** • Written viral hepatitis information will be disseminated to community-based organizations working with high-risk women and youth by **June 2006**. **(Objective met)**	
2.2 Identify the stigma attached to HCV through focus groups of HCV positive clients and their providers by **December 2010.**	• Develop Viral Hepatitis questions for focus groups by **December 2005**. **(Objective not met)** • Identify funding and/or resources for focus groups by **December 2005** **(Objective not met)** • Identify venue for presenting provider with results of focus groups by **2010**. **(Objective not met)** • Develop Viral	• Questions for focus groups on Website and other venues such as Wellness Connection and School of Nursing. • Grants and resources written	• Develop list of questions for focus groups by **December 2005.** **(Objective not met)** • Develop 1 or 2 questions for BRFSS by **December 2005**. **(Objective not met)** • Establish meetings between HEALTH-RI and Brown Medical School Research Dept. by **April 2006**. **(Objective not met)**	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	Hepatitis questions for the Behavior Risk Factor Surveillance Survey (BRFSS) conducted by HEALTH-RI by **December 2005**. **(Objective not met)** • Identify funding and/or resources for BRFSS by **December 2005 (Objective not met)** • Identify venue for presenting provider with results of BRFSS by **2010**.			
2.3 Provide annual professional development programs on viral hepatitis to health care providers by **December 2010**;	• Collaborate with Brown University Medical School to develop a medical education program by **June 2006**. **(Objective not met)** • Provide viral hepatitis education programs at "Grand Rounds" at area hospitals with emphasis on "birthing" hospitals by **2008**. **(Objective met. Dr. Degli Esposti and Dr. Leilekos have begun integrating viral hepatitis education into Grand Rounds at Hasbro and Women & Infants Hospitals)**	• Contractual agreement with medical education program • Yearly Professional Development Program on viral hepatitis • HBV and HCV segment for Bloodborne Pathogens Module • Viral Hepatitis Web page for providers • Grants and resources written • Annual HCV and HBV medical education strategy • Viral Hepatitis Center	• Develop and distribute toolkit for providers by **June 2006. (Objective not met)** • Establish viral hepatitis education program at "Grand Rounds" at area Birthing Hospitals by **December 2005 (Objective met)**. • Explore grants and resources – **ongoing.**	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	• Incorporate HBV/HCV risk behaviors into Bloodborne Pathogens Module by **2010.** • Develop a Viral Hepatitis Clinical Task Force **2006**. **(Objective met and on-going)** • Viral Hepatitis Professional Development Plan for providers (primary care physicians, nurse practitioners, physician assistants and school nurses) by **2007**. • HEALTH web page development by **January 2006. (Objective partially met. The Web page is in the process of being designed and should be accessible by September 30, 2006.)** • Identify funding for provider education by **2007.** • Identify venue for provider education by **2009.** • Establishment of Viral Hepatitis Center **2010**.			

2.4 Advocate for more access to medical care with at least 4 policy makers based on an action plan by **December 2005**;	• Develop a plan of action to foster advocacy between policy makers and VHAG members by **June 2004.** **(Objective met)** • Identify policy makers with interest in VHAG's agenda by **September 2004**. **(Objective met)** • Write a Single Overriding Health Communication Objective (SOHCO) (policy brief) by **December 2005**. **(Objective not met)**	• Action Plan • List of policy maker advocates • Publish Single Overriding Health Communication Objective (SOHCO)	• Write an action plan by **June 2005**. **(Objective met)** • Develop a List Serve of policy maker advocates by **September 2005**. **(Objective not met)** • Develop a Single Overriding Health Communication Objective (SOCHCO) by **December 2005**. **(Objective not met)**	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**
2.5 Train HIV prevention, substance use treatment facilities and other community based organizations staff to deliver primary and secondary prevention education by **December 2005**;	• Collaborate with RI Department of Mental Health, Retardation and Hospitals (MHRH) – Division of Behavioral Healthcare Services, Project REACH and Drug and Alcohol Treatment Association (DATA) by **June 2004**. **(Objective met)** • Provide a six-hour or longer cross training for integration into HIV Prevention, STI clinic, Substance Use/Methadone Treatment and prevention sites by	• Curriculum development team • 6 hour or longer curriculum and trainers • Certification process	• Cross training curriculum-planning team to continue – **on going**. • Deliver at least three trainings by **December 2005**. **(Objective met)**	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	December 2004. **(Objective met)** • Extend certification credits availability to prevention and treatment counselors by **December 2008**. • Include cross training issues on substance abuse, HIV, HCV and STI by **December 2004**. **(Objective met)**			
2.6 Provide perinatal Hepatitis B and C education and outreach to prenatal and pediatric providers by **December 2010.**	• Develop guidelines for identification, case management, treatment and referral of women and infants at risk of perinatal transmission **by 2010.** • Provide education at grand rounds at birthing hospitals by **December 2006**. **(Objective met)** • Assess ways to improve current reporting system (providers, labs, birthing hospitals) to identify women with HBV and/or HCV chronic infection by **2010**. • Include HCV related question to PRAMS (Pregnancy Risk Assessment Monitoring System) by	• Written guidelines • Educational plan • Identification Reporting plan • HCV Question written for PRAMS • Interdisciplinary meetings • Identify morbidity regarding Hepatitis A, B and C among pediatric cases **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #5).** • Promotion of healthy human development through immunization programs, education of providers and families regarding the risk factors of viral hepatitis **(as referenced in**	• Establish a provision plan for referral and medical management of women with HCV chronic infection by **March 2006**. **(Objective met)** • Establish a tracking system to ensure immunoprophylaxis, testing and treatment by **June 2006**.	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	December 2004. **(Objective met)** • Develop Prevention subcommittee work group to address pre-natal and pediatric issues by **December 2004**. **(Objective met)** • Collaborate with Women & Infants (W & I) Hospital to identify Hepatitis B & C positive pregnant women early in pregnancy by **December 2004**. **(Objective met)**	**HEALTH-RI Strategic Plan 2004-2010 Goal #5).**		

GOAL 3: PROVIDE GUIDELINES FOR LOCAL HEALTH CARE PROVIDERS AND CASE MANAGERS FOR IMPLEMENTING POLICIES AND PROCEDURES REGARDING TESTING AND MANAGEMENT OF VIRAL HEPATITIS B AND C OF HIGH-RISK INDIVIDUALS.

Objectives	Activities	Output/Products	Immediate Outcome (2005/2006)	Long Term Outcome (2010)
3.1 Collaborate with the Department of Corrections on case management and discharge planning for HCV positive inmates by **December 2006**;	• Establish relationship with DOC case management and HCV program by **March 2004.** **(Objective met).** • Identify health care providers who are willing to dedicate themselves to the care and/or treatment of HCV positive individuals upon release from prison by **December 2006.** • Develop a program that will ensure that the provider and inmate/patient will develop a relationship thereby reducing the fear of the provider having to deal with a "former inmate", increasing the likelihood that transitional care will be instituted (i.e. the patient understands his/her condition, the options available upon release, and what the	• Interagency meetings • Plan for servicing former inmates outside the Family Life Service area • Resource Directory • Promote ongoing improvement in the quality of health care services and assure compliance with standards for health care services **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #6).** • Engage the health care sector in preventing and controlling infectious diseases and building capacity of providers **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #7 and #8).** •	• Schedule interagency meetings between RIDOC and HCV program – **ongoing**. • Complete Resource and Services Directory by **April 2005**. **(Objective met)** • Distribute Resource and Services Directory by **December 2005**. **(Objective met)**	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	possible outcomes are by **2010**. • Develop a plan with DOC for HCV case management outside of the DOC Family Life Services area by **June 2006.** **(Objective partially met. A discharge planner at DOC has been identified and a plan will be developed shortly)** • Develop a program that resembles the Department of Corrections' HIV program whereby health care providers come into the prison to provide services that can be continued upon an inmate's release. This would involve providers applying for funding to provide such services by **2010**. • Development of a Viral Hepatitis Resource and Services Directory by **December 2004.** **(Objective met)**			
3.2 Collaborate with the Department of Mental Health, Retardation and Hospital's Division of Behavioral Healthcare Services (MHRH) to	• Develop a joint partnership to establish a collaborative work plan by **June 2003**. **(Objective met)**	• Curriculum development team • 6 hour or longer curriculum and trainers • Certification process • Physicians Group	• Continue meetings with cross training curriculum planning team – **ongoing**. • Provide three cross trainings by	

address and integrate HCV into the discipline of substance using and co-occurring disorders by **December 2010**.	• Implement a joint position paper to define roles and activities by **June 2003**. **(Objective met)** • Provide a joint presentation explaining initiative to New England Summer School for Addiction Studies by **July 2003**. **(Objective met)** • Develop e-mail/hard copy lists of names and addresses that both Offices can share by **December 2005**. • Include cross training issues on substance abuse, HIV, HCV and STI by **December 2004**. **(Objective met)** • Provide a six-hour or longer cross training for integration into HIV Prevention, STI clinic, Substance Use/Methadone Treatment and prevention sites by **December 2004**. **(Objective met)** • Extend certification credits availability to prevention and treatment counselors by **December 2008**.	• Insurers meeting • Vaccine Plan • 10 vaccine provided sites • Grants and/or Resources written	**December 2005**. **(Objective met)** • Establish and facilitate joint meetings with Health Care Insurers and Providers by **September 2006**. • Develop a vaccination plan by **December 2005**. **(Objective met)** • Develop a plan to integrate Hepatitis C testing in 5 HIV testing sites by **June 2006**. **(Objective met)** • Continue to explore and pursue grants/resources for funding testing and vaccinations – **ongoing**.	

	• Develop a MHRH Physician Group with representatives from both departments by **July 2006**. **(Objective not met)** • Joint facilitation of meetings with Insurers and Providers by **December 2005**. (**Objective not met but it is in the planning stages.)** • A plan to activate ten sites to provide HAV and/or HBV vaccines by **2010.** • Pursue grants and/or other resources from CDC and other Federal agencies to fund vaccines **2008**.			

GOAL 4: INCREASE IN ACCESSIBILITY AND RESOURCES FOR THE PROVISION OF TESTING, CARE AND TREATMENT OF VIRAL HEPATITIS FOR SPECIALIZED POPULATIONS, SUCH AS HIGH-RISK INDIVIDUALS INCLUDING WOMEN, ADOLESCENTS, INFANTS, AND CHILDREN; INDIVIDUALS WHO ARE UNINSURED, UNDERINSURED, INCARCERATED, OR DISCHARGED FROM PRISON.

Objectives	Activities	Output/Products	Immediate Outcome (2005/2006)	Long Term Outcome (2010)
4.1 Train CTR counselors to offer HCV counseling, testing, and referral by incorporating HCV testing into the CTR training by **December 2006**;	• Incorporate HCV testing training into the existing CTR counselor training by **December 2006**. **(Objective met)** • Develop a plan to activate ten sites to provide HCV screening and referral (5 sites in December 2006 and 5 more sites in December 2008). **(Objective partially met. Four (4) sites are being funded by the State beginning July 1, 2006 and other possible sites are being considered)** • Fund 10 sites to provide HCV screening and referral by **December 2010**. **(Objective partially met. Four (4) sites are being funded by the State beginning July 1, 2006 and other possible sites are being considered**	• Establish a planning group with CTR trainer and HIV staff • CTR/HIV and HCV counselor training curriculum • Grants and resources written • Site plan for high risk individuals	• Develop a planning group to design the training for the HCV testing by **December 2006**. **(Objective met)**	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	• Pursue grants and/or other resources from CDC and MHRH to fund sites annually by **2008**. • Develop HCV test site plan with high-risk community members (i.e. such as the "Bath Houses" and Injecting Drug User (IDU) venues by **December 2006**. **(Objective met)**			
4.2 Integrate perinatal hepatitis C prevention, testing and case management activities into HEALTH-RI's existing Perinatal Hepatitis Prevention Program (PHPP) by **December 2010.**	• Provide referral and medical management for women with HBV and/or HCV chronic infection by **January 2005.** **(Objective met)** • Track all infants born to women with HBV and/or HCV chronic infection to ensure appropriate and timely immunoprophylaxis, testing and treatment of infants by **September 2005**. **(Objective met)**	• Memorandum of Understanding (MOU) for medical management referral services.	• Establish a provision plan for referral and medical management of women with HCV Chronic infection by **January 2005.** **(Objective met)** • Establish a tracking system to ensure immunoprophylaxis, testing and treatment by **September 2005.** **(Objective met)**	

GOAL 5: MAINTAIN EPIDEMIOLOGY FUNCTIONS INCLUDING CASE SURVEILLANCE, OUTBREAK DETECTION, CONTROL INTERVENTIONS, EVALUATION, PLANNING AND PUBLISHING DATA ON VIRAL HEPATITIS TO GUIDE POLICY AND PREVENTION INTERVENTIONS.

Objectives	Activities	Output/Products	Immediate Outcome (2005/2006)	Long Term Outcome (2010)
5.1 The Surveillance Team by the Rhode Island Department of Health to publish an epidemiological profile on viral hepatitis A, B and C by **2005**;	• The Disease Control Representative will maintain case investigations of acute cases of Viral Hepatitis B and C on an on-going basis. **(Objective met and on-going)** • The Disease Control Representative and the National Electronic Telecommunications System for Surveillance (NETSS) Data Entry Clerk will maintain data entry of acute and chronic cases of Hepatitis B and C into NETSS and the Hepatitis Registry respectively on an on-going. **(Objective met and on-going)** • The National Electronic Disease Surveillance System (NEDSS) Coordinator will facilitate the transition from NETSS	• HCV lab reports will be recorded in Chronic Hepatitis Registry HBV and HCV. • Acute HBV and HCV will be reported into NETSS and transmitted weekly to CDC. • NEDSS software to be implemented and staff trained. • New database implemented • Protocol for HBV and HCV data entry written • Evaluation plan for HBV and HCV database established • HBV and HCV data analysis • Expanded HBV and HCV database implemented • Confidentiality forms completed • The epidemiologic report and other information/data	• The Disease Control Representative will maintain case investigations of acute cases of Viral Hepatitis B and C - **ongoing**. • The Disease Control Representative and the National Electronic Telecommunications System for Surveillance (NETSS) Data Entry Clerk will maintain data entry of acute and chronic cases of Hepatitis B and C into NETSS and the Hepatitis Registry respectively - **ongoing**. • The National Electronic Disease Surveillance System (NEDSS) Coordinator will facilitate the transition from NETSS to NEDSS by **June 2006**. **(Objective not met)** • The staff epidemiologist will implement a new	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	to NEDSS **June 2006**. **(Objective not met)** • The staff epidemiologist will implement a new database (based on a review of databases used by other state health departments) for the entry of acute and chronic Viral Hepatitis B and C cases by **December 2006. (Objective not met)** • The staff epidemiologist will write a protocol for Viral Hepatitis B and C data entry by **December 2005**. **(Objective not met)** • The staff epidemiologist will construct an evaluation plan to evaluate the performance of the proposed chronic Viral Hepatitis B and C database **December 2005**. **(Objective not met)** • The surveillance team will implement additional activities that allow for the collection of supplemental information for Viral	pertaining to hepatitis will be utilized to guide policy and program development, implementation, evaluation and retention **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #3).** •	database (based on a review of databases used by other state health departments) for the entry of acute and chronic Viral Hepatitis B and C cases by **December 2006**. • The staff epidemiologist will write a protocol for Viral Hepatitis B and C data entry by **December 2005**. **(Objective not met)** • The staff epidemiologist will construct an evaluation plan to evaluate the performance of the proposed chronic Viral Hepatitis B and C database by **December 2005**. **(Objective not met)** • The staff epidemiologist will analyze, present and disseminate viral hepatitis surveillance data by **December 2005**. **(Objective not met)** • The surveillance team will implement additional activities that allow for the collection of	

	Hepatitis B and C surveillance on an on-going basis by **June 2006.** **(Objective not met)** • Maintain current standards of security and confidentiality for Viral Hepatitis B and C data on an on-going basis. **(Objective met and on going.)**		supplemental information for Viral Hepatitis B and C surveillance by **June 2006**. **(Objective not met)** • Maintain current standards of security and confidentiality for Viral Hepatitis B and C data – **on going**.	

2004/2005
Goals and Objectives

GOAL 1: REDUCTION IN THE TRANSMISSION OF VIRAL HEPATITIS A, B AND C THROUGH EDUCATION AND INCREASE IN THE NUMBER OF PREVENTIVE IMMUNIZATIONS FOR HEPATITIS A AND B AMONG ALL HIGH RISK INDIVIDUALS, ADULTS AND CHILDREN ALIKE.

Objectives	Activities	Output/Products	Immediate Outcome (2004/2005)	Long Term Outcome (2010)
1.1 Develop adult and high-risk adolescent Hepatitis A and B vaccination programs that have sites throughout the state by **2010**;	• A plan to provide linguistically, culturally and developmentally trained vaccine providers to serve high-risk adolescents by **May 2004**. **(Objective met)** • Provide training for HIV Prevention and CTR vendors, STD clinic and Methadone Treatment sites **December 2004. (Objective met)** • A plan to disseminate evidence-based best clinical performance guidelines and educate providers to assure compliance with health care statutes and regulations by **June 2006.** • Pursue grants and/or other resources from CDC, HEALTH-RI and MHRH to fund vaccines **2008**. • Develop HAV and/or HBV vaccination plan	• Vaccine Plan • Community based high-risk vaccine site plan • 10 vaccine provided sites • Grants and/or Resources written	• Work Plan to implement a Hepatitis A & B Vaccination Plan by **December 2006.**	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	with high-risk community members (i.e. such ads the "Bath Houses" and Injecting Drug Users (IDU) venues by **March 2006.** • A plan to activate ten community-based sites to provide HAV and/or HBV vaccines by **2010.** • Provide 10 sites with HAV and/or HBV vaccines **2010**. • A plan to determine if there is a 10% increase in Hepatitis A and B vaccines being given in Rhode Island by **2010**. • Establish an Adult Vaccination Registry by **2010**. • Develop a plan to obtain vaccination status of discharged Training School individuals by **2010**.			

GOAL 2: INCREASE THE UNDERSTANDING AND EDUCATION OF VIRAL HEPATITIS AMONG HEALTH CARE PROVIDERS, POLICY MAKERS AND THE GENERAL PUBLIC AND DECREASE THE CURRENT STIGMA ATTACHED TO HCV INFECTED INDIVIDUALS.

Objectives	Activities	Output/Products	Immediate Outcome (2004/2005)	Long Term Outcome (2010)
2.1 Develop a prevention of viral hepatitis marketing plan for the provider, policy maker and general public community by **December 2010**;	• Collaborate with Viral Hepatitis Advisory Group (VHAG) by **June 2004. (Objective met)** • Develop and Implement a Needs Assessment with health care providers, policy makers and general public by **December 2005.** • Determine what information and dissemination strategies health providers, policy makers and public need and want by **March 2006**. • Disseminate written viral hepatitis information to community-based organizations working with high-risk women and youth by **June 2006.** • Develop a plan to promote Viral Hepatitis prevention and treatment with the	• Needs assessment results • Viral hepatitis resource information/fact sheet at the State House on "Legislative Day" • Blast fax, media, website • Promote ongoing improvement in the quality of health care services and assure compliance with standards fro health care services **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #6).** • Provision of capacity building as needed for providers **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #7).**	• Organize a team to develop the health care providers, policy makers and general public needs assessment by **November 2005**. • Implement an information/resource table at the State House on "Legislative Day" by **May 2005**. **(Objective met)** • Pursue a resolution from the RI General Assembly declaring May as Viral Hepatitis Month by **May 2005**. **(Objective met)** • Present RI's Comprehensive Strategic Plan for the Prevention and Control of Viral Hepatitis to community stakeholders and policymakers by **January 2006**. • Determination of information and dissemination strategies health care	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	policy makers by **June 2006**. • Develop a plan to promote Viral Hepatitis prevention and treatment with the providers by **June 2007.**		providers, policy makers and general public need and want by **June 2006**. • Written viral hepatitis information will be disseminated to community-based organizations working with high-risk women and youth by **June 2006**.	
2.4 Advocate for more access to medical care with at least 4 policy makers based on an action plan by **December 2005**;	• Develop a plan of action to foster advocacy between policy makers and VHAG members by **June 2004. (Objective met)** • Identify policy makers with interest in VHAG's agenda by **September 2004**. **(Objective met)** • Write a Single Overriding Health Communication Objective (SOHCO) (policy brief) by **December 2005**.	• Action Plan • List of policy maker advocates • Publish Single Overriding Health Communication Objective (SOHCO)	• Write an action plan by **June 2005**. **(Objective met)** • Develop a List Serve of policy maker advocates by **September 2005**. • Develop a Single Overriding Health Communication Objective (SOCHCO) by **December 2005**.	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**
2.5 Train HIV prevention, substance use treatment facilities and other community based organizations staff to deliver primary and secondary prevention education by **December**	• Collaborate with RI Department of Mental Health, Retardation and Hospitals (MHRH) – Division of Behavioral Healthcare Services, Project REACH and Drug and	• Curriculum development team • 6 hour or longer curriculum and trainers • Certification process	• Cross training curriculum-planning team to continue – on going. • Deliver at least three trainings by **December 2005**.	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

2005;	Alcohol Treatment Association (DATA) by **June 2004**. **(Objective met).** • Provide a six-hour or longer cross training for integration into HIV Prevention, STI clinic, Substance Use/Methadone Treatment and prevention sites by **December 2004**. **(Objective met)** • Extend certification credits availability to prevention and treatment counselors by **December 2008**. • Include cross training issues on substance abuse, HIV, HCV and STI by **December 2004**. **(Objective met)**			
2.6 Provide perinatal Hepatitis B and C education and outreach to prenatal and pediatric providers by **December 2010.**	• Develop guidelines for identification, case management, treatment and referral of women and infants at risk of perinatal transmission **by 2010.** • Provide education at grand rounds at birthing hospitals by **December 2006**. • Assess ways to improve current reporting system	• Written guidelines • Educational plan • Identification Reporting plan • HCV Question written for PRAMS • Interdisciplinary meetings • Identify morbidity regarding Hepatitis A, B and C among pediatric cases **(as referenced in**	• Establish a provision plan for referral and medical management of women with HCV chronic infection by **March 2006**. • Establish a tracking system to ensure immunoprophylaxis, testing and treatment by **June 2006**.	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	(providers, labs, birthing hospitals) to identify women with HBV and/or HCV chronic infection by **2010**. • Include HCV related question to PRAMS (Pregnancy Risk Assessment Monitoring System) by **December 2004**. **(Objective met)** • Develop Prevention subcommittee work group to address pre-natal and pediatric issues by **December 2004**. **(Objective met)** • Collaborate with Women & Infants (W & I) Hospital to identify Hepatitis B & C positive pregnant women early in pregnancy by **December 2004**. **(Objective met)**	**HEALTH-RI Strategic Plan 2004-2010 Goal #5).** • Promotion of healthy human development through immunization programs, education of providers and families regarding the risk factors of viral hepatitis **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #5).**		

GOAL 3: PROVIDE GUIDELINES FOR LOCAL HEALTH CARE PROVIDERS AND CASE MANAGERS FOR IMPLEMENTING POLICIES AND PROCEDURES REGARDING TESTING AND MANAGEMENT OF VIRAL HEPATITIS B AND C OF HIGH-RISK INDIVIDUALS.

Objectives	Activities	Output/Products	Immediate Outcome (2004/2005)	Long Term Outcome (2010)
3.1 Collaborate with the Department of Corrections on case management and discharge planning for HCV positive inmates by **December 2006**;	• Establish relationship with DOC case management and HCV program by **March 2004. (Objective met).** • Identify health care providers who are willing to dedicate themselves to the care and/or treatment of HCV positive individuals upon release from prison by **December 2006.** • Develop a program that will ensure that the provider and inmate/patient will develop a relationship thereby reducing the fear of the provider having to deal with a "former inmate", increasing the likelihood that transitional care will be instituted (i.e. the patient understands his/her condition, the options available upon	• Interagency meetings • Plan for servicing former inmates outside the Family Life Service area • Resource Directory • Promote ongoing improvement in the quality of health care services and assure compliance with standards for health care services **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #6).** • Engage the health care sector in preventing and controlling infectious diseases and building capacity of providers **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #7 and #8).** •	• Schedule interagency meetings between RIDOC and HCV program – **ongoing**. • Complete Resource and Services Directory by **April 2005**. **(Objective met)** • Distribute Resource and Services Directory by **December 2005**.	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	release, and what the possible outcomes are by **2010**. • Develop a plan with DOC for HCV case management outside of the DOC Family Life Services area by **June 2006.** • Develop a program that resembles the Department of Corrections' HIV program whereby health care providers come into the prison to provide services that can be continued upon an inmate's release. This would involve providers applying for funding to provide such services by **2010**. • Development of a Viral Hepatitis Resource and Services Directory by **December 2004.** **(Objective met)**			
3.2 Collaborate with the Department of Mental Health, Retardation and Hospital's Division of Behavioral Healthcare Services (MHRH) to address and integrate HCV into the discipline of substance using and co-occurring disorders by **December 2010**.	• Develop a joint partnership to establish a collaborative work plan by **June 2003**. **(Objective met)** • Implement a joint position paper to define roles and activities by **June 2003**. **(Objective met)**	• Curriculum development team • 6 hour or longer curriculum and trainers • Certification process • Physicians Group • Insurers meeting • Vaccine Plan • 10 vaccine provided sites • Grants and/or Resources written	• Continue meetings with cross training curriculum planning team – **ongoing**. • Provide three cross trainings by **December 2005**. • Establish and facilitate joint meetings with	

	• Provide a joint presentation explaining initiative to New England Summer School for Addiction Studies by **July 2003**. **(Objective met)** • Develop e-mail/hard copy lists of names and addresses that both Offices can share by **December 2005**. • Include cross training issues on substance abuse, HIV, HCV and STI by **December 2004**. **(Objective met)** • Provide a six-hour or longer cross training for integration into HIV Prevention, STI clinic, Substance Use/Methadone Treatment and prevention sites by **December 2004**. **(Objective met)** • Extend certification credits availability to prevention and treatment counselors by **December 2008**. • Develop a MHRH Physician Group with representatives from both departments by **July 2006**.		Health Care Insurers and Providers by **September 2006**. • Develop a vaccination plan by **December 2005**. • Develop a plan to integrate Hepatitis C testing in 5 HIV testing sites by **June 2006**. • Continue to explore and pursue grants/resources for funding testing and vaccinations – **ongoing**.	

	• Joint facilitation of meetings with Insurers and Providers by **December 2005**. • A plan to activate ten sites to provide HAV and/or HBV vaccines by **2010.** • Pursue grants and/or other resources from CDC and other Federal agencies to fund vaccines **2008**.			

GOAL 4: INCREASE IN ACCESSIBILITY AND RESOURCES FOR THE PROVISION OF TESTING, CARE AND TREATMENT OF VIRAL HEPATITIS FOR SPECIALIZED POPULATIONS, SUCH AS HIGH-RISK INDIVIDUALS INCLUDING WOMEN, ADOLESCENTS, INFANTS, AND CHILDREN; INDIVIDUALS WHO ARE UNINSURED, UNDERINSURED, INCARCERATED, OR DISCHARGED FROM PRISON.

Objectives	Activities	Output/Products	Immediate Outcome (2004/2005)	Long Term Outcome (2010)
4.1 Train CTR counselors to offer HCV counseling, testing, and referral by incorporating HCV testing into the CTR training by **December 2006**;	• Incorporate HCV testing training into the existing CTR counselor training by **December 2006**. • Develop a plan to activate ten sites to provide HCV screening and referral **(5 sites by December 2006 and 5 more sites by December 2008).** • Fund 10 sites to provide HCV screening and referral by **December 2010**. • Pursue grants and/or other resources from CDC and MHRH to fund sites annually by **2008**. • Develop HCV test site plan with high-risk community members (i.e. such as the "Bath Houses" and Injecting Drug User (IDU) venues by **December 2006**.	• Establish a planning group with CTR trainer and HIV staff • CTR/HIV and HCV counselor training curriculum • Grants and resources written • Site plan for high risk individuals	• Develop a planning group to design the training for the HCV testing by **December 2006**.	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

4.2 Integrate perinatal hepatitis C prevention, testing and case management activities into HEALTH-RI's existing Perinatal Hepatitis Prevention Program (PHPP) by **December 2010.**	• Provide referral and medical management for women with HBV and/or HCV chronic infection by **January 2005.** • Track all infants born to women with HBV and/or HCV chronic infection to ensure appropriate and timely immunoprophylaxis, testing and treatment of infants by **September 2005**.	• Memorandum of Understanding (MOU) for medical management referral services.	• Establish a provision plan for referral and medical management of women with HCV Chronic infection by **January 2005. (Objective met)** • Establish a tracking system to ensure immunoprophylaxis, testing and treatment by **September 2005.**	

GOAL 5: MAINTAIN EPIDEMIOLOGY FUNCTIONS INCLUDING CASE SURVEILLANCE, OUTBREAK DETECTION, CONTROL INTERVENTIONS, EVALUATION, PLANNING AND PUBLISHING DATA ON VIRAL HEPATITIS TO GUIDE POLICY AND PREVENTION INTERVENTIONS.

Objectives	Activities	Output/Products	Immediate Outcome (2004/2005)	Long Term Outcome (2010)
5.1 The Surveillance Team by the Rhode Island Department of Health to publish an epidemiological profile on viral hepatitis A, B and C by **2005**;	• The Disease Control Representative will maintain case investigations of acute cases of Viral Hepatitis B and C on an on-going basis. **(Objective met and on-going)** • The Disease Control Representative and the National Electronic Telecommunications System for Surveillance (NETSS) Data Entry Clerk will maintain data entry of acute and chronic cases of Hepatitis B and C into NETSS and the Hepatitis Registry respectively on an on-going. **(Objective met and on-going)** • The National Electronic Disease Surveillance System (NEDSS) Coordinator will facilitate the	• HCV lab reports will be recorded in Chronic Hepatitis Registry HBV and HCV. • Acute HBV and HCV will be reported into NETSS and transmitted weekly to CDC. • NEDSS software to be implemented and staff trained. • New database implemented • Protocol for HBV and HCV data entry written • Evaluation plan for HBV and HCV database established • HBV and HCV data analysis • Expanded HBV and HCV database implemented • Confidentiality forms completed • The epidemiologic report and other	• The Disease Control Representative will maintain case investigations of acute cases of Viral Hepatitis B and C - **ongoing**. • The Disease Control Representative and the National Electronic Telecommunications System for Surveillance (NETSS) Data Entry Clerk will maintain data entry of acute and chronic cases of Hepatitis B and C into NETSS and the Hepatitis Registry respectively - **ongoing**. • The National Electronic Disease Surveillance System (NEDSS) Coordinator will facilitate the transition from NETSS to NEDSS by **June 2006**. • The staff epidemiologist will implement a new	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	transition from NETSS to NEDSS **June 2006**. • The staff epidemiologist will implement a new database (based on a review of databases used by other state health departments) for the entry of acute and chronic Viral Hepatitis B and C cases by **December 2006.** • The staff epidemiologist will write a protocol for Viral Hepatitis B and C data entry by **December 2005**. • The staff epidemiologist will construct an evaluation plan to evaluate the performance of the proposed chronic Viral Hepatitis B and C database **December 2005**. • The surveillance team will implement additional activities that allow for the collection of supplemental information for Viral Hepatitis B and C surveillance on an on-going basis by **June**	information/data pertaining to hepatitis will be utilized to guide policy and program development, implementation, evaluation and retention **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #3).** •	database (based on a review of databases used by other state health departments) for the entry of acute and chronic Viral Hepatitis B and C cases by **December 2006**. • The staff epidemiologist will write a protocol for Viral Hepatitis B and C data entry by **December 2005**. • The staff epidemiologist will construct an evaluation plan to evaluate the performance of the proposed chronic Viral Hepatitis B and C database by **December 2005**. • The staff epidemiologist will analyze, present and disseminate viral hepatitis surveillance data by **December 2005**. • The surveillance team will implement additional activities that allow for the collection of supplemental information for Viral Hepatitis B and C	

	2006. • Maintain current standards of security and confidentiality for Viral Hepatitis B and C data on an on-going basis. **(Objective met and on-going.)**		surveillance by **June 2006**. • Maintain current standards of security and confidentiality for Viral Hepatitis B and C data **- ongoing**.	

2003/2004
Goals and Objectives

GOAL 1: REDUCTION IN THE TRANSMISSION OF VIRAL HEPATITIS A, B AND C THROUGH EDUCATION AND INCREASE IN THE NUMBER OF PREVENTIVE IMMUNIZATIONS FOR HEPATITIS A AND B AMONG ALL HIGH RISK INDIVIDUALS, ADULTS AND CHILDREN ALIKE.

Objectives	Activities	Output/Products	Immediate Outcome (2003/2004)	Long Term Outcome (2010)
1.1 Develop adult and high-risk adolescent Hepatitis A and B vaccination programs that have sites throughout the state by **2010**;	• A plan to provide linguistically, culturally and developmentally trained vaccine providers to serve high-risk adolescents by **May 2004**. **(Objective met)** • Provide training for HIV Prevention and CTR vendors, STD clinic and Methadone Treatment sites **December 2004.** • A plan to disseminate evidence-based best clinical performance guidelines and educate providers to assure compliance with health care statutes and regulations by **December 2005**. • Pursue grants and/or other resources from CDC and MHRH to fund vaccines **2008**. • Develop HAV and/or HBV vaccination plan with high-risk community members	• Vaccine Plan • Community based high-risk vaccine site plan • 10 vaccine provided sites • Grants and/or Resources written	• Diversity plan for vaccine providers by **May 2004. (Objective met)** • Sites where vaccines are administered to adolescents by **September, 2004**: Vaccinate Before You Graduate Program, Crossroads RI, RI Training School. **(Objective met)** • Cross-training plan and curriculum by **December 2004.**	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	(i.e. such ads the "Bath Houses" and Injecting Drug Users (IDU) venues by **December 2005.** • A plan to activate ten community-based sites to provide HAV and/or HBV vaccines by **2010.** • Provide 10 sites with HAV and/or HBV vaccines **2010**. • A plan to determine if there is a 10% increase in Hepatitis A and B vaccines being given in Rhode Island by **December 2010**. • Establish an Adult Vaccination Registry by **2010**. • Develop a plan to obtain vaccination status of discharged Training School individuals by **2010**.			

GOAL 2: INCREASE THE UNDERSTANDING AND EDUCATION OF VIRAL HEPATITIS AMONG HEALTH CARE PROVIDERS, POLICY MAKERS AND THE GENERAL PUBLIC AND DECREASE THE CURRENT STIGMA ATTACHED TO HCV INFECTED INDIVIDUALS.

Objectives	Activities	Output/Products	Immediate Outcome (2003/2004)	Long Term Outcome (2010)
2.1 Develop a prevention of viral hepatitis marketing plan for the providers, policy makers and general public community by **December 2010**;	• Collaborate with Viral Hepatitis Advisory Group (VHAG) by **June 2004. (Objective met)** • Develop and Implement a Needs Assessment with health care providers, policy makers and general public by **December 2005.** • Determine what information and dissemination strategies health providers, policy makers and public need and want by **March 2006**. • Disseminate written viral hepatitis information to community-based organizations working with high-risk women and youth by **September 2005.** • Develop a plan to promote Viral Hepatitis prevention and treatment with the	• Needs assessment results • Viral hepatitis resource information/fact sheet at the State House on "Legislative Day" • Blast fax, media, website	• Implement an information/resource table at the State House on "Legislative Day" in **May 2004. (Objective met)** • Develop a Viral Hepatitis Resource Fact sheet by **December 2004**. • Organize a team to develop the provider needs assessment by **March 2005.**	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	policy makers by **June 2006**. • Develop a plan to promote Viral Hepatitis prevention and treatment with the providers by **June 2007.**			
2.2 Identify the stigma attached to HCV through focus groups of HCV positive clients and their providers by **December 2010.**	• Develop Viral Hepatitis questions for the focus groups by **December 2005**. • Identify funding and/or resources for focus groups by **December 2005.** • Determine Focus group results by **December 2006**. • Identify venue for presenting providers with results of focus groups by **2010**.	• Questions for focus groups • Grants and resources written	• Explore grants and resources by **June 2005.**	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**
2.5 Train HIV prevention, substance use treatment facilities and other community based organizations staff to deliver primary and secondary prevention education by **December 2004**;	• Collaborate with RI Department of Mental Health, Retardation and Hospitals (MHRH) – Division of Behavioral Healthcare Services, Project REACH and Drug and Alcohol Treatment Association (DATA) by **June 2004**. **(Objective met).** • Provide a six-hour cross training for integration into HIV	• Curriculum development team • 6 hour curriculum and trainers • Certification process	Deliver at least one training by **December 2004.**	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	Prevention, STI clinic, Substance Use/Methadone Treatment and prevention sites by **December 2004**. • Extend certification credits availability to prevention and treatment counselors by **December 2005**. • Include cross training issues on substance abuse, HIV, HCV and STI by **December 2004**.			
2.6 Provide perinatal Hepatitis B and C education and outreach to prenatal and pediatric providers by **December 2010.**	• Develop guidelines for identification, case management, treatment and referral of women and infants at risk of perinatal transmission **by 2010.** • Provide education at grand rounds at birthing hospitals by **December 2006**. • Assess ways to improve current reporting system (providers, labs, birthing hospitals) to identify women with HBV and/or HCV chronic infection by **2010**. • Include HCV related question to PRAMS (Pregnancy Risk	• Written guidelines • Educational plan • Identification Reporting plan • HCV Question written for PRAMS • Interdisciplinary meetings	• HCV question for PRAMS written in **2004. (Objective met).** • Meetings between HEALTH-RI and W & I underway in **2004. (Objective met).** • Prevention Subcommittee Work group to address prenatal and pediatric issues by **December 2004.**	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	Assessment Monitoring System) by **December 2004**. • Develop Prevention subcommittee work group to address pre-natal and pediatric issues by **December 2004**. • Collaborate with Women & Infants (W & I) Hospital to identify Hepatitis B & C positive pregnant women early in pregnancy by **December 2004**.			

GOAL 3: PROVIDE GUIDELINES FOR LOCAL HEALTH CARE PROVIDERS AND CASE MANAGERS FOR IMPLEMENTING POLICIES AND PROCEDURES REGARDING TESTING AND MANANGEMENT OF VIRAL HEPATITIS B AND C HIGH-RISK INDIVIDUALS.

Objectives	Activities	Output/Products	Immediate Outcome (2003/2004)	Long Term Outcome (2010)
3.1 Collaborate with the Department of Corrections on case management and discharge planning for HCV positive inmates by **December 2006**;	• Establish relationship with DOC case management and HCV program by **March 2004. (Objective met).** • Identify health care providers who are willing to dedicate themselves to the care and/or treatment of HCV positive individuals upon release from prison by **June 2006.** • Develop a program that will ensure that the provider and inmate/patient will develop a relationship thereby reducing the fear of the provider having to deal with a "former inmate", increasing the likelihood that transitional care will be instituted (i.e. the patient understands his/her condition, the options available upon	• Interagency meetings • Plan for servicing former inmates outside the Family Life Service area • Resource Directory • Promote ongoing improvement in the quality of health care services and assure compliance with standards for health care services **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #6).** • Engage the health care sector in preventing and controlling infectious diseases and building capacity of providers **(as referenced in HEALTH-RI Strategic Plan 2004-2010 Goal #7 and #8).**	• Schedule interagency meetings between RIDOC and HCV program – **ongoing**. • Complete Resource and Services Directory by **April 2005**. • Distribute Resource and Services Directory by **June 2005**.	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	release, and what the possible outcomes are by **2010**. • Develop a plan with DOC for HCV case management outside of the DOC Family Life Services area by **June 2005.** • Develop a program that resembles the Department of Corrections' HIV program whereby health care providers come into the prison to provide services that can be continued upon an inmate's release. This would involve providers applying for funding to provide such services by **2010**. • Development of a Viral Hepatitis Resource Directory by **December 2004.**			
3.2 Collaborate with the Department of Mental Health, Retardation and Hospital's Division of Behavioral Healthcare Services (MHRH) to address and integrate HCV into the discipline of substance using and co-occurring disorders by **December 2010**.	• Develop a joint partnership to establish a collaborative work plan by **June 2003**. **(Objective met)** • Implement a joint position paper to define roles and activities by **June 2003**. **(Objective met)**	• Curriculum development team • 6 hour curriculum and trainers • Certification process • Physicians Group • Insurers meeting • Vaccine Plan • 10 vaccine provided sites • Grants and/or Resources written	• Meetings between MHRH and HCV program began in **2003.** **(Objective met).** • Joint position paper completed in **2003.** **(Objective met).** • Joint presentation provided in **2003.**	

	• Provide a joint presentation explaining initiative to New England Summer School for Addiction Studies by **July 2003**. **(Objective met)** • Develop e-mail/hard copy lists of names and addresses that both Offices can share by **July 2005**. • Include cross training issues on substance abuse, HIV, HCV and STI by **December 2004**. • Provide a six-hour cross training for integration into HIV Prevention, STI clinic, Substance Use/Methadone Treatment and prevention sites by **December 2004**. • Extend certification credits availability to prevention and treatment counselors by **December 2005**. • Develop a MHRH Physician Group with representatives from both departments by **July 2005**. • Joint facilitation of meetings with Insurers		**(Objective met).** • Registry of names and addresses of providers completed by **December 2004.** • Deliver at least one training by **December 2004.**	

	and Providers by **December 2005**. • A plan to activate ten sites to provide HAV and/or HBV vaccines by **2010.** • Pursue grants and/or other resources from CDC and other Federal agencies to fund vaccines **2008**.			

GOAL 4: INCREASE IN ACCESSIBILITY AND RESOURCES FOR THE PROVISION OF TESTING, CARE AND TREATMENT OF VIRAL HEPATITIS FOR SPECIALIZED POPULATIONS, SUCH AS HIGH-RISK INDIVIDUALS INCLUDING WOMEN, ADOLESCENTS, INFANTS AND CHILDREN; INDIVIDUALS WHO ARE UNINSURED, UNDERINSURED, INCARCERATED OR DISCHARGED FROM PRISON.

Objectives	Activities	Output/Products	Immediate Outcome (2003/2004)	Long Term Outcome (2010)
4.1 Train CTR counselors to offer HCV counseling, testing, and referral by incorporating HCV testing into the CTR training by **December 2006**;	• Incorporate HCV testing training into the existing CTR counselor training by **December 2005**. • Develop a plan to activate ten sites to provide HCV screening and referral **(5 sites in December 2005 and 5 more sites in December 2006).** • Fund 10 sites to provide HCV screening and referral by **December 2006**. • Pursue grants and/or other resources from CDC and MHRH to fund sites annually by **December 2006**. • Develop HCV test site plan with high-risk community members (i.e. such as the "Bath Houses" and Injecting Drug User (IDU) venues by **December 2005**.	• Establish a planning group with CTR trainer and HIV staff • CTR/HIV and HCV counselor training curriculum • Grants and resources written • Site plan for high risk individuals	• Organize a planning group by **June 2004**. **(Objective met).** • Develop a planning group to design the training for HCV testing by **June 2005**.	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

4.2 Integrate perinatal hepatitis C prevention, testing and case management activities into HEALTH-RI's existing Perinatal Hepatitis Prevention Program (PHPP) by **December 2010.**	• Provide referral and medical management for women with HBV and/or HCV chronic infection by **January 2005.** • Track all infants born to women with HBV and/or HCV chronic infection to ensure appropriate and timely immunoprophylaxis, testing and treatment of infants by **September 2005**.	• Memorandum of Understanding (MOU) for medical management referral services.	• Establish a Memorandum of Understanding (MOU) for medical management referral services for uninsured and under-insured women identified through the PHPP by **January 2005**. • Establish a Perinatal work group by **September 2004**.	

GOAL 5: MAINTAIN EPIDEMIOLOGY FUNCTIONS INCLUDING CASE SURVEILLANCE, OUTBREAK DETECTION, CONTROL INTERVENTIONS, EVALUATION, AND PLANNING AND PUBLISHING DATA ON VIRAL HEPATITIS TO GUIDE POLICY AND PREVENTION INTERVENTIONS.

Objectives	Activities	Output/Products	Immediate Outcome (2003/2004)	Long Term Outcome (2010)
5.1 The Surveillance Team by the Rhode Island Department of Health will publish an epidemiological profile on viral hepatitis A, B and C by **December 2005**;	• The Disease Control Representative will maintain case investigations of acute cases of Viral Hepatitis B and C on an on-going basis. • The Disease Control Representative and the National Electronic Telecommunications System for Surveillance (NETSS) Data Entry Clerk will maintain data entry of acute and chronic cases of Hepatitis B and C into NETSS and the Hepatitis Registry respectively on an on-going. • The National Electronic Disease Surveillance System (NEDSS) Coordinator will facilitate the transition from NETSS to NEDSS **June 2005**. • The staff epidemiologist will implement a new	• HCV lab reports will be recorded in Chronic Hepatitis Registry HBV and. • Acute HBV and HCV will be reported into NETSS and transmitted weekly to CDC • NEDSS software to be implemented and staff trained. • New database implemented • Protocol for HBV and HCV data entry written • Evaluation plan for HBV and HCV database established • HBV and HCV data analysis • Expanded HBV and HCV database implemented • Confidentiality forms completed	• The Disease Control Representative will maintain case investigations of acute cases of Viral Hepatitis B and C. • The Disease Control Representative and the National Electronic Telecommunications System for Surveillance (NETSS) Data Entry Clerk will maintain data entry of acute and chronic cases of Hepatitis B and C into NETSS and the Hepatitis Registry respectively. • The National Electronic Disease Surveillance System (NEDSS) Coordinator will facilitate the transition from NETSS to NEDSS by **June 2005**. • The staff epidemiologist will implement a new database (based on a	**To decrease the incidence of Viral Hepatitis A, B, and C by 2010.**

	database (based on a review of databases used by other state health departments) for the entry of acute and chronic Viral Hepatitis B and C cases by **December 2004.** • The staff epidemiologist will write a protocol for Viral Hepatitis B and C data entry by **December 2004**. • The staff epidemiologist will construct an evaluation plan to evaluate the performance of the proposed chronic Viral Hepatitis B and C database **June 2005**. • The surveillance team will implement additional activities that allow for the collection of supplemental information for Viral Hepatitis B and C surveillance on an on-going basis. • Maintain current standards of security and confidentiality for Viral Hepatitis B and C data on an on-going basis.		review of databases used by other state health departments) for the entry of acute and chronic Viral Hepatitis B and C cases by **December 2004**. • The staff epidemiologist will write a protocol for Viral Hepatitis B and C data entry by **December 2004**. • The staff epidemiologist will construct an evaluation plan to evaluate the performance of the proposed chronic Viral Hepatitis B and C database by **June 2005**. • The staff epidemiologist, with the assistance of the data manager, will analyze, present and disseminate viral hepatitis surveillance data by **June 2005**. • The surveillance team will implement additional activities that allow for the collection of supplemental information for Viral Hepatitis B and C	

			surveillance. • The surveillance team will hire a data manager (50%) by **January 2005**. • Maintain current standards of security and confidentiality for Viral Hepatitis B and C data.	

Needs, Gaps, Barriers, Challenges and Missed Opportunities:

1.In previous years, in recognition of a need for case management, the State of Rhode Island has funded AIDS Care Ocean State to establish a demonstration project to reduce the spread of HCV in Rhode Island. **Due to a lack of funding, this program has been discontinued.** In the past, HCV Care Coordination was implemented to work as part of the Harm Reduction treatment team in order to provide assistance in accessing resources for HCV testing and treatment to clients referred from the RI Department of Corrections, CODAC Behavioral Healthcare, ENCORE Syringe Exchange and other high-risk clients referred by HEALTH-RI. In the past three and a half years, the Care Coordinator, with her specialized population, has received approximately 500 referrals with only 79 individuals possessing health insurance. The Hepatitis C Coordinator/Program Manager has received telephone inquiries from hundreds of uninsured individuals seeking HCV information, testing and treatment from self-referral and/or other community agencies.
There is a need for case coordination /case management to assist with viral hepatitis prevention, but especially lacking is someone to assist individuals with counseling, referrals and follow-up.

2.Barriers to accessing care have been routinely encountered as many hepatitis C infected individuals are either uninsured or underinsured. The screening/testing sites for the uninsured are very limited but fortunately they are expanding (10 sites statewide are noted) yet treatment is very often unattainable. The dilemma occurs with Pharmaceutical companies willing to assist HCV positive individuals with the combination therapies for the HCV infection, yet the individual cannot access these medications because they are unable to access medical care and/or further testing. In addition to hepatitis medical follow up, other medications and mental health follow up are needed simultaneously and again uninsured and/or under insured are underserved.

3. Another challenge we have come across is the plight of the under-insured. These are Rhode Islanders who have some kind of medical coverage that may have a cap of $1,000 yearly or have a co-pay of 20% equaling $600 monthly for combination therapy meds ($3,000 monthly) alone. Again, one needs to add in the cost of ancillary medications and medical/mental health care. The total treatment with tests, biopsies and medications and medical care is estimated to be $27,000 a year.

4.Missed opportunities to vaccinate men having sex with men (MSM) have been demonstrated with the increase in specific social venues in the state and the shortage of effective interventions, such as vaccinations for HAV AND HBV, predispose MSM to unusually high risk of receiving and/or transmitting Hepatitis A and B. In October 2001, AIDS Project RI began administering Twinrix, HAV & HBV vaccines to gay men in an area bathhouse. From October 1, 2001 to June 30, 2006, 465 men were given 533 the first dose, 352 men were given their second dose, and 170 men received their third dose. It was also reported that almost 30% of the men tested for HBV core antibody are positive.

5. In October 2001, a program to administer Hepatitis B vaccines to Whitmarsh Specialty Clinic patients was established. Record keeping of administered vaccines was initiated as of February 1, 2002, and to date, the HBV vaccine has been offered to 3054 individuals and 1502 have received their first dose; 659 patients received the second dose; and 433 have received their third dose. Individuals who refused the vaccine either declined or asked to be given time to think about it and never returned. Again missed opportunities have occurred to identify persons at high risk of HBV and HCV due to various reasons, such as staff turn over and lack of continuity of information and the importance of HBV and HCV risk assessment. Also, the provision and access to counseling, testing and medical

services for HBV and HCV are not available to Clinic patients or the general public; thus only further hampering the accessibility of care and services the uninsured and underinsured.

6.To integrate the prevention of Viral Hepatitis among Rhode Island's most at-risk adolescents a five-year grant, administered jointly by CrossroadsRI (formerly known as Travelers Aid-RI) and HEALTH-RI's Immunization Program and the Division of Community Health and Equity (formerly known as Disease Prevention and Control) Hepatitis C Program was funded by the Centers for Disease Control and Prevention and has begun to serve this high-risk youth population but there is a definite need to reach high-risk adults to prevent the spread of viral hepatitis. Most adolescents are vaccinated for HBV through legislative mandates but the adults 24-33 years are falling through the cracks. These are the young adults who are experimenting with sex and drugs and yet they are unable to secure HAV/HBV vaccines even if they want them.

7.In 2003, RI Partners in Prevention and Care: Strengthening collaboration to address the issues of HIV, STDs, and Hepatitis among youth in the Juvenile Justice System was developed but strategies to provide access to prevention counseling, testing and medical care needs to be implemented. A joint collaboration between HEALTH-RI's Division of Disease Prevention and Control, Office of HIV & AIDS and RI's Mental Health, Retardation and Hospitals – Division of Behavioral Healthcare Services for the purpose of devising a work plan and curriculum to address the issues of substance use disorders and hepatitis C Virus cross-training for program staff and community based organizations has been developed. Strategies for funding for HCV prevention counseling, testing and access to care in all substance use treatment facilities, especially Methadone programs is of the essence. It is estimated that 90% of Methadone patients at CODAC Behavioral Healthcare (Substance Abuse Treatment Facility) are HCV positive. Again, missed opportunities to prevent further liver damage and/or chronic liver disease are pervasive, due to the lack of vaccine availability to those testing HCV positive. Joint meetings with CODAC Behavioral Healthcare staff have resulted in arrangements for the administration of Twinrix vaccine for HCV+ individuals - who have not previously been vaccinated or tested HBV core antibody+. HEALTH-RI furnished enough vaccine, donated by HEALTH-RI's Immunization Program as it was due to expire, to give 400 individuals a full 3-dose series. As of June 4, 2003 135 HCV+ individuals have been given their first dose, 85 have received their dose, and 3 have received their third dose. 8 individuals who are both HBV & HCV positive received the first doses of HAV vaccine.

8. A joint collaboration between RI Departments of Health and Corrections to promote the integration of Viral Hepatitis prevention, counseling and referral efforts within the corrections facility and upon discharge has begun, but expansion into case management upon discharge is vital to promote the prevention message as well as the access to medical care.

ACHIEVEMENTS:

Since the inception of the Viral Hepatitis Program in 2001 a total of 51 HIV/HCV Provider training modules have been developed and over 83 HCV-specific presentations have been provided to approximately 3173 individuals, including Physicians, Nurses, Social Service Providers, Substance Abuse Treatment Counselors, Hepatitis C+ individuals, Certified Nursing Assistants, Street Outreach workers/volunteers, high-risk adolescents and recovering Substance Disordered individuals/inmates. Informational literature packets were dispensed at each presentation.

A five-year grant, administered jointly by Crossroads-RI (formerly Travelers Aid-RI), the RI Department of Health's Divisions of Family Health - Immunization Program and Community, Health and Equity (formerly known as Disease Prevention and Control) - Viral Hepatitis Program to integrate the prevention of viral hepatitis among Rhode Island's most at-risk adolescents was funded by the Centers for Disease Control and Prevention and has begun to serve this high-risk population. Although they have made contact with over 5,000 high risk adolescents only 14 have received the first dose of HAV vaccine, 25 have received the first dose of HBV, 10 received the second dose and 1 received the third dose. The rate of immunization administration has increased since the beginning of 2005.

In October 2001, AIDS Project RI began administering Twinrix, HAV & HBV vaccines to gay men in an area bathhouse. To date 453 men were given the first dose, 284 men were given their second dose, and 136 men received their third dose. On their first visit, 314 men received Twinrix, 109 received HAV vaccine and 44 received HBV vaccine. At the second dosage, 255 men received Twinrix or HBV vaccine and 152 HAV vaccine (final dosage). On their third visit, 136 men received Twinrix or HBV. It was also reported that almost 30% of the men tested for HBV core antibody are positive.

A program to administer Hepatitis B vaccines to Whitmarsh Specialty Clinic clients was established. Statistics began being recorded as of 2-1-02, to date, the HBV vaccine has been offered to 3054 individuals and 1502 have received their first dose; 659 patients received the second dose; and 433 have received their third dose. Individuals nor procuring the vaccine either outright declined or chose to think about it and never returned.

Joint meetings with CODAC Behavioral Healthcare staff (Substance Abuse Treatment Facility) continue and arrangements for the administration of Twinrix vaccine for HCV+ individuals - who have not previously been vaccinated or tested HBV core antibody+ began on June 4, 2003. As of June 4, 2003 135 HCV+ individuals have been given their first dose, 85 have received their dose, and 3 have received their third dose. 8 individuals who are both HBV & HCV positive received the first doses of HAV vaccine.

A Viral Hepatitis Advisory Group has been convened with a membership of over 60 community-based partners. The group is made up of physicians, nurses, social workers, substance use treatment counselors, correction officials, and individuals infected with Hepatitis C from allover Rhode Island. The group has been assisting HEALTH-RI in formulating a strategic plan to coincide with Rhode Island's Healthy People 2010 Initiative, but without additional financial support we cannot proceed towards a comprehensive viral hepatitis prevention and treatment plan.

In 2002, a joint collaboration between the RI Departments of Health - Division of Health, Community and Equity (formerly known as Disease Prevention and Control), Office of HIV/AIDS and

Viral Hepatitis and the Mental Health, Retardation and Hospitals – Division of Behavioral Healthcare Services, Office of Substance Use Disorder for the purpose of devising a work plan and curriculum to address the issues of substance use disorders and hepatitis C Virus cross-training for program staff and community based organizations. In December 2004, the first two-day cross-training curriculum to address the issues of substance use, mental health and co-occurring disorders as well as viral hepatitis, HIV, TB and STDs for program staff and community-based organizations was presented and well received. Three trainings have been delivered in April and December 2005 and April 2006 since inception.

A joint collaboration between RI Departments of Health and Corrections to promote the integration of Viral Hepatitis prevention, counseling and referral efforts within the corrections facility and upon discharge has been established. The new Medical Director has begun to implement a HCV screening and HAV/HBV vaccination program. Facilitation and development of an Inter-agency work plan between the RI Department of Corrections and the Viral Hepatitis program on case management and discharge planning for HCV positive inmates has been developed but due staff changes at the Dept. of Corrections, it has to be re-introduced for implementation.

Development and implementation of HAV and/or HBV vaccination plan of action with high-risk community members, such as the "Adult Male Bath Houses", Injecting Drug User venues, and locations where HIV and HCV CTR (counseling, testing and referral) is being administered. The RI Department of Health has funded four sites for HCV testing and referral and is collaborating with Miriam Hospital, which is in the process of establishing four sites of their own. The RI Department of Health will be allocating vaccines for their at-risk and/or positive populations.

Development and implementation of a prevention of viral hepatitis marketing plan for providers working with high-risk women and youth.

Collaborated and partnered with the America Liver Foundation to implement an information/resource "Legislative Day" at the Rhode Island State House to disseminate information pertaining to Viral Hepatitis. Proclamations in both the House and the Senate were sponsored declaring, "May as Viral Hepatitis Awareness Month".

A collaboration of medical members of the Viral Hepatitis Advisory Group are partnering together to identify Hepatitis B and C positive pregnant women early in the pregnancy; hence, providing treatment to the women and their unborn children as well as newborns. They are also providing viral hepatitis education programs at "Grand Rounds" at area hospitals with emphasis on "birthing" hospitals.

A clinical task force has been established and is working on Clinical Guidelines for the Medical Management of Hepatitis C for all ages and populations.

A Viral Hepatitis Resource and Services Directory has been written and disseminated to physicians, nurse practioners, substance abuse counselors, school nurse teachers, and school health curriculums. This Directory contains name and addresses of treating physicians, information on websites, support groups, syringe exchange and substance use treatment facilities, and facts about viral hepatitis and HIV/HCV co-infection.

Hepatitis C Virus related questions have been introduced into PRAMS (Pregnancy Risk Assessment Monitoring System) and other questions are being written to be included in the BRFSS (Behavior Risk Factor Surveillance Survey).

A Viral Hepatitis forum was held in May 2003 with over 100 individuals in attendance, space was limited and several individuals were turned away. In November 2003 a Tri-State Regional Hepatitis Summit, in cooperation with the Departments of Health from Connecticut, Massachusetts, Rhode Island and the Hepatitis Foundation International was held with over 160 individuals were in attendance. But the need to integrate viral hepatitis prevention best practices, policies and educational materials into high- risk settings and training for health care professionals is enormous but the HCV team is small and cannot meet all the needs of the community.

RECOMMENDATIONS:

In summary, we need to adopt viral hepatitis prevention strategies to identify effective behavioral interventions to prevent chronic liver disease. We need to identify mechanisms to implement and monitor best practices and the integration of HAV and HBV vaccines availability to **all** individuals who are identified as high-risk or HCV infected. We need to identify means to integrate HBV and HCV protocols, as well as counseling, testing and treatment into high-risk venues/settings.

1. Rhode Island needs to frame the magnitude of the viral hepatitis problem.
   - To sustain surveillance activities to identify new and chronic cases and determine trends in the burden of disease.

2. RI needs to develop the capacity to enable everyone accessibility to medical care.
   - Provision of care for all Rhode Islanders, insured, uninsured and underinsured.
   - Accessibility and availability of preventative HAV and HBV vaccines for adults, testing, diagnosis and treatment of viral hepatitis infection including hepatitis medications and medications associated to counter side effects of said drugs.
   - Identification (testing) of HBV and HCV of all women during pregnancy.

3. RI needs to develop a program that resembles the Department of Corrections HIV program whereby health care providers go to the prison to provide services that can be continued upon an inmate's release.
   - A program such as this will better ensure that the provider and patient will develop a rapport/relationship, thereby reducing fear of the provider having to deal with a "former inmate" and increasing the likelihood that the inmate will access care upon release;
   - Facilitate continuity of care, ensure that a patient understands his/her condition, options available to him/her upon release, and what the possible outcomes are.

4. RI should consider universal screening in high prevalence areas such as the Department of Corrections.

5. RI needs to address the burden on providers to provide testing and medical care.
   - Need to address the financial burden on health centers, clinics, physicians, emergency rooms, etc.
   - Need to address the barriers inflicted by Medicaid, Medicare, Disability, Blue Cross/Blue Shield, United Healthcare and other private insurers
6. RI needs to develop statewide, community-based prevention programs, to include prevention education, counseling, and harm reduction activities, all targeting those individuals at highest risk for viral hepatitis infection.

7. RI needs to determine the health and economic benefits to the State if an effective infrastructure is built to reduce the spread of this virus and the risk of chronic liver disease.
   - Solicit support from policy makers regarding additional funding

Acknowledgements

A Comprehensive/Strategic Plan (the Plan) for viral hepatitis became a reality due to the dedication of key interested partners from a variety of organizations across the State who comprised the Viral Hepatitis Advisory Group, the Planning Group and the Working Group. Special Appreciation and credit goes to the members of the Planning Group and Working Group who devoted countless hours to developing ideas and recommendations that have been incorporated into the Plan.

Viral Hepatitis Prevention and Control Strategic Planning/Working Group Participants:

Hesham Aboshady
RI Department of Health

Dr. Scott Allen
RI Department of Corrections

Debbie Arduino
ROCHE Pharmaceuticals

Meredith Arnold
Hospital Association of RI

Carrie Blake
RICARES

Carol Browning
RI Department of Health

John Buonavolonta
Family Service of RI

Asya Cabral
RI Department of Corrections

James Carleton
CODAC Behavioral Healthcare

Kimberly Claytor
ROCHE Pharmaceuticals

Deborah Davis
RI Department of Corrections

Barbara DeCesare
American Liver Foundation

Dr. Sylvia Degli-Esposti
Women and Infants Hospital

Helen Drew
RI Department of Health

Kenneth Dupuis
Schering Oncology/Biotech

Linda Dziobek
Crossroads RI

Sherri A. Fernandes
AIDS Care Ocean State

Susan Ferreira
Kent County Hospital

Ronald Gonscak
AIDS Project RI

Dr. Syed Lftikhar Hussain
Thundermist Health Center

Richard Iadevaia
RI Department of Corrections

Joanne Johnson
RI Training School

Dr. Michelle Lally
Miriam Hospital

Charlene Lawless
Community Member

Cheryl Leclair
RI Department of Health

Cheryl Lopes
RI Department of Corrections

Lucille Minuto
RI Department of Health

Zoanne Parillo
RI Department of Health

Patricia Raymond
RI Department of Health

Beth Schwartzapfel
Miriam Hospital

Ryan Smith
MERCK/Vaccine Division

Alix Stockwood
AIDS Project RI

Patricia Threats
RI Department of Corrections

Elizabeth Trimmer-Kretchman
RI Department of MHRH

Paul Loberti
RI Department of Health

Dr. Dennis Mikolich
VA Medical Center

Lorraine Asselin Moynihan
RI Department of Health

Dr. Steven Peligian
CODAC Behavioral Healthcare

Midge Sabatini
RI Department of Education

Susan Shepardson
RI Department of Health

Lisa Smolski
RI Free Clinic

Lori Tetreault
Roger Williams Hospital

Cindy Tibert
VA Medical Center

James Wilsey
Roger Williams Hospital

Rhode Island Department of Health
Viral Hepatitis Advisory Group Members

Grace Accetta, RN
HIV Clinical Care Coordinator
Thundermist Health Center

Debbie Arduano, RN
Virology Specialist/Hepatology
ROCHE Pharmaceuticals

Meredith S. Arnold, RN
Hospital Emergency Preparedness Coordinator
Hospital Association of RI

Utpala Bandy, MD, MPH
State Epidemiologist/
Assistant Medical Director
RI Department of Health

Annemarie Beardsworth
Adult Immunization Coordinator
RI Department of Health

Becky Besette, RN
Chief of WIC and Immunization Program
RI Department of Health

Carrie Blake, Coordinator
RI Community for Addiction
Recovery Efforts (RICAREs)

Carol Browning, MS, RN
Community Health Nurse
RI Department of Health

James Carleton, MS
Director of Opioid Treatment Services
CODAC Behavioral Healthcare

Sutopa Chowdhury, MBBS, MPH
HIV/AIDS & HCV Epidemiologist
RI Department of Health

Patricia Cioe, RNP
HIV & HCV Clinic Nurse Practitioner
RI Hospital

Kimberly Claytor
Clinical Specialist
ROCHE Pharmaceuticals

Kim Conklin, RN
Hepatitis Case Manager
Gastro/Intestinal Adult Clinic
RI Hospital

James D'Ambra
CDC Liaison/Coordinator
Urban League of RI

Deborah Davis
Public Health Education Specialist
RI Department of Corrections

Silvia Degli-Esposti, MD, Director
Center for Women's Gastrointestinal Health
Women and Infants Hospital

Anne S. De Groot, MD
Director
TB/HIV Research Lab
Brown Medical School

Rep. Elizabeth M. Dennigan
RI Representative/District 62
RI State House

Helen Drew
Legislative Liaison
RI Department of Health

Rinchen-Tzo Emgushov, MD
Internal Medicine/Infectious Disease
Coastal Medical

Alan Epstein, MD
Department of Gastroenterology
Roger Williams Medical Center

Martha Weston Feldman, RNP
Department of Gastroenterology
Roger Williams Medical Center

Edward Feller, MD
Professor
Brown Medical School

Wenda Ferraioli, RN
Health Services Nurse
Community College of RI (CCRI)

Susan Ferreira
Perinatal Hepatitis B Case Manager
VNA of New England
Kent County Hospital

Paul Fitzgerald, MSW
Executive Director
AIDS Care Ocean State (ACOS)

Mary Jean Francis, MS, RN
Preventive Medicine Coordinator
Providence Community Heath Centers. Inc.

Melissa Murphy Gaitanis, MD
Miriam Hospital

David R. Gifford, MD
Medical Director
RI Department of Health

Amy Goldfarb, MD
Internal Medicine
Coastal Medical, Inc.

Ronald Gonscak
AIDS Project RI

Debra Kay Hebert
Community Member

Syed Iftikhar Hussain, MD
Adult Medicine Clinic
Thundermist Health Center

Richard Iadevaia
Public Health Education Specialist
RI Department of Corrections

Philip Kane
Title III Program Manager
Thundermist Health Center

Francine Knowles, RN
Professor of Nursing
Community College of RI (CCRI)

Myra Kerge
Coordinator
Viral Hepatitis Prevention Among
High Risk Youth
CrossroadsRI

Dr. Michelle Lally
Miriam Hospital

Vincent Lawler
State Legislative Director
Schering-Plough External Affairs

Charlene Lawless
Community Member

Cheryl Leclair
Family Planning Program Manager
RI Department of Health

Paul G. Loberti, MPH
Chief, Office HIV/AIDS & Viral Hepatitis
RI Department of Health

Cheryl Lopes, PhD
Public Health Education Specialist
RI Department of Corrections

Charlene Maguire
Executive Director
AGAPE Center

Mary Anne Miller, RNP
Chief of Primary Care
RI Department of Health

Carla Moreira
Brown University

Ezequiel Neimark, MD
Pediatric Liver Diseases
Hasbro Children's Hospital

Dr. Steven Peligian
Medical Director
CODAC Behavioral Healthcare

David Pugatch, MD
Pediatric Infectious Disease
Hasbro Children's Hospital

Elier Reyes
HIV/HCV CTR Coordinator
AIDS Care Ocean State (ACOS)

Midge Sabatini, RN, Ed.D
HIV/Sexuality Specialist
RI Department of Education

Ryan Smith
Senior Vaccine Specialist
MERCK & Co., Inc/Vaccine Division

Lisa Smolski
Executive Director
RI Free Clinic

Phyllis Losikoff, MD, MPH
Pediatric Infectious Director
RI Training School/
Hasbro Children's Hospital

Dennis Mikolich, MD
VA Medical Center

Lucille Minuto, RN, BSN
Asst. Chief, Office of HIV/AIDS
and Viral Hepatitis
RI Department of Health

Lorraine Asselin Moynihan, MA, MSW
Viral Hepatitis and HIV CTR Program Mgr.
RI Department of Health

Zoanne Parillo
Senior Disease Intervention Specialist
RI Department of Health

Michael Poshkus, MD
Medical Program Director
RI Department of Corrections

Patricia Raymond, RN
Perinatal Viral Hepatitis Program Manager
RI Department of Health

Josiah Rich, MD
Assistant Professor of Medicine and
Community Health (Research)
Brown University of Medicine
The Miriam Hospital

Susan Shepardson
Immunization Program
RI Department of Health

Kimly Soa
Comprehensive Community Action Program:
Family Health Services

Michael Stein, MD
Internal Medicine/HIV & HCV Clinic
RI Hospital

Alix Stockwood
Director of Client Services
AIDS Project RI

Lynn Taylor, MD
Assistant Professor of Medicine (Research)
Brown University School of Medicine
The Miriam Hospital

Cindy Tibert, RN, BSN
Nurse Epidemiologist
Veterans Administration Medical Center

Elizabeth Trimmer-Kretchman
Sr. Public Health Promotions Specialist
RI Department of Mental Health,
Retardation and Hospital
Division of Behavioral Healthcare

Vinnie Velazquez, BA
Program Director
MAP Program

James Wilsey
Chaplain
Roger Williams Medical Center

Alon Zephrani
Intervention Coordinator
Immunology Dept.
The Miriam Hospital