Successful Integration of Hepatitis Vaccination Services into Programs for High-Risk Adults

An Update of State-Based Programs

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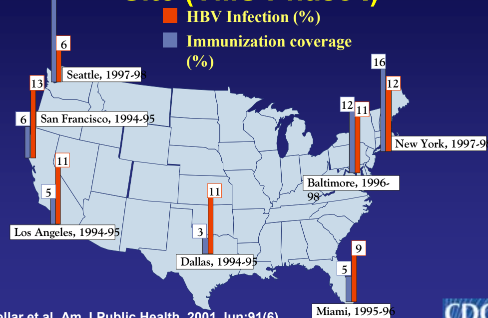
Outline

- Background
  - Why integration of vaccination services makes sense
  - National Hepatitis Prevention Strategy
  - State-based integration programs
- VHIP update
  - What are the successes?
  - Where do we go from here?

Why Integrate Hepatitis Prevention with Other Programs?

- Existing programs serve populations at risk for multiple infections, including viral hepatitis
- Routes of transmission overlap
- Without integration
  - Missed opportunities for prevention
  - Continued transmission of viral hepatitis

HBV Infection and Immunization Coverage, by Site (YMS Phase I)

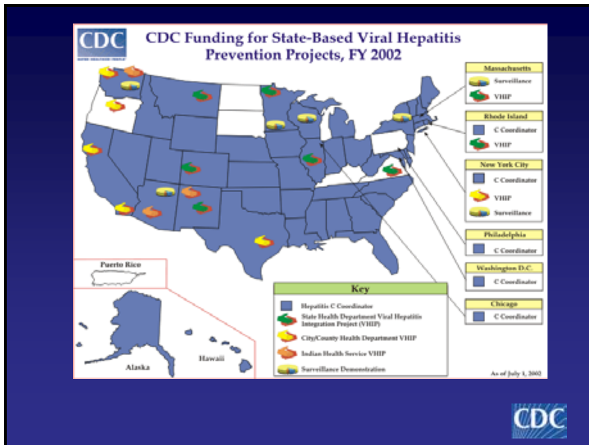


MacKellar et al. Am J Public Health. 2001 Jun;91(6).

National Hepatitis Prevention Strategy: State Model of Partnership in Prevention

CDC Funding for State-Based Hepatitis Integration Activities

- 1997: San Diego Hepatitis B Project
  - Integrating hepatitis B vaccination into STD clinic
- 1999: Viral Hepatitis Integration Projects
  - Seattle/King County
  - New York City
  - Austin/Travis County
- 2000: 15 VHIPs, 16 hep C coordinators
- 2001,02: 18 VHIPs, 48 coordinators
- 2003?



Viral Hepatitis Integration Projects: VHIP

Goals

- Determine the feasibility of integrating hepatitis prevention services into existing programs serving high risk populations
- Identify the most effective strategies and venues to reach and provide services to clients at high risk for hepatitis A, B, and C virus infections

CDC

VHIP – Primary Settings

- **STD Clinics**
  - San Diego
  - Colorado/Denver
  - Houston
  - Multnomah (OR)
  - NYC
  - Illinois
  - VA (HIV integrated)
- **HIV CT**
  - Erie County
  - Seattle/King Cty, WA
  - San Diego
  - Denver
- **Correctional Health**
  - Denver (jail)
  - Rhode Island (prison)
  - San Francisco (jail)
- **Substance Abuse**
  - Multnomah Cty
  - San Diego
  - New Mexico
  - IHS NCI, Thunderbird
- **Other**
  - MN, MT, MA, Phoenix

CDC

What Have the VHIPS Accomplished?

✓ ***Collaboration***

- **HIV, STD, epidemiology/communicable disease, immunizations**
- **Corrections**
- **Substance abuse**
- **Community Planning Groups**
- **Mental health**

✓ ***Staff training/cross-training***

✓ ***Protocols established***

VHIP – San Diego STD Clinic Hepatitis B Vaccination

2/98-1/01*

Eligible per month	**428**
Receive dose #1	**74%**
Receive dose #2	**53%**
Receive dose #3	**30%**

Total number of vaccines administered: 20,772

* **MMWR July 19, 2002**

CDC

VHIP – STD Clinic, IL Hepatitis A, B Vaccination

- Hepatitis A: (6 months)
  - 34/124 (27%) MSM dose 1
  - 63/153 (41%) IDU dose 1
- Hepatitis B: (12 months)
  - 5140/20,831 (25%) dose 1
  - 1829 (36%) dose 2
  - 612 (12%) dose 3

CDC

VHIP – STD Clinic, Denver Hepatitis B Vaccination

- 30,119 clients high risk* 8/99-3/02
- 9148 (30%) "screened"
  - 6132 "eligible"
    - 3856 (63%) accept referral for vaccine
    - 2024 (52%) get dose #1; 1832 (48%) walk out
    - 839 (41%) get dose #2, 353 (17%) #3
  - 2024/6132 (33%) dose #1
- 2024/20,180 est. eligible = 10% dose 1

* IDU, MSM, sex partner, h/o STD, >2 sex partners past 4 mos.

VHIP Colorado STD Clinic Experience

- Colorado barriers identified
  - Providers "too busy" to screen most clients for risk factors for hepatitis B
  - Referral, even down the hall, for vaccine – almost half who "accept" do not get vaccine
- Next steps
  - Offer vaccination for all clients, regardless of specific risk (>80% have risk!)
  - Provide immunization in STD clinic

VHIP HIV CTS Experience Seattle/King County

- 14 service sites - no staff to administer vaccine
- Mostly anonymous HIV testing – reminders, returns for vaccine doses a challenge
- Many MSM clients have private physicians; cannot track whether vaccine obtained elsewhere
- Data collection differs at different sites

Correctional Health Care Hepatitis Vaccination

- San Francisco Jail
  - Of 131 inmates getting dose #1, 88 (67%) received the second dose (6 month period).
- Denver Jail
  - Of 780 inmates seen in 12 month period,
  - 634 (81%) received hepatitis A dose #1;
  - 625 (80%) received hepatitis B dose #1 (at least 25% dose #2)

Correctional Health Care Hepatitis B Vaccination

Rhode Island womens' prison

8 month period

- 875 through intake
- 200 (23%) "already vaccinated"
- 74 (8%) "already had the disease"
- Of 601 eligible
  - 403 (67%) got dose #1
  - 84/403 (21%), dose #2
  - 29/84 (35%), dose #3

San Diego, Substance Abuse Hepatitis B Vaccination

10-20 months*

Site	No. eligible/ month	% Dose 1	% Dose 2	% Dose 3	Total Doses
Methadone Rx	34	44	53	40	290
Drug Rehab	56	36	40	35	700

* MMWR July 19, 2002

Other VHIP Substance Abuse Experience

- IL: 2 needle exchange programs (NEP) A/B combo vaccine available
- Seattle: NEP – immunization nurse ½ day
- NYC: hep C coordinator training NEP staff
- NM: risk reduction/NEP
- IHS: inpatient substance abuse treatment (Seattle); alcohol/drug detox (Gallup, NM)
- Multnomah: NEP, mobile vans (refer to STD for services)
- MT: inpatient drug rx program in Butte

Challenges to One-Stop Shopping in Substance Abuse Settings

- Wide variety of types of services (e.g., in/outpatient, street outreach)
  - NEP – brief encounters
  - Mobile vans, outreach – no clinical staff available
- Likelihood that pre-vaccination screening may be cost-effective; additional time, infrastructure for blood draw
- Lack of electronic data bases for tracking

What Have the VHIPS Accomplished?

Is Integration Feasible?

- STD clinics? Yes.
- HIV CTS? Depends.
- Corrections? Yes, challenging.
- Substance abuse services? ??

What Have the VHIPS Accomplished?

Have we identified the most effective strategies and venues for reaching and providing services to clients at high risk for hepatitis A, B, C?

Most Effective Strategies and Venues?

- Staff education, training, "buy in" for "one dose better than none" attitude
- Combination A/B vaccine (3 vs 5)
- Flexible schedules (0, 1-2, 4-6)
- Shared data systems as clients access different points-of-contact
- Targeting and outreach for MSM, IDU

Most Effective Strategies and Venues?

- STD clinics
  - Existing clinical infrastructure can work
- HIV CTS (non-clinical sites) more challenging
- Corrections settings appear excellent venues for accessing high risk clients, especially IDUs
- Substance abuse prevention, treatment
  - Limited experience thus far; wide variety of setting types

VHIP Barriers Expected

- Lack of money for adult vaccine
- Lack of money for hepatitis C testing
- Lack of referral mechanisms and access for persons identified with chronic HBV or HCV infection
- Separate funding streams
- Politics and turf

Additional VHIP Barriers Identified

- Data systems for tracking/evaluation
- Lack of standard outcome measures; adherence to current guidelines
- Time with client; competing priorities
- One-stop shopping requires multi-talented (trained) staff
- On-site logistics for vaccine administration (licensed staff, storage)
- Administrative/legislative: hiring freezes, legal issues (e.g., parental consent for under-18)

Integrating prevention services for viral hepatitis, HIV/AIDS, STDs, and substance abuse is

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What can WE do?

- Look for opportunities to
  - Collaborate
  - Build on existing strengths
  - Cross train staff
- Navigate turf and funding issues
- Help communicate recommendations
  - MMWRs; ACIP Guidelines
  - 2002 STD Rx Guidelines
- Report and share experiences