

2022 Viral Hepatitis Surveillance Status Report Briefing

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- **Main point of contact for jurisdictions**
- Engaged in data collection activities
- Provided tech support to jurisdictions on completing the survey
- Analyzed data for dissemination

Project Advisors



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Director, Hep B United
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Agenda

Welcome & Introductions

Concept Overview

Report Review

Report for Advocacy

Q&A

Concept Overview

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Surveillance Status Report

- Develop an annual viral hepatitis (B & C) surveillance status report to:
 1. Assess how jurisdictions across the U.S. are measuring the impact of viral hepatitis on their communities
 2. Identify best practices
 3. Highlight areas in need of additional resources
- First report focused on 2021, before expansion of CDC funding, and presented findings from jurisdictions' answers to a survey of about 15 indicators

Surveillance Status Report 1.0

The inaugural version of the Surveillance Status Report had 4 main goals:

- Benchmark the state of viral hepatitis surveillance in the U.S. prior to funding dissemination,
- Establish a baseline to monitor changes over time as additional resources are allocated,
- Assess how jurisdictions across the U.S. are measuring the impact of viral hepatitis on their communities, and
- Highlight areas in need of additional resources.

Surveillance Status Report 2.0

The 2.0 survey worked toward those goals by expanding information about:

- Case investigation activities,
- Data matching,
- Elimination plans/goals,
- Disparities,
- Dedicated capacity, and
- Funding sources.

Concept

Why?

A lack of robust surveillance data limits the ability to:

- Monitor disease burden and related disparities
- Track changes in the viral hepatitis epidemic
- Mount effective public health responses
- Eliminate viral hepatitis in the U.S.

Why Now?

Monitor practices before and after expanded CDC funding:

- In 2021, CDC released expanded surveillance funding
- The report will allow policy makers and other stakeholders to benchmark current capacity
- Annually, it will monitor changes over time

How?

With a steering committee, we:

- Developed a set of indicators for assessing surveillance practices in jurisdictions
- Collected data from jurisdictions on these indicators, analyzed the results, & prepared a status report

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Anne Gaynor, PhD	Association of Public Health Laboratories
Colleen Flanigan	New York State Department of Health
Danica Kuncio, MPH	Philadelphia Department of Public Health
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Kate Moraras, MPH	Hepatitis B Foundation; Hep B United
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Lindsey Sizemore, MPH, CPH	Tennessee Department of Health
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Nicola D. Thompson, PhD	Centers for Disease Control and Prevention
Prabhu Gounder, MD, MPH	LA County Department of Public Health
Risha Irvin	Johns Hopkins University School of Medicine
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Sonia Canzater, MPH, JD	O'Neill Institute, Georgetown University Law Center
Stacey Trooskin, MD, PhD, MPH	Philadelphia FIGHT; Perelman School of Medicine, University of Pennsylvania
Tyler Bartholomew, PhD	IDEA Exchange; University of Miami

Report Review

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Data Methods

- 92% response rate on electronic survey of 59 jurisdictions
- 12 months of 2022
- Emory analyzed data, prioritized findings to highlight in report with steering committee
- Comparisons by:
 - Received prior viral hepatitis funding (pre-2021)
 - Full-time employee dedicated to viral hepatitis (1 or more)
 - Region

Surveillance introduction

Why Surveillance?

Viral Hepatitis Surveillance Vision

Viral hepatitis surveillance programs need to be expanded to help ensure effective prevention and treatment of hepatitis infections.

Collecting information through surveillance can help us to answer questions like:



How many people have current, diagnosed viral hepatitis infections?



How many people have received treatment for hepatitis C? How many people need treatment for hepatitis C? Which groups of people are most in need of treatment for hepatitis C? How many people have achieved sustained virologic response (SVR) or have been cured of their chronic hepatitis C infection?



What are the characteristics of people living with, and who have increased chances of getting, a viral hepatitis infection?

A robust viral hepatitis surveillance system can help us to understand:

- ✓ The burden of viral hepatitis
- ✓ Which groups of people have increased chances of getting viral hepatitis infections
- ✓ How many people need care and treatment for viral hepatitis
- ✓ Inequities in hepatitis care and treatment



Findings in this report reveal what **kinds of viral hepatitis surveillance practices are happening in jurisdictions across the U.S.**, how practices are progressing over time, where gaps exist, and what resources are needed.

Setting the stage

2022 Program Funding

HIV Surveillance
& Prevention Funding
About \$400M*

Viral Hepatitis Surveillance
& Prevention Funding
About \$25.7M**

*<https://www.cdc.gov/hiv/pdf/funding/announcements/ps18-1802/cdc-hiv-ps18-1802-annual-funding-amounts.pdf>
**https://www.cdc.gov/hepatitis/policy/2103_CoAg-FundingAmounts.htm

HIV: An Example of Robust Surveillance

National HIV surveillance provides an illustrative example of effective surveillance practices and how surveillance can be used for prevention and treatment.

HIV surveillance consists of complementary systems to capture information about people living with HIV or an increased chance of getting an HIV infection. **These systems have capacity for data sharing and matching and provide information that allow us to understand characteristics of people that are:**



Diagnosed with HIV



At increased risk for acquiring HIV



Receiving care and treatment for HIV

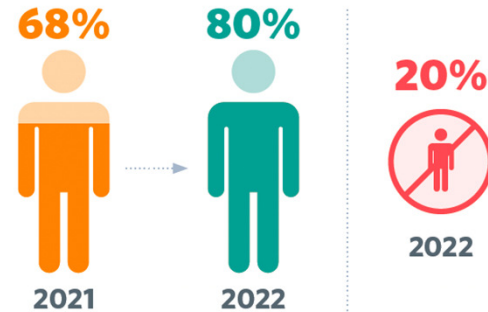


In need of prevention, care, and treatment for HIV

Overview

Jurisdictions with full-time employee dedicated to viral hepatitis surveillance

Though the number of jurisdictions with a full-time employee (FTE) dedicated to viral hepatitis surveillance increased from 68% in 2021 to 80% in 2022, 1/5 (20%) still did not have dedicated staffing in 2022.



Jurisdictions believe they need 3-5 FTEs to conduct viral hepatitis surveillance

To conduct viral hepatitis surveillance activities specified under CDC IVHSP, jurisdictions report that on average, they believe 3-5 full-time employees (FTE) are necessary.



Elimination



Jurisdictions with viral hepatitis elimination plans increased from 24 (43%) in 2021 to 38 (70%) in 2022.
However, only 35% have public elimination plans, and 54% are implementing elimination plans.



In 2022, **only 30% of jurisdictions had capacity to make progress toward elimination goals**, and **33% had capacity to measure progress toward those goals.**



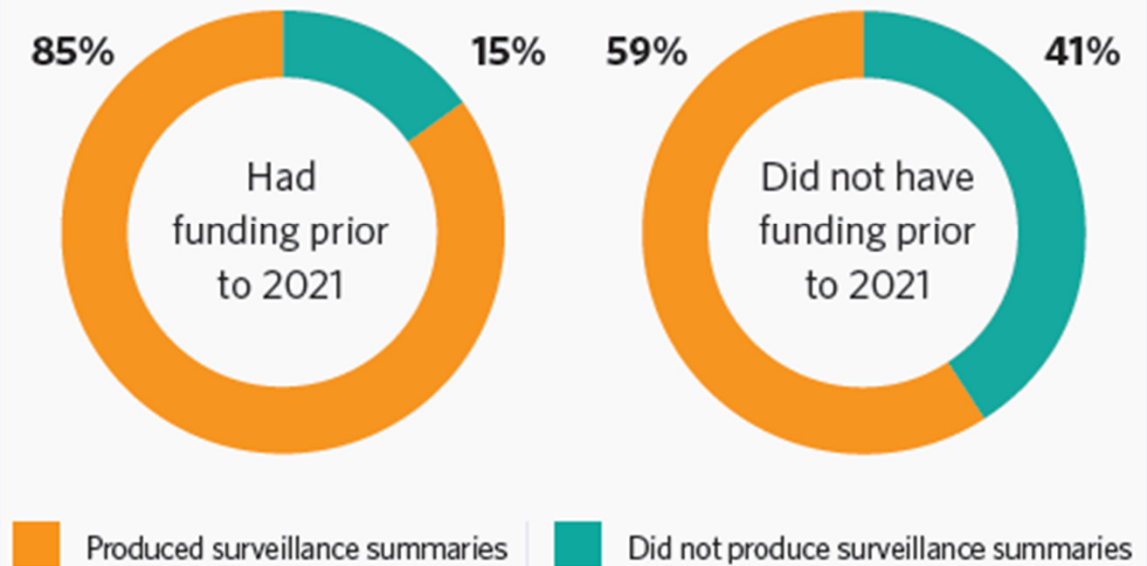
Only 3% of jurisdictions said they could make progress toward elimination goals at current levels of CDC funding for hepatitis surveillance.

Data Dissemination

- Jurisdictions producing viral hepatitis annual surveillance summaries **increased from 55% in 2021 to 65% in 2022**
- Almost **1/3 (35%)** of jurisdictions still **did not produce annual surveillance summaries** in 2022

Data Dissemination by Funding

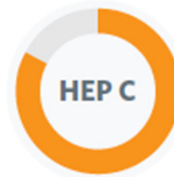
Viral Hepatitis Surveillance Summaries Status by Funding



Case Estimates & Prevalence

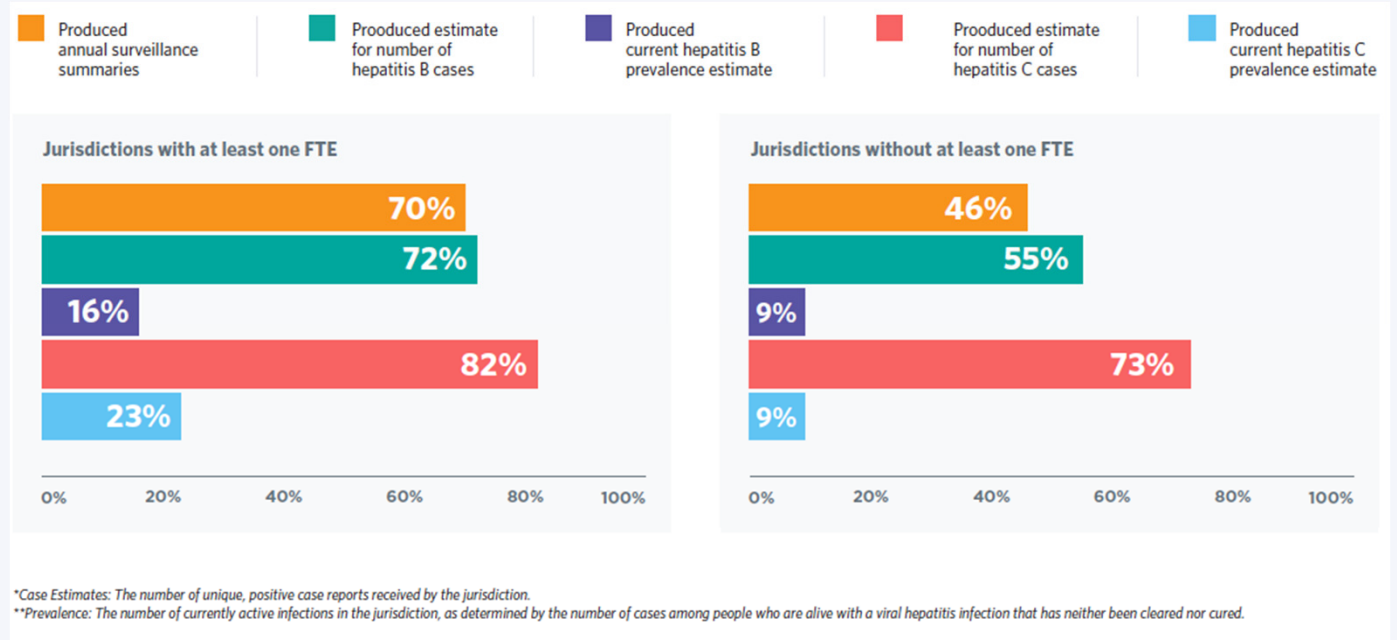


69% of jurisdictions produced annual estimates for the number of hepatitis B cases in 2022, but only 15% produced hepatitis B prevalence estimates.



83% of jurisdictions produced annual estimates for the number of hepatitis C cases in 2022, but only 20% produced hepatitis C prevalence estimates.

Case Estimates & Prevalence by Staffing



Case Investigation & Contact Tracing



Overall, case investigation capacity remained the same over time. In 2021, 80% of jurisdictions either reviewed medical records or contacted healthcare providers for suspected acute (new) hepatitis B infections, while 79% did so in 2022.

And although nearly half (49%) of jurisdictions reported doing any contact tracing for people with suspected or probable acute (new) hepatitis B cases, only 19% of jurisdictions contacted people potentially exposed for more than 50% of acute cases.



Overall, case investigation capacity remained the same over time. In 2021, 71% of jurisdictions either reviewed medical records or contacted healthcare providers for suspected acute (new) hepatitis C infections, while 72% did so in 2022.

And although nearly half (46%) of jurisdictions reported doing any contact tracing for people with suspected or probable acute (new) hepatitis C, only 11% contacted people potentially exposed for more than 50% of acute cases.

Pregnancy Status Data



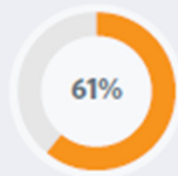
About 40% of infants born to pregnant people living with hepatitis B will develop chronic hepatitis B, yet pregnancy status was considered a reportable condition for hepatitis B for only 71% of jurisdictions.



As of April 2020, CDC recommends prenatal care providers screen all pregnant persons for hepatitis C. However, pregnancy status was considered a reportable condition for hepatitis C for only 46% of jurisdictions.

Health Disparities Data

Percentage of jurisdictions that have adequate data to assess and address viral hepatitis disparities by:



Risk factor (e.g. people who inject drugs)



Race/Ethnicity



Urbanicity



Sexual orientation and gender identity



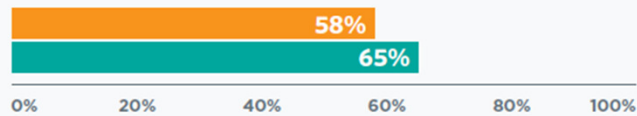
Birthplace

Health Disparities Data by Staffing & Funding

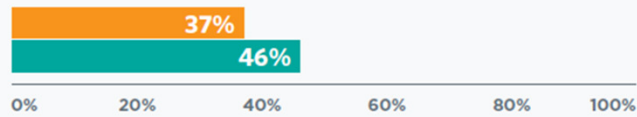
Health Disparities Data by Dedicated Staffing

Jurisdictions with funding and resources for at least one full-time employee (FTE) dedicated to viral hepatitis surveillance were more likely to have adequate data to assess and address health disparities.

Had at least one FTE



Did not have at least one FTE



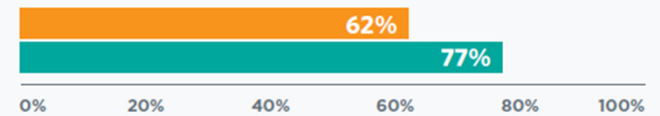
Yes, by race/ethnicity Yes, by risk factor*

*e.g. people who inject drugs

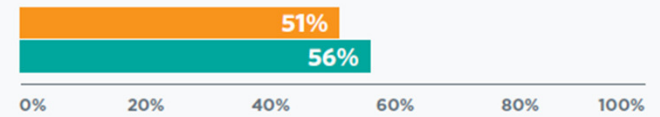
Health Disparities Data by Funding

Jurisdictions with funding prior to 2021 are more likely to have adequate data to assess and address health disparities.

Had funding prior to 2021



Did not have funding prior to 2021



Yes, by race/ethnicity Yes, by risk factor*

Syndemic Data Matching

The number of jurisdictions that conducted any data matching with viral hepatitis surveillance records increased from 68% in 2021 to 83% in 2022.



only 60% of jurisdictions matched viral hepatitis case reports with HIV surveillance data.



Only 37% of jurisdictions matched viral hepatitis case reports with STD surveillance data.

Summary points

- Jurisdictions undertaking many critical viral hepatitis surveillance activities with limited resources
- Data suggest prior funding and having at least 1 FTE dedicated to surveillance activities improves capacity substantially
- Recommendations
 - Invest in infrastructure
 - Increase federal and state funding
 - Target surveillance resources
 - Prioritize dedicating resources toward health disparities data collection and analysis

Next Steps

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Concept

How We'll Use & Promote

- User-friendly report
- Advocacy overview
- Infographics
- Q&A blogs
- Partner amplification for advocacy efforts

HepVu  NASTAD 

2022 Viral Hepatitis Surveillance Status Report

An assessment of the status of viral hepatitis surveillance practices across U.S. jurisdictions in 2022.

Released November 2023

An estimated **2.4 million** people in the U.S. are living with hepatitis C infection, and up to **2.2 million** people could be living with hepatitis B in the U.S. The need for expanded, standardized, and reliable viral hepatitis surveillance continues to impact public health efforts, resources, and the response across the U.S. to this epidemic. A lack of robust surveillance data limits the ability to:

- Monitor the disease burden and related disparities
- Track changes in the epidemic
- Mount effective public health responses
- Eliminate the hepatitis C epidemic in the U.S.

In 2021, the Centers for Disease Control and Prevention (CDC) **released funding** for viral hepatitis surveillance across 59 jurisdictions. Prior to 2021, only 14 states received federal funding specifically for viral hepatitis surveillance. This 2022 update to the 2021 inaugural viral hepatitis surveillance status report builds on the benchmarked state of viral hepatitis surveillance in the U.S. prior to funding dissemination, monitors initial changes over time as additional resources were allocated, assesses how jurisdictions across the U.S. are measuring the impact of viral hepatitis on their communities, and highlights areas where additional resources are needed.

Why Surveillance?

Viral Hepatitis Surveillance Vision

Viral hepatitis surveillance programs need to be expanded to help ensure effective prevention and treatment of hepatitis infections. **Collecting information through surveillance can help us to answer questions like:**

- How many people have current, diagnosed viral hepatitis infections?
- What are the characteristics of people living with, and who have increased chances of getting, a viral hepatitis infection?
- How many people have received treatment for hepatitis C? How many people need treatment for hepatitis C? Which groups of people are most in need of treatment for hepatitis C? How many people have achieved sustained virologic response (SVR) or have been cured of their chronic hepatitis C infection?

A robust viral hepatitis surveillance system can help us to understand:

- The burden of viral hepatitis
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- Inequities in hepatitis care and treatment

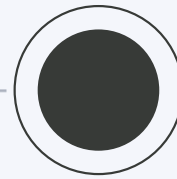
Findings in this report reveal what kinds of viral hepatitis surveillance practices are happening in jurisdictions across the U.S., how practices are progressing over time, where gaps exist, and what resources are needed.

Tentative Timeline



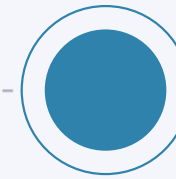
Oct.

- Finalizing Report
- Brief Stakeholders



Nov.

- Launch
- Promote



Dec.

- Start Next Survey

Using the Report for Viral Hepatitis Advocacy

Frank Hood, MPS
Hepatitis B Foundation
Hep B United

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Using the Report for Hepatitis B Advocacy

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Director
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Current Landscape

- 2.4 million living with hepatitis B in U.S.
- COVID impacted hepatitis B screening
 - ~20,000-22,000 new acute cases per year pre-COVID
 - Rate of acute hepatitis B abruptly decreased during 2020 and again decreased by 14% from 2020 to 2021.
- Disproportionately impacted populations include Asian Americans, African Immigrants, Native Hawaiians, Pacific Islanders, and people who use drugs.
- Untreated hepatitis B can lead to liver cancer
 - Liver cancer rates only recently started to decline
- Recent regulation changes seek to improve hepatitis B screening and vaccination rates.



Setting Up States To Fail

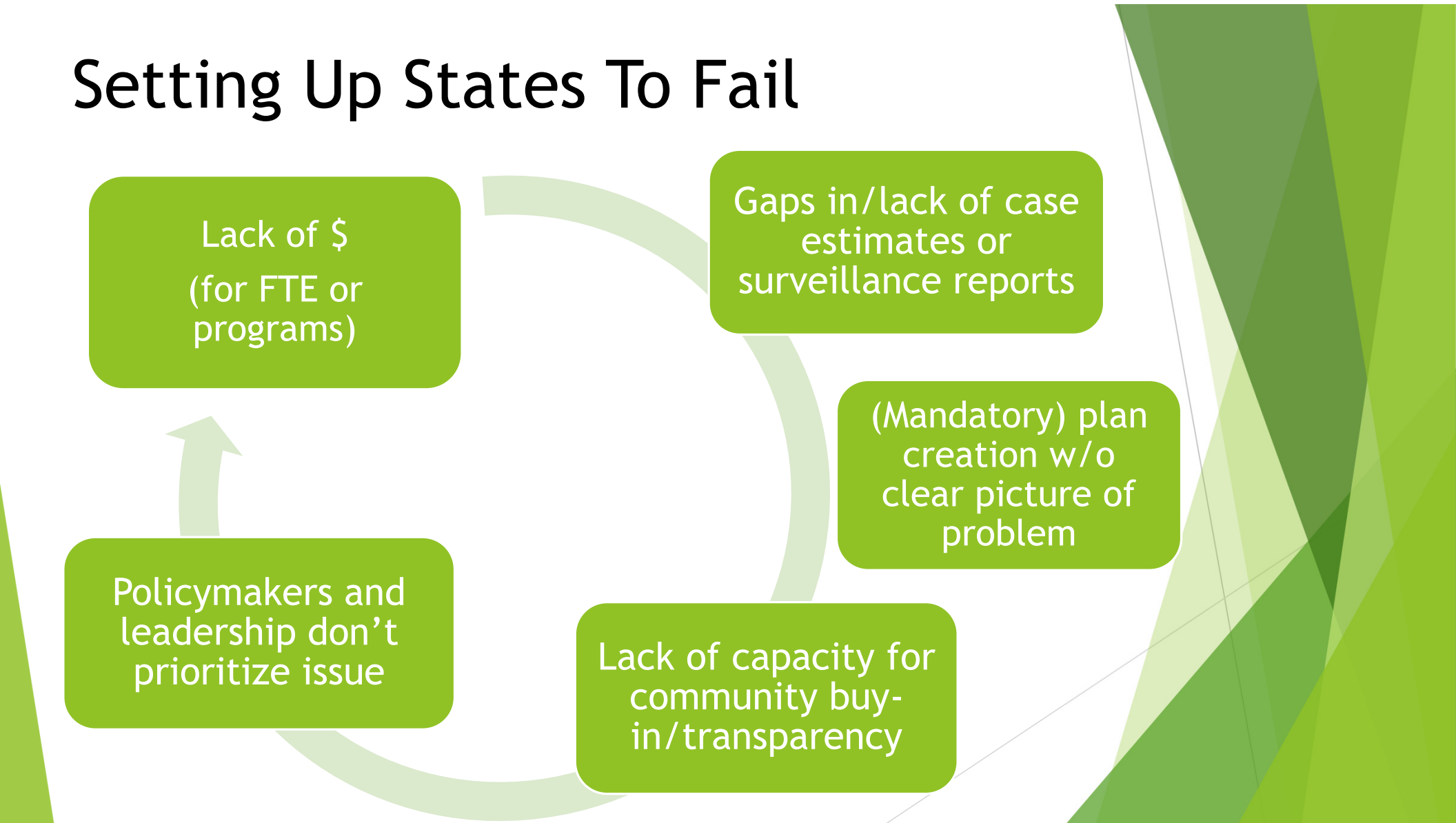
Lack of \$
(for FTE or
programs)

Gaps in/lack of case
estimates or
surveillance reports

(Mandatory) plan
creation w/o
clear picture of
problem

Policymakers and
leadership don't
prioritize issue

Lack of capacity for
community buy-
in/transparency



Setting Up States To Fail

Jurisdictions with Full-Time Employee Dedicated to Viral Hep Surveillance

Though the number of jurisdictions with a full-time employee (FTE) dedicated to viral hepatitis surveillance increased from 68% in 2021 to 80% in 2022, 1/5 (20%) still did not have dedicated staffing in 2022.

Jurisdictions believe they need 3-5 FTEs to Conduct VHS

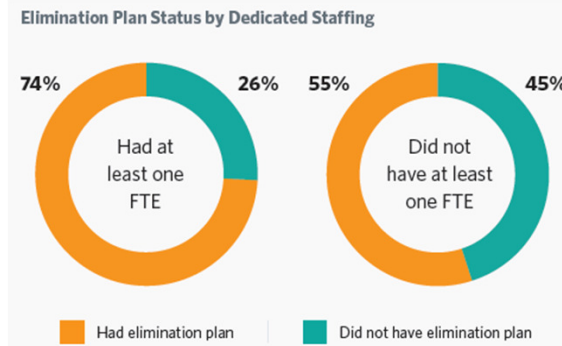
To conduct viral hepatitis surveillance activities specified under CDC IVHSP, jurisdictions report that on average, they believe 3-5 full-time employees (FTE) are necessary.

69% of jurisdictions produced annual estimates for the number of hepatitis B cases in 2022, but only 15% produced hepatitis B prevalence estimates.

Viral Hepatitis Surveillance & Prevention Funding

About \$25.7M

However, only 35% have public elimination plans, and 54% are implementing elimination plans.



Looking Ahead

- Additional data on hepatitis b is informative
 - shows that states greatly need resources to implement the screening guidelines given many states aren't doing contact tracing or measuring chronic B prevalence.
- Concerns remain that states are creating viral hepatitis elimination plans that are hep C elimination plans
 - Helpful for advocacy if future iterations can track what states are doing specifically
- Countering continued attacks on public health infrastructure



Q&A

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