

# Hepatitis Headlines

Issue #3  
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Viral Hepatitis Surveillance and Prevention Unit, Michigan Department of Community Health

[www.michigan.gov/hepatitis](http://www.michigan.gov/hepatitis)

## New Website!

The new and improved viral hepatitis website is currently up and running. We now have a URL: [www.michigan.gov/hepatitis](http://www.michigan.gov/hepatitis) which should make the site easier to navigate to. The site combines information on hepatitis A, B, and C from MDCH Hepatitis, Immunization, and Enteric groups.

The site is separated into two sections: Hepatitis Information for Medical and Public Health Professionals and Hepatitis Information for the Public. The Health Professionals section includes reporting requirements, prevention methods, training opportunities, data and statistics on hepatitis, and relevant hepatitis resources. Hepatitis Info for the Public provides a basic introduction to viral hepatitis. Also included are methods of preventing hepatitis and educational and support resources. Please let us know if you have any feedback about the new look and layout of the site.

--Geoff Brousseau,

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## Thanks and Giving!

Firstly, we know this Fall-themed newsletter is a bit more colorful than how it currently looks outside, but we didn't really want to design the newsletter with an 'overcast' theme. Plus winter doesn't officially start until December 21<sup>st</sup>.

That being said, with the holiday season fast-approaching we thought this would be a good opportunity to shower you with "gifts" from the MDCH Hepatitis Unit. We recently completed work on some large and small projects that we wanted to share, with the hope that you find them interesting, useful, and helpful. Included amongst these fantastic "presents" is the new MDCH Viral Hepatitis Website ([www.michigan.gov/hepatitis](http://www.michigan.gov/hepatitis)), a [HCV Rapid Testing Guideline](#), a new [HCV testing algorithm](#) from the MDCH Bureau of Labs, the [2012 Hepatitis B and C Annual Report](#), and new viral hepatitis MDSS forms. Further details on these projects can be found in this iteration of the newsletter.

Additionally, without sounding too cheesy and cliché, during this time of thanksgiving we'd like to thank you for the role you play in hepatitis surveillance and prevention. Viral hepatitis infections impact a large number of Michiganders and no single entity is capable of conquering the problem on their own. We highly value our relationships and collaborations with healthcare providers, infection preventionists, public health nurses, epidemiologists, laboratories, and prevention partners throughout the State as we continue to fight this public health threat. We know we can't do it without your help!

Finally, we'd like to wish you and yours a safe and very happy Holiday. Come back rested because we look forward to continuing to work with you in the New Year!

--The Viral Hepatitis Unit

Michigan Department  
of Community Health



Rick Snyder, Governor  
James K. Haveman, Director

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## New Viral Hepatitis Forms with MDSS 4.1

MDSS Version 4.1 was recently released on December 4th. With this release comes several system updates, included among them are new versions of the viral hepatitis case detail forms. The forms are being changed to mirror CDC's latest viral hepatitis form changes and it is not anticipated that these changes will create additional work for local health departments.

Though the majority of the fields remain unchanged there are a few modifications worth highlighting:

- Expanded diagnostic test section for all viral hepatitis forms
- Reorganization of HAV form questions
- Added Epi information section for chronic HBV
- Minor question rewording

As always, completion of the fields in the case detail form, to the best of your ability, is much appreciated. Please contact us if you encounter any issues or bugs.

--Joe Coyle  
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**KNOW**  
**HEPATITIS B**

## 2012 Viral Hepatitis Surveillance Report

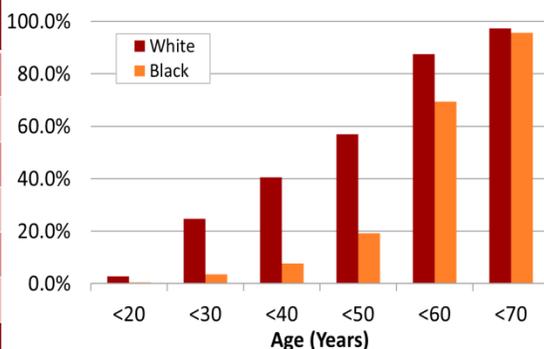
The MDCH Viral Hepatitis Unit recently put the final touches on a fairly comprehensive hepatitis B and C surveillance report covering data submitted to MDSS in 2012. The full report can be found [here](#).

The 38-page report contains information on the epidemiology of hepatitis B and C in Michigan including infection rates and trends by age, sex, and race. Also included is a breakdown of risk factors associated with viral hepatitis acquisition, statistics on viral hepatitis co-infections with HIV, and rates of hepatitis infection by county, health jurisdiction, and public health preparedness region.

The table and graph below come from the report and highlight an interesting finding.

### Age at Chronic Hepatitis C Diagnosis by Race, 2012

| Age (Years)     | White (% of Cases Reported) | Black (% of Cases Reported) |
|-----------------|-----------------------------|-----------------------------|
| ≤20             | 2.8%                        | 0.5%                        |
| ≤30             | 24.7%                       | 3.6%                        |
| ≤40             | 40.6%                       | 7.6%                        |
| ≤50             | 57.0%                       | 19.2%                       |
| ≤60             | 87.5%                       | 69.4%                       |
| ≤70             | 97.3%                       | 95.7%                       |
| <b>Mean Age</b> | <b>44.3 years</b>           | <b>56.2 years</b>           |



The data presented above shows the age at diagnosis of chronic HCV infections stratified by race. The table and graph actually present the same data. On average, whites are reported with chronic hepatitis C at an earlier age than blacks (44.3 vs. 56.2 years). Earlier diagnosis, linkage to care, and treatment has been shown to significantly improve HCV health outcomes. So the fact that blacks are diagnosed over a decade later in life than whites, according to our data, is potentially troublesome. For instance, 40% of white chronic HCV cases reported to MDCH in 2012 were 40 years old or younger. In comparison, only 8% of the black cases were diagnosed at 40 or younger. It remains to be seen whether this observation is due to whites simply acquiring HCV earlier in their lifetime than blacks, explaining why white HCV cases are detected earlier, or whether the groups acquire HCV at approximately the same age but blacks are more likely to go undiagnosed for an extended period of time due to disparities in access to care and diagnostic testing between the races.

We hope you find the rest of the report interesting and informative and if you have additional ideas for data analysis, please let us know!

--Geoff Brousseau, [BrousseauG@michigan.gov](mailto:BrousseauG@michigan.gov)



## Safe Injection Practices in Ambulatory Surgery Centers

Previously, we introduced that the Hepatitis Unit would be surveying ASCs on their knowledge, behavior, and policies regarding injection safety and safe assisted blood glucose monitoring. Since the majority of healthcare-associated viral hepatitis infections occur in outpatient settings, we wanted to measure familiarity with CDC injection safety guidelines in ASCs. In total, 63 ASCs and 287 individual healthcare workers (HCWs) contributed to the surveys. Though the final report has yet to be released, here we discuss some of the preliminary results.

While most facilities had infection control policies that referred to medication vial usage (100%) and aseptic med prep (98%) fewer had policies on diabetes equipment use and cleaning (89%) and use of IV bags as a common source of medication (90%).

Two percent of HCWs said it was okay to use single dose vials for more than one patient and 3% actually said they did so. Similarly, 2% of HCW respondents admitted to pooling medications leftover from single dose vials.

Though the majority of HCWs followed CDC guidance, even a minority practicing incorrectly could potentially lead to many

patients being exposed to someone else's blood. The practices described below in figures 1 and 2 are both against CDC guidelines and have caused healthcare-associated outbreaks in the past.

Figure 1. Do you ever use a bag of intravenous solution as a common med supply for more than one patient?

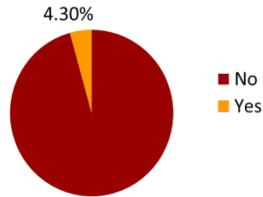
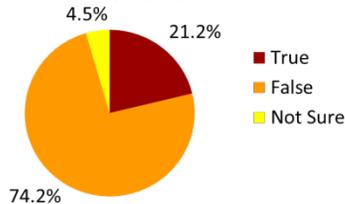


Figure 2. Fingerstick devices can be used on more than one patient as long as the lancet is changed and the device is properly disinfected?



We plan on finalizing the ASC report and distributing similar surveys to long-term care facilities in the future. In addition we have developed a safe injection webinar, posted to our website [here](#), which covers the current CDC injection safety and blood glucose monitoring guidelines.

--Charde' Fisher

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## MDCH HCV Rapid Testing Guideline

As you may already know, OraSure has recently developed and received FDA approval for their Oraquick HCV rapid test for detecting HCV antibody. This test requires only a fingerstick, will give results in about 20 minutes, and is as sensitive and specific as current non-rapid tests. The test is also CLIA-waived meaning it can be administered by non-laboratory sites that obtain a CLIA waiver from the State. In the near future it is anticipated that more sites (e.g. pharmacies) will be conducting HCV rapid tests. For that reason, MDCH developed a [HCV Rapid Testing Guideline](#) that covers the recommended best practices for locations performing these tests including quality assurance, OSHA standards, communicable disease reporting, medical referrals, and appropriate methods for client assessment and pre- and post-test counseling. Feel free to reference this guideline when and if you get questions from rapid testing sites.

## HCV Testing at MDCH BOL

The MDCH Bureau of Labs recently approved a new algorithm for HCV testing using a two-tiered testing method consistent with CDC recommendations.

Specimens will first be tested for HCV antibody and any positive results will then be automatically tested for HCV RNA via PCR. However, to be eligible for HCV RNA testing, the specimen must be stored and transported at 2-8°C or frozen. If the specimen is not cold when it arrives at the MDCH BOL, it will only be screened for HCV antibodies.

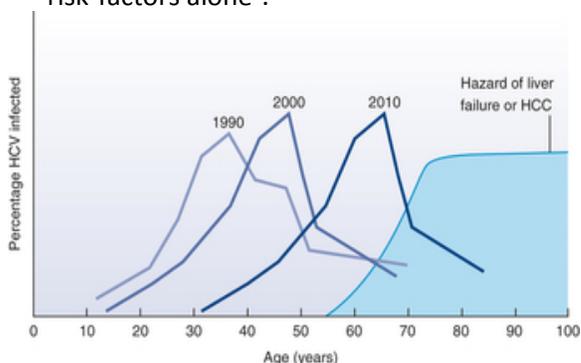
MDCH is offering specimen collection kits to aid in the transportation of cold/frozen specimens. The kit comes with two ice packs (which will need to remain in the freezer until shipment) and can be ordered by calling MDCH Lab Support Services at 517-335-9040 or [online](#).

Currently, the collection kits and HCV testing are provided free of charge. Please note, however, that as testing volumes increase, MDCH may need to charge a fee for this testing.

The full announcement from the BOL can be found [here](#) and any questions regarding the new testing algorithm can be directed to the BOL at 517-335-8063.

## Reducing the Burden of HCV-Related Mortality

As a follow-up to the article we reviewed in our [last newsletter](#), this month we review a different article by the same authors. The article, [The Cost-Effectiveness of Birth-Cohort Screening for Hepatitis C Antibody in U.S. Primary Care Settings](#) used a simulation model to estimate the cost and effectiveness of birth cohort screening for HCV in the United States versus the standard practice of screening based on hepatitis C risk-factors alone<sup>1</sup>.



Baby Boomers, born between 1945 and 1965, account for nearly 75% of all chronic HCV infections among adults in the United States. Unfortunately, the majority of those infected with HCV are unaware of their infection and therefore do not receive needed education, counseling, medical monitoring and/or treatment. As others note in the literature<sup>2</sup>, as this birth cohort ages, without the necessary interventions, liver failure and hepatocellular carcinoma rates will rise.

Using their simulation model, the authors predicted that, in comparison to risk-based screening alone, birth cohort

screening would identify an additional 808,580 cases of HCV infection and prevent 82,000 to 121,000 HCV-related deaths. Overall, while birth-cohort screening was more costly (because of additional testing, doctor's visits, and treatment), the cost-effectiveness was vastly improved. Based partly on these findings, the CDC released a new [recommendation in August 2012](#) that all Baby Boomers receive one-time HCV testing regardless of their risk for hepatitis C.

While last quarter's newsletter painted a pretty bleak outlook regarding the future of HCV infection in the US, this follow-up study shows the potential impact public health interventions can have on HCV disease. Increases in testing, referral to care, and treatment, can lead to better patient outcomes and, in the long run, avert medical costs. Public health professionals are in a unique position to influence testing and referral to care by bridging the gap between clients and providers and by distributing key messages to raise awareness among the public. These efforts can save lives!

--Kim Kirkey  
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<sup>1</sup>Rein DB et al. [The cost-effectiveness of birth-cohort screening for hepatitis C antibody in US primary care settings](#). Ann Intern Med 156 (4):263-270. 2012.

<sup>2</sup>Thomas, DL. [Global control of hepatitis C: where challenge meets opportunity](#). Nature Med 19 (850-858). 2013.



### Save the Date

3/8-3/9 – MSIPC Spring Conference

3/17-3/18 – International Conference on Viral Hepatitis

3/19 – National Hepatitis Corrections Network

### Helpful Links

[www.michigan.gov/hepatitis](http://www.michigan.gov/hepatitis)

[www.michigan.gov/cdinfo](http://www.michigan.gov/cdinfo)

[www.michigan.gov/hai](http://www.michigan.gov/hai)

[CDC Hepatitis](#)

[Know More Hepatitis Campaign](#)

[Know Hepatitis B Campaign](#)

[CDC Hepatitis Risk Assessment](#)

[Hepatitis A](#)

[Hepatitis B](#)

[Hepatitis C](#)

[Institute of Medicine Report on Prevention and Control of Hepatitis in the US](#)

[One and Only Campaign](#)

[Injection Safety Resources](#)

[Hepatitis Occupational Exposure Guideline](#)

[Blood Glucose Monitoring](#)

[ACIP Hepatitis B Vaccination Guide](#)

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