

# Multnomah County Hepatitis C Strategic Plan

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Prepared by  
the  
Multnomah County  
Hepatitis C Community Planning Group  
Portland, Oregon

March 2004

*“We envision a community free of transmission of hepatitis C, where people affected by this disease achieve the highest quality of life possible.”*  
CPG Vision Statement

March 1, 2004

Dear Multnomah County Residents,

I am pleased to announce the publication of the first Multnomah County Hepatitis C Strategic Plan. This publication is the result of two and a half years of commitment and collaborative work by community members for community members with input from the Multnomah County Health Department.

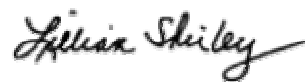
This Strategic Plan is the first one of its type in Oregon. The Plan addresses prevention and care issues of individuals who are at highest risk of contracting Hepatitis C today. It is based on the results of a comprehensive needs assessment process that was undertaken among various provider groups, community members and consumers in the County.

This Plan is intended as a resource and tool for community-based organizations as well as public institutions that are interested in hepatitis program planning and/or grant writing. The Hepatitis C Community Planning Group members developed an extensive list of recommended interventions, divided into high, medium and low priority categories, from which to choose. Many of the interventions - particularly in the high priority category – are based on research-based best practices and known standards of care.

Completion of this Plan renews our public health commitment to address Hepatitis C in our community. Many of the high priority interventions listed have already been successfully integrated into other services within the Health Department such as syringe exchange, Hepatitis C counseling and testing, vaccinations for Hepatitis A and B and community and provider education. Service integration enables us to effectively serve those in our community who are most marginalized and vulnerable to illness.

I congratulate the dedicated members of the Multnomah County Hepatitis C Community Planning Group on completion of the Strategic Plan. It provides new insight and is a key resource to assist interested parties in addressing the public health challenge presented by Hepatitis C in our community.

Sincerely,

A handwritten signature in cursive script that reads "Lillian Shirley".

Lillian Shirley, RN, MPH, MPA  
Director, Multnomah County Health Department

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The members of the Hepatitis C Community Planning Group would also like to thank and acknowledge the diligent work and valuable contributions of several MPH graduate students who interned with us and assisted in the development of the Strategic Plan.

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# Executive Summary

The Multnomah County Hepatitis C Strategic Plan is the outcome of a comprehensive community organizing and needs assessment process. The goals of the Plan are to increase understanding among public and private entities about hepatitis C virus (HCV) prevention and care, to prioritize ways to reduce HCV incidence, and to optimize care for those living with HCV in Multnomah County. This Plan addresses prevention and care issues for individuals who are at highest risk of contracting HCV in our community.

In 1999, members of the Recovery Association Project (RAP) identified HCV as a critical public health issue and brought their concerns forward to the Multnomah Board of County Commissioners and the Multnomah County Health Department (MCHD). Their top concerns included the lack of testing, vaccinations, education, awareness and a community planning process. As a result of RAP's advocacy, the Multnomah County Chair and MCHD Health Officer agreed to commit general funds to establish hepatitis services and to facilitate a community planning process.

In 2000, a study was undertaken to determine the prevalence of HCV among high risk clients in Multnomah County. The most significant outcomes of the survey showed that:

- Of the 988 people tested for HCV, 317 (32%) tested positive.
- The single strongest risk factor for HCV was injection drug use.
- Of the 535 injection drug users (IDU) tested, 293 (55%) were positive.
- Of the 317 people who tested positive for HCV, only 34 (11%) had previously been immunized against hepatitis A and only 33 (10%) had previously been immunized against hepatitis B.

Based upon the 1.8% prevalence data from the NHANES study, MCHD estimates that 12,000-15,000 people living in Multnomah County are infected with HCV.

In 2001, the Multnomah County Hepatitis C Community Planning Group (CPG) was established. Subsequently, a needs assessment was conducted to gain a better understanding of HCV prevention and care from the people living with the disease and the providers who serve them. Needs assessment surveys were distributed to people living with or at risk for HCV, social service providers, western medical providers, complementary and alternative care providers, and the general population to identify HCV prevention and care needs in Multnomah County. Key findings from the surveys included the need for more HCV education, testing, medical care and treatment; alcohol and drug services; housing; and insurance. Service and referral barriers were also cited.

In order to address the key findings of the needs assessment, three goals were developed:

- Goal 1: Expand education efforts to increase knowledge of HCV among providers, HCV+ individuals and the general population.
- Goal 2: Increase primary prevention and harm reduction strategies to decrease the transmission of HCV.
- Goal 3: Improve medical care management of persons living with HCV.

Objectives were subsequently identified and interventions developed. While these intervention recommendations were based upon input from residents, providers, and staff from community based organizations in Multnomah County, it is felt that many of these are applicable to other community organizations, public health programs and providers throughout the state.

# Introduction

The Multnomah County Hepatitis C Strategic Plan is the outcome of a comprehensive community organizing and needs assessment process. The goals of this plan are to increase understanding among public and private entities about HCV prevention and care in Multnomah County, prioritize ways to reduce HCV incidence, and optimize care for those living with HCV. This plan addresses prevention and care issues for individuals at highest risk of contracting HCV in our community.

## The Multnomah County Hepatitis C Community Planning Group

### Background

In 1999, members of the Recovery Association Project (RAP) identified HCV as a critical public health issue and brought their concerns forward to the Multnomah Board of County Commissioners and the Multnomah County Health Department (MCHD). Their top concerns included lack of testing, vaccinations, education, awareness and a community planning process. As a result of RAP's advocacy, the Multnomah County Chair and MCHD Health Officer agreed to commit general funds to establish hepatitis services and to facilitate a community planning process.

The Health Department Hepatitis C Internal Work Group identified several constituencies that should be part of the community planning group:

- **Hepatitis C consumers**, including persons living with, affected by, and at-risk for HCV;
- **Medical care providers**, including both eastern and western care providers as well as primary and specialty care representatives;
- **Multnomah County Health Department staff**, including representatives involved in HCV integration such as the STD Program, Communicable Disease, and the HIV Health Services Center;
- **Allied health providers**, including persons from agencies that provide housing, mental health, addiction, and other services to persons living with, affected by, and at-risk for HCV; and
- **Others**, including policy-makers, insurance providers, pharmaceutical reps, etc.

The Multnomah County HCV Community Planning Group (CPG) process is based on the 2003-2008 Centers for Disease Control and Prevention (CDC) HIV Prevention Community Planning Guidance. The model was designed to facilitate the interaction and partnership of health departments and community members to develop plans suited to the needs of communities infected with, or at-risk for, HIV. The Multnomah County CPG is a less formal version of this planning model and was adapted to focus on the needs of communities within Multnomah County infected with, or at high risk for, HCV.

### Vision & Mission Statements

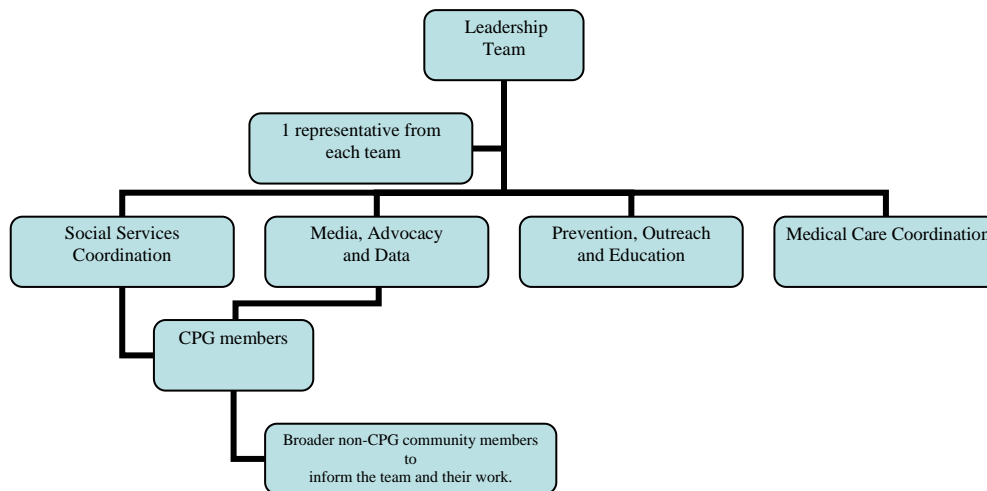
**Vision:** We envision a community free of transmission of hepatitis C, where people affected by this disease achieve the highest quality of life possible.

**Mission:** The mission of the Hepatitis C Community Planning Group is to develop a comprehensive, culturally competent, collaborative approach to the prevention of HCV and to support people affected by the disease through:

- Harm reduction approaches
- Advocacy for full and equal access to information and community health services
- Education to reduce stigma
- Coordination of information, resources, and services

## Structure

Following establishment of the CPG’s vision and mission statements, members developed structured work teams to address key components of HCV prevention and care as identified by the CPG. The following chart illustrates the team structure.



## Work Team Purpose Statements

**Social Services Coordination** – To assess HCV social service needs. Identify existing community resources and gaps in service, and make recommendations based on these findings.

**Media, Advocacy, and Data** – To assess client access to information and community health services. Identify how existing information and services are accessed, gaps in service access, and make recommendations based on these findings.

**Prevention, Outreach and Education** – To assess HCV outreach, education, and prevention needs in the community. Identify existing resources, gaps in service, and make recommendations for outreach, risk education, and educational interventions targeting highest risk clients based on these findings.

**Medical Care Coordination** – To assess HCV treatment, care, and community coordination needs. Identify existing resources and gaps in service, and make recommendations based on these findings.

**Leadership Team** – To plan and provide oversight for the CPG, including agenda development, task implementation, and provision of leadership in meetings through shared facilitation. Comprised of members from each of the other teams.

### **Shared Team Processes**

Each team conducted the following tasks. Members in the Media, Advocacy, and Data team worked with other teams in this process.

- A **resource inventory** that documented “What already exists for HCV [prevention, medical care, social service support, and advocacy] in the Multnomah County community?”
- An **assessment of community** needs including: who should be targeted for services, where we can best reach this population, what health-related interventions have been proven to work with this population, and how and why these HCV prevention and care-related services should be provided (i.e. measurable goals and objectives)?
- An **analysis of the gaps** that compared existing resources (resource inventory) with the identified needs (needs assessment).
- A summary of the resources, needs, and gaps, and a **list of recommendations** to the larger group, based on the findings.

Working in these teams, and through consensus building and the knowledge of group members, the CPG developed five separate needs assessment surveys for the purpose of identifying HCV prevention and care needs and barriers among clients and providers in Multnomah County. There was not a separate needs assessment for Media, Advocacy, and Data.

Results obtained from the needs assessment were compiled, prioritized, and developed into goals, objectives, and recommended interventions.

# Overview of Hepatitis C

More people in the United States are currently infected with hepatitis C than any other chronic, blood borne infection, including HIV. Based on data from the Third National Health and Nutrition Examination Survey (NHANES III), it is estimated that 3.9 million Americans (1.8% of the population) have been infected with HCV and that 2.7 million are chronically infected.<sup>1</sup> It is essential to note that this estimate may be low because NHANES III did not include two groups with high HCV prevalence rates: homeless and incarcerated individuals.

Approximately 41,000 new HCV infections occur each year. HCV is the leading cause of chronic liver disease and liver transplants in the United States, costing over \$600 million and taking approximately 8,000 to 10,000 lives annually.<sup>2</sup> These figures are expected to triple within the next decade due to the improved identification of HCV in priority populations through increased outreach and testing in correctional facilities and among injection drug users.

HCV is a chronic, blood borne, viral infection affecting the liver. HCV infection is chronic in approximately 85% of those infected. Symptoms of acute disease status may include loss of appetite, nausea, diarrhea, fatigue, abdominal pain, and yellowing of the eyes and skin. Only 20-30% of infected individuals experience symptoms, and those who do often experience only mild symptoms. Due to the lack of symptoms experienced, it is quite common for people to be unaware of their disease status for the 10 to 30 years during which progressive liver damage may occur.<sup>2</sup> HCV infection leads to advanced liver disease in 20% of infected individuals, and 1-5% of chronically infected individuals will die from the disease.<sup>2</sup>

## Disease Transmission

Individuals who inject drugs or have ever injected drugs are at highest risk for HCV infection. The blood borne virus is easily spread through sharing contaminated needles and drug-using equipment. Approximately 90% of injection drug users (IDU) who have been injecting for at least five years become infected with HCV.<sup>2</sup> Other risk groups include:

- Individuals who received clotting factor produced before 1987
- Individuals who have ever received long-term hemodialysis
- Recipients of transfusions or organ transplants before 1992
- Health care or emergency workers after possible exposure to HCV-positive blood

Before 1992, blood transfusion accounted for a substantial proportion of HCV infections. HCV screening methods became widely available after 1992. Subsequently, the risk of HCV transmission from blood transfusion was virtually eliminated, and the vast majority of new infections of HCV (60%) in the U.S. are among IDU.

There are mixed findings concerning the risk of HCV infection through sexual contact with infected individuals. Nevertheless, it is believed that sexual transmission of HCV is possible when one partner emits blood and the other receives infected blood into their bloodstream; however, this is not common. Risk for non-sexual household members is low. Infants born to infected mothers have a 5% risk of infection.<sup>2</sup>

## **Hepatitis C Testing**

Many infected individuals are unaware that they have HCV because they have not been screened for the virus and may not experience symptoms for decades. The most common test for HCV is an ELISA antibody screening test. This screening tool detects immune system antibody response to exposure to the virus. If a person has a “reactive” test result, the person has HCV antibodies in their blood and was probably exposed to HCV at some time in their life. A “reactive” result does not necessarily mean that virus is present. An additional confirmatory test, the PCR (polymerase chain reaction), can assess the presence and amount of virus currently in the blood. To determine whether infected individuals will require treatment, a liver biopsy is conducted to measure the amount of inflammation and scar tissue in the liver and to estimate disease progression.

Six genotypes of HCV have been identified, and they each respond differently to treatment. Genotype testing can be conducted to determine the specific HCV viral strain with which a person is infected. Genotype testing is useful for making decisions about treatment, including the type of treatment and treatment duration.<sup>3</sup>

## **Hepatitis C Prevention and Treatment**

There is no vaccine for HCV. Interferon and Ribavirin are considered the standard of care. They are given in combination for 6-12 months, depending on the genotype. The goal of allopathic treatment is to eliminate HCV in the blood. Individuals who are virus-free six months after completing treatment have a 90% or more chance of remaining virus-free five years later.<sup>3</sup>

In addition to allopathic drug treatment therapy, there are many naturopathic therapies and complementary and alternative medical (CAM) treatments that have been effective in protecting liver health, increasing general well-being, assisting in drug and alcohol cessation, and improving quality of life for some individuals living with HCV. Naturopathic and CAM treatment for HCV and related health issues include, but are not limited to, dietary changes, massage, acupuncture, herbal and botanical medicines, vitamin and mineral treatments, and homeopathic medicine. It has not been shown that CAM treatments clear the HCV from the body.

Regardless of which types of treatment are chosen, it is important to select a provider who is experienced working with patients living with HCV.

In addition to treatment, there are behavioral changes that can slow the progression of the disease, protect the liver, and protect others from acquiring HCV. To protect the liver and general health, it is recommended that individuals who have tested positive for HCV:

- Abstain from or reduce illicit drug use
- Eliminate or reduce consumption of alcohol
- Get vaccinated for hepatitis A and B
- See a knowledgeable health care provider

To prevent transmission of HCV, it is recommended that infected individuals:

- Do not share needles or any intravenous drug equipment
- Do not share straws or dollar bills for inhaling drugs
- Do not share tattoo or piercing equipment, toothbrushes, razors or any household items that may draw blood
- Cover cuts and sores on skin

The above recommendations used in combination with drug treatment may slow or stop progression of HCV-related liver disease, prevent further transmission of HCV, and improve quality of life for infected individuals.

# Epidemiology of Hepatitis C in Multnomah County

A study was undertaken to determine the prevalence of HCV among high risk individuals in Multnomah County. From January through August, 2000, in cooperation with several community-based partner organizations, MCHD screened and tested 988 people at risk of exposure to HCV. The testing was offered at various STD and HIV testing and counseling sites, corrections facilities, and at community-based partner organizations.

The outcome of the survey showed that:

- Of the 988 people tested for HCV, 317 (32%) tested positive.
- Of the 317 people who tested positive for HCV, only 34 (11%) had previously been immunized against hepatitis A, and 33 (10%) had previously been immunized against hepatitis B.
- The single strongest risk factor for HCV was injection drug use.
- Of the 535 injection drug users (IDU) tested, 293 (55%) were positive.
- HCV prevalence among IDU increased with age and was highest among the 45-54 year old age group.
- Among IDU, prevalence is highest among those who share needles.
- Among non-IDU risk groups, the prevalence of HCV was low, with a range of 1-4%.

Based upon the 1.8% prevalence data from the NHANES study, MCHD estimates that 12,000-15,000 people living in Multnomah County are infected with HCV.

# Needs Assessment Summary

In fall, 2001, the Multnomah County Hepatitis C Community Planning Group was established. Members of the CPG aimed for a better understanding of Hepatitis C prevention and care from the people living with the disease and the providers who serve them. Consequently, needs assessments were conducted during the fall of 2002 through winter 2003. Goals and intervention recommendations were developed upon learning what is occurring – and not occurring – in the county to prevent transmission and to provide care for people living with HCV. More detailed results, summaries, and analyses from the surveys are included in Appendix B.

## Methodology

### A. Design

Beginning in September 2002, 1,912 surveys were distributed to medical providers, social service providers, complementary and alternative medicine (CAM) providers, community members at risk for, or living with, HCV, and the general population, all within Multnomah County. Of the 1,912 surveys distributed, 779 were returned, yielding a 40.7% response rate. However, 26 surveys had unusable or no data.

### B. Methods

With the exception of the general population assessment, the surveys included both quantitative questions (multiple choice or selection criteria) and qualitative questions (in-depth, short answer). The survey data were entered and stored in a customized Access database. At the conclusion of the study, quantitative data were analyzed using SPSS, and the qualitative items were analyzed using a hand coding system.

### C. Analysis

Appendix B includes the findings for each of the surveys, including both quantitative and qualitative data. The qualitative data provide narrative information that generally supports the quantitative findings. Quotations obtained from individual surveys have been included to emphasize the findings and to preserve individual voice.

The Needs Assessment Summary in Appendix B compares results across surveys to look at similarities and differences based on the respective survey and question. The goal of this broader analysis was to identify discrepancies or disparities of HCV prevention, care, services, and knowledge among varying health care professionals and community members.

## D. Key Findings

### 1. Education

Lack of HCV education and awareness of existing resources were identified as barriers by social service and CAM providers as well as consumers.

Overall, knowledge about HCV and its prevention was fairly high among respondents. A small but significant proportion of respondents held incorrect assumptions about HCV, indicating the need for continued community education.

Sources used for HCV information varied across survey respondents from “doctor” to the internet.

## **2. Five Most Important Services Ranked by Consumers and Providers**

- HCV education
- HCV treatment
- Alcohol and drug services
- Western medical care
- Complementary and alternative medical care (CAM)

## **3. HCV Screening and Testing Availability**

HCV screening and testing were conducted by more than half of provider respondents; testing was targeted to people with elevated liver enzymes, IDU, and “anyone who asked for testing.”

Information given to clients at the time of testing included:

- Hepatitis C transmission risks
- Effects of alcohol, drugs, and/or herbs on the body
- Common HCV symptoms
- Recommendations for hepatitis A and B vaccines

## **4. Housing Needs**

Among the community respondents surveyed, 34% of the consumers did not have stable housing and ranked housing assistance in the top five most important services.

## **5. Insurance**

Among the community respondents surveyed, the majority (77.5%) had Medicaid/Oregon Health Plan (OHP) coverage. Insurance eligibility, costs, and restrictions were identified as barriers to service by western medical providers, social service respondents, and consumers.

## **6. Patient Attributes**

Patient attributes, such as alcohol and drug addiction, depression, or noncompliance, were identified as barriers to service and care by western medical, social service, and CAM providers.

## **7. Referrals & Referral Barriers**

Over half of western medical care providers “never” worked with CAM providers, yet just under half of all CAM providers surveyed “almost always” worked with western medical providers. Over half of CAM providers referred their consumers to western medical providers. Western medical provider resistance to alternative therapies was identified as a barrier by 22% of CAM survey respondents.

## **8. Service Barriers for People with Hepatitis C**

One quarter to one third of consumers reported having been treated badly or denied service because of their HCV status or injection drug use, respectively.

Consumers reported limited access to mental health, alcohol & drug services, medical specialists, alternative medicine, and high quality providers. Additional service barriers reported include waiting lists and time, paperwork, scheduling, language, and transportation.

# Intervention Goals and Recommendations

Based on results of the needs assessment, the CPG identified the following goals:

- Goal 1: Expand education efforts to increase knowledge of HCV among providers, HCV+ individuals and the general population.**
- Goal 2: Increase primary prevention and harm reduction strategies to decrease the transmission of HCV.**
- Goal 3: Improve medical care management of persons living with HCV.**

Objectives were identified and interventions recommended for each. Interventions were prioritized into high, medium and low categories.

## **GOAL 1: Expand education efforts to increase knowledge of HCV among providers, HCV+ individuals and the general population.**

### **Goal 1 Objectives**

- 1.1 Increase education among complementary and alternative medical (CAM) providers.**
- 1.2 Increase education among western medical providers.**
- 1.3 Increase education among the general population to reduce transmission and social stigma around drug use and infectious diseases**
- 1.4 Increase education among social service providers.**
- 1.5 Increase convenient and accessible education among persons with HCV to reduce disease transmission, reduce self-harm, reduce disease progression, and increase chances of treatment.**

#### **Objective 1.1: Increase education among complementary and alternative medical (CAM) providers on:**

- Referrals and resources for client education and support
- Behavioral counseling and multi-infectious disease messages when working with high-risk clients
- Stigma of HCV and how to reduce it
- Cultural competency in working with IDU, HCV+ clients, and persons with chronic disease
- Medical management strategies (i.e. psychological support, and support groups), improve care and reduce misconceptions
- HCV testing for persons at highest risk

## **Objective 1.1**

### **Highest Priority Interventions**

- Offer quarterly or annual gatherings for CAM providers to learn about HCV, get updates, hear about best practices, and share with peers what seems to work and not work with HCV.
- Work with Oregon College of Oriental Medicine Acupuncture Program administrators to integrate HCV into existing curricula.

### **Medium Priority Interventions**

- Educate all Oregon College of Oriental Medicine acupuncture program students on HCV prevention and treatment using existing curricula.
- Arrange weekend CEU-based seminars on HCV; invite well known CAM providers to present.

### **Low Priority Interventions**

- Offer peer education about HCV testing criteria, where to refer clients for testing and vaccines, and standards of CAM care for persons with HCV.
- Encourage research be done in the U.S. on the impact of CAM on HCV; distribute findings.

### **Objective 1.2: Increase education among western medical providers on:**

- Referrals and resources for client education and support
- Behavioral counseling and multi-infectious disease messages when working with high-risk clients
- Stigma of HCV and how to reduce it
- Cultural competency in working with IDU, HCV+ clients, and persons with chronic disease
- Medical and chronic disease management strategies (i.e. CAM, psychological support, and support groups), improve care and reduce misconceptions
- HCV testing for persons at highest risk

## **Objective 1.2**

### **Highest Priority Interventions**

- Arrange pharmaceutical sponsored, CEU-based seminars on HCV.
- Implement quarterly or annual gatherings to learn about HCV, get updates, hear about best practices, and share with peers what seems to work or not work with HCV.

### **Medium Priority Interventions**

- Ensure representation of HCV medical providers at coalition and community health council meetings to provide information and technical assistance on standards of care.
- Educate western providers about the chronic disease self-management model.
- Offer peer education about HCV testing criteria, where to refer clients for testing and vaccines, and standards of medical care for persons with HCV.
- Arrange grand rounds at hospitals on HCV topics.
- Invite medical care members of CPG to educate Multnomah County Health Department medical providers on standards of care and provide annual updates.
- Increase integration between American Medical Association and national CAM institutions.

### **Low Priority Interventions**

- Include HCV in the statewide behavioral risk survey done by the Department of Human Services, Health Services, to survey general population.
- Attend Governor's Council statewide conference to make connections for alcohol and drug issues.
- Explore Eastern and Western medical provider shadowing and job exchange.

**Objective 1.3: Increase education among the general population to reduce transmission and social stigma around drug use and infectious diseases.**

### **Objective 1.3**

#### **Highest Priority Interventions**

- Develop and implement a statewide public education campaign with messages targeting the general population and at-risk populations.
- Develop and implement a local public education campaign with messages targeting the general population and at-risk populations.

#### **Medium Priority Interventions**

- Collaborate with a corporation or foundation to pay for a statewide social marketing campaign.
- Apply for funds from foundations, etc, for local public education campaign.

#### **Low Priority Interventions**

- Advocate state legislature for funding of statewide public education campaign.
- Develop a social marketing campaign utilizing a celebrity (i.e. musician, actor, or actress) who is living with HCV.

### **Objective 1.4: Increase education among social service providers on:**

- Referrals and resources for client education and support
- Behavioral counseling and multi-infectious disease messages when working with high-risk clients
- Cultural competency in working with IDU, HCV+ clients and persons with chronic disease
- HCV testing for persons at highest risk

### **Objective 1.4**

#### **Highest Priority Interventions**

- Provide CEU-based HCV capacity building trainings that cover HCV 101, disease-behavioral risk relationships, and HCV resources.
- Provide one- to three-hour refresher courses to previous HCV capacity building training participants that cover new or changing HCV prevention, care, and treatment issues.
- Educate city and county law enforcement officers about HCV prevention and care.

### **Medium Priority Interventions**

- Maintain up-to-date list of HCV testing sites and criteria for testing; post and/or distribute to target populations.
- Provide state certification for attendance at capacity building trainings, and annual or bi-annual re-certification with refresher sessions.
- Coordinate with HIV education and/or diversity training programs to encourage an expansion of cultural competency discussions to include the culture of injection drug use, chronic disease management, etc.
- Provide peer education about HCV testing criteria, where to refer clients for testing and vaccines, and standards of social service care for persons with HCV.

### **Low Priority Interventions**

- Partner with Oregon Mental Health & Addiction Services (OMAS) to obtain backing and support for reaching out to state and county-funded mental health and alcohol and drug services providers to build awareness about all types of hepatitis (specifically C).
- Participate on statewide Governor's Council on Alcohol & Drug Abuse Programs conferences to make connections for alcohol and drug issues.

**Objective 1.5: Increase convenient and accessible education among persons with HCV to reduce disease transmission, reduce self-harm, reduce disease progression, and increase chances of treatment.**

### **Objective 1.5**

#### **Highest Priority Interventions**

- Staff needle exchange sites with two people to expedite exchange process and enhance behavioral counseling.
- Conduct site- and population-specific HCV outreach, testing, education, vaccinations, and referrals (e.g. two people visit target areas 2-3 times a week with medical items and educational materials to engage clients about HCV).
- Encourage primary medical providers to discuss and support harm reduction strategies among clients in primary care settings.

#### **Medium Priority Interventions**

- Train and support secondary syringe exchange clients to increase access to syringe exchange among clients who otherwise would not utilize the service.
- Utilize social networks to increase peer-to-peer harm reduction.

#### **Low Priority Interventions**

- Educate pharmacists about Oregon syringe disposal and exchange laws to ensure that clean syringes are available without a prescription.
- Educate pharmacists on public health benefits of harm reduction.

**GOAL 2: Increase primary prevention and harm reduction strategies to decrease the transmission of hepatitis.**

**Goal 2 Objectives**

- 2.1 Increase HCV screening and testing among persons at highest risk, specifically persons with lifetime history of injection drug use. Promote knowing one's status for early intervention, education and self-care.**
- 2.2 Increase hepatitis A and B vaccination among past or present injection drug users.**
- 2.3 Increase client use of sterile or clean drug paraphernalia when using with HCV+ partners or partners of unknown HCV status.**

**Objective 2.1: Increase HCV screening and testing among persons at highest risk, specifically persons with lifetime history of injection drug use. Promote knowing one's status for early intervention, education and self-care.**

**Objective 2.1**

**Highest Priority Interventions**

- Conduct peer-based risk reduction counseling with IDUs (peers defined as former users of alcohol and drugs).
- Conduct street-based outreach in designated communities. Work with community liaisons to build trust.
- Educate at-risk populations about recommendations for HCV testing and hepatitis vaccines.
- Provide on-site, on-demand HCV testing for at-risk clients at local social service and medical care sites, syringe exchange sites, alcohol and drug treatment programs, housing programs, and homeless youth programs.
- Educate local community providers of social services and medical care to assess client risk for HCV and refer for testing.
- Educate local complementary and alternative providers to assess client risk for HCV and refer for testing.
- Ensure HCV test results are available by telephone as well as in person.
- Conduct a health communications or promotional campaign to provide information about where and how to access HCV testing. Examples include placing billboard ads in strategic locations (such as near bus terminals, housing developments, and treatment centers), placing ads in free local newspapers, and developing transit ads for city buses, bus benches and mass transit trains.

**Medium Priority Interventions**

- Conduct focus groups with IDUs to understand motivations for HCV testing. Identify previous research and apply lessons learned for quality assurance.
- Develop and distribute HCV testing and screening messages on matchboxes.
- Use incentives (e.g. food vouchers, phone cards) with high risk populations to encourage HCV testing and receipt of results.

### **Low Priority Interventions**

- Lobby manufacturers of home HCV test kits to get reduced or bulk rates for HCV tests reaching affected populations.
- Use incentives with providers (financial or otherwise, such as free test kits) to encourage testing.
- Distribute home HCV test kits at syringe exchange or stationery street outreach sites.
- Conduct outreach at community events attracting target populations most at risk for disease acquisition and transmission.

**Objective 2.2: Increase hepatitis A and B among past and present injection drug users.**

### **Objective 2.2**

#### **Highest Priority Interventions**

- Provide on-site, on-demand low-cost or free vaccine administration to IDUs at STD clinics, needle exchange sites, alcohol and drug treatment centers, primary care clinics, parole and probation offices, correctional facilities, HIV clinics, etc.
- Offer risk reduction counseling for IDUs to encourage and facilitate access to vaccination.
- Educate IDUs to encourage and facilitate access to vaccination.
- Develop and distribute a comprehensive list of standard and necessary services for the prevention and care of persons living with HCV to the Multnomah County Board of County Commissioners (MCBCC) and state legislators.
- Work with local providers to increase knowledge around the need for hepatitis A and B vaccinations.
- Conduct a social marketing campaign to encourage hepatitis A and B vaccinations and inform how and where to access them.
- Collaborate with existing vaccine and other social marketing campaigns both in and out of state.
- Develop brochures to encourage hepatitis A and B vaccinations and inform how and where to access them.

#### **Medium Priority Interventions**

- Offer incentives for IDUs to get vaccinated and to encourage return visits for vaccine completion.
- Advocate the state legislature for all health care providers in Oregon to utilize the statewide adult immunization information system.

**Objective 2.3: Increase client use of sterile or clean drug paraphernalia when using with HCV+ partners or partners of unknown HCV status.**

**Objective 2.3**

**Highest Priority Interventions**

- Provide street-based and mobile syringe disposal and exchange throughout Multnomah County to all IDUs.
- Increase the number of syringe disposal and exchange sites in Multnomah County; target to specific communities at highest risk for disease acquisition.
- Utilize IDU networks to educate peers about HIV, hepatitis, and STD transmission, syringe access, and skills to prevent disease acquisition.
- Educate and lobby state and local legislators regarding the need for legal access to syringe exchange among persons under 18 years of age. Seek changes in county, state and federal paraphernalia laws.
- Educate law enforcement officials regarding the public health benefits of syringe disposal and access sites.
- Educate IDUs about syringe disposal and access sites, their legal rights and how to prevent disease transmission and acquisition.
- Design and distribute a brochure to inform community leaders (law enforcement, legislators, policy makers, university administrators, medical institutions) about the public health and safety benefits of syringe exchange (such as reducing the number of used syringes in parks and other public places).

**Medium Priority Interventions**

- Educate and lobby pharmacists regarding the legality of syringe sales in Oregon; develop penalties for pharmacies that prevent client access.
- Provide access to prevention-related injection drug paraphernalia (cotton, caps, syringes) at alcohol and drug outpatient treatment programs.
- Provide access to prevention-related injection drug paraphernalia (cotton, caps, syringes) at local pharmacies for ease of access and anonymity.
- Develop a social marketing campaign targeted at faith-based leaders to increase understanding of the public health benefits of syringe disposal and exchange.
- Develop and distribute needle exchange schedules via the Internet and local weekly newspapers.

**Low Priority Interventions**

- Work with the American Diabetes Association to advocate for syringe access for everyone.
- Make syringes available through strategically placed vending machines.
- Develop safe injection sites and/or areas.

## **GOAL 3: Improve medical care management of persons living with HCV.**

### **Goal 3 Objectives**

- 3.1 Provide stable, subsidized health care coverage for low-income persons with HCV.**
- 3.2 Ensure that insured and uninsured HCV+ clients have access to interferon-based treatment.**
- 3.3 Increase hepatitis A and B vaccinations among HCV+ and HIV+ individuals.**
- 3.4 Increase primary medical care utilization among insured & uninsured clients with HCV.**
- 3.5 Ensure that insured and uninsured HCV+ clients have access to mental health services including initial and ongoing psychosocial support.**
- 3.6 Ensure that insured and uninsured HCV+ clients have access to drug and alcohol counseling, support and treatment for initial and ongoing liver health.**

### **Objective 3.1: Provide stable, subsidized health care coverage for low-income persons with HCV.**

#### **Objective 3.1**

##### **Highest Priority Interventions**

- Utilize peer mentors to facilitate HCV+ client access to health coverage and care.
- Encourage existing community health clinics to develop a weekly HCV clinic to address the myriad medical needs of persons with HCV.
- Collaborate with existing health care advocates and community organizing agencies.
- Develop and distribute a comprehensive list of standard and necessary services for the prevention and care of persons living with HCV to the MCBCC and state legislators.
- Develop a one-stop, comprehensive HCV medical care facility to address urgent and ongoing needs of persons living with HCV. One-stop to include case managers to assist with health coverage and access to medical care, mental health, alcohol & drug treatment, and basic needs.

##### **Medium Priority Interventions**

- Participate in local health care committees, such as the Community Health Council or Coalition of Community Health Clinics, to represent the comprehensive medical needs of persons affected by HCV.

**Objective 3.2: Ensure that insured and uninsured HCV+ clients have access to interferon-based treatment.**

**Objective 3.2**

**Highest Priority Interventions**

- Advocate Oregon Health Plan administrators to ensure that HCV treatment expenses remain above the OHP cut-off list.
- Encourage pharmaceutical representatives and care clinics to develop alternative access to interferon-based treatment, including direct and ancillary services such as doctor visits, lab costs, pain management medications for persons without insurance.
- Develop and distribute a comprehensive list of standard, necessary and best practice services for the prevention and care of persons living with HCV to primary care medical providers.
- Develop and distribute a comprehensive list of standard and necessary services for the prevention and care of persons living with HCV to the MCBCC and state legislatures.

**Objective 3.3: Increase hepatitis A and B vaccinations among HCV+ and HIV+ individuals.**

**Objective 3.3**

**Highest Priority Interventions**

- Provide on-site, on-demand, low-cost or free vaccine administration to HCV+ and HIV+ clients at the STD clinic, syringe exchange sites, alcohol and drug treatment centers, primary care clinics, parole and probation offices, correctional facilities, HIV clinics, etc.
- Provide education for persons with HCV and/or HIV to encourage and facilitate access to vaccination.
- Lobby the state legislature for all health care providers in Oregon to utilize the statewide adult immunization information system.
- Develop brochures to encourage hepatitis A and B vaccinations and inform how and where to access them.
- Develop and distribute a comprehensive list of standard and necessary services for the prevention and care of persons living with HCV to the MCBCC and state legislators.

**Low Priority Interventions**

- Undertake social marketing campaign to encourage hepatitis A and B vaccinations and inform how and where to access them.
- Provide risk reduction counseling for persons with HCV and/or HIV to encourage vaccination and facilitate access.

**Objective 3.4: Increase primary medical care utilization among insured and uninsured clients with HCV.**

**Objective 3.4**

**Highest Priority Interventions**

- Advocate for the inclusion of HCV as a chronic disease warranting a national public health response, targeting the Health Resources and Services Administration (HRSA) Bureau of Primary Care, as well as the Institute for Health Care Improvement.
- Educate and increase skill among insured HCV+ clients about making medical appointments and planning for future follow-up appointments.
- Encourage local and state health institutions to develop electronic medical record systems which prompt medical care providers about National Institute of Health care guidelines for persons with HCV; the system should remind providers about immunization dosing, delivery of health prevention and care messages, routine laboratory testing expectations and treatment recommendations.

**Medium Priority Interventions**

- Develop and distribute up-to-date lists on low income and/or free primary medical care services to HCV-affected clients and providers.
- Develop and distribute up-to-date lists of medical providers accepting OHP Standard and OHP Plus to HCV-affected clients and their providers.
- Represent HCV+ medical care access issues through participation in local community health clinic coalitions.

**Low Priority Intervention**

- Advocate the state legislature and the MCBCC for increased employer-based health care coverage to assist working HCV+ persons.

**Objective 3.5: Ensure that insured and uninsured HCV+ clients have access to mental health services including initial and ongoing psychosocial support.**

**Objective 3.5**

**Highest Priority Interventions**

- Provide short-term, mental health support to clients living with HCV or at-risk for disease acquisition (i.e. in corrections, STD clinics, and syringe exchange sites).
- Maintain up-to-date resource information about mental health services for distribution to HCV-affected clients and providers.
- Distribute client testimonials to the MCBCC and to state legislators addressing the loss of mental health coverage [and psychotropic medication coverage] and its direct impact to HCV+ clients.
- Write letters to the MCBCC and state legislators increasing awareness about mental health needs for persons living HCV. Develop and distribute a comprehensive list of standard and necessary services for the prevention and care of persons living with HCV to the MCBCC and state legislators.
- Identify any existing research addressing the cost savings of mental health service as it relates to the provision of medical care; distribute any information which supports the cost savings of mental health as a component of health care service.

### **Medium Priority Interventions**

- Distribute mental health resource material to HCV+ affected clients using existing HIV prevention outreach workers.
- Provide basic HCV training to mental health support group facilitators in Multnomah County. Build knowledge of HCV among existing mental health support group facilitators.

### **Low Priority Interventions**

- Market existing HCV peer-based support groups to HCV-affected persons for increased utilization.
- Train and support HCV support group facilitators at least semi-annually with periodic booster training sessions. Standardize expectations and core competencies for persons interested or providing peer support to persons living with HCV.
- Conduct monthly peer-based, psycho-educational support groups for persons living with HCV.

**Objective 3.6: Ensure that insured and uninsured HCV+ clients have access to drug and alcohol counseling, support and treatment for initial and ongoing liver health.**

### **Objective 3.6**

#### **Highest Priority Interventions**

- Utilize peer mentors to assist HCV+ drug affected clients in accessing services supporting alcohol and drug free living.
- Form a consortium of HCV treatment providers to unify and coordinate services.
- Pursue grants and private funding for low-income, HCV+ persons to obtain support and treatment services (perhaps under umbrella of a research grant).
- Update accurate referral list regularly for alcohol & drug providers to include fees, types of services provided and insurance plans.
- Distribute and maintain list of subsidized alcohol and drug providers for HCV support agencies and providers for referral of uninsured persons.
- Collaborate with existing alcohol and drug advocates and community organizing agencies such as the Recovery Association Project.
- Develop and distribute a comprehensive list of standard and necessary services for the prevention and care of persons living with HCV to the MCBCC and state legislators.
- Write letters to the MCBCC and state legislators to increase awareness about the necessity of alcohol and drug treatment for persons living with and affected by HCV.
- Distribute client testimonials to the MCBCC and state legislators addressing the need for alcohol and drug treatment coverage (including access to methadone maintenance, outpatient and residential services) and its direct impact on HCV+ clients.
- Coordinate with correctional agencies to ensure that parole officers and other referral sources have up-to-date information on alcohol and drug programs available to their HCV+ clients.

### **Medium Priority Interventions**

- Participate in advocacy committees and advisory groups to represent the comprehensive needs of persons affected by HCV.

### **Low Priority Interventions**

- Create additional subsidized funding for alcohol and drug providers to be used exclusively to treat HCV+ persons.
- Recommend liver enzyme function tests are performed annually or bi-annually as a condition of ongoing alcohol and drug treatment.

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## Endnotes

- <sup>1</sup> Alter, M.J., Kruszon-Moran, D., Nainan O.V., et al. The Prevalence of Hepatitis C virus infection in the United States, 1988 through 1994.
- <sup>2</sup> Centers for Disease Control and Prevention. Recommendations for Prevention and Control of Hepatitis C Virus (Hepatitis C) Infection and Hepatitis C-related Chronic Disease. MMWR 1998; 47(RR19): 1-39.
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## **APPENDIX A**

# **Social and Environmental Context of Hepatitis C in Multnomah County**

# Social and Environmental Context of Hepatitis C in Multnomah County

## Strengths

### Needle Exchange Services

There are more than one million people in the U.S. who inject drugs. This costs society (in health care, lost productivity, accidents, and crime) more than \$50 billion a year. People who inject drugs are at high risk of contracting HIV, HCV, and HBV. If they contract any of these diseases, their needle-sharing partners, sexual partners, and unborn children may also be at risk for infection.

We know that abstaining from drug use, especially drug use involving needles, is the single best way to reduce the risk of HIV and HCV transmission. We also know that many people who inject drugs will continue to do so, putting themselves and others in the community at risk. Providing a source of sterile syringes and other injection drug use equipment has been shown to reduce the spread of infectious diseases, such as HIV, and provides essential links between injectors, drug treatment programs, and other social services that provide life stability. There is no evidence that needle exchange programs increase the amount of drug use by clients or the wider community. Additionally, mathematical models show the cost effectiveness of exchange programs over five years for clients, their sex partners, and their children at an average cost of \$9,400 per HIV infection prevented. This is far below the \$119,000 lifetime average cost of treating one HIV infected person.

Multnomah County has been providing exchange services since 1989, beginning at Outside In, a community based organization that received county general funds to provide exchange, making it one of the first in the U.S. In the spring of 1996, the Multnomah County Health Department began its own exchange services. MCHD currently hosts 12 sites throughout the week for exchange services. In 2002, MCHD exchanged almost a quarter of a million syringes. In addition to exchange services at these sites, MCHD also provides:

- Safer sex supplies
- Wound care supplies
- Health information (i.e. HIV, HCV, HBV, STDs, abscess care, overdose prevention, etc.)
- Referrals to drug treatment, medical, homeless, and other social services
- Behavioral counseling to decrease risk of infectious diseases and to increase likelihood of clients seeking drug treatment services
- Positive contact with a health care professional that can then build bridges to other health and social services
- Social work support for HCV positive clients

### The Oregon Health Plan

The Oregon Legislature created the Oregon Health Plan (OHP) in 1989 to address the growing problem of Oregonians who lack access to health care. The Legislature identified three reasons for the high rate of uninsured: medical history causing some individuals to be considered too

high of a risk to insure, a lack of funds within the households of the working poor to purchase insurance that may or may not be offered by their employer, and a growing segment of the population living below the federal poverty level that were eligible for publicly funded health care.

OHP operates under a waiver from the federal government that allows the state to serve more low-income people using federal Medicaid money. This is done through an innovative system that prioritizes health care, using a list of hundreds of conditions and their treatments. Higher priority is given to conditions that can be successfully treated, and to avoiding illness through preventive care.

Currently, the full range of HCV western medical care is covered by the OHP including laboratory testing, vaccinations, Interferon and Ribavirin therapy, ongoing primary and specialty care provider visits. OHP has gone through numerous reforms and iterations since its inception, but nonetheless follows the strategy of prioritizing health care.

## **Challenges**

### **Paraphernalia Laws**

Drug paraphernalia laws in Oregon exclude hypodermic syringes, with the exception of hypodermic devices being provided to minors unless there is a demonstrated, lawful need for the minor to possess the syringe, as well as authorization of a physician, parent or legal guardian or by other means acceptable to the seller or donor.

Although it is legal to possess syringes in Oregon, a problem arises when an individual carrying used syringes (for example, someone who is accessing needle exchange services) is stopped by the police. In this case, if the syringes have residual, illicit drugs, they can be used as evidence of possession of a controlled substance. Qualitative data collected at needle exchange sites indicate that this is a deterrent for needle exchange participants to properly dispose of used syringes, increasing multiple uses of syringes as well as dangerous disposal practices (i.e. public garbage disposal, on the ground, in the street or park). Additionally, because needle exchange operates on a one-for-one basis, if an exchange participant does not bring in syringes to exchange, the participant can only receive an emergency health kit (consisting of three syringes) which may be insufficient to fulfill safer injection needs.

### **Drug Free-Zones**

Drug-Free Zones (DFZ) are areas in the city of Portland that are designated by the City Council. In a DFZ, a person is subject to an “exclusion” (meaning they may not enter the designated area without express permission from the police, referred to as a “variance”) from the designated area for a period of 90 days if that person has been arrested based upon probable cause to believe that that person has committed a specified offense within a DFZ. Additionally, a one-year exclusion can be issued under certain circumstances. A variance can be granted to a person with an exclusion to enter the DFZ for certain services, such as meeting with an attorney or a scheduled appointment with a social service provider. More specific information about the DFZs can be found in the city of Portland charter, title 14, addressing public order and police.

Several needle exchange sites are located within DFZs. Because a person can be excluded from an area based on probable cause, many exchange clients say they are afraid to carry used syringes within the zones. Thus, many IDU do not bring used syringes back to the syringe exchange site, increasing the likelihood for syringe-sharing, multiple use, improper disposal, and exposing IDU and other community members to infectious diseases.

A ruling by a Multnomah County judge indicated that the appeal for DFZ exclusions may be unconstitutional. This case resulted in the dismissal of a dozen defendants who decided to challenge the constitutionality of their exclusion appeal. However, most people do not appeal their exclusion and city officials are currently attempting to change the appeals process to respond to this case.

### **Oregon Health Plan**

As of this writing, OHP faces continuing challenges due to rising health care costs, lower-than-projected state revenues, failed tax increases, and a limited Medicaid budget. These circumstances mean that access to health care will be reduced. Specifics about who will lose health care coverage and the associated long term costs remain to be seen.

# General Information about Multnomah County

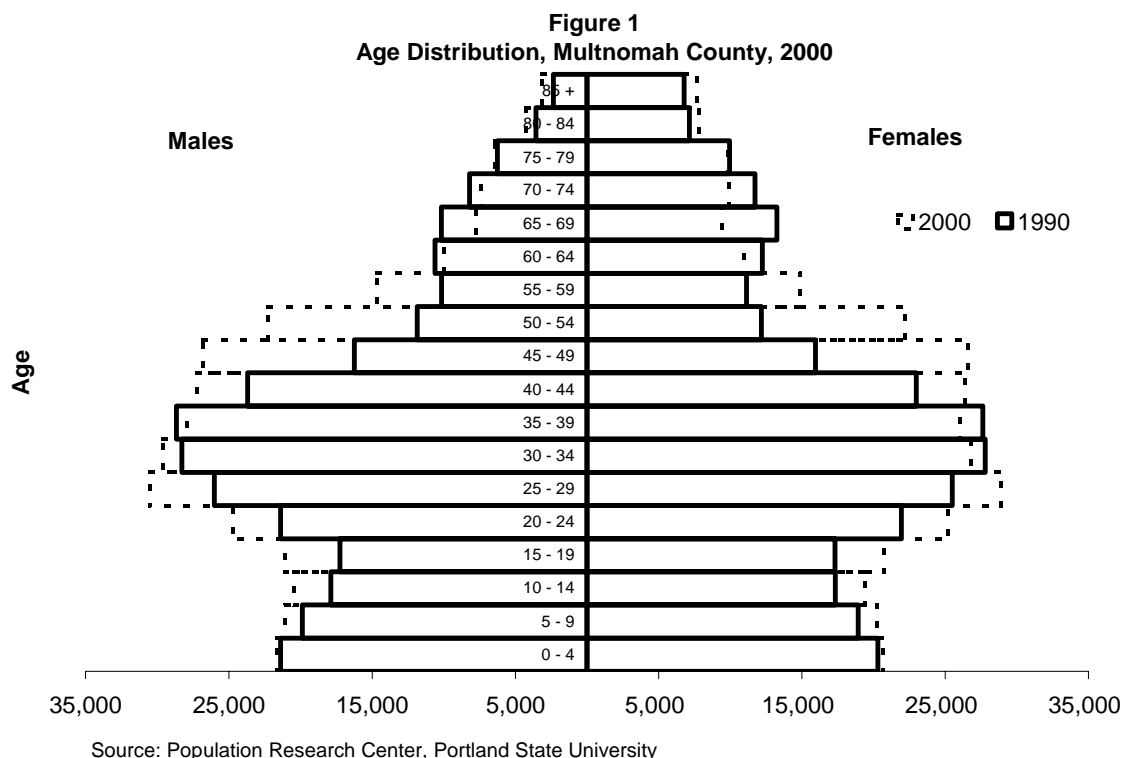
## General Population

Multnomah County is largely urban, and home to 19.3% of Oregon’s population. The city of Portland is the county seat and comprises 80% of the county population. The next largest city is Gresham with 14% of the population. The cities of Troutdale, Fairview, and Wood Village comprise the remainder of the population.

From 1990 to 2000, the population of Multnomah County grew 13%, from 583,887 to 660,486. During the same period, the population of Oregon grew 20%.

## Age Distribution

In 2000, the median age of Multnomah County residents was 35 years. Population growth was not evenly distributed among age groups. Figure 1 shows absolute population growth in the county between 1990 and 2000. The population of adults 74 years and older has remained relatively constant as has the population of very young children (0-4). The population of children (5-9), adolescents (10-19), and young adults (20-29) has increased. The largest increase in the adult population was among 45-54 year olds. The county has seen a decrease in the population of 60-74 year olds and 35-39 year olds.



## Race and Ethnicity

The 2000 U.S. Census asked individuals to respond to the question of race differently than it had in the past. In 2000, individuals had the opportunity to choose more than one racial category to describe themselves. In addition, the category Asian/Pacific Islander was divided into two categories: Asian and Native Hawaiian/other Pacific Islander. This resulted in racial categories

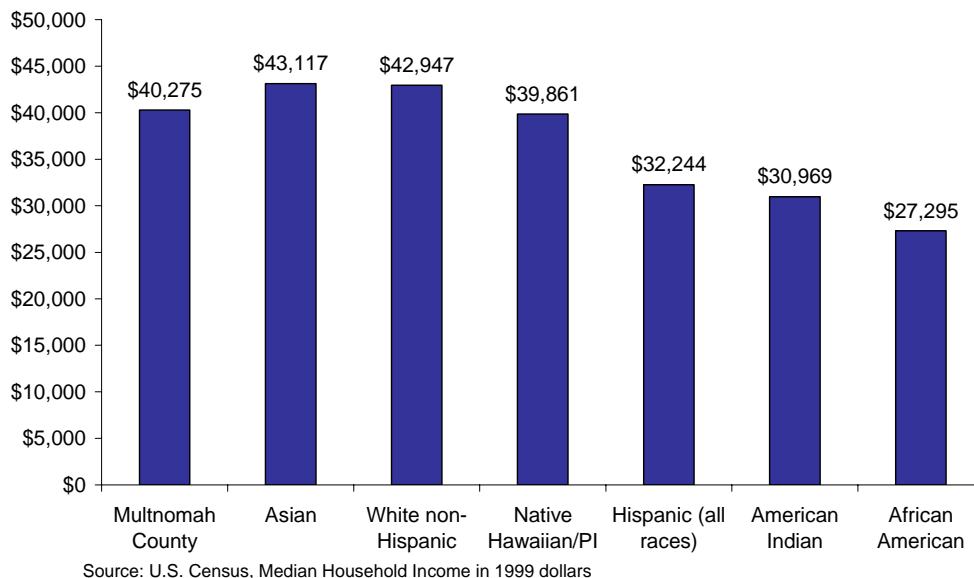
of White, African American, Asian, Native Hawaiian/other Pacific Islander, American Indian, two or more races, and some other race. The question of Hispanic or non-Hispanic ethnicity remained unchanged in 2000. These changes make comparisons to earlier census data on race difficult. According to the 2000 U.S. Census, White non-Hispanics make up the largest percentage of the population of Multnomah County (Table X). Among populations of color, Hispanics make up the largest percentage of the population, followed by African Americans and Asians.

<b>Table X</b>	
<b>Race/Ethnicity</b>	<b>Percent</b>
White non-Hispanic	76.5%
Hispanic (of any race)	7.5%
African American	5.7%
Asian	5.7%
American Indian	1.0%
Native Hawaiian or Pacific Islander	0.4%
Two or more races	4.1%
Some other race	4.0%

### **Income and Poverty**

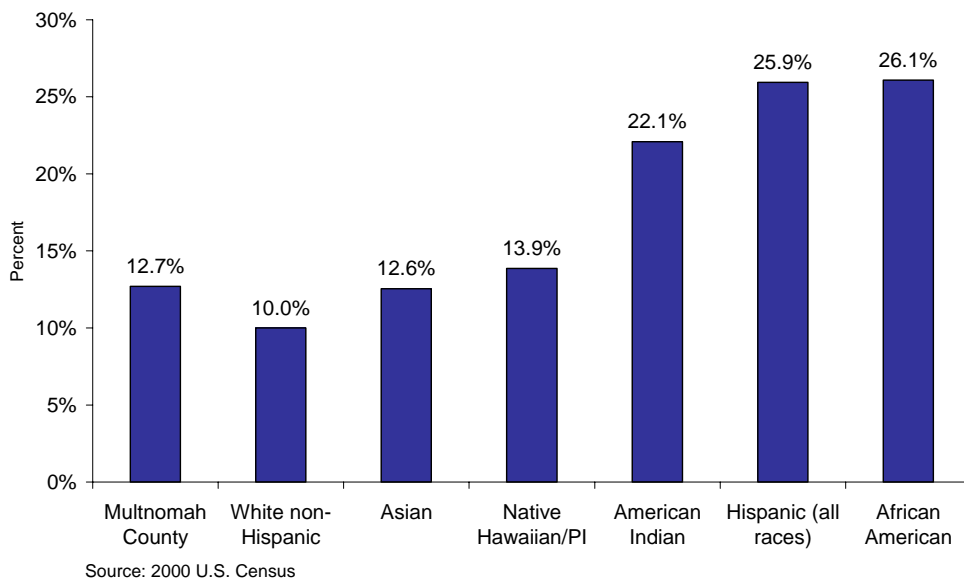
The 2000 U.S. Census reports that, at \$40,275, the median income in Multnomah County was 1.8% higher than median income for Oregon (\$39,575), and 2.8% lower than median income for the United States (\$41,433). In Multnomah County, Hispanic, American Indian, and African American populations have a lower median household income than other racial/ethnic groups. The median household income for African Americans is the lowest of any racial/ethnic group and is 33% lower than the county median household income.

**Median Household Income by Race/Ethnicity  
Multnomah County 2000**



African Americans and Hispanics have higher percentages of individuals at or below 100% of federal poverty level, followed closely by American Indians (Figure 4). The percentage of African Americans in poverty is more than twice as high as for the county as a whole.

**Population below 100% Federal Poverty Level  
Multnomah County 2000**



## **APPENDIX B**

### **Needs Assessment Summary and Individual Survey Results**

# Needs Assessment Summary

This summary compares results across surveys to look at similarities and differences based on the survey respondents and questions. The goal of this broader analysis was to identify discrepancies or disparities of HCV prevention, care, services, and knowledge among varying health care professionals and community members.

## 1. Education

Education was identified as a barrier by 10% of social service respondents, 9% of CAM providers, and 29% of consumers. Survey themes related to education refer to lack of available HCV education and awareness of resources available.

### a. Knowledge of Hepatitis C Information

Overall, knowledge about HCV and its prevention was fairly high among respondents. The vast majority of respondents indicated:

- HCV was a virus that affects the liver
- To prevent HCV, one needs to avoid sharing needles (92% or greater), tattooing and piercing equipment (82% or greater), and unprotected sex with unknown partners (77%-84%).

A small but significant proportion of respondents held incorrect assumptions about HCV (i.e. sexual acquisition risk of HCV), indicating the need for continued community education.

### b. Source of Information and Knowledge

Sources used for additional HCV information were quite different when comparing the Community/High Risk and the General Population surveys with the Provider (CAM and Social Service) surveys.

Specifically, “Doctor” and Health Department were the sources chosen by both Community/High Risk clients and General Population respondents. Social Service providers chose the Health Department and the Internet, while CAM providers indicated the Internet and the Library as preferred sources for further information. Preference for the Internet as a source could possibly reflect differential computer access.

## 2. Five Most Important Services

With the exception of the General Population Survey, each survey included a question about the five most important services for persons with HCV. Consumers and providers ranked the following services among the top five most important services:

- HCV Education
- HCV Treatment
- Alcohol and Drug Services
- Western Medical Care

- Complementary and Alternative Medical Care (CAM)

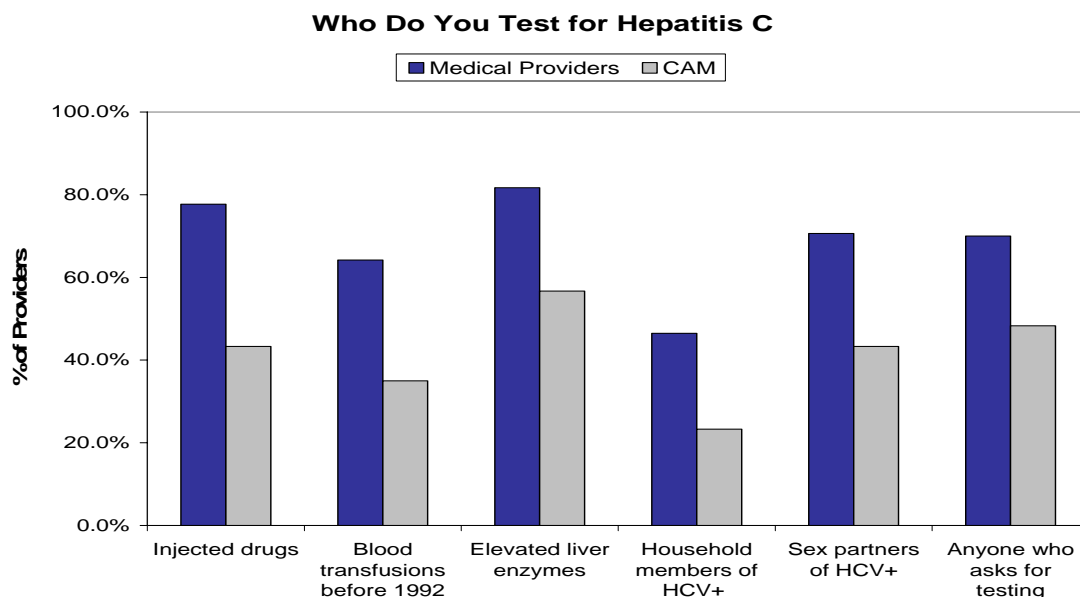
44.2% of consumers ranked help with health care costs in the top five services; however only 21.7% of medical providers and 35% of CAM providers rated this in the top five most important services.

### 3. HCV Screening and Testing Availability

85% of medical providers and 50% of CAM providers offered HCV screening and testing. People with elevated liver enzymes, injection drug users (IDU), and “anyone who asked for testing” were the people most often tested by both medical and CAM providers.

Information given to clients at the time of testing included:

- HCV transmission risks
- Effects of alcohol, drugs, and/or herbs on the body
- Common HCV symptoms
- Recommendations for hepatitis A and B vaccines



### 4. Housing Needs

Of the community/high risk individuals responding, 34% indicated they did not have stable housing, and 9.6% were either “unsure” of their housing situation or indicated that it was “pending”.

23.9% of consumers ranked housing assistance in the top five most important services, but this was ranked low by both medical providers (2.8%) and CAM providers (3.3%). 20.8% of social service providers ranked housing assistance in the top five services.

## **5. Insurance**

Among the community respondents surveyed, 75% indicated they had some kind of insurance. The majority (77.5%) had Medicaid/Oregon Health Plan coverage.

Insurance was identified as a barrier by 38% of western medical providers, 31% of social service respondents, 43% of CAM providers, and 29% of consumers. Specific insurance barriers identified by respondents included eligibility for OHP, cost, and lack of or restricted insurance for mental health, alcohol & drug, and CAM services.

On average, medical providers reported 9.8% of their clients declined recommended treatment due to cost. CAM providers estimated 10.7% declined treatment for cost reasons.\*\*\*

\*\*\*Surveys were conducted prior to the state budget crisis that befell the state affecting all education, public health, public safety, and social services within the counties. Millions of dollars were cut from the budget and one result has been a substantial reduction in the number of people eligible to remain on the Oregon Health Plan (OHP). This has led to approximately 20,000 people either losing their benefits or forced to pay a premium and/or co-payment for health and/or pharmaceutical services.

## **6. Patient Attributes**

Patient attributes were identified as a barrier to service, care, and/or treatment by 13% of western medical providers, 10% of social service respondents, and 9% of CAM providers. Attributes were defined by respondents as: alcoholism, drug abuse, depression, lack of follow up or compliance, and patient resistance to treatment.

## **7. Provider Confidence in Management of Hepatitis C**

When asked to describe their level of confidence in their knowledge of HCV on a scale of 1-5, with 5 being more confident, there was a mean response of 3.18 for medical providers and 3.22 for CAM providers.

CAM providers had a slightly higher mean response (3.03) compared to medical providers (2.37) when asked to rate their confidence in managing HCV positive clients.

## **8. Referrals & Referral Barriers**

Western medical care providers were asked how often they worked with CAM providers. 51.4% said “never” and 26.6% said “on occasion.”

When CAM providers were asked how often they worked with medical providers, 48% said “almost always” and 16% said “always.” 56.7% of CAM providers indicated that they referred to medical care providers, and 13.3% indicated they had experienced barriers when making these referrals.

Western medical provider resistance to alternative therapies was identified as a barrier by 22% of complementary and alternative survey respondents.

25% of social service providers reported encountering barriers to both primary medical care and mental health counseling. One-third (33.5%) of medical providers who referred to specialists reported encountering barriers.

## **9. Service Barriers for People with Hepatitis C**

### **a. Stigma Related to Drug Use History and Disease Status**

22.9% of HCV community respondents indicated having been treated badly or denied service because of their HCV status. Community participants were asked if they had been treated badly or denied service because they told a provider about injection drug use. 29.5% answered “yes.”

### **b. Access to Care**

Of the community respondents surveyed, 31% reported encountering trouble with housing assistance, 29.3% with rent or utility assistance, and 22.6% with health insurance.

Access to care was identified as a barrier by 49% of western medical providers, 48% of social service respondents, 17% of CAM providers, and 29% of consumers.

Access to care and service issues commonly reported among respondents included: limited availability of mental health and alcohol & drug services, lack of specialists, poor treatment by providers, time and waiting lists (3-6 months), paperwork and scheduling (dysfunctional services or systems), limited access to alternative medicine, language barriers, and transportation.

### **c. Treatment Eligibility**

Of the medical providers who responded and indicated that they provided treatment, 48.3% said they required IDU patients to go through a 6-12 month waiting period before beginning treatment. 16.6% of community respondents indicated they were current IDU (within last 3 months), and 37.1% said they were former users (more than 3 months).

## **B1. Community/High Risk Client Survey**

# Community/ High Risk Client Survey

The CPG developed and distributed a 20-question survey to elicit knowledge, attitudes, beliefs, and behavioral information from people at-risk for, or living with, HCV. Out of 210 surveys distributed, a total of 197 surveys were collected, yielding a 93% response rate.

## Methodology

### A. Design

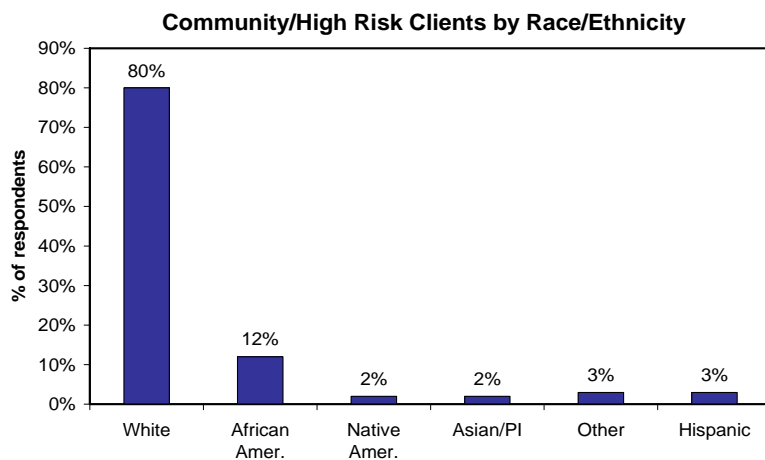
Survey questions were designed as multiple choice or selection criteria questions. Some questions were open-ended to elicit more in-depth answers. In an attempt to identify trends and themes, some questions were repeated to other targeted survey participants (i.e. medical providers, social service providers).

### B. Method

Survey participants were a convenience sample found at eighteen different venues including: mental health groups, youth shelters, drug and alcohol treatment centers, education and support groups, needle exchange sites, street outreach, the Multnomah County STD Clinic, and a parole and probation office.

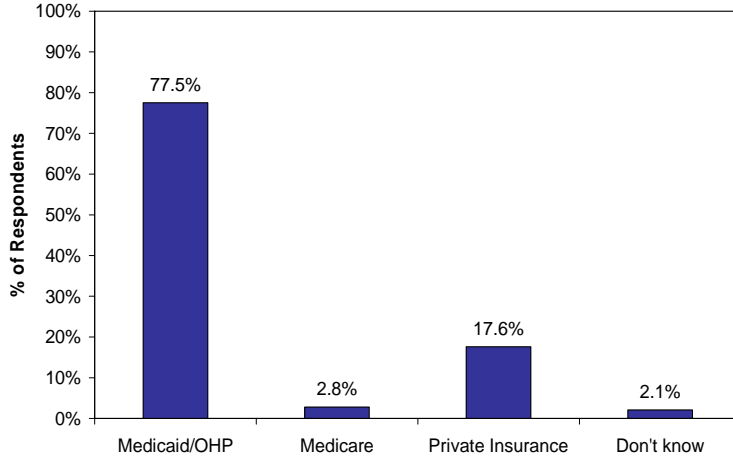
Surveys were distributed between September 18 and September 26, 2002. Several CPG members assisted in distributing the surveys to participants, who in turn were asked to complete the survey at that time to optimize response rates. Survey participants were given a food voucher (average value \$3) as compensation for their time.

## Quantitative Findings



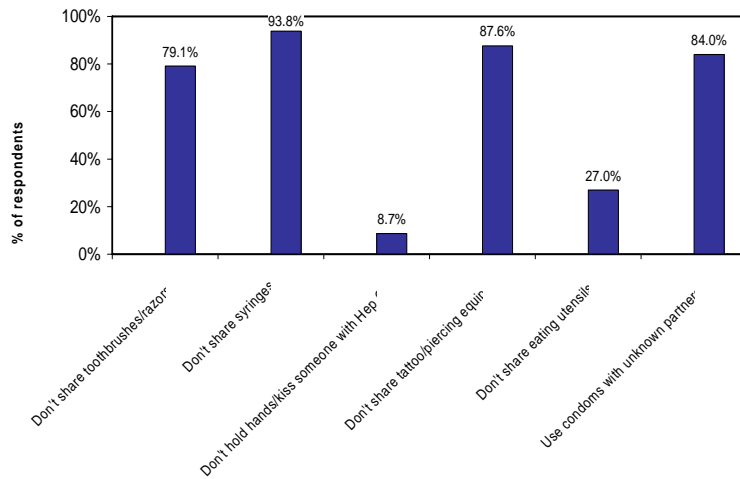
The majority of respondents were White, and 62% were male. More than one-half (56%) of respondents were aged 30-49, and 13% were age 21 or younger. 17% indicated that they were current injection drug users (used within last three months) and 40% said they were former users (over 3 months).

**Type of Health Insurance**



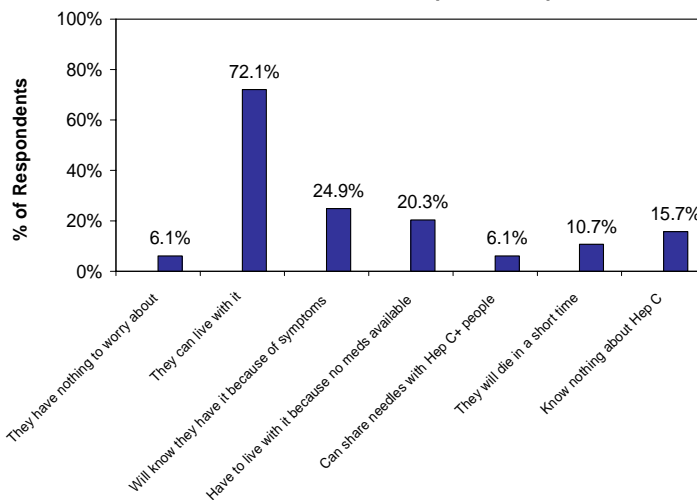
Nearly 98% of respondents indicated that they had some type of health insurance at the time of this survey. The majority (77.5%) had Medicaid/Oregon Health Plan.

**Ways to Stop the Spread of Hepatitis C**

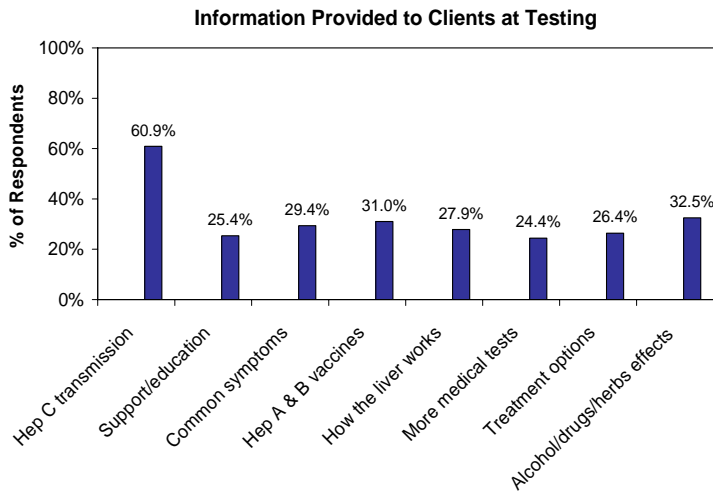


When asked about ways to prevent hepatitis C, nearly 94 % said “don’t share syringes,” 88% said “don’t share tattooing or piercing equipment,” and 84% said “use condoms with unknown sex partners.”

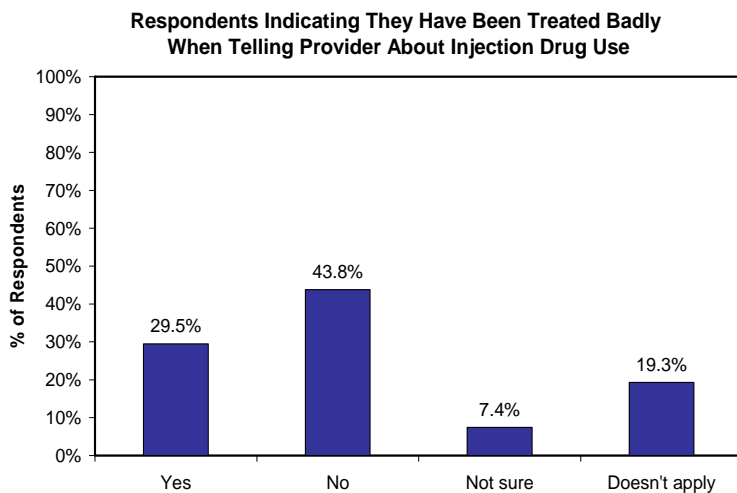
**What Have You Heard About People With Hepatitis C**



Survey participants were asked “What have you heard about people who have hepatitis C?” 72 % said they had heard “they can live with it,” while nearly 16% said, “I know nothing about hepatitis C.” A small but significant proportion of respondents held incorrect assumptions about hepatitis C, indicating the need for continued community education.

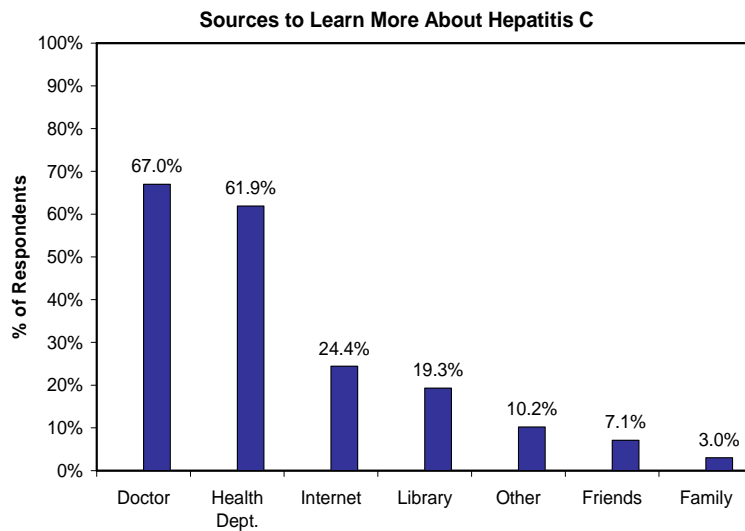


Survey participants were asked what information they were given by their health care provider at the time of testing for hepatitis C. 61% said they were given information on how hepatitis C is transmitted and prevented; 33% were told about the effects of alcohol, drugs, and herbs on the liver, and 31% were informed to get vaccinated for hepatitis A and B.



23% of respondents said that they had been treated badly or denied service because of their hepatitis C status. Participants were also asked if they had ever been treated badly or denied service if they told a provider they had used injection drugs. 29.5% said “yes,” and 7.4% said they were “not sure.”

<b>% of Respondents Experiencing Trouble Obtaining Services</b>	
Housing assistance	31.1%
Rent/utility assistance	29.3%
Health Insurance	22.6%
Food/clothing assistance	21.8%
Mental Health Counseling	21.3%
Hepatitis C education	21.1%
Complementary/alternative care	20.0%
Medical care	19.2%
Support groups	18.3%
Alcohol & Drug Services	17.7%
Hepatitis A&B vaccines	14.6%
Hepatitis C testing	14.6%
Interferon based therapy	12.6%
Case management	12.3%
STD/HIV services	10.5%
Syringe/needle exchange	7.8%



When survey participants were asked to identify places to go to learn more about hepatitis C, “Doctor” (67%) and “Health Department” (61.9%) were the sources chosen most frequently.

<b>Most Important Things for Social Service Provider To Know About Hepatitis C</b>	
How hepatitis C is transmitted	52.3%
Treatment options	43.1%
Sources for support/education	39.1%
Common symptoms	36.0%
How the liver works	29.9%
Changing my lifestyle	25.9%
Self mgmt. education/counseling	25.9%
More medical tests	24.4%
Effects of alcohol/drugs/herbs	22.3%
Hepatitis A & B vaccines	18.8%

Respondents were asked to rate the three most important things they would like social service providers (e.g. case managers or counselors) to know about hepatitis C. The top three were “How hepatitis C is transmitted” (52.3%), treatment options (43.1%), and sources for support or education (39%).

## Qualitative Findings

The following open-ended questions were asked and responses received:

**Question 9:** Are there any services you need that are not listed above?

### Medical Services

- Blood donation (2)
- Comprehensive vaccination services to initiate treat and monitor clients
- Pain management (1)
- HIV testing (1)

### Education

- HCV education and information (5)

### Cost/Financial

- Have all my medicines paid for, not just part of them.
- Insurance coverage for herbal medicine
- Low cost treatment or low cost physician visits

**Question 11:** If you answered YES to any of the above please write about the trouble you had (getting services)

### Insurance

- Lack of insurance, cost of treatment, eligibility for Oregon Health Plan

### Education

- Unaware of resources available, lack of education on HCV

### Access barriers to services

- Treated poorly by providers, housing managers

- Lack of services available
- Homelessness, lack of housing
- Confidentiality problem
- Limited syringe exchange
- Time, waiting lists, paperwork
- Access to alternative medicine
- Access to testing
- Access to fresh food
- Pain, fatigue
- Incarceration

**Miscellaneous Community/High Risk Client Statements:**

- No compliance. Arrogant worker in the system not offering any resources.
- [Physician] seemed as always very detached and uncaring. Offered no solutions as always and said I'll see you in 2 weeks, 'hang in there.'
- Hospital and medical staff treat you like you're contagious and unworthy of help or bare minimum.
- Treated badly by health providers.
- People just treat me like scum when they find my history.
- Floor manager is short with me and not cooperative with my recovery. I will be homeless after Christmas vacation.
- This town is terrible about providing housing assistance for people. I'm an ex-con. I've asked my P.O. for housing assistance and all she did was pass the buck to Central City Concern and they will tell me I'm on a list that will take three weeks. Meanwhile, I'm under a bridge with no food, clothing or money. For an ex-con this is a recipe for trouble.

**Summary & Intervention Opportunities: Community/High Risk Client Survey**

**1. Client Education**

Educational activities should focus on:

- Blood-to-blood transmission of HCV and activities which facilitate blood borne infections.
- Transmission myths (i.e. holding hands) and realities
- Use of condoms or other latex barrier during sex with an HCV-infected person particularly when there is a presence of blood and/or a sexually transmitted disease because STDs, including HIV, heighten the risk of sexual transmission of HCV.

**2. Provider Education**

Health care providers, including health department employees and community social service providers, are perceived as reliable sources of HCV information and support. As such, personnel in contact with persons at-risk for or infected with HCV should, at minimum, be equipped with up-to-date information regarding HCV transmission and prevention, treatment options, and resources for client support or education.

### **3. Testing**

Routine HCV testing is recommended for persons with any history of injection drug use.

### **4. Supportive Services**

- Social service, educational, and resource information should be widely available to persons living with, or at-risk for, HCV.
- Peer support, mentor, and advocacy services may be a cost-effective means of connecting clients with service and information.

### **5. Service Barriers**

More information and discussion on barriers to obtaining service is needed.

### **6. Other**

Alcohol and drug use questions on health history forms could assist with 1) normalizing alcohol, drug use, and addictions, 2) identifying persons at-risk for, or infected with, HCV, and 3) targeting education regarding the effects of alcohol and drugs on the liver and information on community resources.

## **B2. Social Service Provider Survey**

# Social Service Provider Survey

The CPG developed and distributed an 18-question survey to elicit knowledge, attitudes, beliefs, and behavioral information from social service providers (SSP). SSP were defined as personnel working at several community-based organizations including drug and alcohol treatment centers, mental health, and youth groups. A total of 72 surveys were collected out of 156 mailed or hand-delivered, yielding a 46% response rate.

## Methodology

### A. Design

Surveys questions were designed as multiple choice or selection criteria questions. Some questions were open-ended to elicit more in-depth answers. In an attempt to identify trends and themes, some questions were repeated to other targeted survey participants (i.e. medical providers, infected or affected persons with HCV).

### B. Method

Surveys were distributed by mail or hand-delivered during between September 27 and October 18, 2002. A cover letter explaining the survey purpose and deadline, the survey, and a self-addressed stamped envelope were included in each mailing to optimize response rates.

## Quantitative Findings

<b>Describe Your Organization's Services</b>	
Drug & Alcohol	40%
HIV/AIDS	26%
Mental Health	21%
Youth	19%
Housing	19%
Other	18%
Primary care	10%
Specialty medical care	7%
Health Insurance	7%
Child/maternity	4%

When providers were asked to select what best described their agency's services, 40% selected drug & alcohol services, 26% said HIV/AIDS services, and 21% indicated mental health.

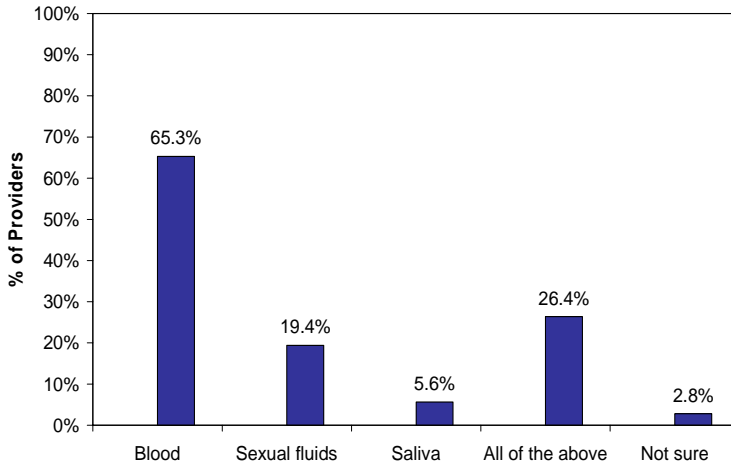
<b>Hepatitis C Specific Services Provided</b>	
Refer to medical services	56.9%
Refer to education class	45.8%
Educational materials	44.3%
Screening and Testing	29.2%
1-1 or Group education	25.0%
Peer education	20.8%
Hepatitis A & B vaccines	16.7%
Acupuncture or massage	16.7%
Herbs or supplements	15.3%
Case management	11.1%
Syringe/needle exchange	11.1%
Support groups	5.6%
Mentoring	1.4%

When asked what type of HCV specific services they provided, referral to medical care was the service offered most frequently, followed by referral to education classes and educational materials.

<b>Provider Awareness of Services Available for HCV</b>	
Hepatitis C testing	90.3%
Hepatitis A&B vaccines	69.4%
Medical care	68.1%
Alcohol and drug services	65.3%
Syringe/needle exchange	63.9%
Hepatitis C Education class	62.5%
Mental Health Counseling	48.6%
Treatment for HCV	47.2%
STD/HIV testing/treatment	47.1%
Case management	43.1%
Complementary or Alternative Care	43.1%
Health Insurance	38.9%
Support groups	26.3%
Transportation assistance	23.6%

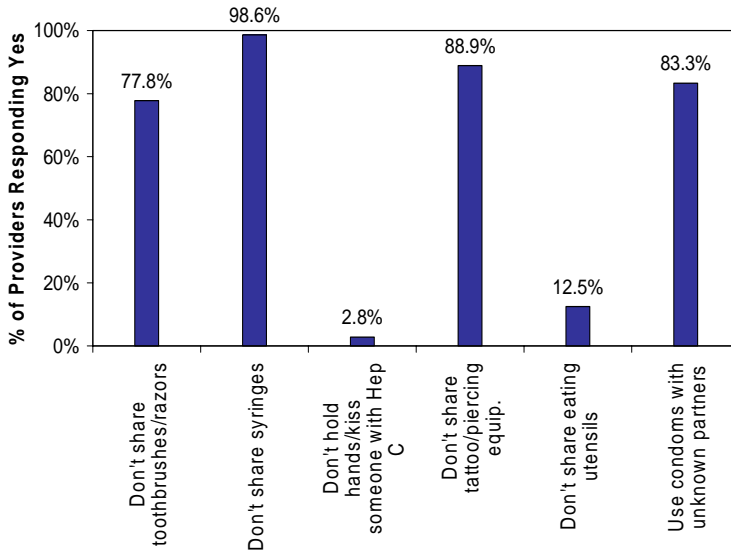
Providers were asked what services they had heard about for their clients with hepatitis C in Multnomah County. Almost all providers (90%) were aware of the availability of hepatitis C testing services. The majority of providers were also aware of hepatitis A&B vaccines, medical care, alcohol/drug services, needle exchange, and education classes.

**How is Hepatitis C Spread?  
Social Service Provider Response**



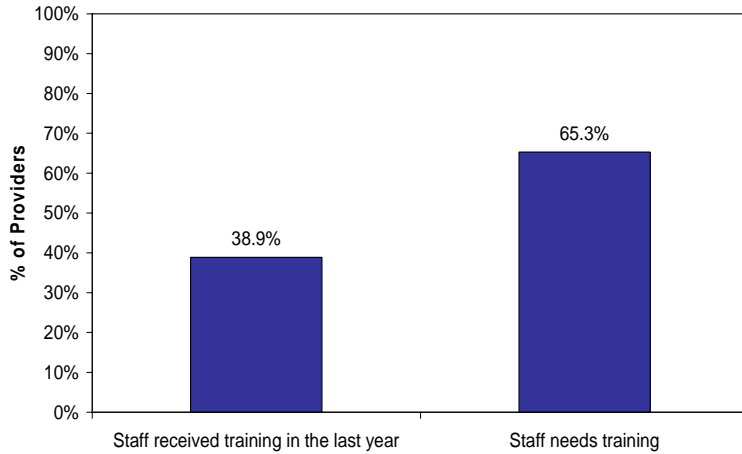
The majority of social service providers surveyed (nearly 99%) knew that hepatitis C was a virus that affected the liver. When asked how hepatitis C is spread, 65% of providers indicated it was spread by blood, 19% by sexual fluids, 6% by saliva, and 26% thought “all of the above.” Nearly 3% of providers were “not sure.”

**Ways to Stop the Spread of Hepatitis C**



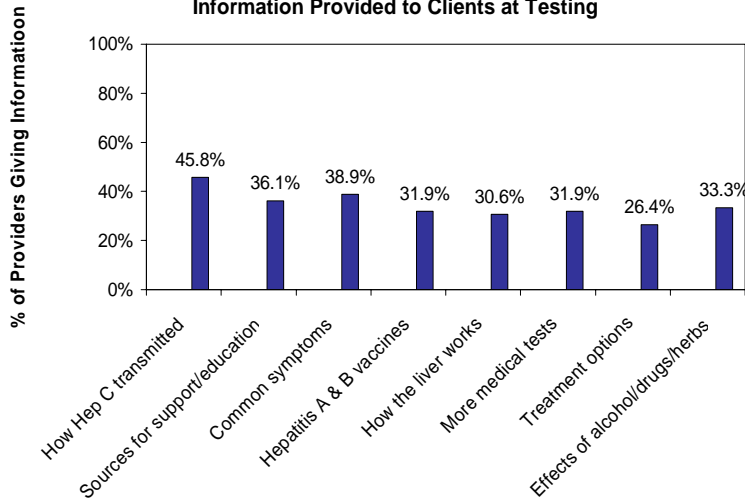
Providers were also asked some ways to stop the spread of hepatitis C. Nearly 99% said not to share syringes, 89% said don't share tattooing or piercing equipment, 83% said using condoms with unknown sex partners, and 78% said don't share toothbrushes or razors.

### Staff Training



Providers were asked if their staff had received training on HCV in the last year, and if they felt their staff needed training. While nearly 39% of providers indicated their staff had received training, almost two-thirds (65%) felt it was needed. Providers were asked to indicate their preferred source for staff training. 69% indicated their first choice was on-site all staff training, followed by reading educational materials (43%).

### Information Provided to Clients at Testing



When asked what type of information was provided to clients upon testing, nearly 46% of providers indicated they gave information on how hepatitis C is transmitted, and common symptoms of hepatitis C (39%). 36% provided information on where to go for support/education, and 33% gave information on the effects of alcohol, drugs, and/or herbs on the liver.

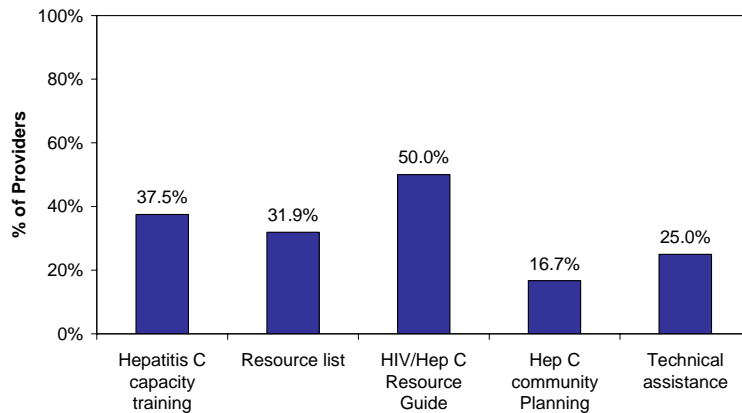
<b>% of Social Service Providers Ranking Five Most Important Services</b>	
Alcohol and Drug Services	59.7%
Hepatitis C education	58.3%
Medical care	56.9%
Hepatitis C Treatment	54.2%
Health Insurance	52.8%
Hepatitis A&B vaccines	34.7%
Support groups	25.0%
Case management	20.8%
Housing assistance	20.8%
Mental Health Counseling	18.1%
Complementary or alternative care	15.2%
STD/HIV services	12.5%
Syringe/needle exchange	11.3%
Rent and/or utility assistance	6.9%
Job assistance	4.2%
Food and/or clothing assistance	4.2%
Transportation	4.2%
Child care	1.4%
Nursing care	0.0%

Social service providers were asked to rank the five most important services for people living with hepatitis C. Alcohol and drug services, hepatitis C education, medical care, hepatitis C treatment, and health insurance were the top five rated services.

<b>% of Social Service Providers Referring to Services</b>	
Primary Medical care	81.1%
Hepatitis C testing	78.6%
Mental Health Counseling	76.5%
Alcohol and drug services	75.5%
STD/HIV testing	72.0%
Education class	71.4%
Health Insurance	68.6%
Hepatitis A&B vaccines	64.7%
Case management	62.5%
Housing	61.7%
Syringe/needle exchange	60.4%
Diet/nutrition	58.0%
Financial assistance	55.3%
Food and/or clothing assistance	52.1%
Rent and/or utility assistance	52.1%
Transportation assistance	49.0%
Interferon based therapy	31.0%
Support groups	28.3%
STD/HIV treatment	21.7%

<b>% of Social Service Providers Experiencing Barriers to Services</b>	
Health Insurance	27.8%
Housing	26.4%
Primary Medical care	25.0%
Mental Health Counseling	25.0%
Financial assistance	25.0%
Rent and/or utility assistance	22.2%
Alcohol and drug services	20.8%
Support groups	16.7%
Transportation assistance	15.3%
Case management	13.9%
Hepatitis C testing	12.5%
Education class	12.5%
Food and/or clothing assistance	12.5%
Diet/nutrition	11.1%
STD/HIV treatment	11.1%
Syringe/needle exchange	9.7%
Hepatitis A&B vaccines	8.3%
Interferon based therapy	8.3%
STD/HIV testing	4.2%

**Social Service Provider Awareness of Hepatitis C Services for Providers**



Social service providers were asked if they had heard of hepatitis C services that were available for service providers. One-half of providers were aware of the HIV/HCV Resource Guide, but only 17% were aware of community planning opportunities.

<b>Desired Topics for Further Education</b>	
Treatment options	58.3%
Community resources	54.2%
Latest research	43.1%
Dual diagnosed HIV/HCV patients	38.9%
Where to refer clients for more medical tests	37.5%
Psychosocial Issues	33.3%
How HCV is transmitted and/or prevented	31.9%
HCV disease progression	27.8%
Effects of alcohol, drugs, herbs on the liver	26.4%
Integrating HCV into programs	23.6%
Common symptoms	23.6%
Client risk reduction	22.2%
How the liver works	19.4%
Interaction of hepatitis A&B	9.7%

## Qualitative Findings

The following open-ended questions were asked and responses received.

**Question 9:** In your management of hepatitis C positive patients, which support or treatment programs do you generally refer clients to, and have you experienced any barriers in referring them?

### Responses (n=77):

#### Services (48% or n=37)

- Availability of Mental Health and A&D services and resources (17)
- Waiting list, “hoops” (14)
- Access to providers (3)
- Transportation, language (3)

#### Insurance (31% or n=24)

- No insurance/cost (9)
- Qualification for OHP (7)
- Eligibility (5)
- Lack of Mental Health and A&D service coverage (3)

#### Patient issues (10% or n=8)

- Patient resistant to engage in services(8)

#### Education (10% or n=8)

- Educational resources needed (8)

**Question 18:** Have you had to change your service delivery to meet the needs of hepatitis C positive clients?

**Responses (n=10):**

- Offer alternative work skills experiences (other than just food services) to our clients
- Clients have been a valuable resource for us to learn more
- Need more information about co-infection with HIV
- Separate “HCV clinic” cancelled due to lack of interest; clients want an integrated approach
- Incorporated a needle exchange site for HCV. This expanded education, training for volunteers and peer educators, supplies: rinse caps, cotton balls, water, tourniquet
- Had to have less stringent requirements for clients who are ill
- More referrals for medical care
- Time for learning or education
- Our county (Washington County) doesn’t provide many (if any) of these services to HCV+ clients. We aren’t testing for it so I pretty much send my highest risk clients to Multnomah County, which puts a bigger burden on them. Many services are not available to incarcerated clients, which makes successful referrals difficult at best. Also, transportation to Multnomah County is a barrier for most clients.

**Miscellaneous Social Service Provider Statements**

- Not enough services; long waiting lists; services don’t respect client populations so clients are resistant to engage; few resources for the number of clients.
- Need more needle exchange programs available
- Hard times for appropriate funding for mental health services
- We focus on alcohol and drug detox, not on continuing care. It would be nice to have brochures offering info about the above things: support groups, etc. Lack of insurance to cover medical/psych. Community referrals.
- Clients on OHP or without insurance cannot find primary care docs. It is very hard to get clients in to see mental health counselors. The paperwork for OHP is difficult and if you make just over the limit you don’t qualify.
- These services are hard to get due to HCV being a long term disease and the only services we have are for short term. Mental health counseling and interferon are a rarity due to funding.”
- Barriers include waiting lists, eligibility based on income or criminal history, services unavailable in area near clients, lack of financial assistance for clients, long application procedures (too much personal info required to apply for services), contact with insensitive and undereducated staff.

**Summary & Intervention Opportunities: Social Service Provider Survey**

**1. Provider Education**

Social service providers are perceived as reliable sources of HCV information and support and should, at minimum, be equipped with up-to-date information regarding HCV transmission and prevention, treatment options, and resources for client support or education.

Social service providers are interested in more than just the “basics” related to HCV. This interest and motivation to learn can cultivate a network of highly skilled, specialized educators in a variety of social service institutions servicing HCV positive clients. In-depth and booster training should be widely available to social service providers. There are opportunities to further inform social service providers about availability of existing, no-cost HCV training.

Educational activities should focus on:

- Blood-to-blood transmission of HCV and activities which facilitate blood borne infections
- Transmission myths (i.e. holding hands) and realities
- Use of condoms or other latex barrier during sex with a HCV-infected person when there is a presence of blood and/or sexually transmitted disease. STDs, including HIV, may heighten the risk of HCV transmission
- The availability of free education classes and peer-based HCV support groups
- Peer support, mentor, and advocacy services being a cost-effective means of connecting clients with services and information
- Community planning opportunities for persons infected or affected with HCV
- Free, monthly, HCV education classes are available and may be underutilized by social service providers. There are opportunities to optimize referrals to these monthly classes.

## **2. Barriers to Services**

More information and discussion on barriers to obtaining service is needed. Community participants surveyed reported barriers in accessing medical care and supportive services. Relationship-building and ongoing exchange of agency information between referents and referral providers may optimize referral outcomes.

Providers realize the importance of health care access, education and alcohol and drug support services for people living with HCV. There remain opportunities; however, there continues to be barriers to access to medical care, mental health, and A&D services among persons without insurance, underinsured, and among persons without citizenship or documentation.

## **3. Other Recommendations**

- For greater representation of HCV knowledge, attitudes, beliefs, and needs, expanded survey participation beyond a convenient sample of providers should be considered.
- Expand distribution of the HCV resource list and HIV/HCV Resource Guide to social service providers.

## **B3. Complementary and Alternative Medical Provider Survey**

# Complementary and Alternative Medical (CAM) Provider Survey

The CPG developed and distributed a 17-question survey to elicit knowledge, attitudes, beliefs, and behavioral information from complementary and alternative medical providers (CAM). CAM were defined as Acupuncturists, Naturopaths, and Chinese Herbalists. A total of 60 surveys were collected out of 213 mailed or hand-delivered yielding a 28% response rate.

## Methodology

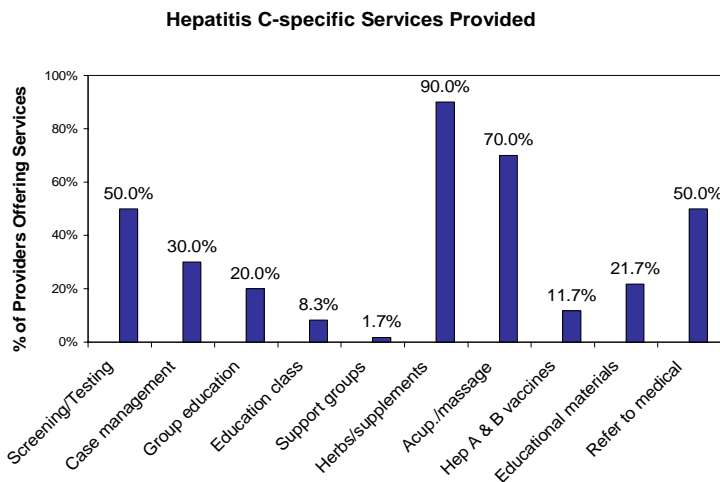
### A. Design

Survey questions were designed as multiple choice or selection criteria questions. Some questions were open-ended to elicit more in-depth answers. In an attempt to identify trends and themes, some questions were repeated to other targeted survey participants (i.e. medical providers, infected or affected persons with HCV).

### B. Method

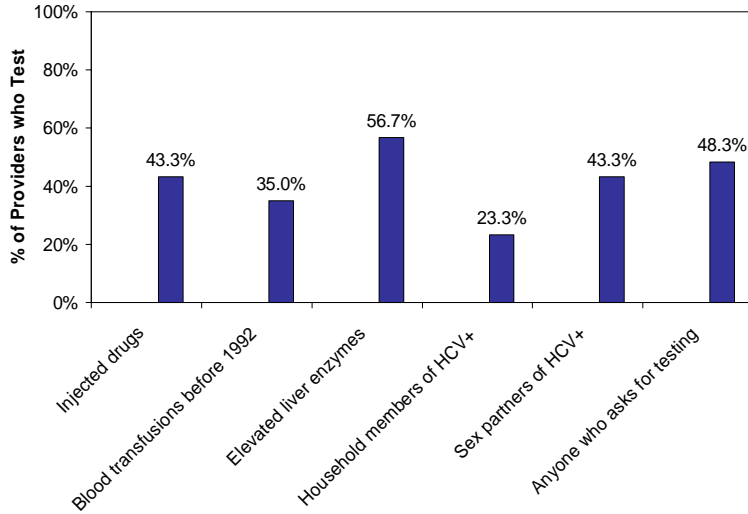
Surveys were distributed by mail or hand-delivered between October 1 and 18, 2002. A cover letter (explaining the survey purpose and deadline), the survey, and a self-addressed stamped envelope were included in each mailing to optimize response rates.

## Quantitative Findings



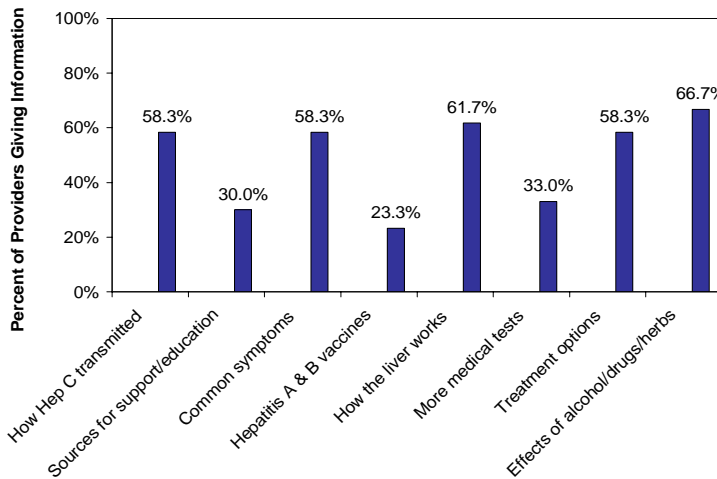
When asked what type of HCV specific services they provided, 90% of providers supplied herbs/supplements and 70% provided acupuncture/massage services. Fifty percent of providers indicated they offered screening and testing, and the same number said they provided referrals for medical services. 30% provided case management, 22% provided educational materials, and 20% offered one-to-one or group education.

**Who Do You Test for Hepatitis C**



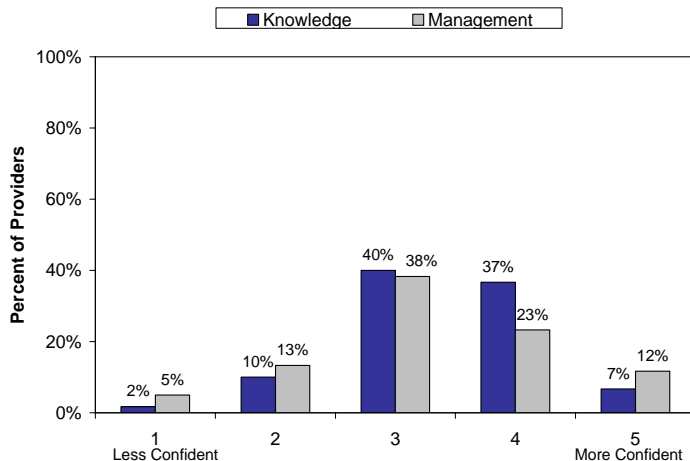
When asked which clients they test for hepatitis C, 57% of providers reported testing when clients had elevated liver enzymes, and 43% tested for clients who either had injected or snorted drugs, or who were a sex partner of someone who was hepatitis C positive. 48% of providers indicated that they tested anyone who requested testing. If they did not provide testing themselves, 58% indicated that they knew where to refer patients for testing for HCV.

**Information Provided to Clients at Testing**



When asked what type of information was provided to clients upon testing, two-thirds of providers indicated they gave information on the effects of alcohol, drugs, and/or herbs on the liver, and 62% provided information on how the liver works and how to protect it. 58% provided information on how hepatitis C is transmitted and prevented, and treatment options.

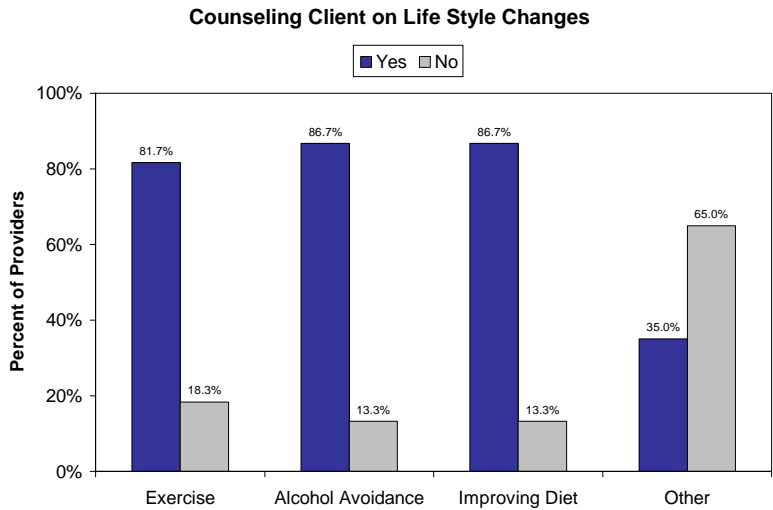
**Provider Confidence Level in Knowledge and Management of Hepatitis C**



When asked to describe their level of confidence in their knowledge of hepatitis C on a scale of 1-5, with 5 being more confident, there was a mean response of 3.22. The mean response when asked to rate their confidence in managing hepatitis C positive clients was 3.03. In the management of hepatitis C clients, 53% of providers indicated that they “always” or “almost always” worked with allopathic medical providers.

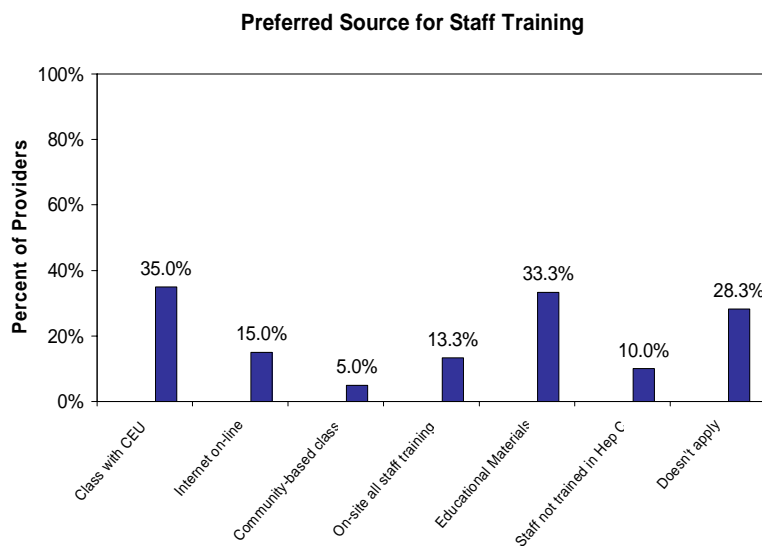
% of CAM Providers Ranking Five Most Important Services	
Complementary or Alternative Care	71.7%
Hepatitis C Treatment	58.3%
Hepatitis C Education	50.0%
Alcohol and Drug Services	45.0%
Health Insurance	45.0%
Medical care	41.7%
Help with health care costs	35.0%
Case management	31.7%
Support and social groups	25.0%
Mental Health Counseling	11.7%
Syringe/needle exchange	6.7%
STD/HIV services	6.7%
Hepatitis A&B vaccines	5.0%
Food and/or clothing assistance	3.3%
Housing assistance	3.3%

Providers were asked to rank the five most important services for people living with hepatitis C. In addition to those services listed in the table, the following were *not* rated in the top five services by any provider: rental assistance, transportation, child care, job assistance, or nursing care. When asked if they had needed to change their services to meet the needs of people living with hepatitis C, near 98% responded “no”.



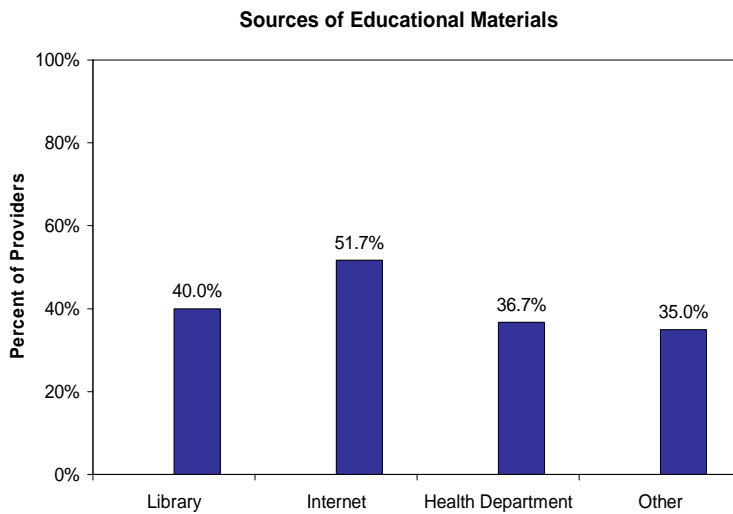
When asked if they counseled hepatitis C patients on lifestyle changes, 82% of providers gave counseling on exercise, and 87% provided counseling on alcohol avoidance and improving the client’s diet. Some of the other topics discussed included stress reduction and relaxation techniques, avoiding the risk of infecting others, and increasing water intake.

<b>% of CAM Providers Referring to Services</b>	
Western Medical care	56.7%
Hepatitis C testing	46.7%
Diet/nutrition	33.3%
Mental Health Counseling	30.0%
Alcohol and drug services	30.0%
Support groups	28.3%
STD/HIV testing	26.7%
Interferon based therapy	23.3%
Case management	23.3%
Hepatitis A&B vaccines	21.7%
STD/HIV treatment	21.7%
Education class	18.3%
Health Insurance	15.0%
Syringe/needle exchange	10.0%
Housing	6.7%
Food and/or clothing assistance	5.0%
Rent and/or utility assistance	5.0%
Financial assistance	5.0%
Transportation assistance	3.3%



Providers were asked to indicate their preferred source for staff training. 35% indicated their choice was a class with continuing education credit, followed by educational materials (33%), internet on-line (15%), and on-site all staff training (13%). 28% said this question did not apply to their staff.

<b>Desired Topics for Further Education</b>	
Latest research	66.7%
Treatment options	58.3%
Community resources	53.3%
Hepatitis C disease progression	40.0%
Where to refer clients for more medical tests	36.7%
Dual diagnosed HIV/HCV patients	20.0%
How HCV is transmitted and/or prevented	15.0%
Interaction of hepatitis A&B	15.0%
Psychosocial Issues	13.3%
Effects of alcohol, drugs, herbs on the liver	13.3%
Integrating HCV into programs	13.3%
Common symptoms	10.0%
Client risk reduction	8.3%



Providers were asked what sources they used for educational materials on hepatitis C. The most frequently used source of information was the internet (52%), followed by the library (40%), and the Health Department (37%). 35% of providers said they used other sources including professional journals, workshops, and continuing education classes.

## Qualitative Findings

The following open-ended questions were asked and responses received.

**Question 1:** What, if any, hepatitis C-specific services does your practice provide?

**Responses (n=6):**

- Alternative medicine (4)
- Life skills counseling (2)

**Question 3:** Which of the following clients do you test for hepatitis C?

**Responses (n=4):**

- Children of mothers with HCV, people who suspect they have HCV or have clinical history, and recommended partners of clients

**Question 5:** If information is provided to clients upon testing for hepatitis C, what information do you include?

**Responses (n=5):**

- Alternative medicine options, lifestyle and/or diet counseling, if clients want information we discuss (patient driven), more information on test
- Some people are asymptomatic and seeking treatment to prevent future symptoms

**Question 10:** Do you counsel hepatitis C positive patients to consider any of the following lifestyle changes?

**Responses (n=23):**

- Lifestyle counseling (diet, breathing) (35% or n=8)
- Stress management (30% or n=7)
- Alternative medicine (22% or n= 5)
- Preventive behavior (9% or n=2)
- Referral (4% or n=1)

**Question 13:** Have you had to change your services to meet the needs of hepatitis C positive clients?

**Responses (n=7):**

- Increase Education (3)
- Increase Services (2)
- Increase Referrals (2)

**Question 14:** In your management of hepatitis C positive patients, which support and/or treatment programs do you generally refer patients to, and have you experienced barriers in referring them?

**Responses (n=23):**

**Insurance (43% or n=10)**

- No insurance/cost/eligibility (7)

- No coverage for alternative medicine (2)
- Patients turned down for treatment after diagnosis (1)

**Medical (22% or n=5):**

- Medical doctors resistant to alternative therapies

**Services (17% or n=3)**

- Waiting lists, access to provider, availability of service

**Patient Issues (9% or n=2)**

- Patients resistant to access services (2)

**Education (9% or n=2)**

- Lack of education on resources available

**Question 15:** What is your preferred source for staff training?

**Responses (n=3):**

- I'm the only one treating people.
- Train them
- Tell front desk about handling trash, cleaning etc.

**Question 17:** What, if any, are your sources of educational material on hepatitis C?

**Responses (n=29):**

- Literature (Journals, articles, books) (11)
- Seminars (class, conferences, workshops) (5)
- Alternative medicine education (5)
- CEUs (3)
- Providers, colleagues (5)

**Miscellaneous Complementary and Alternative Medical Providers Statements:**

- Some medical doctors still are very negative about their patients using complementary natural medicine and occasionally have recommended that our mutual patients not take the herbs or vitamins that I have recommended.
- People's HMOs or insurance carriers not covering naturopathic medicine is the biggest barrier for them having access to my services; their HMO PCPs are often not willing to refer for naturopathic care, therefore they can't get it covered.
- Uncooperative allopathic MDs (not providing testing, not educating patients or giving them uneducated information). Also not enough Internists and Gastroenterologists on OHP provider list.

# **Summary & Intervention Opportunities: Complementary & Alternative Medical Provider Survey**

## **1. Provider Education**

Development and/or distribution of HCV educational literature, with foundations in alternative and complementary care, may be useful to both providers and patients. Ongoing information-sharing targeted to CAM providers regarding the availability of free client-centered HCV education classes, peer-based HCV support groups, and provider trainings may strengthen existing expertise.

CAM providers should, at minimum, be equipped with up-to-date information regarding HCV transmission and prevention, treatment options, and resources for client support or education. Educational activities should focus on:

- Blood-to-blood transmission of HCV and activities which facilitate blood borne infections
- Transmission myths (i.e. holding hands) and realities
- Use of condoms or other latex barrier during sex with a HCV-infected person when there is a presence of blood and/or sexually transmitted disease
- Newest research, treatment options, disease progression, and community resources for support and testing services
- Free, monthly, HCV education classes. These classes are available and may be underutilized by CAM clientele. There are opportunities to optimize referrals.
- Peer support, mentor, and advocacy services as a cost-effective means of connecting CAM clients with service and information

Motivation for participating in educational programs could be increased with the receipt of continuing education credits. The Health Department can improve communication with CAM providers regarding availability of existing educational and supportive programs as well as the ability to provide technical assistance upon request. Outreach to future CAM providers may be facilitated through coordination with local and national CAM colleges and other educational institutions.

## **2. Barriers to Service**

CAM providers realize the importance of health care access, education, and alcohol and drug support services for people living with HCV. Most initial and ongoing CAM support services are not covered by existing health maintenance organizations (HMOs). There remain opportunities to expand access to allopathic and alternative medical care among persons with insurance and those who are underinsured.

## **3. Other Recommendations**

- CAM providers receive specialized training in areas of nutrition, preventive health, and stress reduction. CAM providers can advance the development of, and augment, care standards for persons living with HCV and other chronic conditions.
- Coordination among CAM and allopathic medical care providers could improve health outcomes for persons living with HCV. Research on the impact of CAM on persons at

various stages of liver disease could further legitimize CAM services among cautious allopathic providers and strengthen coordination.

- CAM providers may be a critical source of newly tested HCV-positive clients. Resources directed at CAM providers may be useful to support their existing and possible expanding, efforts in diagnosis, care, and alternative treatment

## **B4. Western Medical Provider Survey**

# Western Medical Provider Survey

The CPG developed and distributed a 16-question survey to elicit knowledge, attitudes, beliefs, and behavioral information from western/allopathic medical care providers. Western medical providers were defined as medical doctors (M.D.), physician assistants (P.A.), and nurse practitioners (N.P.). A total of 1,233 surveys were mailed or hand-delivered to local health clinics, hospitals, and private practitioners. A total of 327 surveys were returned, yielding a 27% response rate.

## Methodology

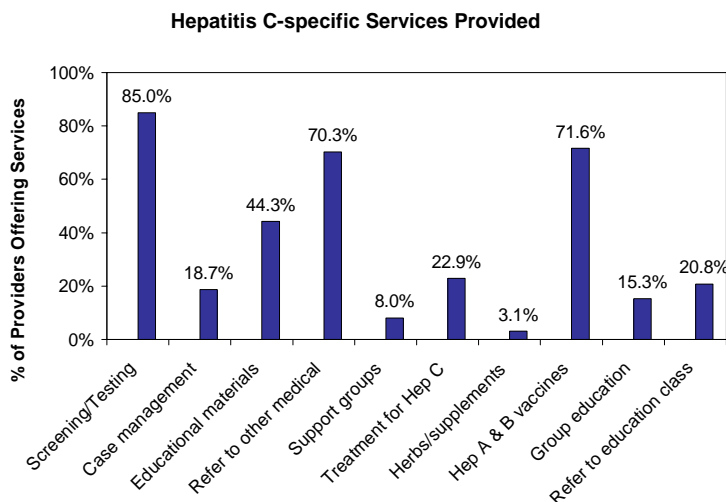
### A. Design

Survey questions were designed as multiple choice or selection criteria questions. Some questions were open-ended to elicit more in-depth answers. In an attempt to identify trends and themes, some questions were repeated to other targeted survey participants (i.e. medical providers, infected or affected persons with HCV).

### B. Method

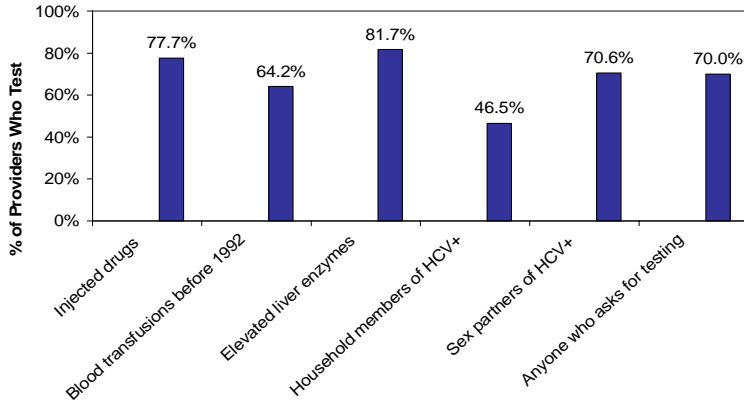
Surveys were distributed by mail or hand-delivered between October 9 and November 8, 2002. A cover letter explaining the survey purpose and deadline, the survey, and a self-addressed stamped envelope were included in each mailing to optimize response rates.

## Quantitative Findings



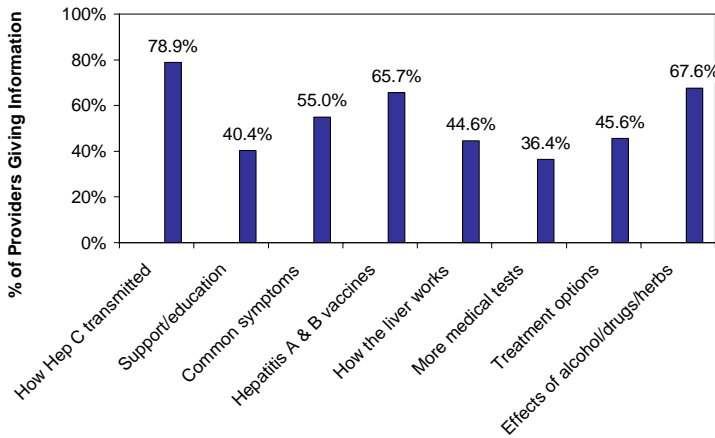
When asked what type of hepatitis C-specific services they provided, 85% of providers offered screening and testing, 72% offered hepatitis A&B vaccines, and 70% provided referral to other medical providers. 44% offered educational materials, and 23% offered treatment for hepatitis C.

**Who Do You Test for Hepatitis C**



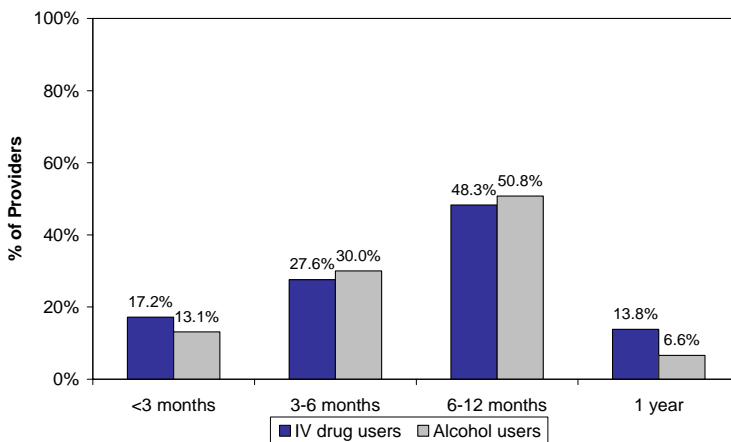
When asked which clients are tested for hepatitis C, 82% of providers tested when clients had elevated liver enzymes, 78% tested for clients who either had injected or inhaled drugs, and 71% tested sex partners of someone who was HCV positive. 70% of providers indicated that they tested anyone who requested testing.

**Information Provided to Clients at Testing**



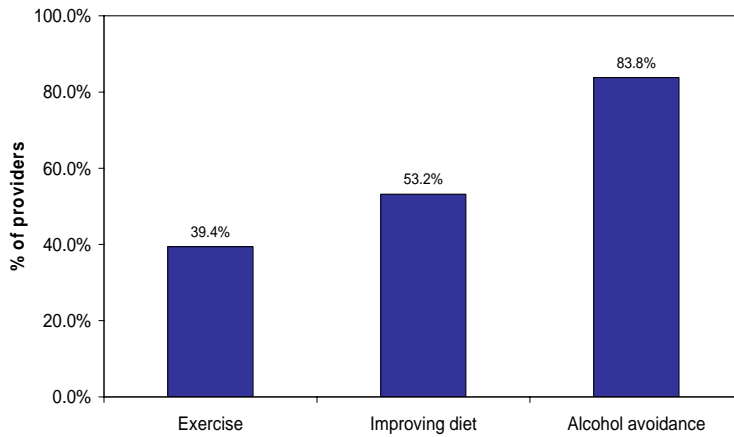
When asked what type of information was provided to clients upon testing, two-thirds of providers indicated they gave information on the effects of alcohol, drugs, and/or herbs on the liver, and 62% provided information on how the liver works and how to protect it. 58% provided information on how hepatitis C is transmitted and prevented, and treatment options.

**Waiting Period for Drug & Alcohol Users to Begin Treatment**



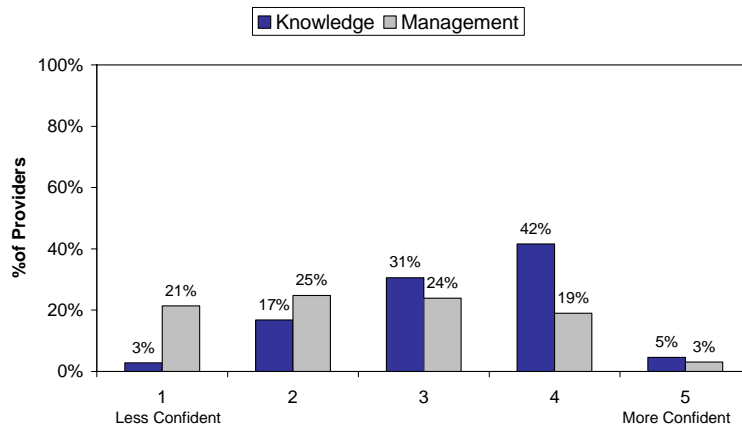
When asked the waiting time they required for patients to begin treatment, one-third of those responding indicated that they did not provide treatment. Of those who responded and indicated that they did provide treatment, a 6-12 month wait period was required by 48% of providers for IDU, and 51% for alcohol users.

**% of Medical Providers Counseling Clients on Life Style Changes**



When asked if they counseled hepatitis C patients on lifestyle changes, 61% of providers gave counseling on exercise, and 84% provided counseling on alcohol avoidance, and 53% on improving the client's diet. Some of the other discussion topics were avoiding Tylenol, avoiding the risk of infecting others, and changes in drug and alcohol use. Nearly 70% of providers indicated that they offered hepatitis A vaccine, and 73% offered hepatitis B vaccine.

**Provider Confidence Level in Knowledge and Management of Hepatitis C**



When asked to describe their level of confidence in their knowledge of hepatitis C on a scale of 1 to 5, with 5 being more confident, there was a mean response of 3.18. The mean response when asked to rate their confidence in managing hepatitis C positive clients was 2.37.

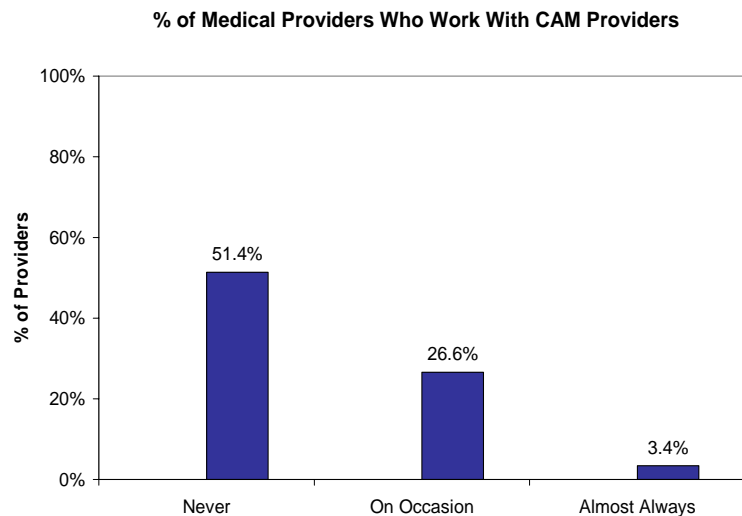
<b>% of Western Medical Providers Ranking Five Most Important Services</b>		
1	Hepatitis C education	74.6%
2	Alcohol and Drug Services	73.1%
3	Hepatitis C Treatment	62.4%
4	Medical care	51.4%
5	Hepatitis A&B vaccines	46.2%
6	Health Insurance	40.4%
7	Case management	26.0%
8	Health care costs	21.7%
9	Mental Health Counseling	20.8%
10	Support groups	19.3%
11	STD/HIV services	14.4%
12	Syringe/needle exchange	11.3%
13	Complementary or alternative care	4.6%
14	Housing assistance	2.8%
15	Job assistance	1.8%
16	Food and/or clothing assistance	1.5%
17	Rent and/or utility assistance	1.2%
18	Transportation	0.9%
19	Nursing care	0.9%
20	Child care	0.6%

<b>% of Providers Referring to Services</b>	
Alcohol and drug services	56.0%
Hepatitis A&B vaccines	49.2%
Hepatitis C testing	48.3%
STD/HIV testing	47.1%
Mental Health Counseling	36.7%
STD/HIV treatment	36.7%
Education class	34.3%
Health Insurance	28.4%
Diet/nutrition	27.2%
Support groups	26.3%
Case management	26.0%
Financial assistance	11.9%
Transportation assistance	11.6%
Syringe/needle exchange	10.7%
Housing	8.9%
Food and/or clothing assistance	8.6%
Rent and/or utility assistance	8.6%
Complementary or Alternative Care	6.7%

Providers were asked to what services they referred. Alcohol & drug services were the most frequently referred service, followed by hepatitis A&B vaccines, hepatitis C testing, STD/HIV testing, and mental health counseling.

% of Western Medical Providers Experiencing Barriers to Services	
Mental Health Counseling	25.4%
Alcohol and drug services	20.5%
Health Insurance	20.5%
Support groups	15.0%
Financial assistance	14.1%
Housing	14.1%
Rent and/or utility assistance	13.5%
Case management	12.5%
Education class	12.2%
Transportation assistance	12.2%
Food and/or clothing assistance	11.6%
Diet/nutrition	11.0%

25% of providers reported experiencing barriers for mental health counseling, and nearly 21% reported barriers to both alcohol & drug services and health insurance. 8% of providers said they encountered barriers for referrals to health insurance. Some of the barriers mentioned in the comments included the limited availability of mental health services, lack of insurance for services, and long waiting lists.



Providers were asked how often they worked with complementary and alternative providers. 51% said “never,” 27% said “on occasion,” and 3% said “almost always.”

## Qualitative Findings

The following open-ended questions were asked and responses received.

**Question 1:** What, if any, hepatitis C-specific services does your office provide?

### Responses (n=21):

- Not applicable or referral (43% or n=9)
- Screening for pregnant women and children (24% or n=5)
- Alternative or homeopathic medicine (19% or n=4)
- Skin treatment or selected testing (10% or n=2)
- Research (5% or n=1)

**Question 3:** Which of the following clients do you test for hepatitis C?

**Responses (n=53):**

- Clients with risky behavior or exposure (blood, alcohol abuse, IDU, MSM) (32% or n=17)
- Clients with symptoms (renal insufficiency or liver problems)( 15% or n=8)
- Chinese, Vietnamese, Vietnam Vets (14% or n=7)
- Clients with other STDs (12% or n=6)
- Pregnant women or children (10% or n=5)
- Tattoos (8% or n= 4)
- Clients with hepatitis A and/or hepatitis B (6% or n=3)
- All clients (4% or n=2)
- Health care workers (2% or n=1)

**Question 4:** If information is provided to clients upon testing for hepatitis C, what information do you include?

**Responses (n=20):**

- Other education or information (40% or n=8)
- None or n/a (35% or n=7)
- Referral (primary care provider, clinic) (20% or n=4)
- Unclear question (5% or n= 1)

**Question 5a:** If you provide standard hepatitis C treatment on-site: what type of treatment do you provide?

**Responses (n=22)**

- Referral (68% or n=15)
- Mental health (14% or n=3)
- Not Applicable (9% or n= 2)
- Lanuindie, Ribavirin (9% or n=2)

**Question 6:** If you refer to a specialist for hepatitis C care, do you experience any barriers to making a referral?

**Responses (n=124):**

**Access to Services (49% or n=61)**

- Long wait (3-6 months), paperwork, lack of specialists, scheduling, dysfunctional services or system, HMOs, language barriers, transportation
- MCHD doesn't have after hours clinic, OHSU doesn't follow through with appointments, Oregon Clinic
- GIs don't want to see these patients

**Insurance (38% or n=47)**

- No insurance, restricted insurance, eligibility for OHP, cost/financial

**Patient attribute (13% or n=16)**

- Alcoholism, substance abuse, depression, patients don't follow up

**Question 8:** Do you counsel hepatitis C positive patients to consider any of the following life style changes?

**Responses (n=68):**

**Drug avoidance (72% or n=49)**

- Tylenol (15)
- Hepatotoxic drugs (9)
- NSAIDs (2)
- Herbal and/or alternative (3)
- Over-the-counter(3)
- Injection drug use (2)
- Acetaminophen (2)
- Alcohol (1)
- Coffee(1)

**Other (19% or n=13)**

- Stress and/or pain management (7)
- Medical care and/or counseling (2)
- Domestic skills (2)
- Immunization for hepatitis A & B (1)
- No sharing of blood (1)

**Safe sexual behavior (9% or n=6)**

**Question 13:** Check the five services you feel are most important for people living with hepatitis C.

**Responses (n=7):**

- Question difficult or unclear (4)
- Not relevant or applicable (3)

**Question 14:** In your management of hepatitis C patients, which support and/or treatment programs do you generally refer patients to?

**Responses (n=24):**

- Not applicable (67% or n=16)
- On-site (17% or n=4)
- Social worker (8% or n= 2)
- General practitioner (8% or n= 2)

**Question 15:** If you circled “yes” to barriers, please describe the problems you had in getting the service(s).

**Responses (n=190):**

**Access to Services (45% or n=85)**

- Availability of services: Mental health, alcohol & drug treatment (38)
- Waitlists , time (24)
- Access to prescribers (mental health, alcohol & drug, and primary care providers) (10)
- Incarceration (5)

**Insurance (35% or n=67)**

- No coverage for mental health, A&D, nutrition (17)
- Eligibility (17)
- No insurance, cost (31)
- Can't get OHP (2)

**Education (12% or n=22)**

- Don't know resources available or where to refer (19)
- Don't understand HCV (2)
- Unclear of needle exchange options (1)

**Patient Attribute (8% or n= 11)**

- Lack of interest (6)
- Don't pass clean and sober requirement (3)
- Confusing way to apply or obtain services...inefficient for uneducated patients (2)

**Miscellaneous Western Medical Provider Statements**

- There is very little availability of mental health care in this state, poor access to prescribers, no money for therapy, and long waits to access.
- Alcohol & drug services: rarely available, long waiting lists. Mental health is overwhelmed in this city and close to a joke now! I'm lucky to get my homeless patients into a shelter and even then, the shelters are often dangerous.
- Difficult and long wait for mental health & social services. Drug addiction programs are inadequate, slow, and not long enough. One of my hepatitis C+ IDU patients tried multiple “short term” programs. He died of an OD in a park!
- No one wants to see these patients.
- None of my patients qualify for or seek treatment.
- Time, time, time, time.

# Summary & Intervention Opportunities: Western Medical Provider Survey

## 1. Provider Education

Ongoing information-sharing targeted to medical providers regarding the availability of free client-centered HCV education classes, peer-based HCV support groups, and provider trainings may strengthen existing expertise.

There are opportunities to further prevention and care through increases in education on transmission risks and the effects of alcohol on liver health. Educational activities should focus on:

- Blood-to-blood transmission of HCV and activities which facilitate blood borne infections (injection drug use)
- Use of latex barrier during sex with a HCV-infected person when there is a presence of blood and/or sexually transmitted disease
- Consistent messages on the use of Tylenol, pain relievers, and anti-inflammatory medications
- Alcohol abstinence counseling or referrals; alcohol risk reduction counseling should be encouraged in lieu of abstinence where appropriate.
- Recommendations for hepatitis A and hepatitis B vaccines among patients with HCV

Distribution of HCV educational literature directed to local medical clinics and private practitioners may be useful to both providers and patients.

## 2. Barriers to Service

- Expanded access to insurance, mental health, and A&D services would benefit HCV affected persons without insurance, underinsured, and among persons without citizenship or documentation.
- Coordination among allopathic medical care and CAM providers could improve health outcomes for persons living with HCV.
- Research on the impact of CAM on persons at various stages of liver disease could further legitimize CAM services among cautious allopathic providers and strengthen coordination.
- Distribution of research findings on IDU successes in completing therapy could improve treatment availability to this population.

## 3. Testing

- Antibody testing for HCV remains sensitive, resulting in a high percentage of false positive results when no risk history exists. Providers can further narrow their testing population to persons with an injection drug, transfusion, transplant, and/or elevated enzyme history to maximize result accuracy and reduce testing costs.
- Provider initiation of discussion on drug use transmission risks and liver health may reduce client fear about disclosure and strengthen patient-provider communication.

#### **4. Provider Capacity for Treatment**

There exist opportunities to increase the number and capacity of primary medical providers to provide Interferon and Ribavirin therapy. Increases in knowledge of HCV and confidence in managing patients with HCV can be achieved through ongoing training activities which offer participation incentives, such as continuing education credits. Training should be conducted by experienced and recognized western medical colleagues.

## **B5. General Population Survey**

# General Population Survey

The CPG developed and distributed a brief, six-question questionnaire that was designed to assess knowledge about hepatitis C among the general population. 97 out of 100 surveys were collected, yielding a response rate of 97%.

The general population surveys were administered by CPG members and were conducted at varied locations in Portland including a community center, shopping mall, basketball game, university, a downtown park, HIV testing site, grocery stores, a Saturday “craft” market, and the train station.

## Methodology

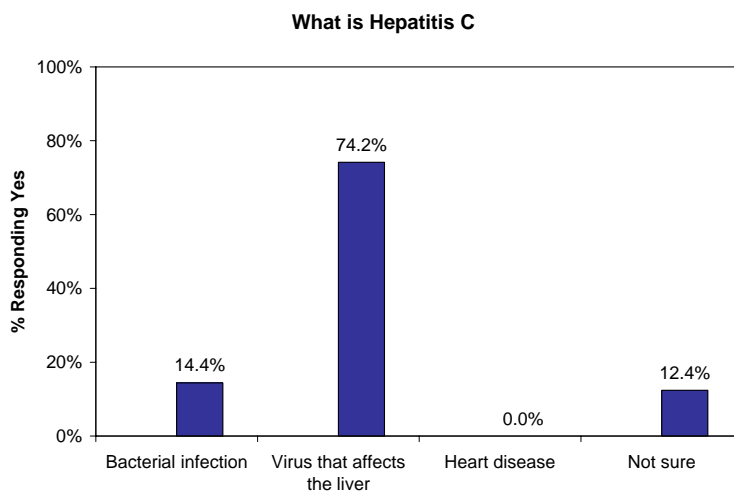
### A. Design

Surveys questions were designed as multiple choice or selection criteria questions. In an attempt to identify trends and themes, some questions were repeated to other targeted survey participants (i.e. medical providers, infected or affected persons with HCV).

### B. Method

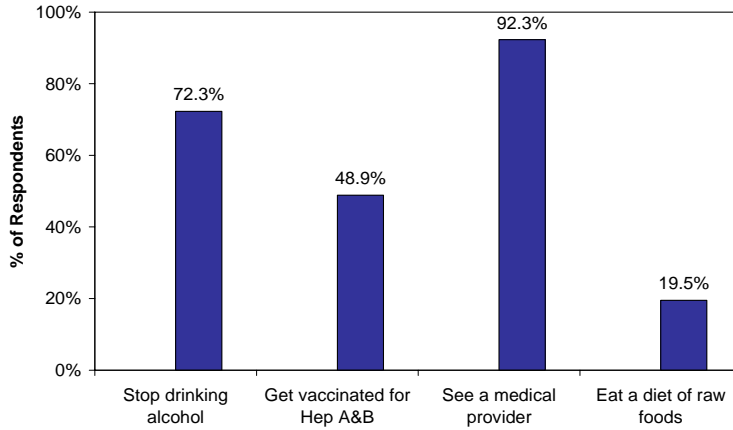
Surveys were administered by CPG members; members were available at local venues and asked a convenient sample of the population if they would complete a questionnaire on HCV. Members asked participants the questions and recorded responses.

## Quantitative Findings



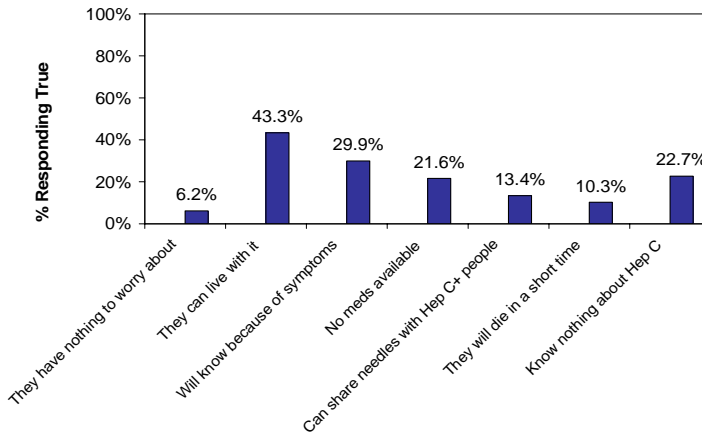
When asked the question, “What is hepatitis C?” 74% of those surveyed responded correctly that it was a virus that affected the liver. When asked what kind of activities spread hepatitis C, 91% indicated injection drug use, 75% said having unprotected sex, and 70% said tattooing and body piercing.

**What People with Hepatitis C Can Do to Care for Themselves**



Survey participants were asked what people with hepatitis C can do to take care of themselves. 92% said “see a medical provider,” 72% said “stop drinking alcohol,” and 49% said “get vaccinated for hepatitis A and B.”

**Common Beliefs About Hepatitis C**



Survey participants were asked “What have you heard about people who have hepatitis C?” The chart below shows the percent of responses. 43% said they had heard “they can live with it,” while 23% said “I know nothing about hepatitis C.”

**Sources of Information**

Doctor	75.3%
Health Department	48.5%
Internet	34.0%
Library	18.6%
Friends	9.3%
Family	6.2%
Other	0.1%

Survey participants were asked to identify the top two places to go to learn more about hepatitis C. 75% rated “doctor” as their top source for more information, followed by “Health Department” at 49%.

## **Summary & Intervention Opportunities: General Population Survey**

### **1. Provider Education**

Health care providers and health department employees are perceived as reliable sources of HCV information and support by the general population. As such, personnel in contact with persons at-risk for, or infected with, HCV should, at minimum, be equipped with up-to-date information regarding HCV transmission and prevention, treatment options, and resources for client support or education.

### **2. General Population Education**

Educational activities should focus on:

- Blood-to-blood transmission of HCV and activities which facilitate blood borne infections
- Transmission myths (i.e. holding hands) and realities
- Use of condoms or other latex barrier during sex with a HCV-infected person when there is a presence of blood and/or sexually transmitted disease
- Recommendations for hepatitis A and B vaccines among the general population and those at risk for complications of viral hepatitis infection

# **APPENDIX C**

## **Glossary**

# Glossary

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**Acute hepatitis C:** Newly acquired hepatitis C virus that sometimes, but not always, is accompanied by symptoms.

**Allopathic:** Commonly known as “western medicine,” this is a method of treating disease with remedies that produce effects different from those caused by the disease itself.

**AIDS:** Acquired Immune Deficiency Syndrome.

**Barriers:** Conditions that affect the ability to address and/or carry out recommended actions.

**CAM:** Complementary and alternative medicine (treatments other than and/or in addition to western medical intervention).

**CEUs:** Continuing Education Units.

**Chronic hepatitis C:** A state of hepatitis C that usually begins about six months after initial infection and results in liver inflammation; occurs when the disease does not clear up or resolve spontaneously, often leading to permanent liver damage.

**Disparities:** The condition or fact of being unequal as in age, rank or degree; unlikeness or incongruity.

**Epidemiology:** The study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems.

**Harm Reduction:** A set of practical strategies, including syringe access and disposal, which reduce negative consequences of drug use; incorporates a range of approaches from safer use to abstinence.

**Hepatitis A:** A virus transmitted most often through fecal-oral contact or water. HAV is almost never chronic and rarely leads to liver damage. There is a vaccine against hepatitis A.

**Hepatitis B:** A virus transmitted through blood, sexual contact and perinatally. Like hepatitis C, it can result in chronic disease and permanent liver damage. A vaccine against hepatitis B has been available since 1982. Groups at high risk of contracting hepatitis B include men who have sex with men and injection drug users.

**Hepatitis C:** A virus transmitted through direct blood-to-blood contact; attacks cells in the liver and often going undetected for years or decades. Blood exposure can result from unsafe injection drug practices, perinatal transmission or through occupational health hazards such as needle stick injuries. Hepatitis C can result in scarring of the liver (cirrhosis), liver cancer and death. There is no vaccine for hepatitis C.

**High Risk Group:** A group in the community with an elevated risk of disease.

**Human Immunodeficiency Virus (HIV):** A family of viruses that results in the acquired immune deficiency syndrome (AIDS).

**Integration:** The process of combining parts into an integral whole; to bring together into a unified or integrated whole.

**Interferon:** A genetically-engineered product used in allopathic treatment of hepatitis B and C and other viruses.

**Intervention:** To occur so as to modify an activity or set of activities to which a person or group is exposed in order to change the person or group's behavior.

**Needs Assessment:** The process of obtaining and analyzing findings through multiple methods of information and data collection to determine, through community participation, the type and extent of unmet needs in a particular population.

**Prevalence:** The number of infected individuals in a population at a given point in time.

**Ribavirin:** An anti-virus drug used in combination with Interferon in allopathic treatment of hepatitis C.