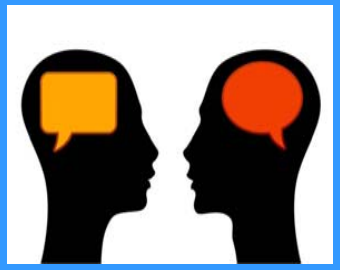


Just a Few More Questions…

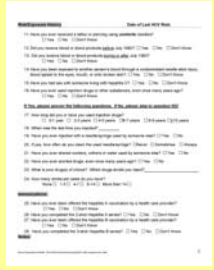
Integrating Hepatitis C Risk Assessment into HIV Counseling, Testing, and Referral Data Collection

Introduction

In June 2011, the Hawai'i State Department of Health's (DOH) STD AIDS Prevention Branch (SAPB) in collaboration with the Adult Viral Hepatitis Prevention Coordinator (AVHPC) implemented enhanced integration of hepatitis B and C testing/referrals at all contracted and partner agencies that offered HIV rapid testing provided through DOH. The DOH had contracted Luther Consulting, LLC to create a modified version of *EvaluationWeb* to not only collect mandated CDC-reportable HIV counseling, testing, and referral (CTR) data but also to collect hepatitis risk assessment and testing data. Prior to implementation of this integrated data collection program, the AVHPC had been collecting hepatitis risk factor data on a separate CTR form since 2002. The intent of the integrated form was two-fold: 1) integrated CTR and data collection could be simplified since many of the same questions would not be repeated, and 2) hepatitis risk assessment (and subsequent testing or referral) would be a mandated part of the CTR session.

Materials and Methods

The the Adult Viral Hepatitis Prevention Coordinator (AVHPC) collaborated with SAPB and its contracted and partner agencies (including AIDS service organizations, community health centers, hepatitis-focused coalitions, and more) to develop the data collection form and data entry portal. The AVHPC ensured that relevant hepatitis risk assessment and testing questions from the separate hepatitis form was integrated into the new *EvaluationWeb*, or "Luther", form. The resulting form MANDATED that all agencies that provide HIV testing through DOH also ask hepatitis B and C risk assessment and testing referral questions as part of the testing session.



Old Form: 4625 hep C antibody tests
December 1, 2002 to May 30, 2011

Results

By mandating the inclusion of viral hepatitis risk factors into the HIV testing session, the amount of hepatitis C testing for eligible, at-risk clients increased from approximately 1000 tests during the 6 months prior to *EvaluationWeb* implementation (on June 1, 2011) to 1764 for the 6 months after implementation. From January 1 2012 to June 30 2012, the testing numbers increased to 1808 tests, most likely due to implementation of HCV rapid testing at each agency.

EvaluationWeb provides a user-friendly report generator that can determine the number of hepatitis tests conducted, associated risk factors, and positivity rate for hep C antibody and/or hep B surface antigen tests. Hepatitis C antibody positivity rates after implementation of integrated CTR at DOH testing sites were lower. This may be accounted for by the increased number of testing sites since 2002 and reported screening of non-eligible clients. Additionally, previous testing may have identified many hepatitis C positive clients at many of these sites. However, evaluation of eligible risk factors for hep C screening should also be performed.

New Form: 3572 hep C antibody tests
June 1, 2011 to June 30, 2012

Conclusions

Streamlining, integrating, and mandating viral hepatitis risk assessment as part of HIV CTR data collection can increase hepatitis screening rates for at-risk individuals who present for HIV screening. By including risk factor, demographic, and geographic data in data collection, the integrated *EvaluationWeb* model also provides enhanced program evaluation and monitoring for both HIV and viral hepatitis CTR, especially to determine how to most effectively use limited resources to identify the maximum number of positive individuals. For example, the AVHPC can look at data to determine high-impact testing sites and populations so as to allocate limited resources appropriately.

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Next Steps

As program and evaluation needs evolve, the data collected via *EvaluationWeb* will also change. In future updates of the program, the AVHPP hopes to incorporate questions for hepatitis B and C linkage-to-care similar to the questions required for HIV positive results. Additional hepatitis B risk questions such as exposure through sexual or household contact should be added, and questions about prior immunizations should also be made part of the standard risk assessment instead of just for hepatitis B screenings. Hepatitis C risk questions should be clarified and reevaluated based on positivity rates. They should also include baby boomer age cohort risk even though testing for this age group (with no other risk) is not available through these programs. Finally, questions on access to insurance will become important for allocating resources for outreach as healthcare reform is implemented.

Questions? Email Thaddeus Pham at thaddeus.pham@doh.hawaii.gov

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