Hepatitis C: A Public Health Opportunity in our Prisons
The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:

- Advisory Board: Gilead Sciences
- Received honoraria for lectures from Gilead Sciences and Janssen Pharmaceuticals.
HEPATITIS C – BASIC EPIDEMIOLOGY

- CDC estimates **3.2 million** living with HCV (1-2% of US Population)
- **Actual number probably ~5 million** – why?
- Most common blood borne infection in US
- **About 17,000 new infections annually**
  - Mostly among young PWID...who we incarcerate
  - Other risk factors include blood transfusions pre-1992, hemophilia, tattoos, intranasal drug use, MSM
- Number of new infections peaked in the 1980s
- **About 75% of those with chronic HCV are baby boomers** (birth year 1945-1965)
HEPATITIS C – BASIC EPIDEMIOLOGY

50-70% of those with HCV unaware of their infection

Leading cause of liver transplants and major cause of liver cancer

HCV Mortality – ~5/100k and rising$^{1}$

Almost $8 billion in HC costs and rising$^{2,3}$

Treatment options rapidly improving
  • Shorter duration, better efficacy, fewer side effects

HEPATITIS C CASCADE OF CARE IN UNITED STATES

- Chronic HCV: 100% (3,200,000)
- HCV Detected: 50%
- Referred to Care: 35%
- HCV Treated: 9%
- Achieved SVR: 6%

• More than 2.2 million people incarcerated (1 in 3 Americans have been incarcerated)  

• Higher likelihood of past risk behavior for hepatitis C (HCV)
  • Drug offenders = 16% (210,200 inmates) of the total state prison population in 2012 in US.  
  • ~24% of state prison inmates have history of IDU  
  • ~17% of State and 18% of Federal prisoners committed crime to obtain money for drugs  
  • Other risks = tattoos, unprotected sex

• We know that risk behaviors persist in prisons and jails despite zero-tolerance policies and that disease transmission occurs  

• Result = HCV rates: 1-2% general pop vs. ~17.4% corrections

PUBLIC HEALTH AND HCV CORRECTIONS

- No national epi surveillance system for prisons/jails
- Correctional systems are not uniform:
  - Prisons vs. Jails, Federal vs. State, Private vs. Public
- The priority for corrections is security, not public health
- HCV treatment is expensive and changing rapidly
- Disincentive to test if unable to offer treatment?
- Only 12 state prison systems routinely tested for HCV between 2001 and 2012

Screening practices vary widely
  - With symptoms
  - By request
  - Risk based (baby boomers, IDU history, new tattoos)
  - Universal opt-out
  - Entry vs. release
  - Access to confirmatory testing
Opportunities Vary in Prison vs. Jail

Prison
- Longer sentences (2-3yrs)
- Bigger HS’s budgets
- Better healthcare infrastructure
- Screening limited/variable
- Treatment more feasible
  - Many don’t treat
  - Treatment limited when available

Jail
- Short length of stay (days or weeks)
- Treatment less feasible
  - Limited infrastructure
  - Short sentences
  - Smaller budgets
- Testing varies but happens: linkage to care is key
- Treatment may be feasible with shorter duration
- Education and prevention
Many Questions are Unanswered

- What is the role of corrections in public health?
- Is treating hepatitis C in corrections cost effective for the community, and for correctional institutions?
- How do we solve challenges together, involving all stakeholders (community and correctional health)?
- How can we increase the capacity of correctional healthcare service providers for HCV?
- How can improve coordination of services between institutions and the community, and how can we leverage the ACA to do so?
Thank you!

For more info, please visit:

www.hcvinprison.org
www.hepeducation.org

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