

# HEPATITIS C VIRUS (HCV) IN NEW MEXICO: STATEWIDE COMPREHENSIVE PLAN AND PROFILE OF THE EPIDEMIC



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New Mexico  
Hepatitis C Coalition

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Since the Coalition is not an independent, non-profit organization, its leadership represents three organizations that provide extensive services related to HCV. These entities provided extensive support for the process and to ensure completion of this plan.

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## MISSION OF THE NEW MEXICO HEPATITIS C COALITION

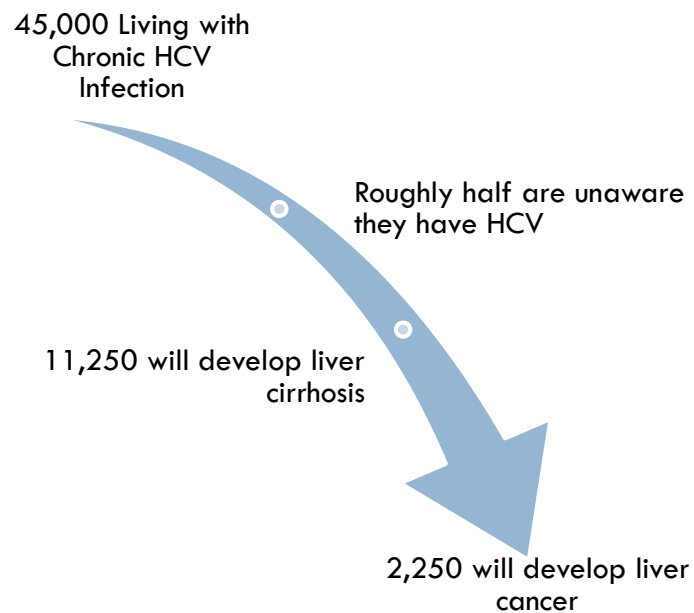
**New Mexico will prioritize the prevention, testing and treatment of infection with hepatitis C virus (HCV) in order to reduce the number of new infections as well as cure the infection in those currently living with HCV, thereby reducing the negative health impacts of this disease.**

## OVERVIEW OF HEPATITIS C AND NEW MEXICO EPIDEMIOLOGY

The Centers for Disease Control and Prevention (CDC) recently reported that hepatitis C kills more Americans than any other infectious disease, surpassing the total combined number of deaths from a total of 60 common, infectious diseases including HIV, staph/MRSA and tuberculosis. Although hepatitis C is declared a curable disease, many go untreated, new infections continue to grow and barriers continue to exist that limit access to a cure.

It is estimated that 2.7 – 3.9 million Americans are living with chronic hepatitis C infection. (Prevention, 2014) Most persons living with HCV have few symptoms of illness until 10 to 30 years after initial infection, when life threatening health complications can develop, including end-stage liver disease, liver cancer and eventually death. With limited sign and symptoms indicating disease, as many as three out of four people living with hepatitis C do not even know they have it. (Prevention, 2014)

New Mexico is not spared when it comes to infection and burden of disease. It is estimated that 45,000 New Mexicans are living with chronic infections of hepatitis C virus (HCV).



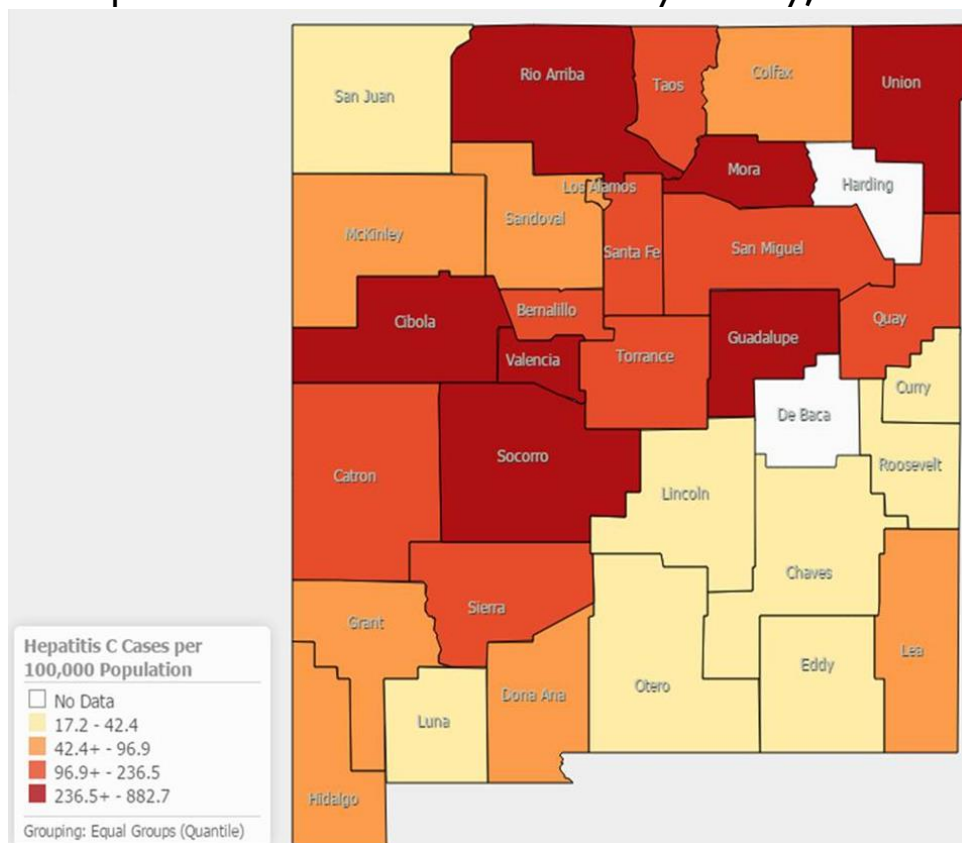
Hepatitis C is the world's most common blood borne pathogen. It is transmitted through blood-to-blood transmission with someone previously infected. The most frequently reported risk factors for transmission include:

- Sharing needles, syringes or equipment for injecting illicit substances or prescribed medications;
- Sharing needles or equipment, including ink, for tattooing;

- Encountering a needle stick injury in health care settings;
- Receiving a blood transfusion before 1992;
- Being born to a mother who has hepatitis C;
- Sharing personal care items such as razors, toothbrushes or nail clippers;
- Having sexual contact with someone infected with HCV. (Center for Disease Control and Prevention, 2016)

Hepatitis C does not discriminate against individuals and is not limited to people who inject illicit substances. A significant proportion of all persons with HCV are “Baby Boomers” who were born between 1945 and 1965. The national data suggests that 75% of adults living with HCV are individuals who were born during this time. Persons in this age group are five times more likely than other individuals to be infected. (Center for Disease Control and Prevention, 2012) Many of these individuals have been living with the disease for many years to decades, increasing their risk of liver disease and cancer (Jr, 2006).

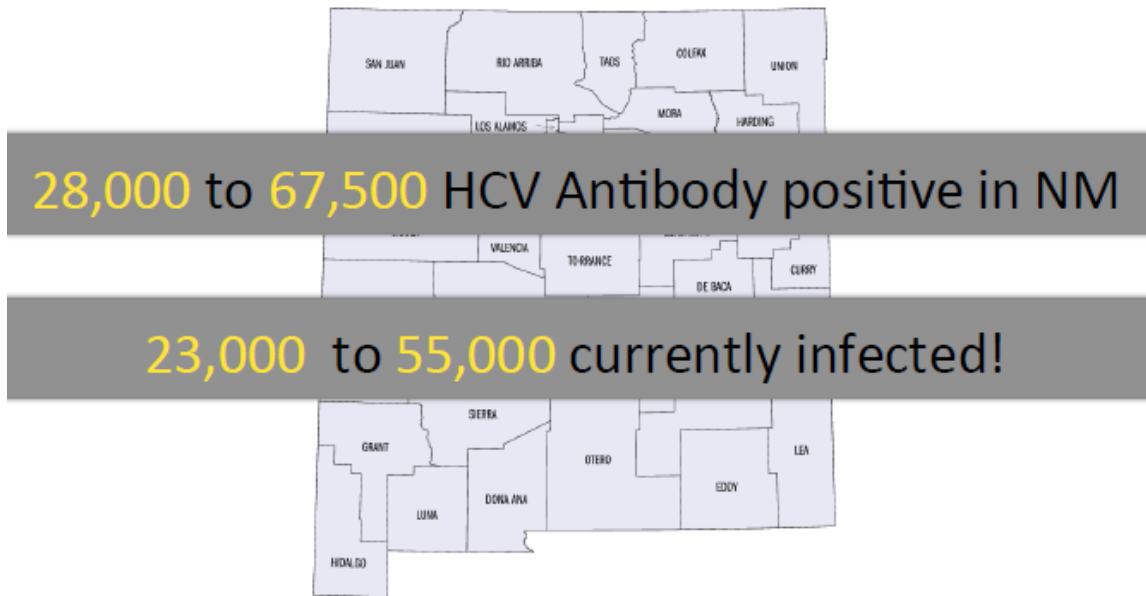
### Hepatitis C Rates in New Mexico by County, 2015



Dates are from NM IBIS on 5/9/2016



# Prevalence of HCV in New Mexico



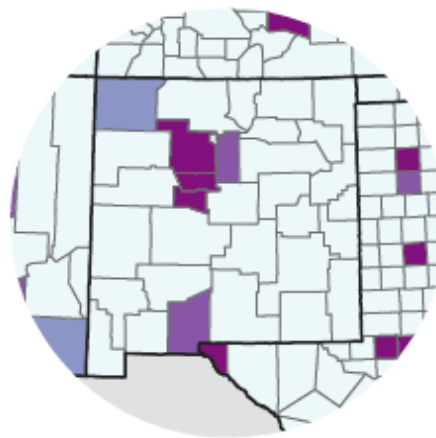
Source: Dr. Kimberly Page, UNM

## OVERVIEW OF HEALTH CARE RESPONSE AND RESOURCES FOR HCV TREATMENT

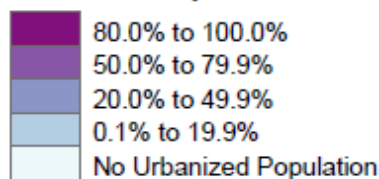
New Mexico is a geographically large, population dense state. The majority of specialists who have the skills and capacity to treat hepatitis C practice in the Albuquerque metropolitan area. Thirty-two of New Mexico's thirty-three counties are defined as medically underserved. The lack of physicians trained to manage and treat HCV is particularly significant in rural areas. For those who are referred to specialists, waits for appointments may take months.

Moreover, the health care system is often difficult to navigate because care and treatment may require health insurance coverage and coordination among primary care providers, specialists, drug treatment programs, mental health professionals and pharmacies. Even when persons with HCV are insured, insurance programs may not cover all necessary HCV services.

### Percent Population Residing in Urbanized Areas by County (2010)



#### Urbanized Population



Source: Dr. Kimberly Page, UNM

In addition to provider and funding deficits to cure HCV, stigma continues to be a barrier to receiving care and treatment. The stigma that HCV is a “drug users” disease permeates into public and private insurance coverage and is demonstrated by efforts to restrict access to life saving treatment, whether overall or for

specific stigmatized sub-populations. These restrictions are not evidence-based, nor are they best practice. Such restrictive barriers to treatment contradict national medical practice guidelines that unequivocally support treating all HCV patients. These restrictions on treatment also contradict public policy, are discriminatory, may violate medical necessity provisions in private insurance contracts and can be violations of federal and state regulations and laws.

On November 5, 2015, the Centers for Medicare and Medicaid Services (CMS) recognized that restrictions on HCV treatment in place among State Medicaid programs around the country were illegal. They issued guidance to the individual states urging them to review their practices and cover treatment consistent with established medical practice guidelines. That guidance can be found here: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/hcv-communication.html>. With litigation cases occurring around the country, states are beginning to cover hepatitis C medications for their Medicaid recipients without regard to fibrosis score to meet their state and federal Medicaid requirements. (Ninburg, 2016) New Mexico has been ahead of the curve in ensuring access and insurance coverage, particularly for persons with Medicaid.

New Mexico has taken the lead in responding to HCV in a progressive and inclusive fashion. In particular, New Mexico's Medicaid Program has been reviewing the epidemiology and needs for persons living with HCV for several years to identify mechanisms for expanding access to treatment. Their work has been both innovative and strategic in complying with and going beyond federal guidance. The Medicaid Program strived to establish evidence-based policies regarding access that would meet the program's goals, including to ensure broader access and remove restrictive barriers that had no scientific basis. Revised Medicaid policies were established on December 1, 2015 and went into effect immediately (Medical Assistance Division, State of New Mexico, 2015). These HCV-specific policies ended two old and outdated barriers: documented abstinence from any illicit substance or alcohol and required consultation by a provider with a specialist prior to treatment. These modifications will allow New Mexico to get a better handle on new cases as people who are currently experiencing substance use and addiction can be treated and prevent future cases of infection.

New Mexico strives to expand treatment over the next 3 – 5 years to eventually offer curative therapies to all persons living with HCV. Previously, treatment would be covered only for the sickest of individuals infected with HCV – namely treating only those with a liver fibrosis score of F3 and F4. The phased approach will expand this access over the coming years. At this time, New Mexico's Medicaid program increased treatment to be accessible to persons with more recent infections, documented with a liver fibrosis score of F2 (Medical Assistance Division, State of New Mexico, 2015). Over time, expansion to those with F0 and F1

scores will ensure that all New Mexicans who are living with HCV can be treated within the next five years through expanded access via Medicaid.

In addition to Medicaid changes, innovative projects and programs have been founded in New Mexico. The syringe services program operated by the Hepatitis and Harm Reduction Program of the New Mexico Department of Health (NMDOH) was approved by state law in 1997 and started operations in 1998. With this early initiation, New Mexico became the second state in the nation with such a statewide program to be implemented, legally, to provide individuals struggling with addiction sanitary equipment to prevent disease transmission.

New Mexico is also home to one of the most well-known and innovative approaches to respond to HCV – and which is being replicated around the nation and world. Project ECHO® at the University of New Mexico Health Sciences Center (UNMHSC) has been a game-changer in the delivery of hepatitis C and other chronic disease treatment and care. Finally, the UNMHSC is currently involved in studies to test the efficacy and safety of a vaccine aimed to prevent the development of chronic hepatitis C.

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## OVERVIEW OF KEY GAPS AND NEEDS TO RESPOND TO HCV

Although New Mexico is a state of innovation, work remains to provide appropriate, accessible and affordable services to treat, prevent and identify individuals living with hepatitis C. Federal, and state funding for HCV surveillance, testing and treatment has been extremely limited which guides the work, funding for programs and true understanding of the burden of hepatitis C in New Mexico.

Modest sustained funding to detect and treat HCV could greatly alleviate the personal, social and economic burden of this disease. Other areas have been identified to through the stakeholders within the New Mexico Hepatitis C Coalition.

This comprehensive plan identifies eight public health objectives to address the HCV epidemic in New Mexico. These objectives and the unmet needs they address are described in detail in this plan. Of all these proposed actions in response to HCV, the following four objectives are most critical and time sensitive for reducing illness and death from HCV in New Mexico.

### **OBJECTIVE 1A - TESTING: EXPAND ACCESS TO HEPATITIS C VIRUS (HCV) TESTING FOR POPULATIONS AT GREATEST RISK TO HELP PERSONS LEARN THEIR STATUS.**

The Coalition and its partners encourage providers to follow the CDC guidelines to test patients born between 1945 and 1965 for HCV in addition to the groups identified as being at highest risk for HCV. A variety of innovative and effective strategies can expand the number of persons living with HCV who are aware of their infection.

- Increase efforts in highly affected communities to expand HCV knowledge and awareness about testing opportunities and to identify and address barriers.
- Initiate policies and practices in primary care settings (including: primary care, emergency departments, urgent care and department of health facilities) to offer and provide routine testing for HCV to persons at greatest risk to include current and past substance users, gay/bisexual men and other men who have sex with men (MSM).
- Expand targeted testing efforts for current and past substance users, such as testing linked to syringe exchange and substance use treatment services.

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**OBJECTIVE 2A – UNIVERSAL TREATMENT: ELIMINATE HEPATITIS C INFECTION IN NEW MEXICO THROUGH UNIVERSAL ACCESS TO TREATMENT THAT IS AVAILABLE STATEWIDE AND HAS REDUCED BUREAUCRATIC BURDEN.**

To reach the large number of people infected with HCV but who are unaware of their infection, the New Mexico Hepatitis C Coalition and its partners will strive to motivate health care providers to incorporate HCV testing and curative treatment into routine practice. The expansion of treatment by primary care providers and practices, particularly in rural areas and those that have limited access to specialists, can be achieved via provider training and technical assistance offered by Project ECHO and other experts. In addition, there can be greater advocacy to expand coverage for HCV treatment by private health insurance providers, modelled on the innovative changes in Medicaid policies and based on evidence-based best practices.

**OBJECTIVE 3A – PROVIDER TRAINING: EXPAND ACCESS TO BEST PRACTICE TESTING, DIAGNOSIS AND TREATMENT FOR HEPATITIS C STATEWIDE THROUGH PROVIDER TRAINING.**

Too few providers in New Mexico are sufficiently trained and skilled to treat HCV and manage the complicated medical and psychological issues that often emerge during treatment. The New Mexico Hepatitis C Coalition and its partners aim to distribute educational materials, conduct training courses and collaborate with large health care institutions to enhance provider diagnosis, management in HCV care and treatment. The Coalition will continue to promote the Project ECHO telehealth knowledge-sharing networks within New Mexico's rural communities. This guided practice model is the most efficacious and cost effective model in expanding and increasing HCV treatment to rural providers throughout the state.

**OBJECTIVE 4A – SURVEILLANCE: CREATE A HEPATITIS C SURVEILLANCE SYSTEM THAT CAN DESCRIBE THE PREVALENCE, TRENDS AND CORRELATES OF HCV INFECTION.**

New Mexico state law mandates reporting of positive HCV antibody and confirmatory laboratory tests (e.g., HCV RNA) to the Epidemiology and Response Division (ERD) within NMDOH. With dedicated and sustained funding for HCV surveillance, the department could analyze data to continually update the public and providers about progress in addressing the burden of HCV and continually update policies based on the best quality evidence.

## EPIDEMIOLOGY AND PUBLIC HEALTH BURDEN OF HEPATITIS C

Hepatitis C virus (HCV) is an important public health crisis facing our entire nation. Estimates are that as many as 3.5 million Americans may have chronic HCV. While this is a huge number, the true burden of disease is unable to be assessed as there are inadequate resources to conduct high quality HCV surveillance. However, even if much of this needed public health information is not available, clearly HCV is a major issue that leads to chronic illness, morbidity and mortality.

Current estimates show that up to 45,000 New Mexicans are living with chronic HCV. Many live in areas with high levels of poverty, unemployment, and other indices of underlying health disparities. Surveillance is limited for New Mexico, but data is widely available to assess the epidemic in New Mexico's prison population. Since 2009, the New Mexico Corrections Department has been screening and testing every incarcerated person entering the prison system. Through this screening, it is evidenced that over 40% of people coming into the prison system test positive for hepatitis C antibodies. A recent report comparing other state prison systems with similar screening practices identified that New Mexico's prevalence is double that of the next leading state. Recognizing the over 95% of people incarcerated in New Mexico come home, the epidemic within the prisons will eventually hit our communities.

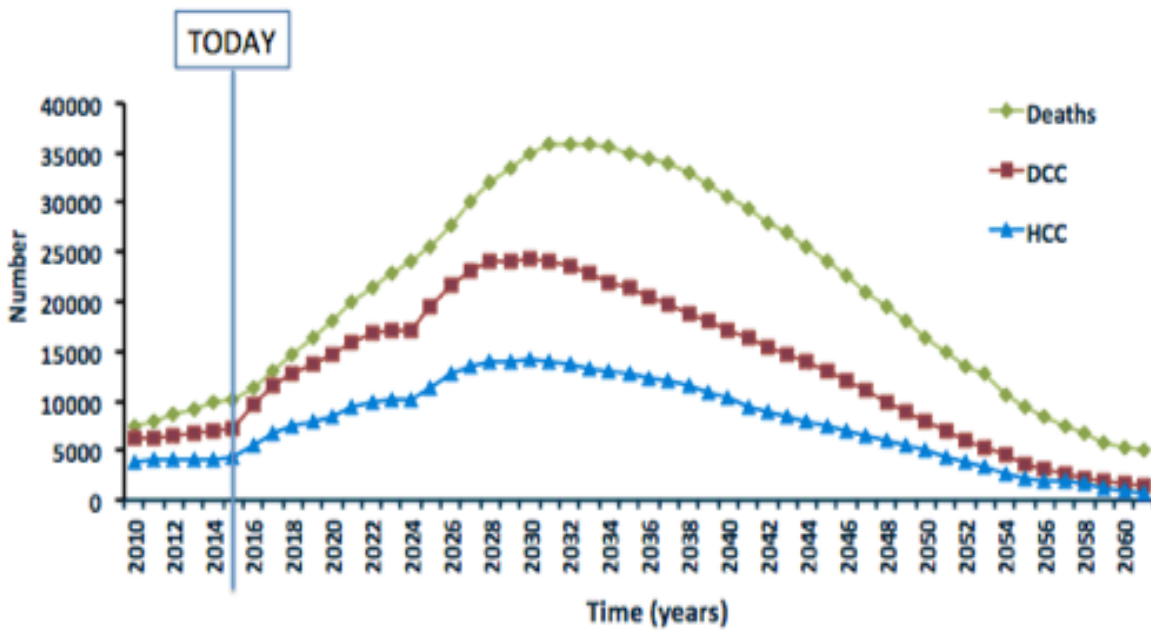
Between the years of 2007 and 2011 more than 3,000 persons with positive HCV test results were reported annually to the New Mexico Department of Health (NMDOH), Epidemiology and Response Division (ERD), many of which represent new infections. As new treatments become available and bring persons with HCV into care, there is more diagnostic testing occurring each year. In 2012, more than 4,000 new cases were reported. Of the newly diagnosed persons reported in 2012, the majority (more than 55%) were under the age of 30. Although these numbers reported are high, the reality is that many remain unaware of their status.

The Center for Disease Control and Prevention (CDC) estimates that 50% to 75% of persons with HCV are unaware of their infection. When left untreated, hepatitis C develops life threatening health risks including liver damage, end-stage liver disease, hepatocellular carcinoma, and eventual death.

The greatest population infected is individuals who were born between 1945 and 1965. The national data suggests that 75% of adults living with HCV are individuals who were born during this time and are 5 times more likely than other individuals to be infected (Center for Disease Control and Prevention, 2012). Many who were infected in the 1940s, 1950s, 1960s and 1970s are now developing end-stage liver disease and other complications that affect quality of life. Chronic HCV has become the most common cause of hepatic failure and accounts for approximately 40% of liver transplants in the U.S.

New Mexico experiences the highest rates of liver cancer in the United States, with 22.46 cases per 100,000 population. This is more than twice the national rate of 10.43 case per 100,000. Costs of premature mortality from HCV and lost productivity alone from 2010 to 2019 are estimated to total \$75 billion.

## Forecasted Burden of HCV-Related Morbidity and Mortality

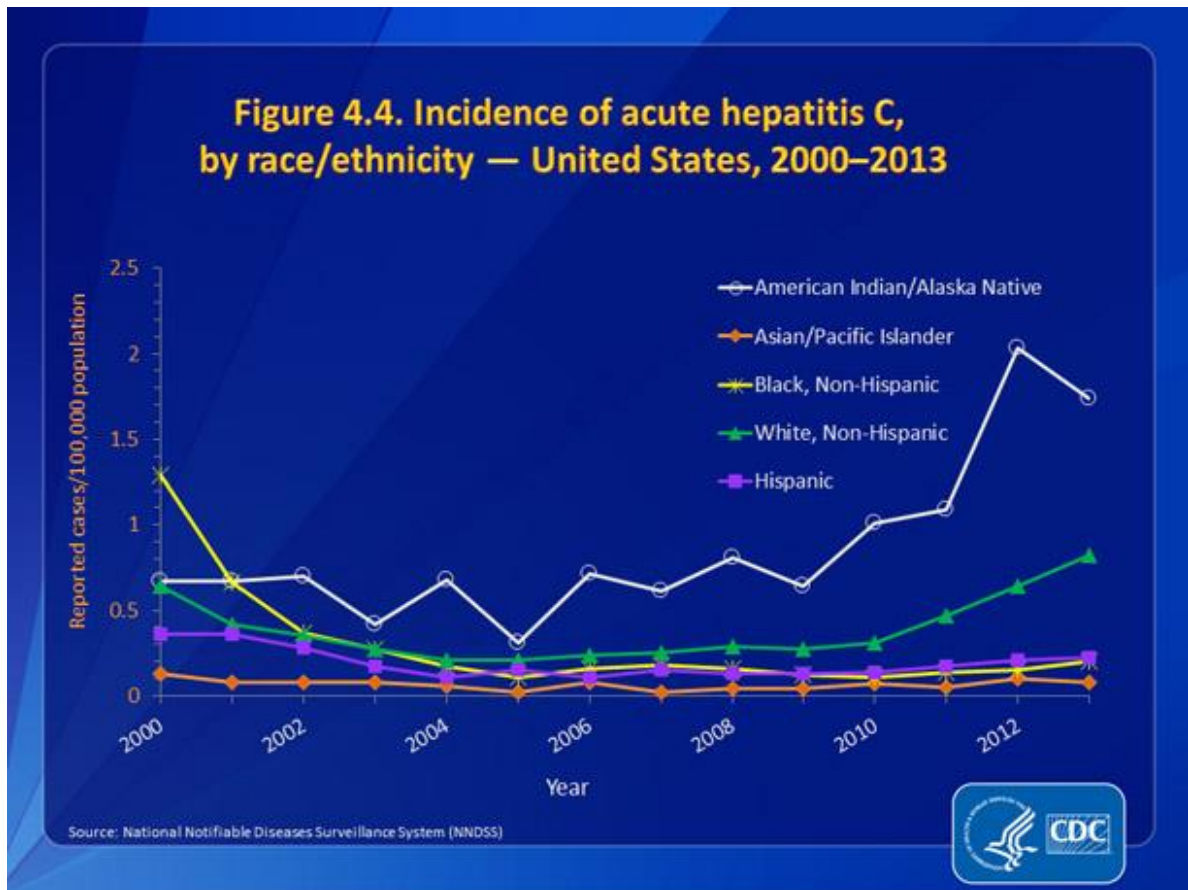


DCC = decompensated cirrhosis; HCC = hepatocellular carcinoma.  
 Rein DB, et al. *Dig Liver Dis.* 2011;43(1):66-72.



HEPATITIS C IN INDIAN COUNTRY

Available data shows that there is higher prevalence of hepatitis C in American Indian and Alaskan Native communities compared with the general population. This is true both nationally and specifically in New Mexico. American Indians represent 8.8% of the population of New Mexico or 183,169 persons (NMDOH, 2015). Due to incomplete surveillance data and a lack of research projects, exact numbers of persons with acute or chronic HCV infection in this population are not available. However, national data from the Centers for Disease Control and Prevention (CDC) show that this ethnic/racial group has had the highest incidence of acute hepatitis C since 2002.



One study done in 2009 reviewed a large number of American Indian/Alaskan Native persons to develop a profile of HCV in this community. While not specific to New Mexico, the work likely reflects the HCV epidemic among American Indians in the state as well. A total of 35,712 American Indians/Alaskan Natives with ICD-9 codes related to HCV were reviewed. All were 18 and older and had these diagnosis codes in the 2-year period between October 2001 and September 2013. Among this group, only a small number of patients

were screened for HCV and 203 were HCV antibody positive. The majority of these individuals (144 or 70%) were RNA positive. The population was disproportionately male. Mean age for males was 40, while the mean for females was 42 (Hillary E. Norton, 2009). The self-reported risk-factors were injection substance use (41%), no risk factor reported (38%), receiving blood or blood products before 1992 (9%), sexual contact (3%), other (6%) and household contact (3%).

The disproportionate rate of HCV among American Indians is of significant concern, both in terms of the high prevalence and related to recent incidence of new infection. Several communities have come together to address this issue, both by raising awareness and by developing coalitions to respond. The Cherokee Nation in neighboring Oklahoma is one of the first communities to develop a Hepatitis C Elimination plan. New Mexico's Project ECHO is an important partner in this work.

New Mexico was pleased to host one of the first events in the country specifically focused on a response to HCV in American Indian communities. The Office of Minority Health Resource Center (OMHRC) and National Native American AIDS Prevention Center (NNAAPC) joined with several New Mexico organizations to host the first Tribal Hepatitis C Summit in Albuquerque on March 2-3, 2016. This meeting addressed the health disparities and treatment barriers that exist on native lands. Both presentations and interactive brainstorming and activities worked to strategize methods to promote health equity, identify resources and build capacity. Attendees included experts, stakeholders and impacted community members, primarily from a diverse array of southwestern tribes. The meeting resulted in a report containing action plans, including first steps in improving prevention, testing, linkage to care, cure, surveillance and harm reduction efforts.

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## STATEWIDE AND NATIONAL PLANNING TO RESPOND TO HCV

Federal funding for public health surveillance of HCV infections and for prevention activities, case management, and treatment has been extremely limited. Of the 2014 funds allocated by the Centers for Disease Control and Prevention's (CDC) National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), only \$16.4 million of \$6.98 billion or just 2.3% was allocated for the response to viral hepatitis (Ward, 2012). Moreover, Congress has never passed legislation that provided safety net access to HCV care and treatment for persons without health insurance, as the Ryan White CARE Act did for persons living with HIV starting in the early 1990s.

In 2010 and 2011, respectively, the Institutes of Medicine (IOM) and Department of Health and Human Services (DHHS) published comprehensive HCV needs assessments and action plans, articulating detailed strategies for controlling the HCV epidemic. (Colvin HM and Mitchell AE, 2010) (Department of Health & Human Services, 2011) Federal budgets, however, have not included the investments needed to implement these important plans.

Since the creation of the first New Mexico Viral Hepatitis Plan in 2004, several documents and advancements have been released that help New Mexico plan and prioritize this revision of our hepatitis C plan. The first was the Institute of Medicine's *Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C*. The second and third were Department of Health and Human Services federal action plan *Combating the Silent Epidemic of Viral Hepatitis* released in 2011 and *Combating the Silent Epidemic of Viral Hepatitis: Action Plan for the Prevention, Care, & Treatment of Viral Hepatitis* released in 2014. These documents are helping advance the field of viral hepatitis and improving much needed guidance to shape the future of hepatitis research, surveillance, prevention and education

The Institute of Medicine report identified that current approach to the prevention and control of chronic hepatitis B and hepatitis C is not working. As a remedy, the IOM recommended increased knowledge and awareness about chronic viral hepatitis among health care providers, social service providers, and the public; improved surveillance for hepatitis B and hepatitis C; and better integration of viral hepatitis services.

The Department of Health and Human Services identified within their federal action plan entitled *Combating the Silent Epidemic of Viral Hepatitis* the following six topic areas, which correspond to the 2010 IOM recommendations:

- Educating Providers and Communities to Reduce Health Disparities;
- Improving Testing, Care, and Treatment to Prevent Liver Disease and Cancer;

- Strengthening Surveillance to Detect Viral Hepatitis Transmission and Disease;
- Eliminating Transmission of Vaccine-Preventable Viral Hepatitis;
- Reducing Viral Hepatitis Caused by Substance-Use Behaviors; and
- Protecting Patients and Workers from Health-Care Associated Viral Hepatitis.

The updated Viral Hepatitis Action Plan builds on the foundation of and momentum generated by the original action plan and includes information to harness new recommendations for health care providers regarding screening for hepatitis C; promises new developments in treatments for hepatitis C; Mounts public awareness of and concern about hepatitis C; and describes the need for expansion of access to viral hepatitis prevention, diagnosis, care, and treatment offered by the Affordable Care Act.

The updated Viral Hepatitis Action Plan details more than 150 actions to be undertaken between 2014 and 2016 by 20 federal agencies or offices across four federal departments. Those actions are organized around six priority areas. The updated Viral Hepatitis Action Plan underscores that its national goals cannot be achieved through federal action alone. Envisioning active involvement and innovation by a broad mix of nonfederal stakeholders from various sectors, both public and private, the plan provides a framework and focus around which all key stakeholders can engage to strengthen the nation's response to viral hepatitis and seeks to leverage opportunities to improve the coordination of viral hepatitis activities across all sectors.

The aforementioned federal documents were used as guidance and models in creating the New Mexico Hepatitis C Coalition, its mission and goals and this comprehensive plan. Without these guiding documents, it would have been an extremely difficult and long process to identify best practices and come to consensus on the most effective current and future strategies and efforts to prevent and cure HCV in New Mexico. Through its diverse and expert participants, the New Mexico Hepatitis C Coalition was able to tailor these priority areas to address the HCV epidemic that we currently face in our state. This comprehensive plan and strategy is a direct reflection of those efforts.

## HEPATITIS C PLANNING IN NEW MEXICO

The New Mexico Hepatitis C Coalition was formed in September 2013 and held its first statewide invitational meeting in May 2014. It follows prior statewide planning and coalition bodies such as the New Mexico Hepatitis C Alliance. Given the changes in the HCV epidemic and its treatment, the new Coalition aimed to build on prior work and expand based on new science and evidence. The immediate goal was to improve New Mexico's statewide response to HCV. Development of this comprehensive plan was designed to identify the best approaches available now to respond to this urgent health issue.

During the 2015 New Mexico legislative session, House Memorial 26 (HM26) was passed to call for a study and development of a comprehensive plan for the state. A proposal to build the HM26 process into the ongoing work of the New Mexico Hepatitis C Coalition was supported by several state agencies. This legislation helped to recruit additional perspectives to the Coalition, expand the group's reach, and increase awareness of this planning effort.

Starting in summer 2015, the Coalition adopted a four-step planning process described in a "Plan 2 Plan", with the goal of completing a new comprehensive statewide plan for the state in summer 2016. The planning steps were as follows.

- Step 1 – MISSION AND GOALS  
Develop a Vision/Mission and Goals for the comprehensive plan
  
- Step 2 – RESOURCE ASSESSMENT  
Assess existing partners and strategies that are responding to HCV in New Mexico
  
- Step 3 – GAPS ANALYSIS  
Assess and summarize key gaps and unmet needs related to HCV education, prevention and care across the state
  
- Step 4 – OBJECTIVES  
Develop Objectives and Strategies for each Goal in the plan

**The following sections describe the details and outcomes of this comprehensive planning process.**

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## COMPREHENSIVE PLAN – STEP 1 - MISSION AND GOALS

The Coalition developed a Mission and four goals for New Mexico's response to the HCV epidemic. These provide an overview of the shared vision for ending the hepatitis C epidemic in the state.

**Mission: New Mexico will prioritize the prevention, testing and treatment of infection with hepatitis C virus (HCV) in order to reduce the number of new infections as well as cure the infection in those currently living with HCV, thereby reducing the negative health impacts of this disease.**

### Goals:

- **Goal 1 - Prevention: Reduce the transmission of HCV by providing harm reduction education and interventions.**
- **Goal 2 - Access to Testing and Services: Cure HCV and reduce negative health impacts by improving access to testing, counseling, support, treatment and comprehensive medical care.**
- **Goal 3 - Education and Training: Reduce stigma, increase awareness and expand resources by providing education and training to at-risk populations, persons with HCV, providers and policy makers.**
- **Goal 4 - Health Disparities: Reduce health disparities related to HCV by advocating for increased resources and appropriate policies for surveillance, prevention and medical services.**

The following documents were reviewed to help guide in the creation of the mission and goals.

- New Mexico Hepatitis C Coalition's  
Mission and Goals
- HHS Action Plan for the Prevention, Care, and Treatment of Viral Hepatitis Updated 2014–2016:  
Goals and Priorities
- CDC Division of Viral Hepatitis (DVH) Strategic Plan Framework  
Vision, Mission and Goals

## COMPREHENSIVE PLAN – STEP 2 - RESOURCE ASSESSMENT: PARTNERS, PROGRAMS & SERVICES

The second step outlined in the Coalition's Plan to Plan was a comprehensive resource assessment. The aim was to build upon the mission and goals by determining the strengths, resources, capacity and programs across the state that were already responding effectively to hepatitis C prevention, care, support and education.

The New Mexico Hepatitis C Coalition had active participation of many of the organizations leading this response. This resource assessment highlights some of the largest programs in New Mexico, as well as their strengths and successes.

### **New Mexico Corrections Department**

The New Mexico Corrections Department (NMCD) began universal screening of hepatitis C for all persons coming into New Mexico prisons since 2009. Through these thorough screening practices, it has become evident that hepatitis C is an epidemic among incarcerated persons in New Mexico, with over 40% of individuals entering New Mexico's prisons testing positive for hepatitis C antibodies.

NMCD has been involved in treating incarcerated persons in New Mexico's prisons for many years, with the help and guidance of the UNMHSC's Project ECHO. The current goal is to treat at least 150 persons per year utilizing the New Mexico Medicaid guidelines for treatment. Persons incarcerated who are treated receive identical community standards of care including the newly released direct acting agents. Treatment includes a comprehensive assessment of liver disease and case presentation with a multidisciplinary faculty utilizing the ECHO model.

In addition to the treatment efforts, Project ECHO and the NMCD have partnered to develop and implement a prison-based peer health education project aimed to increase knowledge and introduce behavior change utilizing harm reduction in order to prevent acute transmission within the prison. The goal of the training is to provide skills and knowledge to a select group of incarcerated persons to become peer educators to conduct monthly, 10 -12 hour long workshops to the general population each month. To date, over 450 peer educators have been trained. The peer educators have provided important education and information to more than 7,500 incarcerated individuals since July 2009.

### **Southwest CARE Center**

Southwest CARE Center's (SCC) Hepatitis C Program is the only comprehensive provider of hepatitis C care in northern New Mexico. The program enrolls approximately 15 new patients per week. While Southwest

CARE has previously provided Hepatitis C treatment to some individuals, the program was greatly expanded in capacity in late 2012 to dramatically expand access to treatment.

SCC's goal is to engage hepatitis C-infected and potentially infected individuals at every level. The agency's specially trained and NMDOH-certified outreach staff offers free, rapid, anonymous Hepatitis C testing both on- and off-site, targeting high-risk individuals.

Once assessed for severity of liver disease, patients infected with hepatitis C are treated and monitored by specialty clinical staff through either standard of care treatment or enrollment in a clinical trial. If a patient is prescribed standard of care treatment, case managers and a prior authorization specialist work with the patient and insurance companies to advocate for coverage of the regimen. If a patient's treatment is denied through insurance, case managers will work with manufacturer assistance programs to obtain treatment when a patient is eligible. If SCC has an enrolling clinical trial for which a patient meets criteria, the patient is invited to be treated through this research program.

In addition, SCC offers assessment using transient elastography to all hepatitis C patients using a FibroScan. This test is an accurate, non-invasive measure of fibrosis, or liver damage.

SCC also provides comprehensive case management services to all hepatitis C patients. Case managers work closely with patients to ensure successful treatment. This work includes connecting patients to community resources for everything from transportation assistance to substance use counseling. Case managers are also integral to linking patients to SCC's behavioral health providers for those in need of therapy and/or psychiatric support.

For those patients who have to defer hepatitis C treatment because of insurance denials or life circumstances, SCC provides monitoring of disease progression and re-evaluation every six months.

### **UNM Project ECHO**

Project ECHO® was originally created with the goal to effectively increase access to hepatitis C treatment in all areas of New Mexico and to monitor outcomes. The primary care providers participating in Project ECHO present patient information to the Hepatitis C Community TeleECHO Clinic, and then each community clinician is given a plan for treatment based on the specialist recommendations. After an individualized hepatitis C treatment plan is established for each patient, frequent follow-ups are conducted to present the patient's treatment status, to relay health related issues that may impede treatment, and to alter the treatment plan as needed to maximize the patient's chance for a cure. Through the use of technology, best-practice protocols, and co-management of case-based learning; rural primary care clinicians deliver Hepatitis C



care that is as safe and effective as that given in a university clinic. The model has since been expanded to many other complex, chronic diseases.

As powerful new HCV medications – with higher cure rates and fewer side effects - became available in early 2014, there was a corresponding increase in interest among primary care providers seeking knowledge and training to enable them to provide hepatitis C treatment for their patients. Outreach efforts by various means were made to health care providers in Taos, Shiprock, Portales, Farmington, Roswell, Grants and other parts of the state to encourage participation in the Project ECHO® Hepatitis C program and to educate clinicians about new screening recommendations and treatment options.

While treatment efficacy has improved, costs for the new medications are high and clinicians have faced challenges in receiving prior authorizations and insurance coverage for these new medications for their patients. Consultation and recommendations from specialists at UNM via Project ECHO® have facilitated the approval process and provided the opportunity for shared experiences of this process by providers. Project ECHO® has created resources for providers to help access medications which include disease specific letters to accompany requests for prior authorization. Most providers have stated access to medications is improved when consultation with Project ECHO® has been conducted and treatment recommendations from Project ECHO® faculty are included in prior authorization forms.

Twenty-six clinicians attended the one-day HCV Provider Training aimed at teaching the skills necessary to treat, manage and present patients to the HCV TeleECHO Clinics. Participating clinicians represented many community-based health care providers including Albuquerque Health Care for the Homeless, Espanola PMG, First Nations Community Healthsource, El Centro Family Health, Roosevelt General Hospital, Northern Navajo Shiprock, Santa Fe Community Guidance Center, IHS Fort Defiance, First Choice and UNM SE Heights Clinic.

A comprehensive outreach plan was established for the IHS clinics to increase provider attendance and participation. Discussion began to potentially increase frequency of the IHS clinic to meet the needs for these providers.

In FY 2014-2015 Project ECHO conducted 42 HCV community clinics, 11 IHS HCV clinics and 10 day long HCV clinician trainings. A total of 105 unique clinicians participated in the HCV community clinics and 33 unique clinicians participated in the IHS clinics. During these clinics 451 unique patients were presented for hepatitis C treatment and a total of 547 patient presentations were performed. Through the HCV clinic 324 patients were recommended for treatment.

### **Project ECHO - The New Mexico Peer Education Project**

The New Mexico Peer Education Project (NMPEP) is an initiative of Project ECHO® which trains incarcerated individuals to conduct peer-led health workshops focusing on HCV, HIV and other communicable diseases in the prison setting. NMPEP continues to maintain eight working peer educator groups in seven of New Mexico's prisons, with hopes to expand to additional sites in the near future. Since its inception, over 450 peer educators have been trained.

### **New Mexico Department of Health (NMDOH) – Hepatitis and Harm Reduction Program**

The NMDOH Hepatitis and Harm Reduction Program has been proactive in addressing the hepatitis C epidemic through collaborative efforts both within NMDOH and through external partnerships, both statewide and national. To ensure that limited governmental resources have the maximum possible impact on hepatitis C prevention and intervention in the state, the Hepatitis and Harm Reduction Program prioritizes the most effective public health and surveillance approaches. Current public health priorities and services include hepatitis C counseling, testing & referral, syringe exchange, and overdose prevention (naloxone distribution).

The Hepatitis and Harm Reduction Program delivers, supports and funds the Under 30 Project (U30). The U30 is an enhanced surveillance project which investigates new HCV infections in persons aged 30 and under in New Mexico. U30 was developed as a response to the increased incidence of HCV from 2006 to 2012. This under 30 age group of mostly injection substance users was seen as the fastest growing age cohort infected with HCV outside of the Baby Boomer population and the most likely to transmit HCV through the sharing of syringes and substance using equipment (cookers, cottons, and tourniquets). During the course of a surveillance investigation individuals are given information on HCV transmission, testing, treatment, health and primary and secondary prevention. Investigators also provide referrals for vaccination of HAV & HBV, syringe exchange sites, the nearest providers who test and treat and substance use treatment including suboxone and/or methadone.

The Harm Reduction Program is one of the most robust programs in the country with a total of 42 exchange sites statewide, including both fixed and mobile outreach locations. It is estimated that during fiscal year 2015-2016 over six million syringes will be exchanged, which is roughly twice the number from just five years prior. The Harm Reduction Program has a better than 97% collection rate which makes it truly beneficial in communities who are experiencing high rates of opioid use combined with injecting behaviors. Participants in the program receive new syringes (exchanged for used), new cookers, cottons, tourniquets, alcohol pads, sharps containers and when available antibacterial cream.

In addition to syringe exchange, overdose prevention is a large component of the Harm Reduction program. Overdose prevention consists of education to community members in identifying an overdose, emergency planning if an overdose should occur, rescue breathing and how to administer naloxone. In addition to providing this valuable education to community participants the Harm Reduction program also oversees the distribution of naloxone to community based organizations who then dispense to community participants.

In 2016, legislation was passed which allows any person (licensed or unlicensed) to distribute naloxone, so long as they either operate under a standing order issued by a licensed prescriber, or who works with a NMDOH Registered Overdose Prevention and Education Program and successfully completes the one-day Hepatitis and Harm Reduction Specialist Certification Training. Naloxone is a medication which reverses the effects of opioids. Prior to the passage of this legislation naloxone could only be dispensed by a licensed provider. The passage of this legislation now makes it possible to increase access to naloxone in communities where the need is great but very few providers are located.

### **New Mexico Department of Health – Southwest Region Hepatitis C Program**

The Southwest Region is the only part of the Public Health Division (PHD) of NMDOH that provides hepatitis C treatment and follow-up directly. This is due to a lack of providers in the Las Cruces area.

The Hepatitis C program is being run by one full time nurse with the assistance of Project ECHO and the Southwest Regional Health Officer. Hepatitis C treatment has changed tremendously with fewer side effects and cure rates of 95-99%. In 2015, the Southwest Region program treated about 40 patients. The majority (38 patients) were cured of their infection, one person relapsed after treatment (treatment failure) and one patient transferred to a private doctor for his treatment.

The program is continuing to partner with Project ECHO to recruit other local providers to build capacity in this region. The program is no longer accepting new patients due to a lack of resources.

### **New Mexico Primary Care Association (NMPCA)**

Incorporated in 1980, the New Mexico Primary Care Association (NMPCA) is a non-profit organization that provides training, technical assistance, and other support services to the Federally Qualified Health Centers (FQHCs) in New Mexico. These FQHCs are also known as Health Center 330 Program Grantees and Community Health Centers (CHCs). FQHCs are located in Medically Underserved Areas and/or offer services to a Medically Underserved Populations. The mission of the NMPCA is to promote the advancement of high quality primary health care services that are financially and geographically accessible, culturally competent and responsive to the communities being served.

There are seventeen FQHC with clinics located in 31 of the 33 counties in New Mexico. Most FQHCs are located in very rural locations. These organizations annually serve over 300,000 individuals at 160 clinic sites. In 2014, 31% of the patients served were uninsured and 38% received Medicaid.

Primary Care Providers at FQHCs currently serve over 3,500 persons with HCV. Many of these providers increase their capacity to respond to and treat HCV by participating in ECHO training. They also receive training and technical assistance through the NMPCA and through partnerships with NMDOH.

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## COMPREHENSIVE PLAN – STEP 3 - GAPS

The Coalition identified a set of gaps for each of the four established Goals. An online survey among Coalition members was used to prioritize these gaps. They were then categorized into groups of related gaps. For each gap area, related problem statements were written.

The following are the results of the Gaps Analysis process conducted by the Coalition.

### **Gap 1: Prevention Priorities**

#### **PROBLEM STATEMENT: INDIVIDUALS AT GREATEST RISK HAVE LIMITED INFORMATION ABOUT AND ACCESS TO ANTIBODY TESTING AND CONFIRMATORY TESTING OPTIONS.**

There is a need for expanded access to and provision of HCV testing to the populations at greatest risk and those with unknown status. This includes need for expanded testing of the Baby Boomer cohort in primary care settings including community health centers. For other populations at risk, there is a need for the greater incorporation of strategies such as engagement of stakeholders and peer educators.

Hepatitis C testing is divided into two tests: an initial antibody test and a confirmatory RNA test. However getting both tests, if antibody positive, can be a barrier to cure. To receive an RNA test, if antibody positive, requires an additional provider visit. Making another appointment with the provider duplicates the resources used (transportation and travel time, copays, social/familial/work rearrangements) to receive the initial antibody test. A need exists for increased access to and provision of confirmatory testing, such as by automatically reflexing reactive screening tests to order and perform a confirmatory test.

#### **PROBLEM STATEMENT: INCARCERATED INDIVIDUALS HAVE LIMITED ACCESS TO TESTING PRE-RELEASE AND HAVE LITTLE TO NO CONTINUATION OF CARE IN THE COMMUNITY.**

Testing is available upon entry to state correctional system, but lack the option for testing upon release. Also sharing the status with individuals prior to release should be required.

#### **PROBLEM STATEMENT: RESOURCES FOR PRIMARY AND SECONDARY PREVENTION STRATEGIES ARE INADEQUATE TO REDUCE TRANSMISSION IN NEW MEXICO.**

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There is a great need for more resources and services that prevent hepatitis C virus (HCV) infection (primary and secondary prevention) for prevention work with uninfected persons and efforts to reduce transmission from those living with HCV.

## Gap 2: Testing & Access to Care Priorities

### **PROBLEM STATEMENT: THERE ISN'T ADEQUATE CAPACITY FOR BUPRENORPHINE TREATMENT IN NEW MEXICO TO TREAT OPIATE ADDICTION IN INDIVIDUALS AT RISK FOR AND INFECTED WITH HEPATITIS C.**

Increase the number of providers who are licensed and willing to prescribe Suboxone. Identify new strategies to overcome barriers such as changing the limitations on number of patients served, ending the limitation that prescription is only by physicians and reducing the paperwork burden.

### **PROBLEM STATEMENT: NEW MEXICO HAS NOT IMPLEMENTED UNIVERSAL TREATMENT ACCESS FOR PEOPLE LIVING WITH HEPATITIS C.**

Statewide vision or shared goal for universal treatment access to address HCV elimination in New Mexico.

### **PROBLEM STATEMENT: NEW MEXICO LACKS A STATEWIDE NETWORK TO ENHANCE INFORMATION, REFERRALS AND COORDINATION OF HEPATITIS C PREVENTION AND TREATMENT, PARTICULARLY IN RURAL AREAS.**

Need to formalize and improve linkages and referrals to HCV care and treatment, including efforts to ensure continuity of care from a variety of settings including syringe services programs, correctional facilities and substance use treatment programs. Can make linkage better by enhancing communication and encouraging a “warm hand-off”.

### **PROBLEM STATEMENT: INSURANCE COMPANIES' AND MANAGED CARE ORGANIZATIONS' REQUIREMENTS FOR PRIOR AUTHORIZATION CREATES EXTREME, TIME-CONSUMING BURDENS FOR CLINICIANS AND MEDICAL TEAMS TREATING HEPATITIS C.**

Prior authorization for treatment is a significant barrier to care and a burden for clinicians and medical practices. Need to streamline and/or implement a universal prior authorization process to decrease the work demand for providers.

### **Gap 3: Education and Training Priorities**

#### **PROBLEM STATEMENT: THERE IS INADEQUATE FUNDING AND RESOURCES FOR SURVEILLANCE OF HEPATITIS C MORBIDITY AND MORTALITY.**

Legislators and other policy makers need to understand the burden of HCV across the state to allow them to take positive actions. This needs to include the costs both of providing treatment and of not providing treatment (i.e. human and medical costs).

#### **PROBLEM STATEMENT: STIGMA AND DISCRIMINATION TOWARDS INDIVIDUALS LIVING WITH HEPATITIS C, ESPECIALLY THOSE WITH PAST AND PRESENT INJECTION DRUG USE, OCCURS IN THE HEALTH FIELD.**

Clinicians lack skills on working with populations at risk for HCV. Providers need education on the demographics and risk profile of HCV and the skills on how to work with persons who use and former users of substances including injection substance users. Reducing stigma related to injection substance use through education about addiction.

#### **PROBLEM STATEMENT: KNOWLEDGE AND EXPERTISE OF HEPATITIS C DIAGNOSIS, TREATMENT AND LINKAGE TO CARE IS LACKING IN PRIMARY CARE SETTINGS.**

Many clinicians and providers still need training on HCV, including doing a work up and preparing a patient for treatment. This can help reduce stigma and misinformation among providers about working with persons with HCV.

### **Gap 4: Health Disparities**

#### **PROBLEM STATEMENT: THERE IS INADEQUATE FUNDING AND RESOURCES FOR SURVEILLANCE OF HEPATITIS C MORBIDITY AND MORTALITY.**

Need to conduct comprehensive statewide HCV surveillance to be able to describe the disease burden and demographics. This data is needed for prioritizing gaps and needs, allocating resources, improving programs and reducing disparities. Having complete data will allow development of an HCV Care Continuum, modeled on the HIV Continuum. Drastically increase resources for HCV surveillance.

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**PROBLEM STATEMENT: INDIVIDUALS WHO HAVE HEPATITIS C HAVE GREATER CO-MORBIDITIES AND SOCIAL DETERMINANTS OF HEALTH THAT AFFECT THEIR ABILITY TO NAVIGATE SERVICES.**

Need to improve access to HCV treatment and services for populations with greater barriers and fewer resources. Utilize care coordination and navigation services to eliminate gaps including transportation, access, provider linkages, costs, and housing.

Need to increase awareness of the public health principle that prisoner health is community health. Over 98% of incarcerated persons will return to communities. Leverage incarceration as an opportunity to reach persons at risk with education and services

**PROBLEM STATEMENT: ADVOCACY BY PROFESSIONALS WORKING IN THE HCV FIELD AND PATIENTS LIVING WITH HEPATITIS C IN NEW MEXICO DOES NOT HAVE A FORUM TO INFLUENCE POLICY CHANGE.**

Need to increase access to HCV treatment by creating a voice and forum to advocate for treatment cost reductions and changes in policies.



## COMPREHENSIVE PLAN – STEP 4 - OBJECTIVES & STRATEGIES TO RESPOND TO HEPATITIS C IN NEW MEXICO

Objectives and strategies for each of the four comprehensive plan Goals were developed based on the gaps analysis and problem statements.

### **Goal 1: Prevention - Reduce the transmission of HCV by providing harm reduction education and interventions.**

**OBJECTIVE 1A - TESTING: EXPAND ACCESS TO HEPATITIS C VIRUS (HCV) TESTING FOR POPULATIONS AT GREATEST RISK TO HELP PERSONS LEARN THEIR STATUS.**

**OBJECTIVE 1B - PREVENTION: EXPAND EFFORTS TO PREVENT TRANSMISSION OF HEPATITIS C AMONG POPULATIONS AT GREATEST RISK.**

**STRATEGY A: MAKE SYRINGE SERVICE PROGRAMS AVAILABLE TO PERSONS WHO INJECT SUBSTANCES AND ARE UNDER AGE 18 THROUGH CHANGES IN LAW AND POLICY.**

**STRATEGY B: ADVOCATE FOR THE AVAILABILITY OF STERILE SYRINGES AND TATTOOING EQUIPMENT FOR PERSONS WHO ARE INCARCERATED.**

**STRATEGY C: ESTABLISH A MODEL SAFER INJECTION FACILITY IN NEW MEXICO.**

### **Goal 2: Testing & Access to Care - Cure HCV and reduce negative health impacts by improving access to testing, counseling, support, treatment and comprehensive medical care.**

**OBJECTIVE 2A – UNIVERSAL TREATMENT: ELIMINATE HEPATITIS C INFECTION IN NEW MEXICO THROUGH UNIVERSAL ACCESS TO TREATMENT THAT IS AVAILABLE STATEWIDE AND HAS REDUCED BUREAUCRATIC BURDEN.**

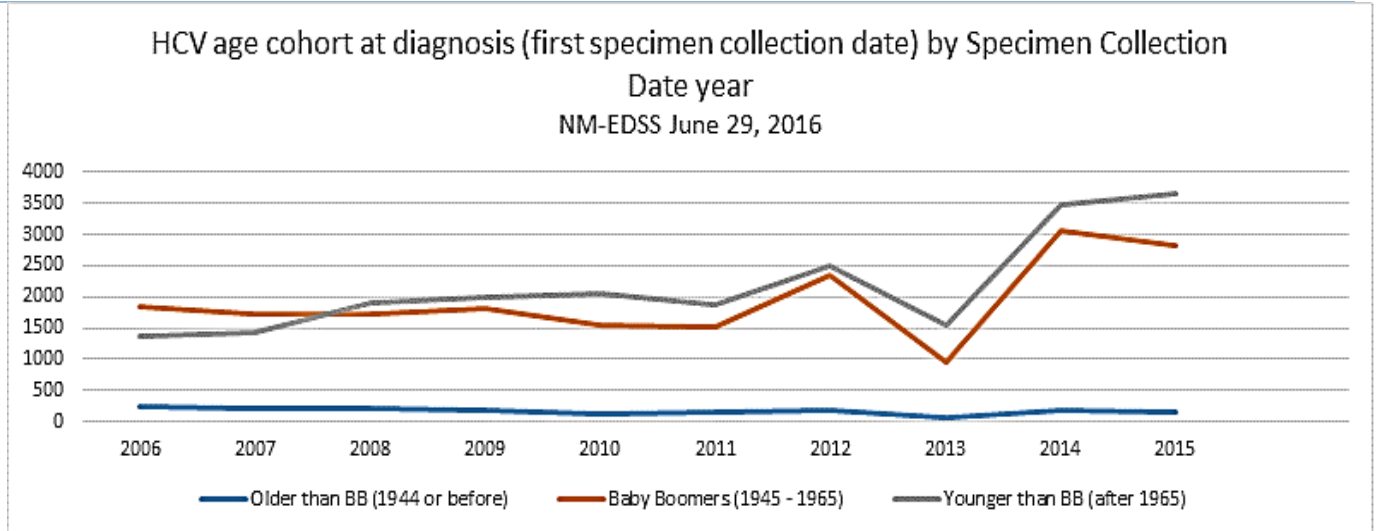
**STRATEGY A: EXPAND PROVISION OF TREATMENT FOR HCV BY PRIMARY CARE PROVIDERS, PARTICULARLY IN RURAL AREAS AND THOSE THAT HAVE LIMITED ACCESS TO SPECIALISTS, VIA PROVIDER TRAINING AND TECHNICAL ASSISTANCE OFFERED BY PROJECT ECHO AND OTHER EXPERTS.**

**STRATEGY B: CONTINUE TO EXPAND COVERAGE FOR HCV TREATMENT BY PRIVATE HEALTH INSURANCE PROVIDERS, MODELLED ON THE INNOVATIVE CHANGES IN MEDICAID POLICIES AND BASED ON EVIDENCE-BASED BEST PRACTICES.**

**OBJECTIVE 2B – SUBSTANCE TREATMENT: EXPAND ACCESS TO AND CAPACITY OF LOW-THRESHOLD TREATMENT FOR SUBSTANCE USE, INCLUDING MEDICATION ASSISTED THERAPY (MAT) SUCH AS BUPRENORPHINE/SUBOXONE, FOR BOTH ADULTS AND ADOLESCENTS.**

**STRATEGY A: INCREASE THE NUMBER OF PERSONS RECEIVING BUPRENORPHINE/SUBOXONE BY EXPANDING THE NUMBER AND TYPE OF PROVIDERS WHO ARE LICENSED AND DELIVERING THIS MAT OPTION.**

**STRATEGY B: EXPAND ACCESS TO HCV TESTING BY PROVIDING IT ON-SITE AT PROGRAMS AND FACILITIES THAT OFFER SUBSTANCE ABUSE TREATMENT.**



**Goal 3: Education and Training - Reduce stigma, increase awareness and expand resources by providing education and training to at-risk populations, persons with HCV, providers and policy makers.**

**OBJECTIVE 3A – PROVIDER TRAINING: EXPAND ACCESS TO BEST PRACTICE TESTING, DIAGNOSIS AND TREATMENT FOR HEPATITIS C STATEWIDE THROUGH PROVIDER TRAINING.**

**STRATEGY A: TRAIN PROVIDERS TO ESTABLISH A NORM IN DIVERSE HEALTH CARE SETTINGS (INCLUDING PRIMARY CARE, EMERGENCY DEPARTMENTS, AND PUBLIC HEALTH OFFICES) TO OFFER AND PROVIDE ROUTINE TESTING FOR HCV TO PERSONS AT GREATEST RISK, INCLUDING PAST AND PRESENT SUBSTANCE USERS, GAY/BISEXUAL MEN AND OTHER MEN WHO HAVE SEX WITH MEN (MSM).**

**STRATEGY B: EXPAND PROVISION OF TREATMENT FOR HCV BY PRIMARY CARE PROVIDERS, PARTICULARLY IN RURAL AREAS AND THOSE THAT HAVE LIMITED ACCESS TO SPECIALISTS, VIA PROVIDER TRAINING AND TECHNICAL ASSISTANCE OFFERED BY PROJECT ECHO**

**AND OTHER EXPERTS.**

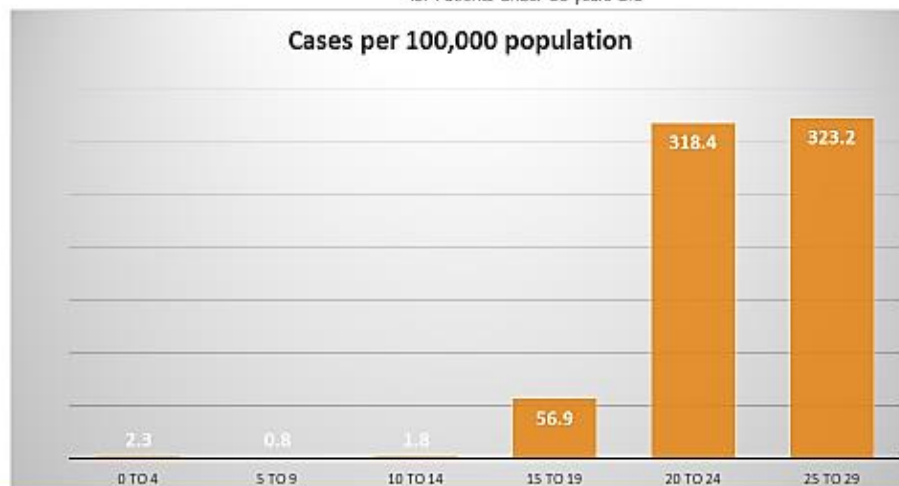
**OBJECTIVE 3B – REDUCE STIGMA: IMPROVE HEALTH OUTCOMES FOR PERSONS LIVING WITH HEPATITIS C THROUGH EDUCATIONAL PROGRAMS THAT REDUCE STIGMA AND DISCRIMINATION.**

**STRATEGY A: IMPLEMENT A STATEWIDE PUBLIC EDUCATION CAMPAIGN TO RAISE AWARENESS OF HCV AND AVAILABLE SERVICES, WHILE REDUCING STIGMA.**

**STRATEGY B: EMPOWER PERSONS LIVING WITH HEPATITIS C, INCLUDING THOSE WHO HAVE BEEN CURED, TO BE VISIBLE ADVOCATES, ROLE MODELS AND SPOKESPEOPLE.**

**Goal 4: Health Disparities - Reduce health disparities related to HCV by advocating for increased resources and appropriate policies for surveillance, prevention and medical services.**

Hepatitis C Infections Rate by Age at Diagnosis,  
New Mexico, 2011-2015  
for Patients under 30 years Old



Data are from NM IBIS on 5/9/2016

**OBJECTIVE 4A – SURVEILLANCE: CREATE A HEPATITIS C SURVEILLANCE SYSTEM THAT CAN DESCRIBE THE PREVALENCE, TRENDS AND CORRELATES OF HCV INFECTION.**

**STRATEGY A: COMPLETE DATA RECOVERY ON A BACKLOG OF CASES FROM 2013 – 2015 TO CREATE A 3-YEAR TREND.**

**STRATEGY B: BUILD A ROBUST AND SUSTAINABLE SURVEILLANCE SYSTEM TO ENSURE ONGOING AND COMPREHENSIVE SURVEILLANCE OF HEPATITIS C.**

**OBJECTIVE 4B – POLICY: IMPLEMENT BEST PRACTICES IN POLICY AND ENSURE ADEQUATE RESOURCES BY EXPANDING ADVOCACY AND GIVING A VOICE TO EXPERTS AND PERSONS LIVING WITH HEPATITIS C.**

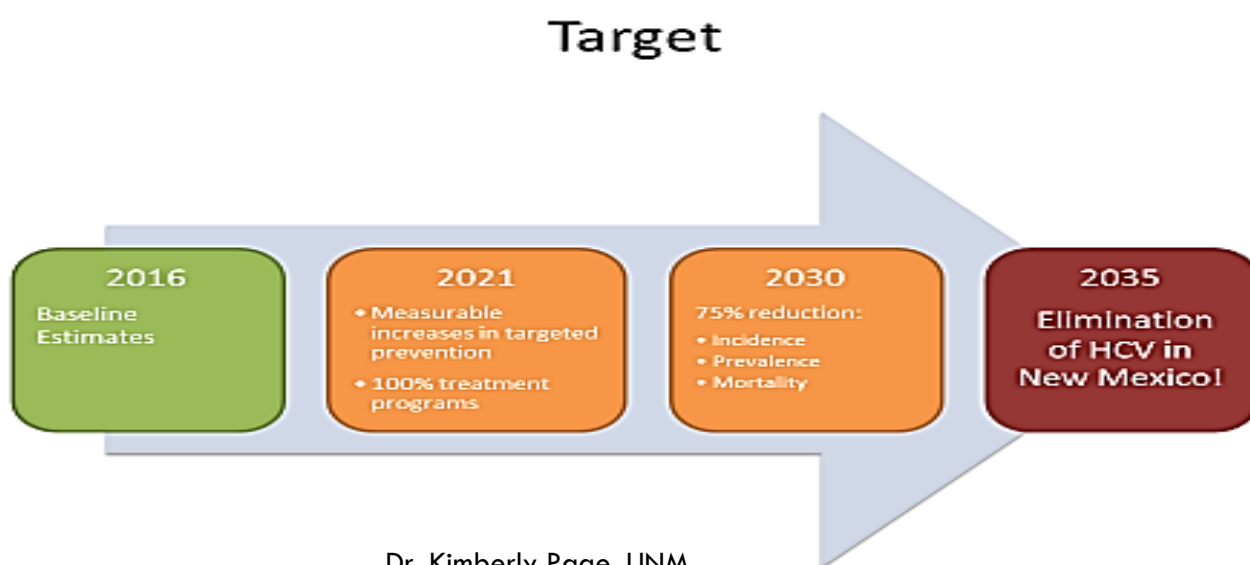
**STRATEGY A: PROVIDE TRAINING ON HOW TO DO POLICY AND ADVOCACY, TO INCREASE THE INVOLVEMENT OF PERSONS LIVING WITH HCV IN NEW MEXICO IN NATIONAL AND STATE-LEVEL WORK.**

**STRATEGY B: COORDINATE A STRONG AND UNIFIED VOICE FROM NEW MEXICO ON FAIR PRICING OF HCV MEDICATIONS.**

## NEXT STEPS AND WORK TO ELIMINATE HEPATITIS C

Hepatitis C is a significant problem in our state, country and world. With advanced technologies and new medications that are approved, available and have highly successful rates of cure, elimination of hepatitis C is becoming a feasible option.

Many places around the world are looking to eliminate hepatitis C from their communities. New Mexico has begun discussions and planning, in the hopes of being of the first states to have a formal and operational plan to eliminate hepatitis C. Initial discussions have included review of public health concepts and theories. Models show that it may be feasible to eliminate hepatitis C within a foreseeable time, perhaps just 20 – 30 years!



New Mexico is uniquely armed to work towards eliminating hepatitis C. For the last two decades, the state has been in the forefront of innovative programs and practices. A few examples include:

- Promoting the harm reduction philosophy and making tools available for safer practices in injecting substances to reduce transmission of HCV and HIV
- Working on vaccine trials and other research on hepatitis C and disease epidemiology
- Offering treatment to community members and incarcerated individuals through innovative programs
- Development of the unique and innovative Project ECHO to expand access to treatment and care

New Mexico can continue to lead the country's work in combating hepatitis C. Models and programs serving the state's residents can test these concepts and their outcomes for the unique racial and cultural diversity that can be applied to populations throughout our country and the world.

Bringing hepatitis C to the forefront of public health issues is a complex project that will take time, require public interest, increased resources and requires we collectively address current barriers. But the work in planning and advocacy has already begun.

In May 2016, Project ECHO hosted the first meeting toward eliminating hepatitis C in New Mexico. This discussion engaged major stakeholders representing the New Mexico Department of Health, Research and Epidemiology from the University of New Mexico Health Sciences Center, the Centers of Disease Control and Prevention (CDC) Division of Viral Hepatitis, and experts working in substance abuse and overdose prevention fields. The work continued at the end of May, where additional stakeholders were identified and planning began to create a New Mexico Hepatitis C Elimination Plan. Four major areas were identified and discussed as guiding categories towards elimination of hepatitis C:

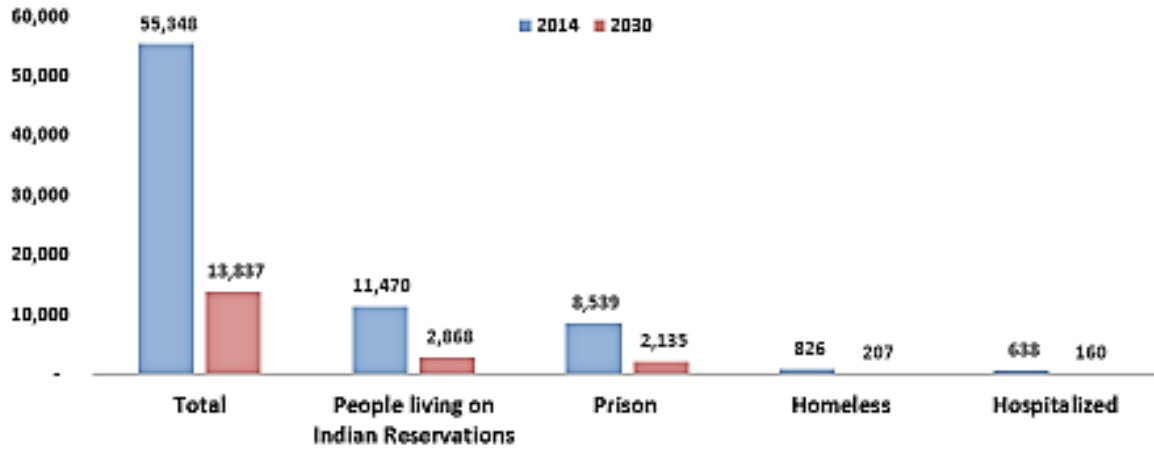
- Strategic Information
- Ending Transmission
- Resolving Chronic Infection
- Incorporating Public Information

Each guiding category has major subcategories where key stakeholders in the field will develop a comprehensive plan to support and enhance services towards resolution of disease with impact on the morbidity and mortality of hepatitis C. Monthly meetings have been established to continue to work on creation of this plan and identifying funding resources.

The participants in the New Mexico Hepatitis C Coalition hope to see New Mexico continue as a leader in the response to hepatitis C. It is our hope that the state will continue to be a major innovator and supporter of progressive, comprehensive work for the health of New Mexico communities and join the mission toward elimination of hepatitis C in New Mexico.

# Impact

## ESTIMATED CHRONIC HCV INFECTIONS: 2014 V 2030 (UPPER ESTIMATES)



Source: Dr. Kimberly Page, UNM