Minnesota Viral Hepatitis Elimination Plan

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Executive summary

Viral hepatitis is a significant public health threat in the United States. There are vaccines available to prevent hepatitis A and hepatitis B, treatment to reduce the impact of hepatitis B infection, and a cure to eliminate hepatitis C. Despite these tools, viral hepatitis elimination remains out of reach within Minnesota. The Minnesota Viral Hepatitis Elimination Coalition was established by the Hepatitis Unit at the Minnesota Department of Health (MDH). This group of advocates and stakeholders created this document to lay the groundwork to effectively eliminate viral hepatitis A, B, and C in Minnesota. This viral hepatitis elimination plan serves as a framework to be utilized by stakeholders across the state of Minnesota. The components of this plan must be assessed within each agency or organization and implemented where appropriate to effectively progress towards viral hepatitis elimination. The coalition's mission and vision that guided the development of the Minnesota Viral Hepatitis Elimination Plan are:

Mission: Eliminating viral hepatitis in Minnesota by preventing new infections and treating existing infections.

Vision: The elimination of viral hepatitis in Minnesota, where all people at risk of or living with viral hepatitis have equitable access to the tools they need to achieve the best health outcomes, have equitable access to programs and services, and there is enhanced surveillance to prevent the spread of viral hepatitis.

Defining viral hepatitis elimination

The World Health Organization (WHO) defines hepatitis elimination as a 90% decrease in new infections and a 65% decrease in deaths attributed to viral hepatitis by 2030, using 2015 data as a baseline. For this elimination plan, MDH defines viral hepatitis elimination in the same way, using state level data and programmatic evaluation to determine the success of our elimination efforts in Minnesota.

Elimination plan outline

The Viral Hepatitis Elimination Plan follows a four-pillar approach:

1. **Diagnose** all people living with viral hepatitis
2. **Prevent** new viral hepatitis infections
3. **Treat** all existing viral hepatitis infections and cure all existing hepatitis C infections.
4. **Respond** to the unique needs of people at risk of or living with viral hepatitis and respond to all viral hepatitis outbreaks in a timely manner.

Within each pillar are overarching goals, objectives, and activities. The activities outline necessary actions to meet each objective. The objectives serve as the key outcomes needed to achieve each goal.

Glossary of frequently abbreviated and field specific terms

Confirmatory testing: Testing that confirms that presence of a current viral hepatitis infection.

DHS: Minnesota Department of Human Services

DOC: Minnesota Department of Corrections

EMR: Electronic Medical Records

FQHC: Federally Qualified Health Center

Harm reduction: Strategies to address and mitigate the harms associated with drug use. This includes reducing the spread of infectious disease. Harm reduction acknowledges that drug use is part of our world and works to minimize potential harmful effects rather than ignore, condemn, or criminalize drug use.

HAV: Hepatitis A virus

HBV: Hepatitis B virus

HCV: Hepatitis C virus

HDV: Hepatitis D virus, also called hepatitis delta

Jail: Operated by local law enforcement such as a sheriff, a police chief, or a county or city administrator. Individuals confined in jail settings are typically incarcerated during pre-sentencing or for a sentence of less than one year. There are no private jails in Minnesota.

Local public health (LPH): City and county public health departments.

MIIC: Minnesota Immunization Information Connection. A confidential electronic system that collects and stores the immunization records of people living in Minnesota. MIIC compiles immunizations into one person-level record, even if immunizations are administered at different locations across the state.

Perinatal: The period immediately before and after birth and used in the context of preventing, identifying, and treating transmission of viral hepatitis from birthing parent to child.

Point of care test (POC): A test used to screen for or diagnose a disease. These tests produce results on-site in a short period of time. These tests generally do not require blood to be drawn or sent to a lab for processing. There are currently approved POC screening and confirmatory tests for HCV.

Prison: Operated by the state Department of Corrections or the Federal Bureau of Prisons. Individuals are confined in prison settings after they are convicted of a criminal offense, typically for a sentence of more than one year. There are no private prisons in Minnesota.

PWID: Persons who inject drugs

Screening: Testing asymptomatic individuals to detect infections.

SSP: Syringe Service Program

Tribal health: Public health and health care systems under tribal jurisdiction.

MDH: Minnesota Department of Health

Introduction

There are nearly 60,000 people known to be living in Minnesota with chronic viral hepatitis[i]. Despite the availability of curative treatment for HCV and vaccines for hepatitis A and B, viral hepatitis remains a notable public health issue. Viral hepatitis is a liver infection caused by a virus. The most common types of viral hepatitis are hepatitis A, B, and C.

- **Hepatitis A virus (HAV):** HAV is a vaccine-preventable infection that causes short-term (acute) illness. It is a fecal-oral disease, caused by ingesting the fecal matter of an infected person, commonly transmitted through person-to-person contact or by consuming contaminated food or drink.
- **Hepatitis B virus (HBV):** HBV is a vaccine preventable infection that can cause short-term (acute) and long-term (chronic) illness. Most adults who are newly infected with HBV do not become chronically infected. Alternatively, approximately 90% of infants and 30% of children aged 1-5 will develop lifelong disease if infected with HBV. Hepatitis B is spread when blood or bodily fluids from a person with an HBV infection enters the body of someone who is not infected. Hepatitis B is most commonly spread through sexual contact, sharing injection drug equipment, from birth parent to child during birth, and by sharing personal care items such as toothbrushes or razors. There is no cure for HBV. Those living with or at risk of HBV are also at risk of a co-occurring hepatitis D virus (HDV) infection. Hepatitis D infection occurs only in the presence of hepatitis B infection and having both infections can lead to more severe liver disease. Individuals can become infected with both viruses simultaneously or HDV can be contracted following an initial HBV infection. Because of this unique relationship, the HBV vaccine protects individuals from both HBV and HDV.
- **Hepatitis C virus (HCV):** HCV is an infection that can cause short-term (acute) and long-term (chronic) illness. Approximately 75% of people who contract HCV will develop chronic infections. HCV is spread when the blood from a person with an HCV infection enters the body of someone who is not infected. Common modes of transmission include sharing injection drug use equipment, receiving tattoos or piercings in unregulated settings where equipment is not properly sterilized, and health care associated exposures. HCV can also be transmitted during sexual contact and from birth parent to child during birth, though these are less common routes of transmission. There is no vaccine for HCV, but there is a cure.

Combined, these types of viral hepatitis impact thousands of people living in Minnesota each year. When left untreated, viral hepatitis can damage the liver, causing scarring (cirrhosis), liver cancer, liver failure, and death.

To prevent further morbidity and mortality and provide effective treatment to those already living with viral hepatitis, it was imperative that Minnesota develop a comprehensive viral hepatitis elimination plan. This elimination plan provides a roadmap for reducing new viral hepatitis infections, treating those already diagnosed, and addressing the social determinants of health and psychosocial needs associated with an increased risk of viral hepatitis.

The purpose of this plan is to identify and, wherever possible, implement the activities that will eliminate viral hepatitis in Minnesota in alignment with MDH's mission to protect, maintain and improve the health of all Minnesotans.

The goals, objectives, and activities laid out in this plan were developed through consultation with the Minnesota Statewide Hepatitis Elimination Coalition. This coalition was made up of 44

members and included staff from multiple agencies across the state, including local public health, the Department of Corrections, syringe service programs, hospitals, primary care clinics, Health Care for the Homeless, and the University of Minnesota.

Defining priority populations

Priority populations for viral hepatitis elimination in Minnesota include:

- **Current or formerly incarcerated individuals:** HCV is the most common type of viral hepatitis found in jails and prisons. There are over 1.8 million people currently incarcerated in US jails and prisons[ii] and HCV prevalence in state prisons is nearly nine times higher than in the general population in the United States[iii]. The most common way incarcerated people get hepatitis C is by sharing tools used for injecting drugs, tattooing, and piercing.
- **Persons who inject drugs (PWID):** PWID are at an increased risk of contracting viral hepatitis because there is an ongoing risk for exposure to blood through the sharing of injection drug use equipment, including needles, syringes, cotton, cookers, tourniquets, and water. It is important to note that the act of injecting drugs does not inherently increase risk. It is the sharing of these supplies that increases the risk.
- **Individuals born outside of the United States in countries where viral hepatitis is widespread (endemic):** HBV is highly endemic in parts of Southeast Asia, China, sub-Saharan Africa, and South America. HBV is endemic to a lesser extent in parts of Eastern and Southern Europe, the Middle East, and Japan. HAV is endemic across the developing world.
- **Pregnancy:** Prenatal blood tests should always include screening for HBV and HCV. It is particularly important to monitor hepatitis infections during pregnancy, both to ensure appropriate care is given to treat disease during or after pregnancy and to prevent and identify infection in newborns.
- **Persons experiencing homelessness:** This population is at increased risk for HAV, HBV, and HCV. HAV infections are associated with contaminated food and water, lack of access to proper hygiene such as handwashing stations, and congregate living conditions, such as shelter and encampment settings.
- **American Indian/Alaskan native (AI/AN) persons:** AI/AN people in Minnesota are disproportionately impacted by hepatitis C virus (HCV). For every 100,000 AI/AN people, about 2,400 are living with HCV. When looking at the White population, only 300 out of every 100,000 people have HCV. Rates of HCV are eight times higher in AI/AN populations compared with White populations. Higher HCV rates among AI/AN are linked to barriers in health care access, historical and generational trauma, and social and economic challenges.
- **Black/African American persons:** Black/African American people in Minnesota are also at increased risk of hepatitis infection. Approximately 970 out of every 100,000 Black/African American persons are living with HCV, compared to 300 per 100,000 White people. Hepatitis B virus (HBV) rates are also much higher—1,920 per 100,000 Black/African American people, compared to 60 per 100,000 White persons. The higher rates of HBV infection are largely driven by pre-existing infections in those who relocate to the US from areas where HBV is more common. These disparities are also linked to barriers such as stigma, limited English proficiency, and unequal access to care.

- **Persons living with HIV:** People living with HIV may be at increased risk of contracting HCV, as the social determinants of health for hepatitis C and HIV are often similar. Furthermore, uncontrolled HIV weakens the immune system, making a person more susceptible to other viruses, such as HAV, HBV, and HCV.
- These priority populations are not independent of one another. Individuals at risk of or living with viral hepatitis are likely to be members of more than one priority population. For example, people experiencing homelessness may be more likely to fall into another population identified to have increased risk of contracting HBV and HCV, such as PWID, American Indian/Alaskan Native (AI/AN) persons, or those who are formerly incarcerated.

Engagement and planning process

Elimination planning resulted from grant funding provided to MDH by the Centers for Disease Control and Prevention (CDC). MDH determined that this elimination plan should include strategies for eliminating the forms of viral hepatitis that are most frequently seen in the United States, as well as input from stakeholders across the state and an emphasis on strategies for eliminating viral hepatitis in priority populations.

To develop a meaningful and successful strategy, MDH began by gathering input from stakeholders across the state who are committed to hepatitis elimination. Partner organizations for potential stakeholder meetings were identified by answering the following questions:

- **Who serves priority populations:** See page 5 for additional information on priority populations.
- What other systems frequently work with people at risk of or living with viral hepatitis? What systems other than health care need to be at the table?
- What are the physiological and safety needs of people at risk of or living with viral hepatitis? What needs must be met before a person is ready to access testing and treatment?
- **What are the geographic differences in hepatitis response across the state?** For example, how do the needs of providers and patients in Minnesota's Iron Range differ from those in Minneapolis?
- **What agencies will need or want to be involved in the response?** To plan a statewide response, we need to include agencies across the enterprise, such as the Department of Corrections, the Department of Human Services, and local public health.

To ensure each of these partners were represented in this work, MDH consulted with partner organizations, colleagues, and individuals committed to the elimination of hepatitis to solicit the names of agencies and individuals who should be included. MDH welcomed participation from any interested person or agency who became aware of the elimination coalition at any point during the elimination planning process.

Based on the number of participants and the depth of the work involved, MDH determined that forming a coalition would be the most effective way to gather the necessary input and develop strategies for elimination. The coalition was convened in December 2023 and consisted of 44 participants across 21 agencies.

Coalition agreements and values

The coalition relied on a set of community agreements and values to ensure the process ran smoothly and that conflict could be addressed in a timely and meaningful way.

Community agreements:

- **All voices carry equal weight**: Everyone has a right to be heard and to share how their experience and work supports viral hepatitis elimination.
- **We are all experts:** Respect everyone's professional and lived experience, acknowledge where you may fall short and where another person may fill gaps in your own knowledge.
- **Respect the process:** This space is for sharing a variety of ideas, including those that may not make it in the final plan. Respect the process of collaboration and engage to your fullest extent.
- **Acknowledging the barriers and gaps**: In a perfect world all ideas could be implemented and funded, but we must acknowledge some things can happen right away and other ideas will take time and funding to fully implement.

Community values:

- **Collaborative approach**: Inclusive, sustained engagement and collaboration across the clinical, non-clinical, and community subcommittee participants.
- **Capacity building**: Improve ability at the individual and organizational level to effectively address viral hepatitis prevention, treatment, testing, and care.
- **Sustainability and resilience:** Ensure any system put in place to eliminate viral hepatitis is sustainable and fosters partnerships and collaborations that have the capacity to endure over time.
- **Community engagement and empowerment:** Acknowledge and actively include impacted communities and key stakeholders in elimination planning and implementation. Empower communities to take ownership and action in these elimination efforts.
- **Equity and accessibility:** Increase access to testing, prevention, treatment, and care among all Minnesotans, with a particular emphasis on priority populations as identified by the coalition.
- **Feasibility:** Ensure the proposed plan is practical and achievable and aligns with current or realistic resources, logistical considerations, and stakeholder buy-in.

Subcommittees

To ensure coalition members had ample time to discuss goals, objectives, and activities and that no one agency or field was overrepresented during conversation, coalition members self-selected into one of three subcommittees:

1. **Data and strategic information:** This group focused on the enhancement of viral hepatitis surveillance, monitoring, and management. This included data systems, data collection, and disease outcomes designed to better describe, understand, and reduce the burden of viral hepatitis.

2. **Clinical strategies:** This group focused on improvements in provider education, testing, treatment, and linkage to care in clinically based viral hepatitis services. This included care delivered by primary care providers, specialty care providers, hospital-based services, and low-barrier, low-cost health services such as those provided by federally qualified health centers and Health Care for the Homeless.
3. **Community based response:** This group focused on improvement of health education, prevention, and treatment services among community-based settings with an emphasis on settings which typically serve priority populations, such as people experiencing homelessness, people who use drugs, and incarcerated persons. Examples of these settings include harm reduction organizations and service providers working with unhoused populations.

Subcommittees met every other month, and full coalition meetings were held in alternate months. Each subcommittee meeting focused on one of the four pillars of elimination. Full coalition meetings focused on highlighting changes made to the elimination plan based on subcommittee conversations.

The coalition meetings concluded in October 2024. The result of this work is eight overarching goals with numerous objectives and activities that are intended to eliminate viral hepatitis in Minnesota by 2030. These goals, objectives, and activities are shared on page 9. See the Appendix for more detailed information on the feasibility, lead and partner agencies, and next steps for each of these goals, objectives, and activities.

Four pillars plan

The goals, objectives, and activities of this elimination plan are divided into four strategies, called pillars. The four-pillar approach was selected, in part, because it has been successfully used to develop a strategic plan for ending the HIV epidemic in the US and viral hepatitis and HIV often have overlapping risk factors and impact similar populations.

The four pillars include:

1. Diagnose

Diagnose all people with viral hepatitis.

- **Goal 1:** Improve access to equitable and patient centered viral hepatitis testing services for all Minnesotans.
- **Goal 2:** Increase knowledge of hepatitis A, B, and C testing among non-clinical service providers (e.g., public health, harm reduction, etc.) who are most likely to interact with groups at increased risk of viral hepatitis.

2. Prevent

Prevent new viral hepatitis infections.

- **Goal 3:** Decrease rates of all new viral hepatitis infections in Minnesota.

- **Goal 4:** Leverage a harm reduction approach to decrease rates of hepatitis C infections among people who inject drugs.

3. Treat

Treat all existing viral hepatitis infections and cure all existing hepatitis C infections.

- **Goal 5:** Increase rates of referral to viral hepatitis treatment by primary care providers, community service providers, and other non-clinical service providers.
- **Goal 6:** Provide patient, staff, and organizational education on how to navigate health insurance requirements for viral hepatitis treatment.

4. Respond

Respond to the unique needs of people at risk of or living with viral hepatitis and respond to all viral hepatitis outbreaks in a timely manner.

- **Goal 7:** Strengthen viral hepatitis outbreak detection and response, disease reporting, and disease surveillance.
- **Goal 8:** Strengthen relationships between clinical and non-clinical providers whose primary population includes those at increased risk of viral hepatitis.

This elimination plan was developed in the context of asking coalition members, "What needs to happen to eliminate viral hepatitis in Minnesota?". The objectives and activities described below are a result of these conversations. Due to the nature of these conversations, MDH recognizes that some of the identified objectives and activities cannot be implemented without changes in funding, statutes, or organizational capacity. These objectives and activities remain in the plan as an indication of what the community of viral hepatitis providers and advocates have deemed essential for elimination. A detailed description of each activity and the feasibility of its implementation can be found in Appendix A.

Goals objectives and activities

Diagnose

Goal 1: Improve access to equitable and patient centered viral hepatitis testing services for Minnesotans

Objective 1.1: Increase rates of confirmatory testing among those who have received at least one reactive screening test in their lifetime.

Activities:

- 1.1.1: Develop a "plug and play" navigation and referral toolkit for hepatitis B and C that can be easily implemented by organizations and health care providers.
- 1.1.2: Pilot linkage to care programs for individuals newly diagnosed with acute or chronic hepatitis B and hepatitis C.

- 1.1.3: Develop and distribute resources (written, recorded, etc.) on best practices for working with priority populations and other marginalized groups at risk of or living with viral hepatitis.
- 1.1.4: Develop a system, such as a "care passport," that allows patients to access care more seamlessly across health care systems by carrying their health records from one location to another.

Objective 1.2: Increase health care provider awareness and appropriate implementation of the CDC hepatitis A, B, and C screening and testing recommendations.

Activities:

- 1.2.1: Conduct a series of viral hepatitis needs assessments for clinicians and health care providers OR develop a template that allows clinics, health care systems, and other entities to conduct in-house needs assessments.
- 1.2.2: Ensure CDC hepatitis screening and testing recommendations are appropriately implemented in identified health care settings – either in response to results of a needs assessment or known gaps in care.
- 1.2.3: Develop and distribute patient resources (e.g., education, referral locations, etc.) to health care organizations that frequently serve priority populations.
- 1.2.4.: Advertise already existing continuing education and consultation opportunities, such as Project ECHO, for clinical and non-clinical service providers.
- 1.2.5: Develop and host provider training on screening and vaccination guidelines for hepatitis A, B, and C.
- 1.2.6: Develop and distribute resources for patients receiving initial screening or confirmatory testing that can be distributed peer-to-peer on hepatitis related topics such as sanitation, harm reduction, treatment as prevention, insurance navigation, and the steps of diagnosing a viral hepatitis infection.
- 1.2.7: Develop a campaign regarding stigma-free routine viral hepatitis testing with an emphasis on introducing routine viral hepatitis testing in primary care settings.
- 1.2.8: Develop a standard of care for viral hepatitis screening that promotes use of opt-out screening in primary care and emergency medicine.
- 1.2.9: Expand opportunities for viral hepatitis testing in state and federal prisons.
- 1.2.10: Expand opportunities for viral hepatitis testing and vaccination in city and county jails.

Objective 1.3: Improve awareness of general viral hepatitis testing requirements, rates of point of care testing, confirmatory testing, automatic reflex testing, and test reporting.

Activities:

- 1.3.1: Advocate for a lab standard that requires all reactive hepatitis C screening test to automatically reflex to confirmatory testing.

- 1.3.2: Utilize electronic medical record (EMR) order sets to standardize diagnostic care across a variety of clinical settings and increase the ease of moving patients along the viral hepatitis care cascade.
- 1.3.3: Ensure that all reportable testing results are appropriately sent to MDH, including point of care testing.
- 1.3.4: Support community partners in implementation of rapid HCV RNA POC testing and develop a system to easily report RNA results from POC tests.
- 1.3.5: Ensure that all people living with hepatitis B receive hepatitis D screening.

Objective 1.4: Identify the geographic and social barriers surrounding a viral hepatitis diagnosis. Develop and implement strategies for reducing or removing those barriers.

Activities:

- 1.4.1: Collaborate with stakeholders to determine what data are necessary to collect in order to provide population-specific information to clinical and non-clinical service providers that improves testing availability and uptake.
- 1.4.2: Host listening sessions with priority populations to assess what barriers to viral hepatitis testing exist and work with multidisciplinary teams to lower or remove these barriers.
- 1.4.3: Host listening sessions with agencies that serve priority populations to assess what barriers to viral hepatitis testing exist and work with multidisciplinary teams to lower or remove these barriers.
- 1.4.4: Identify the unique barriers to viral hepatitis testing for each geographic region of Minnesota through collaboration across sectors.

Goal 2: Increase knowledge of hepatitis A, B and C testing among non-clinical service providers (e.g., public health, harm reduction, etc.) who are most likely to interact with groups at increased risk of viral hepatitis

Objective 2.1: Identify existing gaps in viral hepatitis knowledge for service providers and use these findings to enable them to provide targeted hepatitis A, B, and C education for those at increased risk of viral hepatitis.

Activities:

- 2.1.1: Conduct a series of viral hepatitis needs assessments for community service providers OR develop guidelines that allow community organizations, local public health, and other entities to conduct workplace needs assessments.
- 2.1.2: Partner with non-clinical service providers to develop and distribute resources (e.g., education, referral locations, etc.) to organizations that frequently serve priority populations as identified by the needs assessments.
- 2.1.3.: Develop and advertise continuing education and consultation opportunities, such as Project ECHO, for clinical and non-clinical service providers.

- 2.1.4: Develop and distribute resources for patients receiving initial screening or confirmatory testing that can be distributed from peer-to-peer on topics such as sanitation, harm reduction, treatment as prevention, insurance navigation and the steps of diagnosing a viral hepatitis infection.

Objective 2.2: Develop models for novel pathways of rapid testing and prompt referral for confirmatory testing and/or follow-up care in non-clinical settings for people at risk of viral hepatitis.

Activities:

- 2.2.1: Increase rapid hepatitis C screening among Syringe Service Programs (SSPs) and other non-clinical service providers to serve as a linkage to hepatitis C confirmatory testing and follow-up care.
- 2.2.2: Build relationships between SSPs, substance use disorder treatment centers, and non-clinical service providers that perform hepatitis C confirmatory testing (and follow-up care) and utilize these relationships to ensure that patients receive care that is free of stigma and consistent with harm-reduction principles.
- 2.2.3: Ensure that all non-clinical service providers who offer field testing pair rapid HIV testing with hepatitis C testing whenever possible.
- 2.2.4: Continuously evaluate and implement new confirmatory testing options that could allow people to be diagnosed and linked to care in the most efficient manner.

Prevent

Goal 3: Decrease rates of all new viral hepatitis infections in Minnesota.

Objective 3.1: Identify and address barriers to accessing viral hepatitis prevention, screening, and treatment among priority populations and implement strategies to reduce or remove those barriers.

Activities:

- 3.1.1: Conduct a community needs assessment to identify gaps along the hepatitis B and C care cascades OR develop guidelines that allow community organizations, clinics and health care systems, local public health, and other entities to conduct needs assessments for the communities they serve.
- 3.1.2: Provide technical assistance to community organizations, clinics and health care systems, local public health, and other entities to create a network of harm-reduction educators who can provide high quality harm reduction education to clinicians/prescribers using a model of peer-to-peer education or training from a subject matter expert.
- 3.1.3: Publish infectious disease guidance for those providing care in encampments or other unsheltered settings, including best practices for reducing transmission of viral hepatitis.
- 3.1.4: Expand the number of providers who are aware of, trained in, and have capacity to treat hepatitis C in primary care and addiction medicine settings.

- 3.1.5: Develop and maintain a repository of viral hepatitis educational materials for clinical and non-clinical providers and the public.

Objective 3.2: Eliminate perinatal transmission of hepatitis B and C.

Activities:

- 3.2.1: Ensure CDC hepatitis screening and testing recommendations during pregnancy are appropriately implemented in perinatal care and that all positive results are appropriately reported to MDH.
- 3.2.2: Ensure identification of pregnancy among hepatitis B and hepatitis C positive patients is properly reported to public health.
- 3.2.3 Ensure all individuals who are pregnant and positive for hepatitis B and/or hepatitis C are linked to care and receive proper education regarding their infection, how to reduce vertical transmission, and post-natal care.
- 3.2.4: Educate clinical and non-clinical care providers on recommendations for screening, reporting, referral, and treatment to prevent vertical transmission of viral hepatitis.
- 3.2.5: Ensure all infants exposed to hepatitis B receive appropriate post-exposure prophylaxis, a full HBV vaccine series, and post-vaccination serologic testing, with those testing results properly reported to public health.
- 3.2.6: Use existing perinatal HIV and hepatitis B infrastructure to support similar efforts for perinatal HCV.
- 3.2.7: Engage household contacts and sexual partners of those diagnosed with hepatitis B during pregnancy in routine hepatitis B testing and linkage to care.

Objective 3.3: Increase rates of hepatitis A & B vaccination, particularly among priority populations.

Activities:

- 3.3.1: Ensure health care providers are aware of hepatitis vaccination recommendations.
- 3.3.2: Identify primary care clinics in need of a standard vaccination assessment and administration plan for all vaccine eligible patients and work with them (if requested) to develop and implement that plan.
- 3.3.3: Assess the readiness of large health care systems to provide timely routine HAV and HBV vaccinations in all settings, including primary and emergency care.
- 3.3.4: Support community settings in identifying and implementing the essential components needed to provide vaccine in these settings.
- 3.3.5: Partner with universities and professional societies to offer viral hepatitis education targeted towards specific medical professions (e.g., ACOG training for OB/GYNs).
- 3.3.6: Expand opportunities for hepatitis A and B vaccination in state and federal prisons.
- 3.3.7: Expand opportunities for hepatitis A and B vaccination in city and county jails.

Objective 3.4: Ensure all vaccine doses administered in non-traditional locations (e.g., street medicine, events) are appropriately documented in the Minnesota Immunization Information Connection (MIIC) vaccine registry.

Activities:

- 3.4.1: Identify the number of vaccine doses and location of vaccine doses administered in non-traditional settings per year and work with these sites to identify best practices for administering vaccine in these settings.
- 3.4.2: Partner with the Vaccine Preventable Disease (VPD) section at MDH to better understand and streamline MIIC vaccination recording.
- 3.4.3: Meet with sites who would like to implement vaccine programs and identify any barriers that may arise in program implementation.
- 3.4.4: Work with identified sites to mitigate barriers to properly implementing vaccine programs.

Goal 4: Leverage a harm reduction approach to decrease rates of hepatitis C infections among people who inject drugs.

Objective: 4.1: Ensure all harm reduction and SSP programs have access to rapid hepatitis C screening tests and up-to-date information on viral hepatitis harm reduction strategies.

Activities:

- 4.1.1: Distribute rapid hepatitis C screening tests to identified facilities and programs in need, as funding allows.
- 4.1.2: Develop ongoing education for staff at SSPs and other harm reduction programs on hepatitis C testing, providing education for priority populations, and adapting viral hepatitis prevention strategies to align with the changing landscape of drug use.
- 4.1.3: Establish routine participation from MDH hepatitis staff in already established harm reduction meetings (e.g., HIV Outbreak and Public Engagement [HOPE] group, the Minnesota SSP Network, or the Twin Cities Harm Reduction Group) OR develop a separate viral hepatitis focused harm reduction group as a means of continuously engaging harm reduction organizations and strengthening relationships between these organizations and MDH.

Objective 4.2 Reduce rates of new viral hepatitis infections associated with sharing needles, other injection equipment, and personal care items.

Activities:

- 4.2.1: Increase access to and awareness of safer drug-use supplies.
- 4.2.2: Increase awareness of shared personal care items that may increase risk of HCV/HBV transmission (e.g., toothbrushes, razors, and nail clippers).

- 4.2.3: Increase access to personal care items that improve individual health and wellbeing (e.g. sanitation wipes for cleaning, menstrual products, shampoo/conditioner, and socks).
- 4.2.4: Partner with community organizations to develop initiatives to educate the public about injection alternatives, risk of viral hepatitis infection, and personal and community benefits of viral hepatitis treatment.

Treat

Goal 5: Increase rates of referral to viral hepatitis treatment by primary care providers, community service providers, and other non-clinical service providers.

Objective 5.1: Improve accessibility and awareness of treatment and navigation options for hepatitis B and C.

Activities:

- 5.1.1: Decrease barriers to accessing treatment through reduced-cost or free treatment options by increasing enrollment in Medicare and Medicaid and referrals to Federally Qualified Health Centers (FQHCs), with an emphasis in priority populations, including those who are new to the United States and have insurance coverage for only a limited period.
- 5.1.2: Advocate for continued and expanded access to telehealth appointments for viral hepatitis treatment.
- 5.1.3: Identify all supports needed following a hepatitis C diagnosis and treatment prescription to ensure patients can take the full course of medication.
- 5.1.4: Develop a public health case management system for those who need additional support navigating the system of diagnosis and treatment.
- 5.1.5: Develop and/or advertise additional education materials (guidelines, workflows, communities of practice) for clinicians who want to treat hepatitis B and C.

Objective 5.2: Increase percentage of people with hepatitis C who cure their infection.

Activities:

- 5.2.1: Develop a toolkit that promotes a standardized protocol following a reactive hepatitis C antibody test that can be implemented in multiple settings (e.g., field testing, clinic settings, inpatient settings) to ensure timely follow-up testing and treatment.
- 5.2.2: Follow model of simultaneous evaluation, treatment, and partner testing based on rapid testing results using the Rapid ART model of HIV treatment and the empiric model of syphilis treatment.
- 5.2.3: Support health care systems or other organizations in the development of a hepatitis C hotline where health care providers may consult one another as part of routine care.
- 5.2.4: Consult with DHS on access to care (e.g., the prior authorization process, reducing barriers to care).

- 5.2.5: Increase rates of repeat hepatitis C testing and treatment in primary care settings for those with ongoing risk factors.
- 5.2.6: Improve epidemiological tracking of hepatitis C by utilizing a care cascade.
- 5.2.7: Develop, publish, and maintain a list of locations that offer hepatitis C treatment in Minnesota.
- 5.2.8: Identify and implement the necessary components of offering treatment in the community (e.g., mobile medicine and co-located treatment services)

Goal 6: Provide patient, staff, and organization education on how to navigate health insurance requirements for viral hepatitis treatment

Objective 6.1: Engage with clinical and non-clinical organizations to provide continued outreach to communicate Medicaid enrollment timelines and criteria.

Activities:

- 6.1.1: Establish a reimbursable community health worker program to support marginalized populations in identifying and accessing key information regarding their hepatitis A, B, and/or C infections, including insurance navigation.
- 6.1.2: Partner with libraries, warming centers, and other high traffic areas to offer drop-in insurance navigation.

Objective 6.2: Provide timely and accessible education, outreach, and resources to support health insurance enrollment and understanding of insurance benefits.

Activities:

- 6.2.1: Develop materials and/or trainings that address state or federal changes that may impact the ability to access viral hepatitis treatment or care.
- 6.2.2: Develop or share an already developed toolkit for navigating Medicaid benefits when living with extenuating circumstances (e.g., homelessness, new arrivals to the United States, English language learner).
- 6.2.3: Work with DHS and/or MN Department of Commerce to identify existing treatment prerequisites.

Objective 6.3: Ensure equitable access to viral hepatitis resources for patients and the public.

Activities:

- 6.3.1: Develop and publish a comprehensive resource page with information on insurance navigation, transportation, medication adherence and other resources related to the social determinants of health surrounding a viral hepatitis diagnosis.
- 6.3.2: Partner with staff at libraries and other community hubs to distribute resources.
- 6.3.3: Ensure all community partners receive adequate training on any newly developed materials, including toolkits, portals, or other online navigation tools.

- 6.3.4: Prioritize outreach to communities historically impacted by systemic disinvestment and policy changes.

Respond

Goal 7: Strengthen viral hepatitis outbreak detection and response, disease reporting and disease surveillance.

Objective 7.1: Identify all hepatitis A, B, and C clusters and/or outbreaks within the state of Minnesota and report outbreak information back to organizations impacted, based on geographic location and populations of interest.

Activities:

- 7.1.1: Collaborate with clinical and community stakeholders to identify populations at increased risk of contracting hepatitis A, B, and C.
- 7.1.2: Develop and implement a cluster detection and response plan for hepatitis A, B, and C.
- 7.1.3: Identify or develop routes of communication for quickly disseminating data and changes in testing and reporting guidance to relevant organizations.
- 7.1.4: Develop a syndemic/integrated response to hepatitis C outbreak detection by working with other disease areas to test for hepatitis C when there are outbreaks of diseases with similar risk factors, such as HIV or syphilis.

Objective 7.2 Improve completeness of hepatitis A, B, C, and D disease reporting, evaluation, and dissemination.

Activities:

- 7.2.1: Establish and maintain routine communication between public health, clinical, and non-clinical sectors regarding trends in data and how these trends can inform direct service.
- 7.2.2: Strengthen mechanisms for hepatitis B screening and sustaining care among those most at risk, including new arrivals to the United States.
- 7.2.3: Develop provider guidance for automatic hepatitis D screening among those with a hepatitis B diagnosis.
- 7.2.4: Increase compliance with viral hepatitis reporting requirements, including supplemental patient information and viral hepatitis pregnancy and birth reports, by providing training and website resources.

Objective 7.3: Routinely analyze and disseminate viral hepatitis data to improve testing, detection, and linkage to care for hepatitis A, B and C.

Activities:

- 7.3.1: Develop and publish a yearly surveillance report with data and information beneficial for both clinical and non-clinical service providers.

- 7.3.2: Utilize data from the surveillance report to identify current populations and geographic regions most impacted by viral hepatitis and use this data to develop targeted interventions for viral hepatitis prevention.
- 7.3.3: Resume yearly data webinar with MDH HIV/STI staff.

Goal 8: Strengthen relationships between clinical and non-clinical providers whose primary population includes those at increased risk of viral hepatitis.

Objective 8.1: Close the gap in diagnosis and treatment among those most at risk of contracting viral hepatitis by improving outcomes among these populations.

Activities:

- 8.1.1: Conduct key informant interviews among clinical and non-clinical service providers and identify non-medical barriers to detection, treatment, and response.
- 8.1.2: In medical and non-medical settings, implement up to date resources, training and/or tools that respond to identified causes of inequitable access to testing and treatment.
- 8.1.3: Identify areas of clinical and non-clinical practice that can integrate viral hepatitis care and develop standardized training for these locations that include information on harm reduction, person-centered care, and viral hepatitis.
- 8.1.4: Develop or identify a community of practice for clinical and non-clinical service providers who work in hepatitis to easily disseminate information and plan multi-agency response efforts.

Objective 8.2: In partnership with overlapping disease areas, identify and respond to non-medical needs associated with improved outcomes in viral hepatitis prevention, diagnosis, and treatment.

Activities:

- 8.2.1: Identify overlapping disease areas in state and local public health, which may include, but is not limited to HIV, sexually transmitted infections, and vaccine preventable diseases, and develop a cross-sector working relationship for all following activities under objective 8.2.
- 8.2.2: Conduct a needs assessment survey among viral hepatitis patients, or individuals at risk of contracting viral hepatitis, to identify non-medical barriers and needs affecting prevention, diagnosis, and treatment outcomes.
- 8.2.3: Develop a workplan to respond to the barriers identified in 8.2.2.

Elimination goals outside of the scope of this coalition

These goals are outside of the scope of this coalition but may inform conversations when looking at programming piloted in other states and countries.

- Revise health insurance requirements for treatment to reflect changing landscape of viral hepatitis.

- Obtain additional funding for comprehensive harm reduction supplies and hepatitis medications.
- Fund or operate an overdose prevention site or improve the safety of the drug supply to reduce the chaotic nature of drug use and limit the need to use unknown drugs in an unsafe manner.
- Develop prevention, diagnosis, and treatment recommendations for non-viral hepatitis, such as autoimmune hepatitis, alcoholic hepatitis, and drug-induced hepatitis.

Necessary partnerships

Coalition members have identified key partnerships that are essential in addressing the unique challenges of viral hepatitis elimination. Collaborative engagement among these partners will support the development of elimination strategies that are tailored and sustainably integrated into public health and health care systems across the state. Partnerships are listed in alphabetical order and are not intended to be read as order of importance.

- Viral Hepatitis Elimination Coalition members and their organizations
- Behavioral Health and Substance Use Disorder Treatment Centers
- City and County Public Health Departments (LPH)
- Community-Based Organizations (CBOs)
- Community Health Workers, Peer Educators, Case Managers
- Community Mental Health Services
- Department of Corrections (DOC) and Reentry Programs
- Department of Human Services
- Health Insurance Programs
- Laboratory and Diagnostic Facilities
- Library Systems and Community Hubs
- Minnesota Academy of Family Physicians (MAFP)
- Minnesota APRN Coalition
- Minnesota Association of Community Mental Health Programs (MACMHP)
- Minnesota Department of Health (MDH)
- Minnesota Medical Association (MMA)
- Minnesota Section of the American College of Obstetricians and Gynecologists (MN ACOG)
- People with Lived Experience
- Pharmacies
- Syringe Service Providers (SSPs) and other harm reduction organizations
- Tribal, State, County, and Federal Health Care Systems

Barriers and challenges

The following barriers and challenges were acknowledged by the viral hepatitis coalition. This list does not represent all barriers and challenges to implementation of viral hepatitis elimination efforts.

Statewide, increased funding is critical to expanding capacity for activities aimed at elimination of viral hepatitis. Without secure and sufficient resources, the sustainability and scalability of these initiatives will be severely hindered, and in some cases, impossible to achieve.

Many activities require specialized personnel, including community health workers, peer educators, and case managers. Staffing of such professionals will be dependent on system specific staffing capacity. Workforce shortages and capacity limitations, particularly in rural and underserved areas, present significant challenges to the effectiveness of elimination efforts. Geographic disparities further worsen these issues, potentially limiting hepatitis outreach. Consequently, implementation efforts will largely depend on the feasibility of individual activities and the capacity of the systems responsible for their execution.

Effective elimination strategies rely on strong communication, coordination, and engagement among multiple agencies and personnel. Ensuring that all necessary partners are actively involved is challenging and may hinder efficient and successful elimination efforts.

Reaching key populations in need of hepatitis care requires addressing stigma within health systems and the mistrust of health systems among these individuals. This emphasizes the importance of building trust in patient-provider relationships. Additionally, barriers to affordable hepatitis care and treatment remain prevalent, including prior authorization requirements, limited harm reduction services, and challenges in providing continuous care for people currently incarcerated or recently released from a correctional setting.

Addressing social determinants of health is vital to improving outcomes for individuals affected by viral hepatitis. Reducing health disparities depends on resolving issues such as food insecurity, housing instability, lack of transportation, and limitations in health care coverage, all of which create significant gaps in preventing, diagnosing, and treating viral hepatitis infections.

Call to action

This viral hepatitis elimination plan serves as a framework to be utilized by stakeholders across the state of Minnesota. The components of this plan must be assessed at the agency or organization level and implemented wherever appropriate and feasible. These actions are necessary to progress towards diagnosing all people living with viral hepatitis, preventing new infections, treating existing infections, and responding to outbreaks in a timely manner while addressing the unique needs of the most impacted populations.

Appendix A: Comprehensive list of all goals/objectives/activities and partners involved

The following activities have been assigned a lead agency, partner agencies, a level of feasibility, and any relevant notes and comments to help guide focus areas of elimination plan implementation. Each section of the table is defined as follows:

- **Lead agency:** The agency or agencies who would likely be best positioned to lead this work.
- **Partner agencies:** Any agency that would likely be involved in ensuring this work is successfully completed. For this appendix, the identified partners have been grouped into several broad categories. These categories include:
  - Health care systems: hospitals and clinics, behavioral health, substance use disorder treatment centers, community mental health services, laboratory and diagnostic facilities, pharmacies, and Tribal, state, county, and federal health care systems.
  - Community partners: community-based organizations (CBOs), community health workers, peer educators and case managers, library systems and community hubs, people with lived experience, and Viral Hepatitis Elimination Coalition members and their organizations.
  - Local public health: city and county public health departments.
  - DOC: includes county and state correctional entities and reentry programs
  - DHS
  - Insurance programs
  - Medical Organizations: MAFP, Minnesota APRN Coalition, MACMHP, MMA, MN ACOG
  - MDH
- **Feasibility level:** How this work is given staffing and funding levels at the time of the plan's development. Each activity is assessed independently – many activities may be feasible at the current moment or with increased funding and/or staffing. However, even if an activity could occur, not all activities could occur simultaneously without substantial investment in viral hepatitis elimination.
  - 1: Activities with feasibility level 1 could be easily implemented by the lead agency with current staffing and funding levels.
  - 2: Activities with feasibility level 2 could be implemented by the lead agency but would require significant participation of partner agencies, additional funding, or both.
  - 3: Activities with feasibility level 3 cannot be reasonably implemented without a large increase in funding, staffing, legislative changes, and/or collaboration between partner agencies.
- **Notes and comments:** A brief description of why the feasibility level was selected, potential next steps, and any identifiable roadblocks. These notes focus primarily on the role and responsibilities of MDH in the implementation of the activity. Other lead and partner agencies would also have responsibilities in ensuring successful implementation of each activity.

Goal 1: Improve access to equitable and patient centered viral hepatitis testing services for all Minnesotans.

Objective 1.1: Increase rates of confirmatory testing among those who have received at least one reactive screening test in their lifetime.

Activity	Lead Agency	Partner Agencies	Feasibility Level	Notes & Comments
1.1.1: Develop a "plug and play" navigation and referral toolkit for hepatitis B and C that can be easily implemented by organizations and health care providers.	MDH	-	1	Current hepatitis staff at MDH have capacity to develop and distribute this toolkit.
1.1.2: Pilot linkage to care programs for individuals newly diagnosed with acute or chronic hepatitis B and hepatitis C.	MDH	Health care systems	2	MDH could work with select health systems to design and implement linkage to care programs, but additional staffing or funding may be necessary.
1.1.3: Develop and distribute resources (written, recorded, etc.) on best practices for working with priority populations and other marginalized groups at risk of or living with viral hepatitis.	MDH	-	1	Current hepatitis staff at MDH could develop and distribute these resources with the support of other sections and units at MDH that also work with identified priority populations.
1.1.4: Develop a system, such as a "care passport" that allows patients to access care more seamlessly across health care systems by carrying their health records from one location to another.	MDH	Health care systems	3	MDH could work with select health systems to design and implement a care passport system, but additional staffing or funding would be necessary to expand or streamline this system (e.g., making the care passport statewide or digitizing it).

Objective 1.2: Increase health care provider awareness and appropriate implementation of the CDC hepatitis A, B, and C screening and testing recommendations.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
1.2.1: Conduct a series of viral hepatitis needs assessments for clinicians and health care providers OR develop a template that allows clinics, health care systems, and other entities to conduct in-house needs assessments.	MDH, health care systems	-	2	MDH could develop a toolkit for clinics, health care systems, and other entities to conduct their own needs assessments, but would need additional funding to conduct needs assessments on behalf of clinics, health care systems, and other entities.
1.2.2: Ensure CDC hepatitis screening and testing recommendations are appropriately implemented in identified health care settings – either in response to results of a needs assessment or known gaps in care.	MDH, health care systems	Medical organizations	2	MDH can provide patient and provider education resources. Health care systems would be responsible for ensuring recommendations are built into clinical workflows.
1.2.3: Develop and distribute patient resources (e.g., education, referral locations, etc.) to health care organizations that frequently serve priority populations.	MDH	Health care systems, medical organizations	2	Current hepatitis staff at MDH could develop and distribute these resources, however distribution would be based on completion of viral hepatitis needs assessment from activities stated above.
1.2.4.: Advertise already existing continuing education and consultation opportunities, such as Project ECHO, for clinical and non-clinical service providers.	Health care systems	-	1	Current hepatitis staff at MDH could continue to advertise existing education and consultation activities and can develop continuing education and consultation activities that are funded by partner agencies or have no associated cost.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
1.2.5: Develop and host provider training on screening and vaccination guidelines for hepatitis A, B, and C.	MDH, health care systems	-	2	Current hepatitis staff at MDH could develop this training and may be able to host them on a limited basis (e.g., quarterly).
1.2.6: Develop and distribute resources for patients receiving initial screening or confirmatory testing that can be distributed peer-to-peer on hepatitis related topics such as sanitation, harm reduction, treatment as prevention, insurance navigation, and the steps of diagnosing a viral hepatitis infection.	MDH	-	1	Current hepatitis staff at MDH could develop and distribute these resources with the support of other sections and units at MDH that also work with identified populations who would benefit from peer-to-peer resource distribution.
1.2.7: Develop a campaign regarding stigma-free routine viral hepatitis testing with an emphasis on introducing routine viral hepatitis testing in primary care settings.	MDH, health care systems	-	3	Developing a comprehensive campaign would require funding and staffing that is currently unavailable.
1.2.8: Develop a standard of care for viral hepatitis screening that promotes use of opt-out screening in primary care and emergency medicine.	Health care systems	MDH, medical organizations	2	MDH could develop and distribute this standard of care but cannot require health care agencies to adopt this standard.
1.2.9: Expand opportunities for viral hepatitis testing in state and federal prisons.	DOC	MDH	2	The DOC offers opt-out HCV testing to all incarcerated people upon entry. Individuals with reactive HCV tests are also offered HBV testing, HBV vaccine, and HAV vaccine. Expanding testing for priority populations may be possible but will require additional funding to pay for testing.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
1.2.10: Expand opportunities for viral hepatitis testing and vaccination in city and county jails.	Local public health	MDH	3	There is currently no funding mechanism for increasing access to testing and treatment in city and county jails. To complete this activity, funding must be acquired either by the state or by the jurisdictions in which the jails operate.

Objective 1.3: Improve awareness of general viral hepatitis testing requirements, rates of point of care testing, confirmatory testing, automatic reflex testing, and test reporting.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
1.3.1: Advocate for a lab standard that requires all reactive hepatitis C screening tests to automatically reflex to confirmatory testing.	MDH	-	2	MDH could develop and distribute this standard of care but cannot require health care agencies to adopt this standard. MDH may consider promoting APHL viral hepatitis lab standards instead. See APHL: Viral Hepatitis (www.aphl.org/programs/infectious_disease/Pages/Viral-Hepatitis.aspx).
1.3.2: Utilize electronic medical record (EMR) order sets to standardize diagnostic care across a variety of clinical settings and increase the ease of moving patients along the viral hepatitis care cascade.	Health care systems	MDH	2	MDH could promote the use of EMR order sets, but this activity will require the participation of health care settings to develop and implement these order sets.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
1.3.3: Ensure that all reportable testing results are appropriately sent to MDH, including point of care testing.	MDH, health care systems	Community partners	2	MDH could amplify efforts focusing on reporting awareness and compliance, but the agency conducting testing is ultimately responsible for ensuring results are appropriately reported.
1.3.4: Support community partners in implementation of rapid HCV RNA POC testing and develop a system to easily report RNA results from POC tests.	MDH	Community partners	2	The current cost of rapid POC testing instruments is a barrier. MDH may partner with a health care system, local public health, or community organization to support rapid RNA testing if funding becomes available. The reporting process of results would depend on the health system or organization involved in the testing.
1.3.5: Ensure that all people living with hepatitis B receive hepatitis D screening.	Health care systems	MDH	2	MDH could promote HDV reflex testing for those with an HBV diagnosis but cannot require health care systems to conduct this testing.

Objective 1.4: Identify the geographic and social barriers surrounding a viral hepatitis diagnosis. Develop and implement strategies for reducing or removing those barriers.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
1.4.1: Collaborate with stakeholders to determine what data are necessary to collect in order to provide population-specific information to clinical and non-clinical service providers that improves testing availability and uptake.	MDH	Community partners, health care systems	1	Current hepatitis staff at MDH could develop and conduct a survey for community partners and health care systems to determine what demographic data are deemed essential to provide usable and actionable data.
1.4.2: Host listening sessions with priority populations to assess what barriers to viral hepatitis testing exist and work with multidisciplinary teams to lower or remove these barriers.	MDH, community partners	-	2	Current hepatitis staff at MDH may have the capacity to host these listening sessions, but the inclusion of external consultants to support listening sessions would not be possible without additional funding.
1.4.3: Host listening sessions with agencies that serve priority populations to assess what barriers to viral hepatitis testing exist and work with multidisciplinary teams to lower or remove these barriers.	MDH, community partners	Agencies that specifically serve priority populations	2	Current hepatitis staff at MDH may have the capacity to host these listening sessions, but the inclusion of external consultants to support listening sessions would not be possible without additional funding.
1.4.4: Identify the unique barriers to viral hepatitis testing for each geographic region of Minnesota through collaboration across sectors.	MDH	Local public health	2	Current hepatitis staff at MDH may have capacity to consult with field service epidemiologists and local public health to understand geographic barriers to viral hepatitis testing.

Goal 2: Increase knowledge of hepatitis A, B and C testing among non-clinical service providers (e.g., public health, harm reduction, etc.) who are most likely to interact with groups at increased risk of viral hepatitis.

Objective 2.1: Identify where gaps in viral hepatitis knowledge exist for service providers and use these findings to enable them to provide targeted hepatitis A, B, and C education for those at increased risk of viral hepatitis.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
2.1.1: Conduct a series of viral hepatitis needs assessments for community service providers OR develop guidelines that allows community organizations, local public health, and other entities to conduct workplace needs assessments.	MDH, community partners	-	2	MDH could develop a toolkit for clinics, health care systems, and other entities to conduct their own needs assessments, but would need additional funding to conduct these needs assessments on behalf of community partners.
2.1.2: Partner with non-clinical service providers to develop and distribute resources (e.g., education, referral locations, etc.) to organizations that frequently serve priority populations as identified by the needs assessments.	MDH, community partners	Medical organizations	1	Current hepatitis staff at MDH could develop and distribute these resources to any interested health care system once independent organizations have completed their needs assessments
2.1.3.: Develop and advertise continuing education and consultation opportunities, such as Project ECHO, for clinical and non-clinical service providers.	MDH	-	1	Current hepatitis staff at MDH could continue to advertise already existing continuing education and consultation activities and can develop continuing education and consultation activities that are funded by partner agencies or have no associated cost.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
2.1.4: Develop and distribute resources for patients receiving initial screening or confirmatory testing that can be distributed from peer-to-peer on topics such as sanitation, harm reduction, treatment as prevention, insurance navigation, and the steps of diagnosing a viral hepatitis infection.	MDH	Community partners, medical organizations	1	Current hepatitis staff at MDH could develop and distribute these resources with the support of other sections and units at MDH that also work with identified populations who would benefit from peer-to-peer resource distribution.

Objective 2.2: Develop models for novel pathways of rapid testing and prompt referral for confirmatory testing and/or follow-up care in non-clinical settings for people at risk of viral hepatitis.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
2.2.1: Increase rapid hepatitis C screening among Syringe Service Programs (SSPs) and other non-clinical service providers to serve as a linkage to hepatitis C confirmatory testing and follow-up care.	MDH	SSPs	2	MDH funded SSPs have access to rapid HCV tests and could increase testing by empowering program participants to access these tests at a higher rate, which would require staff and client interest and education. SSPs that do not receive state funding would need access to funding for test kits and staff to increase rates of testing.
2.2.2: Build relationships between SSPs, substance use disorder treatment centers, and non-clinical service providers that perform hepatitis C confirmatory testing (and follow-up care) and utilize these relationships to ensure that patients receive care that is free of stigma and consistent with harm-reduction principles.	MDH	DHS, community partners	2	Relationship building is possible but ensuring those relationships are stigma free and there are partnerships available in key geographic areas across the state would involve extensive engagement and strong collaboration with partner agencies.
2.2.3: Ensure that all non-clinical service providers who offer field testing are pairing rapid HIV testing with hepatitis C testing whenever possible.	Community partners	MDH	2	MDH could work with non-clinical service providers who offer HIV testing to recommend pairing HIV and HCV testing but cannot require currently funded partners to implement these recommendations. Future grant applications may prioritize this testing approach and/or funding testing kits.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
2.2.4: Continuously evaluate and implement new confirmatory testing options that could allow people to be diagnosed and linked to care in the most efficient manner.	MDH	-	2	MDH will continue to evaluate new confirmatory testing options that improve the speed and accuracy of diagnosis. Implementation of these testing options will depend on the availability of funding and interest in testing strategies by community partners.

Goal 3: Decrease rates of all new viral hepatitis infections in Minnesota.

Objective 3.1: Identify and address barriers to accessing viral hepatitis prevention, screening, and treatment among priority populations and implement strategies to reduce or remove those barriers.

Activity	Lead Agency	Partner Agency	Feasibility Level	Note and Comments
3.1.1: Conduct a community needs assessment to identify gaps along the hepatitis B and C care cascades OR develop guidelines that allow community organizations, clinics and health care systems, local public health, and other entities to conduct needs assessments for the communities they serve.	MDH, community partners, health care systems	-	2	MDH could develop a toolkit for community organizations, clinics and health care systems, local public health, and other entities to conduct their own needs assessments, but would need additional funding to conduct these needs assessments on behalf of community partners.

Activity	Lead Agency	Partner Agency	Feasibility Level	Note and Comments
3.1.2: Provide technical assistance to community organizations, clinics and health care systems, local public health, and other entities to create a network of harm-reduction educators who can provide high quality harm reduction education to clinicians/prescribers using a model of peer-to-peer education or training from a subject matter expert.	Community partners, health systems, local public health	MDH	3	Current hepatitis staff could provide hepatitis education and resources to interested entities but cannot spearhead this effort. Implementation of this activity is dependent on the capacity of community organizations, clinics and health care systems, local public health, and other entities to engage in this work.
3.1.3: Publish infectious disease guidance for those providing care in encampments or other unsheltered settings, including best practices for reducing transmission of viral hepatitis.	MDH	LPH	1	This activity has been completed. Guidance can be found at Promoting Health and Preventing Infectious Disease in Homeless Encampments (www.health.state.mn.us/communities/homeless/coe/encampment.pdf)
3.1.4: Expand the number of providers who are aware of, trained in, and have capacity to treat hepatitis C in primary care and addiction medicine settings.	Health care systems	MDH, DHS	2	MDH could develop and disseminate guidance on treating HCV in primary care and addiction medicine settings but cannot enforce the expansion of testing and treatment in these settings.

Activity	Lead Agency	Partner Agency	Feasibility Level	Note and Comments
3.1.5: Develop and maintain a repository of viral hepatitis educational materials for clinical and non-clinical providers and the public.	MDH	-	1	Current hepatitis staff at MDH have already developed and maintain these resources.

Objective 3.2 Eliminate perinatal transmission of hepatitis B and C.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
3.2.1: Ensure CDC hepatitis screening and testing recommendations during pregnancy are appropriately implemented in perinatal care and that all positive results are appropriately reported to MDH.	Health care systems	MDH	1	MN state statute requires reporting hepatitis B or C infection during pregnancy to MDH. MDH continues to advocate for screening early in every pregnancy.
3.2.2 Ensure identification of pregnancy among hepatitis B and hepatitis C positive patients is properly reported to public health.	Health care systems	MDH	1	MN state statute requires reporting pregnancy in HBV or HCV positive patients to MDH. MDH continues to work towards 100% reporting compliance.
3.2.3 Ensure all individuals who are pregnant and positive for hepatitis B and/or hepatitis C are linked to care and receive proper education regarding their infection, how to reduce vertical transmission, and post-natal care.	Health care systems	MDH	2	Ensuring appropriate referrals would be dependent on the provider and would likely include the use of case managers and nursing staff. This may also involve the use of transportation services and low-cost or free services, which is not always realistic or possible.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
3.2.4: Educate clinical and non-clinical care providers on recommendations for screening, reporting, referral, and treatment to prevent vertical transmission of viral hepatitis.	MDH	Health systems, medical organizations	2	MDH could continue to expand their outreach and partnerships to communicate up to date hepatitis care recommendations. Recommendations regarding referral or treatment would need review by clinical partners.
3.2.5: Ensure all infants exposed to hepatitis B receive appropriate post-exposure prophylaxis, a full HBV vaccine series, and post-vaccination serologic testing, with those testing results properly reported to public health.	MDH	Health systems	2	MDH has a strong hepatitis B perinatal program that relies on the work of LPH in reaching patients and their providers. MDH can continue to encourage appropriate treatment, vaccine, and reporting of PVST, but proper reporting will depend on the accountability of the individual health system.
3.2.6: Use existing perinatal HIV and hepatitis B infrastructure to support similar efforts for perinatal HCV.	MDH	Health systems	2	MDH is well positioned to create a program that supports hepatitis C perinatal infections. However, limited staffing has not allowed for creation of this program.
3.2.7 Engage household contacts and sexual partners of those diagnosed with hepatitis B during pregnancy in routine hepatitis B testing and linkage to care.	Health care systems	MDH, LPH	2	MDH currently has a strong hepatitis B perinatal program that relies on the work of LPH in reaching patients and their providers. With additional funding, this program could continue to prioritize outreach to household and sexual contacts.

Objective 3.3: Increase rates of hepatitis A & B vaccination, particularly among priority populations.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
3.3.1: Ensure health care providers are aware of hepatitis vaccination recommendations.	MDH	Health care systems, local public health, medical organizations	1	MDH could utilize already developed vaccine educational materials and advertise these materials to health care systems.
3.3.2: Identify primary care clinics in need of a standard vaccination assessment and administration plan for all vaccine eligible patients and work with them (if requested) to develop and implement that plan.	Health care systems	MDH	1	Current hepatitis staff and vaccine preventable disease staff at MDH continuously educate on proper vaccination administration. MDH could work with primary care clinics to ensure routine hepatitis vaccination assessment and administration.
3.3.3: Assess the readiness of large health care systems to provide timely routine HAV and HBV vaccinations in all settings, including primary and emergency care.	MDH	Health systems	1	This activity is in progress.
3.3.4: Support community settings in identifying and implementing the essential components needed to provide vaccine in these settings.	MDH	Community partners	2	MDH could develop guidance for working with community partners to identify components necessary to provide vaccine, which can be offered based on community interest. MDH cannot require vaccinators to utilize this guidance.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
3.3.5: Partner with universities and professional societies to offer viral hepatitis education targeted towards specific medical professions (e.g., ACOG training for OB/GYNs).	Health care systems	MDH, professional societies	3	There is no current mechanism to implement this partnership, but health care systems may work with universities and professional societies to develop this mechanism. No state funding is available to support these partnerships.
3.3.6: Expand opportunities for hepatitis A and B vaccination in state and federal prisons.	DOC	MDH	2	The DOC offers opt-out HCV testing to all incarcerated people upon entry. Individuals with reactive HCV tests are also offered HBV testing, HBV vaccine, and HAV vaccine. Expanding testing for priority populations may be possible but will require additional funding to purchase tests. Access to vaccination in federal prisons is regulated by the Federal Bureau of Prisons.
3.3.7: Expand opportunities for hepatitis A and B vaccination in city and county jails.	Local public health	MDH	3	There is currently no funding mechanism for increasing access to testing and treatment in city and county jails. To complete this activity, funding must be acquired either by the state or by the jurisdiction(s) in which the jails operate.

Objective 3.4: Ensure all vaccine doses administered in non-traditional locations (e.g., street medicine, events) are appropriately documented in the Minnesota Immunization Information Connection (MIIC) vaccine registry.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
3.4.1: Identify the number of vaccine doses and location of vaccine doses administered in non-traditional settings per year and work with these sites to identify best practices for administering vaccine in these settings.	MDH	Community partners who administer vaccine	2	This activity is feasible for any doses purchased through the Minnesota Vaccines for Children Program or the Uninsured and Underinsured Adult Vaccine Program. There is currently no feasible way to track vaccines purchased at market-rate and administered in non-traditional settings.
3.4.2: Partner with the Vaccine Preventable Disease (VPD) section at MDH to better understand and streamline MIIC vaccination recording.	MDH	Local public health, health systems	2	Current hepatitis staff at MDH have the capacity to work collaboratively with the VPD section to better understand MIIC vaccination recording. VPD staffing capacity and priorities may limit the ability to respond to any identified issues.
3.4.3: Meet with sites who would like to implement vaccine programs and identify any barriers that may arise in program implementation.	MDH	Local public health, community partners	1	Current hepatitis staff at MDH, in partnership with the VPD section, have capacity to meet with a limited number of sites that indicate interest in identifying barriers to program implementation.
3.4.4: Work with identified sites to mitigate barriers in order to properly implement vaccine programs.	MDH	Local public health, community partners	2	Current hepatitis staff at MDH, in partnership with the VPD section, have the capacity to meet with any potential site that indicates interest in mitigating potential barriers that may arise. MDH does not have the funding to provide supplies or personnel to support vaccination programming.

Goal 4: Leverage a harm reduction approach to decrease rates of hepatitis C infections among people who inject drugs.

Objective: 4.1: Ensure all harm reduction and SSP programs have access to rapid hepatitis C screening tests and up-to-date information on viral hepatitis harm reduction strategies.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
4.1.1: Distribute rapid hepatitis C screening tests to identified facilities and programs in need, as funding allows.	MDH	Local public health, community partners	2	The HIV/STI group at MDH already distributes tests to MDH funded SSPs. Furthermore, the Hepatitis Unit at MDH distributes tests to other unfunded entities as funding allows. At the time of publishing there is currently no available funding for test distribution.
4.1.2: Develop ongoing education for staff at SSPs and other harm reduction programs on hepatitis C testing, providing education for priority populations, and adapting viral hepatitis prevention strategies to align with the changing landscape of drug use.	MDH	SSPs	1	Current hepatitis staff at MDH could develop and distribute these resources.
4.1.3: Establish routine participation from MDH hepatitis staff in already established harm reduction meetings (e.g., HIV Outbreak and Public Engagement [HOPE] group, the Minnesota SSP Network, or the Twin Cities Harm Reduction Group) OR develop a separate viral hepatitis focused harm reduction group as a means of continuously engaging harm reduction organizations and strengthening relationships between these organizations and MDH.	MDH	Community partners, health systems	1	Current hepatitis staff at MDH could establish and host a viral hepatitis harm reduction meeting. Establishing and hosting this meeting is dependent on community/health care interest and capacity to attend. There may be advantages to participating in already existing groups.

Objective 4.2 Reduce rates of new viral hepatitis infections associated with sharing needles, other injection equipment, and personal care items.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
4.2.1: Increase access to and awareness of safer drug-use supplies.	MDH	Community partners	2	Current hepatitis staff at MDH, in partnership with HIV/STI staff, have the capacity to support efforts to increase awareness of safer drug-use supplies. At time of publishing, funding is not available to purchase safer drug-use supplies, but efforts to include this work in future grant funding are supported.
4.2.2: Increase awareness of shared personal care items that may increase risk of HCV/HBV transmission (e.g., toothbrushes, razors, and nail clippers).	MDH	Community partners	1	Current hepatitis staff at MDH, in partnership with HIV/STI staff, have the capacity to support efforts that increase awareness of risks in sharing personal care items.
4.2.3: Increase access to personal care items that improve individual health and wellbeing (e.g. sanitation wipes for cleaning, menstrual products, shampoo/conditioner, and socks).	MDH	Community partners	2	At time of publishing, funding is not available to purchase personal care items, but efforts to include these supplies in future grant funding are supported.
4.2.4: Partner with community organizations to develop initiatives to educate the public about injection alternatives, risk of viral hepatitis infection, and personal and community benefits of viral hepatitis treatment.	Community partners	MDH	2	Current hepatitis staff at MDH do not have the capacity to lead these efforts but would prioritize the implementation of this activity if funding becomes available.

Goal 5: Increase rates of referral to viral hepatitis treatment by primary care providers, community service providers, and other non-clinical service providers.

Objective 5.1: Improve accessibility and awareness of treatment and navigation options for hepatitis B and C.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
5.1.1: Decrease barriers to accessing treatment through reduced-cost or free treatment options by increasing enrollment in Medicare and Medicaid and referrals to Federally Qualified Health Centers (FQHCs), with an emphasis in priority populations, including those who are new to the United States and have insurance coverage for only a limited period.	DHS	MDH, local public health	3	MDH does not have jurisdiction over DHS priorities. MDH will continue to partner with DHS partners to identify opportunities to expand and simplify access to treatment.
5.1.2: Advocate for continued and expanded access to telehealth appointments for viral hepatitis treatment.	DHS	Health care systems, MDH	3	MDH does not have jurisdiction over DHS priorities. MDH will continue to work with DHS partners to identify all opportunities to expand and simplify access to treatment.
5.1.3: Identify all supports needed following a hepatitis C diagnosis and treatment prescription to ensure patients can take the full course of medication.	Health care systems	Community partners, MDH	1	MDH hepatitis staff could provide technical assistance to any health care system interested in performing a comprehensive review of supports needed to ensure patients can take full course of medication.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
5.1.4: Develop a public health case management system for those who need additional support navigating the system of diagnosis and treatment.	MDH	DHS	3	Current hepatitis staff at MDH do not have capacity or funding to develop, implement, or oversee a case management program.
5.1.5: Develop and/or advertise additional education materials (guidelines, workflows, communities of practice) for clinicians who want to treat hepatitis B and C.	MDH	health care systems, medical organizations	1	Current hepatitis staff at MDH have the capacity to develop and advertise educational materials. Recommendations regarding referral or treatment would need review by clinical partners.

Objective 5.2: Increase percentage of people with hepatitis C who cure their infection.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
5.2.1: Develop a toolkit that promotes a standardized protocol following a reactive hepatitis C antibody test that can be implemented in multiple settings (e.g., field testing, clinic settings, inpatient settings) to ensure timely follow-up testing and treatment.	MDH	Health care systems, community partners	1	Current hepatitis staff at MDH could develop and distribute this toolkit. Use of the toolkit will depend on the health care system and community partners interest and capacity to implement this protocol.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
5.2.2: Follow model of simultaneous evaluation, treatment and partner testing based on rapid testing results using the Rapid ART model of HIV treatment and the empiric model of syphilis treatment.	Health care systems	-	3	Protocols for simultaneous evaluation, treatment, and partner evaluation need to be implemented by individual health care systems and generally require guidance from national health agencies (i.e., CDC, AASLD).
5.2.3: Support health care systems or other organizations in the development of a hepatitis C hotline where health care providers may consult one another as part of routine care.	Health care systems	-	3	MDH does not currently have the capacity to fund, develop, or implement this activity.
5.2.4: Consult with DHS on access to care (e.g., the prior authorization process, reducing barriers to care).	MDH, health care Systems, Community Partners	DHS	1	This activity was completed following collaboration with the viral hepatitis elimination coalition and prior to publication of the viral hepatitis elimination plan. However, continuous advocacy is needed to reduce barriers in access to care and allow all patients easy access to treatment.
5.2.5: Increase rates of repeat hepatitis C testing and treatment in primary care settings for those with ongoing risk factors.	Health care systems, medical organizations	MDH	1	Current hepatitis staff at MDH could develop and distribute this guidance on repeat testing. Use of the guidance will depend on interest from health care systems and community partners and the capacity to implement this protocol.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
5.2.6: Improve epidemiological tracking of hepatitis C by utilizing a care cascade.	MDH	Local public health, health care systems	1	This activity is already in progress.
5.2.7: Develop, publish, and maintain a list of locations that offer hepatitis C treatment in Minnesota.	MDH	Local public health, health care systems	2	Current hepatitis staff at MDH could complete this activity. The development of this list will be dependent on local public health and health care system capacity to contribute and list comprehensiveness cannot be guaranteed.
5.2.8: Identify and implement the necessary components of offering treatment in the community (e.g., mobile medicine and co-located treatment services)	Health care systems	MDH	3	MDH, health care systems, and community partners could explore the feasibility of this activity and develop a roadmap for these services. At the time of publishing, there is insufficient staffing and funding to implement treatment in the community. Furthermore, there are multiple legislative and organizational policies that may prohibit implementing treatment.

Goal 6: Provide patient, staff, and organization education on how to navigate health insurance requirements for viral hepatitis treatment.

Objective 6.1: Engage with clinical and non-clinical organizations to provide continued outreach to communicate Medicaid enrollment timelines and criteria.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
6.1.1: Establish a reimbursable community health worker program to support marginalized populations in identifying and accessing key information regarding their hepatitis A, B, and/or C infections, including insurance navigation.	DHS	MDH	3	Health care worker programs typically fall under the jurisdiction of DHS, which utilizes state and federal funding to support this programming. State and federal hepatitis funding does not support community health worker programming.
6.1.2: Partner with libraries, warming centers, and other high traffic areas to offer drop-in insurance navigation.	DHS, Local Public Health	MDH, community partners	2	Current hepatitis staff at MDH have the capacity to provide insurance navigation materials to libraries, warming centers, and other high-traffic areas. Current staff do not have capacity to provide technical assistance or staffing for insurance navigation events. Participation in the distribution of these materials would be dependent on the interest and capacity of community partners.

Objective 6.2: Provide timely and accessible education, outreach, and resources to support health insurance enrollment and understanding of insurance benefits.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
6.2.1: Develop materials and/or training that address state or federal changes that may impact the ability to access viral hepatitis treatment or care.	MDH	-	1	This activity is already in progress.
6.2.2: Develop or share an already developed toolkit for navigating Medicaid benefits when living with extenuating circumstances (e.g., homelessness, new arrivals to the United States, English language learner).	DHS, local public health	MDH	2	Current hepatitis staff at MDH could partner with local public health and DHS to develop this toolkit. The development and distribution of this toolkit will depend on the capacity and interest of partner agencies to engage in this work.
6.2.3: Work with DHS and/or MN Department of Commerce to identify existing treatment prerequisites.	MDH	DHS, Minnesota Department of Commerce	1	Current MDH staff have the capacity to work across the enterprise to identify existing treatment perquisites for Medicare and Medicaid.

Objective 6.3: Ensure equitable access to viral hepatitis resources for patients and the public.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
6.3.1: Develop and publish a comprehensive resource page with information on insurance navigation, transportation, medication adherence and other resources related to the social determinants of health surrounding a viral hepatitis diagnosis.	MDH	DHS	1	Current hepatitis staff at MDH could develop, publish, and maintain this resource page using newly developed and already existing resources (e.g., creating new fact sheets and compiling existing local, state, and national public health resources).
6.3.2: Partner with staff at libraries and other community hubs to distribute resources.	MDH	Community partners	1	Current hepatitis staff at MDH have capacity to partner in distributing these resources. Distribution of resources is dependent on the interest and capacity of community partners to house these resources.
6.3.3: Ensure all community partners receive adequate training on any newly developed materials, including toolkits, portals, or other online navigation tools.	MDH	Health care systems, community partners	2	Current hepatitis staff at MDH do not have capacity or funding to host individual training for health care systems and community partners. Limited capacity exists to develop training documents and host drop-in training courses for any interested parties.
6.3.4: Prioritize outreach to communities historically impacted by systemic disinvestment and policy changes.	Community partners, health care systems, DHS	MDH	2	Current hepatitis staff at MDH could support collaborative efforts to reach impacted communities that may benefit from viral hepatitis resources available through their insurance.

Goal 7: Strengthen viral hepatitis outbreak detection and response, disease reporting and disease surveillance.

Objective 7.1: Identify all hepatitis A, B, and C clusters and/or outbreaks within the state of Minnesota and report outbreak information back to organizations impacted, based on geographic location and populations of interest.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
7.1.1: Collaborate with clinical and community stakeholders to identify populations at increased risk of contracting hepatitis A, B, and C.	MDH	Community partners, health care systems	1	This activity was completed through the coalition process
7.1.2: Develop and implement a cluster detection and response plan for hepatitis A, B, and C.	MDH	-	1	This activity is already in progress.
7.1.3: Identify or develop routes of communication for quickly disseminating data and changes in testing and reporting guidance to relevant organizations.	MDH	-	1	This activity is already in progress.
7.1.4: Develop a syndemic/integrated response to hepatitis C outbreak detection by working with other disease areas to test for hepatitis C when there are outbreaks of diseases with similar risk factors, such as HIV or syphilis.	MDH	Community partners, health care systems	1	Current hepatitis staff at MDH have the capacity to work with other divisions and sections at MDH that support the prevention of diseases with similar risk factors.

Objective 7.2 Improve completeness of hepatitis A, B, C, and D disease reporting, evaluation, and dissemination.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
7.2.1: Establish and maintain routine communication between public health, clinical, and non-clinical sectors regarding trends in data and how these trends can inform direct service.	MDH	-	1	This activity is already in progress.
7.2.2: Strengthen mechanisms for hepatitis B screening and sustaining care among those most at risk, including new arrivals to the United States.	MDH	Health care systems, community partners who serve immigrants and refugees	2	Current staff at MDH have the capacity to connect with refugee health and additional community partners to improve hepatitis care among new arrivals, but strategic interventions may be limited due to funding.
7.2.3: Develop provider guidance for automatic hepatitis D screening among those with a hepatitis B diagnosis.	MDH	Health care systems, medical organizations	2	Current hepatitis staff at MDH have the capacity to develop testing protocols. Protocol uptake will depend on the interest and capacity of health care systems and individual providers.
7.2.4: Increase compliance with viral hepatitis reporting requirements, including supplemental patient information and viral hepatitis pregnancy and birth reports, by providing trainings and website resources.	MDH	-	2	Current MDH hepatitis staff work with health systems and providers to ensure proper reporting and could continue to provide resources and education on reporting updates and requirements. However, reporting compliance is dependent on the health systems and community organizations.

Objective 7.3: Routinely analyze and disseminate viral hepatitis data to improve testing, detection, and linkage to care for hepatitis A, B and C.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
7.3.1: Develop and publish a yearly surveillance report with data and information beneficial for both clinical and non-clinical service providers.	MDH	-	1	This activity is already in progress.
7.3.2: Utilize data from the surveillance report to identify current populations and geographic regions most impacted by viral hepatitis and use this data to develop targeted interventions for viral hepatitis prevention.	MDH	Community partners, local public health	1	This activity is already in progress.
7.3.3: Resume yearly data webinar with MDH HIV/STI staff.	MDH	-	1	This activity is already in progress.

Goal 8: Strengthen relationships between clinical and non-clinical providers whose primary population includes those at increased risk of viral hepatitis.

Objective 8.1: Close the gap in diagnosis and treatment among those most at risk of contracting viral hepatitis by improving outcomes among these populations.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
8.1.1: Conduct key informant interviews among clinical and non-clinical service providers and identify non-medical barriers to detection, treatment, and response.	MDH	Community partners	3	Current hepatitis staff at MDH do not have the capacity to lead these efforts but would prioritize the implementation of this activity if funding becomes available.
8.1.2: In medical and non-medical settings, implement up to date resources, training and/or tools that respond to identified causes of inequitable access to testing and treatment.	Health care systems, community partners	MDH, medical organizations	3	Current hepatitis staff at MDH do not have the capacity to lead these efforts but could support health care systems and community partners by providing technical assistance to those implementing these resources, training, and tools.
8.1.3: Identify areas of clinical and non-clinical practice that can integrate viral hepatitis care and develop standardized training for these locations that include information on harm reduction, person-centered care, and viral hepatitis.	Health care systems, community partners	MDH	2	Current hepatitis staff at MDH do not have the capacity to lead these efforts but could support health care systems and community partners by providing technical assistance to those wishing to implement these resources, training, and tools.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
8.1.4: Develop or identify a community of practice for clinical and non-clinical service providers who work in hepatitis to easily disseminate information and plan multi-agency response efforts.	Health care systems, community partners	MDH	2	Current hepatitis staff at MDH do not have capacity to lead these efforts but could support health care systems and community partners by providing technical assistance. The implementation of a community of practice would depend on the interest and capacity of health care systems and community partners to lead such work.

Objective 8.2: In partnership with overlapping disease areas, identify and respond to non-medical needs associated with improved outcomes in viral hepatitis prevention, diagnosis, and treatment.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
8.2.1: Identify overlapping disease areas in state and local public health, which may include, but is not limited to, HIV, sexually transmitted infections, and vaccine preventable diseases, and develop a cross-sector working relationship for all following activities under objective 8.2.	MDH	-	1	Current hepatitis staff at MDH have the capacity to identify overlapping disease areas in partnership with other sections and units at MDH that also work with identified priority populations.
8.2.2: Conduct a needs assessment survey among viral hepatitis patients, or individuals at risk of contracting viral hepatitis, to identify non-medical barriers and needs affecting prevention, diagnosis, and treatment outcomes.	MDH	-	3	Current hepatitis staff at MDH, in partnership with other sections and units at MDH, do not currently have capacity or funding to conduct a needs assessment but would prioritize this activity if funding becomes available.

Activity	Lead Agency	Partner Agency	Feasibility Level	Notes and Comments
8.2.3: Develop a workplan to respond to the barriers identified in 8.2.2.	MDH	-	3	The development of this workplan requires successful completion of Activity 8.2.2., which currently does not have the funding necessary for completion.

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