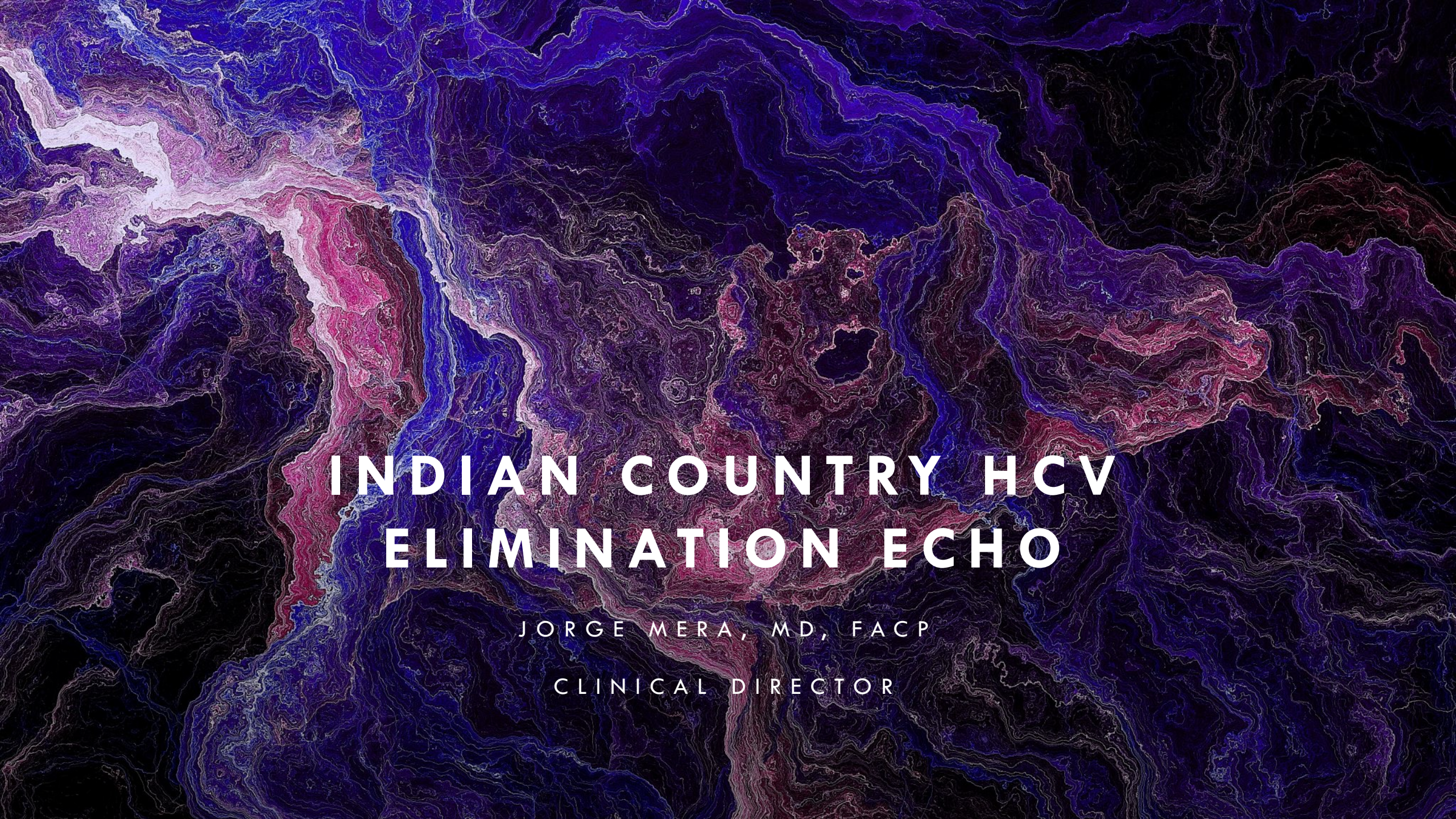


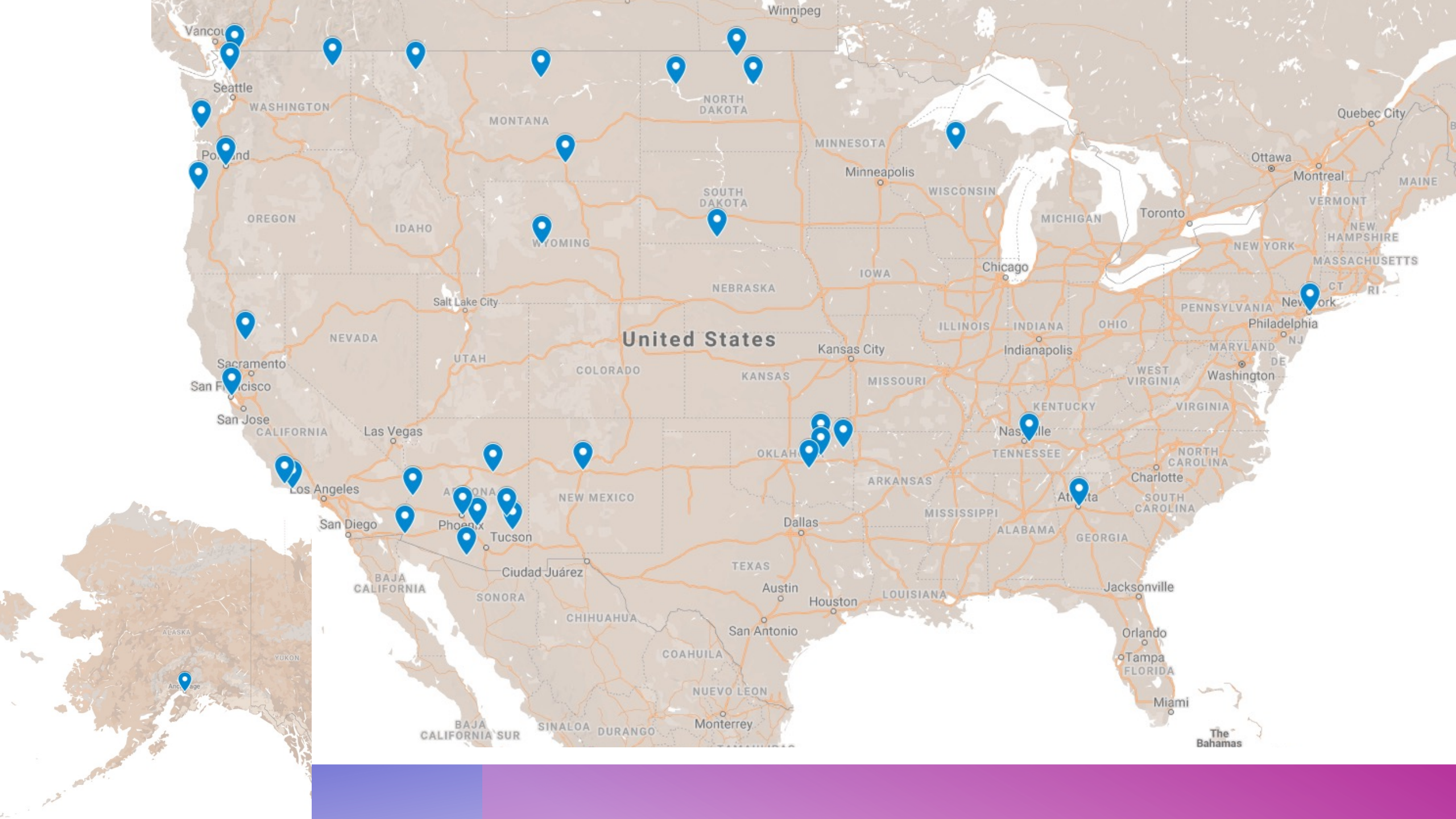
INDIAN COUNTRY HCV ELIMINATION ECHO

JORGE MERA, MD, FACP

CLINICAL DIRECTOR

Participating Tribes, Clinics, and Programs

- **Alaska**
  - Alaska Native Tribal Health Consortium
  - Americorps VISTA (ANTHC)
  - DU
- **Arizona**
  - Gila River
  - Health Center/Colorado
  - Navajo
  - Phoenix Area HIS
  - Salt River Pima-Maricopa Indian Community
  - San Carlos Apache
  - Tohono O'odham
- **California**
  - American Indian Health Services
  - Northern Valley Indian Health
  - Quechan CHR Program
  - Santa Ynez Tribal Health Clinic
- **Montana**
  - Confederated Tribes of Salish and Kootenai
  - Crow/Northern Cheyenne
  - Fort Belknap IHS
- **North Dakota**
  - Belcourt IHS
  - Three Affiliated Tribes/Elbowoods Memorial Health Center
  - Spirit Lake Health Center
- **Oklahoma**
  - Cherokee Nation
  - Muscogee Creek
  - National Indian Women's Health Resource Center
  - Wewoka
- **Oregon**
  - Confederated Tribes of Siletz Indians
- **South Dakota**
  - Rosebud IHS
- **Washington**
  - Colville
  - Nooksack
  - Shoalwater Bay
  - Swinomish/didg^{w}álič
- **Wyoming**
  - Wind River Cares
- **Tribal Epidemiology Centers**
  - United South and Eastern Tribes
  - Albuquerque Indian Health Board
  - Great Lakes Inter-tribal Epidemiology Center
  - Northwest Portland Area Indian Health Board
- **Partners**
  - Office of the Assistant Secretary for HHS
  - Centers for Disease Control
  - Health and Human Services
  - Multnomah County Public Health
  - Pacific County Health and Human Services Department


Winnipeg
Seattle
WASHINGTON
MONTANA
NORTH DAKOTA
MINNESOTA
Minneapolis
Quebec City
Ottawa
Montreal
MAINE
VERMONT
NEW HAMPSHIRE
MASSACHUSETTS
CT
RI
NEW YORK
New York
Philadelphia
NJ
PENNSYLVANIA
OREGON
IDAHO
WYOMING
SOUTH DAKOTA
WISCONSIN
MICHIGAN
Toronto
Chicago
IOWA
NEBRASKA
Salt Lake City
NEVADA
UTAH
COLORADO
KANSAS
MISSOURI
ILLINOIS
INDIANA
OHIO
Indianapolis
Kansas City
MARYLAND
DE
Washington
WEST VIRGINIA
VIRGINIA
KENTUCKY
TENNESSEE
NORTH CAROLINA
Charlotte
SOUTH CAROLINA
ARKANSAS
MISSISSIPPI
ALABAMA
GEORGIA
Jacksonville
Orlando
Tampa
FLORIDA
Miami
The Bahamas
LOUISIANA
Houston
Austin
San Antonio
Dallas
TEXAS
OKLAHOMA
NEW MEXICO
Las Vegas
Los Angeles
San Diego
Phoenix
Tucson
Ciudad Juárez
BAJA CALIFORNIA
SONORA
CHIHUAHUA
COAHUILA
NUEVO LEON
Monterrey
BAJA CALIFORNIA SUR
SINALOA
DURANGO
San Francisco
Sacramento
San Jose
CALIFORNIA
United States
ALASKA
YUKON

INDIAN COUNTRY ECHO

Indian Country Hepatitis C Elimination ECHO

To successfully prevent and treat HCV, the Northwest Portland Area Indian Health Board, along with our federal and tribal partners, have developed the Hepatitis C Elimination ECHO for AI/AN Communities. In this 12 session ECHO, you will find the rationale, program design, as well as the tools that can be used by healthcare providers and tribal decision-makers to develop and enhance community-tailored HCV micro-elimination programs. (CE will be provided. Both continuing education and a separate certificate of completion will be offered - see page 2 for additional requirements)

Program Schedule

ECHO Sessions (Each session will be followed by a 30-minute discussion for Q and A)

- **April 6th 12-1pm PST**
  - Introductions
  - *HCV Elimination Overview* (Presenters: Jorge Mera, MD; Justin Iwasaki, MD)
    - Review upcoming curriculum covered during the program
    - Review elimination template to be used to present draft HCV elimination plan for your tribe/community
- **April 13th 12-1pm PST**
  - *Screening for Hepatitis C* (Presenters: Jorge Mera, MD; Whitney Essex, FNP)
    - Recommendations
    - Strategies/Testing Outside of Primary Care Clinic
    - Screening Priority Populations
  - Learning from Tribes
    - *HCV Screening: Lessons learned from Sicangu Oyate* (Presenter: Hannah Wenger, MD)
- **April 20th 12-1pm PST**
  - *Patient Centered Care* (Presenter: Jessica Rienstra, BSN)
    - Case Management/Outreach/Engagement
  - Learning from Tribes
    - *How Lummi Nation is Providing Patient Centered Care* (Presenters: Danayle Wilson)
- **April 27th 12-1pm PST**
  - HCV Treatment & Medications
    - *DAA Overview & Common Med Interactions* (Presenter: Paulina Deming, PharmD)
    - *Simplified Treatment Overview* (Presenter: Justin Iwasaki, MD)
  - Learning from Tribes
    - *Pharmacy Led HCV Treatment for Assiniboine & Sioux Tribes* (Presenter: Brad Moran, PharmD)
- **May 4th 12-1pm PST**
  - *Medications for Addiction Treatment and the HCV Provider* (Presenter: Jessica Gregg, MD, PhD)
  - Learning from Tribes
    - *Providing a Cure and Treatment at Penobscot Nation* (Presenter: Nadine Villani, FNP)
    - *HCV and SUD Treatment at dídg"álič* (Presenter: Melissa McFarland, FNP)
- **May 11th 12-1 pm PST**
  - *Indigenous Harm Reduction* (Presenter: Annette Hubbard, BHA)
  - Learning from Tribes
    - *Eastern Band Cherokee Harm Reduction* (Presenter: Vickie Bradley, RN, MPH)
    - *Red Lake Harm Reduction* (Presenter: Samantha Gustafson, PharmD)
- The following 6 sessions will focus on presentation of Tribe's and Organization's Individual HCV Elimination Strategies and provide time for feedback and discussion (schedule on pg. 2)

Connect Information

All sessions take place virtually using the zoom platform. To join via Zoom, simply click here at the time of each session:

- https://echo.zoom.us/j/94011662996?pwd=NEJnVC8xQ0g3UVltNHFkOVFCQm5SUT09
- **Enter password: ECHO**

Strategy Sharing Sessions (Please note - In order to receive a certificate upon course completion, completing a draft HCV Elimination Strategy Presentation is required)

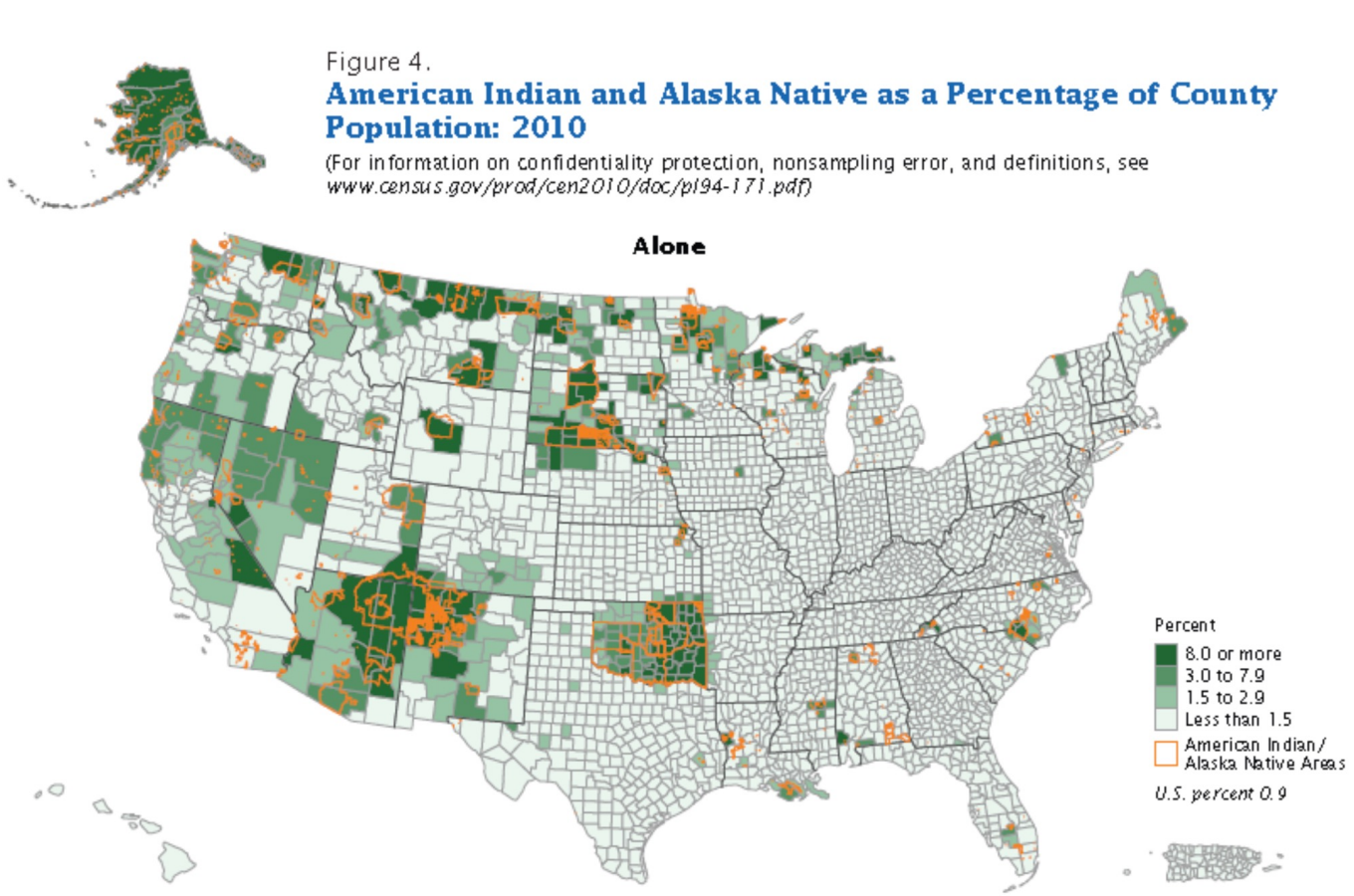
- **May 18th @ 12pm PT**
  - *Tohono O'odham's HCV Elimination Strategy* (15 min) – Cody Juan, Eugenia Mattias, Erika Reyas
    - Feedback (15 min) – Participants/Faculty
  - *TBD* (15 min) – TBD
    - Feedback (15 min) – Participants/Faculty
- **May 25th @ 12pm PT**
  - *Rosebud IHS HCV Elimination Strategy* (15 min) – Rodger An, Anna Fox
    - Feedback (15 min) – Participants/Faculty
  - *Confederated Tribes of Salish and Kootenai's HCV Elimination Strategy* (15 min) – Bernadette Corum, Cameron Neiss, Jessi Cahoon
    - Feedback (15 min) – Participants/Faculty
- **June 1st @ 12pm PT**
  - *Crow/Northern Cheyenne's HCV Elimination Strategy* (15 min) – Theresa Emmerling
    - Feedback (15 min) – Participants/Faculty
  - *Belcourt IHS HCV Elimination Strategy* (15 min) – Jolene Keplin
    - Feedback (15 min) – Participants/Faculty
- **June 8th @ 12pm PT**
  - *Swinomish/didg"álič HCV Elimination Strategy* (15 min) – Melissa McFarland, Kasey Johnson
    - Feedback (15 min) – Participants/Faculty
  - *Salt River Pima's HCV Elimination Strategy* (15 min) – Malkia Yussuf, Marianne Bennett
    - Feedback (15 min) – Participants/Faculty
- **June 15th @ 12pm PT**
  - *Three Affiliated Tribes' HCV Elimination Strategy* (15 min) – Kathryn Eagle-Williams, Lenaya Martin
    - Feedback (15 min) – Participants/Faculty
  - *Colville's HCV Elimination Strategy* (15 min) – Larry Smith
    - Feedback (15 min) – Participants/Faculty
- **June 22nd @ 12pm PT**
  - *Alaska Native Tribal Health Consortium/South Central Foundation's HCV Elimination Strategy* (15 min) – Brian McMahon, Lisa Townshend-Bulson, Annette Hewitt, Madalene Mandap, Matthew Begay-Bruno
    - Feedback (15 min) – Participants/Faculty
  - *Spirit Lake's HCV Elimination Strategy* (15 min) – Tana Triepke, Joseph de la Paz
    - Feedback (15 min) – Participants/Faculty
  - *Evaluation Discussion* (30 min) – Cardea

Connect Information

All sessions take place virtually using the zoom platform. To join via Zoom, simply click here at the time of each session:

- **https://echo.zoom.us/j/94011662996?pwd=NEJnVC8xQ0g3UVltNHFkOVFCQm5SUT09**
- **Enter password: ECHO**

AMERICAN INDIAN/ALASKA NATIVE (AI/AN) STATISTICS IN THE UNITED STATES



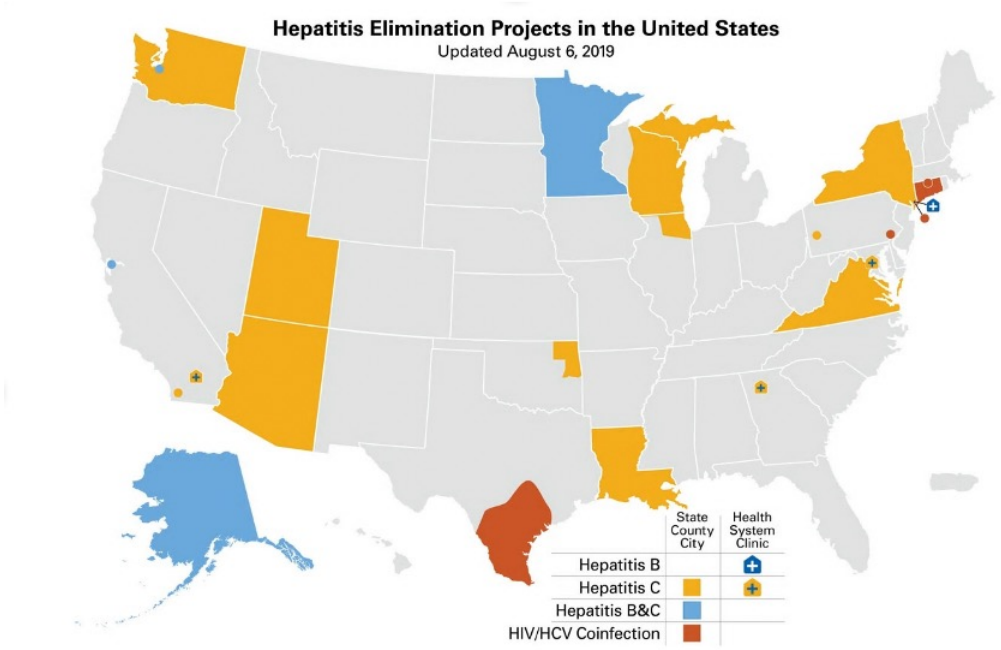
- 573 Federally recognized tribes
- 5.2 million AI/AN alone or in combination
- California and Oklahoma have the highest rate of AI/AN population

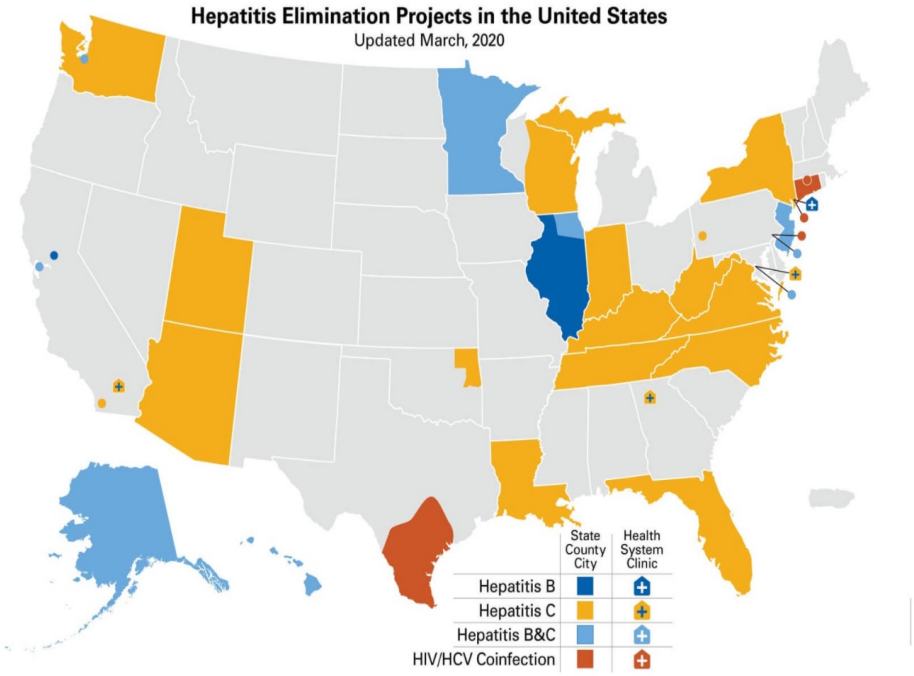
Hepatitis C in AI/AN in the US

- HCV disproportionately affects AI/AN[1,2]
- The AI/AN HCV **mortality** rate is 10.8 deaths per 100,000, compared to 4.5 per 100,000 nationally.
- From 2015 to 2016, **incidence** rates of acute HCV among AI/ANs rose from 1.8 to 3.1 cases per 100,000.
- Rates of **chronic liver disease** and cirrhosis deaths are 2.3 times higher among AI/ANs than Whites.

1. Centers for Disease Control and Prevention. Surveillance for Viral Hepatitis: United States, 2016. Retrieved from https://www.cdc.gov/hepatitis/statistics/2016surveillance/commentary.htm
2. Center for Disease Control and Prevention. Deaths: Final Data for 2014. https://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_04.pdf
3. US Census Bureau. https://www.census.gov/www. Accessed Nov 2, 2019

HCV/HBV ELIMINATION PROJECTS IN THE USA

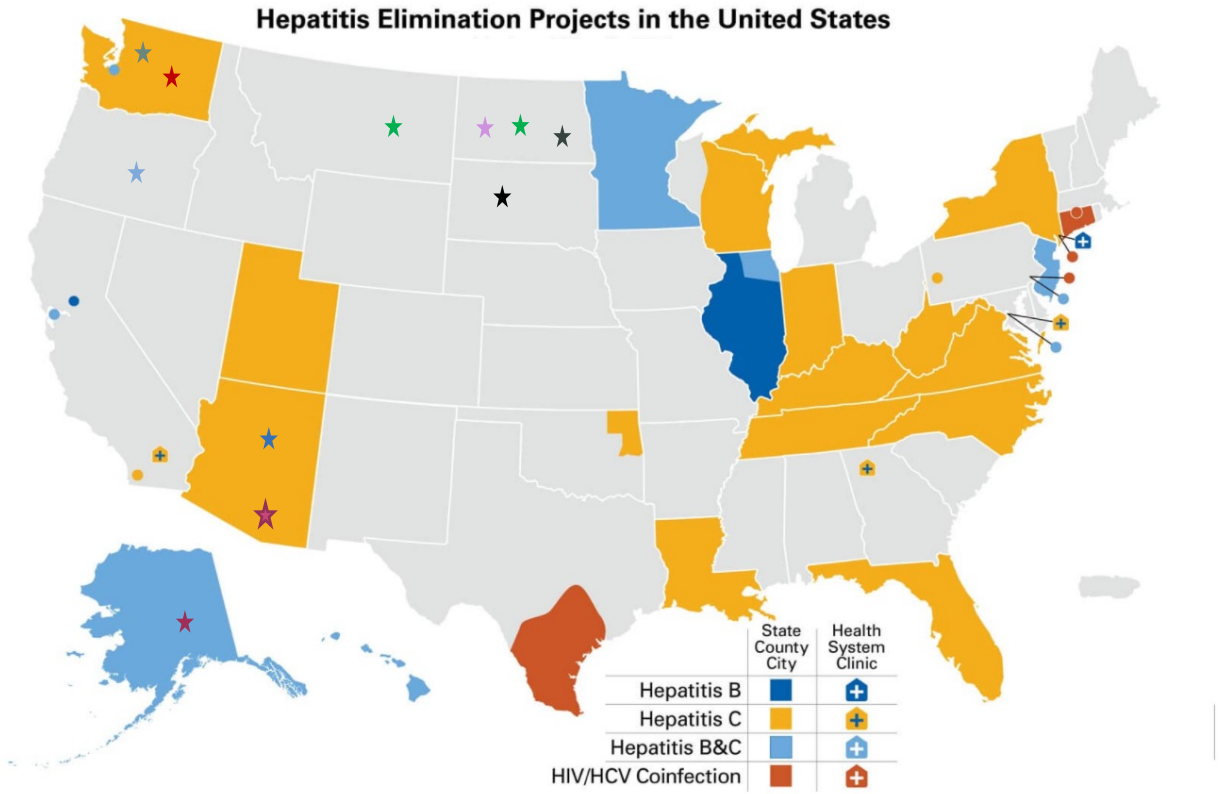




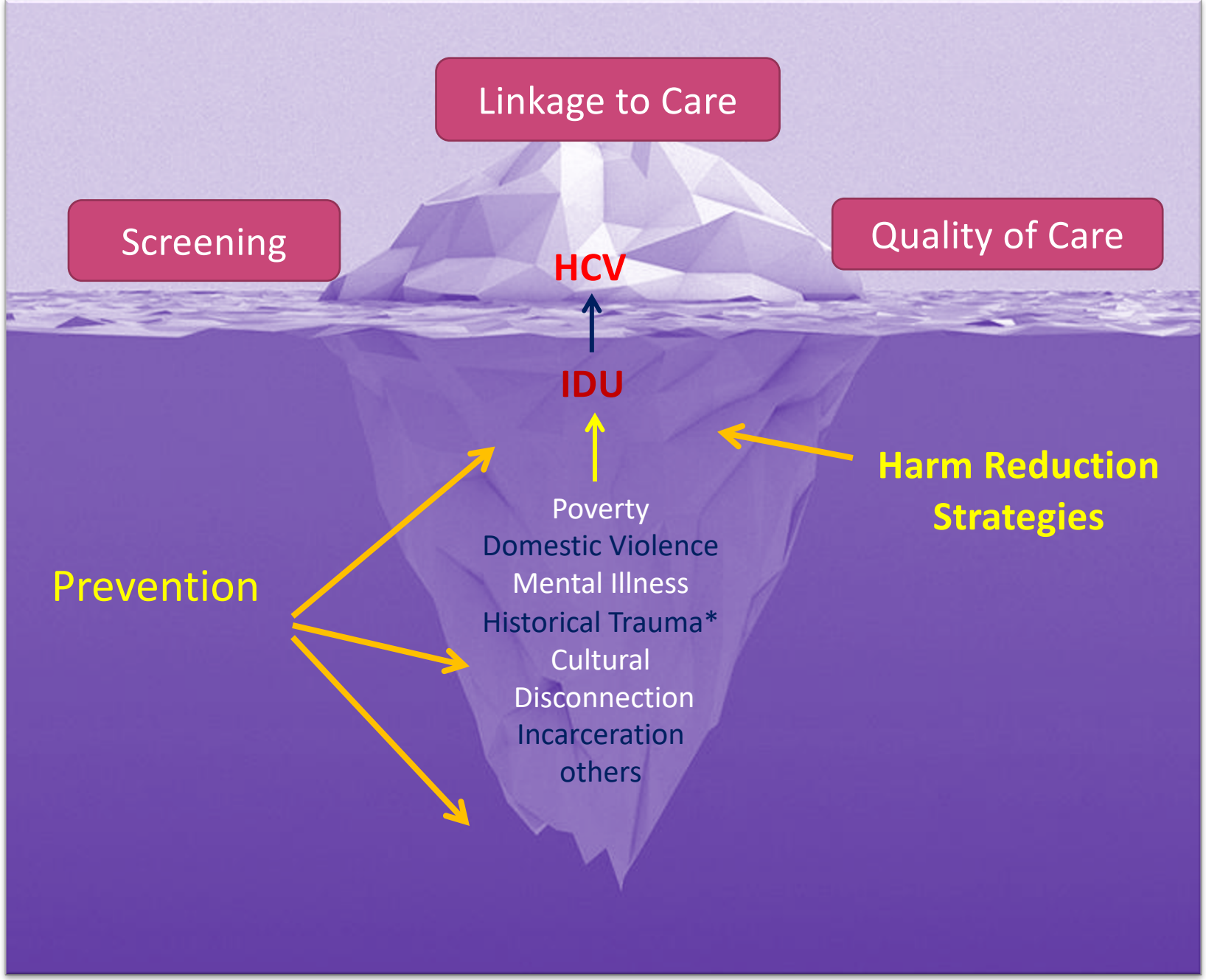
This resource will be updated regularly. If you are part of a new, newly expanded, or established elimination effort and would like to be added to this map, please email Jessica.Deerin@hhs.gov with a description of your project and a link to online information.

HCV ELIMINATION PROJECTS IN THE USA

- Tohono O' odham's
- Rosebud IHS
- Confederated Tribes of Salish and Kootenais
- Crow/Northern Cheyenne's
- Belcourt IHS
- Swinomish Didg^{w}alic
- Salt River Pimas
- Three Affiliated Tribes
- Colville's
- Alaska Native Tribal Health Consortium
- Spirit Lake's



This resource will be updated regularly. If you are part of a new, newly expanded, or established elimination effort and would like to be added to this map, please email Jessica.Deerin@hhs.gov with a description of your project and a link to online information.

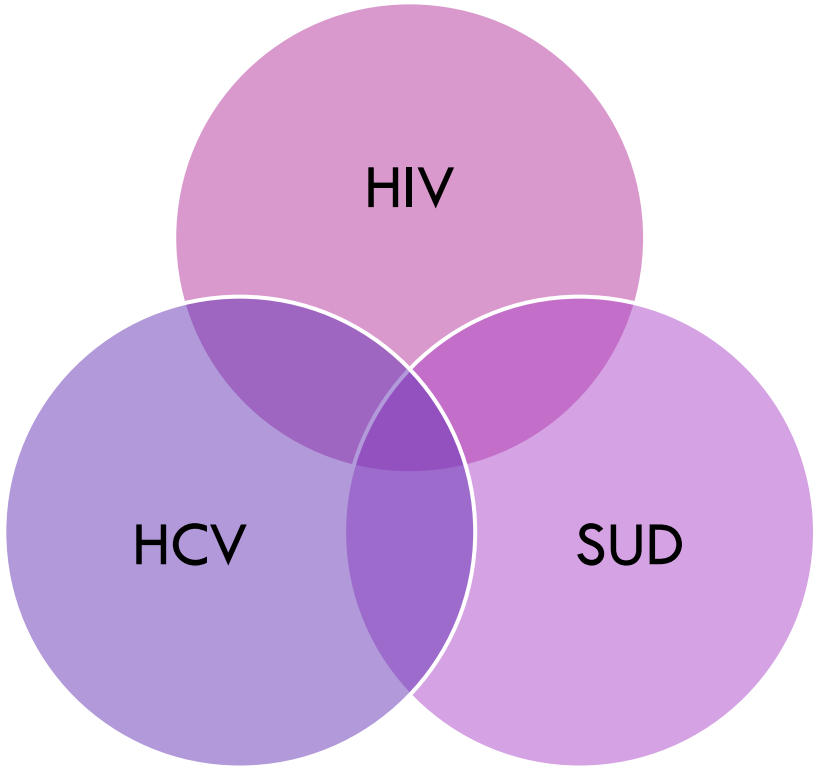


*Maria Yellow Horse Brave Heart Journal of Psychoactive Drugs Vol. 35, Iss. 1, 2003

SYNDEMIC: DEFINITION

- Syndemic is the clustering of two or more epidemics interacting synergistically and contributing, as a result of their interaction, to excess burden of disease in a population

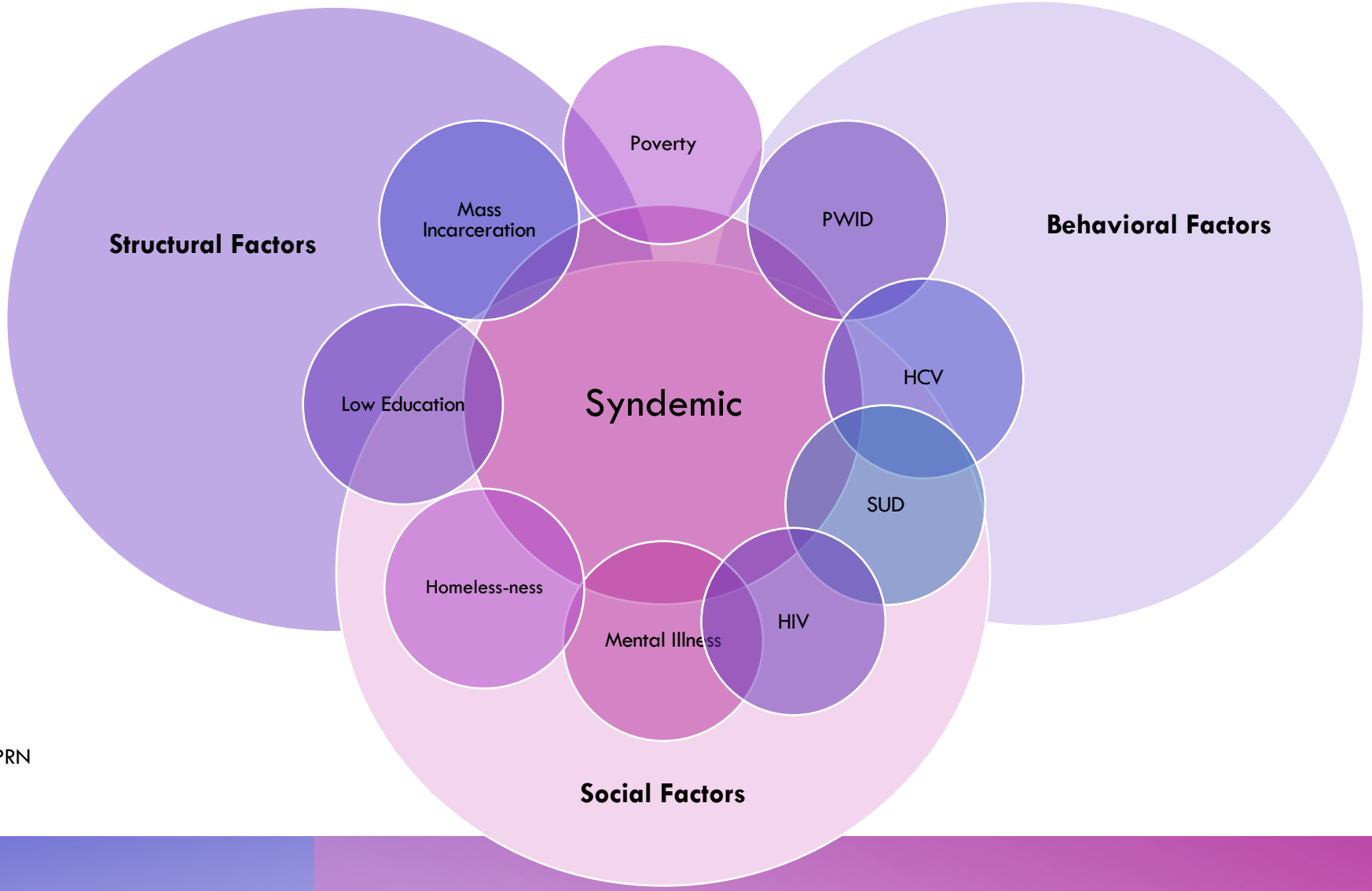
- The three core principles are
  - **Clustering** of two or more conditions in a specific population
  - Their **synergism** in producing adverse outcomes
  - **Precipitation and propagation** by large scale social, cultural, economic and social forces



HIV: Human Immunodeficiency Virus
HCV: Hepatitis C virus
SUD: Substance Use Disorder

Singer, M. and Clair, S. (2003), Syndemics and Public Health: Reconceptualizing Disease in Bio-Social Context. Medical Anthropology Quarterly, 17: 423-441. https://doi.org/10.1525/maq.2003.17.4.423

SYNDEMIC: COMPLEX VIEW



Slide Courtesy of Whitney Essex, APRN

HCV ELIMINATION: DEFINITIONS AND GOALS

Definition:

- Elimination of hepatitis C as a ***public health problem***

Goals:

- **National Viral Hepatitis Action Plan 2017-2020[1]**
  - Decrease in new infections by 60 % by the year 2020
  - Decrease in mortality by 25 % by the year 2020

- **National Academy of Sciences[2]**
  - Decrease the incidence of new infections by 90% by the year 2030
  - Decrease in mortality by 65 % by the year 2030

1. https://www.cdc.gov/hepatitis/hhs-actionplan.htm 2. National Academies of Sciences, Engineering, and Medicine. 2017. ***A National Strategy for the Elimination of Hepatitis B and C: Phase Two Report.*** Washington, DC: The National Academies Press

NATIONAL VIRAL HEPATITIS PROGRESS REPORT

	Baseline 2017 data year	2018 Observed (Annual Target*)	2025 Goal 2023 data year	Status
Reduce estimated† new hepatitis C virus infections by ≥20%	44,700	50,300 (43,083)	35,000	✗
Reduce reported rate‡ of new hepatitis C virus infections among persons who inject drugs¶ by ≥25%	2.3	2.6 (2.2)	1.7	✗
Reduce reported rate‡ of hepatitis C-related deaths by ≥20%	4.13	3.72 (3.94)	3.00	✓
Reduce reported rate‡ of hepatitis C-related deaths among American Indians and Alaska Natives by ≥30%	10.24	9.05 (9.73)	7.17	✓
Reduce reported rate‡ of hepatitis C-related deaths among non-Hispanic Blacks by ≥30%	7.03	6.31 (6.68)	4.92	✓

*Annual targets assume a constant (linear) rate of change from the observed baseline (2017) to the 2025 goal (2023 data year).
†The number of estimated viral hepatitis infections was determined by multiplying the number of reported cases by a factor that adjusted for under-ascertainment and under-reporting (CDC 2018 Surveillance Summary and Klevens, et al, 2014).
‡Per 100,000 U.S. population.
¶Persons aged 18–40 years serve as a proxy for persons who inject drugs.

✓ Met or exceeded current annual target

→ Moving ***toward*** annual target, but annual target was not fully met

✗ Annual target was not met and has not changed or moved ***away*** from annual target

https://www.cdc.gov/hepatitis/policy/pdfs/NationalProgressReport2019.pdf

NATIONAL VIRAL HEPATITIS ACTION PLAN 2025

Goal 1	**Reduce new viral hepatitis infections** • Reduce rates of high-risk drug use associated with new viral hepatitis cases and decrease perinatal viral hepatitis infections • Reduce estimated new HCV infections from 44,700 in 2017 to ≤ 35,000 in 2023 and ≤ 4,400 in 2028
Goal 2	**Reduce viral hepatitis-related morbidity and mortality** • Increase proportion of people with hepatitis C who have cleared hepatitis C virus infection ≥ 35% by 2025 and ≥ 85% by 2030

GOAL 3: REDUCE VIRAL HEPATITIS RELATED DISPARITIES

Increase	**Increase utilization of hepatitis C prevention services among PWID** • Reduce reported rate of new HCV infections among PWID* per 100,000 population from 2.3 in 2017 to ≤ 1.7 in 2023 and ≤ 0.2 in 2028
Increase	**Increase utilization of hepatitis C testing and linkage to care among disproportionately affected racial/ethnic groups** • Reduce reported rate of hepatitis C-related deaths among AI/ANs per 100,000 population from 10.24 in 2017 to ≤ 7.17 in 2023 and ≤ 3.58 in 2028 • Reduce reported rate of hepatitis C-related deaths among non-Hispanic Blacks per 100,000 population from 7.03 in 2017 to ≤ 4.92 in 2023 and ≤ 2.46 in 2028

https://www.cdc.gov/hepatitis/pdfs/DVH-StrategicPlan2020-2025.pdf

GOAL 4: ESTABLISH COMPREHENSIVE NATIONAL VIRAL HEPATITIS SURVEILLANCE FOR PUBLIC HEALTH ACTION

Strengthen	**Strengthen capacity of jurisdictions to accurately report and describe the burden of viral hepatitis in their jurisdiction** • Increase proportion of funded jurisdictions that report all viral hepatitis notifiable conditions to CDC to 90% by 2025 • Increase proportion of funded jurisdictions that meet CDC quality standards for completeness and timeliness to 90% by 2025
Strengthen	**Strengthen capacity of jurisdictions to analyze, describe, and disseminate their viral hepatitis data for public health action** • Increase proportion of funded jurisdictions that have analyzed and disseminated surveillance data for public health action to 90% by 2025 • Increase proportion of all viral hepatitis clusters/outbreaks that are reported to CDC within 30 days to 90% by 2022

https://www.cdc.gov/hepatitis/pdfs/DVH-StrategicPlan2020-2025.pdf

KEY CONCEPTS TO GUIDE HCV ELIMINATION

Decrease the burden of HCV related liver diseases by treating the chronically infected population

- Birth cohort (patients born between 1945-1965/1975*)
- Anyone infected for 20 + years or with multiple liver comorbidities

Decrease new infections by preventing transmission

- **Mainly target the younger population who are PWID**
  - *Treatment as prevention* /MAT/Needle and syringe programs
- Address unsafe medical practices
- Address sexual transmission in MSM

PWID: People Who Inject Drugs
Medication Assisted Treatment
MSM: Men who have Sex with Men

Edlin BR, Winkelstein ER. 2014. Antiviral Research. 110:79-93
Grebely J, Dore GJ. 2014. Antiviral Research. 104:62-72
*Shah H, Bilodeau M, et al. CMAJ June 04, 2018 190 (22) E677-E687

HCV MACRO-ELIMINATION

Launched at a National level

Covers the whole HCV infected population

Main Stakeholder is the government

Resources are widely available

- Screening strategy-Linkage to care-Treatment
- Harm Reduction
- SSP and MAT

Interventions designed by modeling and population-based information

Examples: Country of Georgia, Iceland, Australia etc.

Lazarus JV, Safreed-Harmon K, Thursz MR et al. The Micro-Elimination Approach to Eliminating Hepatitis C: Strategic and Operational Considerations. Seminars in Liver Disease, 2018,38 (3);181-192.

HCV MICRO-ELIMINATION

Concept

Breaking down national goals into smaller goals for individual population segments for which treatment and prevention interventions can be delivered more quickly and efficiently using targeted methods

Criteria

- **Plan in place**
  - To achieve high levels of HCV diagnosis and treatment
- **Defined population**
  - Within a specified time frame
- **Achievable annual targets**
  - Ideally based on mathematical modeling
- **Plan developed by multi-stakeholder process**
- **Progress and outcomes**
  - Monitored
  - Publicly reported

HCV MICRO-ELIMINATION: POPULATIONS TO BE TARGETED

Aboriginal and Indigenous communities
Birth cohorts with high HCV prevalence
Children of HCV Infected mothers
Hemodialysis recipients
HIV/HCV Co-infected individuals
Migrants from high-prevalence Countries
People Who Inject Drugs
People with hemophilia and other inherited blood disorders
Prisoners

Lazarus JV, Safreed-Harmon K, Thursz MR et al. The Micro-Elimination Approach to Eliminating Hepatitis C: Strategic and Operational Considerations. Seminars in Liver Disease, 2018,38 (3);181-192.

HCV MICRO-ELIMINATION: POPULATIONS TO BE TARGETED

Aboriginal and Indigenous communities	**Birth cohorts with high HCV prevalence**
	Children of HCV Infected mothers
	Hemodialysis recipients
	HIV/HCV Co-infected individuals
	People Who Inject Drugs
	People with hemophilia and other inherited blood disorders
	Prisoners

Lazarus JV, Safreed-Harmon K, Thursz MR et al. The Micro-Elimination Approach to Eliminating Hepatitis C: Strategic and Operational Considerations. Seminars in Liver Disease, 2018,38 (3);181-192.

HCV MICRO-ELIMINATION PROGRAM: QUESTIONS YOU SHOULD ASK

What population are you going to target and why?

- What is the HCV prevalence of that population
- What does your cascade of care look like?

Who are your stakeholders?

What are your goals?

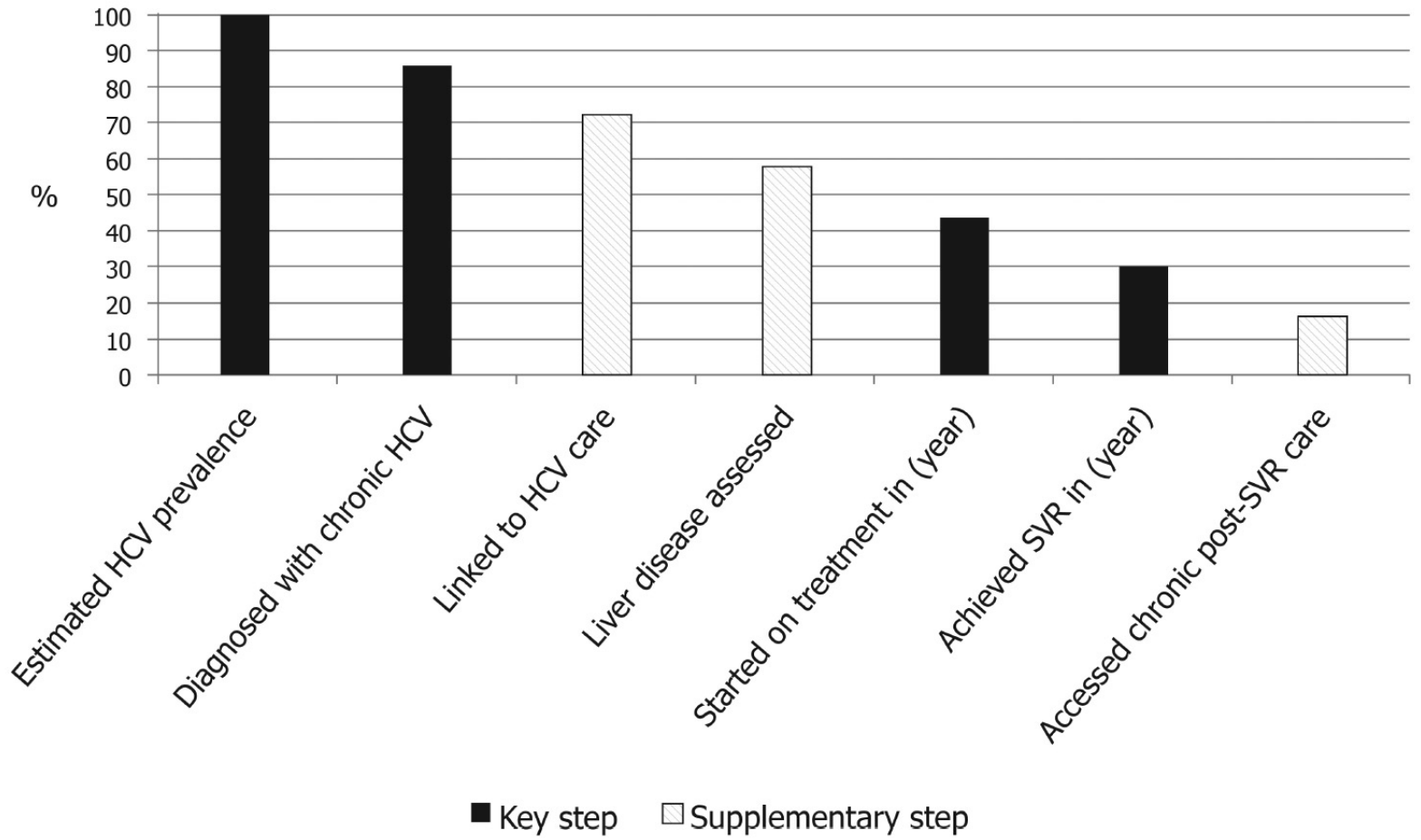
- What are your targets and what is your strategy to achieve them?

What human resources will you have available?

How are you going to get your DAAs for this population?

What will be your harm reduction strategies?

HCV CASCADE OF CARE



Safreed-Harmon K, Blach S, Aleman S, et al. The Consensus Hepatitis C Cascade of Care: Standardized Reporting to Monitor Progress Toward Elimination, *Clinical Infectious Diseases*, Volume 69, Issue 12, 15 December 2019, Pages 2218–2227, https://doi.org/10.1093/cid/ciz714

CHEROKEE NATION HCV ELIMINATION PROGRAM

HCV Elimination Program launched November 2015

- Gilead Foundation Grant to financially support the program
- DAAs obtained through patient assistance programs, Medicaid and private insurers

Goal: ***Eliminate HCV from individuals who accessed the Cherokee Nation Health Services***

Partnerships

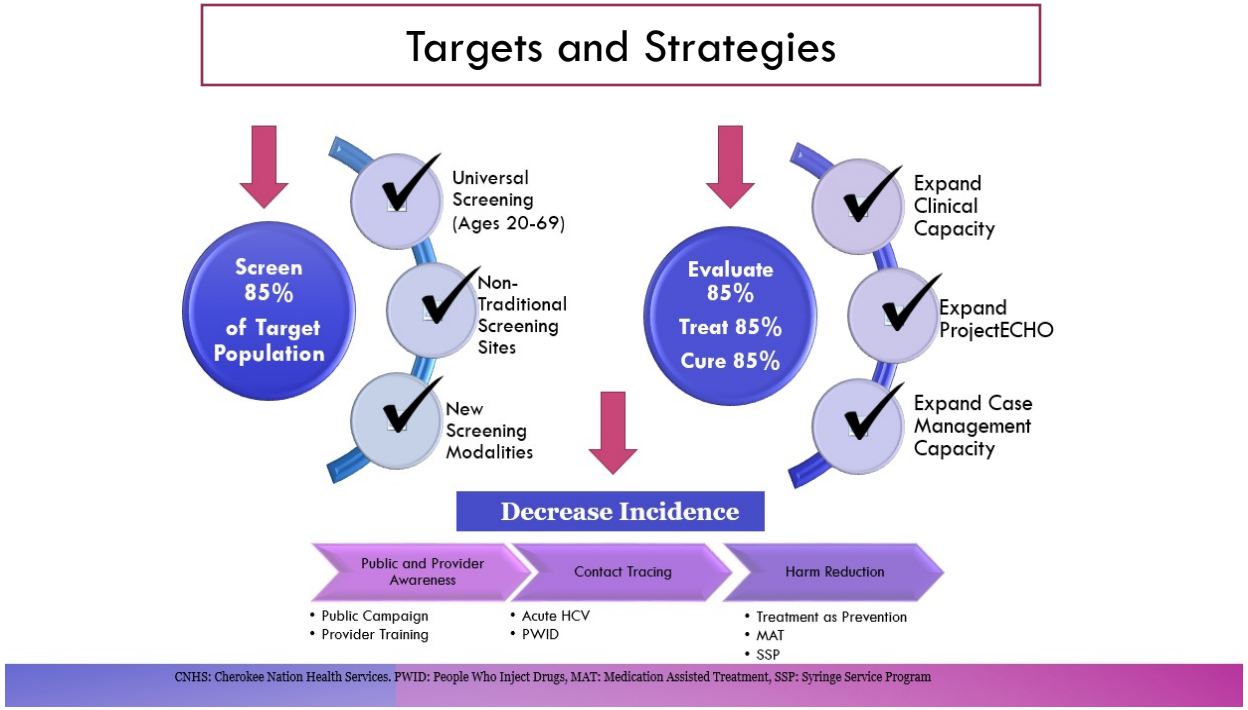
- CDC: Technical assistance, Global Hepatitis Outbreak
- Surveillance Technology (GHOST)
- University of Oklahoma
- University of New Mexico
- Oklahoma State Department of Health
- Cardea

"As Native people and as Cherokee Nation citizens, we must keep striving to eliminate hepatitis C from our population."
Chief Bill John Baker

CNHS HCV ELIMINATION PROGRAM GOALS TARGETS AND STRATEGIES

- **Program Goals**
  - Secure political commitment
  - Expand the HCV screening program
  - Expand HCV clinical capacity
  - Decrease new HCV Infections

- **Program Targets**
  - **Screen 85%** of those who accessed the CNHS
  - **Evaluate 85%** of those who had a detectable HCV RNA by a provider trained in HCV management and treatment
  - **Initiate HCV treatment in 85%** of those individuals evaluated
  - **Document cure in 85%** of those who initiated treatment



CNHS: Cherokee Nation Health Services. PWID: People Who Inject Drugs, MAT: Medication Assisted Treatment, SSP: Syringe Service Program

INDIAN COUNTRY ECHO

HCV Elimination Planning Checklist

(*HCV Elimination Strategy presentation required for course certificate)

☐ Data, Monitoring, and Evaluation

What information is needed (e.g. build cascade of care, positivity rate, percentage of population screened, patient panel)? Who will compile this information? _____

Identified needs? _____

☐ Screening

Think about what settings (e.g. dental, community events, routine visits, age range)? With what staff?

_____

Identified needs? _____

☐ Patient Advocacy/Follow-Up/Outreach

Think about what settings? With what staff (e.g. CHR, Peer specialist, Case Manager)?

_____

Identified needs? _____

☐ Access to HCV Medication

Think about what settings (pharmacy window, nurse visit, MAT clinic, delivery)? With what staff?

_____

Identified needs? _____

☐ SUD tx/MAT

Think about what settings (e.g. OBOT, OTP)? With what staff (Nurse, PH, Pharmacy, Primary Care)?

_____

Identified needs? _____

☐ Harm Reduction

Think about what settings? With what staff (e.g. Primary Care, Behavioral Health, PH, Nursing)?

_____

Identified needs? _____

HCV Elimination Plan Summary

(include identified needs, how to address noted barriers, key stakeholders/champions, short/long term goals and implementation ideas):

_____

_____

_____

_____

_____

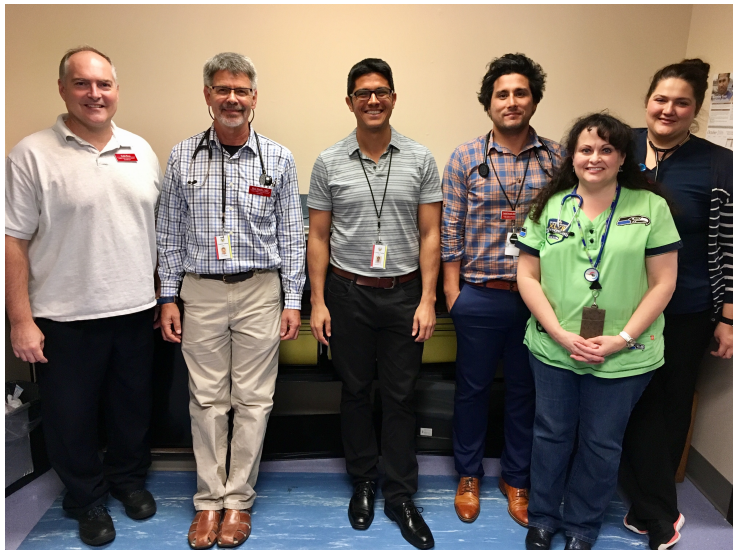
_____

_____

_____

Treating Chronic Hepatitis C at the Lummi Tribal Health Center

"We are proving that hepatitis C is treatable in our communities, by our own providers"



30 **Indian Country dying from a curable disease (Opinion)**

287 shares

The Northwest Portland Area Indian Health Board and other local tribal organizations hosted "American Indian Day Celebration" in downtown Portland last year to raise awareness of the challenges that American Indian people face in this country. *(Thomas Boyd/The Oregonian)*

This Issue | Views 6,275 | Citations 0 | Print | Email

Viewpoint

August 23/30, 2016

The Need to Expand Access to Hepatitis C Virus Drugs in the Indian Health Service

Jessica Leston, MPH[1]; Joe Finkbonner, RPh, MHA[2]

Author Affiliations

JAMA. 2016;316(8):817-818. doi:10.1001/jama.2016.7186

Full Text

The American Indian/Native Alaska population is disproportionately affected by hepatitis C virus (HCV). The most recent national data show American Indian/Alaska Native people with both the highest rate of acute HCV infection and the highest HCV-related mortality rate of any US racial/ethnic group.[1] In 2013, the latest national data available, rates of acute HCV infection were 1.7 per 100 000 American Indian/Alaska Native persons.[1] From 2009 through 2013, their HCV-related mortality rate increased by 23.2%, accounting for 324 deaths in 2013.[1] The American Indian/Alaska Native mortality rate of 12.2 deaths per100 000 population is more than double the national rate of 5.0 per 100 000.[1] Although prevalence data are limited, one national study estimates 120 000 persons living on Indian reservations are positive for the HCV antibody.[2] Another study has